

REPORTS OF BOARD OF TRUSTEES

The following reports, 1-38, were presented by J. James Rohack, MD, Chair:

1. NEW SPECIALTY ORGANIZATION REPRESENTATION IN THE HOUSE OF DELEGATES

HOUSE ACTION: RECOMMENDATION ADOPTED AND REMAINDER OF REPORT FILED

The Board of Trustees and the Specialty and Service Society (SSS) considered the application of the American Academy of Disability Evaluating Physicians for representation in the American Medical Association House of Delegates. The application was first reviewed by the AMA-SSS Credentials Committee and presented to the SSS Assembly for consideration.

The application was considered using criteria developed by the Council on Long Range Planning and Development and adopted by the House (Policy G-600.020, AMA Policy Database). A summary of the guidelines is attached under Exhibit A. Objective guidelines include numbers 1, 3, 4, 5, 6, 7, 8, 9, and 10. The subjective guideline is number 2.

Organizations seeking admission are asked to provide appropriate membership information to the AMA. That information is analyzed to determine AMA membership, as required under criterion 3. A summary of this information is attached to this report as Exhibit B.

In addition, organizations must submit a letter of application in a designated format. This format lists the above-mentioned guidelines followed by the organization's explanation of how it meets each criterion.

Before a society is eligible for admission to the House of Delegates, it must participate in the SSS for three years. The American Academy of Disability Evaluating Physicians was admitted to the SSS in 1994 and has been a member in good standing since.

Review of the materials and discussion during the SSS meeting at the 2004 Interim Meeting indicated that the American Academy of Disability Evaluating Physicians meets the criteria for representation in the House of Delegates.

RECOMMENDATIONS

Therefore, the Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

That the American Academy of Disability Evaluating Physicians be granted representation in the American Medical Association House of Delegates.

APPENDIX

Exhibit A - Summary of Guidelines for Admission to the House

The following guidelines shall be utilized in evaluating specialty society applications for representation in the AMA House of Delegates (new specialty organization applications will be considered only at Annual Meetings of the House of Delegates):

1. The organization must not be in conflict with the Constitution and Bylaws of our AMA with regard to discrimination in membership.

2. The organization must:
 - (a) represent a field of medicine that has recognized scientific validity;
 - (b) not have board certification as its primary focus; and
 - (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
 - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - (b) a specialty organization must demonstrate that it has a minimum of 250 AMA members and that thirty-five percent (35%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that thirty-five percent (35%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit B - A-04 House of Delegates Applicants

Society	American Academy of Disability Evaluating Physicians
1. Organization must not be in conflict with the Constitution and Bylaws of the AMA with regard to discrimination of membership	In compliance
2. Scientifically valid, not primarily focused on board certification	In compliance
3. Meets minimum AMA membership thresholds	In compliance 404/1070 (37.76%)
4. Established longer than 5 years	Founded in 1987
5. Physicians comprise majority of voting membership	In compliance
6. Membership voluntary and society reported members who are current in dues payment, eligible to vote and hold office within their society	In compliance
7. Society is active and holds at least one meeting per year	In compliance
8. Society is national in scope and has members in the majority of states	In compliance
9. Application to HOD supported by official statement from organization's governing body	In compliance
10. US Chapter, if society is international	US-based

**2. FEDERATED AMBULATORY SURGERY ASSOCIATION -
OFFICIAL OBSERVER STATUS IN THE HOUSE OF DELEGATES**

**HOUSE ACTION: RECOMMENDATION ADOPTED AND
REMAINDER OF REPORT FILED**

The Federated Ambulatory Surgery Association has requested Official Observer status in the House of Delegates. The American Medical Association Bylaws state the following regarding Official Observers (B-2.15 and B-2.151, AMA Policy Database):

2.15 Official Observer.

National organizations may apply to the Board of Trustees of the American Medical Association for official observer status in the AMA House of Delegates. Applicants must demonstrate compliance with guidelines for official observers adopted by the House of Delegates, and the Board of Trustees shall make a recommendation to the House of Delegates concerning the application. The House of Delegates will make the final determination on the conferring of official observer status.

2.151 Rights and Privileges. Organizations with official observer status are invited to send one representative to observe the actions of the House of Delegates at all meetings of the AMA House of Delegates. Official observers have the right to speak and debate on the floor of the House upon invitation from the Speaker. Official observers do not have the right to introduce business, introduce an amendment, make a motion, or vote.

In addition, the Board of Trustees uses the following general guidelines as a basis for considering the eligibility of organizations to be recommended to receive an invitation to send Official Observers to meetings of the AMA House of Delegates:

1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both.
2. The organization should be national in scope and have similar goals and concerns about health care issues.
3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the House of Delegates.
4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

This report details the Board's review of the FASA regarding the above guidelines. FASA is the umbrella organization for ambulatory surgery centers (ASCs), and represents single- and multi-specialty ASCs throughout the nation. It was founded in 1974, four years after the first ASC opened in Phoenix, Arizona, and is the leading organization for ASCs in the US. FASA's membership consists of more than 1400 ASCs. Physicians founded the organization and continue to play a major role in its activities--its current and immediate past presidents are physicians, as have been 9 of the 13 presidents in FASA's history.

FASA and the AMA work together on a regular basis, sharing information and at times working in concert to achieve advocacy goals. There is excellent interchange between the staffs of the two organizations, as well as between FASA and state and specialty societies. FASA is a national organization, and was one of the cofounders of the Accreditation Association for Ambulatory Health Care, which is an Official Observer to the House.

FASA can add a unique perspective and bring expertise in the area of ambulatory surgery, particularly since ASCs are a distinct segment of our health care delivery system. Finally, FASA is a national non-profit organization representing facilities and their professionals; it has no religious, social, cultural, or economic interests that would serve to disqualify it from Official Observer status.

One prominent example of the compatibility between the AMA and FASA is the advocacy effort by both organizations in response to the Centers for Medicare and Medicaid Services' November 2004 ambulatory surgery center coverage update. The ASC coverage update would remove 100 treatments from those covered by Medicare. At the 2004 Interim Meeting, the AMA adopted Resolution 837, "Opposition to CMS Elimination of ASC Payments," which called on the AMA to advocate against the proposed rule; in January, the AMA recommended that CMS drop the deletion proposal altogether.

RECOMMENDATION

The Board of Trustees has reviewed extensive materials provided by FASA, and believes that the group would be a welcome addition to the House's deliberations. Therefore, the Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

That our American Medical Association grant the Federated Ambulatory Surgery Association Official Observer Status in the House of Delegates.

3. 2004 GRANTS AND DONATIONS

HOUSE ACTION: FILED

In response to Resolution 612 (A-99), attached is an informational financial report which details all grants or donations received by the American Medical Association during 2004.

AMA GRANTS AND DONATIONS FOR THE YEAR ENDING DECEMBER 31, 2004

Funding Institution	Project	Amounts in Thousands Funding
<u>Government Funding:</u>		
Agency for Healthcare Research and Quality	Patient Preferences For Disclosure: A National Survey	\$ 48
Center for Disease Control	Disaster Life Support Program with University of Georgia	85
Department of Health and Human Services	Diabetes Alliance	5
Department of Health and Human Services	Partnership for Healthcare Research and Quality	275
Maternal and Child Health Bureau	Partnership in Program Planning for Adolescent Health	126
National Highway Transportation Safety Administration	Elder Driver's Guide	65
Total Government Grants		604
<u>Private Foundations:</u>		
World Medical Association	First National Congress for Public Health Readiness	62
AMA Foundation	Obesity Workshop	5
AMA Foundation	International Public Health Contribution Award	75
AMA Foundation	Health Literacy Program - Train the Trainer	65
AMA Foundation	Science News Media Briefings - Epilepsy	76
Robert Wood Johnson Foundation	Development of Kit on Adult Obesity	36
Robert Wood Johnson Foundation	National Program Office on Tobacco - Smokeless States Program	447
Robert Wood Johnson Foundation	National Program Office to Reduce Underage Drinking Through Coalitions	685
Robert Wood Johnson Foundation	National Program Office to Reduce High Risk Drinking Among College Students	578
Robert Wood Johnson Foundation	Smokeless States Communications Grant	41
Robert Wood Johnson Foundation	Physician Forum on Disparities in Health Care	82
Total Private Foundations		2,152
<u>University Contributors:</u>		
Temple University	Physician Syringe Prescription Survey	30
Total University Funding		30
<u>Other Non-Profit Contributors:</u>		
American College of Physicians	Diabetes Alliance	2
American Academy of Family Physicians	Diabetes Alliance	2
American Academy of Pediatrics	National Advisory Council On Family Violence	3
The CNA Corporation	Diabetes Alliance	4
American Osteopathic Association	Disaster Preparedness Program	5
Total Other Non-Profit Funding		16
<u>Industry Supported Educational Grants:</u>		
Pfizer	Disparities Speakers Kit	100
Procter & Gamble	Health Education Products - Osteoporosis	200
Eli Lilly & Company	Depression in Primary Care CME & Patient Education Program	235
Johnson & Johnson	Nathan Davis Award	103
Pfizer	Nathan Davis Award	50
Merck & Company Inc.	Nathan Davis Award	50
Purdue Pharma	Nathan Davis Award	50

Industry Supported Educational Grants, cont.:

Johnson & Johnson	Science News Media Briefings - Patient Compliance	160
Allergan	Science News Media Briefings - Neuromuscular Diseases	30
Merck & Company Inc.	National Conference - Continuing Medical Education	5
Bayer	National Conference - Continuing Medical Education	5
Procter & Gamble	National Conference - Continuing Medical Education	3
Pfizer	National Conference - Continuing Medical Education	15
Cephalon, Inc.	Science Reporting Conference	75
Total Industry Supported Educational Grants		<u>1,081</u>
	Total Grants & Donations	<u>\$3,883</u>

4. UPDATE ON CORPORATE RELATIONSHIPS**HOUSE ACTION: FILED****PURPOSE**

The purpose of this informational report is to update the House of Delegates on the results of the Year 2004 Corporate Review process from January 1 through December 31, 2004, as mandated in BOT Report-20-A-97.

BACKGROUND

At the 2002 Annual Meeting, the American Medical Association House of Delegates approved revised principles to govern the AMA's corporate relationships. These "Guidelines for American Medical Association Corporate Relationships" were incorporated into the corporate review process. AMA managers are responsible for reviewing all projects to make sure that they are in keeping with these guidelines. Corporate activities that lend the AMA name or logo to a company, non-Federation association, or foundation, or include commercial support, must undergo review and recommendations by the Corporate Review Team.

The Corporate Review Team evaluates each project with the following criteria:

- Type, purpose, and duration of the activity;
- AMA objective the activity serves;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA logo;
- Conflict with AMA Corporate Guidelines;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement; and
- Status of single and multiple supporters.

Chaired by the Senior Vice President, Governance and Operations, the Corporate Review Team includes vice presidents and senior managers from the following areas: Ethics Standards; Business Products; Advocacy; Corporate Law; Science; Finance; Membership; Communications; and Publishing. It meets each month (see Appendix A).

The AMA Board of Trustees is informed of all corporate arrangements. The Board conducts an in-depth random audit of approximately 10 CRT-reviewed projects on an annual basis. In addition, the Executive Committee of the Board reviews and must approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.
- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Any other activity upon request of a dissenting member of the Corporate Review Team.
- Any other activity upon request of the Corporate Review Team.

Executive Committee decisions are then confirmed by the full BOT.

YEAR 2004 RESULTS

From January 1 through December 31, 2004, 59 new activities were reviewed; 49 were approved, ten were initially reviewed and returned for further development due to incomplete information. Of the approved projects, 24 were conferences/media briefings/events; 15 were education/information or content materials; three were member service provider programs; two were business arrangements including a book program and partnership; and five were "other" projects.

CONCLUSION

The Board of Trustees believes that the corporate review process as outlined in Appendix A continues to be successfully integrated into the AMA's organizational culture and provides an opportunity for cross-functional interchange. The ongoing challenge is to balance the assessment of risk while nurturing an environment where creative programs are sponsored.

APPENDIX A - CORPORATE REVIEW PROCESS OVERVIEW

The AMA Board of Trustees is informed of all corporate arrangements. The Board conducts an in-depth random audit of approximately 10 CRT-reviewed projects on an annual basis. The Corporate Review Team reviews and makes recommendations regarding the following types of activities:

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to ACCME Standards and Essentials.
- Independent and company-sponsored foundation supported projects.
- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks; examples are consumer books and physician-oriented *Guides to the Evaluation of Permanent Impairment*. This does not include database licensing.)
- Member service provider programs such as new AMA Solutions or insurance programs, and member benefits.
- Third-party relationships such as joint ventures, business partnerships, or co-branding.
- Non-profit association collaborations outside of the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.
- Collaboration with academic institutions only if there is corporate sponsorship.
- AMA product provider programs where the AMA sells third parties' non-publication products in the physician catalog.
- Vendor requests for usage of AMA name beyond a client listing.

For the above-specified activities, if the CRT recommends approval, the project proceeds. These CRT recommendations are updated quarterly and summarized annually for information to the Executive Committee.

In addition, the Executive Committee of the AMA BOT reviews and must approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.
- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Upon request of a dissenting member of the Corporate Review Team.
- Any other activity upon request of the Corporate Review Team.

Executive Committee decisions are then confirmed by the full Board of Trustees.

APPENDIX B - SUMMARY OF CORPORATE REVIEW RECOMMENDATIONS - ANNUAL REPORT 2004

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Recommended Approval Date</u>
Conferences/Media Briefings/Events			
1100-0405	Employee Health and Fitness Day - American Medical Association Health and Fitness Day to promote a healthy and fit lifestyle.	John Buck Management Company	04/21/2004
1101-0042	AMA Support of JCR Symposium Entitled "Health Care at the Crossroads: Organ Donation in the 21st Century." - JCR symposium to focus on influences contributing to gap between supply and demand for organ donations, strategies to narrow the organ donation gap.	American Dental Association American College of Physicians Association of Organ Procurement Organizations National Kidney Foundation North American Transplant Coordination Organization American College of Surgeons	02/20/2004
1101-0048	Institute for Quality in Laboratory Medicine - A high level 2004 strategic meeting of partnering organizations to set direction for formation of new Institute for Quality in Laboratory Medicine.	American Osteopathic Association National Quality Forum American Society for Clinical Pathology College of American Pathologists DHHS-Lead Organization CDC-Lead Organization	07/21/2004
1101-0049	JCAHO Conference Support - Patient Safety/Nursing Staffing & Leadership - JCAHO is planning to advance the public policy initiative on Nurse staffing.	JCAHO	07/21/2004
1101-0052	JCAHO National Summit - Medical Abbreviations - To address problems arising from the misuse and misinterpretation of abbreviations used in health care. AMA to co-convene.	JCAHO	09/21/2004
1101-0053	JCAHO Medical Liability Reform: A Prescription for Patient Safety...New Solutions to an Old Dilemma - Symposium to address the legislative and systems-based solutions to reduced medical error, improve health care quality, and provide optimal patient care.	JCAHO	09/22/2004
1101-0172	NPSF Congress Co-Convenor Request - To co-convene 7th Annual NPSF Patient Safety Congress.	NPSF Congress	11/17/2004

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Recommended Approval Date</u>
Conferences/Media Briefings/Events, cont.			
1104-0151	E-Powered Patients' Symposium - Collaboration between the Institute for Ethics at the AMA and the Foundation for Accountability (FACCT) to conduct a symposium for physician thought leaders in the ethical and professional implications of tracking patient medical histories online.	The Foundation for Accountability (FACCT)	04/21/2004
2207-0230	E-Health Initiative Health IT Summit - AMA to co-sponsor an educational conference sponsored by the E-Health Initiative to address the policy and practical aspects of implementing health information technology.	E-Health Initiative	08/26/2004
2207-0233	AMA Sponsorship of Congressional Briefing on the Public Health Prevention of Child Sexual Abuse Developed by Stop It Now - To sponsor, along with American Association of Public Health, congressional briefing on stopping child sexual abuse with StopItNow.	American Public Health Association Stop It Now	04/27/2004
2207-0234	CMS Town Hall Meetings on Hospital Quality - Local "Town Hall" listening session sponsored by members of the National Voluntary Hospital Quality Initiative.	Centers for Medicare and Medicaid Services American Hospital Association Federation of American Hospitals AFL-CIO AARP AAMC National Association of Children's Hospitals Related Institutions (NACHRI) Consumer-Purchaser Disclosure Project National Partnership for Women & Families Consumers Union	04/27/2004
3301-0127	Workgroup for Electronic Data Interchange (WEDI) 2004 Fall Conference - The Workgroup for Electronic Data Interchange (WEDI) is a not-for-profit organization formally named in the Health Insurance Portability and Accountability Act (HIPAA) as consultant to the Secretary of the Department of Health and Human Services to address standards for electronic transactions and other administrative simplification issues. WEDI requested the AMA's support and logo on conference materials along with The American Hospital Association and the Blue Cross Blue Shield Association.	Workgroup for Electronic Data Interchange American Hospital Association Blue Cross/Blue Shield	10/20/2004

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Recommended Approval Date</u>
Conferences/Media Briefings/Events, cont.			
4401-0131	AMA Participation in National Minority Health Month (NMHM) - AMA to partner in the National Minority Health Month (NMHM) 2004 National Summit on Racial Health Disparities Summit.	National Minority Mental Health Foundation Disease Management Association of America Alliance of Minority Medical Associations Department of Health & Human Services	03/17/2004
5503-0045	AMA Technology Summit - To provide members and office staff appropriate tools to select and implement a full functioning EMR.	Coker Group	08/26/2004
6601-0301	AMA-MSS Research Poster Award - The Medical Student Section (MSS) Governing Council to offer Second Annual MSS Poster award at the MMS Interim Meeting in Atlanta in December 2004. Award presented in association with educational grant from the Pfizer Medical Humanities Initiative.	Pfizer	09/22/2004
6601-0301	AMA/JCR/JCAHO Jointly Sponsored Quarterly Web-Based Audio Conference - Audio education conferences for medical staffs and others.	Joint Commission on Accreditation of Healthcare Organizations Joint Commission Resources	02/20/2004
6602-0011	Pfizer Funding of 2005 Excellence in Medicine Award.	Pfizer	12/15/2004
6602-0012	Pfizer Funding of 2005 Minority Scholars Fund.	Pfizer	12/15/2004
6602-0013	AMA Foundation Annual Meeting Celebration - 2004 - To educate AMA members, generate contributions for the Foundation and celebrate the 100th Anniversary of the Council on Medical Education.	Novo Nordisk Pharmaceuticals, Inc. Northern Trust Bank	06/07/2004
6602-0017	Epilepsy Media Briefing - To raise awareness of the media and public regarding developments in epilepsy and the new guidelines.	GlaxoSmithKline	04/12/2004
6602-0018	Adult and Child Attention Deficit Disorder Media Briefing - To raise awareness of the media and public regarding developments in adult and child attention deficit disorder.	Shire Pharmaceuticals	04/12/2004
6602-0019	Science Reporters Conference - The American Medical Association sponsors this annual two-day conference for medical journalists. Featuring ground breaking study findings and pioneering medical research.	Merck, Co., Inc. Aventis GlaxoSmithKline Yamanouchi Pharma	09/13/2004

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Recommended Approval Date</u>
Conferences/Media Briefings/Events, cont.			
6602-0020	HIV/AIDS Medial Briefing - To raise awareness of the media and public regarding the developments in HIV/AIDS.	Boehringer Ingelheim Corp	12/17/2004
6602-0021	2005 Pain Management Media Briefing - To raise awareness of the media and thus the public regarding the developments in each me briefing's topic.	Purdue Pharma L.P.	12/20/2004
Educational/Informational/Content Development			
1100-0189	AMA Medication Counseling Guidelines/NCPIE - To inform and educate physicians about counseling their patients about prescribed medications.	NCPIE	06/30/2004
1100-0191	ISMP's Medication Safety Self-Assessment - Letter of support for the Institute for Safe Medication Practices (ISMP), the American Hospital Association (AHA), and the Health Research and Educational Trust (HRET), ISMP's Medication Safety Self-Assessment for Hospitals.	Institute for Safe Medication Practices American Hospital Association Health Research and Educational Trust Commonwealth Fund	03/17/2004
1101-0040	Roadmaps for Clinical Practice - Immunization Guide - To produce Immunization Roadmap Guide which include individual booklets on Improving Immunization: Addressing Racial and Ethnic Disparities in Adult, Adolescent and Pediatric Patients.	Merck Co., Inc. GlaxoSmithKline Aventis Pasteur	02/20/2004
1101-0050	AMA/USHMM Educational Outreach Program - Following a CEJA preview of the United States Holocaust Memorial Museum (USHMM) exhibit entitled "Deadly Medicine: Creating the Master Race" in April, 2004, the USHMM Center for Advanced Holocaust Studies University Programs Division and the AMA Institute for Ethics are collaborating on a lecture series based on the exhibition. There are potentially eight programs to be scheduled at various medical schools in the United States.	United States Holocaust Memorial Museum	07/21/2004
1101-0056	AMA-Progeny Family History Drawing Program - Family history drawing program with Progeny Software for AMA Web for physicians and patients.	Progeny Software, LLC	10/20/2004
1101-0057	CME Program on Adult Obesity - AHRQ, working through Discovery Health, is producing a CME program (through CDC) on DVD for physicians free of charge.	Discovery Health AHRQ AAFP American Heart Association	11/17/2004

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Recommended Approval Date</u>
	Educational/Informational/Content Development, cont.		
1102-0019	Performance Measures Development for Chronic Obstructive Pulmonary Disease - For development of the COPD measures.	Delmarva Foundation, Inc.	10/20/2004
1102-0023	AMA/IHI "Campaign to Save 100,000 Lives" - Advance quality of healthcare by engaging providers across the nation in an urgent drive to enhance performance; to support providers as they implement proven improvement interventions.	Institute for Healthcare Improvements	12/05/2004
1103-0002	AMA Carnegie Foundation Collaboration - Under this collaborative arrangement, the AMA and the Carnegie Foundation for the Advancement of Teaching will combine resources to examine the current state of medical education, both at the undergraduate and graduate level.	Carnegie Foundation	01/14//2004
1103-0029	Influenza Outreach Program - To facilitate AMA participation in an educational program for healthcare professionals and public to improve the continuum of care in influenza disease.	Becton Dickinson	10/10/2004
1104-0148	Ethical Force Program Funded by Commonwealth Fund - Ethical Force Program Patient - Centered Communications Initiative.	Commonwealth Fund	11/17/2004
1104-0149	American Bar Association - AMA Professional Standards Educational Collaborative - ABA's Standing Committee on Professionalism and AMA Institute for Ethics to develop CBA-TV Cable Access show on professionalism and professional standards.	American Bar Association	07/21/2004
1104-0152	AMA-Health Research and Educational Trust Collaboration - The Health Research and Educational Trust (HRET) will work with the Institute for Ethics at the AMA to support their Ethical Force Program's initiative on Patient Centered Communication.	Health Research and Education Trust	03/17/2004
5502-0042	Patient-INFORM.org - patient-INFORM provides patients and caregivers online access to reliable research about diagnosis and treatment of diseases.	American Heart Association American Diabetes Association American Cancer Society	11/17/2004
6601-0299	American Association of Medical Assistants - Feature AMA quote in their brochure.	American Association of Medical Assistants	05/06/2004

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Recommended Approval Date</u>
Business Arrangements			
2207-0232	Cigna Settlement/MCAG Proposal - Provide physicians an avenue to quickly and efficiently submit claims to CIGNA for retrospective relief associated with the settlement.	MCAG	07/28/2004
5504-0060	A Piece of My Mind - To expand distribution channel for previously published book.	John Wiley & Sons	09/22/2004
Member Service Providers			
4402-0306	Senior Physician Travel - To provide a travel membership benefit for senior physicians.	Intrav	06/30/2004
5505-0014	AMA Insurance Agency Disability Insurance - To provide proprietary group disability plan through AMA Insurance Agency.	Markman and Associates Professional Services Employer's Trust Professional Benefit Consultants	08/11/2004
5505-0015	AMA Insurance Agency Sponsored Health Savings Accounts - Lumenous - To provide physicians with outlet for Health Savings Accounts and High-Deductible Health Plans through an AMA - Sponsored Program.	Affinity Financial Corporation Lumenos, Inc. MSAver Resources, LLC	09/22/2004
Other			
1100-0190	Dr. Palmisano Comment on Cover Wrap of John Goodman book, <i>Lives At Risk: Single-Payer National Health Insurance Around the World</i>	N/A	05/28/2004
1101-0041	Possible AMA "Sponsorship" of Massachusetts Medical Society's Continuity of Care Record (CCR) Project - The MSS sought AMA sponsorship to promote the dissemination of the CCR as a standard for approval by ASTM International. The purpose of the CCR is to provide doctors with standard document and a toolset to communicate critical medical information.	ASTM International	02/25/2004
1101-0044	Integrity Proposal for the USAN Program - New Integrity data portal.	Prous Science	05/11/2004
1102-0020	Quality Healthcare Alliance - The Hawaii Quality Healthcare Alliance (QHA) is a statewide, not for profit, quality improvement initiative involving multiple stakeholders in Hawaii. A primary goal of the QHA is to foster continuous quality improvement through the adoption of physician performance measures form the AMA-led Physician Consortium for Performance Improvement (the Consortium) and their integration into technology and electronic medical records.	Hawaii Medical Association Hawaii Business Health Council Hawaii Independent Physicians Association e-Health Foundation Markle Foundation	03/16/2004

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Recommended Approval Date</u>
Other, cont.			
5503-0068	AMA Forrester Technology Research - Practice Management IT research resulting in new products and services with members-only and member favoring benefits.	Forrester Research	02/20/2004

5. PAY-FOR-PERFORMANCE PRINCIPLES AND GUIDELINES

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTIONS 217, 218, AND 219 AND REMAINDER OF REPORT FILED

BACKGROUND

The latest managed care phenomenon has been the proliferation of physician and hospital incentive programs, particularly those commonly referred to as physician “Pay-for-Performance” (PFP) programs. These physician PFP programs vary greatly in their design and implementation but most are designed to provide some type of financial incentive to physicians who meet, or show improvement in achieving, certain standards or performance measures that are established by the program’s sponsoring health plan or employer group. When these PFP programs are patient-centric and based on evidence-based quality measures, they can be a positive force in the health care system; however, when these programs emphasize cost savings over quality, or are poorly implemented relying on flawed data, they can serve to destroy the patient/physician relationship and negatively affect the quality of care.

In response to this sudden growth of PFP programs, the American Medical Association’s Chair of the Board, J. James Rohack, MD, and Executive Vice President and CEO, Michael D. Maves, MD, MBA, appointed a Staff Task Force in October 2004 to prepare a white paper on physician PFP. The Board of Trustees approved this white paper at its December meeting and distributed it to the House of Delegates at the 2004 Interim Meeting. The paper was also distributed to the Federation of Medicine and is available to AMA members on the AMA web site.

The Speaker of the House of Delegates, Nancy H. Nielsen, MD, PhD, also requested staff to assemble an educational program on PFP for the 2004 Interim Meeting. Dr. Nielsen moderated this two-hour program, “Pay-for-Performance: The Good, The Bad, and The Ugly,” that was attended by more than 500 members of the House of Delegates and Federation staff. The speakers included: Ronald P. Bangasser, MD, Past President, California Medical Association, who provided the overview of PFP; Jennifer Daley, Senior Vice President, Clinical Quality & Chief Medical Officer, Tenant Health care, who described the data problems that can exist with PFP programs; Sean R. Tunis, MD, Chief Clinical Officer, Centers for Medicare and Medicaid Services, who described the government’s involvement in PFP; and Michael Cropp, MD, President and CEO, Independent Health, who described his organization’s involvement in implementing successful PFP programs. This session was videotaped and is now accessible on the AMA web site for viewing by AMA members only. Physicians who watch this video have been approved by the AMA to receive two category 1 credits towards the AMA Physicians Recognition Award.

Following the successful release of the white paper and the educational program on PFP, Dr. Rohack appointed a Board/Council Task Force on Pay-for-Performance. The AMA did not have any policy on PFP, and this Task Force was charged with creating a document that could serve as the basis for AMA testimony when asked to comment about PFP. This Task Force was composed of five Board members: Drs. John H. Armstrong, Chair; Herman I. Abromowitz; Peter W. Carmel; Cyril M. Hetsko; and, William G. Plested, III. AMA Council representatives to the Task Force included: Drs. Susan Rudd Bailey, Council on Medical Education; Ronald P. Bangasser, Council on Medical Service; Philip E. McCarthy, Council on Legislation; John W. McMahon, Sr., Council on Ethical and Judicial Affairs; Melvyn L. Sterling, Council on Scientific Affairs; and, Robert M. Wah, Council on Long Range Planning and Development. Additionally, Drs. John C. Nelson and Nancy H. Nielsen participated in the Task Force’s deliberations.

The Task Force met frequently via conference call and used e-mail extensively to continue communications between meetings. The Task Force produced two documents.

The *Principles for Pay-for-Performance* is an overarching document that sets five general principles for the operation of PFP programs:

- Ensure quality of care;
- Foster the patient/physician relationship;
- Offer voluntary physician participation;
- Use accurate and fair reporting; and
- Provide fair and equitable program incentives.

The *Guidelines for Pay-for-Performance* supports the five principles and provides a more detailed description of what a fair and ethical PFP program should look like.

Before the *Principles* and *Guidelines* documents were given to the Board of Trustees, the Task Force shared their draft documents with the six Councils, as well as the Organized Medical Staff Section, the Section on Medical Schools, and the Advisory Committee on Group Practice Physicians. The Task Force received and incorporated numerous suggestions from these groups into the two documents and submitted the final drafts to the Board of Trustees at its February 23rd meeting. The Board of Trustees approved both the *Principles* and *Guidelines* documents as the position of the AMA regarding PFP.

The *Principles* and *Guidelines* were released to the public via a press release on March 2. The *Principles* and *Guidelines* were widely disseminated throughout the Federation and have been well reported by the general and trade press. These two documents have also been shared with members of Congress and various regulatory agencies and have served as the basis for AMA testimony on PFP. These two documents, as well as the white paper and the video presentation, are located on the AMA web site at www.ama-assn.org/go/pfp.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

Recommendation 1

That the following *Principles for Pay-for-Performance* and *Guidelines for Pay-for-Performance* be adopted as the official policy of the American Medical Association.

Principles for Pay-for-Performance Programs

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. *Ensure quality of care* - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
2. *Foster the patient/physician relationship* - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
3. *Offer voluntary physician participation* - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

4. *Use accurate data and fair reporting* - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.
5. *Provide fair and equitable program incentives* - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

Guidelines for Pay-for-Performance Programs

Safe, effective, and affordable health care for all Americans is the American Medical Association's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's *Principles for Pay-for-Performance Programs* and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality of care measures must be the primary measures used in any program.
 1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
 2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
 3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
 4. Performance measures should be scored against both absolute values and relative improvement in those values.
 5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.
 6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
 7. Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care.
 1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socioeconomic groups, as well as those with specific medical conditions, or the physicians who serve these patients.

2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient de-selection.
 - Programs must recognize outcome limitations caused by patient non-compliance, and sponsors of PFP programs should attempt to minimize non-compliance through plan design.

Physician Participation

- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice. Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
 1. Programs should provide physicians with tools to facilitate participation.
 2. Programs should be designed to minimize financial and technological barriers to physician participation.
- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
 1. Programs should use accurate administrative data and data abstracted from medical records.
 2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
 3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
 1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
 2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.
- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.
- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not financially penalize physicians based on factors outside of the physician's control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.

Recommendation 2

That our AMA oppose private payer, Congressional, or Centers for Medicare and Medicaid Services Pay-for-Performance initiatives if they do not meet the AMA's *Principles and Guidelines for Pay-for-Performance*.

6. PHYSICIAN-TO-PHYSICIAN COMMUNICATION

HOUSE ACTION: RECOMMENDATION ADOPTED AND REMAINDER OF REPORT FILED

INTRODUCTION

This report provides information on activities undertaken in response to Resolution 725 (A-04), which was introduced by the Colorado Delegation and adopted as amended by the House of Delegates at the 2004 Annual Meeting. Resolution 725 asks:

That our American Medical Association study and report back with recommendations for action on how to improve communication between physicians and among health systems as patients transition from one health care setting to another, and that these recommendations may include:

1. Definition of the basic package of information to be included with a transfer;
2. Lists of tests completed, but results pending, including how these results may be accessed;
3. Lists of tests and procedures planned, but not completed, including who, when and where such tests and procedures shall be done;
4. Name, specialty and telephone number of each physician caring for the patient;
5. Preparation of a discharge summary at the time of transfer, explaining the outcomes of the presenting complaints;
6. Outpatient consultation forms detailing the reasons a specialty consultation has been requested;
7. Means of transmitting information, including written and electronic formats; and
8. Identification of who may be notified should communication fail; and

That our AMA work with other interested organizations to improve physician-to-physician communications.

This report describes existing AMA policy on patient discharge and transfer from facilities and summarizes ongoing activities related to the concerns expressed in Resolution 725, including: (1) a description of relevant Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation standards; (2) collaborative patient safety activities undertaken through the Institute for Healthcare Improvement (IHI) “100K Lives Campaign”; and (3) AMA activities supporting the development of the continuity of care record (CCR).

DISCUSSION

Existing AMA policy establishes a number of principles related to appropriate inter-facility transfer of patients (H-130.948, H-130.957, H-130.968, H-130.966, H-130.965, H-130.964, H-130.961, H-130.973, H-130.982, and H-160.942 [AMA Policy Database]). Particularly pertinent is Policy H-160.942, which addresses the use of evidence-based discharge criteria to protect patient interests in the discharge process by supporting the principle that the needs of patients must be matched to settings with the ability to meet those needs. Additionally, Policy H-160.942 delineates the type of information necessary to support continuity of patient care and stipulates that without such information the receiving facility should not accept the transfer.

In addition, the AMA has adopted the American College of Emergency Physicians statement, Principles on Appropriate Interhospital Patient Transfer (H-130.961), to guide the transfer of emergency room patients to other facilities.

AMA Involvement in JCAHO Standards Development

The AMA participates in the development of accreditation standards in a variety of clinical settings (hospital, ambulatory care, long-term care, home care, behavioral health care, network) through its significant representation on the JCAHO Board of Commissioners, JCAHO’s Standards and Survey Procedures Committee, JCAHO’s Professional and Technical Advisory Committees, and JCAHO Advisory Councils. Numerous JCAHO accreditation standards address communications and information flow on patient transfers and discharge. The following examples from the 2005 Comprehensive Accreditation Manual for Hospitals address some elements of the requested recommendations of Resolution 725, including:

1. Definition of the basic package of information to be included with a transfer.

The transfer or discharge of a patient to another level of care, treatment, and services, different professionals, or different settings is based on the patient’s assessed needs and the hospital’s capabilities. Planning for transfer or discharge involves the patient and all appropriate licensed independent practitioners, staff, and family members involved in the patient’s care, treatment, and services. When the patient is transferred, information provided to the patient includes the following: the reason they are being transferred, and alternatives to transfer, if any. When the patient is discharged, information provided to the patient includes the following: the reason for being discharged, the anticipated need for continued care, treatment, and services after discharge. When indicated, the patient is educated about how to obtain further care, treatment, and services to meet his or her identified needs. When indicated and before discharge, the hospital arranges for or helps the family arrange for services needed to meet the patient’s needs after discharge. Written discharge instructions in a form the patient can understand are given to the patient and/or those responsible for providing continuing care (Standard PC.15.20, Elements of Performance [EP] 3, 4, 6, 7, 8, 9).

When a patient is transferred or discharged, appropriate information related to the care, treatment, and services provided is exchanged with other service providers. The hospital communicates appropriate information to any organization or provider to which the patient is transferred or discharged. The information shared includes the following, as appropriate to the care, treatment, and services provided: the reason for transfer or discharge, the patient’s physical and psychological status, a summary of care, treatment, and services provided and progress toward goals, community resources or referrals provided to the patient (Standard PC.15.30, EP 1, 2).

2. Lists of tests completed, but results pending, including how these results may be accessed.

3. Lists of tests and procedures planned, but not completed, including who, when and where such tests and procedures shall be done.

The hospital can provide access to all relevant information from a patient's record when needed for use in patient care, treatment, and services. To facilitate continuity of care, providers have access to information about all previous care, treatment, and services provided to a patient by the hospital. There is a manual or automated mechanism to track the location of all components of the medical record. The hospital uses a system to assemble required information or make available a summary of information related to patient care, treatment, and services when the patient is seen (Standard IM.6.60, Rationale, EP 1, 2).

4. Name, specialty and telephone number of each physician caring for the patient.

The hospital has a complete and accurate medical record for every individual assessed, cared for, treated, or served. Every medical record entry is dated, the author identified and, when necessary according to law or regulation and hospital policy, is authenticated. At a minimum, the following are authenticated either by written signature, electronic signature, or computer key or rubber stamp: the history and physical examination, operative report, consultations, discharge summary (Standard IM.6.10, EP 4, 5).

5. Preparation of a discharge summary at the time of transfer, explaining the outcomes of the presenting complaints.

At times of discharge or transfer, appropriate information will be exchanged with other service providers. A concise discharge summary providing information to other caregivers and facilitating continuity of care includes the following: the reason for hospitalization, significant findings, procedures performed, care/treatment/services provided, the patient's condition at discharge, information to the patient and family, as appropriate (Standard PC.15.30, IM.6.10 EP 7).

6. Outpatient consultation forms detailing the reasons a specialty consultation has been requested.

Information and education is provided to each patient regarding future continued care, services, and treatment. Furthermore, the management and coordination of each patient's care, treatment, and services is the responsibility of a practitioner with appropriate privileges. Medical staff standards specify the following: a patient's general medical condition is managed and coordinated by a physician; there is communication among all practitioners involved in a patient's care, treatment, and services; licensed independent practitioners with appropriate privileges manage and coordinate a patient's care, treatment, and services; the organized medical staff, through its designated mechanism, determines the circumstances under which consultation or management by a physician or other licensed independent practitioner is required and consultation is obtained as required (Standards PC.15.20, PC.15.30, MS.2.20 EP 1, 2, 3, 4).

7. Means of transmitting information, including written and electronic formats.

Patient-specific data and information are contained in the medical record, both inpatient and outpatient, to facilitate patient care, treatment, and services, serve as a financial and legal record, aid in research, support decision analysis, and guide professional and organization performance improvement. This information may be maintained as a paper record or as electronic health information (Standard IM.6.10, Rationale for IM.6.10).

8. Identification of who may be notified should communication fail.

When indicated, a patient is educated on how to obtain further services. Furthermore, communication should be effective throughout the hospital. Effective communication occurs in the hospital, among the hospital's programs, among related hospitals, with outside organizations, and with a patient and family, as appropriate. Additionally, care, treatment, and services are provided in an interdisciplinary, collaborative manner. The hospital has a process to receive or share relevant patient information to facilitate appropriate coordination and continuity when a patient is referred to other care, treatment, and service providers. There is a process to resolve duplication or conflict with either internal or external resources (Standard PC.15.20 EP 7, Standard LC.3.60 EP 2, PC.5.50 EP 1, PC.5.60 EP 3, 4).

AMA/IHI Activities Supporting Elements of Resolution 725 (A-04)

In addition to accreditation standards activities, the AMA is presently partnering with the IHI on a safety campaign aimed at instituting evidence-based systems changes in hospitals that can prevent avoidable patient deaths. On December 14, 2004, at the IHI's National Forum in Orlando, Florida, AMA President John C. Nelson, MD, announced AMA's partnership when Don Berwick, MD, President and CEO of IHI, publicly introduced the campaign. The six components of the campaign are:

1. Deliver reliable care for acute myocardial infarctions by implementing five specific interventions: beta-blockers at admission, aspirin at admission, ACE inhibitor, reperfusion, and beta-blockers at discharge; also, smoking cessation counseling when appropriate.
2. Prevent central line infections by adhering to: hand hygiene, barrier precautions, chlorhexidine skin antiseptics, catheter site and administration protocols, and no routine replacement, rather strive to discontinue catheter use as quickly as possible.
3. Prevent surgical site infections by redesign of systems to reduce risk factors and optimize evidence-based processes of care: antibiotic prophylaxis guideline, appropriate hair removal (i.e., avoid shaving surgical sites when this is not necessary), and perioperative glucose control.
4. Prevent ventilator-associated pneumonias with five specific interventions: elevation of head of the bed by 30 degrees, peptic ulcer prophylaxis, deep venous thrombosis prophylaxis, lightening sedative use intermittently, and strict hand washing norms.
5. Prevent adverse drug events through "Medication Reconciliation," which is a formal process of identifying the most accurate list of all medications the patient is taking against the physician's admission, transfer, and/or discharge orders, notifying the physician of discrepancies, and documenting needed changes.
6. Deploy "Rapid Response" teams that can quickly respond to early signs of patient distress, such as cardiac arrest and shock, and respond to the patient's needs in minutes rather than hours.

Physician-to-physician communication across systems in the delivery of care is an essential element of each intervention of the campaign. Medication Reconciliation and Rapid Response Teams (RRTs) are hospital systems interventions that focus on the delivery of patient care in instances of transitions or changes in health status.

To improve the current medication information process, Medication Reconciliation involves notifying the physician of discrepancies in patient medications, resolving disparate information through a defined communications process, documenting the physician's changes, and communicating the reconciled information across the health care system.

The purpose of an RRT, or Medical Emergency Team, is to bring critical care expertise to the patient's bedside or wherever this level of care is needed. RRTs proactively respond to acute patient deterioration to prevent a cardiopulmonary arrest or adverse event from occurring. When staff recognizes changes in a patient's condition--such as acute changes in vital signs or oxygen saturation, decreased urine output, or altered mental function--staff communicates this information to the RRT, which then evaluates the patient and provides appropriate interventions.

As these teams have evolved, health care systems have established communication protocols between RRTs and attending physicians. The type of decisions made by RRTs necessitate timely and accurate communication. RRT consultations are not intended to take the place of immediate consultations with the physician or to replace the attending physician's involvement in that process of care. Therefore, after the RRT consultation, staff notifies the appropriate physician of the RRT consultation and, in many instances, staff places concurrent calls to the attending physician and the RRT.

AMA Activities on the Continuity of Care Record

Recognizing that it is critical to find new, better, and more efficient ways for physicians to access timely and relevant patient information with which to make clinical decisions and to have that information available at various points of care, the AMA has communicated its support for the Continuity of Care Record (CCR). Based on a national standard that enables communication and data exchange between disparate systems, the CCR is a summary of personal health information that clinicians can send when a patient is referred and that patients can carry with them to promote continuity, quality, and safety of care. The CCR captures information such as current medications, diagnoses, recent treatments, and patient and physician demographics. It is envisioned that the CCR will help enhance patient safety, prevent medical mistakes, reduce administrative costs, and make doctor visits more productive.

CONCLUSION

Given the breadth of existing AMA policy and continued Clinical Quality Improvement activities with accreditation standards, IHI, and the CCR, the AMA continues to make significant strides in the requested recommendations contained in Resolution 725.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

That our American Medical Association continue to be actively engaged in Clinical Quality Improvement activities that address accreditation standards and the Continuity of Care Record, and that involve collaboration with the Institute for Healthcare Improvement.

7. ANNUAL TOBACCO REPORT 2005

HOUSE ACTION: FILED

This report is an update on tobacco control and prevention efforts that have occurred since the last report was submitted to the American Medical Association House of Delegates at its 2003 Interim Meeting (AMA Policy D-490.983, "Annual Tobacco Report," AMA Policy Database). While much has occurred, this report will merely summarize the highlights through February 2005 and provide access or links to further information.

SMOKELESS STATES NATIONAL TOBACCO POLICY INITIATIVE

The ten-year investment by The Robert Wood Johnson Foundation and the American Medical Association to support and administer the SmokeLess States National Tobacco Policy Initiative came to a close in June 2004. The staff located at our AMA who administered the program and provided technical assistance to the 42 state coalitions ended their employee contracts and found new positions both in and outside our AMA. The state coalitions and their staffs were greatly affected by the reduction in funding support and many dramatically downgraded their efforts and ability to advance sweeping tobacco control policies. Despite the uncertainty and dramatic changes, several efforts to pass and effect policies at the state and local level during 2004 continued to the end. The final newsletter (May 2004) included an overview of the ten-year progress on clean indoor air policies, tobacco tax increases and cessation efforts (see www.ama-assn.org/ama1/pub/upload/mm/375/policy_focus2ndqtr04.pdf). In addition, the newsletter included a state-by-state overview of the evolution of specific efforts during both phases of the SmokeLess States' program (six years as the Tobacco Prevention and Control Program and four years as the National Tobacco Policy Initiative) (see www.ama-assn.org/ama1/pub/upload/mm/375/accomplishments94-00.pdf and www.ama-assn.org/ama1/pub/upload/mm/375/accomplishments01-04.pdf respectively).

CLEAN INDOOR AIR

Great progress has been made in eliminating secondhand smoke. Currently, more than one-third of all workers nationwide enjoy the benefits of smokefree workplaces and more than 4,700 communities are covered by strong local or state smokefree laws. In August 2004, local smokefree ordinances were pending in at least 68 local communities across the country.

Today, the following states have strong, comprehensive, clean indoor air laws: California, Connecticut, Delaware, Maine, Massachusetts, New York, and Rhode Island; Florida, Idaho, and Utah have passed smokefree laws that only exempt stand-alone bars.

Additionally, the past two years have brought several foreign actions regarding smokefree public places. For example, in 2004, Ireland became one of the most widely publicized countries to go smokefree (including restaurants AND pubs). Other countries have passed strong smokefree laws including: Italy, New Zealand, Norway, Sweden (effective June 2005) and Thailand.

The science connecting secondhand smoke exposure to increased risk of death and disease continues to build. A study released in the June 30, 2004 issue of the British Medical Journal found that a nonsmoker's risk of developing coronary heart disease (CHD) increases by 50-60% when exposed to secondhand smoke. For a copy of the full article, please go to: bmj.bmjournals.com/cgi/content/abstract/bmj.38146.427188.55v1.

Finally, 2005 represents the 15th anniversary of smokefree airlines--on February 25, 1990 the "no-smoking" sign was permanently posted on all US domestic airline flights.

TOBACCO EXCISE TAXES

Since January 1, 2002, more than 35 states have increased cigarette taxes--by as little as 8 cents to as much as 75 cents a pack. Three states currently have cigarette excise taxes that are equal to/exceed \$2.00 a pack: Rhode Island has the highest cigarette tax at \$2.46 per pack, followed by New Jersey at \$2.40 and Michigan at \$2.00. During the same period of time, the number of Internet cigarette sales has exploded with an estimated 800-1000 sites offering an average savings of 50 percent of actual costs. The collection of taxes over the Internet is increasingly problematic for state and local governments, however several states are subpoenaing sales lists of Internet operations and targeting specific consumers to pay their individual levies. See Appendix for a list of (as of January 1, 2005) cigarette tax increases by state per year 2000-2005 or go to: <http://tobaccofreekids.org/research/factsheets/pdf/0097.pdf>.

TOBACCO USE CESSATION

Much progress has been made in the area of tobacco use cessation; however, much still remains to be done to assure that physicians are well-armed with the tools to assess and assist their patients in quitting their addiction to tobacco. Recently, the American Legacy Foundation funded the Association of American Medical Colleges (AAMC) to develop and conduct a National Survey of Physician Perspectives on Barriers to Helping Patients to Stop Smoking. Our AMA has been involved in the development of the survey instrument.

The federal government is currently funding a national quitline (1-800-QUIT-NOW) and new regulations requiring Medicare to support counseling and treatment should soon be released. On December 23, 2004, the Centers for Medicare and Medicaid Services (CMS) announced a proposal to cover tobacco cessation counseling services under Medicare and our AMA submitted a response to the proposed regulations.

The North American Quitline Consortium was launched on September 20, 2004, and has accomplished several activities including: development of a minimal data set for evaluating quitlines, hosting a conference call series on promising approaches to quitline operations, and submitting comments to the US Federal Government regarding the proposal to cover cessation services for Medicare beneficiaries. Go to www.NAQuitline.org for more information.

The tobacco industry as well has been involved in tobacco cessation. Philip Morris USA is giving out free information on how to quit smoking. The Richmond-based tobacco company has set up a special page at its web site (www.philipmorrisusa.com) where people can download or order a quit-smoking guide. The 48-page guide, which also can be ordered by phone, includes tips on quitting, testimonials from former smokers, and numerous phone numbers and web addresses for other groups that offer smoking-cessation assistance. The QuitAssist guide is the latest effort by the company to respond to public scrutiny as tobacco companies battle lawsuits and debate federal regulation of the industry. Philip Morris and three other US cigarette companies are fighting a \$280 billion civil racketeering lawsuit filed by the US Justice Department, which accuses the companies of a 50-year conspiracy to deceive the public about the dangers of smoking. (Note: our AMA has strongly supported the lawsuit and written former Attorney General Ashcroft to recommend the US seek specific, effective remedies.)

RESEARCH FUNDING FROM TOBACCO INDUSTRY

As of December 2004, 17 universities in the US had schools, departments, or centers that prohibit the acceptance of tobacco industry funding for research. The 17 universities include 22 academic units: 13 Schools of Public Health (Arizona, Columbia, Harvard, Johns Hopkins, Iowa, Loma Linda, North Carolina, Puerto Rico, South Carolina, UC Berkeley, UCLA, University of Medicine & Dentistry of New Jersey, Washington); three Schools of Medicine (Emory, Harvard, Johns Hopkins); one School of Nursing (UCLA); one Department of Medicine (UC San Francisco) and one Department of Family and Preventive Medicine (UC San Diego); and three Comprehensive

Cancer Centers (Ohio State, UC San Diego, UC San Francisco). [This list appears on the UC Berkeley Center for Family and Community Health web site at <http://socrates.berkeley.edu/%7Ejmm716/Reports.html>.] Of the 22 academic units that appear on this list, 13 have written policies that prohibit the acceptance of tobacco industry funding for research, and 9 units have signed a contract with the American Legacy Foundation that prohibits acceptance of tobacco industry funding for the duration of the contract.

YOUTH TOBACCO ISSUES

The 1998 legal settlement between the states and the tobacco companies prohibited the tobacco companies from taking “any action, directly or indirectly, to target youth... in the advertising, promotion or marketing of tobacco products.” However, since the settlement, the tobacco companies have increased their marketing expenditures by more than 84 percent to a record \$12.7 billion a year, or \$34.8 million a day, according to the Federal Trade Commission. Much of this marketing is still targeted at children.

One of the tobacco industry’s most outrageous new tactics is the introduction of candy-flavored cigarettes and smokeless tobacco products:

- R.J. Reynolds, the same company that once marketed cigarettes to children with a cartoon character, Joe Camel, has launched a series of flavored cigarettes, including a pineapple and coconut-flavored cigarette called “Kauai Kolada” and a citrus-flavored cigarette called “Twista Lime.” In November 2004, it introduced Camel “Winter Blends” in flavors including “Winter Warm Toffee” and “Winter MochaMint.”
- Brown & Williamson has introduced flavored versions of its Kool cigarettes with names like “Caribbean Chill,” “Midnight Berry,” “Mocha Taboo,” and “Mintrigue.”
- The U.S. Smokeless Tobacco Company is marketing spit tobacco with flavors including berry blend, mint, wintergreen, apple blend, vanilla, and cherry.

Brown & Williamson has also promoted its Kool cigarettes with hip-hop music themes and images that have particular appeal to African-American youth.

There are several ongoing efforts to stop the tobacco companies from continuing to target children. Several state attorneys general have sued tobacco companies for violating the state settlement’s prohibition on targeting children. In addition, the federal government is pursuing a lawsuit against the tobacco companies that, among other things, seeks to stop tobacco marketing to children. Congress is considering legislation granting the US Food and Drug Administration authority over tobacco products, including the authority to ban flavored cigarettes and crack down on other forms of tobacco marketing and sales to children. For an overview of the advertisements go to: <http://www.tobaccofreekids.org/reports/targeting/>. (Note: our AMA supported a Senate Bill which passed in 2004, but did not make it to the President’s desk for signature.)

As part of the campaign to improve its image and prove to policy makers that it is a reformed company, Philip Morris provides grants to community groups that work with youth (e.g., Boys and Girls Clubs and Big Brothers Big Sisters). While these grants are often large and are tempting for youth-serving organizations in need of funding, they are fraught with peril. The money for these grants is the profits of an industry that markets a deadly and addictive product. Each year in this country tobacco use kills more than 400,000 people and over 7,000 children become new regular, daily smokers. Philip Morris funnels its grants to youth organizations through an initiative called Positive Youth Development and an overview of this effort and the grant process can be found on the PM web site: http://www.philipmorrisusa.com/en/policies_practices/ysp.asp.

FRAMEWORK CONVENTION ON TOBACCO CONTROL (FCTC)

The Framework Convention on Tobacco Control (FCTC), the world’s first public health treaty, is a legally binding treaty negotiated by the 192 member nations of the World Health Assembly of the World Health Organization. The FCTC contains measures designed to reduce the health and economic impacts of tobacco. The final agreement, reached in May 2003, provides the basic tools for countries to enact comprehensive tobacco control legislation on Advertising, Promotion and Sponsorship, Packaging and Labeling, Secondhand Smoke, Taxation & Duty Free Sales, Product Regulation & Ingredient Disclosure, and Liability.

Currently, 168 countries have signed and 58 have ratified the treaty. The US signed, but has not ratified the treaty which went into force on February 27, 2005. Our AMA sent letters to President Bush in November 2003 and April 2004 urging the US to sign the treaty. In February 2005, the AMA was part of a partners' coalition letter led by the Campaign for Tobacco-Free Kids (CTFK) to President Bush encouraging him to send the treaty to the Senate for ratification.

According to the June 2004 Board report on International Trade Agreements, it is also important for our AMA to work with other interested organizations to continue to advocate for AMA policy on tobacco and alcohol. The report included new policies: (1) that our AMA monitor developments on US international trade agreements that involve the provision of medical services and the distribution and advertising of alcohol and tobacco; and (2) that our AMA continue to strongly advocate for US ratification of the Framework Convention on Tobacco Control.

MASTER SETTLEMENT AGREEMENT

Three states--Maine, Delaware and Mississippi--currently fund tobacco prevention programs at minimum levels recommended by the US Centers for Disease Control and Prevention (CDC). Thirty-seven states and the District of Columbia fund these programs at less than half the CDC minimum or provide no state funding at all. States' funding for tobacco prevention programs has been cut by 28 percent over the last three years and, collectively, \$538 million is budgeted for tobacco prevention this year.

In contrast, tobacco companies have increased their annual marketing expenditures to a record \$12.7 billion a year, according to the Federal Trade Commission. This means the tobacco companies spend more than \$23 to market cigarettes and other tobacco products in the US for every dollar the states spend on programs to protect children from tobacco. The tobacco companies spend more on marketing in a single day--at least \$34 million--than 46 states and the District of Columbia spend in an entire year on tobacco prevention.

States have cut funding for tobacco prevention despite collecting a record \$20 billion this year in tobacco-generated revenue from the tobacco settlement and tobacco taxes. State tobacco revenues have skyrocketed because 38 states and DC have increased tobacco taxes in the past three years, some more than once (see Appendix for Tobacco Prevention and Control Spending, American Lung Association, State of Tobacco Control 2004).

A small Canadian tobacco firm, Grand River Enterprises Six Nations (Grand River), is using the North American Free Trade Agreement (NAFTA) to challenge the 1998 Master Settlement Agreement (MSA) between 46 states and four major US tobacco firms. The suit seeks \$340 million in compensation from the US government for the ways in which the MSA has purportedly infringed Grand River's NAFTA-established rights. States' Attorneys General have no standing in NAFTA investor-state disputes and depend on the US Trade Representative to defend States' interests. A tribunal decision in favor of Grand River would give Mexican and Canadian tobacco firms a back door out of the MSA, erasing the level playing field for US tobacco firms and undermining the settlement as a whole.

EVENTS AND OPPORTUNITIES

Many events and activities are occurring in support of tobacco control:

- World No Tobacco Day was May 31, 2005. The US Coalition for World No Tobacco Day 2005 released a Call for Community Grant Applications (see: www.wntd.org). Grants of up to \$2000 were awarded to organizations across the nation to conduct advocacy activities for World No Tobacco Day. This year's theme was Health Professionals and Tobacco Control. Special consideration was given to applications that reflected the theme and to organizations that work with health professionals.
- The National Tobacco Control Conference was held May 3-5 in Chicago, Illinois. The title of this year's conference was Turning Point: Challenges and Opportunities in Tobacco Control in the Next Decade.
- The North American Quitline Consortium met May 2-3 in Chicago, Illinois.
- The meeting Addressing Tobacco in Managed Care was held May 3, 2005 at the Hotel Sofitel in Rosemont, Illinois.
- The 13th World Conference on Tobacco or Health will be held July 12-15, 2006 in Washington, DC. This conference will occur immediately following the International Cancer Congress (UICC) held in DC earlier that week. The American Cancer Society is the lead sponsor for both meetings.

(Appendixes to Report 7 of the Board of Trustees are available from the Office of Program Development.)

**8. STATE TOBACCO TAX REVENUE INCREASES AND
RESPONSIBLE USE OF RESULTING FUNDS
(RESOLUTION 803, I-03)**

**HOUSE ACTION: RECOMMENDATION ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 803 (I-03) AND
REMAINDER OF REPORT FILED**

At the 2003 Interim Meeting, the House of Delegates referred Resolution 803 to the Board of Trustees. Introduced by the Medical Student Section, Resolution 803 calls for the AMA to “support increases in the taxation of tobacco products with revenue from any such tax increases appropriated exclusively for the following uses: (1) Educational, counter-advertising, and cessation programs designed to decrease the prevalence or the adverse effects of tobacco use, [and] (2) Health related costs associated with tobacco use.”

BACKGROUND

Since January 1, 2002, more than 35 states have increased cigarette taxes by as little as 8 cents to as much as 75 cents a pack. However, revenues have been used to fill state budget deficits and fund state programs such as education and Medicaid. Until June 2004, our AMA, through the SmokeLess States National Tobacco Policy Initiative, actively led and supported state efforts to increase state tobacco excise taxes and to appropriate revenues for tobacco use reduction efforts.

As of December 2004, only three states--Maine, Delaware, and Mississippi--fund tobacco prevention programs at minimum levels recommended by the US Centers for Disease Control and Prevention (CDC). Thirty-seven states and the District of Columbia fund these programs at less than half the CDC minimum or provide no state funding at all. States funding for tobacco prevention programs has been cut by 28 percent over the last three years and collectively, \$538 million is budgeted for tobacco prevention for FY2005.

States have cut funding for tobacco prevention despite collecting a record \$20 billion this year in tobacco-generated revenue from the tobacco settlement and tobacco taxes. State tobacco revenues have skyrocketed because states and the District of Columbia have increased tobacco taxes in the past three years, some more than once.

Several polls have been conducted to ascertain the broad public and voter support for cigarette tax increases and whether support wanes when funds are earmarked for various programs. In every state in which the question was asked, voters expressed strong support for cigarette tax increases that directed some of the new revenue to support programs to reduce youth tobacco use (see Appendix for a list of [as of January 1, 2005] Cigarette Tax Increases by State per Year 2000-2005 and Table on State Tobacco Prevention Spending vs. State Tobacco Revenues).

DISCUSSION OF ISSUE

During the 2004 Annual Meeting of the House of Delegates, Council on Scientific Affairs Report 3, “Consolidation Report of House Policies on Tobacco and Smoking,” was adopted. In that process, specific policies were summarized and incorporated in a streamlined set of easy-to-use and accessible policies. While the outcome was a consolidated report, specific language under tobacco taxes (Policy H-495.987, AMA Policy Database) does not directly address the concerns expressed in Resolution 803. For example, current AMA policy addressing tobacco tax funds states “federal excise taxes” but does not include “state and local excise taxes” in the text.

While polls show broad support for appropriating tobacco tax revenues for programs aimed at reducing youth tobacco use, many state legislative processes do not support earmarking of said revenues. Therefore, approving policy that specifically states “increases in the taxation of tobacco products with revenues...*appropriated exclusively* for the following uses...” [emphasis added] may disregard state legislative practices and overshadow the intent of funding tobacco control programs

AMA POLICY

Current AMA policy on tobacco taxation explicitly states that “Our AMA will work for and encourages all levels of the Federation and other interested groups to support efforts, including legislation, to pass increased excise taxes on tobacco in order to discourage smoking.” It also states that “an increase in federal excise taxes for tobacco should include provisions to make funds available that would be allocated to health care needs and health education, and for the treatment of those who have already been afflicted by tobacco-caused illness, including nicotine dependence, and to support counter-advertising efforts” (Policy H-495.987).

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 803 (I-03), and that the remainder of this report be filed:

That Policy H-495.987, “Tobacco Taxes,” be amended by addition and deletion as follows:

(1) Our AMA will work for and encourages all levels of the Federation and other interested groups to support efforts, including education and legislation, to pass increased federal, state, and local excise taxes on tobacco in order to discourage ~~smoking~~ tobacco use.

(2) An increase in federal, state, and local excise taxes for tobacco should include provisions to make substantial funds available that would be allocated to health care needs and health education, and for the treatment of those who have already been afflicted by tobacco-caused illness, including nicotine dependence, and to support counter-advertising efforts.

(Appendix to Report 8 of the Board of Trustees is available from the Office of Program Development.)

9. HEALTH CARE FOR THE VICTIMS OF THE POSTAL ANTHRAX ATTACKS OF 2001 (RESOLUTION 919, I-04)

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 919 (I-04) AND REMAINDER OF REPORT FILED

INTRODUCTION

This report responds to Resolution 919 (I-04). The House of Delegates referred Resolve 1 of Resolution 919 to the Board for the development of a report back to the House. Resolve 1 asks “that our AMA policy be to ensure that the victims of the 2001 postal anthrax attacks receive health care paid for by the United States government for anthrax-related medical problems.” In developing this report, the Board relied upon the work and counsel of the Council on Legislation, acting in its advisory capacity to the Board.

BACKGROUND

This resolution was sponsored by the Maryland Delegation at the behest of a physician in Baltimore who treated several of the victims of the 2001 postal anthrax attacks. These patients, who were federal postal employees or contractors, were denied coverage by their health plans for anthrax-related medical care. The health plans argued that the anthrax attacks were “acts of war,” and therefore anthrax-related medical claims were not covered under the victims’ policies.

While sympathetic to the plight of the victims of the anthrax attacks, the Reference Committee recommended against adopting Resolution 919. The House of Delegates voted to refer the first resolve of Resolution 919 to the Board for a report back to the House.

DISCUSSION

The basic rationale behind Resolution 919 is that the individuals affected by the 2001 anthrax attacks were victims of bioterrorism against the United States and therefore, should be eligible for medical care covered by the federal government. The issue raised--i.e., who should be responsible for providing and paying for medical care to the victims of bioterrorism, specifically the anthrax attacks of 2001--certainly merits discussion. Victims of the anthrax attacks, especially those with inhalation anthrax, needed immediate medical treatment once their symptoms developed, and in many cases, continuing treatment. At least one of the postal service workers exposed to anthrax-laden dust but who did not test positive for inhalation anthrax was diagnosed with Aborted Anthrax Syndrome and has required continuing medical care. Three of the anthrax victims who are from Maryland experienced extreme difficulty in obtaining reimbursement of their medical bills: their health plans claimed they were victims of an "act of war," and therefore their medical claims were not covered under their policies. Two of the victims finally received coverage from their health plans after public pressure from physicians and medical societies.

Although the postal workers who were seriously ill qualified for workers' compensation, coverage of their medical bills was limited to one year unless partial or full disability could be proven. It has been difficult to prove disability, however, because there are no criteria for making a determination of a partial or full disability resulting from exposure to inhalation anthrax. It has also been difficult for these individuals to obtain private health insurance. The refusal by their health plans to cover the victims' treatment resulted in delays in medical care and additional stress for the patients and their physicians, many of whom were unfamiliar with how to treat anthrax symptoms and were learning as they went along.

Testimony at the Reference Committee was unanimous in expressing sympathy for victims of the postal anthrax attacks and in acknowledging that it was absolutely crucial that these victims--and victims of future attacks--receive the best care available. The Board strongly agrees with the Reference Committee that the anthrax victims should receive appropriate care.

The Board also strongly agrees with the Reference Committee that the position taken by the health plans in denying coverage for anthrax-related medical claims was completely inappropriate and an abrogation of their contractual responsibilities to their policyholders. First, the source and the individual(s) responsible for the attacks have yet to be determined, so it was inappropriate for the health plans to deny claims based on an "act of war" exclusion. Second, such a determination cannot and should not be made by health plans alone. In fact, the Commissioner of Insurance for the State of Maryland stated that although war exclusions are permitted in health insurance, HMO, and life insurance contracts issued or delivered in Maryland, a carrier would not be able to use such exclusions to deny benefits for an act of terrorism, such as the anthrax attacks of 2001, because such losses would not result from a declared war. Adopting Resolution 919 would appear to validate the health plans' contention that the 2001 postal anthrax attacks were an act of war, thereby letting them completely "off the hook" and setting a dangerous precedent. The Board strongly believes that health plans must be held accountable to their policyholders so that they do not avoid responsibility for medical services and treatment that they are obligated to cover.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 919 (I-04) and the remainder of this report be filed:

1. That our American Medical Association advocate the issue of health plans' responsibility to pay for health services provided to victims for anthrax-related medical care as a result of the 2001 postal anthrax attacks with the appropriate federal agencies, such as the Office of Personnel Management, and with the trade association representing the health insurance industry, e.g., America's Health Insurance Plans.
2. That our AMA study how the "act of war" exclusion in health insurance contracts should be defined and examine ways that the AMA might work with health insurance companies to ensure that individuals injured as a result of future bioterrorism events receive appropriate health care that is covered by their insurance policies.

10. LIABILITY PROTECTION FOR ADULT VACCINES (RESOLUTION 710, I-04)

HOUSE ACTION: RECOMMENDATION ADOPTED IN LIEU OF RESOLUTION 710 (I-04) AND REMAINDER OF REPORT FILED

INTRODUCTION

This report responds to Resolution 710 (I-04). The House of Delegates referred Resolution 710 to the Board for the development of a report back to the House at the 2005 Annual Meeting. Resolution 710 calls upon the AMA to support legislation to expand the scope of the Vaccine Injury Compensation Program (VICP) to apply to all recommended adult vaccines, including influenza. In developing this report, the Board relied upon the work and counsel of the Council on Legislation, acting in its advisory capacity to the Board.

BACKGROUND

Sponsored by the Minnesota Delegation, Resolution 710 was prompted, in part, by the influenza vaccine shortage that occurred this past fall. The 2004-2005 flu vaccine shortage, however, was not the only vaccine shortage experienced in recent years. From fall 2000 to summer 2002, there were unprecedented shortages of five childhood vaccines that protect against eight of the eleven vaccine-preventable infectious diseases in the United States. Those shortages focused attention on the nature of the vaccine market that had led to such problems, including: manufacturing and supply issues; the high cost and complexity of development, approval, manufacturing, and distribution of vaccines; the decreased number of manufacturers; and the lack of investment in vaccine manufacturing facilities. Pharmaceutical companies face declining financial incentives to develop and produce vaccines because vaccines often produce lower revenues than drugs. Indeed, the number of manufacturers of recommended vaccines for the United States market has decreased from more than 25 companies 30 years ago to only five today.

Both the 2003 report issued by the Institute of Medicine (IOM), "Financing Vaccines in the 21st Century: Assuring Access and Availability" (National Academy of Sciences), and AMA Board of Trustees Report 28-I-04, "United States Influenza Vaccine Supply: Update and Future Directions for Adult Immunization," discuss the challenges involved in ensuring a stable vaccine supply. According to the IOM report, "The risks and costs to manufacturers associated with vaccine production have increased. Key factors include regulation, removal of the preservative thimerosal, and an increase in vaccine injury lawsuits." BOT Report 28 concludes that there is a critical need to develop an infrastructure in which adult vaccines can be delivered to all adults, including those who are uninsured or underserved. While liability concerns about adverse events following the administration of most current vaccines, including influenza, have been alleviated by the VICP, newly developed adult vaccines may not necessarily fall under the protection of the VICP. Liability protection for vaccine manufacturers for adverse events still must be provided, especially for newly developed adult vaccines, in order to continue to decrease current manufacturers' risk and to support the entry of new manufacturers into the US market.

VACCINE INJURY COMPENSATION PROGRAM

In the early 1980's, reports and news stories of adverse reactions to vaccines, particularly DTP (diphtheria, tetanus, pertussis), created major liability concerns for vaccine manufacturers and health care providers. The safety of the DTP vaccine was called into question, and many lawsuits were filed against vaccine manufacturers and health care providers. Vaccination rates among children began to fall. Some companies dropped out of the vaccine manufacturing business altogether, while others that remained in the market began to raise their prices to cover future liability costs. Significant vaccine shortages developed as a result.

In response, Congress passed the National Childhood Vaccine Injury Act of 1986 (PL 99-660), which established the National Vaccine Injury Compensation Program (VICP). The VICP, which went into effect on October 1, 1988, was created to ensure an adequate supply of vaccines, stabilize vaccine costs, and establish and maintain an accessible and efficient forum for individuals thought to be injured by childhood vaccines. The compensation program is a no-fault alternative to the traditional tort system for resolving vaccine injury claims. The VICP has helped to stabilize the US vaccine market by providing liability protection to both vaccine companies and health care providers, by encouraging research and development of new and safer vaccines, and by providing a more streamlined and less adversarial alternative to the traditional tort system for resolving claims.

Vaccines are added to the VICP when they are routinely recommended for children by the Advisory Committee on Immunization Practices. Vaccines currently covered include: diphtheria, tetanus, pertussis (DTP, DTaP, DT, TT or Td), measles, mumps, rubella (MMR or any components), polio (OPV or IPV), hepatitis B, haemophilus influenza type b (Hib), varicella, rotavirus, pneumococcal conjugate, hepatitis A and influenza. The latter two vaccines were added recently. To date, pneumococcal polysaccharide vaccine, recommended for adults, is not protected under the VICP.

The VICP is administered jointly by the Department of Health and Human Services (DHHS), the US Court of Federal Claims, and the Department of Justice. A claim may be made for any injury or death thought to be the result of a covered vaccine. Claims may be filed by the injured individual, or a parent, legal guardian, or trustee may file on behalf of a child or an incapacitated individual. Compensable injuries are either those listed in the Vaccine Injury Table or those which claimants can prove were caused by the vaccine. Eight years' retroactive coverage is provided for vaccines and vaccine-related adverse events newly added for coverage under the VICP. Compensation is allowed for past and future medical expenses, pain and suffering, and lost wages, and may also be awarded for attorneys' fees and costs. Damages are capped for pain and suffering and wrongful death. Awards are paid from the Vaccine Injury Compensation Trust Fund, which is funded from an excise tax imposed on manufacturers based on every dose of covered vaccine that is purchased. The Trust Fund currently has about \$2 billion.

Although the VICP was established to address liability concerns arising out of children's vaccines, the DHHS has taken the position that claims may be filed on behalf of infants, children, adolescents, or adults receiving VICP-covered vaccines. With the addition of hepatitis A and influenza, all vaccines currently recommended for adults are now included in the VICP, with the exception of the pneumococcal polysaccharide vaccine.

DISCUSSION

Pursuant to BOT Report 28-I-04, the AMA is working with the Centers for Disease Control and Prevention (CDC) and other stakeholders to develop recommendations on the best methods for achieving a stable adult vaccine market and strong adult (and adolescent) immunization program in the United States. Expanding the VICP to cover all routinely recommended or encouraged vaccines for adults would be one way to address liability factors leading to vaccine shortages. The CDC is considering this option in addition to other proposals to ensure a stable vaccine supply and create an effective vaccine financing and distribution program for uninsured adults. Congress is also looking at various proposals to improve and stabilize the nation's vaccine supply, especially with respect to the influenza vaccine. Supporting the expansion of the VICP to include adult vaccines would be consistent with, and help to advance, the recommendations in BOT Report 28 that were adopted at the 2004 Interim Meeting.

RECOMMENDATION

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 710 (I-04) and the remainder of this report be filed:

That our American Medical Association support the expansion of the Vaccine Injury Compensation Fund to include any vaccine encouraged or recommended by the Advisory Committee on Immunization Practices for routine use in the adult population.

11. UPDATED ACCME STANDARDS FOR COMMERCIAL SUPPORT

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

At the 2004 Interim Meeting, the House of Delegates adopted the following recommendation in lieu of Resolution 830 and directed that the remainder of Board of Trustees Report 19-I-04 be filed:

That our American Medical Association communicate actively with the Accreditation Council for Continuing Medical Education (ACCME) regarding the implementation of the Updated Standards for Commercial Support (USCS), including the Interpretation and Application of Standard 2.3, Resolution of Personal Conflicts of Interest, in such a manner that will ensure workable options for resolving conflicts of interest and bias issues, which will not unfairly or unduly prohibit or impede the free flow of scientific information or discourage participation by physicians in CME activities; and, that our AMA work with ACCME in taking appropriate actions to prevent any future misinterpretation of these guidelines, and report back to the House at the 2005 Annual Meeting.

BACKGROUND

The ACCME Board of Directors, including the three directors nominated by the AMA, unanimously adopted the USCS for continuing medical education (available from the Division of Continuing Physician Professional Development) on April 1-2, 2004. These updated standards incorporated broad input from stakeholder groups including the AMA, state medical societies, medical specialty societies, and other CME providers. The AMA Council on Medical Education recommended approval of the USCS at its June 2004 meeting and the AMA Board of Trustees approved them on July 28, 2004. All seven member organizations of the ACCME submitted their written approval of the USCS by September 28, 2004, at which time the standards took effect.

The USCS, grounded in principles embodied in the Council on Ethical and Judicial Affairs Opinions 8.061 and 9.011, were designed to enable a free flow of information in CME activities through an open process for resolving conflicts of interest. Through their endorsement, both the Council on Medical Education and Board of Trustees have expressed their belief that the updated standards improve significantly on past ACCME policy.

The majority of new requirements embodied in the USCS have been accepted in the CME community with little or no apprehension. However, early interpretations of one Element, 2.3, which states: "The provider must have implemented a mechanism to identify and resolve all conflicts of interest prior to the education activity being delivered to learners," have caused anxiety for some CME providers. These providers have raised concerns regarding undue burdens being placed on the CME process to address the new requirement for resolving conflicts of interest.

The ACCME timeline for demonstrating compliance with the USCS indicates that only new CME providers will be expected to demonstrate full compliance with the USCS beginning in November 2005. For presently accredited providers, there will be a gradual phase-in beginning with accreditation decisions in November 2006. The phase-in will continue through 2010, at which time all activities reviewed for all providers should be in compliance with the USCS.

This report describes AMA's activities to collect feedback from members concerning implementation of the USCS as well as efforts to communicate with the ACCME to ensure workable options for resolving conflicts of interest and bias issues. The ACCME's initiatives to support implementation of the USCS also are detailed.

UPDATED STANDARDS FOR COMMERCIAL SUPPORT IMPLEMENTATION ACTIVITIES

The AMA's Annual Conference of the National Task Force for CME Provider/ Industry Collaboration in September 2004 served as the initial platform for discussion of the newly approved ACCME updated Standards. The ACCME presented examples of how CME providers might demonstrate compliance with Element 2.3 and announced that it would post on its web site answers to providers' questions related to implementation of the updated Standards.

In January 2005 the ACCME disseminated a compendium of “tools” to help the CME community implement the USCS. This toolkit, which was made available to all CME providers, included not only sample faculty correspondence and disclosure forms but also self-assessment and educational materials to help providers understand how compliance with the USCS can be achieved. Surveyor training, highlighting the graduated timeline for compliance with the USCS, was also conducted in January 2005.

The ACCME launched an extensive initiative to reach out to the CME community to explain and interpret the USCS. This has included teleconferences and face-to-face meetings with the CME leadership of 38 state medical societies (representing some 1700 state-accredited CME providers), meetings with compliance and marketing staff of pharmaceutical companies, as well as a first ever meeting with government CME providers. The Alliance for Continuing Medical Education Annual Meeting in January 2005 provided an opportunity for the ACCME to meet face-to-face with hundreds of CME providers in plenary sessions and then more closely with smaller groups of participants in the various provider section meetings. The ACCME also met with the CEOs of the Council of Medical Specialty Societies (CMSS) and then presented at the CMSS Spring Meeting in March 2005.

In addition, the ACCME invited representatives of both the Society for Academic Continuing Medical Education and CME Directors of the CMSS to a meeting where these providers shared the mechanisms they already have in place for identifying and resolving conflicts of interest. The ACCME affirmed that many of these mechanisms, including peer review of CME content and articulating faculty expectations along with monitoring and follow up, do appear to demonstrate compliance with the requirements of the Element 2.3. Participants at these meetings have expressed relief that initial concerns about resolving conflicts of interest may have been unwarranted. Many providers now recognize that they already have mechanisms in place to identify and resolve conflicts of interest.

AMA MEMBER COMMUNICATION AND FEEDBACK INITIATIVES

The AMA has initiated efforts to seek direct communication from its members and CME providers related to the ongoing implementation of the new ACCME standards. The AMA has, and will continue to use its web site, Continuing Physician Professional Development (CPPD) newsletter and blast email services to communicate with members and providers. These services will share compliance mechanisms that the AMA itself has developed in response to the new ACCME requirements, and give members the opportunity to provide feedback. The AMA will facilitate sessions at its CPPD regional meetings to gather information concerning providers’ experiences with implementation of the USCS in the field. Discussion of this issue will be a priority agenda item at meetings hosted by the AMA including: the May 2005 meeting of the National Task Force for CME Provider/Industry Collaboration and the CPPD Town Hall Meeting with state medical societies held during the AMA 2005 Annual Meeting. Finally, a plenary session and interactive case studies focused on practical ways to resolve conflicts of interest will be featured sessions at the October 2005 Annual Conference of the National Task Force for CME Provider/ Industry Collaboration hosted by the AMA.

AMA AND ACCME LEADERSHIP DISCUSSIONS

Feedback gathered from the initiatives described will be used to inform discussions with ACCME leadership aimed at assuring that the requirement for resolving conflicts of interest does not impede the delivery of certified CME activities, an interest that the AMA and ACCME both share. The AMA co-hosted a very productive joint meeting of the ACCME Board of Directors and the Council on Medical Education on March 11, 2005. The agenda for that meeting included a report on the implementation of the USCS, which fostered extensive discussion of how the ACCME and the AMA had addressed the initial misinterpretation of the mechanics for demonstrating compliance with Element 2.3. The dialogue also reinforced the correlation between Council on Ethical and Judicial Affairs Opinions 8.061 and 9.011 and the requirements of the USCS.

AMA nominees to the ACCME Board of Directors, two of whom also serve on the Council on Medical Education, will meet on a periodic basis to receive updates regarding the data collected from AMA members and CME providers through AMA communication initiatives. Additional meetings with ACCME leadership will be scheduled, if needed, as implementation of the USCS proceeds.

SUMMARY AND RECOMMENDATIONS

The AMA has set in place appropriate activities to monitor implementation of the ACCME updated Standards for Commercial Support so as to assure workable options for resolving conflicts of interest and bias issues. Dialogue with AMA members, CME providers and the ACCME needs to continue to prevent any future misinterpretation of these guidelines. Therefore, the Board of Trustees recommends that the following be adopted and that the remainder of this report be filed:

1. That our American Medical Association create opportunities for ongoing dialogue with AMA members and continuing medical education (CME) providers to discuss effective mechanisms for resolving conflicts of interest and assuring independent and balanced content in certified CME activities.
2. That our AMA communicate actively with the Accreditation Council for Continuing Medical Education during the early implementation of the of the updated Standards for Commercial Support, in such a manner that will ensure workable options for resolving conflicts of interest and bias issues.
3. That our AMA report back to the House of Delegates at the 2007 Annual Meeting concerning these activities.

12. COUNCIL ON LEGISLATION SUNSET REVIEW OF 1995 HOUSE POLICIES

HOUSE ACTION: RECOMMENDATION ADOPTED AND REMAINDER OF REPORT FILED

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110, AMA Policy Database). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- In the spring of each year, the House policies that are subject to review under the policy sunset mechanism are identified.
- Using the areas of expertise of the AMA Councils as a guide, the staffs of the AMA Councils determine which policies should be reviewed by which Councils.
- For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy. A justification must be provided for the recommended action on each policy.
- The Speakers assign the policy sunset reports for consideration by the appropriate Reference Committees.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

Staff review of the AMA Policy Database this year found several policies that are more than 10 years old, but which were inadvertently overlooked in previous sunset reviews. These policies are included this year along with the 1995 policies. In this report, the Board of Trustees presents the Council on Legislation's recommendations on the disposition of the House policies that were assigned to it. The Council on Legislation's recommendations on policies are presented in the Appendix to this report.

RECOMMENDATION

The Board of Trustees recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX

<i>Policy Number</i>	<i>Title</i>	<i>Recommended Action and Rationale.</i>
H-435.965	“Clear and Convincing” Standard of Proof in Medical Liability Cases	Retain. This is still relevant policy as to standard of proof.
H-5.998	Public Funding of Abortion Services	Retain. There is no later policy statement on this issue.
H-15.960	Motor Vehicle and Bicycle Safety	Retain. While there are other policies that have been reaffirmed that touch on these same issues, this is the most complete single statement about seat belt and helmet safety issues. Also, it is the only policy on failure to use seat belt as a primary offence. Many states have adopted, but not all.
H-40.992	Prohibition of Pay Allowances to Military Physicians Serving in Managerial and Administrative Positions	Retain. There is no later policy on this issue and military pay issues continue to be of significant concern.
H-120.966	Opposition to Payment for Prescription-Switching	Rescind. The policy being advocated is comprehensively dealt with in the following statements: H-120.959 DVA Non-Physician Prescribing Authority. H-285.965 Managed Care Cost Containment Involving Prescription Drugs. E-8.135 Cost Containment Involving Prescription Drugs in Health Care Plans.
H-130.986	Good Samaritan Law	Retain. While all states have passed Good Samaritan laws, some do not apply in all situations.
H-260.967	Freedom from CLIA	Rescind. Subsequent policy calls for modification, rather than repeal of CLIA: H-260.980 Clinical Laboratory Improvement Act of 1988.
H-270.970	Regulation - Only if Epidemiologic Data to Document Problem and a Logical Solution to Same	Rescind. The following policy reaffirmed at A-02 conveys the same policy: H-270.995 Federal Regulations and Cost Controls.
H-270.971	Legal Protection for Medical Materials and Devices	Rescind. This policy has been accomplished through passage of the Biomaterials Access Assurance Act of 1998 Public Law 105-230 105th Congress.
H-270.988	Line-Item Veto	Rescind. Before retaining this policy, the House should have the opportunity to fully debate the potential ramifications given the current funding and payment issues relating to Medicare and other federally funded health care programs.
H-270.989	Balanced Federal Budget	Rescind. Before retaining this policy, the House should have the opportunity to fully debate the potential ramifications given the current funding and payment issues relating to Medicare and other federally funded health care programs.
H-275.984	Legislative Action	Retain. Massachusetts still has this requirement. There is no later policy specifically on this issue and it is consistent with the following directive: D-390.985 Medicare Balance Billing.
H-280.995	Medicare Coverage of “Skilled Nursing Care”	Retain. There is still much confusion in this area and there is no subsequent policy addressing these specifics.
H-285.966	Managed Care Insurance Requirements	Rescind. Superseded by subsequent policy as follows: H-435.966 Prohibit Third Party Payors from Requiring Professional Liability Coverage Beyond Mandated Limits.
H-390.993	Opposition to Regulations Promulgated to Implement the 1982 PL 97248 (TEFRA)	Rescind. This issue involved a 20 year-old policy change regarding whether physicians were reimbursed under Part A or Part B of Medicare for services related to the supervision of hospital units. This has not been an issue in the last decade. Physicians are reimbursed under part B for services related to individual patients.

13. FEASIBILITY STUDY ON THE DEVELOPMENT OF CPT COMPLIANT CODE EDITS

HOUSE ACTION: FILED

INTRODUCTION

This Board of Trustees report discusses the ongoing feasibility study under taken by the American Medical Association in response to Resolution 709 (A-04). Since the feasibility study is still in process, and all interview data needs to be analyzed and proposed options for meeting the objectives of Resolution 709 need to be developed, this report is for informational purposes only.

BACKGROUND

At the 2004 Annual Meeting of the House of Delegates, Reference Committee G considered Resolution 709. This resolution called on the AMA to seek the passage of federal legislation to mandate that if a company uses CPT coding, that these codes have to be followed completely and cannot be selectively altered. During the course of discussion at the reference committee an amendment was offered by the Texas Delegation that substantially changed the resolution by focusing on the use of edits (code combinations) and the need to develop edits that were consistent with CPT rules and guidelines.

Based on testimony at the reference committee and the support received for the Texas amendment, the reference committee developed a substitute resolution that called for a study and report back to the House of Delegates on the feasibility of developing a national standard for the utilization of codes, code combinations, and modifiers that is consistent with all CPT codes, guidelines, and conventions, and that would be used by all commercial and governmental payers. Substitute Resolution 709 was adopted by the House of Delegates.

The basis for the substitute resolution was concern that, although AMA policy opposes modifications to CPT codes, insurers often use claim editing software and lists of CPT code combinations that may or may not be reported together, to inappropriately bundle CPT codes. This practice saves payers money and penalizes physicians. The proposed substitute language asks the AMA to study the feasibility of developing code combinations that are consistent with CPT and will be transparent to physicians.

DISCUSSION

Shortly after the Annual Meeting, the AMA contracted with Health Policy Alternatives (HPA) for help in carrying out Resolution 709. HPA will be assessing the feasibility of developing code combinations as a national standard for the utilization of CPT codes, code combinations and modifiers that is consistent with all CPT codes, guidelines, and conventions, and that would be used by all commercial and governmental payers. HPA is a Washington DC-based consulting group that specializes in evaluating and designing legislative and regulatory proposals, developing and analyzing options to achieve the strategic goals of its clients, drafting legislation, and developing ideas on a wide array of health policy and related areas. HPA has provided services to a broad range of clients, including associations representing hospitals, physicians, and other practitioners, academic health centers, insurers, health delivery organizations, health policy centers, consumer groups, foundations, and individual companies. The two principals involved in the feasibility study have extensive experience in the Medicare program and with private health insurance. They were both also previously members of the CPT Editorial Panel.

Analysis of CPT-consistent code edit development must assess:

1. What are the legislative or regulatory factors present in the states that have recently emerged and how can these be addressed?
2. How does the deliberate exclusion of CPT guidelines impact the use of CPT compliant code edits and what is required to adopt CPT guidelines?
3. How would the work of developing code edits change the CPT Editorial Panel process and the activities of CPT Advisors?

Recently the issue of industry standards for code edits has been raised as part of prompt pay legislation in several states. Specifically, in Texas code editing software that benefits payers is being pushed as a standard against medical society efforts to hold CPT guidelines as the standard. Without computer-interpretable CPT guidelines in the form of edits, organized medicine is at a disadvantage. However, it is unclear how the designation of edits based on CPT guidelines as an industry standard would relate to the standards established under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (PL 104-191).

Under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act, the Department of Health and Human Services (HHS) adopted the combination of the Healthcare Common Procedure Coding System (HCPCS) and CPT as the coding system for physicians' services and other health care services. However, HHS chose not to include CPT operational guidelines or instructions as part of the standard code set. In fact, but for the Official International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Guidelines for Coding and Reporting, HHS chose not to include operational guidelines or instructions as part of the standard for any other code set. The Department did agree that standardization of code set guidelines "is highly desirable" but concluded that "there are many current practical barriers to achieving such standardization." These included: (1) operational guidelines for some code sets are more complete than others; (2) objective, operational definitions for most codes are not available and the level of detail varies widely from code to code; and (3) the processes for developing guidelines and instructions are typically not open and include limited participation compared to the code development processes.

In sum, while CPT (in combination with HCPCS) has been designated the standard code set for physicians' services and other health care services, this designation does not require private and public payers to adopt CPT guidelines and conventions, nor does it affect the way in which these payers handle code combinations and modifiers. The feasibility study needs to evaluate the political environment that caused HHS to not recognize CPT guidelines, and the potential for change.

The current CPT editorial processes are oriented toward the development of text based code descriptors and guidelines. This is very different from the computer driven analysis of code combinations and the required clinical scrutiny of procedures included and procedures excluded. The enormous number of edits and the need to continually refine the edits with each coding or guideline change would potentially require changes to the existing CPT editorial process. The feasibility study needs to evaluate the current CPT workload on the national medical specialty societies that participate in CPT, the technical requirements of edit development, and potential changes to accommodate both.

FEASIBILITY STUDY METHODOLOGY

Given the existence of the National Correct Coding Initiative (NCCI) and commercial claims editing products, differences in payer, physician, patient and other stakeholder perspectives about coding and related matters, and a host of political and practical considerations, any proposal to develop a National Standard for the utilization of CPT codes, code combinations and modifiers, would need to address a number of issues and concerns. To assist the AMA in determining the feasibility of developing a National Standard for the utilization of CPT codes, code combinations and modifiers, the study will provide background information about several relevant matters. These include: CPT itself and its companion publication, *CPT Assistant*; CPT use by public and private payers; the NCCI developed by the Centers for Medicare and Medicaid Services (CMS); proprietary code edits; ICD-9-CM, a separate coding system for patient diagnoses and for procedural services provided in the inpatient hospital setting; HCPCS; and a few other miscellaneous issues.

The study will be based on a review of a wide range of written documents and online reference materials. It will also be based on more than two dozen structured interviews with representatives of key stakeholders in CPT and other individuals with relevant expertise and experience. These included the following:

- Representatives of the CPT Editorial Panel, the CPT Advisory Committee, the Health Care Professionals Advisory Committee (HCPAC), and the AMA Specialty Society Relative Value Update Committee (RUC);
- Physician and staff representatives of physician specialty societies, state medical societies, and national organizations representing non-physician health professionals;
- Representatives of hospitals, professional coders, and coding consultants;

- Representatives of the Centers for Medicare and Medicaid Services, Medicare contractors, the National Center for Health Statistics, the National Committee on Vital and Health Statistics and other agencies of the US Department of Health and Human Services;
- Physician and staff representatives of private insurance companies and managed care organizations, and the national associations representing their interests; and
- Individuals knowledgeable about proprietary claims editing programs.

The interviews are expected to be conducted by telephone and will likely last 45 to 60 minutes. All those participating in the interviews will be assured that any information gathered through them would not be attributed to individuals by name. This will facilitate a frank and open exchange. In addition to the structured interviews, the study will include discussions with the AMA staff involved with CPT and *CPT Assistant*, and from informal conversations with a wide range of individuals knowledgeable about CPT coding and related matters.

CONCLUSION

The result of the feasibility study will be a thorough analysis of the political and technical circumstances surrounding the development of CPT compliant code combinations and their required use. The feasibility study will also generate a series of options for implementing necessary elements of the code edit development process and associated benefits and costs for each. These options will require in-depth analysis by AMA staff and relevant CPT stakeholders.

The feasibility study is still in process; all interview data needs to be collected and analyzed, proposed options for meeting the objectives of Resolution 709 need to be developed, and staff needs time to evaluate the final report and the options. The study and options will be presented at the AMA House of Delegates Interim Meeting in December 2005.

14. NATIONAL INSTITUTES OF HEALTH PUBLIC ACCESS POLICY (RESOLUTION 723, I-04)

HOUSE ACTION: RECOMMENDATION ADOPTED (RESOLUTION 723, I-04 NOT ADOPTED) AND REMAINDER OF REPORT FILED

At its 2004 Interim Meeting the House of Delegates, Reference Committee J considered Resolution 723, "Medical Research Publishing Proposal from NIH," submitted by American College of Rheumatology and American Society of Hematology. The resolution was referred for decision with request for a report back to the Board of Trustees.

Resolution 723 asked that:

Our AMA (1) oppose the current "NIH Public Access Policy" proposal until answers are provided regarding the specific mechanisms of implementation, the cost to the National Institutes of Health (NIH) budget and resulting impacts on grant funding, the extent of access to the unpublished research results, copyright protection issues for authors and the impact on scientific publishing and professional organizations; (2) that our AMA work with the government, the NIH, Congress and other relevant constituents to develop a reasonable timeline for continued discussion of the issue; (3) that our AMA work with relevant constituencies to propose changes that meet the broad intent of a new paradigm for publishing the results of NIH sponsored medical research without introducing mandates that have a negative impact on researchers, medical associations and other involved parties; and (4) that our AMA use its resources to educate the membership throughout the progression of these activities.

In a November 16, 2004, letter to Dr. Elias A. Zerhouni, Director, National Institutes of Health, the AMA submitted comments concerning NIH's Notice of Enhanced Public Access to NIH Research Information, 69 FR 56074 (September 17, 2004):

As the publisher of the *Journal of the American Medical Association (JAMA)* and the *Archives Journals*, the AMA strongly supports the broad intent of NIH's proposal, i.e., ensuring the widespread availability of the results of NIH-funded research. Expanded access to research results and information benefits physicians,

other health professionals, researchers, and the public, and helps to advance science through wider dissemination of new knowledge. We appreciate NIH's recognition of the need for consideration of the business and economic implications of its proposal. That being said, however, we are concerned with how NIH intends to implement its proposal. The basic elements of NIH's proposal, as currently structured, could have serious negative consequences not only for scientific publishing, but also for the medical and scientific societies that sponsor many of the nonprofit journals. The publishing process of *JAMA* and other prestigious medical and scientific journals provides extensive value-added features for patients and clinicians.

The value added by the publication process is significant, and we are concerned that NIH's proposal could ultimately result in undermining the integrity and quality of the information being provided through this process. NIH's proposal could have significant financial implications for the non-profit organizations and medical specialty societies that sponsor and publish medical research, particularly those that specialize in "niche" medical research. Most of these organizations' scholarly and publishing activities support their operations in part from their medical journal subscriptions, and the medical subspecialty societies, in particular, may depend heavily on their subscription revenue to sponsor their educational and other activities. If these organizations are negatively impacted by this proposal, they might limit or shut down their publications, to the overall detriment of scientific research, and the organizations themselves might have to curtail their activities.

We also are concerned about copyright issues. The articles published in *JAMA* and other similar journals are copyrighted to protect their quality and intellectual integrity. This copyright protection is critical to prevent the misuse of scientific data. NIH's proposal does not address copyright issues at all. The AMA strongly believes that it is critical to the integrity of the medical publishing enterprise that publishers retain the copyrights to their published articles. We urge the NIH to make clear that its proposal does not make any change to copyright law, that copyright notices will continue to appear on copyrighted publications, and to indicate what uses of copyrighted repository materials are prohibited.

We do not believe that a central repository of research articles, operated and controlled by the NIH, is necessary or is the best approach to achieving NIH's goal of enhanced public access. Publishers such as the AMA already make much of this material available online, free of charge or for a modest fee. For example, the AMA offers all of the research articles published in *JAMA* free on our web site six months after publication no matter how they are funded. In addition, each issue of *JAMA* offers one of the featured articles free of charge upon publication for one week. Moreover, the NIH proposal does not address how to help patients and their families interpret the complex science reported in journal articles in an appropriate context so that they can understand and apply the clinical relevance of such studies to their own situations. To that end, the weekly patient page of *JAMA*, which is linked to an article in that issue, is written specifically for the public, and clinicians are encouraged to provide free copies to their patients. Medical publishers, including medical societies such as the AMA and commercial publishers, are planning a voluntary initiative called INFORM, which will make available relevant medical information with interpretation and context, to patients free-of-charge. A pilot project is scheduled to start in early 2005.

What the NIH is proposing will require a significant financial investment. At a time of record deficits, where will the funding come to expand NIH's digital repository, which currently houses only a small portion of the biomedical literature? Will such funding come at the expense of further investment in biomedical research and negatively impact NIH grant funding? The AMA and other publishers have already invested millions of dollars into developing successful online repositories that use unique identifiers and interlinking capabilities to facilitate reliability, authentication, and discoverability of published research. These repositories include not only NIH-funded research, but all articles, editorials, commentaries, perspectives, news, and letters published by the journals, creating a comprehensive body of knowledge that is constantly growing. Most medical and science journals, including *JAMA* and the *Archives Journals*, have digital object identifiers attached to each article. These are deposited with a number of services--such as CrossRef--that provide interlinking of articles. For example, if an individual is reading a *JAMA* article online and finds a reference to an article in another medical journal, a simple click on the reference connects the reader to that article. These links work rather seamlessly among the thousands of journals that participate in CrossRef.

Given such investment by the private sector, we recommend that NIH reconsider its proposal to expand PMC to create a central government research repository. Existing publishers such as the AMA are already serving this purpose through the extensive networks described above. We propose that the NLM should continue to receive abstracts in its PMC archive, with the abstracts linked to publisher sites. The articles themselves should continue to reside on the publisher's site, even when they are made available for free after an appropriate period of time. As indicated earlier, the copyright for the published articles must be retained by the publisher.

Under NIH's proposal, the public would have free access to publications resulting from NIH-sponsored research within six months after publication. Six months after publication may be the appropriate timeframe for publishers of weekly publications such as *JAMA* to recoup their investment. However, for monthly or less frequent publications, six months may not provide enough time for publishers to recoup their investments; for such publications, one year would be more appropriate before allowing free access. We recommend that NIH clarify what it means by "publication" as the trigger point for free access. Many journals now post articles online for subscribers as soon as the papers are accepted for publication, which is often well in advance of the release of the printed publication. We believe that "publication" means publication in the official format of journals, i.e., print versions for some and online for others, for purposes of triggering the time period to allow free public access.

Finally, as NIH itself acknowledges, altering the long-standing business models used by most publishers will have business and economic implications that need to be considered. We think it is important to give publishers at least a two year window to make the transition to any free access model proposed by NIH.

In conclusion, we urge NIH to proceed cautiously in implementing this proposal so that the concerns of all of the affected stakeholders can be fully considered and the potential impact on publishers can be fully evaluated. The AMA shares the NIH's goal of ensuring public access to publications resulting from NIH-funded research, and looks forward to working with the NIH as this proposal moves forward.

Subsequent to transmittal of the letter, AMA staff reiterated the AMA position through professional publishing organizations such as American Association of Publishers and the International Association of Scientific, Technical, and Medical Publishers, and in meetings with Dr. Zerhouni and NIH staff.

The NIH announced its policy on this subject on February 3, 2005:

Beginning May 2, 2005, NIH-funded investigators are requested to submit an electronic version of the author's final manuscript upon acceptance for publication, resulting from research supported, in whole or in part, with direct costs from NIH. The author's final manuscript is defined as the final version accepted for journal publication, and includes all modifications from the publishing peer review process.

This Policy applies to all research grant and career development award mechanisms, cooperative agreements, contracts, Institutional and Individual Ruth L. Kirschstein National Research Service Awards, as well as NIH intramural research studies. The Policy applies to peer-reviewed research publications, resulting from research supported in whole or in part with direct costs from NIH, but it does not apply to book chapters, editorials, reviews, or conference proceedings.

Under this Policy, electronic submission will be made directly to the NIH National Library of Medicine's (NLM) PubMed Central (PMC): <http://www.pubmedcentral.nih.gov>. PMC is the NIH digital repository of full-text, peer-reviewed biomedical, behavioral, and clinical research journals. It is a publicly-accessible, stable, permanent, and searchable electronic archive.

At the time of submission, the author will specify the timing of the posting of his or her final manuscript for public accessibility through PMC. Posting for public accessibility through PMC is requested and strongly encouraged as soon as possible (and within twelve months of the publisher's official date of final publication).

The publisher may choose to furnish PMC with the publisher's final version, which will supersede the author's final version. Also, if the publisher agrees, public access to the publisher's final version in PMC can occur sooner than the timing originally specified by the author for the author's final version.

Effective with progress reports submitted for Fiscal Year 2006 funding, this Policy provides an alternative means, via PMC, for NIH-supported investigators to fulfill the existing requirement to provide publications as part of progress reports. Though the NIH anticipates that investigators will use this opportunity to submit their manuscripts, sending electronic copies is voluntary and will not be a factor in the review of scientific progress.

By creating an archive of peer-reviewed, NIH-funded research publications, NIH is helping health care providers, educators, and scientists to more readily exchange research results and the public to have greater access to health-related research publications. As the archive grows, the public will be more readily able to access an increasing number of these publications.

Once the system is operational, modifications and enhancements will be made as needed. An NIH Public Access Advisory Working Group will be established to advise NIH/NLM on implementation and assess progress in meeting the goals of the NIH Public Access Policy.

This Policy is intended to improve the internal management of the Federal government, and is not intended to create any right or benefit, substantive or procedural, enforceable at law by a party against the United States, its agencies, its officers, or any person.

Areas of concern identified by the AMA and in Resolution 723 by the AMA are largely addressed by the NIH policy.

RECOMMENDATION

Therefore, the Board of Trustees recommends that Resolution 723 (I-04) not be adopted and the remainder of this report be filed.

15. DEVELOPMENT OF CPT CODES FOR COORDINATION OF CARE BETWEEN PHYSICIANS (RESOLUTION 724, A-04)

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 724 (A-04) AND REMAINDER OF REPORT FILED

BACKGROUND

At the 2004 Annual Meeting of the American Medical Association House of Delegates, Reference Committee G considered Resolution 724. This resolution was introduced by the Illinois Delegation and asks the AMA to work toward the establishment of CPT codes that provide for coordination of care or for continuity of services by the patient's personal physician while the patient is under the care of a hospitalist; and study this issue and take action as soon as possible to strongly support a policy: (1) forbidding mandatory use of hospitalists by opposing their mandatory use by any institution or health care payer including, but not limited to, managed care organizations and the Centers for Medicare and Medicaid Services; and (2) providing for consideration of patients who are incapacitated at the time of admission and have pre-existing agreements with their physicians to deliver continuing care in the event they are hospitalized and cannot express a desire to see their personal physicians.

The AMA House of Delegates referred Resolution 724 to the AMA Board of Trustees. The following Board report is in response to this referral and will review existing CPT codes and guidelines in the Case Management and Evaluation and Management sections. Existing AMA policy in support of the primary care physician will also be reviewed along with the nature and cause of the continuity of care problem. Finally, based on these analyses recommendations will be offered.

DISCUSSION OF ISSUES

The Reference Committee recommended that the following existing AMA policy be reaffirmed in lieu of the original Resolution 724:

D-285.999 Mandatory Use of Hospitalists

Our AMA will continue its advocacy of Policy H-285.932 [has been consolidated. See H-285.964.], in both its private sector and Joint Commission activities by opposing the mandatory use of hospitalists and providing resources and support to physicians facing implementation of mandatory hospitalist policies. (Sub. Res. 714, I-98)

H-285.964 Admitting Officer and Hospitalist Programs.

AMA policy states that: (1) managed care plan enrollees and prospective enrollees should receive prior notification regarding the implementation and use of “admitting officer” or “hospitalist” programs; (2) participation in “admitting officer” or “hospitalist programs” developed and implemented by managed care or other health care organizations should be at the voluntary discretion of the patient and the patient’s physician; (3) hospitalist systems when initiated by a hospital or managed care organization should be developed consistent with AMA policy on medical staff bylaws and implemented with approval of the organized medical staff to assure that the principles and structure of the autonomous and self-governing medical staff are retained. (4) Hospitals and other health care organizations should not compel physicians by contractual obligation to assign their patients to “Hospitalists” and that no punitive measure should be imposed on physicians or patients who decline participation in “hospitalists programs.” (5) AMA opposes any hospitalist model that disrupts the patient/physician relationship or the continuity of patient care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants. (Sub. Res. 714, I-95; Amended by CMS Rep. 4, A-98; Reaffirmed: Res. 819, A-99; Reaffirmation I-99; Reaffirmed: Res. 812, A-02)

H-225.960 The Emerging Use of Hospitalists: Implications for Medical Education.

It is the policy of our AMA that the use of a hospitalist physician as the physician of record during a hospitalization must be voluntary and the assignment of responsibility to the hospitalist physician must be based on the consent of the patient’s personal physician and the patient. (CME Rep. 2, A-99; Reaffirmation I-99; Reaffirmed: Res. 812, A-02)

On the floor of the House, the Reference Committee recommendation for reaffirmation was not accepted and instead the issue was referred to the American Medical Association Board of Trustees. This action suggests that the House of Delegates believes that the development of CPT codes that recognize the value of the primary care physician and the importance of coordination between the primary care physicians and the hospitalist in providing care for the patient are needed. Since AMA policy opposes “any hospitalist model that disrupts the patient/physician relationship or the continuity of patient care” (see H-285.964 above), the current resolution asks for a means to implement this policy through coding.

In addition to problems associated with coordination of care and obstruction of the patient/physician relationship, the motivation for Resolution 724 is the problem of payers not allowing multiple claims to be submitted by both the hospitalist and the primary care physician for the same patient on the same day. Thus, the implication is that the development of a CPT code to describe physician to physician communication in order to coordinate the care of a patient while the patient is under the care of a hospitalist will alleviate these problems. This report will discuss the benefit and outcome of having such CPT code, and will review existing CPT codes for case management services.

DISCUSSION OF CPT CODES AND PAYMENT POLICY

The CPT code set does not have existing codes that completely capture physician to physician communication in circumstances where a primary care physician and a hospitalist are both providing care for a patient. Existing CPT codes in the Case Management section describe circumstances in which a “physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient”. In circumstances where care is provided by both a primary care physician and a hospitalist it is unclear which physician is responsible for the direct care of the patient. This confusion is exacerbated by payment policies of third party payers which mandate use of hospitalist without consideration for the primary care physician.

CPT codes 99361, *Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes*, and 99362, *Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 60 minutes*, are codes to describe team conferences coordinated and led by the physician who has direct responsibility for care of the patient. Even if the issue of which physician has direct responsibility for care were resolved, these team conference codes would not be appropriate since they describe meetings with multiple individuals some of whom may not be health care professionals.

CPT codes under case management services also contain codes for telephone calls. The following codes potentially would allow for communication between the primary care physician and a hospitalist:

99371 - Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (e.g., nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (e.g., to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy).

99372 - Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (e.g., nurses, therapists, social workers, nutritionists, physicians, pharmacists); intermediate (e.g., to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care).

99373 - Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (e.g., nurses, therapists, social workers, nutritionists, physicians, pharmacists); complex or lengthy (e.g., lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan).

While these codes do allow for physician-to-physician communication, they are limited to telephone communication and are still constrained by the confusion surrounding which physician is directly responsible for the care of the patient. Other CPT codes that may seem to initially apply to these circumstances, such as office or inpatient consultations are not applicable since consults are limited to situations in which the consult is requested by another physician.

Although the CPT code set does not have codes that completely describe physician to physician communication for circumstances in which a primary care physician and a hospitalist are both providing care for a patient, the lack of appropriately descriptive codes is not responsible for payment or communication problems, and the development of an appropriate code would not eliminate them. The primary source of difficulty is the payment policies of third party payers that mandate the use of hospitalists and restrict payment to primary care physicians. As was discussed in testimony before the Reference Committee, payers have adopted these policies to save money and the existence of appropriate CPT codes for physician to physician communication would not change the fiscal orientation of payers. Such CPT codes would simply be ignored and not paid. The routine denial of payment for the above telephone call codes are an example of this.

The only resolution to communication, payment and potential patient care problems is the adoption by payers of existing AMA policy that supports the value and central role of the primary care physician when their patient is admitted to the hospital. Such policy would allow the primary care physician to submit CPT case management codes, but more importantly would permit the primary care physician to submit claims for inpatient Evaluation and Management codes (99217 - 99239) on days they provide care to their patient. For example, AMA Policy H-225.960 states; "the assignment of responsibility to the hospitalist physician must be based on the consent of the patient's personal physician and the patient." Such consent would help to eliminate confusion for both physicians and plans.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 724 (A-04) and the remainder of this report be filed:

1. That American Medical Association Policy H-225.960, "The Emerging Use of Hospitalists: Implications for Medical Education," be retitled as "Voluntary Use of Hospitalists and Required Consent" to properly reflect its intention.
2. That our AMA reaffirm Policies: D-285.999, "Mandatory Use of Hospitalists"; H-285.964, "Admitting Officer and Hospitalist Programs"; and H-225.960, "Voluntary Use of Hospitalists and Required Consent."

16. PROFESSIONAL LIABILITY ALTERNATIVE FINANCING (RESOLUTION 231, A-04)

HOUSE ACTION: RECOMMENDATION ADOPTED IN LIEU OF RESOLUTION 231 (A-04) AND REMAINDER OF REPORT FILED

INTRODUCTION

At the 2004 Annual Meeting, the House of Delegates referred Resolution 231, introduced by the Iowa Delegation, to the Board of Trustees. This resolution asks our AMA to "study the feasibility of seeking federal legislation for a tax-exempt alternative financing mechanism specific to physician groups' ability to retain earnings in a private professional liability trust solely for medical liability insurance coverage."

BACKGROUND

As the medical liability crisis continues to grow, physicians are finding it more difficult to obtain and afford medical liability insurance, especially in certain geographic areas and for several high-risk specialties. Our AMA has remained committed to our advocacy campaign to seek passage of effective federal tort reforms based on Medical Injury Compensation Reform Act (MICRA), and has vigorously communicated to Congress, state legislatures, and the public the affect the current medical liability crisis is having on the practice of medicine and patient access to care. In addition, the Board of Trustees has remained firm in its conviction, based on empirical evidence, that limits on non-economic damages and other MICRA reforms are the most effective means to stabilize the medical liability insurance market in the near term. In addition to MICRA, the Board, with input and guidance from the Council on Legislation, has studied and reported on numerous other constructs that could enhance MICRA reforms (see Board Reports 32-A-03 and 13-I-03). Resolution 231 offers another construct to supplement MICRA reforms. As with the constructs in Board Reports 32 and 13, in evaluating Resolution 231 the Board was guided by a simple two-part test. First, will the proposed change or proposal be more likely than not to lower physician medical liability premiums significantly? Second, will the suggested reform be politically viable? For each test, the Board also weighed the advantages and disadvantages, both political and financial, of this Resolution.

PROFESSIONAL LIABILITY ALTERNATIVE FINANCING

In many areas of the country, the medical liability crisis has caused liability insurance premiums to skyrocket, which in turn has prompted physicians to seek out or develop alternatives (beyond MICRA) to reduce their insurance costs. As evidenced by Resolution 231, the idea of establishing a self-insurance trust to pay medical liability claims is one such alternative. A self-insurance trust is an arrangement whereby a provider (e.g., non-profit hospital) contributes monies to a self-insurance reserve that is held by an independent entity and is specifically dedicated to the payment of liability claims. These arrangements sometimes replace commercial medical liability insurance coverage. It is more common, however, for providers to utilize a self-insurance trust to cover a high deductible under a purchased commercial medical liability insurance policy. The self-insured exposure is commonly referred to as a "self-insured retention." Under this approach, the provider only self-insures up to an agreed upon dollar amount, and the

commercial insurance carrier provides coverage for amounts over the self-insured retention. In general, the advantages of self-insurance trusts are more for administrative efficiency (control and lower operating costs) than tax purposes. One disadvantage is that risk is not transferred broadly and one bad case could wipe out a trust and leave a defendant personally liable for any unsettled damage awards.

The idea of self-insurance trusts is not new. Some large group practices have established self-insurance trusts (COPIC was established as a self-insurance trust before it converted to an insurance company in 1984). Also, non-profit (exempt) hospitals have long set aside funds to cover their own liability risks. In general, entities established and controlled by such hospitals to act as self-insurance trusts have also been recognized as exempt as long as a substantial part of their business activity is not providing “commercial-type” insurance. Where the commercial insurance market fails to offer affordable coverage, these arrangements may substitute for or supplement commercially purchased insurance.

Under existing tax law, however, it does not appear feasible for physicians (or physician groups) to establish a professional liability trust that would meet the criteria of Resolution 231. The inability of medical practices (individual or group) to retain earnings for medical liability insurance coverage under current tax law is an aspect of the general rule that contributions to self-insurance reserves are *not* deductible. “The reason for this rule is that a taxpayer is not considered to have incurred a deductible expense for payments in the current year when the funds remain available (and accruing income) to satisfy its obligations in later years.” *Anesthesia Service Medical Group, Inc. v. Commissioner*, 825 F.2d 241 (9th Cir. 1987). This case appears to be the only one that has applied this rule to a liability insurance trust maintained by a medical practice. Nevertheless, it has been cited in numerous other cases and IRS rulings applying the rule in other contexts. It is thus one of the leading cases and is remains the legal precedent.

Under current law, if a medical practice purchases medical liability insurance from an insurance company the premiums are a deductible business expense. There is thus a tax incentive to purchase liability insurance rather than self-insure, even though self-insurance may be considered a financing mechanism that makes more sense from a business perspective in some cases. One argument for the type of legislation called for by Resolution 231 would be that it is more economically efficient than purchasing insurance from a third-party commercial entity. Such legislation might also lower the cost of liability insurance for physicians and indirectly help lower the cost of health care.

The Board considered two aspects of insurance taxation that are outside the scope of Resolution 231. First, Internal Revenue Code section 501(c)(15) provides a tax exemption to non-life insurance companies with gross receipts under \$600,000 per year (more than 50% of receipts must be from premiums). Although limited, a company formed under this section by a group of small medical practices might be an alternative to a self-insurance trust in some cases. Second, there is something called a “medical malpractice self-insurance pool” which appears to be similar to what is proposed by Resolution 231. Under current tax law, however, a medical malpractice self-insurance pool cannot serve as a substitute for the type of trust called for by Resolution 231 because such an arrangement only qualifies if it was in existence in 1984.

AMENDING THE TAX CODE

For the reasons discussed above, the Board has determined that it does not appear feasible under existing tax law for physicians to establish a professional liability trust with the tax advantages envisioned in Resolution 231. The Board therefore considered whether it is politically viable attempt to amend the Internal Revenue Code to allow earnings retained by such trusts to be tax exempt and any contributions to such trusts to be deductible expenses. The Board also discussed whether such amendment would be more likely than not to lower physician medical liability premiums significantly.

As the Board discussed in Board Report 32-A-03, the House should be aware that, beyond the proven reforms of MICRA, comprehensive data supporting added reforms are scarce. The Board has initially determined, however, that the reform called for in Resolution 231 could hold particular promise as a potential MICRA enhancement, especially for group practices that may be able to supplement high-deductible medical liability insurance policies with a trust to cover small claims. The combination of lower insurance premiums (due to a higher deductible) and a tax deduction may prove to save money overall. While the degree of savings would vary among specialties and geographic regions, the Board believes that such an option should be available to all physicians and group practices.

The Council on Legislation advised the Board that drafting an amendment to the Internal Revenue Code to allow for the tax benefits called for in Resolution 231 is essentially a straightforward legislative exercise. The Council reported that section 162 (Trade or Business Expenses) of the Internal Revenue Code could be amended to allow contributions to a medical liability trust to be a deductible expense, and section 501(c) (List of Exempt Organizations) could be amended to specifically list medical liability trusts as being exempt from paying taxes. The degree to which such an amendment is politically viable would likely depend on how much federal revenue would be lost as estimated by the Congressional Budget Office.

In addition, the President has stated that medical liability reform that includes a cap on non-economic damages is at the top of his agenda for his second term. As the Board has previously stated, our AMA's first order of business is to stabilize medical liability insurance premiums by advocating for the enactment of proven reforms and then look at the various promising long-term options. In that regard, the Board is focusing now on passage of legislation supported by the President, based on proven MICRA reforms, and which passed in the House of Representatives twice in the 108th Congress. At some point in time, however, it will be necessary to add to the achievement of national MICRA reforms and the Board believes that our AMA would benefit by having policy in place supporting professional liability trusts as envisioned in Resolution 231, as well as a legislative proposal drafted and available that would amend the Internal Revenue Code to allow such trusts.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 231 (A-04) and that the remainder of this report be filed:

That our American Medical Association support legislation that would amend the Internal Revenue Code to allow medical professionals and entities to establish tax-exempt professional liability trusts to pay medical liability claims.

17. TORT REFORM

HOUSE ACTION: FILED

BACKGROUND

Substitute Resolution 921 was adopted by the House of Delegates at the 2004 Interim Meeting. The first two resolves of this substitute resolution call on our AMA to "continue to pursue MICRA-based [medical liability] reform as the top priority," and "continue to pursue [medical] liability reform efforts by any and all legislative options that would fundamentally change our medical liability system to create fair and equitable remuneration for injured patients and to promote patients' access to health care." The third resolve, and the main subject of this informational report, calls on the Board of Trustees to "report on its coalition-building activities on efforts to reform our civil justice system and make this report available to the general membership by the 2005 Annual Meeting."

The Board developed this informational report with the assistance of its Task Force on Medical Liability Reform and the Council on Legislation. The report includes a review of the following: (1) AMA policy on building coalitions and creating task forces to address all aspects of medical liability reform, including current Policies H-435.972, D-165.980, D-435.992, and H-435.969 (AMA Policy Database); and (2) AMA coalition-building activities on efforts to bring about reforms to the civil justice system. These activities include our AMA's collaboration with Congress, the Administration, state medical societies, national medical specialty societies, the Health Coalition on Liability and Access, the American Tort Reform Association, the US Chamber of Commerce, the National Conference of State Legislators, the National Association of Insurance Commissioners, the National Conference of Insurance Legislators, the AMA Alliance, and Common Good. Past Board reports provide a detailed overview of previous AMA medical liability reform activities relating to our coalition-building policies discussed below (see Board Reports 35-A-02, 23-I-02, 31-A-03, 32-A-03, 13-I-03, and 17-I-03).

AMA POLICY

The House of Delegates has adopted several policies over the past decade calling on our AMA to build coalitions and create task forces to address all aspects of medical liability reform. H-435.972 was adopted in 1992 (reaffirmed in 2003) and calls on our AMA to continue to address the need for effective nationwide liability reform through the AMA's coalition-building activities and efforts on behalf of state and federal liability reform.

D-165.980, adopted in 2001, is the first recent effort by the House of Delegates to restate our commitment to building coalitions to advocate for medical liability reform. It calls on our AMA to convene a coalition of state and national medical specialty associations to develop and implement a comprehensive strategic plan that will address all aspects of the growing professional liability crisis. This was accomplished at various levels within the House of Medicine (see Board Reports 35-A-02 and 23-I-02), and continues through our AMA's Advocacy Resource Center (ARC), the AMA's annual State Legislative Strategy Conference, regular meetings/conference calls with state medical society staff, and the Medical Liability Reform Workgroup of national medical specialty societies in conjunction with our AMA's Washington, DC office. Policy D-165.980 has also guided our coalition building activities with state medical societies by restating long-standing AMA policy that any federal solution to the medical liability crisis "shall not preempt state constitutional, statutory, regulatory and common laws that set caps or other restrictions on liability awards which are lower or more comprehensive than the caps on liability awards established by such federal legislation" (also see Policy H-435.964).

Our AMA is further directed by policy to build coalitions with non-physician groups that are impacted by our national's broken civil justice system and seek similar liability reforms. Policy D-435.992 calls on our AMA to "recruit a broad-based coalition composed of Federation members (state/county/specialty societies), trade and professional associations, small and large businesses, medical groups, farmers, non-profit organizations, local governmental associations, patient advocacy groups and other supportive groups to promulgate a public information campaign on the issues of civil liability reform." This policy also calls for the development of "a broad-based and sustained grassroots member mobilization campaign to communicate its call for immediate legislative relief from the current tort system to our congressional representatives and senators," as well as a liability reform task force to "work with state and national medical specialty societies to develop and implement a comprehensive strategic plan that will address all aspects of the growing medical liability crisis to ensure that federal medical liability reform legislation continues to move forward through the legislative process."

As discussed below, our AMA has established or joined coalitions that support the development of alternatives to the current civil justice system that go beyond Medical Injury Compensation Reform Act (MICRA). Our participation in these coalitions is guided by AMA policy (see H-435.969, H-435.968, H-435.967, D-435.987, and D-435.997) and in no way diminishes our fundamental support for prompt enactment of effective federal medical liability reforms based on MICRA. The Board remains firm in its conviction, based on empirical evidence, that limits on non-economic damages and other MICRA reforms are the most effective means to stabilize the medical liability insurance market in the near term. Our policy recognizes, however, the critical need to work with other like-minded organizations to build on the base of MICRA reforms as soon as this federal legislation is enacted. Therefore, in addition to MICRA, the Board, with input and guidance from the Council on Legislation, has studied and reported on numerous other constructs that could enhance MICRA reforms (see Board Reports 32-A-03 and 13-I-03). These studies have helped provide the Board with an understanding of the complexities, potential effectiveness, and limitations of liability reforms beyond MICRA, such as health courts, that are being developed or considered by other organizations that participate in coalitions or otherwise hold discussions with our AMA.

COALITION BUILDING AND OTHER ACTIVITIES

The beginning of the 109th Congress and the 2005 state legislative season has brought new vigor to our AMA's national medical liability reform campaign. From the very start of 2005, our AMA has been ready with an action plan that includes working with our existing coalitions on MICRA-based medical liability reforms and participating in coalitions that support broader tort reforms such as those regarding class-action and asbestos litigation.

At our AMA's State Legislative Strategy Conference in early January 2005, AMA Chair J. James Rohack, MD laid out a six-step plan to build momentum for congressional action this year. This plan was developed in conjunction with White House staff and as a build-up to the President's State of the Union Address on February 2. The plan included working with each state medical society in asking physician and patient grassroots activists to contact their US Representative and Senators urging prompt action on meaningful medical liability reform and hosting one or

more bipartisan town hall meetings during the week of February 21. As part of this effort, our AMA activated 350,000 patients and utilized the AMA Grassroots Action Center located on the “AMA in Washington” section of the AMA web site. The plan also called for our AMA to coordinate with state medical societies the logistics of the town hall meetings, develop a schedule of meetings with top Democratic prospects in the US Senate, develop a list of patient and physician media contacts, and seek contributions to a data base of patient and physician cases that highlight the loss of patient access to care and the indirect costs of the broken civil justice system. This data base is intended to be shared with the Federation.

Lastly, the plan acknowledged that federal medical liability reform is part of a broader tort reform agenda in Congress and the White House. At the time this report was drafted in mid-March the President had already signed into law a class action reform bill passed by Congress. Our AMA is well positioned through our involvement with two prominent coalitions to support efforts to pass legislation on broader reforms, such as asbestos litigation reform. First, Dr. Maves serves on the Board of the US Chamber of Commerce’s Institute for Legal Reform. AMA staff also has worked closely in the past with counterparts at the US Chamber and will continue to do so in the 109th Congress. Second, our AMA is a founding member and serves on the Board of the American Tort Reform Association, which supports general tort reform.

The following is a summary of other activities that relate to our AMA’s ongoing and growing involvement in coalitions to advocate for effective medical liability reforms.

Health Coalition on Liability and Access (HCLA)

Our AMA is a founding member of HCLA (www.hcla.org) and holds a seat on the HCLA Board. HCLA is a national advocacy coalition united in the strong belief that federal medical liability reform laws are needed to bring greater fairness, timeliness, and cost-effectiveness to our system of civil justice. HCLA focuses its total efforts on medical liability reform and its membership is directly interested in the medical liability issue. HCLA holds bi-weekly meetings and other meetings as necessary.

American Tort Reform Association (ATRA)

Our AMA is a founding member of ATRA (www.atra.org) and has served on the ATRA Board since its inception in 1986. Our AMA also co-chairs the ATRA Subcommittee on Medical Liability Reform with the America’s Health Insurance Plans (AHIP). ATRA supports general tort reform and has strong policy in support of medical liability reform. It accomplishes its legislative agenda by working with state tort reform coalitions, and serves as a clearinghouse of information from approximately 40 state tort reform coalitions. Each fall, ATRA hosts a planning conference at which coalition leaders meet to discuss past successes and future strategies. The ATRA Board meets on a regular basis. ATRA also sends out a weekly legislative update to keep members abreast of state and federal tort reform initiatives, judicial elections, and the activities of the plaintiffs’ bar.

Advocacy Resource Center (ARC)

The ARC created a multi-faceted, comprehensive campaign on medical liability reform, providing legislative, communications, and legal support to state medical societies. In particular, the ARC maintains a summary of key medical liability reform laws in the fifty states and tracks and analyzes current state legislative activity. The ARC also provides talking points, model testimony, model legislation, data, and other advocacy tools for the states to use in their legislative efforts. In addition, the ARC organized the 2005 State Legislative Strategy Conference in January. This forum provided a unique opportunity for leaders from the state and national medical specialty societies to discuss strategies to advocate for medical liability reform in the states during the 2005 legislative sessions. The ARC’s efforts on medical liability reform are part of a multi-division AMA effort that includes Health Policy, Health Law, Legislative Counsel, Political Affairs, Government Affairs, and Communications in developing the various ARC advocacy materials that are shared with Federation.

AMA/National Specialty Medical Society Medical Liability Reform (MLR) Workgroup

The AMA/National Specialty Medical Society MLR Workgroup is comprised of 11 specialty societies that have representatives in Washington, DC. The Workgroup meets on a regular basis at our AMA’s Washington office to share information, develop strategies for advancing medical liability reform legislation in Congress, and develop a

consistent message for communications with the Hill, media, and other organizations. The Workgroup has also met with senior congressional staff to communicate our common goal to seek passage of effective medical liability reform legislation this year.

National Association of Insurance Commissioners (NAIC)

The NAIC (www.naic.org) is a national organization composed of insurance regulators from the fifty states. The NAIC provides a forum for regulators to provide uniform policies on insurance issues when appropriate. The ARC worked closely with the NAIC Property and Casualty Insurance Committee and Market Conditions Working Group in developing a comprehensive report on the medical liability insurance market. The ARC advocated on behalf of organized medicine by providing written comments on numerous versions of the report. ARC staff also represented our AMA during NAIC meetings and conference calls when critical elements of the language and substance of the report were discussed, including changes proposed by groups that oppose medical liability reform. Our presence at these meetings was critical in ensuring that members of the committee heard from organized medicine.

National Conference of Insurance Legislators (NCOIL)

The ARC has worked closely with NCOIL (www.ncoil.org), an organization of state legislators interested in insurance issues. When NCOIL considered new policy supporting state efforts to consider medical liability reforms that, among other things, cap non-economic and punitive damages, ARC staff participated in panel discussions, and provided oral and written testimony on the proposed policy. During these discussions, ARC staff ensured that committee members understood our AMA's medical liability reform policy. The ARC continues to work closely with NCOIL on both medical liability reform and patient safety to ensure that AMA policy and the interests of organized medicine continue to have a voice before this important group.

The National Conference of State Legislators (NCSL)

NCSL (www.ncsl.org) is a bipartisan organization that serves state legislators and their staff through research and by providing forums for state leaders to discuss ideas on pressing issues facing state legislators. During the past six years our AMA has participated in a joint booth with at least a dozen other national medical societies, including the American Academy of Family Physicians, American Academy of Ophthalmology, American Academy of Otolaryngology-Head & Neck Surgery, American Academy of Pediatrics, American College of Cardiology, American College of Obstetricians and Gynecologists, American College of Surgeons, American Osteopathic Association, American Society of Anesthesiologists, and American Society of Plastic Surgeons at NCSL's Annual Meeting. Also, the state medical society from the state where the meeting is being held is asked to participate in our "Physicians Advocating for Patients" booth, which is now one of the largest in the exhibition hall. Over the past few years the common theme of the booth has been the need for medical liability reform. NCSL is in the process of forming a task force composed of key stakeholders in the medical liability reform debate. The purpose of the task force is to discuss strategies for medical liability reform. The ARC has been invited to participate in the task force.

AMA Alliance

As the volunteer arm of our AMA (www.ama-assn.org/ama/pub/category/2109.html), the Alliance's mission is to build healthy communities and support the family of medicine with sound legislation and health care projects throughout the United States and abroad. To support our AMA's medical liability reform efforts, Alliance members campaign for legislators and ballot initiatives that support the family of medicine's issues, organize get-out-the-vote drives and voter registration for physicians and health care workers so they can vote for medicine-friendly candidates, contact their legislators regarding local and national medical liability reform legislation, organize and run phone and e-mail chains regarding relevant legislation, plan "Day at the Capitol" events to lobby legislators about medicine-friendly legislation, encourage physicians and Alliance members to contribute to AMPAC and state PACs, and distribute AMA's medical liability materials to doctors offices, such as the Physician Action Kit, 2005 Health Care Advocacy Agenda cards, and fall 2004 advertisements on "Healing the System." In 2005, the Alliance worked closely with the Medical Association of Georgia to "keep doctors in Georgia" by promoting meaningful tort reform legislation in the Georgia legislature.

US Chamber of Commerce/Institute for Legal Reform

The US Chamber of Commerce's Institute for Legal Reform (ILR) (www.instituteforlegalreform.com) was established in 1998 as a 501(c)(6) tax-exempt, separately incorporated affiliate of the US Chamber of Commerce. The ILR works to make America's civil justice system simpler, fairer, and faster for all. Regarding medical liability reform, the ILR supports federal legislation that would place a cap on the amount of damages that could be awarded in medical liability lawsuits and works with health-care liability stakeholders at the federal and state levels to help pass medical liability reform legislation. The mission and goals of the ILR are to: neutralize plaintiff trial lawyers' excessive influence over the legal and political systems; ensure enactment of common sense legal reform and related legislation; promote the election or selection of pro-legal reform judges and other public officials; create and maintain public support for legal reform, including building alliances with groups and organizations to advance the legal reform agenda; reform the class action system to make it simpler, fairer and faster; enact common sense reforms to ensure fairness in liability suits; ensure damage awards are fair and equitable; eliminate frivolous lawsuits; and enforce legal ethics rules. As noted above, Dr. Maves serves on the Board of the ILR.

AMA National Advocacy Conference (NAC)

Our AMA's March 2005 National Advocacy Conference in Washington, DC provided an opportunity to impact the framework of the national medical liability reform agenda. Attendees making Hill visits were asked to focus on liability reform, Medicare physician payment formula, and patient safety issues, as well as other key issues. Several breakout sessions provided attendees with material, advice, and strategies for delivering a strong, effective, and consistent advocacy message to the Hill on these critical issues. More than 600 physician leaders attended, and followed up by directly lobbying their respective Senators and Members of Congress. Also, the Medical Student Section and Resident and Fellow Section of the AMA were represented by close to 300 of their members and played an important role lobbying on the Hill during the NAC. The conference drew a broad array of speakers from both houses of Congress, the Administration, and respected public policy institutions.

Grassroots

Substantial grassroots activities have taken place so far this year, including the mobilization of activists to persuade Senators to support effective liability reforms. The leadership of the US Senate remains committed to moving MLR legislation in the near future and our AMA is prepared to launch a full-scale grassroots campaign when the issue comes up in that chamber. Our AMA has nearly 100,000 physicians who are actively participating in a grassroots network to call attention to the problem and effectuate change. Patients are involved as well. Our AMA Patients' Action Network currently has nearly a half-million patients advocating for effective reforms by way of well over one-and-a-half million communications to their respective Members of Congress.

National House Call

The AMA National House Call mission is to drive the nation's top health care issues, including medical liability reform, into public debate to initiate meaningful reform at the state and federal levels. National House Call goes directly to local communities, listens to citizen concerns, holds public and private meetings with physicians and medical students, and strongly advocates for reform. Since its 1999 launch, the NHC has visited 31 states and the District of Columbia, making nearly 600 appearances in more than 150 cities. In 2004 alone, the NHC conducted more than 50 individual radio, television, and newspaper interviews, met with 15 editorial boards, and made more than 50 individual stops in small towns and large cities from coast to coast. National House Call also has met with presidential candidates, governors, and state and federal officials, and discussed health care issues with literally hundreds of newspaper, magazine, radio, and television reporters. Radio and newspaper ads also are a key component used to raise public awareness of key health care issues.

Through our National House Call program, AMA leaders have joined state and local medical societies to participate in physician rallies in numerous states. Thus far in 2005, our AMA has joined physicians at public rallies, town hall meetings, and legislatures in Oregon, South Carolina, and Tennessee. Also, during the NAC meeting in March, our AMA joined the Medical Society of the District of Columbia in a press conference calling on the Mayor and DC Council to take immediate action to enact medical malpractice reform legislation. These rallies have garnered considerable media attention and helped unite physicians. A strong effort will continue throughout the year to coordinate many of the campaign activities with AMA press events.

Communications

Communications has been an integral component in our AMA's effort to build coalition support for medical liability reform. Communications engages in regular collaboration with state and national medical specialty societies to share new research--pro and con material, timely anecdotes, and updates to the key physician contacts that are shared with Members of Congress, the Administration, and media. Communications' work with the ARC on state crisis backrounders also has been a key coalition-building exercise for the past several years, assuring that crisis states and our AMA are in accord with the criteria for determining "what is a crisis" in a particular state. Communications also works closely with the ARC to develop state-specific messages as part of National House Call activities. These activities are in addition to the daily efforts by Communications to initiate letters to the editor and op-eds, respond to media inquiries, and ensuring our AMA message is communicated in a timely, appropriate, and effective manner.

Common Good

Common Good is a bipartisan coalition whose mission is to restore common sense and reliability to American law. One of its goals is to create a system of justice that is reliable for all parties. Because of the highly technical nature of modern medicine, Common Good believes that a new system of medical justice is necessary. One idea is to create a specialized court system, similar to the patent court system. Special health courts would oversee lawsuits brought against physicians. In such courts, the judge would be specially trained in medical liability litigation. In theory, these judges would be more capable of moving a case to trial quickly and would be better prepared to settle such cases prior to convening a trial. Details of a health court system have not yet been formerly developed, but federal legislation was proposed in the previous Congress for a state-based demonstration project of a health court system. Our AMA is not a member of this coalition, but does meet regularly with its primary advocate, Philip Howard, as well as Common Good staff, to maintain an open dialogue on ideas for improving our civil justice system.

CONCLUSION

As we move forward into 2005 and the 109th Congress, the Board is committed to building and maintaining coalitions to advocate for federal and state medical liability reform. We will be working closely with national medical specialty societies, congressional leaders, the White House, HCLA, ILR, and others to determine the best strategy for passing a federal bill that the President can sign into law. We will also work closely with state medical societies and state societies, ATRA, and others to push for effective state reforms. Along the way, we will continue to be guided by two core principles: federal legislation must not do any harm to those states that have enacted effective medical liability reforms, and support for federal bills is contingent on determinations by actuarial experts that proposals will stabilize and ultimately reduce medical liability insurance premiums and improve patient access to care. The Board will keep our House of Medicine informed as we move forward on this high-priority issue.

18. FAIR PAYMENT FOR PROFESSIONAL LIABILITY INSURANCE (RESOLUTION 712, I-04)

HOUSE ACTION: RECOMMENDATION ADOPTED IN LIEU OF RESOLUTION 712 (I-04) AND REMAINDER OF REPORT FILED

At the 2004 Interim Meeting, the American Medical Association House of Delegates referred Resolution 712, "Fair Payment for Professional Liability Insurance," to the Board of Trustees for report back at the 2005 Annual Meeting. This resolution calls on the AMA to: (1) develop alternative methodologies that will accurately account for the actual costs of professional liability insurance (PLI); and (2) in consultation with national medical specialty societies, develop recommendations for alternative methods for Medicare PLI reimbursement.

This report summarizes the existing methodology employed by the Centers for Medicare and Medicaid Service (CMS) to pay physicians for their costs of PLI under the Resource-Based Relative Value Scale (RBRVS). This report discusses the AMA/Specialty Society RVS Update Committee's (RUC) actions to date and highlights the committee's success in halting a decrease in payment to many of the specialties who are facing escalating PLI costs. In addition, the report explains the recent RUC recommendations to CMS and other ongoing efforts that may lead to a further correction of the PLI relative values on January 1, 2006 and beyond. Finally, the report explains the payment methodology preferred by the authors of the Resolution 712 and outlines the advantages and disadvantages of such an approach.

AMA POLICY

AMA policy supports an active role for organized medicine in ensuring that the payment to physicians for PLI costs is fair and based on reliable data. This policy specifically states that our AMA will: (1) continue its current activities to seek correction of the inadequate professional liability insurance component in the RBRVS formula; (2) continue its current activities to seek action from the CMS to update the PLI relative value unit component of the RBRVS to correctly account for the current relative cost of PLI and its funding; and (3) support federal legislation to provide additional funds for this correction and update of the PLI relative value component of the RBRVS, rather than simply making adjustments in a budget-neutral fashion (Policy D-400.988, AMA Policy Database). The AMA Board of Trustees presented an informational report at the 2004 Annual Meeting describing the progress in each of these areas and discussed how PLI premiums are reflected in the individual PLI relative values, the geographic payment adjustments, and the Medicare conversion factor.

PLI RELATIVE VALUE METHODOLOGY

The Medicare RBRVS was implemented on January 1, 1992. At that time, only the work component of this payment system was resource-based. The practice expense and PLI components were based on historical charges. In 1999, CMS began a four-year transition to resource-based practice expense relative values. The Balanced Budget Act of 1997 required the development of resource-based PLI relative value units. In 2000, CMS initiated a three-year transition to resource-based PLI relative values units. Effective January 1, 2002, all components of the RBRVS were considered to be resource-based. On average, PLI costs comprise less than 4% of the RBRVS, while physician work accounts for 52% and practice expense accounts for 44% of the RBRVS.

In implementing the new PLI relative values, CMS considered previous reports of the Physician Payment Review Commission (PPRC) and the Medicare Payment Advisory Commission (MedPAC). The PPRC had recommended that CMS collect PLI premium data across insurers and assemble the data by risk groups. MedPAC had previously recommended that CMS base the PLI relative values on actual claims related to specific procedures. In the Final Rule for the 2000 Medicare Physician Payment Schedule, CMS announced that it would not use the MedPAC approach as this type of data was not available and it is not possible to correlate claims paid to a specific Current Procedural Terminology (CPT[®]) code, when a combination of services are performed.

CMS uses a number of data sources in developing PLI relative values, including: (1) actual and projected PLI premium data; (2) Medicare utilization data to determine which specialties perform each individual CPT code; and (3) the assigned physician work relative value for each service. CMS contracted with Bearing Point (formerly KPMG Consulting) to develop its methodology, collect premium data, and perform the necessary analysis to compute the PLI relative values. CMS is required, by statute, to review and potentially revise the PLI relative values not less than every five years. On January 1, 2005, CMS published revised PLI relative values, utilizing existing methodology with updated data, again collected by its contractor Bearing Point. The methodology utilized to develop PLI relative values is described in the following steps:

Step 1

A national average PLI premium was calculated for each specialty using 2001-2002 actual data and 2003 projected data. Premiums were collected by the contractor who surveyed the State Departments of Insurance. All premiums collected are based on a \$1 million/\$3 million mature claims-made-policy (a policy covering claims made, rather than services provided during the policy term). The contractor was able to obtain 2001 premium data for 48 states,

but only 33 states were able to provide data for 2002 as they had not yet obtained premium data from the primary insurers in their state at the time of the survey. In responding to criticism that the 2001 and 2002 data were not current, CMS also projected specialty premiums for 2003 using the annual percentage changes in premiums from 1999 to 2002 in each geographic locality.

The CMS contractor collected premium data for twenty specialties. However, CMS relied on this premium data to calculate the average annual premiums for only eight specialties. The average annual premiums for the other twelve specialties are based on either rating manuals from five selected insurers (Medical Assurance, Truck Insurance, Medical Mutual Liability Insurance Company, St. Paul, and Medical Protective) or a combination of the collected premium data and rating manuals. For all other specialties, CMS either utilized the rating manuals from the five selected insurers or crosswalked one specialty's premiums to another specialty (e.g., neuropsychiatry was crosswalked to psychiatry).

Step 2

Risk factors (nonsurgical and surgical) were calculated for each specialty by dividing the national average premium for each specialty by specialty with the lowest average premium. For example, the thoracic surgery risk factor is 6.91 compared to the psychiatry nonsurgical risk factor at 1.11. CMS applied the surgical risk factors to CPT codes 10000 to 69999 and the non-surgical risk factor to all other services. CMS allows exceptions and has assigned surgical risk factors to codes that describe cardiac catheterization services. In addition, CMS allows a higher surgical risk factor for orthopaedic surgeons who perform spine surgery. Higher obstetric premiums and risk factors are also used for CPT codes that describe obstetrical services.

Step 3

PLI relative values were calculated for each CPT code. The percentage of a specific service provided by each specialty was multiplied by the specialties' risk factor, and the product was then summed across specialties by service. This yielded a specialty-weighted PLI relative value that was then multiplied by a physician work relative value for that code to account for differences in risk-of-service. In instances where the work relative value equaled zero, CMS retained the current professional liability relative values (i.e., based on historical charges). A simplistic illustration of this methodology is as follows:

Illustration

Medicare utilization data are utilized to determine which specialties perform the service described by the CPT code:

CPT Code 11401	
Dermatology	38%
Family Practice	23%
General Surgery	25%
Internal Medicine	7%
Plastic Surgery	7%

CPT code 11401 is deemed to be "surgical." The percentage is then multiplied by the specialties' surgical risk factors:

Dermatology	$.38 \times 1.86 = 0.71$
Family Practice	$.23 \times 4.26 = 0.97$
General Surgery	$.25 \times 6.13 = 1.53$
Internal Medicine	$.07 \times 2.48 = 0.17$
Plastic Surgery	$.07 \times 6.92 = 0.48$
Total	3.86

The products for all specialties for the procedure are then summed, yielding a specialty-weighted PLI relative value, reflecting the weighted PLI costs across all specialties for that procedure:

CPT Code 11401 = 3.86

This number will then be multiplied by the procedure's work relative value to account for differences in risk-of-service:

CPT Code 11401 3.86×1.23 (work relative value) = 4.75

The PLI relative value from above is adjusted to scale to the PLI relative values available.

CPT Code 11401 $4.75 \times 0.021 = 0.10$ PLI relative value

Step 4

The calculated PLI relative values are then additionally adjusted for budget neutrality to maintain the same level of expenditures for PLI. CMS maintains the same pool of PLI relative values. Any modifications to the underlying data will only redistribute the PLI relative values between services and specialties.

RUC REVIEW AND RECOMMENDATIONS OF THE PLI METHODOLOGY AND DATA

In anticipation of the five-year update to the PLI relative values, the RUC created a Professional Liability Insurance Workgroup. The PLI Workgroup has met numerous times since 2003 and has reviewed the CMS methodology and underlying data in great detail. The Workgroup has made a number of recommendations to CMS, several of which have been implemented. The RUC is in the process of developing additional recommendations that are anticipated to further improve the PLI valuation on January 1, 2006, and beyond. The RUC's specific recommendations and the status of CMS consideration are outlined below:

Premium Data

The RUC has criticized the PLI premium data, utilized by CMS for both the PLI relative values and the Geographic Practice Cost Indices (GPCIs), as outdated, particularly in light of the recent PLI premium crisis. Currently, CMS utilizes actual 2001 and 2002 data and projected 2003 data. The RUC had urged CMS to determine the exponential rate of growth in the PLI premium data from 2001 to 2003 to predict 2004 premium data. The RUC further requested that CMS use this predicted 2004 data only and not weight-average these data with data from previous years. In addition, the RUC has also recommended that CMS use data on the cost of tail coverage in the determination of PLI annual premium data. Finally, the RUC recommends that PLI data be collected and utilized for all specialties rather than for the very few specialties that are currently based on actual data.

CMS has been responsive in sharing the actual premium data collected with the RUC. The complete database of summary data was shared with the RUC in 2004. The agency has stated that it is receptive to working with the RUC and organized medicine to collect more recent premium data, including tail coverage costs, for a wider range of specialties. However, CMS has stated that it will not consider the use of projected 2004 data and that the agency preference is to continue using an average of several years of data. The RUC is currently in discussions with CMS regarding the possibility of using other data sources. One potential opportunity may be to work with the Physician Insurers Association of American (PIAA) to collect 2004 and 2005 data from their member companies. The PIAA has expressed a willingness to participate with this project. RUC representatives are in current discussions with CMS staff regarding a new PLI premium collection effort utilizing PIAA member companies.

Crosswalks to Specialties/Professions Without Premium Data

Data were not available from either collected premiums or rating manuals for nearly 30 specialties and other health care professionals. CMS, therefore, chose to crosswalk these specialties/professions to other specialties with data, based on the judgment of the contractor's medical staff. The RUC PLI Workgroup reviewed each of these crosswalks at their February 2005 meeting and has submitted a number of recommendations to revise these crosswalks for the 2006 Medicare Physician Payment Schedule. The majority of these changes relate to non-MD/DO professions (e.g., clinical psychologist, licensed clinical social worker, occupational therapist, optician, optometrist, chiropractor, and physical therapist) where CMS had originally estimated that these professions PLI premiums were equivalent to an average of all physicians (approximately \$20,000). The RUC recommended that each of these professions instead be assigned the very lowest risk factor of 1.00 as an interim measure. The lowest risk factor of 1.00, serving as the denominator to compare all other specialties, is based on an annual premium amount of \$6,152.

The RUC understands that an annual premium of \$6,152 still greatly overestimates the actual premiums paid by these non-MD/DO health care professionals. The RUC has urged CMS to collect actual data for these professions. It is estimated that the lack of any data collection for these professions has led to compression in the premium data and risk factor analysis. For example, CMS currently utilizes an annual premium estimate of \$73,848 for neurosurgery and divides this by the lowest premium estimate of \$6,152 to calculate a risk factor of 12.00. If, however, CMS were to utilize actual premium data for one of these professions of \$1,000, the risk factor for neurosurgery increases from 12.00 to 73.84. CMS is currently working with a contractor to collect practice expense data for non-MD/DO health care professionals. The AMA is working with CMS to also collect PLI premium costs as part of this survey.

Medicare Utilization Data

CMS utilizes the 2003 Medicare utilization database to determine which specialties perform each service in order to assign risk factors to individual CPT codes. The RUC has identified a number of issues with this utilization data and has recommended that CMS use the dominant specialty to determine the risk factor assignment for the CPT code. The RUC has viewed this to be consistent with the typical patient methodology utilized to value the other components of the RBRVS. To date, CMS has been reluctant to use the “dominant specialty” approach as the agency prefers to reflect all of those specialties that perform the procedure in the methodology. However, CMS has agreed to work with the RUC to improve the utilization data. In 2005, the CMS implemented the RUC’s recommendation to remove all assistant-at-surgery claims from the analysis. This single improvement changed the -0.6% reduction in payment for neurosurgery, outlined in the August 5, 2004 Proposed Rule, to a .3% increase in payment implemented on January 1, 2005.

The RUC is currently working on two further improvements in the utilization data. For approximately 2,000 services described within CPT, fewer than 100 services are provided to Medicare patients each year. The RUC will review each of these 2,000 services and indicate to CMS the expected specialty for each of these CPT codes. The RUC will recommend that this expected specialty data be utilized, rather than the annual utilization data that often includes a number of gross errors that could greatly impact the payment of these rare procedures. For example, in one year, the only claim for hand replantation was from psychiatry. CMS is also working with the RUC to review codes with utilization greater than 100 to remove anomalous data. The RUC will review proposals to remove data beyond a certain threshold (i.e., specialties performing less than 2%, 5%, 7% of a service) at their April 2005 RUC meeting. It is expected that these further improvements to the Medicare utilization data would be implemented by January 1, 2006.

ALTERNATIVE METHODOLOGY TO PAY PHYSICIANS FOR PLI COSTS

The dramatic increases in PLI premiums, coupled with the flawed data utilized in the current CMS methodology, have led some specialties to call for alternative methods for Medicare to pay physicians for PLI costs. The American Association of Neurological Surgeons and the Congress of Neurological Surgeons, authors of Resolution 712, are interested in a methodology for payment of PLI costs that is independent of CPT coding and the RBRVS.

The primary concept proposed is that CMS might capture the PLI costs of the individual practicing physician and then pay that physician directly for the Medicare portion of those costs. Neurosurgery has argued that PLI costs are not directly related to the volume or variety of procedures. In addition, the current payment methodology may overcompensate some health care professionals for their actual PLI costs, while failing to appropriately cover the costs of those specialties who are facing escalating PLI premiums.

Without readily available representative case mix data, the AMA has reviewed the following two anecdotal examples of actual PLI payment based on the RBRVS system:

1. Physical therapists report their services in 15-minute increments (i.e., four CPT codes may be typically reported for each hour worked). 2003 survey data from the American Physical Therapy Association confirms that typical independently practicing physical therapist works 2,000 hours per year (40 hours per week x 50 weeks). A physical therapist would, therefore, report approximately 8,000 CPT codes per year. Most physical therapy CPT codes are assigned a PLI relative value of 0.02. Therefore, one can calculate that the typical physical

2. therapist would collect 160 PLI relative values per year (8,000 x 0.02). Utilizing the 2005 Medicare conversion factor of \$37.90, it is estimated that physical therapists would collect \$6,064 per year for PLI costs if all payers used the RBRVS with the Medicare conversion factor. It is estimated that this is an overpayment for actual PLI costs incurred.
3. A neurosurgeon's annual claims data were reviewed and compared to productivity reports from the Medical Group Management Association (MGMA). These MGMA reports summarize total relative values, outpatient visits, and procedures for neurosurgery. The annual claims data for this single neurosurgeon's practice indicated a total of 501 PLI relative values out of a total of 12,070 relative values. In addition, PLI relative values associated with Evaluation and Management services were estimated. These data were then extrapolated to the MGMA total relative value productivity data of the 25th, 50th and 75th percentile as follows:

	<u>25th %</u>	<u>50th %</u>	<u>75th %</u>
Total Relative Values	15,000	18,000	22,000
Extrapolated Procedure PLI Relative Values	623	747	913
Extrapolated E&M PLI Relative Values	92	120	168
Computed PLI payment	\$27,099	\$32,860	\$40,970

CMS is currently utilizing data that reflects that the annual average PLI premium costs for neurosurgery is \$73,848. The above analysis indicates that if all payers were utilizing the RBRVS and the Medicare conversion factor, the average neurosurgeon would receive approximately \$32,860 in payment to cover PLI costs. This payment amount would not even cover one-half of a neurosurgeon's annual PLI premiums, which reflect costs prior to the current PLI crisis.

The fiscal note assigned to Resolution 712 was estimated to be \$108,233. This includes estimated staff cost of \$23,233 to develop this alternative methodology and lobby because any such methodology would require legislation. In addition, consultant fees of \$85,000 were estimated to perform thorough analysis to collect actual physician case mix data and compute impact analyses of converting to this alternative methodology. The above two examples are anecdotal and these arguments and analysis would need to be significantly improved to lead to any conclusive impacts across specialties.

Other considerations beyond the actual Medicare payment amounts would also need to be considered before exploring such an alternative methodology for PLI payment. Even if the AMA were to be successful in seeking legislation to require Medicare to pay physicians for their direct share of PLI costs, would private payers also compensate physicians in the same manner? Another potential problem relates to privacy issues. Physicians may not wish to submit their actual annual premium costs to Medicare. Any reported estimate of the percentage of Medicare patients in a given practice would also likely be open to audit by Medicare. Physicians may also not want this additional intrusion into their practice.

LEGISLATIVE STRATEGY

In 2004, CMS updated the components of the RBRVS to be consistent with the Medical Economic Index (MEI). As PLI costs became a larger percentage share of the MEI, all relative values (work, practice expense, and PLI) were simply re-scaled in a budget neutral fashion, rather than increasing the Medicare conversion factor to account for these increased PLI costs. The cut to the 2002 conversion factor of 5.4% and pending cuts in 2006 and beyond, only heighten the concern that Medicare payments will not cover the costs of PLI. The AMA is working closely with medical specialty societies to eliminate the flawed sustainable growth rate system formula, which does not allow for actual increases in payment to account for these escalating PLI premiums. Along with a Medicare update fix, medical liability reform is one of our AMA's top priorities.

Each of these legislative priorities is centered at doing what is best for all physicians. The AMA Board of Trustees believes that the AMA's focus should remain on these priorities that will benefit all physicians. The Board is optimistic that the RUC will continue to make improvements to the PLI relative values through recommendations to CMS that will improve the relativity and ultimately help those medical specialties who have suffered the most throughout this medical liability crisis.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 712 (I-04) and the remainder of this report be filed:

That our American Medical Association reaffirm Policy D-400.988, which states that our AMA will: (1) continue its current activities to seek correction of the inadequate professional liability insurance (PLI) component of the Resource-Based Relative Value Scale; (2) continue its current activities to seek action from the Centers for Medicare and Medicaid Services to update the PLI relative value units to correctly account for the current relative value costs of professional liability insurance and its funding; and (3) support federal legislation to provide additional funds for this correction and update of the PLI component of the RBRVS, rather than simply making adjustments in a budget-neutral fashion.

REPORT 19 WAS WITHDRAWN

20. PHYSICIAN CONSORTIUM FOR PERFORMANCE IMPROVEMENT

HOUSE ACTION: FILED

At the request of the American Medical Association Board of Trustees Task Force on Quality, Safety, and EHR, this report, which is being provided to the House of Delegates for its information and involvement, provides an update on the AMA-convened Physician Consortium for Performance Improvement.

MEMBERSHIP, MISSION, AND VISION

The Physician Consortium for Performance Improvement (the Consortium), which established its name, mission, and vision in November 2000, identifies and develops performance measurement resources to assist physicians in enhancing the quality of care. As of March 2005, the Consortium included more than 65 national medical specialty societies; eight state medical associations; experts in methodology and data collection; the Agency for Healthcare Research and Quality (AHRQ); and the Centers for Medicare and Medicaid Services (CMS). The Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance (NCQA) are liaison members of the Consortium. The Consortium is convened and staffed by the AMA, which also provides independent consultants to support the Consortium.

The vision of the Consortium, a physician-led initiative, is to fulfill the responsibility of physicians to patient care and public health and safety by: (1) becoming the leading source organization for evidence-based performance measures and outcomes reporting tools for physicians; and (2) ensuring that all components of the medical profession have a leadership role in all national forums seeking to evaluate the quality of patient care. The mission of the Consortium is to improve patient health and safety by identifying and developing evidence-based clinical performance measures that enhance quality of patient care and that foster accountability; promoting the implementation of effective and relevant clinical performance improvement activities; and advancing the science of clinical performance measurement and improvement.

CLINICAL PERFORMANCE MEASURES

As of March 2005, the Consortium had completed clinical performance measurement sets intended for practicing physicians for the following conditions and preventive care and screening topics:

- Adult diabetes (developed by the National Diabetes Quality Improvement Alliance);
- Asthma;
- Chronic obstructive pulmonary disease;

- Community-acquired bacterial pneumonia;
- Coronary artery disease (developed in collaboration with the American College of Cardiology and the American Heart Association);
- Heart failure (developed in collaboration with the American College of Cardiology and the American Heart Association);
- Hypertension (developed in collaboration with the American College of Cardiology and the American Heart Association);
- Major depressive disorder;
- Osteoarthritis of the knee (developed in collaboration with the American Academy of Orthopaedic Surgeons);
- Prenatal testing; and
- Preventive Care and Screening Measures:
 - Colorectal cancer screening;
 - Influenza immunization, adult;
 - Screening mammography;
 - Problem drinking; and
 - Tobacco use cessation.

The Consortium plans to develop measures for the following topics in 2005:

- Atrial fibrillation (to be developed in collaboration with the American College of Cardiology and the American Heart Association);
- Child and adolescent major depressive disorder;
- Pediatric gastroenteritis (to be developed in collaboration with the American Academy of Pediatrics and the American Academy of Family Physicians); and
- Peri-operative care (to be developed in collaboration with the American College of Surgeons, the National Surgical Quality Improvement Program, and the Veterans Administration).

In addition, the Consortium will conduct reviews of several existing measurement sets in 2005 to ensure they remain current with clinical recommendations and the results of measure testing.

Any Consortium member or interested party may submit a topic to the Consortium for possible measure development. The Consortium also considers topics of interest to national groups, including AHRQ, CMS, the National Quality Forum, and the Institute of Medicine. Suggested topics are reviewed against a set of established criteria and voted on by the full Consortium.

National medical specialty societies may serve as “lead organizations” with the Consortium in developing measurement sets. As of March 2005, the following societies have served, or will serve, as lead organizations:

- American Academy of Family Physicians.
- American Academy of Orthopaedic Surgeons;
- American Academy of Pediatrics;
- American College of Cardiology; and
- American Heart Association;

The Consortium is in active discussions with the following societies regarding measurement development or review of existing measures:

- American Academy of Neurology;
- American Academy of Ophthalmology;
- American Academy of Otolaryngology-Head and Neck Surgery;
- American Association of Clinical Endocrinologists;
- American Society of Clinical Oncology; and
- Renal Physicians Association.

PROCESS AND HALLMARKS OF CONSORTIUM PERFORMANCE MEASURE DEVELOPMENT

When a topic is selected for measure development, the Consortium convenes a Work Group that includes volunteers from the Consortium membership, additional clinicians and medical professionals knowledgeable of the topic, and representatives from the patient, employer, and health plan communities. Following Consortium and public comment periods, the Work Group seeks consensus in making a recommendation to the full Consortium. The Consortium makes the final determination by vote as to whether the set should be approved for widespread distribution for testing and use.

Regardless of the topic of the measures, several Consortium hallmarks apply:

- the measures are based on evidence provided in clinical practice guidelines;
- the Work Groups include cross-specialty representation;
- the Work Groups solicit comments from the Consortium and the public;
- the measurement sets and data collection vehicles may serve as both measurement tools and interventions; and
- the measures are relevant for clinical practice by considering medical and patient reasons why a guideline recommendation may not be followed.

MAINTAINING THE INTEGRITY OF CONSORTIUM WORK

The AMA holds copyright on the performance measures on behalf of the Consortium, which is an unincorporated entity. The copyright enables the Consortium to: (a) protect the uniformity and integrity of the measures; (b) update its measures as necessary; and (c) retire or withdraw outdated measures--a patient safety issue.

Consortium members and others can use the measures for any noncommercial purpose; e.g., use by health care providers in connection with their practices is not a commercial use. Commercial use is defined as the sale, license, or distribution of measures for commercial gain, or incorporation of the measures into a product or service that is sold, licensed, or distributed for commercial gain. The Consortium has authorized the AMA, on behalf of the Consortium, to negotiate license agreements as appropriate, for commercial uses of the measures to promote their implementation. The AMA has developed a royalty-free licensing agreement template for use of the measures by vendors of electronic health records.

USE OF CONSORTIUM MEASURES

The Consortium measures are intended to assist physicians in enhancing the quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. The measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its measures for all potential applications but encourages the testing and evaluation of its measures for multiple purposes, including point-of-care information for patient management; aggregate patient data for systems analysis; continuing medical education credit; components of maintenance of certification for board certification; health plan and payer requests for data; and pay-for-performance programs.

NATIONAL RECOGNITION OF CONSORTIUM WORK

In late 2002, CMS requested that the Consortium develop performance measures for testing in its Doctors' Office Quality and Doctors' Office Quality-Information Technology pilot projects. CMS covered the costs to develop the measures, which were completed in early 2003, for coronary artery disease, heart failure, hypertension, osteoarthritis, and major depressive disorder. Also at the request of CMS, in 2004-2005 the Consortium developed performance measures for chronic obstructive pulmonary disease; these measures will be tested in the CMS Chronic Care Improvement Project. Additionally, David Brailer, MD, PhD, the National Coordinator for Health Information Technology, released a framework for strategic action in July 2004 that called for streamlining quality and health status monitoring and noted the use of Consortium measures in CMS pilot projects as part of this strategy.

The National Quality Forum (NQF) has initiated an ambulatory care performance measure project. Phase II of the project includes an expedited review of measures submitted jointly by CMS, the AMA/Consortium, and NCQA. The NQF board is expecting to vote on the measures in July, following recommendations from technical committees and member comments. The AMA has entered an agreement with NQF, on behalf of the Consortium, to maintain the Consortium measures endorsed by NQF.

Additionally, America's Health Insurance Plans, the American College of Physicians, American Academy of Family Physicians, and AHRQ have formed a group charged with identifying a "starter set" of measures that can be used by health plans in pay-for-performance programs. Participants in the initial meetings expressed interest in considering Consortium and NCQA measures for inclusion in its starter set.

INTEGRATION OF CONSORTIUM MEASURES INTO HEALTH INFORMATION TECHNOLOGY

The AMA is working with three different practice sites in the Chicago area to test the ability to enter data and retrieve reports from electronic health systems based on the specifications for the Consortium's measures. This work is partially funded by two AHRQ grants.

21. AMA PERFORMANCE, ACTIVITIES, AND STATUS IN 2004

HOUSE ACTION: FILED

INTRODUCTION

At the 2003 Annual Meeting, the House of Delegates adopted Council on Long Range Planning and Development Report 1, which proposed consolidation of numerous Board of Trustees reports into a smaller number of coordinated reports (Policy G-605.050, Annual Reporting Responsibilities of the AMA Board of Trustees). Previously, the Board was required to submit more than 20 reports to the House annually on a variety of topics. Most of these were informational in nature, and in aggregate produced more than 250 pages of material. CLPRD Report 1 proposed a consolidated approach consisting of a four key reports each year that cover much of the same content in a more concise format. More detailed information on many of these topics will be available on the AMA web site.

One of the reports required by the new policy is an annual omnibus report that provides highlights on AMA's performance, activities, and status in the previous calendar year.

MAJOR THEMES AND ACTIVITIES FOR 2004

The 2004 AMA Plan identified four overarching themes for the year: marshalling the forces of organized medicine to craft solutions for key advocacy initiatives, demonstrating value to our members and potential members, recommitting our historical pledge to the betterment of public health, and continuing efforts to streamline governance and operational functions. Key activities targeted for 2004 were all aimed at achieving these objectives. The following information is organized around the major topics covered in the 2004 AMA Plan, since summarizing performance relative to the strategic plan is one of the purposes of the new reporting format.

MARKETING COMMUNICATIONS

Membership Marketing

Membership continued to be the target of major developmental work in 2004, and significant steps were made to begin to revitalize the AMA brand to proactively reshape the AMA value proposition to drive sustainable membership growth. Following House action on the Report of the Committee on Organization of Organizations that endorsed maintaining the AMA as an organization of individual members in 2004, the Board and AMA staff continued to focus on strategies to enhance membership.

The key strategies call for enhancing the overall value provided by the AMA to physicians through focused, high-impact activities as well as enhanced member benefits; reshaping the AMA's marketing related both to partnering with the Federation on membership recruitment as well as direct membership; enhancing two-way communications between the AMA and members; providing more opportunity for member participation in the AMA; and enhancing the positioning and operational aspects of internal membership recruitment, retention, and servicing processes. In addition, the strategic plan called for elevating the membership marketing functions in the organization.

The AMA ended the year 2004 with 244,530 members. This 2.5 percent rate of decline was an improvement over the prior year when the AMA experienced a 3.7 percent drop in membership. The Federation delivered 145,905 members and 98,625 members came through AMA direct marketing initiatives. 2004 dues revenues were \$48.1 million with the average dues rate improving from \$195 to \$196.

In September 2004, the AMA announced the appointment of Gary Epstein as Chief Marketing Officer. Mr. Epstein brings extensive marketing communications and strategic branding expertise to the organization. Through his leadership, the AMA will reinvigorate the AMA brand, enhance the member value proposition, streamline and integrate member communications, and deliver targeted physician and patient communications.

Guided by analysis of management consulting firm of McKinsey and Company, and support from AMA leadership, Mr. Epstein has reorganized the marketing, membership, and communications divisions to streamline the ability of the AMA to demonstrate the important and distinctive role for the AMA around three major goals:

- Greater physician involvement in AMA decisions and actions.
- More focused advocacy.
- Improved communication.

The AMA also convened the first of a series of open forum roundtable discussions in major cities throughout the country and launched a Member Connect survey research program to help direct the AMA's agenda-setting and identify emerging topics.

Integrated Brand Management and Strategy

As part of the reorganization, new areas were formed to help provide cross-functional leadership to clarify and ensure brand consistency across the Association. By centralizing creative services for the Association in a single place, the AMA can ensure consistent messaging and "look and feel" across all member and employee touchpoints.

Integrated Communications Services (ICS) - Working with all areas of the AMA, ICS created communications plans and tools to develop, promote, and deliver products, programs and services. ICS managed 600 projects in 2004. Highlights include:

- Brand definition through work on (1) a wave of Member Connect physician surveys; (2) the first member Roundtable Discussion Forums; (3) visual identity scans to assess brand confusion; and (4) redesign of the Interim Meeting in a transition to a new brand look.
- Publications on competition in health insurance, physician professional liability, managed care contracts, and audits, and relating to representatives of state insurance agencies and health plans.
- Credentialing product advertising to introduce enhanced value of the Physician Profiles Service, based on official designation of the American Board of Medical Specialties.
- Advocacy efforts including marketing and communications for the President's Forum, National Advocacy Conference, Healing the System Campaign, National House Call, and National Conference of State Legislators.

Plans for responsibilities of ICS to be divided between two units were undertaken. Creative Brand Services will be responsible for all creative projects. This unit will write, design and produce all materials needed by the association. Brand Management will help create marketing plans for AMA initiatives/products and serve a new contact management role--keeping track of all AMA mailings.

Web Site Communications - During 2004, the editorial team led a major overhaul of the AMA web site, focusing primarily on new navigation and the site architecture. While more work will be done to improve the "look and feel" of the site, today's site is in line with our new brand statement--emphasizing the areas our members have told us are most important to them.

Employee Communications - The primary vehicle for internal communication continues to be a daily, afternoon e-mail newsletter. To reflect our new brand strategy, this newsletter is now called MyConnection and has been reorganized to emphasize employees and the workplace community. The transition to MyConnection was very smooth, and staff response continues to be very positive. We also have greatly increased our use of the intranet. It now serves as a news vehicle and helps connect employees to each other.

Employee Communications plays an essential role in supporting employee events of all kinds, including: the all-employee meetings held by Dr. Maves, fundraisers (raising donations for a number of causes including the Greater Chicago Food Depository and Project Hope), and brand training for employees. In the upcoming year, this area will take on increased responsibility for ongoing brand training for employees.

Member Publications - Under the recent reorganization to emphasize marketing of the Association to members and potential members, the staffs of *American Medical News* and the *AMA Voice* suite of publications now report to Member Publications.

In 2004, *American Medical News* demonstrated its continued success in competing against all other medical publications for readers, as measured by syndicated readership scores. The newspaper is now the No. 4 physician publication in its key competitive rating, up from 13th place in 1997. It demonstrated similar growth across its entire range of readership measurements. In 2004, the paper published 48 issues containing news and information focused tightly on serving reader needs for valuable, reliable information about today's medical practice environment. In editorials each week, the paper advocates for the policies of the AMA, and every issue of the publication provides opportunities for AMA leaders to tell readers about the Association's activities.

The all-member publication, *AMA Voice*, was published six times in 2004. This publication clearly articulates AMA activities on behalf of America's physicians and patients. In 2005, *AMA Voice* will be completely redesigned to showcase the new AMA brand and will become a monthly publication to provide greater immediacy for AMA's accomplishments. It will emphasize progress on the AMA's advocacy agenda, provide information about how members can get involved with the AMA, and include information of particular interest to the Association's sections and special interest groups.

Member Publications also published 36 smaller, quarterly *AMA Voice* newsletters in 2004 covering issues of particular interest to each of the AMA's sections and special groups.

In 2004, the Association's weekly electronic newsletter, *eVoice*, incorporated more graphics and photography as it served an audience that grew to more than 70,000 member and non-member physicians and medical students.

External Communications

News and Information - During 2004, AMA Media Relations used various communication outreach strategies to keep AMA prominently in the public eye: more than 125 press releases/statements; 30 letters to the editor, 25 editorial board visits; and 23 op-ed articles by AMA Trustees placed in external publications. Multiple press events were held to promote AMA policies adopted during the House of Delegates' Meetings. Additional press events promoted AMA advocacy on medical liability reform, seat belt safety, foodborne illness, health literacy, flu vaccine, and scope of practice. While cost-prohibitive to determine the complete scope of the AMA's national media outreach efforts, an analysis by US Newswire during October 2004 showed 4,167 media "hits" for that one month. (One "hit" is one news story.) Extrapolated over one year, that is 50,000 AMA stories annually.

Science News - In 2004 the AMA Science News Department expanded its ability to educate the public on vital health care issues by conveying the latest medical advances through national media briefings. 2004 briefings included programs on Alzheimer's Disease, Engaging the Patient, Epilepsy, Attention Deficit Hyperactivity Disorder, and the AMA's 23rd Annual Science News Reporters Conference, which included breaking news from the National Institute on Aging and other timely medical issues. The conference generated an unprecedented 65 million media impressions in print, broadcast, and on the Internet.

Media coverage of Science News topics included national television networks, major metropolitan daily newspapers as well as influential medical web sites and trade journals. Coverage was enhanced by the addition of radio media tours and audio news releases featuring expert medical presenters. Video news releases are transmitted via satellite to hundreds of TV stations nationwide as well as streamed on the media briefing page of the AMA web site.

JAMA/Archives Media Relations - The *JAMA/Archives* media relations department continues to generate extensive media coverage for the ten medical journals published by the AMA--*JAMA* and the nine specialty journals, the *Archives*. In 2004, 365 news releases were written and distributed to highlight studies from *JAMA* and the *Archives* journals along with 48 video news releases. There were two media briefings in 2004--one on Global Health at the

National Press Club in Washington, DC, and one on the latest HIV/AIDS research at the start of the 2004 International AIDS Conference in Bangkok, Thailand in July. The number of journalists in the US and internationally requesting *JAMA/Archives* information continues to grow, as do media placements which were up by 20 percent for *JAMA* and up by 70 percent for the *Archives* journals.

Leadership Communications - AMA speechwriters researched and wrote 273 individual projects for the Association's leadership in 2004. Heaviest emphasis was on medical liability reform with nearly equal emphasis on both the AMA's advocacy toward public health and quality improvement efforts. Both "Vital Speeches" and "Executive Speeches" reprinted AMA President Dr. John Nelson's 2004 Interim Meeting State of the AMA mid-term report. "Vital Speeches" also reprinted his Fitness Forward Foundation remarks, "Discovery, Opportunity, Choices--the DOC Model for Public Health."

A pilot project to expand AMA speaking opportunities resulted in four early successes, including invitations for Dr. Nelson to speak at the Harvard Business School Club of Chicago, Houston Business Partnership, the Milken Institute Global Health Conference, and Town Hall-Los Angeles.

Advocacy Communications - The Advocacy Communications team worked in concert with key AMA and Federation staff to develop messages and disseminate those messages on Capitol Hill and in state legislatures throughout the country. Print and video materials were used to help medical societies advance ballot initiatives in support of medical liability reform, and the National House Call made 12 separate media-advocacy tours comprising more than 50 individual stops, conducted more than 50 individual radio, television, and newspaper interviews, and took part in seven public rallies.

During the US presidential race, print ads urging the candidates to address the nation's most pressing health care issues were placed in *The New York Times* and in regional newspapers where the candidates held debates. The AMA partnered with state and county medical societies on two of the ads.

KEY ADVOCACY INITIATIVES

Advocacy on behalf of physicians and their patients is a principal AMA activity. A separate summary of legislative and regulatory activities was distributed at the 2004 Interim Meeting, so only a brief summary is being reported here.

Medical liability reform - On May 12, 2004, the US House of Representatives passed, for the second time in the 108th Congress, medical liability reform legislation, by a vote of 229-197. In the US Senate, the AMA secured 49 votes on a motion to proceed on a medical liability vote--the most ever achieved in the Senate on medical liability reform. President Bush and Senate Majority Leader Dr. Bill Frist each have praised the AMA for its leadership on the issue. The AMA Patients' Action Network helped boost public awareness of the issue in key states with more than 340,000 patient activists--40,000 more than expected. More than 250 million online impressions were achieved in the patient-activists recruitment program.

At the state level, the Advocacy Resource Center continued its comprehensive, multi-dimensional state MLR advocacy campaign, and worked closely with more than 20 individual state societies in efforts to secure strong liability reforms. Expertise was provided on issues such as drafting legislative language, providing supporting data for use in testimony, meetings with legislators, and providing guidance and support on a number of strategic issues, drawing from the experience of other state medical societies.

Medicare physician payment reform and regulatory relief - The AMA focused efforts on educating Members of the House Energy & Commerce and Ways and Means Committees and the Senate Finance Committee, as well as House and Senate Leadership, on the necessity of a permanent Medicare physician payment formula, as no legislation was expected in 2004. The AMA also educated all other members of the House and Senate on the issue and convinced 73 senators and 273 representatives to sign on to a letter to the CMS administrator requesting changes to the Medicare physician payment formula. The AMA also wrote more than 100 letters to Congress, the administration, and federal agencies on the Medicare physician payment (SGR) increases for 2004 and 2005, the Medicare Advantage program, Medicare prescription drug benefits, Medicare discount drug cards and more.

Important advocacy efforts in 2004 also included successful lobbying to defeat proposals to charge physicians user fees for duplicate claims under the Medicare program and protecting the health care safety net by preventing reductions in the Medicaid program in the FY 2005 budget resolution.

Expanding coverage for the uninsured and increasing access to care - The AMA broadly circulated AMA proposals to expand coverage for the uninsured to US representatives and senators. Outreach also included publication of an article coauthored by Dr. Palmisano summarizing AMA's proposal for health system reform, and presenting AMA cost and coverage simulations. "Expanding Insurance Coverage Through Tax Credits, Consumer Choice, and Market Enhancements: The American Medical Association Proposal for Health Insurance Reform," was published in the May 12, 2004, issue of the *JAMA*. Dr. Palmisano also coauthored a response to letters to the editor of *JAMA* from single-payer enthusiasts (Sept. 8, 2004). The AMA continues as a national partner of the Robert Wood Johnson Foundation's Cover the Uninsured Week.

Managed care reform - The AMA continued its major campaign to address private payer manipulation of CPT codes, guidelines, and conventions that disadvantages practicing physicians. Direct outreach included: holding numerous meetings with high ranking medical directors representing a number of national and regional health insurers to discuss continuing problems and assisting medical societies in the ongoing monitoring of the Aetna and CIGNA settlements.

2004 highlights also included distributing the first installment of a comprehensive legislative advocacy kit to address a number of payment abuses by health insurers and managed care organizations, assisting state medical societies in their efforts to scale back the reach of ERISA's preemption provisions, and publishing several products such as the revised *Competition in Health Insurance* to help support the AMA's ongoing opposition to managed care consolidation.

Clinical quality improvement and patient safety - The AMA took the lead in a coalition of provider and consumer organizations in an effort to achieve a legislative compromise on patient safety in the Congress. Legislation passed the House by a vote of 416-8 and a Senate bill passed unanimously. While the House and Senate were unable to resolve their differences, there was optimism for action in 2005. The AMA also signed on as a strategic partner for an 18-month campaign spearheaded by the Institute for Healthcare Improvement, which aims to improve survival rates at hospitals by addressing six quality platforms. The AMA plans to engage its members on this project during 2005. A legislative victory was had when the AMA and a coalition of specialty societies successfully advocated that eye surgery in facilities operated by the US Department of Veterans Affairs should only be performed by surgeons and not optometrists.

Improving public health - Two major public health initiatives included:

- Promoting healthy lifestyles: The AMA Sponsored a National Summit on Obesity in October 2004. More than 180 physicians and other health professionals contributed to identifying strategic actions for the prevention, assessment and management of obesity that focus on workplace, schools, communities and medical practice. Collaboration with the Centers for Disease Control and the Health Resources and Services Administration led to updated recommendations for the prevention, assessment, and management of child and adolescent overweight and obesity.
- Eliminating health disparities: Successful lobbying led to passage of the "Sickle Cell Treatment Act of 2003," legislation which increases health care access for patients by providing federal matching funds for Sickle Cell Disease-related services under Medicaid, making it easier for physicians to treat patients--primarily African-Americans--with the disease and increasing state funding for physician and laboratory services. Successful lobbying also led to passage of the "Access to Rural Physicians Improvement Act of 2004" (H.R. 4453), a bill that eased the placement of physicians in underserved areas by extending the deadline for foreign medical graduates seeking waivers of the two-year foreign residence requirement under the J-1 visa program.

AMPAC - The AMA Political Action Committee (AMPAC) made big political gains on behalf of organized medicine in the 2004 election cycle--earning a #4 ranking by *National Journal* in a post-election analysis of winning percentages of the top interest groups in the most competitive House and Senate races. According to the *National Journal* analysis, AMPAC supported successful candidates in more key races than any other top interest group--76 percent of competitive House races and 88 percent of critical Senate races.

Litigation Center - The Litigation Center, a coalition of the American Medical Association and all 50 state medical societies plus the District of Columbia, represents the medical profession in the courts, in accordance with AMA policies. Specialty societies may and do request assistance from the Litigation Center. Issues addressed by the Litigation Center during 2004 included medical liability reform (*Ferdon v. Wisconsin Patients' Compensation Fund*), Medicaid funding (*OKAAP v. Fogarty*), False Claims Act requirements (*United States ex rel. Walker v. R&F Properties*), and claims by managed care organizations for repayments from physicians (Arkansas Blue Cross Blue Shield Lupron Payments). A complete listing of matters addressed by the Litigation Center is accessible on the AMA web site.

PROFESSIONAL STANDARDS

The Professional Standards Group continues to focus its efforts on providing physicians with the foundations of professionalism. The Group's strategic plan provides a continuum of support for the medical profession that:

- Promotes and strengthens the foundation of ethics and professionalism in medicine;
- Encourages the development of medical knowledge;
- Integrates that knowledge into medical practice and public health;
- Measures and analyzes clinical outcomes to improve medical performance and knowledge;
- Encourages the refinement of health and medical practice based on evaluation and data; and
- Mobilizes physicians and patients to take leadership roles in community-based policy activities and initiatives

The areas within Professional Standards working to achieve these objectives are Science, Quality, and Public Health; Medical Education; and Ethics Standards.

Science, Quality, and Public Health

The Science, Quality, and Public Health area is charged with promoting medical and public health science, collecting that knowledge, and disseminating it to physicians. The unit is responsible for the AMA's medicine and public health advocacy initiatives and helping to prepare medicine in the event of a disaster. The unit coordinates the development of physician-driven clinical practice guidelines and performance measurements. The area also provides support to the Council on Scientific Affairs in its development of public health and medical science policy.

Disaster Preparedness and Public Health - The National Disaster Life Support program has trained more than 6,000 physicians and other health professionals and first responders for disasters and other public health emergencies. The AMA's Center for Disaster Preparedness and Emergency Response has been awarded three grants, from the US Department of Homeland Security, the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration, to extend disaster preparedness initiatives throughout the country. On July 20-22, 2004, the AMA, in partnership with the CDC, presented the First National Congress on Public Health Readiness, in Washington, DC. The conference was attended by 800 participants, approximately 200 of whom were physicians.

Science and Public Health: Infectious Diseases and Influenza Vaccine - The AMA continues to be directly involved with federal vaccine and infectious disease initiatives, including vaccine safety, hepatitis vaccine programs, influenza pandemic planning, meningitis, tuberculosis, as well as other infectious diseases. The AMA has worked closely with the CDC and others to address the critical vaccine supply issues that arose at the end of 2004. In particular, the AMA co-sponsored the National Influenza Vaccine Summit to inform physicians about the current vaccine reallocation plan.

Foodborne Illness - The Second Edition of *Diagnosis and Management of Foodborne Illnesses: A Primer for Physicians* was launched at a National Press Club press conference and has been well-received by physicians.

Health Disparities, Obesity, and Violence Initiatives - The AMA Summit on Obesity, held October 19-20, 2004, and supported by a grant from the AMA Foundation, focused on physician roles in schools, communities, worksites, and medical practices. Recommendations coming out of the Summit will be presented at the 2005 Annual Meeting in a report from the Council on Scientific Affairs. The Commission to End Disparities in Health Care met on July 31-August 1, 2004, in conjunction with the annual meeting of the National Medical Association. A mission and vision

statement was approved and has now been approved by more than 28 organizations. The AMA sponsored the fall meeting of the Advisory Council on Violence and Abuse on November 5-6, 2004, and focused on the interface of medicine, public health, and the law as related to violence during pregnancy.

Physician Consortium for Performance Improvement (The Consortium) - Eighty-one Consortium measures now encompass 14 clinical topics and development work is underway with the CMS and specialty societies for chronic obstructive pulmonary disease, adolescent major depressive disorder, atrial fibrillation, and perioperative care. Discussions have been held with the National Quality Forum, the National Alliance for Healthcare Information Technology, the Institute for Healthcare Improvement, the Centers for Medicare and Medicaid Services, and other national health care quality improvement organizations to identify specific activities to further deploy use of Consortium-developed measures.

Patient Safety and Electronic Health Records - The AMA announced its partnership with the Institute for Healthcare Improvement and others on patient safety initiatives and working with the federal government and other health care organizations to develop standards for electronic health records.

Alcohol and Other Drug Abuse - The AMA was selected for a two-year contract with the National Institute on Drug Abuse to conduct needs assessments and outreach to primary care physicians who address children and adolescent drug issues.

Medical Education

The Medical Education area develops, disseminates, and implements medical education policies and standards that ensure the highest quality of physician education and patient care. Under the guidance of the Council on Medical Education and the Section on Medical Schools, the area addresses issues covering the entire continuum of medical education. The area is responsible for the AMA Physician's Recognition Award, FREIDA Online, and the Graduate Medical Education and Health Professions Career and Education Directories. The AMA works with the Association of American Medical Colleges in accrediting medical schools through the Liaison Committee on Medical Education (LCME). Significant efforts include the following:

Medical Student Debt - The Council on Medical Education and Section on Medical Schools are working to identify and disseminate strategies to reduce the debt burden of young physicians.

Work Hour Study - A study protocol and questionnaire have been developed to survey medical students, resident physicians, and attending faculty on the impact of ACGME duty hours changes. More than 65 medical schools have volunteered to participate in the study to date.

Career Paths of Physicians Study - Funding has been received for a study of the career paths of physicians. Issues being looked at include relocations, retooling, retraining, socioeconomic status, specialty, geography, and age.

Physician Workforce - The Council on Medical Education has reviewed current AMA policy on physician workforce and developed recommendations for changes to make policy consistent with current data and thinking about physician supply and distribution. The Council has also proposed strategies to increase the physician supply.

New Approaches to AMA PRA Category 1 Credit - The Council on Medical Education approved AMA PRA Category 1 credit for performance improvement (PI) activities. These guidelines will enable CME providers and physicians to work on the design and implementation of structured PI interventions that capture learning from a retrospective assessment of practice, a prospective application of appropriate measurement sets, and a careful evaluation of the results. The Council recently approved a proposal to offer Category 1 credit for Internet Point of Care. Physicians can now be awarded Category 1 credit for interactive, physician directed use of clinical databases at the point of care.

Proposed New Medical Schools - The AMA Secretariat of the LCME continues to provide consultation to a number of groups considering the development of new medical schools.

Ethics Standards

The Ethics Standards area is responsible for developing ethical standards and policies for the medical profession, conducting research on relevant professionalism issues in medicine, and producing educational products and programs for medical students, residents and practicing physicians. Some significant accomplishments during 2004 include:

Chicago Symposium on Medicine, Ethics and Society - In cooperation with the Chicagoland Chamber of Commerce, the Institute of Medicine of Chicago, and the MacLean Center at the University of Chicago, the AMA hosted public symposium events with leading experts on such topics as the FDA and drug safety, and medical error and residency training.

Strategies for Teaching and Evaluating Professionalism (STEP) - The 10 medical school STEP partners continued with their development of new instructional and assessment methods in professionalism, with expected completion by May 2005.

Virtual Mentor - The AMA's monthly online ethics journal has continued to build on its editorial quality and readership base. Virtual Mentor (www.virtualmentor.org) reached an all time peak, with 60,000 hits per month and is highly praised by medical educators that download its information for use with students and residents.

WorldScopes - This project has distributed thousands of stethoscopes domestically to workers caring for the uninsured in free clinics and internationally to medical students in Guatemala, nurses in Uganda, and physicians in Afghanistan. The project expects to pass out 10,000 stethoscopes collected by mid 2005.

Ethical Force Program - This program develops consensus on how to address ethical challenges facing health care, creates recommendations for coordinated organizational actions, and produces tool kits to help organizations perform self-assessments for quality improvement in each area. The program has pilot tested its tool kit on health information privacy in four hospitals, each of which responded positively to the results. The program published articles on its Fair Health Care Coverage Decisions report in the American Journal of Bioethics and the *New England Journal of Medicine*, and created a brochure for patients on the topic.

Online Fellowship in Ethics for Physician Leaders - The Institute for Ethics has partnered with the Bioethics Center at the Medical College of Wisconsin to create an Online Fellowship in Ethics specifically geared to the needs of practicing physicians. There are 23 fellows currently enrolled in the program; 21 are physicians and 13 are AMA members. Four physicians have completed the entire fellowship, which requires them to attend a portion of the AMA Annual Meeting.

US Holocaust Memorial Museum Education Collaborative - The Institute for Ethics teamed with the US Holocaust Memorial Museum in an educational outreach collaborative based on the museum's exhibit documenting Nazi war crimes of a medical nature, "Deadly Medicine: Creating the Master Race." Representatives of the Museum and the Institute for Ethics have conducted lectures in 5 states on "Nazis and Medical Ethics: Context and Lessons," which have been attended by more than a thousand physicians, students, and members of the public.

Medical Ethics Day - The AMA joined other national medical associations in celebrating the first annual Medical Ethics Day on September 18th, 2004, as declared by the World Medical Association. Events to remind physicians and the general public that medical ethics is integral to the practice of good medicine included a radio news release on the value of hospital ethics committees, and a panel of experts who discussed the AMA Code of Medical Ethics.

BUSINESS OPERATIONS

The Publishing and Business Services Group is committed to the continued growth of overall contribution margin by ensuring that products and services are high quality, high value, essential to professional practice, and support and enhance AMA membership.

Overall, the goal of AMA Business is to provide bottom line support for AMA programs in order to promote the art and science of medicine and the betterment of public health. Creating new products and services that physicians rely upon in all aspects of their professional life will lead to continued growth of the AMA's membership.

AMA Insurance Agency

The AMA Insurance Agency (AMAIA) currently offers more than two dozen products to physicians, medical students, residents, their families, and office staff. These products focus on life, health and property/casualty and meet the wide-ranging needs of these groups. Several new products are in development.

Through an existing relationship with MSaver Resources, LLC, AMAIA is providing immediate access to physicians for Health Savings Accounts (HSA). One of the country's leading HSA administrators, MSaver can arrange, through multiple agreements with financial institutions and insurance companies, an HSA, a qualified High Deductible Health Plan, or both. A special physician-only toll free number has been established for the AMA to afford personalized, consultative services. Discussions are under way to develop a unique physician-centric feature or benefit to enhance membership appeal.

Books and Products

AMA Books and Products includes three separate but related businesses--AMA Press, AMA Solutions, and the Unified Service Center.

AMA Press is a premier medical publisher. Our flagship publications are in the area of CPT information and other reimbursement products. In addition, AMA Press produces various publications in the areas of clinical information, practice management, career resources, and statistical publications. AMA Press continues to lead in the area of HIPAA compliance and education. *HIPAA: A Short- and Long-Term Perspective for Health Care*, *Field Guide to HIPAA Implementation*, *HIPAA Policies and Procedures Desk Reference*, and the HIPAA Privacy Tool Kit have all been introduced within the past year and provide a wealth of resources to assist readers with the implementation process. AMA Press continues its leading role in the reimbursement publishing area.

AMA Solutions provides products and services for physicians and physician practices. These offerings include an AMA-sponsored credit card, discounted medical and surgical supplies, information technology products, office equipment, and other services. AMA Solutions has made significant progress in building the value proposition for members. Solutions has worked diligently to bring new products to our members and improve current vendor offerings.

The AMA Books and Products group generated more than \$62 million in revenue in 2004. Continued focus on strategic pricing, new product development and prudent expense management is planned.

The Unified Service Center provides a central location to respond to the needs of all members, potential members and customers. Service is based on a constituent-based service model that puts the caller in touch with a representative trained to respond to their questions, minimizing the need for transfers. This ability to provide one-stop shopping has allowed the AMA to provide measurably improved service to our members and customers.

Internet and Database Operations

The unit successfully negotiated the dissolution of Preference Solutions.

Long-standing efforts continued throughout 2004 to further enhance the quality and content of the AMA Physician Masterfile. Nearly 200,000 office addresses and 250,000 preferred mailing addresses were updated during 2004. The undeliverable rate remained steady during 2004, between 2 and 3 percent.

The physician profiles product continues with positive results. The profile volume was increased by more than 10 percent compared to 2003, and a new Physician Assistant Profile product was launched.

The Internet and Database Operations unit was separated mid-year in 2004, but combined financial results increased to \$40 million compared to \$36.8 million in 2003. The AMA, its licensees, and pharmaceutical manufacturers also adopted language in 2004 giving physicians the ability of opting out of having their prescribing data released to pharmaceutical sales representatives and other third parties. This will go into effect in 2006.

Scientific Publications

The primary mission of the Publications and Multimedia Applications Group is to provide the highest quality medical and scientific information to physicians through AMA scientific publications (*JAMA* and the *Archives Journals*) and *American Medical News*. Through these publications, the Publications Group plays a pre-eminent role in fulfilling a key objective of the AMA to be “The world’s leader in obtaining, synthesizing, integrating, and disseminating information on health and medical practice.” *JAMA* and the *Archives Journals*, highly regarded as world-class scientific medical publications, enhance the AMA’s reputation in the medical community. They also give the AMA a presence in global scientific communities and the highest levels of the governance of health care worldwide. These scientific publications also make a significant contribution in net margin to the AMA. In addition, *JAMA* and *American Medical News* are an important tangible benefit of AMA membership. Recently, the Publications Group has added to the list of AMA membership benefits the online access to its complete portfolio of publications and online, journal-based continuing medical education

The AMA continues to focus on improvement of the scientific publication infrastructure. To this end, a major build-out of an integrated online content delivery system was completed in the first quarter of 2004. In addition, implementation is under way for a series of significant enhancements to the AMA’s core editorial systems. These changes will continue to ensure the leadership position of all AMA publications.

AMA Publications accounted for nearly \$76 million in revenue and more than \$20 million in contribution margin in 2004. Industry trends such as fewer new products, mergers and acquisitions in the pharmaceutical industry, and other factors have contributed to some softening in the display advertising market, however AMA Publications has continued to remain resilient despite these downward trends. The key to continued growth will be careful management of existing revenue streams and development of new ones.

INTERNATIONAL HEALTH

The AMA is involved in international health with a targeted strategy of programs, advocacy and business ventures. The AMA, through a cross-organizational team, collaborates on international endeavors leveraging information, contacts and opportunities.

World Medical Association (WMA) - As the predominant national medical association in the United States, the AMA is the only national medical association eligible for membership in the WMA. AMA participation in the WMA provides a unique forum to advance AMA policy and advocacy issues and provides an opportunity to form relationships with counterpart organizations that can have wide-ranging benefits to the AMA as a whole. At the 2004 meeting, AMA-proposed language revising the WMA Declaration of Helsinki--a seminal document that guides researchers who use human subjects in their work--and the language will now appear as a note of clarification regarding post-trial access to care by study subjects.

In an increasingly global community, participation within the WMA is important to the AMA’s future. The AMA serves regularly in important leadership roles. In October 2004, Dr. Yank D. Coble, Jr., was inaugurated as WMA’s President. Dr. John C. Nelson currently serves as the Chair of the Finance and Planning Committee.

The AMA derives numerous benefits from its membership and involvement in the WMA:

- Strengthening AMA policy development;
- Identifying emerging issues and finding solutions to common problems;
- Casting AMA in a favorable light around the world and at home;
- Fulfilling the AMA’s professional obligation to share knowledge;
- Helping the AMA identify new ways to educate and assist physicians worldwide;
- Enhancing the AMA’s reputation as an activist in international health; and
- Forming critical relationships with medical leaders around the world that can lead to important business opportunities.

International Outreach - The AMA continued its participation in and contributions to international efforts, including offering the AMA’s assistance to nations affected by the tsunami that devastated much of south Asia in late 2004. A link was added to the AMA web site to direct visitors’ contributions to relief efforts, and the AMA sent more than \$25,000 to Project Hope.

The AMA also joined the Canadian Medical Association to present the International Conference on Physician Health October 13-16. The Office of International Medicine received groups from Korea, Thailand, Canada, and Israel in 2004, and also hosted visitors from nine nations at the 2004 Annual Meeting. AMA officers also attended meetings of the British, Canadian, and Indian medical associations. The AMA also continues to liaison with US-based international health groups, including the Global Health Council, Health Volunteers Overseas, the World Bank, and the Fogarty Center at the National Institutes of Health. The AMA also continued as a member of the Health Internetwork Access Research Initiative (HINARI). Under the auspices of the World Health Organization, HINARI makes medical and scientific journals available at no cost or minimal cost to the world's most needy nations.

International Business Opportunities - Key international business opportunities and successes in 2004 include:

- Continuing physician professional development work, including recent agreements with Mexico, Spain, Singapore, and the Union of European Medical Specialists.
- Significant progress toward incorporating CPT into the health care systems of countries outside the United States, including Poland. A contract was signed to customize CPT for use throughout South Africa; discussions were held regarding potential use of CPT within the European Union; and discussions also were held with South Korea, Peru, Japan, and Israel.
- Print subscription revenue increased 6.5 percent, and site licensing revenues tripled over 2003 levels. International editions of *JAMA* totaled 17 editions in 15 languages with a combined circulation of 300,000; and nine international *Archives* editions in 5 languages with a combined circulation of 28,000.

LEADERSHIP, MANAGEMENT, AND GOVERNANCE

The House action that called for this consolidated omnibus report included specific reference to a number of previous separate reports on a variety of leadership and governance topics that should be covered in this annual omnibus report.

AMA Financial Performance - The AMA achieved positive financial results in 2004. In 2004, the AMA continued efforts to grow revenue, contain costs, and focus spending on a high impact agenda on behalf of members. The 2004 financial performance was better than originally expected due to a variety of factors including better overall economic conditions, continued diligence in achieving increased revenue, and stewarding resources wisely. More detailed information on AMA's financial results, including the audited financial statements, is available in the AMA Annual Report.

Information on the expenses associated with the AMA councils, sections, and special groups is provided to the Board of Trustees as part of the annual budget and its ongoing financial overview role. This information is also shared with Reference Committee F by the Board Finance Committee as part of the special briefings of the Reference Committee.

General Officer and EVP Compensation

General Officer Compensation - Each year, the House receives a report from the Committee of the House of Delegates on Compensation of the AMA General Officers. The report submitted to the House at the 2004 Interim meeting provided detailed information on officer compensation for the period July 1, 2003 through June 30, 2004. At the 2005 Interim Meeting a report will be submitted covering the period July 1, 2004 through June 30, 2005.

EVP Compensation - During 2004, pursuant to his employment, total cash compensation attributed to Dr. Maves as AMA Executive Vice President was \$497,340 in base salary, \$76,000 in bonuses, and \$8,400 in automobile allowance. Additional amounts per that contract were paid as follows: \$6,192 for life insurance, \$948 for health club membership, and \$1,160 for parking.

Audit Committee

The Audit Committee of the Board has several responsibilities in addition to its principal role of ensuring that the AMA's finances are properly audited. A report of the activities of the Audit Committee for the period July 1, 2004 to June 30, 2005, which is consistent with the Audit Committee's work year, will be provided at the 2005 Interim Meeting. The 2004 AMA Annual Report provides information on AMA finances in 2004, including the audited financial statements.

Board Self-Evaluation

The Board has established and refined its self-evaluation process as called for by the House. This is now a regular part of the Board's activities and is guided by the Audit Committee.

Board Representation Program

The Board representation program covers assignments of Board members to attend meetings of other organizations, institutions, and audiences to represent the AMA. This includes a substantial number of speeches as well as giving testimony before legislative bodies, speaking to the media, and attending rallies or similar events. The Board has a specific process for reviewing the many invitations that are received and deciding which ones to accept and who on the Board should be assigned. The Chair of the Board is the principal decision-maker related to representation assignments. 2004 was a very busy year, in large part due to the active campaign related to medical liability reform and other legislative and public health issues.

Each year, the House receives a report from the Committee of the House of Delegates on Compensation of the AMA General Officers. The report submitted to the House at the 2004 Interim Meeting provided detailed information on the representation program for the period July 1, 2003 through June 30, 2004. At the 2005 Interim Meeting, a report will be submitted covering the period July 1, 2004 through June 30, 2005.

Corporate Review Team Activities

The CRT reviews current and proposed activities that involve the use of the AMA name or logo with a company, non-federation association, or foundation, or include commercial support, to ensure that such proposed relationships comply with principles adopted by the House of Delegates to govern the AMA's corporate relationships. From January 1, 2004 through December 31, 2004, 59 new activities were reviewed; 49 were approved, 10 were initially reviewed and returned for further development due to incomplete information. Of the approved projects, 24 were conferences/media briefings/events; 15 were education/information or content materials; three were member service provider programs; two were business arrangements, including a book program and partnership; and five were "other" projects. More detailed information is included in a separate Board of Trustees report at the 2005 Annual Meeting.

22. SPECIALTY HOSPITALS AND THEIR IMPACT ON HEALTH CARE - UPDATE

HOUSE ACTION: FILED

At the 2004 Interim Meeting, the House of Delegates (HOD) adopted Recommendations 1-9, and 11-12 and referred Recommendation 10 of Board of Trustees Report 15, "Specialty Hospitals and Impact on Health Care."

1. That it is the policy of the AMA to support and encourage competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care.
2. That our AMA oppose efforts to either temporarily or permanently extend the 18-month moratorium on physician referrals to specialty hospitals in which they have an ownership interest.
3. That our AMA support changes in the inpatient and outpatient Medicare prospective payment systems to eliminate the need for cross-subsidization by more accurately reflecting the relative costs of hospital care.

4. That our AMA support federal legislation and/or regulations that would fix the flawed methodology for allocating Medicare and Medicaid Disproportionate Share Hospital (DSH) payments to help ensure the financial viability of safety-net hospitals so they can continue to provide adequate access to health care for indigent patients.
5. That our AMA reaffirm Policy H-215.970, which states that the current reporting mechanism should be modified to monitor accurately the provision of care by hospitals to economically disadvantaged patients so that policies and programs targeted to support the safety net and the populations these hospitals serve can be reviewed for effectiveness.
6. That our AMA reaffirm Policy H-240.963, which states that Medicare and Medicaid subsidies and contracts related to the care of economically disadvantaged patients should be sufficiently allocated to hospitals on the basis of their service to this population in order to prevent the loss of services provided by these facilities.
7. That our AMA reaffirm Policy H-240.964, which states that our AMA recognizes the special mission of public hospitals and supports federal financial assistance for such hospitals; and advocates that studies be carried out to evaluate whether special consideration for public hospitals is justified in the form of national or state financial assistance, and if so, it should be implemented.
8. That our AMA encourage physicians who contemplate formation of a specialty hospital to consider the best health interests of the community they serve. Physicians should explore the opportunities to enter into joint ventures with existing community hospitals before proceeding with the formation of a physician-owned specialty hospital.
9. That our AMA oppose the enactment of federal certificate of need (CON) legislation and support state medical associations in their advocacy efforts to repeal current CON statutes and to oppose the reinstatement of CON legislation or its expansion to physician-owned ambulatory health care facilities.
10. That our AMA develop model state legislation to prohibit corporations, with the exception of business corporations established as professional corporations to practice medicine and are controlled by physicians, from directly employing physicians, (i.e., “corporate practice of medicine doctrine”).
11. That our AMA amend AMA Policy H-130.945, “Overcrowding and Hospital EMS Diversion,” by addition and deletion to read as follows:
 - (3) to support the establishment of local, multi-organizational task forces, with representation from hospital medical staffs, to devise local solutions to the problem of emergency department overcrowding, ~~and~~ ambulance diversion, and physician on-call coverage, and encourage the exchange of information among these groups.
12. That our AMA continue to monitor the specialty hospital issue and report back to the House of Delegates at the 2005 Annual Meeting.

Subsequent to the adoption of these recommendations, the AMA has aggressively advocated AMA policy on physician-owned specialty hospitals to key policymakers. This informational report describes the AMA’s activities to implement the recommendations adopted at the 2004 Interim Meeting and provides a summary of the Medicare Payment Advisory Commission (MedPAC) Report to Congress on Physician-Owned Specialty Hospitals, the preliminary results of the Centers for Medicare and Medicaid Services (CMS) study of physician-owned specialty hospitals, several other new studies, and recent hospital industry initiatives.

BACKGROUND

In response to lobbying by the hospital industry, Congress included Section 507 in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (PL 108-173). This section imposed an 18-month moratorium on physician referrals to certain specialty hospitals in which the physician has an ownership interest, unless the hospital was in operation or under development before November 18, 2003. The moratorium is scheduled to expire on June 8, 2005.

The MMA defines specialty hospitals as hospitals that are physician-owned and “primarily or exclusively engaged” in the care and treatment of patients with a cardiac or orthopaedic condition, patients receiving a surgical procedure, or any other specialized category of services designated by the Secretary of the Department of Health and Human Services (HHS). The law also required MedPAC, in consultation with the Government Accountability Office (GAO) and HHS, to conduct relevant studies and submit reports with recommendations to Congress for legislative or administrative changes within 15 months of enactment, (e.g., by March 8, 2005).

AMA ADVOCACY ON SPECIALTY HOSPITALS

After adoption of Board of Trustees Report 15-I-04, the AMA shared the report with MedPAC and CMS so that they would be familiar with the AMA’s views as they prepared their reports. The AMA then worked to build support for the AMA positions among the MedPAC commissioners while the MedPAC report was under development.

On March 8, 2005, AMA Trustee William Plested, MD, testified on behalf of the AMA at a House Ways and Means Health Subcommittee hearing on physician-owned specialty hospitals. The AMA also submitted a statement for the record to Senate Finance Committee hearing held on the same day. The AMA outlined the factors that have led to physician investment in specialty hospitals, described the available evidence on efficiency, quality of care, and patient satisfaction with specialty hospitals, and provided a vigorous response to the hospital industry’s claims that the emergence of physician-owned specialty hospitals is in conflict with the best interests of patients.

The AMA pointed out that, whereas some hospitals have started their own specialty hospitals and others have partnered with their physicians economically and clinically in forming specialty hospitals, the hospital industry has primarily attacked physician ownership of specialty hospitals in an attempt to eliminate competition. While hospital leaders claim that physician referrals to physician-owned specialty hospitals amount to “channeling” patients to these hospitals, the AMA noted that hospitals are actually the ones that “channel” patients by:

- purchasing physician practices and directing the physician referrals to the hospital;
- operating health plans with network referral requirements; and
- adopting policies that force physicians to only refer patients to their facilities.

The AMA also provided the Congress with an exhibit showing examples of these “channeling” practices. In advocating the AMA’s policy positions, the AMA has also repeatedly underscored the fact that physicians are ethically and legally permitted to own a hospital and to refer patients there if they treat patients at that hospital.

The AMA has urged Congress to support competition, refine hospital payment rates to eliminate the need for hospitals to cross-subsidize lower paid services with the revenues for more highly paid services, and revise disproportionate share payments to better support true safety-net hospitals. The AMA urged that Congress should allow the moratorium on physician referrals to specialty hospitals in which they have an ownership interest to lapse in June 2005 as per the MMA.

In addition to advocacy with Congress and the Administration, the AMA has also worked to ensure balanced coverage of physician-owned specialty hospital issues in the media. For example, after Federation of American Hospitals President Charles Kahn published an article titled, “A health-care loophole,” in the *Washington Times*, AMA President John Nelson, MD, submitted a letter to editor. The AMA response pointed out that the hospital industry’s fear of competition from specialty hospitals, a blizzard of skewed statistics, and the industry’s failure to identify any compelling reason to restrict the growth of physician-owned specialty hospitals is why the AMA, the *Wall Street Journal* and *Washington Times* have endorsed them as a reasonable alternative to traditional hospitals for some patient care. Further, competition forces existing hospitals to work cooperatively with their medical staffs to improve care and innovate in order to keep attracting patients.

MEDPAC REPORT TO CONGRESS ON PHYSICIAN-OWNED SPECIALTY HOSPITALS

On March 8, 2005, MedPAC released its report to Congress on “Physician-Owned Specialty Hospitals” and MedPAC Chairman Glenn Hackbarth testified at the hearings held by the Senate Finance Committee and the House Way and Means Health Subcommittee. MedPAC’s analysis and report is based on data from 48 hospitals (12 heart, 25 orthopaedic, and 11 surgical hospitals) that met MedPAC’s criteria for physician-owned specialty hospitals, which were:

- Be physician-owned;
- Have at least 45 percent of the hospital's Medicare cases be cardiac, orthopaedic, or surgical services, or at least 66 percent in two major diagnostic categories with the primary one being cardiac, orthopaedic, or surgical;
- Have a minimum volume of 25 total Medicare cases during 2003; and
- Have submitted Medicare cost reports and claims for 2002.

Key findings of the MedPAC study were:

- Overall utilization rates in communities with specialty heart hospitals did not rise any more rapidly than in other communities.
- The financial impact on community hospitals in the markets in which physician-owned specialty hospitals are located has been limited. Hospitals in communities with specialty hospitals have demonstrated financial performance comparable to other community hospitals.
- Physician-owned specialty hospitals, thus far, do not have lower costs for Medicare patients than community hospitals but their patients have shorter lengths of stay.
- Specialty hospital patients are generally less severe (and hence expected to be relatively more profitable than average) and are concentrated in particular diagnosis-related groups (DRGs), some of which are relatively more profitable.
- Specialty hospitals tend to have lower shares of Medicaid patients than community hospitals.
- Many of the differences in profitability across and within DRGs that create financial incentives for patient selection can be reduced by improving Medicare's inpatient prospective payment system (IPPS) for acute care hospitals.

Based on its analysis and findings, MedPAC made the following recommendations:

1. The HHS Secretary should improve payment accuracy in the IPPS by:
 - refining the current DRGs to more fully capture differences in severity of illness among patients,
 - basing the DRG relative weights on the estimated cost of providing care rather than on charges, and
 - basing the weight on the national average of hospitals' relative value in each DRG.
2. The Congress should amend the law to give the Secretary authority to adjust the DRG relative weights to account for differences in the prevalence of high-cost outlier cases.
3. The Congress and the Secretary should implement the case-mix measurement and outlier policies over a transitional period.
4. The Congress should extend the current moratorium on specialty hospitals to January 1, 2007.
5. The Congress should grant the Secretary the authority to regulate gainsharing arrangements between physicians and hospitals and to regulate those arrangements to protect the quality of care and minimize financial incentives that could affect physician referrals.

At its December 2004 meeting, MedPAC also considered a draft recommendation to remove the "whole hospital exception" under the Ethics in Patient Referrals Act (Stark I and II). The Commission decided against including elimination of the whole hospital exception in its final recommendations.

Other significant findings in the MedPAC report include, but are not limited to, the following:

Specialty Hospital Ownership - MedPAC found that physician ownership of specialty hospitals varied. Physicians at heart hospitals own an average of 35 percent, while those at surgical hospitals own about 73 percent. About one-third of orthopaedic and surgical specialty hospitals were owned entirely by their physicians, but no heart hospital was. In about one-third of specialty hospitals, the largest share owned by a single physician is two percent or less. In about one-fifth of the hospitals, one physician owned at least 15 percent of the facility. All of the physician-owned specialty hospitals are for-profit, compared with 20 percent of all IPPS hospitals. In some cases, community hospitals have ownership interests in the specialty hospitals. In others, the specialty hospital is owned by a national chain. Eight of the twelve heart hospitals are owned in part by MedCath Corporation.

Specialty Hospital Size - Physician-owned specialty hospitals are small. Heart hospitals are the largest, averaging 52 beds. The average orthopaedic hospital has 16 beds and the average surgical hospital has 14.

Specialty Hospital Emergency Departments - Eight of the twelve heart hospitals have emergency departments compared with only one of the eleven surgical hospitals. Heart hospitals with emergency departments are staffed 24-hours/day compared to only one orthopaedic and no surgical hospitals with similar staffing.

Motivations for Establishing Specialty Hospitals - MedPAC found that a primary motivation for establishing specialty hospitals is greater physician control of hospital operations and increased productivity. The smaller size of specialty hospitals and their design creates a hospital environment that is more satisfying for patients. Some specialty hospitals have a higher ratio of nurses to patients which may contribute to shorter lengths of stay and improved patient outcomes. In addition to increasing their productivity, physician investors may be able to augment their professional fees by retaining a portion of the hospital profits. The annual distributions of some specialty hospitals have exceeded 20 percent of the physicians' initial investment.

Competition - MedPAC found that some hospital administrators admitted that competition with specialty hospitals has had a positive impact on their operations. They also identified some of the strategies community hospitals have utilized to discourage members of their medical staff from investing in a competing specialty hospitals, e.g., economic credentialing.

CMS PRELIMINARY FINDINGS

The MMA required HHS to study referral patterns of physician-owned specialty hospitals, to assess quality of care and patient satisfaction, and to examine the differences in uncompensated care and tax payments between specialty hospitals and community hospitals. CMS contracted with RTI International to conduct the technical analysis. On March 8, 2005, Tom Gustafson, Deputy Director of CMS' Center for Medicare Management, testified before the Senate Finance Committee and the House Way and Means Health Subcommittee. He presented the factual findings of the RTI analysis and that will underlie the CMS report to Congress.

RTI made site visits to: Dayton, OH; Fresno, CA; Rapid City, IA; Hot Springs, AR; Oklahoma City, OK; and Tucson, AZ. These six market areas include 11 of the 59 cardiac, surgery, and orthopaedic specialty hospitals that were in operation by the end of 2003. Within each market area, specialty hospital managers, physician owners, and staff were interviewed along with executives of several local hospitals. Focus groups of patients treated in specialty hospitals were convened to assess patient satisfaction. Referral patterns were analyzed using Medicare claims data for 2003. The Agency for Health Research and Quality (AHRQ) inpatient hospital quality indicators were used to assess the quality of care at the study hospitals and local community hospitals in the six markets. Data obtained from the Internal Revenue Service and specialty hospitals were used to estimate total tax payments and uncompensated care for the eleven hospitals.

The study demonstrated that cardiac hospitals are very different from surgical and orthopaedic hospitals. Cardiac hospitals have a higher average daily census (40 patients), an emergency department, and other features such as community outreach programs. Cardiac hospitals treated 34,000 Medicare cases in 2003 and Medicare beneficiaries accounted for about two-thirds of their inpatient days. Nationally, physicians own about a 49 percent share in cardiac hospitals and typically a national corporation, e.g., MedCath, or a non-profit hospital owns the majority share. In the markets studied, the aggregate physician ownership in all types of specialty hospitals averages approximately 34 percent. The average ownership share per physician in those hospitals is 0.9 percent, with individual ownership share per physician ranging from 1.0 to 9.8 percent, with a median of 0.6 percent and an average per physician share of 0.9 percent.

Surgical and orthopaedic hospitals were found to more closely resemble ambulatory surgery centers because they focus primarily on outpatient services. Their aggregate average daily census of inpatients is only about five patients. Physician ownership in the aggregate averaged 80 percent for the surgical and orthopaedic hospitals in the study. The average ownership share per physician is 2.2 percent, with individual ownership shares per physicians ranging from 0.1 percent to 22.5 percent, with a median of 0.9 percent. The balance is typically owned by a non-profit hospital or a national corporation. Medicare patients account for about 40 percent of the inpatient days of these hospitals.

The study found that the majority of Medicare patients are admitted or referred by a physician owner, but that they do not admit exclusively to the specialty hospitals they own. They also refer a similar but slightly lower proportion of their patients to the local general hospital.

Using the AHRQ quality indicators, measures of quality at cardiac hospitals are generally at least as good and in some cases better than local general hospitals. Complication and mortality rates are lower at cardiac specialty hospitals even when adjusted for severity. Due to the small number of discharges, a statistically valid assessment could not be made for surgery and orthopaedic hospitals.

Patient satisfaction is extremely high in cardiac, surgical and orthopaedic hospitals. Medicare patients in the study had large private rooms, quiet surroundings, adjacent sleeping rooms for family members if needed, easy parking, and good food. Patients also had very favorable perceptions of the clinical quality of care they received.

Relative to their net incomes, specialty hospitals provide about 40 percent of the share of uncompensated care that local community hospitals provide; however, specialty hospitals pay significant real estate and property taxes. As a result, the total proportion of net revenue that specialty hospitals devote to both uncompensated care and taxes significantly exceeds the proportion of net revenue that community hospitals devote to uncompensated care.

Overall, the Medicare cardiac patients treated in general hospitals were more severely ill than those treated in the cardiac specialty hospitals in most of the study sites, but in some of the markets studied, cardiac hospitals had a higher average severity than the general hospital. There was no difference in referral patterns for physician owners as compared to non-owners.

The proportion of patients transferred from cardiac hospitals to general hospitals (about 1 percent) is about the same as the proportion of patients transferred between general hospitals. The proportion of severely ill patients transferred from cardiac hospitals to general hospitals was similar to patients in the same DRG who were transferred between general hospitals. The number of cases transferred from surgical and orthopaedic hospitals to general hospitals was too small to draw any conclusions.

AMERICAN HOSPITAL ASSOCIATION (AHA) REPORT

On February 16, 2005, the AHA released a report prepared by McManis Consulting for the AHA, Colorado Hospital and Health Association, Kansas Hospital Association, Nebraska Hospital Association, and South Dakota Association of Healthcare Organizations. The report focused on the impact of physician-owned specialty hospitals on general hospitals in four communities: Oklahoma City, OK; Lincoln, NE; Wichita, KS; and the Black Hills region of South Dakota. The study was designed to support the industry's position that Congress should permanently ban physician referrals to physician-owned specialty hospitals by demonstrating that physician-owned specialty hospitals have had a significant impact on general hospitals' market share for those services provided by specialty hospitals. The report includes no information about the significant efforts that physician investors in specialty hospitals made to work with their general hospitals to resolve the underlying problems that ultimately lead them to build a specialty hospital.

AMERICAN SURGICAL HOSPITAL ASSOCIATION (ASHA)

In early March 2005, ASHA released a report prepared by the Health Economics Consulting Group for ASHA and the South Dakota Association of Specialty Care Providers. The report was based on published studies and reports, a survey of specialty hospitals, site visits to two specialty hospitals in California and three in South Dakota, Medicare cost reports, quality data from HealthGrades, and market data from the Bureau of Health Profession's Area Resource File. The following major findings were reported:

- An important factor contributing to the growth of specialty hospitals is that some procedures or specialized services are more profitable than others given existing Medicare and private payment rates.
- There are economic advantages to specialization.
- Specialty hospitals appear to have equal or better patient outcomes compared to general hospital counterparts.
- HealthGrades data indicate that there are no significant differences in mortality rates between specialty hospitals and general hospitals in the same geographic area.
- Survey results suggest that the intensity and quality of services are likely to be higher in specialty hospitals.

- There is no evidence, other than anecdotal, to suggest that general hospitals have been financially harmed by specialty hospital competition, or that such competition is undesirable from a societal perspective. Profit margins of general hospitals have not been affected by the entry of specialty hospitals. The most important predictor of general hospital profitability was the extent of competition from other general hospitals in the same market area. General hospitals residing in markets with at least one specialty hospital have higher profit margins than those that do not compete with specialty hospitals.
- There is no direct evidence that physician self-referral is motivated primarily or disproportionately by financial incentives associated with physician ownership.
- There is no evidence to support the contention that physician self-referral to specialty hospitals has any adverse effect on patient or societal welfare. The direct financial incentive for physician self-referral associated with physician investment in specialty hospitals is unlikely to play a major role in a physician's use of a specialty hospital, because the extent of investment for the vast majority of physicians with ownership interests in specialty hospitals is small compared to the extent of physician ownership of ancillary services and is small relative to the more direct financial incentive associated with fee-for-service payment for physician services.
- There is no evidence that self-referrals result in worse outcomes than other types of referral.

HOSPITAL INDUSTRY LEGISLATIVE AND ADVOCACY INITIATIVES

Restricting the growth of so-called "limited service providers" is one of AHA's top 2005 legislative and advocacy priorities. The hospital industry immediately began lobbying the 109th Congress on the importance of extending the moratorium on physician-owned specialty hospitals and removing the "whole hospital exemption" from the Stark law that enables physicians to refer patients to hospitals in which they have an ownership interest. On the same day that AHA released its report on the impact of specialty hospitals on community hospitals, hospital leaders spent the day on Capitol Hill meeting with Members of Congress to seek their support for legislation to make the moratorium permanent.

On March 8, 2005, hospital leaders joined the AMA, MedPAC, and CMS in submitting testimony to the Senate Finance Committee and the House Way and Means Health Subcommittee, and urged legislators to enact legislation that would prohibit physicians from referring patients to specialty hospitals in which they have an ownership interest. In AHA's statement for the record, its President stated, "Physician ownership and referral of patients--when combined--can cause serious conflicts of interest that may not be in the best interests of the patient."

In addition to advocacy efforts at the national level, state hospital associations have continued to lobby their state legislatures to pass legislation to limit physician-owned specialty hospitals. For example, on March 14, 2005, the Texas Hospital Association released a study claiming that the growth of physician-owned businesses, such as specialty hospitals, ambulatory surgery centers, and diagnostic testing centers, threatens the survival of hospitals in rural and underserved areas. Texas leads the nation in physician-owned specialty hospitals. At least eleven bills have been introduced in the Texas legislature to limit such hospitals, by calling for everything from a moratorium on allowing physicians to refer their patients to facilities they own to requiring physicians to disclose their ownership interest to patients.

In addition to lobbying Congress to make the moratorium permanent, on February 28, 2005, the Federation of American Hospitals (FAH) filed a petition with HHS Secretary Michael Leavitt requesting the Department to revise the regulation that implements the "whole hospital" exception in order to effectively prohibit referrals to physician-owned specialty hospitals. The FAH argues that physician-owned specialty hospitals are the functional equivalent of a hospital subdivision and do not satisfy congressional intent for the whole hospital exception, which contemplates a financial relationship between a physician and an institution that is sufficiently diluted so that a physician-owner's referral pattern could not affect personal financial performance. FAH proposes that CMS amend its regulation to apply the whole hospital exemption only to so-called "full-service" acute care hospitals which provide substantial and varied services. FAH believes that HHS has the legal authority to revise the regulation. If HHS denies its petition or fails to act by June 8, 2005, FAH intends to pursue judicial review under the Administrative Procedures Act in federal district court.

At the time this Board Report was prepared, the AMA was developing a response to the FAH petition.

CONCLUSION

Although the hospital industry has continued its aggressive campaign to eliminate competition from physician-owned specialty hospitals, much of the new data that have emerged through the development of the MedPAC, CMS, ASHA and other reports have done more to support than to rebut the AMA's policy positions. The AMA will continue to strongly advocate AMA policy on physician-owned specialty hospitals. The Board will keep the House informed of new developments on this issue as appropriate.

23. PRINCIPLES FOR INCIDENT-BASED PEER REVIEW AND DISCIPLINING AT HEALTH CARE ORGANIZATIONS (BOARD OF TRUSTEES REPORT 17, I-04)

HOUSE ACTION: REFERRED FOR DECISION

INTRODUCTION

At the 2004 Interim Meeting, the House of Delegates referred Board of Trustees Report 17, "Principles for Incident-Based Peer Review and Disciplining at Health Care Facilities," to revisit the recommendations. Board Report 17 responded to Resolution 835 that was adopted at the 2003 Interim Meeting. Resolution 835, introduced by the Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont Delegations, asked the American Medical Association Board of Trustees to study and report back at the 2004 Annual Meeting the advisability of adopting the Massachusetts Medical Society (MMS) Model Principles for Incident-Based Peer Review and Disciplining at Health Care Facilities (Model Principles). It also asked the AMA to send the Model Principles to all state medical societies and all medical staffs in the United States and be prominently posted on the AMA's web site should they be adopted by our AMA.

Many of the Model Principles are existing AMA policy, but some of them should be incorporated, sometimes with modifications, into AMA policy. In the process of comparing the Model Principles with AMA policy, the Board identified ambiguities and some inconsistencies in AMA policy. This report compares the Model Principles with AMA policies related to physician peer review, corrective action, and due process in hospitals and other institutions and recommends consolidation and amendments to AMA policies where it is appropriate.

BACKGROUND

The demands for greater accountability in health care by governmental, business, and consumer groups, and the continued advancement in technology and patient safety, require objective and systematic evaluation of the care provided by physicians and hospital employees. Peer review is an ongoing process of clinical departments and standing committees to assess and evaluate the medical care delivered to patients and improve the quality and safety of medical care provided in hospitals and other facilities. It should also be an educational process for physicians to assure quality medical services. Intensified peer review may be initiated in response to the circumstances of a single case or a pattern or trend in performance. The AMA has developed several policies to ensure that the principles of fairness and due process are afforded any physician whose medical care and professional conduct is being reviewed.

The MMS is concerned "that the systems to identify and improve poor quality have little teeth due to the paucity of adequate remedial resources," and "the lack of objectivity and due process may make peer review, as it is currently practiced, ineffective and may create innocent victims out of competent physicians, deprive patients of their services, and expose physician reviews to legal liability." More specifically, the MMS is concerned that current peer evaluations are often based on a single untoward event or quality review screens, (e.g., unplanned return to the operating room) rather than a pattern of care based on statistical approaches. The demarcation between quality improvement and the corrective action process is not always clear when the peer review process is triggered by an adverse or sentinel event. To ensure that peer review, as required under federal and state law, is effective in achieving the goal of quality improvement, while being fair, transparent, and credible, the MMS developed model principles to guide peer review activities for health care facilities.

HEALTH CARE QUALITY IMPROVEMENT ACT

The Health Care Quality Improvement Act (HCQIA) of 1986 was enacted to encourage physicians to participate in peer review committees by granting limited immunity from civil liability (claims from monetary damages). HCQIA is codified in Section 11101 et.seq. of Title 42 of the United States Code. HCQIA also established a national reporting system (National Practitioner Data Bank) intended to restrict the ability of incompetent physicians to move from state to state by requiring disclosure of the physicians' previous disciplinary or peer review action.

To qualify for immunity under HCQIA, the professional review action must meet certain minimal standards. It must be taken in the reasonable belief that it will further the quality of health care. The physician under review must have received appropriate notice of the proposed action and of the hearing itself. The hearing must be held before a mutually agreed upon arbitrator or before a hearing officer or hearing panel not in direct economic competition with the physician involved. In the hearing, the accused physician is entitled to representation by an attorney, to a record of the proceedings, to call, examine, and cross-examine witnesses, to present relevant evidence, regardless of its admissibility in a court of law, and to submit a written statement at the close of the hearing. Upon completion of the hearing, the physician has the right to receive the written recommendation of the arbitrator, hearing officer, or hearing panel and the right to receive a written decision of the health care entity. The recommendation and the decision are to include the basis for the conclusions reached.

Certain of the procedural protections can be relaxed in the event of a threatened health care emergency. A hearing is not required in the case of a suspension or restriction of clinical privileges for a period not longer than fourteen days, during which an investigation is conducted to determine the need for a professional review action. Clinical privileges can be immediately suspended or restricted where the failure to take such an action may result in an imminent danger to the health of an individual, provided that the physician receives a subsequent notice and the right to a hearing or other adequate procedures.

MMS MODEL PRINCIPLES

The Model Principles consist of 27 statements, each of which is separately discussed below.

1. Model Principle 1 states that patient safety and quality of care is the goal of peer review. Principle 1 is indirectly addressed in AMA Ethical Opinion E-4.07 and Policy H-230.989[1] (AMA Policy Database), but the Board believes it should be explicitly stated in AMA policies related to peer review.
2. Model Principle 2 states, in effect, that all relevant facts and circumstances should be considered before invoking a disciplinary procedure. While this point is not specifically included in Policy H-265.998, it is self evident and therefore unnecessary for inclusion in AMA policy.
3. Model Principle 3 states that all relevant information should be obtained promptly and then made available to the subject physician. After the information has been obtained, the issues should be discussed with the subject physician, and alternative courses of action should be considered before proceeding to the formal peer review process. Policy H-225.992 addresses the first part of Principle 3 and it should be amended to incorporate the second part of this principle.
4. Model Principle 4 states that the process must be mindful and attuned to the prevention of medical errors and recommend appropriate system changes to minimize them. The Principles of Medical Ethics II, III, and VII address a physician's ethical responsibility to participate in performance improvement. Since the Principles of Medical Ethics are general, Principle 4 should be included in the amendments to Policy H-375.984.
5. Model Principle 5 states that the "triggers that initiate a peer review within a health care facility should be valid, transparent and available to all member physicians and should be uniformly applied to all cases and physicians." AMA Ethical Opinion E-9.05 and Policies H-225.992, H-230.989, H-375.983, and H-375.997 provide that peer review must have established principles and procedures that provide a fair and objective hearing to any physician whose care or professional conduct is being reviewed. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right of a hearing, the opportunity to be present and to rebut the evidence, and the opportunity to present a defense. The composition of a hearing panel sitting in judgment of a physician should include a significant number of persons at a similar level of training.

They have an ethical responsibility to be guided primarily by concern for the welfare and best interests of patients. The intent of Principle 5 is addressed by current policy so no action is needed on this model principle.

6. Model Principle 6 states that physicians' health and impairment issues should be identified and managed by a medical review committee, separate from the disciplinary process. Policies H-235.977 and H-275.940 address Principle 6 so no action is needed on this model principle.
7. Model Principle 7 states that peer review actions should, at minimum, meet HCQIA standards for federal immunity. AMA Policy H-375.983 addresses Principle 7; however, since Principle 7 is articulated more clearly, Policy H-375.983 should be amended.
8. Model Principle 8 states that summary suspension or restriction of clinical privileges may only be used to prevent imminent danger to health. Such summary actions must be followed by adequate notice and hearing procedures prior to becoming final. Principle 8 is taken from the HCQIA and should be included in AMA policy. A charge of "imminent danger to health of any individual" should be adequate for the chief of staff, medical executive committee or clinical department chair to summarily suspend clinical privileges, but the medical executive committee should meet within fourteen days to review and consider the summary suspension. The medical executive committee should be able to modify, continue or terminate the summary suspension. Upon request, the affected physician may attend and make a statement concerning the issues under investigation, but the meeting with the medical executive committee shall not constitute the physician's fair hearing.
9. Model Principle 9 states that all parties involved in the peer review process must preserve its confidentiality, but all facts obtained for and in the peer review process should be made available to the subject physician. Policies H-375.992, H-375.993, and H-375.997 address Principle 9 so no action is needed on this model principle.
10. Model Principle 10 states that direct economic competitors of the subject physician are to be barred from serving on the peer review panel. It also states that the panel should include a fair representation of specialists or sub-specialists from the subject physician's specialty or subspecialty, whenever feasible. The restriction against direct economic competitors is already addressed by Policy H-375.983[2f], but the policy provides that physicians serving on the panel need not be in the same specialty as the physician involved. The Board believes that current policy should be amended to include a fair representation of the same specialist/sub-specialist as the physician involved, whenever feasible.
11. Model Principle 11 states that physicians should rotate service on the peer review committee. A peer review panel is usually appointed for each hearing so it is not feasible to rotate service on them. Policy H-375.983 recommends that the members of the hearing panel be physicians who have the respect of the medical community. The medical staff bylaws should include language on how physicians are elected or selected to serve on the medical executive committee and other committees. Each member of the medical staff should be appointed to a clinical department that reviews the quality and safety of patient care and establishes professional standards. No action is needed on Principle 11.
12. Model Principle 12 states that membership on the peer review committee should be open to all physicians on the medical staff and should not be restricted to those physicians who have an exclusive contract with the hospital, salaried physicians, or those on the faculty. Principle 12 is consistent with Policy H-375.990 that states that peer review of the performance of hospital medical staff physicians should be objective and supervised by physicians. The addition of Principle 12 would strengthen and clarify Policy H-375.990.
13. Model Principle 13 states that only physicians should be voting members of formal peer review committees convened for disciplinary matters. Currently Policy H-375.983[2f] states that a peer review panel should consist of physicians. The addition of "only" to the current policy would make it consistent with Principle 13.
14. Model Principle 14 states that whenever a peer review committee adequately representing the specialty or subspecialty of the subject physician cannot be adequately constituted with physicians from within the institution, while excluding direct economic competitors, qualified external consultants or an external peer review panel through another appropriate institution should be appointed to conduct the peer review. Ethical Opinion E-4.07 states that physicians involved in the granting, denying, or termination of hospital privileges

have an ethical responsibility to be guided primarily by concern for the welfare and best interests of patients in discharging this responsibility. Although, D-375.996 provides that medical staffs include bylaw provisions that provide for an external and impartial review when there is an allegation by a reviewed physician that he or she has not received an objective, impartial peer review, the Board believes a policy should be added to provide guidance on external peer review.

15. Model Principle 15 states that physicians serving on the peer review committee should receive information and training in the elements and essentials of peer review. The Board believes that the physicians serving on a hearing panel should be instructed by the hearing officer or attorney advising the panel on the requirements of the HCQIA, state peer review statutes, and their ethical obligations (i.e., E-9.05). Principle 15 should be included in AMA policy.
16. Model Principle 16 states that the hospital or other organization on whose behalf the peer review is done must ensure that the physicians serving on any peer review committee are provided with appropriate indemnification and insurance for peer review acts taken in good faith. The organization must also provide assistance to the committee in abiding by the HCQIA requirements for federal immunity. Policies H-225.976 and H-225.977 address Principle 16, so no action is needed on this model principle.
17. The first sentence of Model Principle 17 states that the peer review committee should be guided by generally accepted clinical guidelines and established standards and practices. This sentence should be included in AMA policy, but "hearing panel" should be substituted for "peer review committee". The second sentence of Principle 17 states that those guidelines, standards, and practices must be made available to the subject physician before a hearing. This sentence should not be included in AMA policy. Medical practice cannot be readily codified. It is too complicated to be set forth in the manner contemplated by the second sentence of Principle 17. However, Section 11112 of the HCQIA requires that the physician subject to peer review must be given the reasons for the proposed professional review action, a right to call, examine, and cross-examine witnesses, the opportunity to present evidence determined to be relevant by the hearing officer, and submit a written statement at the close of the hearing, among other rights.
18. Model Principle 18 states that clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible. To the extent possible, clinical guidelines, standards, and practices used for evaluation of quality of care should be made available to members of the clinical department, but it is too complicated to be a general requirement, as set forth by Principle 18.
19. Model Principle 19 states that, wherever feasible, structured assessment instruments and multiple reviewers should be used to increase reliability. Principle 19 is unclear and should not be included in AMA policy.
20. Model Principle 20 states that, where feasible, statistical analysis to compare with peers' performance must be used with appropriate case mix adjustments. The Board believes that information management systems and statistical analysis with de-identified information and appropriate case mix adjustment can be useful tools that medical staff committees can utilize to assess the quality and safety of medical care provided in the institution, but it does not believe Principle 20 should be included in AMA policy. The peer review panel or hearing officer should determine whether it is appropriate to utilize case mix adjustments.
21. Model Principle 21 states that not less than 30 days notice should be given to the subject physician for any formal hearing or appeal. Since Principle 21 is consistent with the HCQIA it will be addressed to the proposed amendment to Policy H-375.983.
22. Model Principle 22 states that all pertinent information obtained by the peer review committee should be made available to the subject physician in a timely manner before the hearing. In response to some physicians not being able to obtain copies of medical records and other information necessary to prepare for the peer review hearing, the House of Delegates adopted Policy H-230.957 at the 2004 Annual Meeting. It asks our AMA to support legislation guaranteeing that physicians engaged in staff privileges disputes have free and full access to all medical records related to those disputes so they can adequately defend themselves. In addition, Policy H-225.992 provides that physicians accused of an infraction of medical staff bylaws, rules, regulations, policies or procedures should be promptly notified that an investigation is being conducted and given an opportunity to respond. As a result, no action is needed on Principle 22.

23. Model Principle 23 states that, to the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome. Principle 23 should be added to Policy H-265.998.
24. Model Principle 24 states that any conclusion reached or action recommended or taken should be based upon the information presented to the peer review committee and make available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a 'reasonably prudent person' standard." The first sentence of Model Principle 24 is very similar to Principle 22. The essence of peer review is that physicians should assess their peers based on all available evidence, and based on their personal discretion and professional experience. As written, the second and third sentences may be inconsistent with HCQIA §11112(b)(3)(C)(iv), which allows the presentation of any relevant evidence, regardless of its admissibility in a court of law. As a result, the second and third sentences of Principle 24, as modified, should be added to Policy H-375.983.
25. Model Principle 25 states that the conclusion reached and action recommended by a health care facility should include, as an important focus, steps for remediation, as needed, for the subject physician and for the system. Model Principle 25, as phrased, gives undue weight to the remedial aspects of peer review. The Board believes that if the language is modified to indicate that the conclusion reached and action recommended "may" include steps for remediation and if the phrase "as an important focus" is eliminated, Principle 25 should be included in AMA policy.
26. Model Principle 26 states that the findings, recommendations, and actions of the peer review committee should not be vague or stated in general terms but should clearly and specifically state in writing the nature of the physician's act or omission, how it deviated from the standard of care, what the standard is and its source, and what specific step the physician could have taken or not taken to meet the standard of care. The Board supports inclusion of Principle 26 in AMA policy as modified: "The peer review panel should endeavor to state its findings, recommendations, and findings as concretely as possible." While the general proposition of Principle 26, which seeks clarity of language, is desirable, this objective must be weighed against the danger of making the peer review process too legalistic. If Model 26, as presently phrased, were to be incorporated verbatim into medical staff bylaws, physicians' attorneys would have a wide avenue for attacking the final judgments of peer review panels.
27. Model Principle 27 states that a process should be available to appeal any disciplinary finding of a health care facility, but it does not state to whom the appeal should be taken or the scope of the issues that can be reviewed. Principle 27 is consistent with Policy H-225.997[2], which vests final authority for termination of medical staff privileges in the hospital governing body. The hospital governing body is responsible for the conduct of the hospital, including oversight of patient safety, quality of care, and clinical performance. It exercises its fiduciary responsibilities, in part, through oversight, review, approval, and/or implementation of the medical staff's actions. As long as peer review is conducted fairly, it should be the responsibility of the medical staff, not subject to second-guessing by the governing body, to evaluate the professional competence, education, experience, and qualifications of the physicians within the health care facility. Since Principle 27 is addressed by Policy H-225.997[2], it is unnecessary and no action is needed.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Board of Trustees Report 17 (I-04) and that the remainder of this report be filed:

1. That the AMA amend Policy H-375.984, "Peer Review," to add Model Principle 1 to read as follows:

Quality of care and patient safety is the goal of peer review. Peer review should also address the prevention of medical errors and appropriate system changes to minimize them. The AMA affirms that it is the ethical duty of a physician to share truthfully quality care information regarding a colleague when requested by an authorized credentialing body, so long as the information that is shared is not a proceeding or a document protected by statute or regulation as confidential peer review information. (Sub. Res. 93, A-88; Reaffirmed: Sunset Report, I-98)

2. That the AMA amend Policy H-225.992 to incorporate Model Principles 3 and 22, and change the title to "Right to Relevant Information," to read as follows:

(1) The AMA advocates "timely notice" and "opportunity to rebut" any adverse entry in the medical staff ~~physician member's personal-credential file~~, believes that any ~~hospital-health care organization~~ file on a physician should be opened to him or her for inspection, and supports inclusion of these provisions in the hospital medical staff bylaws. (2) All relevant information pertaining to a potential peer review action should be obtained promptly from the subject physician. Relevant information includes, but is not limited to, pre-event factors, names of other health professionals involved in the care of the patient, and the contributing environmental factors of the health care facility/system. (3) A physician accused of an infraction of medical staff bylaws, rules, regulations, policies or procedures and faced with potential peer review action shall be promptly notified that an investigation is being conducted and shall be given an opportunity to respond. (4) All material information obtained by the peer review committee regarding the subject of the peer review should be made available to the physician under review in a timely manner prior to the hearing. (5) The investigating individual or body shall interview the practitioner, unless the practitioner waives his/her right to be heard, to evaluate the potential charges and explore alternative courses of action before proceeding to the formal peer review process. (Res. 121, I-83; Reaffirmed: CLRPD Rep. I-93-1; Modified by Sub. Res. 801, A-94)

3. That the AMA amend Policy H-375.983(2), "Peer Review after Patrick v. Burget," to read as follows and change the title to "Appropriate Peer Review Procedures."

~~(2) Our AMA urges hospitals, medical staffs, and peer reviewers to review the guidelines for peer review conduct in Health Care Quality Improvement Act of 1986 and to observe the following guidelines~~ Peer review procedures and actions should, at a minimum, meet the Health Care Quality Improvement Act of 1986 standards for federal immunity: (a) In any situation where it appears that a disciplinary proceeding may be instigated against a physician that could result in the substantial loss or termination of the physician's medical staff membership and/or clinical privileges, the advice and guidance of legal counsel should be sought ~~by those persons who are involved in this phase of the peer review process.~~ The accused physician should have legal counsel separate from the health care organization or medical staff. The health care organization/medical staff attorney should undertake the procedures needed to prepare attorney's participation should continue in preparation for the hearing including the written notice of charges, the marshaling of evidence and the facts, and the selection of witnesses. The health care organization/medical staff attorney should be instructed that his or her role includes is not that of a prosecutor, but as an advisor in assuring that the proceedings are conducted fairly, bearing in mind the objectives of protecting consumers of health care and the physician involved against false or exaggerated charges. The role of the attorney for the accused physician is solely to defend his or her client.

(b) The medical executive committee may recommend to the governing body that a hearing officer be appointed to conduct the hearing. The medical executive committee shall recommend a hearing officer to the governing body. The governing body shall be deemed to approve the selection unless it provides written notice to the medical executive committee stating the reasons for its objections within five days. If an attorney is sought to be the hearing officer, those solo attorneys or attorneys from a firm regularly used by the hospital, medical staff, or the involved medical staff member or applicant for membership for legal advice regarding their affairs and activities should not be eligible to serve as a hearing officer. The hearing officer shall gain no direct financial benefit from the outcome.

~~(b)-(c)~~ The attorney advising the hearing panel medical staff/health care organization and the attorney representing the physician involved should be accorded reasonable latitude in cross-examination, but acrimony should not be allowed by the hearing body/panel or hearing officer.

~~(e)-(d)~~ Substantial latitude should be permitted in the presentation of evidence, medical reference works and testimony, within reasonable time constraints and the discretion of the hearing body/panel or hearing officer.

~~(d)-(e)~~ A court reporter should be present to make a verbatim transcript of the hearing which should be available to the parties and the costs borne by the hospital or health care entity organization.

~~(e)-(f)~~ Within the discretion of the hearing body/panel or hearing officer, witnesses may be requested to testify under oath.

~~(f)-(g)~~ The hearing body/panel should only consist of physicians, none of whom are direct economic competitors with the physician involved or who stand to gain through a recommendation or decision adverse to the physician. It is desirable that members of the hearing body/panel be physicians who have the respect of the medical community, and should include a fair representation of the same specialists/subspecialist physicians as the physician involved, whenever feasible.

~~(g)~~ ~~(h)~~ Physicians who are direct economic competitors of the physician involved may testify as witnesses, whether they are called by the physician or the hearing panel or the ~~hospital health care organization~~, but a physician should not be deprived of his or her privileges solely on the basis of medical testimony by economic competitors. In any proceedings that result in the termination of privileges, there should be testimony from one or more physicians who are not economic competitors or who do not stand to gain economically by an adverse action, but who are knowledgeable in the treatment, patient care management and areas of medical practice or judgment upon which the adverse action is based.

(i) The hearing body/panel should lend credence to evidence brought before it in a manner reflective of the specificity of the evidence, and personal or economic biases of witnesses. Hearing bodies/panels should apply the "reasonable prudent person" standard.

~~(h)~~ ~~(j)~~ When investigation indicates that a disciplinary proceeding is warranted for the purpose of reducing, restricting, or terminating a physician's hospital privileges, he or she should not be permitted to resign without a finding that his or her termination occurred without cause. The disciplinary proceedings should be conducted by the hearing body/panel or hearing officer with the presentation of testimony and evidence, irrespective of whether the physician involved chooses not to be present. (BOT Rep. MMM, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: BOT Rep. 8, I-01)

4. That the AMA amend Policy H-265.998, "Guidelines for Due Process," to incorporate Model Principles 25 and 26 to read as follows:

While it is not possible to develop universal guidelines for due process, voluntary utilization of the following general guidelines for due process, adapted in each instance to suit the circumstances and conditions of the ~~institution or health care organization~~ and within the requirements of the applicable laws of the jurisdiction, should assist in providing the type of hearing which the law in each jurisdiction requires:

(1) The physician should be provided with a statement, or a specific listing, of the charges made against him or her.

(2) The physician is entitled to adequate notice of the right to a hearing and a reasonable opportunity to prepare for the hearing.

(3) It is the duty and responsibility of the hearing body/panel or hearing officer to conduct a fair, objective and independent hearing pursuant to established rules.

(4) The rules of procedure should clearly define the extent to which attorneys may participate in the hearing.

(5) The physician against whom the charges are made should have the opportunity to be present at the hearing and hear all of the evidence against him or her.

(6) The physician is entitled to the opportunity to present a defense to the charges against him or her.

(7) To the extent feasible, the hearing body/panel or hearing officer should evaluate the process of care given while blinded to the outcome.

~~(7)~~ ~~(8)~~ The hearing body/panel or hearing officer should render a decision based on the evidence produced at the hearing.

(9) The conclusions reached and actions recommended by the hearing body/panel or hearing officer should include, as appropriate, remedial steps for the physician and for the health care facility itself.

(10) The hearing body/panel or hearing officer should endeavor to state its findings, recommendations, and actions as concretely as possible. When feasible, the hearing body/panel or hearing officer should include terms that permit measurement and validation of the completed remediation process.

(11) Within 10 days of the receipt of the hearing body/panel or hearing officer decision, the physician or medical executive committee has the right to request an appellate review. The written request for an appellate review shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for an appeal of the decision shall be: (a) substantial non-compliance with the procedures required in the medical staff bylaws, applicable law, or application of law which has created demonstrable prejudice; (b) insufficient evidence in the hearing record to support the decision. If an appellate review is to be conducted, the appeal board shall schedule the appellate review and provide notice to the physician and medical executive committee. The governing body may sit as the appeal board or it may appoint an appeal board composed of not less than three members of the governing body. The appeal board shall consider the record of the hearing before the hearing body/panel or hearing officer, but may accept additional oral or written evidence, subject to a foundation that information could not have been made available during the hearing. The appeal board shall present its recommendation to the governing body as to whether the governing body should affirm, modify or reverse the hearing body/panel or hearing officer decision. If the appeal board determines that a fair procedure has not been afforded, the matter can be remanded to the hearing body/panel or hearing officer for further review and recommendation.

~~(8)~~(12) In any hearing, the interest of patients and the public must be protected. (BOT Rep. II, A-80; Reaffirmed: Sunset Report, I-98)

5. That the AMA amend Policy H-375.990, "Peer Review of the Performance of Hospital Medical Staff Physicians," to incorporate Model Principle 12 to read as follows:

Our AMA encourages peer review of the performance of hospital medical staff physicians, which is objective and supervised by physicians. Membership on peer review committees and hearing bodies/panels should be open to all physicians on the medical staff and should not be restricted to those physicians who have an exclusive contract with the hospital, salaried physicians, or those on the faculty.

6. That the AMA adopt the following new policy, based on Model Principle 8:

Summary suspension of clinical privileges is an extraordinary remedy which should be used only when the physician's continued practice presents an "imminent danger to the health of any individual." The decision to summarily suspend a member's medical staff membership or clinical privileges should be made by the chief of staff, chair or vice-chair of the member's clinical department, or medical executive committee. The medical executive committee (MEC) must meet as soon as possible, but in no event more than 14 days after the summary suspension is imposed, to review and consider the summary suspension. The MEC should be able to modify, continue or terminate the summary suspension. The suspended physician must be invited to attend and make a statement concerning the issues under investigation, but the meeting with the MEC shall not constitute the physician's fair hearing.

7. That the AMA adopt the following new policy, based on Model Principle 14:

At the request of a medical staff department or of a member under review, or at its own initiative to promote adequate and unbiased review, the medical executive committee shall arrange for an external peer review through the state or local medical society, the relevant specialty society or other source appropriate to obtain professional and impartial clinical assessment.

8. That the AMA adopt the following new policy, based on Model Principle 15:

Physicians serving on the hearing body/panel should receive information and training in the elements and essentials of peer review.

9. That the AMA adopt the following new policy, based on the first sentence of Model Principle 17:

The hearing body/panel of a health care organization should be guided by generally accepted clinical guidelines and established standards in making its determination.

10. That the AMA rescind Policy H-225.976 because it is a duplication of Policy H-225.977.

11. That our AMA make available in the next revision of its *Physicians' Guide to Medical Staff Organization Bylaws*, as a separate and distinct appendix, the new and amended policies relating to peer review.

12. That our AMA develop and make available to all state medical societies and all hospital medical staffs in the United States, after the recommendations of this Board Report are finalized, a separate document entitled, "Principles for Incident-Based Peer Review."

APPENDIX - AMA POLICY, ETHICAL OPINIONS, AND DIRECTIVES ON PEER REVIEW/CORRECTIVE ACTION/DUE PROCESS

E-4.07 Staff Privileges

The mutual objective of both the governing board and the medical staff is to improve the quality and efficiency of patient care in the hospital. Decisions regarding hospital privileges should be based upon the training, experience, and demonstrated competence of candidates, taking into consideration the availability of facilities and the overall medical needs of the community, the hospital, and especially patients. Privileges should not be based on numbers of

patients admitted to the facility or the economic or insurance status of the patient. Personal friendships, antagonisms, jurisdictional disputes, or fear of competition should not play a role in making these decisions. Physicians who are involved in the granting, denying, or termination of hospital privileges have an ethical responsibility to be guided primarily by concern for the welfare and best interests of patients in discharging this responsibility. (IV, VI, VII) Issued July 1983; Updated June 1994.

E-9.031 Reporting Impaired, Incompetent, or Unethical Colleagues

Physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues in accordance with the legal requirements in each state and assisted by the following guidelines:

Impairment. Impairment should be reported to the hospital's in-house impairment program, if available. Otherwise, either the chief of an appropriate clinical service or the chief of the hospital staff should be alerted. Reports may also be made directly to an external impaired physician program. Practicing physicians who do not have hospital privileges should be reported directly to an impaired physician program. If none of these steps would facilitate the entrance of the impaired physician into an impairment program, then the impaired physician should be reported directly to the state licensing board.

Incompetence. Initial reports of incompetence should be made to the appropriate clinical authority who would be empowered to assess the potential impact on patient welfare and to facilitate remedial action. The hospital peer review body should be notified where appropriate. Incompetence which poses an immediate threat to the health of patients should be reported directly to the state licensing board. Incompetence by physicians without a hospital affiliation should be reported to the local or state medical society and/or the state licensing or disciplinary board.

Unethical conduct. With the exception of incompetence or impairment, unethical behavior should be reported in accordance with the following guidelines:

Unethical conduct that threatens patient care or welfare should be reported to the appropriate authority for a particular clinical service.

Unethical behavior which violates state licensing provisions should be reported to the state licensing board. Unethical conduct which violates criminal statutes must be reported to the appropriate law enforcement authorities. All other unethical conduct should be reported to the local or state medical society.

Where the inappropriate behavior of a physician continues despite the initial report(s), the reporting physician should report to a higher or additional authority. The person or body receiving the initial report should notify the reporting physician when appropriate action has been taken. Physicians who receive reports of inappropriate behavior have an ethical duty to critically and objectively evaluate the reported information and to assure that identified deficiencies are either remedied or further reported to a higher or additional authority. Anonymous reports should receive appropriate review and confidential investigation. Physicians who are under scrutiny or charge should be protected by the rules of confidentiality until such charges are proven or until the physician is exonerated. Issued March 1992 based on the report "Reporting Impaired, Incompetent, or Unethical Colleagues," Issued January 1992; Updated June 1994. (II)

E-9.05 Due Process

The basic principles of a fair and objective hearing should always be accorded to the physician or medical student whose professional conduct is being reviewed. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right of a hearing, the opportunity to be present and to rebut the evidence, and the opportunity to present a defense. These principles apply when the hearing body is a medical society tribunal, medical staff committee, or other similar body composed of peers. The composition of committees sitting in judgment of medical students, residents, or fellows should include a significant number of persons at a similar level of training.

These principles of fair play apply in all disciplinary hearings and in any other type of hearing in which the reputation, professional status, or livelihood of the physician or medical student may be negatively impacted.

All physicians and medical students are urged to observe diligently these fundamental safeguards of due process whenever they are called upon to serve on a committee which will pass judgment on a peer. All medical societies and institutions are urged to review their constitutions and bylaws and/or policies to make sure that these instruments provide for such procedural safeguards. (II, III, VII) Issued prior to April 1977; Updated June 1994.

E-9.10 Peer Review

Medical society ethics committees, hospital credentials and utilization committees, and other forms of peer review have been long established by organized medicine to scrutinize physicians' professional conduct. At least to some extent, each of these types of peer review can be said to impinge upon the absolute professional freedom of physicians. They are, nonetheless, recognized and accepted. They are necessary and committees performing such work act ethically as long as principles of due process (Opinion E-9.05) are observed. They balance the physician's right to exercise medical judgment freely with the obligation to do so wisely and temperately. Issued prior to April 1977; Updated June 1994. (II, III, VII)

H-225.976 Risks For Hospital Medical Staff Physicians

The AMA reaffirms Resolution 183 (I-89), which states that the AMA (a) adopt as policy that every physician who serves as medical staff president, head of a medical staff department, a member of a medical staff peer review or quality review committee or acts in any hospital and/or medical staff administrative capacity, absent malice, should be fully indemnified and held harmless by the hospital; and (b) notify the American Hospital Association of this policy. (Sub. Res. 12, I-90; Amended by CLRPD Rep. 1, I-95)

H-225.977 Liability Coverage for Physician Members of Hospital Committees

Our AMA believes that every physician who serves as medical staff president, head of a medical staff department, a member of a medical staff peer review or quality review committee or acts in any hospital and/or medical staff administrative capacity, absent malice, should be fully indemnified and held harmless by the hospital. (Res. 183, I-89; Reaffirmed: Sunset Report, A-00)

H-225.992 Right to a Hearing

(1) The AMA advocates "timely notice" and "opportunity to rebut" any adverse entry in the medical staff physician's personal file, believes that any hospital file on a physician should be opened to him for inspection, and supports inclusion of these provisions in the hospital medical staff bylaws. (2) A physician accused of an infraction of medical staff bylaws, rules, regulations, policies or procedures shall be promptly notified that an investigation is being conducted and shall be given an opportunity to respond. The investigating individual or body shall interview the practitioner unless the practitioner waives his/her right to be heard. (Res. 121, I-83; Reaffirmed: CLRPD Rep. I-93-1; Modified by Sub. Res. 801, A-94)

H-230.984 Peer Review of the Performance of Hospital Medical Staff Physicians

The AMA (1) encourages state and local medical associations to establish procedures and committees for monitoring, upon the request of the medical staff, the effectiveness of hospital medical staff peer review; and (2) supports working with the AHA and other appropriate organizations to devise methods to encourage the development of such programs. (CMS Rep. E, I-86; Reaffirmed: Sunset Report, I-96)

H-230.989 Patient Protection and Clinical Privileges

Concerning the granting of staff and clinical privileges in hospitals and other health care facilities, the AMA believes: (1) the best interests of patients should be the predominant consideration; (2) the accordance and delineation of privileges should be determined on an individual basis, commensurate with an applicant's education, training, experience, and demonstrated current competence. In implementing these criteria, each facility should formulate and apply reasonable, nondiscriminatory standards for the evaluation of an applicant's credentials, free of anti-competitive intent or purpose; (3) differences among health care practitioners in their clinical privileges are acceptable to the extent that each has a scientific basis....

H-235.968 Physician Review of Medical Staff Activities

The AMA recommends that hospital medical staffs have a policy that would allow minutes of medical staff committees, except minutes concerning peer review or corrective action information, be made available for review by medical staff members in the medical staff office; and recommends that the medical executive committee approve all reports, policies and recommendations from medical staff clinical departments and committees and have a process to distribute significant changes to the members of the medical staff. (BOT Rep. 10, A-96)

H-235.977 Medical Staff Committees to Assist Impaired or Distressed Physicians

Our AMA recognizes the importance of early recognition of impaired or distressed physicians, and encourages hospital medical staffs to have provisions in their bylaws for a mechanism to address the physical and mental health of their medical staff and housestaff members. (Sub. Res. 67, A-89; Reaffirmed: BOT Rep. 17 and Sunset Report, A-00)

H-235.987 Right of Committees of Medical Staffs to Meet in Executive Sessions

The AMA (1) supports the right of any hospital medical staff committee to meet in executive session, with only voting members of the medical staff present, in order to permit open and free discussion of issues such as peer review and to maintain confidentiality; and (2) encourages individual medical staffs to incorporate provisions in their bylaws to affirm this right. (Res. 182, A-84; Reaffirmed by CLRPD Rep. 3 - I-94)

H-265.998 Guidelines for Due Process

While it is not possible to develop universal guidelines for due process, voluntary utilization of the following general guidelines for due process, adapted in each instance to suit the circumstances and conditions of the institution or organization and within the requirements of the applicable laws of the jurisdiction, should assist in providing the type of hearing which the law in each jurisdiction requires:

- (1) The physician should be provided with a statement, or a specific listing, of the charges made against him.
- (2) The physician is entitled to adequate notice of the right to a hearing and a reasonable opportunity to prepare for the hearing.
- (3) It is the duty and responsibility of the hearing body to conduct a fair, objective and independent hearing pursuant to established rules.
- (4) The rules of procedure should clearly define the extent to which attorneys may participate in the hearing.
- (5) The physician against whom the charges are made should have the opportunity to be present at the hearing and hear all of the evidence against him.
- (6) The physician is entitled to the opportunity to present a defense to the charges against him.
- (7) The hearing body should render a decision based on the evidence produced at the hearing.
- (8) In any hearing, the interest of patients and the public must be protected. (BOT Rep. II, A-80; Reaffirmed: I-98)

H-275.940 Physician Impairment

The AMA adopts the policy that, except in the case of summary suspension necessary to protect patients from imminent harm, no adverse action be taken against the privileges of a physician by a hospital, managed care organization or insurer based on a claim of physician impairment without a suitable due process hearing in accordance with medical staff bylaws to determine the facts related to the allegations of impairment and, where appropriate, a careful clinical evaluation of the physician. (Res. 701, I-97)

H-275.965 Health Care Quality Improvement Act of 1986 Amendments

The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists. (Res. 203, A-88)

H-285.998 Managed Care

...(5) Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payors should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed....

H-300.973 Promoting Quality Assurance, Peer Review, and Continuing Medical Education

The AMA:

- (1) reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and continuing medical education activities; (2) to encourage hospitals and other organizations in which quality assurance, peer review, and continuing medical education activities are conducted to provide recognition to physicians who participate voluntarily; (3) to increase its efforts to make physicians aware that participation in the voluntary quality assurance and peer review functions of their hospital medical staffs and other organizations provides credit toward the AMA's Physicians' Recognition Award; and (4) to continue to study additional incentives for physicians to participate in voluntary quality assurance, peer review, and continuing medical education activities. (BOT Rep. SS, I-91)

H-315.983 Patient Privacy and Confidentiality

....(4) Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. ... (BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01)

H-320.968 Approaches to Increase Payor Accountability

....(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payors to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed;....

H-375.966 Peer Review Protection Under Federal Law.

Our AMA supports: (1) federal legislation that will enhance protection of peer review information even if such information is shared with governmental agencies in an effort to better and more comprehensively analyze the patient safety measures and quality of healthcare measures being utilized in clinical settings; and (2) federal legislation to afford peer-review protection to information sharing and reporting in the context of patient safety and quality improvement. (Res. 239, A-01; Appended: BOT Rep. 14, I-02)

H-375.967 Supervision and Proctoring by Facility Medical Staff

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. (CMS Rep. 3, A-99)

H-375.968 Supervision and Proctoring by Facility Medical Staff.

Our AMA policy states that medical staff supervision refers to the imposition, usually involuntary and usually subsequent to an adverse event, of significant consultation, oversight, or close monitoring of a physician who has privileges and whose clinical competence, cognitive skills, procedural skills, or outcomes have been questioned. Supervision usually is limited to particular competencies under question and may apply to any site of service (CMS Rep. 3, A-99)

H-375.969 Physician Access to Performance Profile Data.

AMA policy is that every physician should be given a copy of his/her practice performance profile information at least annually by each organization retaining such physician information. (Res. 827, A-98)

H-375.972 Lack of Federal Peer Review Confidentiality Protection.

Our AMA will seek to vigorously pursue enactment of federal legislation to prohibit discovery of records, information, and documents obtained during the course of professional review proceedings. (Res. 221, I-96; Reaffirmed: BOT Rep. 13, I-00; Reaffirmation A-01; Reaffirmed: BOT Rep. 8, I-01; Reaffirmed: CMS Rep. 6, I-02)

H-375.977 Peer Review - Caused Litigation

The AMA urges medical staffs to review their hospital's policies for directors and officers liability and general liability coverage to determine if the policy provides defense, indemnity, or loss of income coverage for those members of the medical staff who are involved in a lawsuit as a result of the activities they have performed in good faith, conducting official peer review responsibilities or other official administrative duties of the medical staff. (Res. 707, I-92)

H-375.979 Litigation Over Hospital Peer Review Decisions

Our AMA believes that it is important to minimize expensive and time-consuming litigation over hospital peer review decisions if hospital peer review is to be a successful and effective mechanism for assuring the quality and appropriateness of hospital services. The AMA, therefore, recommends that state medical societies pursue one of the following alternatives to help minimize litigation over peer review decisions: (1) seek state legislation to create a forum that would qualify hospital peer review in the state for the state action exemption; (2) create a privately organized forum that would not qualify for the state exemption but would minimize the possibility of litigation by allowing for an objective evaluation of the decision outside of the hospital; and (3) pursue legislation that would create procedural protections designed to ensure fairness in the hospital peer review process that are the equivalent of or more substantial than those set forth in the Health Care Quality Improvement Act of 1986, or encourage hospital medical staffs to adopt bylaws with the requisite protections. (BOT Rep. DD, A-91; Reaffirmation A-00)

H-375.982 Peer Review Defined as the Practice of Medicine.

Our AMA defines the act of peer review as the practice of medicine and encourages state medical associations to consider similar action. (Res. 104, A-89; Reaffirmed: Sunset Report, A-00)

H-375.983 Peer Review after Patrick v. Burget

(1) Our AMA urges state medical associations to investigate applicable state law to determine if additional state agency supervision of peer review is needed to meet the active state supervision requirement set forth by the Supreme Court.

(2) Our AMA urges hospitals, medical staffs, and peer reviewers to review the guidelines for peer review conduct in Health Care Quality Improvement Act of 1986 and to observe the following guidelines: (a) In any situation where it appears that a disciplinary proceeding may be instigated against a physician that could result in the substantial loss or termination of the physician's clinical privileges, the advice and guidance of legal counsel should be sought by those persons who are involved in this phase of the peer review process. The attorney's participation should continue in preparation for the hearing including the written notice of charges, the marshaling of evidence and the facts, and the selection of witnesses. The attorney should be instructed that his role is not that of a prosecutor, but as an advisor in assuring that the proceedings are conducted fairly, bearing in mind the objectives of protecting consumers of health care and the physician involved against false or exaggerated charges.

(b) The attorney advising the hearing panel and the attorney representing the physician involved should be accorded reasonable latitude in cross-examination, but acrimony should not be allowed by the hearing panel.

(c) Substantial latitude should be permitted in the presentation of evidence, medical reference works and testimony, within reasonable time constraints and the discretion of the hearing panel.

(d) A court reporter should be present to make a verbatim transcript of the hearing which should be available to the parties and the costs borne by the hospital or health care entity.

(e) Within the discretion of the hearing panel, witnesses may be requested to testify under oath.

(f) The hearing panel should consist of physicians, none of whom are direct economic competitors with the physician involved or who stand to gain through a recommendation or decision adverse to the physician. It is desirable that members of the hearing panel be physicians who have the respect of the medical community, but they need not be in the same specialty as the physician involved.

(g) Physicians who are direct economic competitors of the physician involved may testify as witnesses, whether they are called by the physician or the hearing panel or the hospital, but a physician should not be deprived of his privileges solely on the basis of medical testimony by economic competitors. In any proceedings that result in the termination of privileges, there should be testimony from one or more physicians who are not economic competitors or who do not stand to gain economically by an adverse action, but who are knowledgeable in the treatment, patient care management and areas of medical practice or judgment upon which the adverse action is based.

(h) When investigation indicates that a disciplinary proceeding is warranted for the purpose of terminating a physician's hospital privileges, he should not be permitted to resign without a finding that his termination occurred without cause. The disciplinary proceedings should be conducted by the hearing panel with the presentation of testimony and evidence, irrespective of whether the physician involved chooses not to be present. (BOT Rep. MMM, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: BOT Rep. 8, I-01)

H-375.984 Peer Review.

The AMA affirms that it is the ethical duty of a physician to share truthfully quality care information regarding a colleague when requested by an authorized credentialing body, so long as the information that is shared is not a proceeding or a document protected by statute or regulation as confidential peer review information. (Sub. Res. 93, A-88; Reaffirmed: Sunset Report, I-98)

H-375.987 Bias in Peer Review Proceedings

Our AMA reaffirms its encouragement of state and local medical associations to establish procedures and committees to monitor, upon the request of the medical staff, the effectiveness of hospital medical staff review. (CMS Rep. E, I-86; Reaffirmed: I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BOT Rep. 8, I-01)

H-375.989 Protection of Peer Review Records in Litigation.

Our AMA believes that for peer review to be effective, peer review data must be kept confidential. (Sub. Res. 68, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: BOT Rep. 8, I-01)

H-375.990 Peer Review of the Performance of Hospital Medical Staff Physicians

Our AMA encourages peer review of the performance of hospital medical staff physicians, which is objective and supervised by physicians. (Res. 57, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: BOT Rep. 8, I-01)

H-375.992 Confidentiality of Staff Activity

Our AMA (1) supports efforts to ensure the preservation of quality care activities as a primary function of the medical staff, through affirmation of the need for confidentiality codes relevant to medical staff peer review activities; and (2) encourages state medical societies to seek the strengthening of existing laws and the promulgation of laws in those states where confidentiality codes do not exist. (Sub. Res. 116, I-83; Reaffirmed: CLRPD Rep. I-93-1; Reaffirmed: BOT Rep. 8, I-01)

H-375.993 Confidentiality in Medical Staff Peer Review.

Our AMA encourages medical staff peer review committees to consider excluding non-physicians when evaluating the professional practices of fully licensed physicians. (Sub. Res. 147, A-83; Reaffirmed: CLRPD Rep. I-93-1; Reaffirmed: BOT Rep. 8, I-01)

H-375.997 Voluntary Medical Peer Review

The AMA advocates the following principles for voluntary medical peer review:

- (1) Medical peer review is an organized effort to evaluate and analyze medical care services delivered to patients and to assure the quality and appropriateness of these services. Peer review should exist to maintain and improve the quality of medical care.
- (2) Medical peer review should be a local process.
- (3) Physicians should be ultimately responsible for all peer review of medical care.
- (4) Physicians involved in peer review should be representatives of the medical community; participation should be structured to maximize the involvement of the medical community. Any peer review process should provide for consideration of the views of individual physicians or groups of physicians or institutions under review.
- (5) Peer review evaluations should be based on appropriateness, medical necessity and efficiency of services to assure quality medical care.
- (6) Any system of medical peer review should have established procedures.
- (7) Peer review of medical practice and the patterns of medical practice of individual physicians, groups of physicians, and physicians within institutions should be an ongoing process of assessment and evaluation.
- (8) Peer review should be an educational process for physicians to assure quality medical services.
- (9) Any peer review process should protect the confidentiality of medical information obtained and used in conducting peer review. (CMS Rep. A, I-81; Reaffirmed: CLRPD Rep. F, I-91)

H-450.965 Medical Staff Leadership in Continuous Quality Improvement

The AMA will work with the AHA to assure that hospitals, in their continuous quality improvement/total quality management (CQI/TQM) programs, include practicing physicians in the development and implementation of such programs, especially the development of criteria sets and clinical indicators; provide feedback on CQI/TQM findings to physicians on a confidential basis; and inform all members of the medical staff on the CQI/TQM programs developed. (Sub. Res. 701, A-94)

H-450.997 Quality Assurance and Peer Review for Hospital Sponsored Programs

The AMA urges hospital medical staffs to make certain that all hospital sponsored, initiated, or affiliated medical services have appropriate peer review and quality assurance programs. (Sub. Res. 92, I-84; Reaffirmed by CLRPD Rep. 3 - I-94)

D-375.996 Peer Review Immunity

Our AMA: (1) recommends that medical staffs adopt bylaws that provide for a peer review process that is consistent with HCQIA criteria and AMA policy;

(2) recommends medical staffs include bylaw provisions that provide an option or alternative for external and impartial review when there is an allegation by a reviewed physician;

(3) recommends that if physicians believe that negligent or misdirected peer review is a problem, legislative action be considered at the state level to assure a fair due process proceeding for physicians subject to review;

(4) shall request that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) require medical staff bylaws to include due process protections for peer review, including the option for external and impartial review; and

(5) shall continue to monitor the legal and regulatory challenges to peer review immunity and non-discoverability of peer review records and proceedings, as well as consider legislative remedies, including the feasibility and impact of amending HCQIA to provide the option for external peer review for hospital medical staff physicians. (BOT Rep. 25, A-02)

24. AMA PARTICIPATION IN INTERNATIONAL ACTIVITIES

HOUSE ACTION: FILED

INTRODUCTION

This informational report presents an overview of the AMA's international activities. The report highlights targeted efforts to advance specific goals that further the AMA's policy and business interests by using a consistent integrated strategy. Our goal is to demonstrate the present and potential value of the AMA's international work.

At the 1997 Interim Meeting, the House of Delegates adopted Resolution 622, which asked that a full disclosure of all direct and indirect costs resulting from the AMA's membership in and support of the World Medical Association (WMA) be included in the Board of Trustees' annual report to the House of Delegates. This report responds to that resolution. As the predominant national medical association in the United States, the AMA is the only national medical association eligible for membership in the WMA. This membership creates a beneficial synergy among the AMA's relationship-building, advocacy, and business interests.

INTERNATIONAL STRATEGY

In June 1999, the Board of Trustees approved an international strategy for the AMA which defined a set of 11 core activities that integrated and leveraged one to the other. The overarching principles of the AMA strategy are:

- Adherence to the AMA's core purpose and core values;
- Facilitation of information sharing on health and medical practice worldwide;
- Promotion of the AMA's standards of excellence in medical ethics, practice, and education;
- Strengthening of the fiscal soundness and membership value of the AMA;
- Engaging in activities where the AMA contributes unique value at the same time it creates value for its members; and
- Pursuing international activities which are self-funding and do not detract from US operations.

In some cases this strategy calls for accelerating and more aggressively advancing existing activities. In other cases new opportunities are developed. In all cases, opportunities are evaluated on the basis of feasibility, practicality, and consistency with AMA core values. The following is a summary of 2004 activities.

CONTINUING PHYSICIAN PROFESSIONAL DEVELOPMENT

In 2004, Continuing Physician Professional Development (CPPD) continued its work toward the development of shared global standards for continuing medical education credit. Building on a letter of understanding already in place with Mexico's National Academy of Medicine, a formal agreement between the AMA and the Academy was signed in the fall of 2004. This agreement will allow the launch of a continuing medical education pilot project in the second quarter of 2005. Similar agreements are already in place with Spain, Singapore and the Union of European Medical Specialists.

The CPPD International Conference Recognition program approved and recognized eleven international continuing medical education conferences in 2004. These are international conferences the AMA has approved for AMA Physician Recognition Award (PRA) Category 1 credit. These approvals generated \$37,525 in revenue, driven by both program fees and certificate activity. In addition, the approval process by which the Accreditation Council for Continuing Medical Education accredited providers may issue AMA PRA Category 1 credit to international physicians yielded \$25,750 for the 542 activities approved.

CURRENT PROCEDURAL TERMINOLOGY

Interest in incorporating Current Procedural Terminology (CPT) into the health care systems of countries outside the US continues to grow. While several countries have expressed interest in CPT and management has worked to develop relationships with physician organizations and government health care agencies in these countries, the rate of actual adoption of CPT is very slow and has been limited by leadership change within the medical societies and the government. This year CPT staff interacted with at least five foreign countries and groups, including:

- South Africa - A contract was signed to customize CPT and make it available for use throughout South Africa. The South African Medical Association has been working with the national Department of Health and private insurance companies to have CPT adopted for all physician reporting.
- Poland - The AMA delivered a proposal to the Polish Chamber of Physicians and Dentists (PCPD) to provide consultative advice on developing a process for the translation of CPT to Polish. An initial meeting in Poland took place in February 2004 to refine the memorandum of understanding. Representatives from the PCPD visited the CPT Editorial Panel meeting in August 2004 and a finalized memorandum of understanding was signed shortly after. According to schedule the PCPD developed a draft translation of a portion of CPT and initiated plans to pilot test the translation among physicians and hospital/practice administrators. AMA staff visited the PCPD in early January 2005 to refine the proposed pilot, meet with representatives of the Health Ministry and the national health fund and to begin training participants in CPT coding principles and guidelines. A final agreement is currently being negotiated and plans are being made for a US visit in the fall of 2005.
- European Union - Initial discussions were held with Praha Communications, *JAMA/Archives* publisher for Central and Eastern Europe, regarding possible opportunities for the use of CPT within the EU. The use of CPT to resolve patient mobility and financial restitution matters will be explored more fully in 2005.
- South Korea - The Korean Medical Association (KMA) sent a 24-person delegation to Chicago to visit the RUC as part of the KMA's effort to develop an RBRVS-based system. CPT staff took advantage of their visit to present the CPT Editorial Panel process and the advantages of using CPT for physician payment and data analysis. Interest was expressed at having AMA CPT and RUC staff attend a conference on coding and the RBRVS in South Korea.
- Peru - Licensing information and material describing the CPT Editorial process and uses for health care payment and analysis were sent to the Peru Health Ministry. A letter from AMA senior management was also transmitted offering additional information and assistance in developing a version of CPT for use in Peru.
- Japan - In 2003, the AMA signed a memorandum of understanding with the Japan Medical Association (JMA) regarding translation and testing of CPT for clinical accuracy and commercial viability. Representatives from the JMA attended the CPT Editorial Panel meeting in November 2003 and spent time discussing the role of coding in the US health care system. The AMA also reviewed a draft portion of CPT translated into Japanese. Although substantial progress toward a Japanese version of CPT was made in 2003, the leadership of the Japanese Medical Association changed in 2004 and postponed all CPT development efforts. AMA is attempting to restart the initiative.

- Israel - The AMA received a proposal for licensing CPT for several government-run hospitals. The proposed fee structure was unduly complicated and the AMA is attempting to negotiate a more simple licensing structure that will meet the needs of the Health Ministry and the AMA.

INTERNATIONAL BUSINESS & DEVELOPMENT - SCIENTIFIC PUBLICATIONS

Globally, print subscription revenue increased 6.5%. Country leaders in sales growth were India, Australia, and Japan. Despite marketplace changes that have seen dramatic declines in print sales and a shift to online, non-US print sales in particular remained stable. Journal subscription growth leaders were *Archives of Facial Plastic Surgery* and *Archives of Internal Medicine*. Site licensing continued to represent Circulation Sales & Marketing's greatest growth product line, nearly tripling revenues over 2003 levels. Revenue from electronic licensing was about one-third international.

International editions of *JAMA* in 2004 totaled 17 editions in 15 languages, with a combined circulation of 300,000. There were nine international Archives editions in five languages with a combined circulation of 28,000. New international editions were *JAMA-Hellas* (Greece) and *JAMA-Serbia-Montenegro*. Editions that ceased in 2004 were *JAMA-Brasil*, *JAMA-Hungary*, *JAMA-Poland*, *JAMA-Français*, and *Archives of General Psychiatry-Hungary*.

The Health Internetwork Access Research Initiative (HINARI) continued as an AMA initiative under the auspices of the World Health Organization. This project makes medical and scientific journals available at no cost or at minimal cost to the world's poorest countries. The HINARI project now includes 1000 institutions from 99 of the 113 eligible countries. The project gives access to more than 2000 journals, including *JAMA* and the Archives journals.

INTERNATIONAL ADVOCACY

The Office of International Medicine (OIM) received groups of visitors from Korea, Thailand, Canada, and Israel in 2004. At the Annual Meeting, the OIM hosted 14 visitors from 9 nations. Areas of interest for these international visitors included physician certification, continuing medical education, and advocacy. AMA officers attended meetings of the British, Canadian, and Indian Medical Associations. The AMA was represented at the World Health Organization's 57th Assembly in Geneva in May and officers met with several minister-level officials of the United States Embassy in Tokyo, Japan, in October. In addition to overseas organizations, the AMA continues its liaison with US-based international health groups such as the Global Health Council, Health Volunteers Overseas, the World Bank, the Fogarty Center at the National Institutes of Health, and the Office of International Health at the Department of Health and Human Services.

On December 26, 2004, a tsunami devastated much of coastal south Asia. The AMA responded by sending letters of condolence to all affected national medical associations and by offering the AMA's assistance. A link was added to the AMA web site homepage to direct members' contributions to the relief efforts. The AMA matched the donations made at an AMA staff fundraiser. As a result, more than \$25,000 was sent to Project Hope and its hospital ship, Mercy.

The OIM webpage listing volunteer opportunities is very popular with members. The page is updated monthly and highlights activities and openings for volunteers at Health Volunteers Overseas and other volunteer organizations. In addition to the webpage, members wanting to reach other physicians interested in international medical service have been able to publicize specific opportunities using AMA communications vehicles and the International Health Volunteers Overseas web site.

INTERNATIONAL AWARDS

The Dr. Nathan Davis International Awards in Medicine and Public Health were presented at the opening of the House of Delegates on Saturday, June 12, 2004, by AMA President Donald J. Palmisano, MD, JD. The awards have been presented annually since 2000 and consist of a \$20,000 grant and an engraved crystal award piece. Judges were Dr. Gerald T. Keusch of Boston, MA; Representative Gregory Meeks of Washington, DC; Dr. Robert Hecht of Washington, DC; Dr. Evarist Feliu of Badalona, Spain; and Drs. Donald J. Palmisano and John C. Nelson from the AMA. The Federation was a vital source of nominations for these awards. The awards are supported by unrestricted grants from corporate sponsors.

This year the Outstanding Global Health Initiative was awarded to the Addis Ababa Fistula Hospital in Addis Ababa, Ethiopia. Founded by Drs. Reginald and Catherine Hamlin in 1974, this hospital has treated more than 25,000 girls and women who suffer from obstetric fistula, a debilitating childbirth injury common in the developing world. No woman is turned away and all services are provided free of charge.

The 2004 Outstanding International Physician award was given to Dr. Shankar Man Rai, a plastic surgeon from Nepal. Dr. Rai has dedicated his entire career to charitable service, performing free surgeries for impoverished children with birth defects and disabling injuries such as cleft lip and burns. Since 1992, Dr. Rai has worked with Interplast, a humanitarian organization that provides free reconstructive surgery to people in developing countries. In 1999, he established the first Interplast surgical outreach program to provide free surgeries and speech therapy in Kathmandu and rural Nepal.

MEDICAL ETHICS DAY

In September 2003, the World Medical Association passed a resolution designating September 18 as Medical Ethics Day. This date was chosen because the WMA was founded on September 18, 1947. All national medical associations were encouraged to annually observe this day.

The AMA supported this resolution by holding its first Medical Ethics Day in 2004. The commemoration included a press release and a panel discussion on the AMA Code of Medical Ethics at the Hyatt Hotel on September 17. It also provided the AMA with an opportunity to assure patients and the general public of the medical profession's commitment to ethics and professionalism. It is through this commitment that the medical profession preserves its integrity and the trust it inspires. The AMA Ethics Unit also featured a special edition of its *Virtual Mentor* on its web site and used the occasion to highlight WorldScopes, a collection drive for stethoscopes for distribution to physicians around the world who have none.

INTERNATIONAL CONFERENCE ON PHYSICIAN HEALTH

Presented by the AMA and the Canadian Medical Association, the International Conference on Physician Health was held October 13-16, 2004, in Oak Brook, Illinois. The theme for the conference was "Successes and Challenges in Creating a Health Culture in Medicine," and included panel discussion, speakers and workshop sessions. These activities were designed to explore topics such as the management of illness or impairment and wellness challenges for medical students and residents. More than 200 people attended this conference, representing 11 countries.

THE WORLD MEDICAL ASSOCIATION

The Board of Trustees believes in our global responsibility to participate in and contribute to sound international health policy and the promotion of global health through the World Medical Association. This is our investment in creating and sustaining health systems and good health practices worldwide. It is also a demonstration of our professional duty to share information and to apply the principles of the Declaration of Professional Responsibility: Medicine's Social Contract with Humanity. Many doctors and health-related organizations around the world look to the WMA for policy leadership ethical guidance and as a link to the world's physicians.

The WMA was formed in 1947 as a forum for physicians from all over the world. The WMA is a private organization of national medical associations and was the first non-governmental agency which dealt with the concerns of the medical profession. It continues to be the only forum for all national medical associations. The need for such an organization is substantiated by the fact that in its 58-year history, the organization has grown from 27 members to 89. New associations continue to apply for membership as global reorganization occurs. The AMA serves regularly in important leadership roles. In October 2004, Dr. Yank D. Coble, Jr., was inaugurated as WMA's President. Dr. John C. Nelson currently serves as the Chair of the Finance and Planning Committee.

The AMA derives numerous benefits from its membership and involvement in the WMA:

- Strengthening our own policy development;
- Identifying emerging issues and finding solutions to common problems;
- Casting AMA in a favorable light around the world and at home;

- Fulfilling our professional obligation to share knowledge;
- Helping us identify new ways to educate and assist physicians worldwide;
- Enhancing our reputation as an activist in international health; and
- Forming critical relationships with medical leaders around the world that can lead to important business opportunities.

The Board of Trustees recognizes that the AMA must work with limited resources and a more focused set of priorities. At the same time, the WMA remains the only forum for national medical associations around the world, and the AMA is the only medical association from the US that is eligible for membership. AMA leadership can make a critical difference in establishing effective partnerships for global health. The agenda is so large that no single sector or organization can succeed alone. Bridges need to be continually built and maintained.

All physicians and medical students are eligible to join the WMA as associate members. Associate members receive a membership card, a subscription to the Association's journal, and such other benefits as the Council may approve. Associate members may attend open meetings of the WMA General Assembly upon payment of the registration fee and may attend open meetings of the World Medical Association Council. Membership dues are currently \$40 per year.

At the 2004 General Assembly in Tokyo, the national medical associations of Vietnam and Estonia were accepted as the newest members of the WMA. Under the grant established by the AMA in 2002 to fund travel expenses for representatives of developing countries, two physicians were able to attend the Tokyo meeting, one from Estonia and one from Armenia. Neither of these countries had ever been able to attend prior to 2004 due to lack of funds.

Overview of Selected Current WMA Issues

Health Emergencies Communication and Coordination - Building on lessons learned during the SARS outbreak in Canada and elsewhere, the 2004 General Assembly in Tokyo approved a new statement on health emergencies communication. The statement urges all physicians to be alert to and knowledgeable of disease surveillance and control capabilities for responding to unusual clusters of diseases and symptoms, and to work closely with local, national and international health authorities to develop and implement disaster preparedness and response protocols.

Water and Health - This statement was adopted by the General Assembly in Tokyo to raise awareness among physicians of the integral relationship between clean, uncontaminated water and human health. The statement encourages physicians to support international and national programs designed to provide access to safe drinking water at low cost to all and to prevent the pollution of water supplies. It also encourages the implementation of emergency water supply programs designed cooperatively with regional and community authorities.

Note of Clarification to Paragraph 30 of the Declaration of Helsinki - Revisions to the longstanding and widely consulted WMA Declaration of Helsinki were completed at the Tokyo Assembly meeting. The Declaration is a seminal document that guides researchers who use human subjects in their work. Language proposed by the AMA will now appear as a note of clarification to the existing paragraph 30 which discusses post-trial access to care by study subjects.

Obesity - A timely new statement was introduced that outlines the worldwide problem of obesity and the doctor's role in its prevention. Culturally responsive care to improve the treatment and management of obesity and diet-related diseases is emphasized. The statement also points out the economic impact of resultant poor health on economic growth.

In response to inquiries from national medical associations, the AMA has worked with its WMA colleagues to respond to allegations that US military physicians may have been involved in the mistreatment of prisoners in Iraq and at Guantanamo Bay in Cuba. The AMA has received repeated assurances from the highest levels that the US military and civilian leadership understands these issues and that they will investigate allegations and take corrective action if necessary. The AMA reiterated its position that physicians must never use their medical skills to intentionally harm patients.

WMA Financial Data

In 2004, the AMA paid \$286,000 in annual membership dues to the WMA. This entitled the AMA to 3 of 17 votes in the Council and 13 votes in the Assembly. The AMA's dues payment accounted for approximately 17.4% of the WMA's annual budget of \$1,644,836. The major expenses related to the AMA's participation in the WMA are:

DIRECT EXPENSE	\$286,000
Membership Dues	
*INDIRECT EXPENSE	\$183,185
Salaries and Wages	\$ 66,075
Benefits	\$ 17,179
Travel and Meetings	\$ 95,367
Printing and Postage	\$ 1,240
Telephone	\$ 1,978
All Other	\$ 1,346
TOTAL 2004 EXPENSE	\$469,185

* - All figures are net.

CONCLUSION

The AMA is involved in international health with a targeted strategy of programs, advocacy, and business ventures. Through a cross-organizational team, the AMA collaborates on international endeavors leveraging information, contacts, and opportunities. Our participation in the WMA provides us a unique forum to advance AMA policy and advocacy issues and allows us to form relationships with counterpart organizations that can have wide-ranging benefits to the AMA as a whole. In an increasingly global community, these opportunities are important to our future.

25. AMERICAN MEDICAL ASSOCIATION WOMEN PHYSICIANS CONGRESS STATUS REPORT

HOUSE ACTION: FILED**INTRODUCTION**

The Women Physicians Congress (WPC) is an American Medical Association special interest group dedicated to identifying and addressing women physician professional and women's health issues. It serves as an inclusive advocacy and networking forum for AMA members to strengthen the voice of women in the AMA and broaden AMA outreach to this important member constituency.

In 2004, the AMA celebrated 25 years of a formal women in medicine program. The WPC was established in 1997 to replace an advisory committee structure. An elected Governing Council guides the activities of the WPC and works with members to address women in medicine concerns, increase AMA membership among women, and enhance the AMA's ability to represent women physicians and patients.

This informational report presents an overview of the progress and contributions of women physicians and summary of the recent activities of the WPC.

WOMEN IN THE PROFESSION AND THE AMA

The number and influence of women physicians and medical students continues to increase, enriching both the profession and the AMA. The WPC encourages the full participation of women physicians through traditional as well as new pathways for involvement. It provides a forum for identifying and highlighting issues important to women that might be lost in other debates, as well as helping the AMA reduce barriers that may prevent the advancement of women in the profession or organized medicine.

Today, almost 26% of US physicians are female, compared to 17% in 1990 and 12% in 1980. The most dramatic growth is found in medical school, where almost 50% of medical students enrolled are women. Since 1996, the number of female medical students and physicians has grown an average of 3.8% annually, in contrast to an overall physician/student growth of 2.2%.

Women physicians have assumed important leadership positions throughout the profession and organized medicine. There also has been a slow but steady increase in the percentage of women physicians in the AMA House of Delegates. The most recent report of the Council on Long Range Planning and Development on the "Demographic Characteristics of AMA Leadership," showed that 16.6% of all AMA Delegates and 17.3% of Alternate Delegates at year-end 2004 were female.

Looking back over the past few years, for which only state delegation comparisons are available, the percentage of female Delegates/Alternate Delegates increased from 13% in 1997 to 15.7% in 1999. In contrast, female physicians comprised less than 5.7% of Delegates/Alternates a decade before. Also significant was the election of the first female Speaker of the AMA House.

ACTIVITIES/ACCOMPLISHMENTS OF THE WOMEN PHYSICIANS CONGRESS

The WPC has an impressive history of activities, accomplishments, and policy and programming initiatives. These are summarized in the remainder of this report within the following key categories: Membership, Member Involvement, Communications, and Advocacy.

MEMBERSHIP

Any interested AMA member physician or medical student can elect to join the WPC. Non-AMA members are allowed to join on a limited basis but cannot vote, hold office nor access AMA member benefits. Admission of AMA non members is an WPC initiative aimed at establishing a meaningful dialogue with potential AMA members.

Increasing AMA and WPC membership and member satisfaction remains a central goal for the WPC. However, membership continues to be a challenge for the AMA in all member segments, including women, although the AMA decrease in market share has been less among women than among men physicians.

Recent key membership activities and accomplishments are as follows:

- New members of the WPC receive a welcome letter with an encouragement to join or renew their membership in the AMA. This message is repeated on an ongoing basis in all WPC communications.
- WPC membership has increased to over 4000 members, broadening its reach and ability to highlight AMA efforts for women in medicine and women's health issues.
- Between 2001 to 2004, the percentage of AMA members who were women increased from 23% to almost 25%.
- All members of the WPC Governing Council serve as AMA membership recruiters.
- The WPC develops and/or presents resources, such as its Residency Interview Guide and the WIM Data Source, as benefits exclusive to AMA members.

MEMBER INVOLVEMENT

There are numerous ways for WPC members to be involved in the WPC. Activities are created with a member-centric approach keeping in mind the time constraints and varying levels of interest among members. Listed below are recent activities and resources made available to physicians and medical students to initiate or increase their involvement in the WPC:

- The 2005 WPC Women Physicians Summit was held in conjunction with the National Advocacy Conference. The annual Summit provides opportunities for physicians to develop leadership skills, network with colleagues, mentor medical students, and obtain CME credits. A tally of the evaluation forms from the 2005 Summit showed a high level of attendee satisfaction, as shown through these excerpted comments:

"I encouraged my colleagues and students to attend the WPC Summit. This year I brought three colleagues and two students with me and now they want to be involved with the AMA and the WPC."

“If it weren’t for the work of the AMA WPC, we wouldn’t have these excellent [sexual harassment] guidelines and policy. This is the sort of document that every organization should be distributing and using.”

“I attended the Summit last year and when I got back to my office, I wrote to my specialty society executive about the value of this meeting and the WPC. I was then asked to assume the position of WPC Liaison for our society.”

“Every physician should hear what [the speaker] had to say about the need for more women physician leaders.”

- The WPC, through its Women’s Caucus, has organized subcommittees to address leadership development and establishing a scholarship or awards program, in order to create opportunities for increased WPC member involvement and as a conduit for new ideas to reach the Governing Council.
- The number of WPC Liaisons from state and specialty medical associations has increased from 70 to 85. WPC Liaisons share their associations’ activities with other members at the WPC Women Physicians Summit and are kept informed of AMA activities and opportunities to share with their state and specialty members.
- WPC members were surveyed to determine the priorities and expectations of the WPC. Members were enthusiastic and optimistic about the opportunities that the WPC affords to promote women physicians in leadership. Significantly, most respondents indicated that they learn about general AMA activities through WPC communications.
- WPC Liaisons are exposed to multiple opportunities in leadership development, networking, and mentoring at WPC meetings and Women’s Caucus held each June and December.
- WPC members elect at-large governing council members and four slotted positions for the Medical Student, Resident and Fellow, and Young Physician Sections, and the American Medical Women’s Association from an outstanding roster of candidates. Elections are held annually to maintain staggered terms and promote opportunities for leadership.

COMMUNICATION

An ongoing communications network is maintained to exchange information with members of the WPC. This includes electronic bulletins and/or e-newsletters, print newsletters, and a dedicated WPC web site. The web site includes information on joining the WPC and the AMA; statistics and historical information on women in medicine; AMA policy on professional and women’s health issues; and links to advocacy information, women physician specialty groups, meetings of interest, and other resources.

Listed below are WPC communication highlights:

- The WPC commemorated the Women in Medicine 25th anniversary with feature articles and resources that highlighted the history and accomplishments of women in medicine. A well-received PowerPoint presentation was developed and made available to the Federation for Women in Medicine Month.
- The *Residency Interview Guide* was updated to assist medical students with their residency interviews and address gender-related interview questions. On the WPC web site, this resource received hundreds of unique visits per week for several months.
- Quarterly newsletters are mailed to WPC members highlighting AMA initiatives, women in medicine professional issues, and women’s health issues.
- A WPC Governing Council Online Business Center was created for Council members to access business documents, significantly reducing mailing and printing costs.
- Weekly *eVoice* messages communicate WPC information on women’s health and professional issues and AMA opportunities that are of particular interest to women physicians.
- The WPC maintains an ongoing working relationship with the AMA communications and membership groups to convey the women in medicine perspective in AMA messaging and membership mailings.

- The September Women in Medicine Month campaign is promoted to the WPC members and throughout the AMA to highlight the accomplishments and contributions of women in medicine. WPC members are encouraged to commemorate the month in their communities and/or medical societies.
- The WPC pursues opportunities to speak for women in the AMA, e.g., a letter to the editor in *AMNews* on the benefits to the medical profession related to the increasing number of women in medicine.
- The WPC conducts an active liaison function for the AMA with the American Medical Women's Association, state and specialty societies, and other women in medicine groups with mutual concerns. In particular, the WPC has worked with the American Academy of Pediatrics on developing a resource on part-time practice options.
- The WPC web site content constantly evolves to include timely information on women's health and other issues. The number of unique visits to the web site has increased steadily over the past two years, and averages over 1600 unique visits per week.

ADVOCACY

The WPC does not have a formal role in the AMA House but does influence policy through its relationships with the Board of Trustees, Councils, and Sections, and through other existing mechanisms. In addition, many of the WPC Governing Council members are Delegates or Alternate Delegates in the House and often speak as individuals on behalf of the WPC.

Recent advocacy activities of the WPC include:

- The WPC contributes to AMA policy development and advocacy which has led to the recent adoption of AMA policy on issues such as diagnostic mammography and emergency contraception; as well as the development of a comprehensive resource on addressing sexual harassment issues in the medical profession.
- At the WPC-sponsored Women's Caucus, items of business before the House are discussed and debated, allowing Delegates in attendance to carry forward the information to their respective delegations.
- The WPC works with the Washington office on items related to legislation and lobbying efforts on women in medicine and women's health issues.
- An AMA women in medicine policy compendium is maintained and is requested by members frequently for advocacy efforts or to meet professional interests.

CONCLUSION

The AMA is committed to strengthening the membership and voice of women in the AMA including supporting the efforts of the WPC and has renewed the WPC Charter for a period extending from June 2005 to June 2009. The Board of Trustees thanks the following members of the 2004-2005 WPC Governing Council for their ongoing efforts:

- Willarda V. Edwards, MD, MBA, Internal Medicine; Baltimore, MD, At-Large Representative, Chair
- Judith L. Mates, MD, Obstetrics/Gynecology; San Francisco, CA, At-Large Representative, Vice Chair
- Mary Gayle Armstrong, MD, Family Practice; Madison, MS, At-Large Representative
- Jane van Dis, MD, Obstetrics and Gynecology; La Canada, CA, Resident and Fellow Section Representative
- Lasya Gaur, University of Wisconsin Medical School, Medical Student Section Representative
- Patrice Harris, MD, Psychiatry; Atlanta, GA, At-Large Representative, Caucus Co-Chair
- Debra R. Judelson, MD, Cardiovascular Diseases/Internal Medicine; Beverly Hills, CA, American Medical Women's Association Representative
- Erin E. Tracy, MD, MPH, Obstetrics and Gynecology; Shoreham, MA, Young Physicians Section Representative, Caucus Co-Chair

**26. INTERNET LISTING OF EXPERT WITNESSES
(RESOLUTION 6, A-04; BOARD OF TRUSTEES REPORT 27, I-04)**

**HOUSE ACTION: RECOMMENDATION ADOPTED
(RESOLUTION 6, A-04 NOT ADOPTED) AND
REMAINDER OF REPORT FILED**

At the 2004 Annual Meeting, the Florida Delegation introduced Resolution 6, which would require the AMA to develop and maintain a list, to be posted on the Internet, of physicians who testify as expert witnesses for either the plaintiff or the defendant in alleged medical malpractice cases. Although the Reference Committee recommended that Resolution 6 not be adopted, the House of Delegates referred the resolution to the Board of Trustees for a report at the Interim Meeting.

Pursuant to such referral, the Board of Trustees submitted Report 27-I-04, which also recommended against the proposal. The report stated: "The contemplated list would duplicate existing information resources available to interested physicians or their counsel, would be difficult and costly to implement, and would be unlikely to be useful for physicians." However, at the 2004 Interim Meeting, Reference Committee F found "considerable discrepancy between the testimony it heard and the information presented in the report." It therefore referred the matter back to the Board of Trustees, with directions that "more comprehensive information be gathered, including from the organizations that offer similar services." This would allow the House of Delegates to make "an informed decision on the cost/benefit of such a service." The present report responds to this directive.

METHODOLOGIES FOR CREATING EXPERT WITNESS LISTS

The Board knows of no means, for any reasonable amount of money, by which the AMA could develop an even modestly comprehensive list of the type contemplated. The vast majority of medical malpractice suits are filed in state (county) courts, with no centralized or publicly accessible database. While the court files in these cases are typically matters of public record, usually they are able to be examined by a personal trip to the courthouse. The person who makes the trip to the courthouse would have to know how to segregate medical malpractice suits from other types of cases, a process whose difficulty varies greatly from court to court. Even if the AMA were somehow able to identify the appropriate court files, it is not clear how a researcher could readily identify medical expert witnesses.

There are many internet listings of physicians who have testified as medical experts. None of these lists is even remotely comprehensive. Because the persons who compile these lists generally do so for financial reasons, the Board had difficulty in learning the methods used to prepare such lists. However, AMA staff did speak with a knowledgeable person in that industry, who was able to provide significant insights. Much of what follows is taken from this person's information. To preserve his confidence, his name is not given.

There are three basic methods for compiling lists of medical expert testimony, which are discussed below.

Surveys

The most comprehensive method of ascertaining the names of testifying medical experts is to send questionnaires to lawyers who have tried medical malpractice cases and ask them to complete and return the questionnaires. In principle, the lawyers' names can be learned by reviewing court files. As explained above, this is generally impractical, but some courts do separate cases into different types. A researcher can review selective court files and cull out the medical malpractice cases. Among other variables, this method depends on having lawyers respond to the questionnaires. Because of the labor intensive nature of this effort and its dependence on attorneys' cooperation, it is attempted in only a few jurisdictions. When employed, it is generally used to identify information about all jury trial cases, rather than solely medical malpractice cases.

Although the survey method is the most comprehensive means of gathering information on expert witnesses, the AMA understands that no such survey claims that it is fully able to identify all testifying experts (or all testifying medical experts) in even a limited geographic area.

Anecdotes

A less comprehensive and more widely used means of gathering information about expert witnesses depends on anecdotes. Litigation data resource companies may see certain cases reported in newspapers, or they may learn of them through word of mouth. They may then review the court files and/or contact the attorneys for information.

Copying

The third means of compiling such lists is to copy information on other lists. In general, those who provide lists of expert witnesses do so for financial reasons, and therefore the owners of such lists prohibit copying. Thus, while the copying of expert witness lists may be licensed, often it is not.

It can be difficult to prevent unauthorized copying, and frequently those who might have grounds for a potential lawsuit simply decline to pursue the infringers. However, when copying has been particularly blatant or notorious, infringement suits have been brought.

WWW.MEDICALEXPERTREPORT.COM AND JURY VERDICT REPORTERS

The Florida Medical Association's (FMA) proposal for an AMA expert witness website may have originated from the web site *www.medicalexpertreport.com*, which is linked to the FMA website. The web site at *www.medicalexpertreport.com* lists physicians who have testified as expert witnesses in Florida. It also lists information about the cases in which they have testified. The web site bears the disclaimer "This site is only a sample of the medical experts rendering opinions in the State of Florida...Over time, it is the intent of this website to provide more comprehensive data." At the bottom of each case entry is a box for "Data Source." In the Data Source boxes that the AMA examined, the letters "FJVR" are written, with what appears to be a date and page number. Presumably, "FJVR" stands for "*Florida Jury Verdict Reporter*."

AMA staff attempted to contact the proprietors of this website, through an e-mail address provided on it, in order to learn more information about it. However, the proprietors did not respond to the AMA inquiry. AMA staff was also unsuccessful in obtaining more information from FMA.

As a follow up to the *Florida Jury Verdict Reporter* reference, AMA staff contacted the *Cook County Jury Verdict Reporter* for more information about it and about related publications. The AMA learned that there are approximately 20 "Jury Verdict" reporters published throughout the country. They maintain a loose affiliation but are not commonly owned.

Some of the "Jury Verdict" reporters report on case results through the "survey" method discussed above, and some use the "anecdotes" method. Their total coverage includes about half the United States, and the charge for an annual subscription is approximately \$400 to \$500 per reporter. Since the "Jury Verdict" reporters cover cases in which a jury has been empanelled, their scope is both under inclusive and over inclusive to the preparation of an internet listing of expert witnesses. The publishers of the "Jury Verdict" reporters generally prohibit copying.

CONCLUSION

The Board of Trustees adheres to the position taken in its Report 27-I-04. That report indicated that the contemplated list would duplicate existing information resources available to interested physicians or their counsel and would be difficult and costly to implement. It also pointed out that, while experienced medical malpractice attorneys ordinarily have familiarity with expert witness lists, inexperienced attorneys may not. An attorney representing the plaintiff is more likely to be inexperienced than an attorney retained by a medical malpractice insurance carrier. On balance then, an additional list of expert witnesses is more likely to help those suing physicians than to help physicians themselves.

RECOMMENDATION

The Board of Trustees recommends that Resolution 6 (A-04) not be adopted, and the remainder of this report be filed.

**27. ADMINISTRATIVE AND LIABILITY SURCHARGES
(RESOLUTION 213, A-04; BOARD OF TRUSTEES REPORT 20-I-04)**

**HOUSE ACTION: RECOMMENDATION ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 213 (A-04) AND
AND BOARD OF TRUSTEES REPORT 20-I-04 AND
REMAINDER OF REPORT FILED
WITH CHANGE IN TITLE**

BACKGROUND

Resolution 213, introduced by the District of Columbia Delegation at the 2004 Annual Meeting, asked that the AMA study, support and develop guidelines regarding physician “liability surcharges.” Resolution 213 was referred by the House of Delegates to the Board of Trustees. BOT Report 20, “Liability Surcharges in Physician Offices,” was presented at the 2004 Interim Meeting. At that meeting, the House of Delegates referred Report 20 back to the Board so that the report’s scope could be broadened to develop guidelines regarding all “administrative surcharges,” and to offer physicians further guidance as to when and how both liability and administrative surcharges can appropriately be charged.

DISCUSSION OF ISSUE

AMA Policy

The AMA has no policy directed specifically at physician surcharges. However, AMA Policy H-385.989, “Payment for Physician Services,” (AMA Policy Database) states, “Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment” (see also H-383.989). Two separate policies, each entitled “Payment for Physicians’ Services,” H-383.990 and H-380.992, support the right of physicians to establish fair and equitable fees.

Additionally, Policy H-285.943 announces the AMA’s opposition to managed care contract provisions that prohibit physician payment for the provision of administrative services, and encourages physicians entering into managed care contracts to seek specific reimbursement for provision of administrative services.

Administrative Surcharges

Physicians are increasingly levying administrative surcharges on their patients to obtain reimbursement for provision of non-medical, non-insurance covered services. While “administrative fees” are not defined in law, the term is commonly associated with fees charged for specific support services such as: providing copies of medical records; filling out forms/writing letters for school, work, travel and other patient activities; phone calls made on the patients’ behalf; emails sent to patients; no-show fees and other services. Administrative fees may also offset costs associated with implementation of unfunded regulatory schemes, such as those imposed under the Health Insurance Accountability and Portability Act, the Occupational Safety and Health Administration and Clinical Laboratory Improvement Amendments regulations, and health information technology initiatives like electronic medical records. In short, administrative fees are charged to cover the cost of administrative functions surrounding the provision of medical care. In contrast, “liability surcharges” are imposed specifically to defray the cost of medical professional liability insurance (PLI) premiums.

While historically physicians may have provided administrative services free of charge, continuing declines in service reimbursement coupled with rising overhead costs fueled by PLI premiums and regulatory mandates, make medical practice financially infeasible for many physicians unless some costs are passed on to patients. Access to care could be compromised if more physicians find practicing medicine financially unviable.

Legal Aspects of and Barriers to Surcharges

Administrative and liability surcharges attempt to offset different costs borne by physicians. Physicians will find they have greater leeway, though still subject to restrictions, in implementing administrative surcharges as compared to liability surcharges. Reimbursement rates paid physicians by private insurers usually are intended to account for

liability premium costs, and physicians are usually contractually prohibited from “double charging” patients for costs already reimbursed. Administrative fees, however, typically cover non-reimbursed services. Because physicians are not receiving double payments by charging patients for these services, physicians are more likely to be able to implement these fees.

Administrative Surcharges

Privately-Insured Patients

Private payer contracts and state law and regulations may prevent physicians from charging patients for any services already reimbursed to the physician by an insurer. Physicians may be able to charge patients for non-insurance-covered services, such as certain administrative services.

Contracts between private health care insurers and physicians may consider that administrative costs a physician incurs are “bundled,” or included, in health service payments made by the payer to a physician. Contracts will commonly prohibit physicians from charging a patient redundantly for costs already bundled. Because most contracts do not clearly define which services are covered or bundled, physicians will have to determine with each insurer with whom they contract whether administrative costs are already reimbursed.

Contracts may also forbid physicians from charging patients any fees “above and beyond” what the payer agrees to reimburse to the physician, even if costs associated with administrative tasks are not specifically prohibited.

State balance billing laws commonly prohibit “in-network” physicians from charging patients for covered services. To avoid violating these laws, physicians should survey their state’s laws with the assistance of counsel, and, if a balance billing law exists, determine what services are covered under contract. Violation of balance billing laws may lead a health plan carrier to de-select a contracting physician from its network, among other penalties.

State insurance regulations complicate the issue and should also be reviewed with the assistance of counsel. Certain states protect enrollees in private insurance plans from being billed for any sums beyond what the insurance company reimburses, aside from co-payments and deductibles (see e.g., Connecticut Code §381.193(c) and §20-7(f)(9)(b) (2004)).

Physicians are advised to retain counsel to review their contracts and determine if applicable “balance billing” restrictions exist. Where a contractual barrier exists, physicians may consider renegotiation to assure adequate payment for administrative costs either directly from the payer or by surcharging in-network patients.

Publicly-Insured Patients

The propriety of administrative surcharges is difficult to assess in respect of Medicare or Medicaid-covered patients. Physicians can bill patients only for services not covered by and unrelated to those billed to Medicare or Medicaid. Again, what constitutes a covered charge is not clear.

The Health and Human Services’ Office of the Inspector General (OIG) alert (OIG Alerts Physicians About Added Charges For Covered Services, March 31, 2004) reminded physicians that “when participating providers request any other payment for covered services from Medicare patients they are liable for substantial penalties and exclusion from Medicare and other Federal health care programs.” The OIG takes the position that non-participating physicians could also be “subject to penalties and exclusion for overcharging beneficiaries for covered services.” The OIG indicated that Medicare already reimburses for services like “coordination of care with other providers,” “a comprehensive assessment and plan for optimum health” and “extra time” spent on patient care. While certain services may not be reimbursed by Medicare, the OIG has not provided any clarification or guidance.

Physicians are urged to check with their regional Medicare and Medicaid carriers for guidance on whether the administrative and overhead costs portions of the Medicare physician fee schedule already reimburse for the provision of the particular administrative service of interest to the physician.

Liability Surcharges

As detailed in “Liability Surcharges in Physician Offices,” (BOT Report 20-I-04), network service contracts between physicians and private insurance payers often prohibit physicians from levying redundant or supplementary charges upon insured patients. State law and regulations may impose similar restrictions. Likewise, physicians who accept Medicare and Medicaid reimbursement are prohibited from charging publicly insured patients for costs associated with PLI because these costs are already accounted for in reimbursement rates. In short, substantial legal barriers exist to implementing liability surcharges on patients except for those who are uninsured or pay out of pocket.

Political and Ethical Considerations

In instances where physicians are neither prohibited by contract, nor by state or federal law or regulation, from assessing a surcharge, political and ethical implications must next be considered.

A physician’s thorough explanation to a patient of the reasons behind an administrative surcharge may underscore the value of a physician’s time and expertise, and bring attention to declining reimbursement rates and rising overhead. Explanation of the reasons for a liability surcharge may help patients better understand the current medical liability crisis and the connection between costs associated with litigation and the rising cost of healthcare, along with access to care issues. Patients, however, often resent additional charges when their out of pocket health care expenses are rising and physicians remain relatively well-paid.

If not properly explained, surcharges have the potential to alienate patients and harm the physician-patient relationship. Many physicians believe that administrative and PLI-associated costs must be absorbed by physicians and not passed on if there is any risk of patients losing access to care. Critics point to surcharges as evidence that physicians care predominantly about personal pocketbook issues rather than patient concerns.

The AMA has no express ethical guidelines regarding surcharges. Physicians do have an obligation to support access to medical care (Principle IX of the “Principles of Medical Ethics” and E-9.065). More specifically, Opinion E-6.12, “Forgiveness or Waiver of Co-Insurance Payments,” states, “When a co-payment is a barrier to needed care because of financial hardship, physicians should forgive or waive the co-payment.” By analogy, physicians should not impose a surcharge if it would constitute a barrier to needed care. Surcharges should then be “reasonable” and voluntary. However, in fulfilling their obligation to support access, it is not expected that physicians would compromise the viability of their practice (E-10.05). Ethical considerations caution that surcharges should not be applied without a careful balancing of patient and physician interests.

Notice must be given in advance of implementation of a surcharge (particularly to those publicly-insured). Most physicians offer an opt-out or hardship waiver option. Any fee should be accompanied by an explanation of why it is being instated. Communications should make clear that the patient’s decision whether or not to pay will have no affect on the physician-patient relationship or quality of care. A physician cannot treat patients differently based on whether a fee is paid, particularly if the non-paying patient is publicly-insured.

Implementing Surcharges

Implementation of surcharges must be handled with care. Physicians may find barriers to surcharges so significant that they become impractical.

To start, Medicare and Medicaid patients must be exempted from liability surcharges outright. Assessing an administrative fee is permissible, provided these patients are not charged for anything already reimbursed by the government. Defining exactly what is and is not covered is difficult and misguided efforts will face severe potential penalties. Physicians should consult their local Medicare and Medicaid carriers to determine what services are covered. Implementation of an administrative fee should be preceded by advance notice and explanation.

Next state law restrictions on surcharging publicly and privately insured patients must be identified, along with restrictions in existing network contracts with private payers. Even where no contract restrictions appear, it may still be advisable to inform private payers in advance of implementing a surcharge. Physicians have reported that even where a private insurer does not prohibit surcharges, the insurer is not enthusiastic about this practice.

After taking account of these limitations, physicians may find a relatively small number of patients remain eligible for a surcharge. Physicians should consider the fairness and practicality of charging a small portion of their total patient base a surcharge.

Finally, there are logistical considerations. Administrative surcharges might be administered based on the volume or type of administrative services provided or as a flat, periodic fee. Liability surcharges are typically periodic, assessed annually, quarterly, per visit or otherwise. Physicians may alternatively request a “donation” from patients to help offset administrative costs. Such an approach may be more likely to survive OIG scrutiny, given that the physician is not charging for any particular service rendered.

Common Surcharges

State law can affect the appropriateness of the following. Consultation with counsel is strongly recommended.

Widely accepted administrative fees include those charged for:

- filling out forms for school/camp/employment wellness/disability outside of an office visit;
- copies of medical records (state law may impose price limitations);
- no shows for appointments (if equally applicable to all patients); and
- returned checks.

Sometimes acceptable administrative fees (subject to verification there are no contractual or regulatory prohibitions) include those for:

- e-mail consultations;
- phone consultations; and
- prescription refill requests.

Fees that must not be charged publicly-insured patients, and are of questionable validity for privately-insured, include those for:

- PLI premium offset;
- coordination of care with other providers;
- a comprehensive assessment and plan for optimum health; and
- extra time spent on patient care.

Model Contract Language

Physicians may seek to negotiate with private insurance payers for contract language that permits surcharging. An example of such language, which should be reviewed with the physician’s counsel and tailored to the situation at hand, follows:

“Administrative surcharges” - Nothing in this contract shall affect the right the physician-signatory to charge insureds a reasonable and otherwise legal surcharge for individual or aggregated administrative services conducted for the benefit of the insured with the insureds’ agreement after being fully informed about the surcharge and the probability that such surcharge will not be reimbursed by the insureds’ health plan, unless such services are otherwise specifically identified and reimbursed under this contract.

“Liability surcharges” - Nothing in this contract shall affect the right the physician-signatory to charge insureds a reasonable and otherwise legal surcharge to defray the physician’s liability insurance premium costs, with the insureds’ agreement after being fully informed about the surcharge and the probability that such surcharge will not be reimbursed by their health plan, unless this cost is specifically identified and reimbursed under this contract.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 213 (A-04) and Board of Trustees Report 20-I-04 and the remainder of this report be filed:

That our American Medical Association support the ability of physicians to institute an “administrative surcharge” and/or a “liability surcharge.”

28. CRIMINALIZATION OF PHYSICIAN DEPARTURE FROM GUIDELINES AND STANDARDS

HOUSE ACTION: RECOMMENDATION ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

INTRODUCTION

This report is in response to Resolution 718 (I-04), introduced by the Louisiana Delegation at the 2004 Interim Meeting. The impetus of Resolution 718 (I-04) was the perceived influenza vaccine “shortage” occurring in the summer and autumn of 2004. In response to this “shortage,” several states exercised their emergency powers to mandate compliance with the Centers of Disease Control and Prevention (CDC) recommendations for the use of available supplies of influenza vaccine. Some states threatened criminal sanctions against any physician who did not comply with these mandates.

Resolution 718 (I-04) calls on the American Medical Association to examine: “(1) the need for a national clarification of the terms guidelines (parameters, algorithms, etc.) vs. standards (mandating compliance) for medical care and resource allocation; (2) the legal, moral, and ethical impact of appropriate departure from guidelines or standards, the clarification of what constitutes appropriate departure, and the rights of physicians and other health care providers accused of non-compliance with a guideline or standard; and (3) the legal, moral and ethical impact of the criminalization of medical decisions and actions of physicians and other health care providers who appropriately depart from such guidelines and standards.”

This report addresses the practical difficulties that arise when the government attempts to allocate medical resources. Government guidelines often lead to inefficient results when they are solely in response to variable, short-term circumstances. By the time a guideline is determined and then published, the facts upon which it was based may have changed dramatically. Such was the case when the influenza vaccine “shortage” turned into a “surplus,” with unused vaccinations being discarded as waste.

This report also discusses current AMA policies--including policies that oppose the criminalization of health care decision-making, ethical opinions that discuss the obligations of physicians to their patients and the collaborative nature of the patient-physician relationship, and policies that support due process and peer review--as well as the need for new policies.

DISCUSSION

On October 5, 2004, Chiron Corporation announced that none of its influenza vaccine (Fluvirin) would be unavailable for distribution in the United States for the 2004-2005 influenza season (*Interim Influenza Vaccination Recommendations: 2004-2005*, at www.cdc.gov/od/oc/media/pressrel/r041005.htm). The company indicated that the Medicines and Healthcare products Regulatory Agency in the United Kingdom, where Fluvirin is produced, had suspended the company’s license to manufacture the vaccine in its Liverpool facility for 3 months, preventing any release of this vaccine for the 2004-2005 influenza season.

CDC Recommendations

The CDC estimated that this suspension would cause an immediate shortage in the United States, by reducing the expected supply of trivalent inactivated influenza vaccine available during the 2004-2005 influenza season by approximately one half. In response to this expected shortage, the CDC issued recommendations, which were formally accepted by the Advisory Committee on Immunization Practices, stating that the following groups should be given the highest priority for available doses of influenza vaccine:

- all children aged 6-23 months;
- adults aged 65 years and older;
- persons aged 2-64 years with underlying chronic medical conditions;
- pregnant women;
- residents of nursing homes and long-term care facilities;

- children 6 months-18 years of age on chronic aspirin therapy;
- health-care workers with direct patient care; and
- out-of-home caregivers and household contacts of children aged <6 months.

The CDC further recommended:

- Intranasally administered, live, attenuated influenza vaccine, if available, should be encouraged for healthy persons who are aged 5-49 years and are not pregnant, including health-care workers (except those who care for severely immunocompromised patients in special care units) and persons caring for children aged <6 months.
- Certain children aged <9 years require 2 doses of vaccine if they have not previously been vaccinated. All children at high risk for complications from influenza, including those aged 6-23 months, who present for vaccination, should be vaccinated with a first or second dose, depending on vaccination status. However, doses should not be held in reserve to ensure that 2 doses will be available. Instead, available vaccine should be used to vaccinate persons in priority groups on a first-come, first-serve basis.

Individuals not placed in a priority group were asked to forego or defer vaccination.

State Emergency Orders

In response to the perceived shortage of influenza vaccine, several states, exercising their emergency powers, ordered compliance with the CDC recommendations. Among the states that issued such emergency orders were: California, Connecticut, Delaware, the District of Columbia, Florida, Iowa, Massachusetts, Michigan, Mississippi, Missouri, New Mexico, Oklahoma, Oregon, South Carolina, Vermont, and Wisconsin (*2004-2005 Influenza Vaccine Shortage: State Resources*, at www.astho.org/templates/display_pub.php?pub_id=1258&admin=1).

Although most of these emergency orders simply urged compliance with the CDC recommendations, some of them contained enforcement provisions, including potential criminal liability and imprisonment.

For instance, the District of Columbia order states:

“Any person who willfully does not comply with the influenza vaccine distribution requirements in section 219 shall be guilty of a misdemeanor and, upon conviction, subject to a fine not to exceed one thousand dollars (\$1,000).”

The Michigan order states:

“[A] person who violates this order is guilty of a misdemeanor punishable by imprisonment for not more than 6 month, or a fine of not more than \$200.00 or both.”

Similarly, the Vermont order states:

“[A]ny person who fails or neglects to obey or comply with this Order is subject to a criminal penalty of fine and/or imprisonment.”

In Oregon, the Department of Human Services stated that medical professionals licensed by state boards could also be subject to sanctions from those boards for violations.

In addition to potential criminal liability and imprisonment, violation of these state emergency orders had several possible collateral consequences, including loss of medical licensure and loss of hospital staff privileges (see e.g., MCLS §333.16221 and Fla. Stat. §458.331 [2004]).

Shortage to Surplus

What was initially perceived as a shortage ultimately became a surplus (Rob Stein, “Vaccine Shortage Turns to Surplus,” *Washington Post*, January 22, 2005, A01). Federal officials reported that nearly 5 million doses remained in the government’s hastily purchased stockpile. Consequently, instead of running out of shots during the 2004-2005 influenza season, the government would end up discarding unused vaccine.

In response to this unexpected turnaround, the CDC relaxed its guidelines in December to encourage more people to get vaccinated, and it later dropped its recommendations entirely. Federal and state officials also launched a campaign to persuade more people to get vaccinated, especially those at highest risk from the flu. These moves, however, failed to bolster demand significantly, partly because the influenza season was relatively mild. In January, a CDC survey reported that only 10 states said they may need more vaccine, making it unlikely the remaining federal reserves would be sold.

Some cities (Cleveland and New York City) and states (Illinois and New Mexico) pledged to collectively acquire supplies of influenza vaccine from Europe (Ceci Connolly, "N.Y. Mayor Has Plans To Import Flu Shots," *Washington Post*, November 11, 2004, A03). This plan, however, ultimately failed, with the cities and states now arguing as to who should pay the \$6 million expense (John Chase and Peter Gorner, "State May Be Stuck On Vaccine Partners Backing Out, And Flu Shot Can't Be Imported," *Chicago Tribune*, January 28, 2005).

According to federal officials, the vaccine surplus was the result of a combination of factors, including spotty availability of vaccine, a relatively mild influenza season, and too many people voluntarily forgoing shots to help out those perceived as more in need (Stein, *supra*, A03).

As a result, millions in taxpayer dollars were wasted, and many people were left unprotected. The surplus has also prompted concern that the confusing situation could have long-term implications for the nation's ability to protect itself against influenza, which claims thousands of lives each year. According to experts, the surplus has made it even more difficult to persuade manufacturers to produce more vaccine in future years, a goal public health officials have long pursued, as well as undermining years of efforts to encourage more Americans to get routinely vaccinated. "The problem with a set of stuttering, changing recommendations year by year is confusion," said Greg Poland of the Mayo Clinic. "I worry that it sends the wrong message to the public about the seriousness of influenza and the imperatives for why they should get immunized. One year we say 'You're in the high-risk group,' and then next year we say 'You're not.' The public is confused."

Guidelines vs. Standards

The emergency orders imposed by several state governments raise the issue of whether recommendations of resource allocations (i.e., "guidelines") should be enforceable as mandated "standards." This distinction between "guidelines" and "standards" was recognized in the AMA Council on Scientific Affairs Report 1-I-94. CSA Report 1-I-94 discussed the CDC's and National Vaccine Advisory Committee's promulgation of a set of standards for pediatric immunization practices in response to the resurgence of measles from 1989 to 1991. The report stated:

"The Council is of the opinion that the word "standards" does not appear to capture the intent of the 1991 recommendation of the National Vaccine Advisory Committee which called for standards to guide immunization practices. The word "guidelines" appears to be a better choice in this connection."

The "standards," were meant to represent "what are the most essential and desirable immunization policies and practices in an immunization service." They were not meant to be binding. Thus, the Council on Scientific Affairs opined that the term "guidelines" was more appropriate to describe these recommendations, as they were not meant to be legally enforceable.

AMA Policies concerning guidelines or standards include:

H-410.980 Principles for the Implementation of Clinical Practice Guidelines at the Local/State/Regional Level

Our AMA has adopted the following principles regarding the implementation of clinical practice guidelines at the local/state/regional level:....(7) clinical practice guidelines implemented at the local/state/regional level shall acknowledge the ability of physicians to depart from the recommendations in clinical practice guidelines, when appropriate, in the care of individual patients.

H-410.961 Adding a Disclaimer to Clinical Practice Guidelines

Our AMA recommends that all specialty and subspecialty societies the placement of a disclaimer on each clinical practice guideline reaffirming that guidelines are not a substitute for the experience and judgment of a physician and are developed to enhance the physician's ability to practice evidence-based medicine.

H-410.970 Use of Practice Parameters

Our AMA: (1) urges organizations that have developed practice parameters to recognize that practice parameters are educational tools, not mechanisms to determine reimbursement or credentialing, to assist physicians in clinical decision making and are not replacements for clinical decision making. Physicians must retain autonomy to vary from practice parameters without retribution in order to provide the quality of care that meets the individual needs of their patients....

None of the state emergency orders issued in response to the perceived influenza vaccine shortage included disclaimers or language accounting for the autonomy of medical decision-making or the right of physicians to depart from the CDC recommendations. The enforcement provisions of some of these orders also affirmatively prohibited physicians from making exceptions to the CDC recommendations.

The right, or duty, of physicians to employ medical resources in accordance with their best medical judgments, rather than government guidelines or standards, is based on a fundamental aspect of the patient-physician relationship. The Code of Medical Ethics states that “health and well-being of patients depends upon a collaborative effort between physician and patient,” wherein the “patient has a basic right to have available adequate health care” (E-10.01 Fundamental Elements of the Patient-Physician Relationship). The Code also states:

“...The relationship between patient and physician is based on trust and gives rise to physicians’ ethical obligations to place patients’ welfare above their own self-interest and above obligations to other groups, and to advocate for their patients’ welfare.

“Within the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount” (E-10.015 The Patient-Physician Relationship).

Criminalization of Medical Decision-Making

Although the AMA does not defend intentional misconduct, it clearly opposes the prosecution of physicians for medical decisions that were made in good faith. While governmental guidelines or standards can serve a valuable purpose in setting national priorities, they should leave room for individual clinical judgment. If criminal sanctions are threatened, physicians would have a strong incentive to exercise their judgment in a way that would avoid penalties. Consequently, they may refuse outright to see patients whose medical condition might force them to choose between patient welfare and adherence to the criminally enforced guidelines. Perhaps an exception should be made in cases of an actual, present emergency, but the perceived shortage of influenza vaccine fell far short of such a circumstance.

AMA Policies addressing this issue include:

H-160.946 The Criminalization of Health Care Decision-Making

The AMA opposes the attempted criminalization of health care decision making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision making.

H-160.954 Criminalization of Medical Judgment

(1) Our AMA continues to take all reasonable and necessary steps to insure that medical decision-making, exercised in good faith, does not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties.

D-160.999 Opposition to Criminalizing Health Care Decisions

Our AMA will educate physicians regarding the continuing threat posed by the criminalization of healthcare decision-making and the existence of our model legislation “An Act to Prohibit the Criminalization of Healthcare Decision-Making.”

RECOMMENDATION

The Board of Trustees recommends that the following be adopted and that the remainder of this report be filed:

That our American Medical Association condemn the criminalization of medical decisions and actions by physicians and other health care providers who in loyalty to their patients and who in proper exercise of their clinical judgment depart from established medical care and resource allocation guidelines or standards for appropriate reasons, and that the AMA seek and/or support legislation or rules/regulations at the federal and state levels preventing such criminalization.

29. PATIENT CONFIDENTIALITY AND USA PATRIOT ACT (RESOLUTION 902, I-04)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED WITH CHANGE IN TITLE

BACKGROUND

At the 2004 Interim Meeting, Resolution 902, "USA Patriot Act," was introduced by the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association. Resolution 902 asked that the AMA "(1) study the potential impact of the USA Patriot Act on patient confidentiality; (2) develop recommendations for physicians who are contacted for information about patients pursuant to provisions of the USA Patriot Act; and (3) advocate for such modifications to the USA Patriot Act as may be necessary to protect patient confidentiality and minimize legal liability for physicians." Reference Committee L communicated the confusion physicians have over the USA Patriot Act's exact disclosure requirements and their concern for the impact that disclosures could have on the physician-patient relationship and patient confidentiality. The House of Delegates referred Resolution 902 to the Board of Trustees.

DISCUSSION OF ISSUE

AMA Policy

AMA policy recognizing and protecting patient privacy and confidentiality as sacrosanct is long-standing and voluminous. The policy presumption in favor of honoring patient confidentiality can be overridden in only select circumstances, such as waiver, a strong public health or safety reason or where required by law.

In Policy H-140.900 (AMA Policy Database), "A Declaration of Professional Responsibility," physicians pledge to "[p]rotect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others."

Ethical Opinion E-5.05, "Confidentiality," states, "[t]he information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree....The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law. The obligation to safeguard patient confidences is subject to certain exceptions which are ethically and legally justified because of overriding social considerations." As examples of justified exceptions, AMA policy suggests scenarios involving "a patient [who] threatens to inflict serious bodily harm to another person or to him or herself" and incidents reportable under the law such as "communicable diseases and gun shot and knife wounds."

Ethical Opinion E-5.059, "Privacy in the Context of Health Care," states that, "[p]hysicians must seek to protect patient privacy in all of its forms....Such respect for patient privacy is a fundamental expression of patient autonomy and is a prerequisite to building the trust that is at the core of the patient-physician relationship....Patients should be informed of any significant infringement on their privacy of which they may otherwise be unaware" (see also H-320.994, H-315.978).

Policy H-315.983, "Patient Privacy and Confidentiality," reads:

"(1) Our AMA affirms the following key principles....(a) That there exists a basic right of patients to privacy of their medical information and records...; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability;...(d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure...."

"(8) When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

"(9) Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures...."

In Policy H-315.999, "Confidential Patient Information to Fourth Parties," it is stated that "[o]ur AMA will investigate, and challenge where appropriate, the authority of federal agents (including armed law enforcement agents) to obtain confidential patient information in the absence of appropriate search warrants."

The USA Patriot Act

The "United and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001," better known as the USA "Patriot Act" (Public Law 107-56) was passed on October 21, 2001. Section 215 of the Act provides that "[t]he Director of the Federal Bureau of Investigation ("FBI") or a designee...may make an application for an order requiring the production of any tangible things (including books, records, papers, documents, and other items) for an investigation to protect against international terrorism or clandestine intelligence activities, provided that such investigation of a United States person is not conducted solely upon the basis of activities protected by the first amendment to the Constitution."

Applications shall be made to a judge and "shall specify that the records concerned are sought for an authorized investigation...to obtain foreign intelligence information not concerning a United States person or to protect against international terrorism or clandestine intelligence activities." After application, "the judge shall enter an ex parte order as requested, or as modified, approving the release of records if the judge finds that the application meets the requirements of this section." Meanwhile, "[a]n order under this subsection shall not disclose that it is issued for purposes of an investigation," and, "[n]o person shall disclose to any other person (other than those persons necessary to produce the tangible things under this section) that the FBI has sought or obtained tangible things under this section."

The statute immunizes from liability any person who produces tangible things pursuant to an order (50 USC §1861[e]).

Under this statute, physicians can be ordered without a subpoena or warrant to produce a patient's medical record and they are prohibited from informing the patient of the occurrence. Section 215 of the Act is scheduled to sunset on December 31, 2005.

Comparing AMA Policy to the Requirements of the Patriot Act

AMA policies recognize a handful of instances in which patient confidentiality is permissibly circumvented or breached, including where there is a(n): serious threat to the patient's health and safety or that of others; express consent or waiver; legal mandate; reportable communicable disease present; or legitimate law enforcement inquiry. AMA policy advances a number of safeguards surrounding any disclosure.

AMA policy specifically recommends safeguard procedures for disclosures requested in the course of a law enforcement investigation. Policy permits these disclosures only after a court order is produced pursuant to a “legitimate” law enforcement inquiry where the law enforcement entity has made a clear and convincing demonstration of need for the information, and shown that there is no alternate information that would satisfy the investigation. Law enforcement interests must additionally be deemed to outweigh the individual’s right to privacy. Additional policy also requires accountability for the disclosure, disclosure of the minimum necessary information in scope and content, and the least identifiable and sensitive disclosure.

Requests for information under the Patriot Act do require a court order; but a judge has no authority to reject an appropriate request for an order. The order need not result from a “legitimate,” but only an “authorized,” investigation. No evidentiary standards exist; indeed, requestors are not obligated to produce any evidence or demonstrate probable cause to procure an order. The patient whose records are requested does not have to be a terrorist suspect, so long as there exists an investigation relating to “international terrorism or clandestine intelligence activities.” All orders are entered and executed without the knowledge of the patient, and physicians are under a legal gag not to disclose the disclosure. No balancing test comparing the requestor’s need for information to the individual’s right to privacy is conducted. Law enforcement need not demonstrate there is no satisfactory alternative to production of the medical record. Disclosure is not necessarily limited to any one part of a medical record; anything “tangible” can be compelled to be disclosed. Because the patient has no knowledge of these activities, they have no way of contesting the disclosure or holding others accountable for it.

Supporters of the Act suggest that it contains sufficient checks and balances to prevent inappropriate disclosures. These checks include permitting only certain officials to make requests, requiring requests come only in the context of authorized investigations and requiring a judge’s order to secure the desired records. Also, persons may not be targeted for investigation solely on the basis of activities protected by the first amendment (e.g., speech that criticizes the Patriot Act). Supporters argue that the Act’s powers also serve the greater good of combating terrorism.

Impact on Patient Confidentiality

The Patriot Act requires the US Attorney General to make semi-annual reports to select committees of Congress about the number of applications granted under Section 215 of the Act. This data, however, cannot be obtained through a Freedom of Information Act request because the reports have been classified as pertaining to “national security” (see e.g., *ACLU v. US Dept. of Justice*, 265 F. Supp. 2d 20 (D.C. Dist. Ct. 2004)). The secretive nature of disclosures pursuant to the Act, and the classification of all records about disclosures which occur, make the Act’s impact on patient confidentiality impossible to track definitively.

Even without hard data, it can be assumed the Act will cause some patients to avoid seeking care, or to be less than forthcoming in the physician’s office. Quality of care may suffer. Unable to protest or even publicly acknowledge a disclosure, medical professionals stand to lose the trust and confidence of their patients and undermine the patient-physician relationship.

Complying with a Court Order for Patient Information

Physicians are legally obligated to turn over patient records pursuant to a court order issued under the Patriot Act. Neither the Health Insurance Portability and Accountability Act (HIPAA) nor state privacy laws provide justification for non-compliance (45 CFR §164.512[f][1]). Pursuant to the Act’s gag provision, disclosures by a physician of patient records produced under the Act cannot be noted in a patient’s medical record or the disclosure log otherwise mandated by HIPAA and required by AMA Policy E-5.059.

Some experts suggest that physicians offer patients general notices that their medical records are subject to government request. Notices can not mention specific situations. Ideally, such notices would be offered before a physician was ever subject to a government request, simply to advise patients.

Physicians will not face liability for handing over medical records, since the Patriot Act immunizes any person from liability to other individuals where that person, in good faith, produces tangible things pursuant to a court order. (50 USC §1861[e]).

Attempts to Amend the Patriot Act

Before the Patriot Act was passed, many concerned legislators unsuccessfully attempted to soften its language. Still the Act passed nearly unanimously. Senator Russell Feingold (D-WI) provided the sole dissenting Senatorial vote on the legislation, and in debate called Section 215 “a truly breathtaking expansion of police power.” He said, “in an *ex parte* application to a secret court, with no showing even that the information is relevant to the investigation, the government can lawfully compel a doctor or hospital to release medical records or a library to release circulation records.”

Many bills attempting to limit the Patriot Act have been introduced since the Act was passed, though none have met with success. Hundreds of counties across the country have passed resolutions opposing part or all of the Act.

Since passage of the Act, various groups (including the American Civil Liberties Union [ACLU]) have filed suits challenging the constitutionality of various sections of the Act. The ACLU unsuccessfully argued that warrantless access to tangible things violates the fourth amendment, which generally bars the government from engaging in unreasonable searches and seizures (i.e., searches conducted without probable cause) (*In re: Sealed Case No. 02-001*, 310 F.3d 717 (US For. Intel. Ct. of Review 2002)). Elsewhere, however, the ACLU successfully argued to a New York district court that portions of the Act violated the first and fourth amendments (*Doe v. Ashcroft*, 334 F. Supp. 2d 471 (S.N.Y. Dist. Ct. 2004)).

Many professional groups have protested the Act, including the National Association of Social Workers, Therapists for Social Responsibility and Therapists for Peace and Justice. The American Library Association, in conjunction with other professional literary groups, also denounced the Act.

The AMA's Role

To date, the AMA has not lobbied on or taken other action directed specifically at the Patriot Act. Section 215 will sunset on the last day of 2005, although President George W. Bush is advocating for reauthorization of “vital tools in the ongoing war on terrorism” (Presidential Press Secretary Scott McClellan, Feb. 1, 2005). Many members of Congress have indicated that reauthorization will face a tough challenge.

If undertaken, AMA advocacy efforts against the Act could focus on two goals: prohibiting the Act’s reauthorization altogether and/or calling for amendment to some of the Act’s more expansive provisions.

If Section 215 is to be reauthorized, enhancing patient confidentiality safeguards should be a priority. Many could be recommended. For example, the term “tangible things” should be narrowed; only specific, discrete and relevant portions of patient medical records should be disclosable; patients subject to disclosures should have to be shown to be the focus or target of or participant in a terrorist or clandestine intelligence investigation; judges should have the discretion to refuse to issue a court order, particularly where there no clear and convincing evidence or demonstration of probable cause that requested information is necessary and/or where alternate sources of information are available; orders should be issued only with the knowledge of the patient to whom the ordered disclosure pertains; the gag provision should be limited to only the most extraordinary circumstances; and the Attorney General should be required to publicly disclose order requests and grants on a periodic basis, among other safeguards mentioned above.

The Act currently offers physicians sufficient protection from liability for disclosure.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

1. That Resolution 902 (I-04) be adopted.
2. That our American Medical Association advocate that Section 215 of the USA Patriot Act sunset as scheduled, or, if the Act is reauthorized, for amendments to Section 215 in accordance with the recommendations presented in this report.

30. REPRESENTATION OF SPECIALTY SOCIETIES IN THE AMA HOUSE OF DELEGATES

HOUSE ACTION: REFERRED

BACKGROUND

At its 2003 Interim Meeting, the House considered Board of Trustees Report 5, "Report on the Request to Consider Freezing the Size of the House of Delegates," and adopted a recommendation that asked that our AMA "develop a mechanism to facilitate the method by which members select the specialty society that represents them." This House action was driven by clear and convincing examples provided in House of Delegates testimony that the current ballot mechanism for specialty society representation does not work as it was originally intended. The ballot was initiated as an implementation strategy for the 1996 objective adopted by the House of Delegates to improve and enhance participation and effectiveness of the specialty societies within the House, and thereby the AMA. Because the ballot has not been as successful as originally envisioned, the desired level of specialty society representation and participation in the AMA has not been optimally achieved. In March 2004, the Board Chair established an Advisory Committee on Specialty Society Representation to advise the Board on how it should respond to the 2003 House action asking for a review of this issue. The Advisory Committee is chaired by the Vice Speaker of the House and includes three specialty society representatives, one representative of the Specialty and Service Society (SSS), one state society representative, and the chair of the Council on Long Range Planning and Development.

The Committee met several times during 2004 and 2005 to define the issue and identify alternative ways to address it, starting with the existing ballot mechanism that was put in place following the 1996 decision by the House of Delegates to change specialty society representation from one delegate per specialty society regardless of size (established in 1978), to a proportional basis of one delegate for every 1,000 members who "select" a society to represent them. This was implemented on a phased basis starting with one delegate for every 2,000 members for a period of three years, and then to the current one-per-one-thousand basis.

The basis for the 1996 decision was that the AMA House should reflect the multiple characteristics and needs of its member population. Over the years, as specialization has grown, physicians increasingly have come to identify themselves as specialists, and as family medicine became a recognized specialty the concept of "general practice" quickly began to disappear. Hence, in today's world every physician has a geographic base (state and county) and a specialty base. Physicians tend to look to geographically based organizations primarily to meet certain professional needs and to specialty organizations primarily to meet other professional needs. The change in specialty society representation was intended to reflect this reality, and to put state societies and specialty societies on the same basis with regard to representation in the AMA House of Delegates (i.e., based on the number of AMA members).

The mechanism established in 1996 for physicians to select the specialty society through which to be represented in the AMA House was a ballot. The ballot approach was designed to compensate for the fact that most physicians are members of only one state society while it is common for them to be members of more than one specialty society. Hence, it is relatively easy for the AMA to determine the number of delegates to which a state society is entitled based solely on its membership numbers, but that is not the case for specialty societies. Initially, the ballot was sent by mail to each AMA member. However, despite substantial efforts by AMA and the specialty societies to raise awareness and encourage balloting, this has proved to be ineffective because of cost (mailing and processing) and poor response (physicians get so much mail that bringing the ballot to their attention is very difficult). Subsequently, the ballot was made electronic and put on the AMA web site, and improvements have been made (some as recently as June 2004) to make the ballot easier to find on the web site and more user-friendly to complete. Work continues to identify further refinements and ways to encourage participation. However, in spite of sustained effort by the AMA and the specialty societies, only about 40% of AMA members have completed a specialty society representation ballot.

The situation described above was the starting point for the Committee's work. The intent of the House, based on the 1978 decision to bring specialty societies into the House, and the 1996 decision to put specialty societies on the same proportional representational basis as state societies (i.e., one delegate for every 1,000 AMA members), provided the context for asking how that intent can best be achieved. It is clear from actual experience as well as testimony at several House of Delegates meetings that the ballot is not an adequate mechanism to fully achieve what the House intended.

The Committee began by considering whether to replace the ballot mechanism altogether or to supplement it as a way to more closely achieve representation of all or most AMA members by a specialty society. The Committee concluded that *supplementing* the ballot mechanism would serve to recognize the efforts that have already been made as the most direct reflection of members' choices. The Committee then looked at a number of different options for allocating the *remaining* AMA members (i.e., those who did not cast a ballot) and decided on the one described in Board of Trustees Report 1-I-04. The essence of that approach is to make "selections of specialty societies" on behalf of non-balloting AMA members through a formula allocation approach. The formula would distribute such "allocated selections" to specialty societies in proportion to the percentage of total AMA members who belong to each society. (Appendix A describes the specific methodology that would be used to implement this approach.) This approach has several advantages:

1. It constitutes an incentive for specialty societies to encourage their members to join the AMA, because the number of delegates each specialty society would receive based on this formula is directly proportional to the rate at which their members join the AMA.
2. It minimizes the amount of additional data gathering and processing by using data already collected by both the AMA and the specialty societies.
3. It is the formula that is most similar to how state society delegations are constituted (i.e., proportional to the percentage of AMA members in each state or specialty), and would result in a specialty delegate distribution that is more similar to state society delegate distribution (although not "parity" with the states because states will always have more delegates than specialties due to how medical students participate and are credited to delegations).
4. It retains the ballot mechanism so that if AMA members want to directly select a specific society to represent them in the House, that option is still available to them.

Estimates were presented in Board Report 1-I-04 using data available in mid-September 2004. The tabulations attached to this report have been updated to reflect year-end 2004 data (see Appendix B). It is estimated that implementation of this proposal would result in a total of 266 specialty society delegates, an increase of 74 specialty society delegate positions relative to the number at the 2004 Interim Meeting. There were 318 state society delegates at the 2004 Interim Meeting. Seventy-four specialty societies would not gain any delegate positions and 35 specialty societies would gain delegate positions. No specialty society would experience a decrease in delegate positions (although once the freeze on delegation size expires at the end of 2005, it is likely that some specialty societies will realize a reduction in delegation size reflecting the overall reduction in AMA membership during the period of the freeze).

INPUT FROM FEDERATION ORGANIZATIONS

At the 2004 Interim Meeting, there was considerable testimony in Reference Committee F on Board Report 1. The Report recommended that the organizations represented in the House of Delegates provide comments to the Board's Advisory Committee by March 1, 2005, as the basis for the Committee to consider what to recommend to the Board of Trustees on this matter. The remainder of this report summarizes the input that has been received and the recommended approach based on the Committee's work.

A number of points were made about the proposed approach at the Interim Meeting Reference Committee F hearing and through the letters and e-mails that were received from Federation organizations after the Interim Meeting. There is a distinct pattern in the responses, with specialty society comments generally favoring the proposed approach, and state society comments generally opposing the approach or raising concerns about it. However, it should be noted that in total, between the Interim Meeting testimony and the subsequent responses, only 12 states plus two state caucuses were heard from, and only 13 specialty societies plus two specialty section councils were heard from. In addition to these, one AMA section and one AMA special group testified at the Interim Meeting. Thus, of the approximately 160 organizations represented in the House, about 18% provided input either at the Interim Meeting or through follow-up correspondence.

At the Interim Meeting, four state delegates indicated opposition to the proposal, and four state delegates and one state caucus expressed a specific concern about the proposal (i.e., whether the membership incentive was adequate; disenfranchising protest votes against the AMA; the possibility that a society could get more than one delegate for every 1000 members; or the overall size of the House). One state delegate and one state caucus expressed support for the proposal at the Interim Meeting. All of the states that replied by letter or e-mail after the Interim Meeting expressed opposition to the proposal, although one indicated that it would be open to considering other approaches.

At the Interim Meeting, eight specialties and two section councils testified, all in support of the proposal. Following the Interim Meeting, seven letters or e-mails were received from specialty societies and two were received from specialty section councils, all in support of the proposal.

One section and one special group testified at the Interim Meeting, both in support of the proposal.

Thus, based on the Interim Meeting testimony and subsequent correspondence, there is a relatively strong pattern of support or opposition/concern related to the proposed approach, with most (but not all) state society testimony and letters opposing or expressing specific concerns and specialty society testimony and letters expressing strong support. The Committee considered the input that was received and also compared the current characteristics of state vs. specialty representation. This is summarized in a grid (see Appendix C). The grid shows the one-per-1000 apportionment similarity, with the states being determined automatically based on membership data and the specialties based on ballots cast. Both states and specialties have a minimum of one delegate. Key differences include how medical students are counted, provisions for additional delegates based on market share or unification, and differences related to grace periods for changes in retention.

The following specific concerns were voiced either at the Interim Meeting or in the subsequent letters that were received.

Disenfranchising "No Votes" - One concern, expressed by several state societies in their letters, is that an allocation process would disenfranchise an AMA member who did not cast a ballot by deliberate choice because (s)he specifically wishes to not be represented by a specialty society in the AMA House. While this exists, such "protest votes" are probably a small percentage of the approximately 122,000 members who have not balloted for a specialty society, as well as a small percentage of the approximately 67,000 AMA direct members who are not members of their state society. However, this could be addressed through an "opt out" mechanism. Any member who does not wish to be represented in the AMA House by a specialty society or a state society could indicate that preference on the AMA web site or on an "opt out form" sent to him or her for that purpose.

The Ballot System is Adequate - Some expressed the view that the ballot is an adequate mechanism that already exists, and special mechanisms should not be implemented just because the specialty societies cannot get all their members to exercise it. The Board understands this sentiment, but disagrees with it. Clearly, the intent of the House action in 1996 that created the ballot mechanism and established the phased plan for proportional representation at 1:1000 was intended to put specialty societies on the same representational basis as the states. The vision and intent was that every AMA member would be represented by one state society and one specialty society, reflecting two of the major dimensions of every physician's professional life. The assumption at the time was that the ballot mechanism would achieve that. However, despite substantial efforts on the part of the AMA and the specialty societies over a period of eight years, it is clear that the ballot mechanism alone will not succeed in achieving this vision and intent. The Board believes that the recommended approach will enable that vision to become a reality most efficiently and fairly.

Use a Ballot or a Formula, But Not Both - Some expressed the view that either the ballot or some allocation system should be used, but not both. The combination approach is recommended because it acknowledges the hard work that has been done over the years to make the ballot work, but at the same time has the potential to achieve the level of representation originally envisioned by the House when the ballot system was first instituted. As indicated above, it is clear that the ballot mechanism alone will never achieve full success, but that the proposed combination of the ballot and an allocation system would produce specialty society representation that is most similar to state society representation.

Membership Incentive - Another concern that has been raised is whether the proposed allocation mechanism provides a strong enough incentive for the specialty societies to promote AMA membership. The extent of the membership incentive inherent in the representational structure of the AMA House of Delegates is probably not very great for either specialty or state societies. In reality, the prospect of a physician's specialty society or state society getting an additional delegate in the AMA House is not likely to be a major membership decision factor for most prospective members. Most physicians are probably not even aware of the AMA governance structure or the potential impact of their membership decision on it. Rather, the recent market research that has been done in

support of the AMA membership strategy points to advocacy activities and other AMA activities as more important factors in the membership decision of most physicians. This is the reason that it is rare to find governance-related information in the membership promotion material of state or specialty societies. Nevertheless, the proposed approach probably provides more of a potential incentive than does the ballot mechanism, because it offers a more direct linkage between the number of AMA members in a specialty society and the number of AMA delegate positions. In any case, exercising this kind of incentive requires substantial effort on the part of a state or specialty society. It is not self-apparent to the physician.

Limitations on Delegation Size - Another concern that was expressed relates to the possibility that, under the proposed approach, a specialty society could end up with more delegate positions than its total AMA membership would entitle it to based on the 1:1000-member ratio. This is true for eight specialty societies as calculated in the attached table (Appendix B) based on year-end 2004 data. This occurs when an organization has been selected by a substantial number of physicians through the ballot mechanism, and then receives “allocated” delegates on top of the delegate positions from the ballots. It was suggested by several of the organizations that testified at the Interim Meeting and/or sent letters that this should not be allowed. The solution would be to limit the number of delegate positions any organization could have to the 1:1000 ratio based on the number of AMA members in that organization. The only exceptions to this would be the additional delegates that relate to how medical students are counted, provisions for additional delegates based on market share or unification, and differences related to grace periods for changes in retention. The Board believes that an artificial “cap” on delegation size is not warranted. If an organization has worked hard to convince enough AMA members that it can best represent them in the AMA House, those physicians should have that option. Also, because of the differences in how medical students relate to delegation size and the special incentives that states currently have related to market share and unification, specialty societies could never have more delegates than state societies. In addition, state societies currently get the benefit of approximately 67,000 AMA direct members who are not members of their state societies. Appendix D provides data on state society delegations in the House of Delegates. The delegate allocation for 2005 includes 315 state society delegates.

Membership Requirement - Another concern that was expressed is that a physician should be a member of a specialty society in order to ballot for that society. AMA Policy G-600.021 (AMA Policy Database) already provides for this. It states: “The specialty representation ballot will indicate that physicians should be members of the specialty society which they select on the ballot to represent them in our AMA/Federation House of Delegates.” However, with the limitations of current data availability, this is difficult to verify, and this policy is implemented “on the honor system.”

Size of the House of Delegates - Another concern that was expressed is that the proposed mechanism would increase the size of the House of Delegates at a time when everyone (the AMA as well as the organizations sending delegates to the AMA) are being very cost conscious. The possibility was raised that a general reapportionment of the House by adopting a different ratio (i.e., other than the 1:1000) would be considered, disrupting established and relatively stable delegations, especially among the states. The Board believes that the increase in the size of the House related to the proposed approach would not necessitate such a change in the apportionment of the House.

There was also concern expressed about the House becoming unwieldy and having difficulty finding adequate meeting space. The size of the House as a logistical issue has been explored several times in recent years by the AMA’s meeting management experts. Their assessment has been that the increase of this magnitude in the size of the House would not be a problem related to being able to keep House meetings at hotel locations. In addition, recent Speakers of the House have indicated that a moderate increase in the size of the House would not be an impediment to the efficient conduct of House business.

Concern was also expressed that the concept of “proxy voting” might resurface as a result of an increase in delegation size of some specialty societies. This is a concept that surfaced in previous discussions (i.e., the Committee on Organization of Organizations) of the AMA House of Delegates, and would involve allowing large delegations to have one delegate cast more than one vote as a way of reducing the number of delegates an organization would have to support. While this was not specifically addressed in any of the letters that were received, the Board does not support this idea and it is not envisioned as part of the proposed approach.

DISCUSSION AND RECOMMENDATIONS

In its work, the Advisory Committee looked at many options and considered the input of those who testified at the Interim Meeting as well as those who provided input by letter or e-mail. After reviewing all of this material, the Committee recommended to the Board that the approach suggested in Board of Trustees Report 1-I-04 be used. The basis for this conclusion is expressed in Board of Trustees Report 1-I-04 and in the discussion above that responds to the various concerns that have been raised. The Board concurs with the Committee's analysis and recommendation.

It is important to note that the Committee's state society representative did not support the current recommendation. One member of the seven-member Advisory Committee is the chief staff officer of a state medical association. Thus, the Committee had input from the perspective of state medical societies throughout its deliberations. Although initial concerns were raised regarding the continued efficacy of the 1996 House action on proportional representation, the state society representative readily agreed to work with the Committee to fulfill its charge since the 1996 action continues to be AMA policy.

While the state society representative on the Committee indicated that he does believe that the recommended allocation method is the best of the allocation alternatives considered, he did vote against the Committee's current recommendation. As an alternative, he suggested an incremental step of squarely presenting to the 2005 Annual Meeting for House approval the more fundamental issue of allocating uncast ballots rather than putting forward a proposal that contains a specific allocation methodology. He suggested this alternative in light of the fact that the House at the 2001 Annual Meeting did not adopt a CLRPD recommendation to allocate ballots, and in light of the well defined differences of opinion between the state and specialty societies reflected in the comments made in reference committee at the Interim Meeting and the subsequently submitted written comments. He also expressed concern that any specific allocation method will be confusing to the rank and file, clouding the more fundamental question of whether the House favors a model of governance that includes representation based upon the allocation of uncast ballots.

The Committee and the Board appreciate the feedback received from state societies, specialty societies, state caucuses, specialty section councils, sections, and special groups. All of the expressions of concern and of support were carefully considered. Clearly, there are both philosophical and technical issues regarding how specialty societies should be represented in the House. The Committee has concluded that there is no perfect solution that will resolve all the concerns of all the participants in the House, and the Board agrees with that assessment. Indeed, as indicated above, the Committee itself was not unanimous on all of these issues. However, using as a touchstone the prior House of Delegates decision to move to a House in which both state societies and specialty societies are represented on the same basis (i.e., 1:1000 AMA members), the Board believes that the proposed approach is the most efficient and equitable way to achieve that goal.

RECOMMENDATION

Note: According to the *Procedures of the House of Delegates*, "If the motion to refer is adopted, all pending or adopted amendments as well as the subject are referred." Accordingly, what is presented below are all matters that were referred. The following is the original recommendation in Board of Trustees Report 30:

It is recommended that the ballot mechanism for specialty representation be maintained and that it be supplemented by an "allocation formula" that assigns non-balloting AMA members of specialty societies in proportion to each specialty society's share of total AMA membership through the process described below, and that the remainder of this report be filed:

- Step 1: Determine the total number of ballots to allocate to the specialty societies that are represented in the AMA House. This step involves accessing the AMA Masterfile to determine how many AMA members who are eligible to cast ballots for specialty societies through the AMA's online balloting system have not done so. All AMA members except for first-, second-, and third-year medical students are eligible to cast ballots for specialty societies.
- Step 2: Using data derived from the five-year reviews of specialty societies, determine the total number of specialty society memberships that can be attributed (or traced) to AMA members. This step involves adding up the number of specialty society members who are also AMA members.

- Step 3: Determine the proportion of those memberships that is associated with each specialty society. This step involves dividing the number of AMA members in each specialty society by the total number of specialty society memberships that are attributable to AMA members.
- Step 4: Determine the number of allocated ballots to allot to each specialty society by multiplying the total number allocated ballots by the society's proportion of AMA memberships.
- Step 5: Determine the total number of ballots for each specialty society by adding the ballots that were cast for the society and the ballots that were allocated to the society.
- Step 6: Allocate delegate positions to specialty societies using the rule that one delegate position is allocated for each 1,000 ballots or portion of 1,000 ballots and that every specialty society that is represented in the House shall be allocated a minimum of one delegate position.

Note: The House of Delegates considered the following recommendations, proposed by Reference Committee F, during its deliberations. The House first adopted Recommendation 1, voted to refer Recommendations 2 through 5, and finally referred the entire issue, including the original recommendation of the report:

1. It is recommended that the ballot mechanism for specialty representation be maintained.
2. That our American Medical Association poll every AMA member about his or her choice of specialty society representation, including the option of no representation, by January 1, 2006, using whatever mechanism(s) is most appropriate.
3. That our AMA provide a list to every specialty society of those members who have selected that society for representation.
4. That AMA membership packets, or some other appropriate annual mailing, include a reminder of the member's specialty society selection along with information on selecting a specialty society.
5. That the Board of Trustees report to the House of Delegates at the 2005 Interim Meeting on steps taken to enhance and simplify the process of selecting a specialty society for representation purposes and prepare a report for the 2006 Annual Meeting outlining the results of the preceding efforts.

The members of the Advisory Committee on Specialty Society Representation are as follows:

Jeremy Lazarus, MD, Chair, Vice Speaker, AMA House of Delegates
 Ronald Bruns, American Society of Anesthesiologists
 David Cook, Medical Association of Georgia
 Arl Van Moore, MD, Radiology Section of the AMA
 Daniel Ostergaard, MD, American Academy of Family Physicians
 Richard Stennes, MD, Specialty and Service Society
 Robert Wah, MD, Chair, Council on Long Range Planning and Development

APPENDIX A - THE METHODOLOGY OF THE PROPOSED DELEGATE ALLOCATION SYSTEM FOR SPECIALTY SOCIETIES

In the delegate allocation system that has been proposed by the Advisory Committee on Specialty Society Representation, the following six steps would be followed to determine how many delegate (and alternate delegate) positions would be allocated to each specialty society:

- Step 1: Determine the total number of ballots to allocate to the specialty societies that are represented in the AMA House. This step involves accessing the AMA Masterfile to determine how many AMA members who are eligible to cast ballots for specialty societies through the AMA's online balloting system have not done so. All AMA members except for first-, second-, and third-year medical students are eligible to cast ballots for specialty societies.

Step 2: Using data derived from the five-year reviews of specialty societies, determine the total number of specialty society memberships that can be attributed (or traced) to AMA members. This step involves adding up the number of specialty society members who are also AMA members.

Step 3: Determine the proportion of those memberships that is associated with each specialty society. This step involves dividing the number of AMA members in each specialty society by the total number of specialty society memberships that are attributable to AMA members.

Step 4: Determine the number of allocated ballots to allot to each specialty society by multiplying the total number allocated ballots by the society's proportion of AMA memberships.

Step 5: Determine the total number of ballots for each specialty society by summing the ballots that were cast for the society and the ballots that were allocated to the society.

Step 6: Allocate delegate positions to specialty societies using the rule that one delegate position is allocated for each 1,000 ballots or portion of 1,000 ballots and that every specialty society that is represented in the House shall be allocated a minimum of one delegate position.

APPENDIX B - ALLOCATION OF SPECIALTY SOCIETY DELEGATES UNDER PROPOSED SYSTEM

No.	The 109 Specialty Societies Represented in the House of Delegates	Size in AMA Members ¹	Percent of AMA Memberships in All Specialty Societies ²	Allocated Ballots in Proposed System ³	Actual Ballots Cast through 12/31/04	Total Ballots using Allocation System ⁴	Delegates in Proposed System ⁵	Actual Delegates for I-04 ⁶	Difference between Actual I-04 and Proposal
1	Aerospace Medical Association	443	0.1846%	225.27	161	386	1	1	0
2	American Academy of Allergy, Asthma and Immunology	546	0.2275%	277.64	390	668	1	1	0
3	American Academy of Child and Adolescent Psychiatry	1,349	0.5620%	685.97	183	869	1	1	0
4	American Academy of Cosmetic Surgery	272	0.1133%	138.31	23	161	1	1	0
5	American Academy of Dermatology	3,467	1.4444%	1,762.97	2,037	3,800	4	3	+1
6	American Academy of Facial Plastic and Reconstructive Surgery	429	0.1787%	218.15	83	301	1	1	0
7	American Academy of Family Physicians	14,311	5.9623%	7,277.13	11,950	19,227	20	16	+4
8	American Academy of Hospice and Palliative Medicine	359	0.1496%	182.55	4	187	1	1	0
9	American Academy of Insurance Medicine	138	0.0575%	70.17	118	188	1	1	0
10	American Academy of Neurology	2,589	1.0786%	1,316.50	1,901	3,218	4	3	+1
11	American Academy of Ophthalmology	4,252	1.7715%	2,162.14	2,357	4,519	5	3	+2
12	American Academy of Orthopaedic Surgeons	5,014	2.0889%	2,549.61	2,446	4,996	5	4	+1
13	American Academy of Otolaryngic Allergy	732	0.3050%	372.22	34	406	1	1	0
14	American Academy of Otolaryngology-Head and Neck Surgery	3,695	1.5394%	1,878.90	2,917	4,796	5	4	+1
15	American Academy of Pain Medicine	523	0.2179%	265.95	167	433	1	1	0
16	American Academy of Pediatrics	6,097	2.5401%	3,100.32	3,270	6,370	7	5	+2
17	American Academy of Pharmaceutical Physicians	260	0.1083%	132.21	0	132	1	1	0
18	American Academy of Physical Medicine and Rehabilitation	1,647	0.6862%	837.50	807	1,644	2	2	0
19	American Academy of Psychiatry and the Law	531	0.2212%	270.01	2	272	1	1	0
20	American Academy of Sleep Medicine	1,079	0.4495%	548.67	69	618	1	1	0
21	American Association for Hand Surgery	327	0.1362%	166.28	0	166	1	1	0
22	American Association for Thoracic Surgery	414	0.1725%	210.52	66	277	1	1	0
23	American Association of Clinical Endocrinologists	1,043	0.4345%	530.36	323	853	1	1	0
24	American Association of Clinical Urologists	1,350	0.5624%	686.47	67	753	1	1	0
25	American Association of Electrodiagnostic Medicine	1,008	0.4200%	512.57	137	650	1	1	0
26	American Association of Gynecologic Laparoscopists	1,162	0.4841%	590.88	2	593	1	1	0

No.	The 109 Specialty Societies Represented in the House of Delegates	Size in AMA Members ¹	Percent of AMA Memberships in All Specialty Societies ²	Allocated Ballots in Proposed System ³	Actual Ballots Cast through 12/31/04	Total Ballots using Allocation System ⁴	Delegates in Proposed System ⁵	Actual Delegates for I-04 ⁶	Difference between Actual I-04 and Proposal
27	American Association of Hip and Knee Surgeons	314	0.1308%	159.67	1	161	1	1	0
28	American Association of Neurological Surgeons	1,234	0.5141%	627.49	896	1,523	2	2	0
29	American Association of Plastic Surgeons	258	0.1075%	131.19	30	161	1	1	0
30	American Association of Public Health Physicians	75	0.0312%	38.14	107	145	1	1	0
31	American Clinical Neurophysiology Society	271	0.1129%	137.80	4	142	1	1	0
32	American College of Allergy, Asthma and Immunology	676	0.2816%	343.75	407	751	1	1	0
33	American College of Cardiology	5,034	2.0973%	2,559.78	1,703	4,263	5	3	+2
34	American College of Chest Physicians	3,179	1.3244%	1,616.52	463	2,080	3	1	+2
35	American College of Emergency Physicians	3,131	1.3044%	1,592.11	2,444	4,036	5	4	+1
36	American College of Gastroenterology	1,674	0.6974%	851.23	453	1,304	2	1	+1
37	American College of Medical Genetics	289	0.1204%	146.96	141	288	1	1	0
38	American College of Medical Quality	280	0.1167%	142.38	53	195	1	1	0
39	American College of Nuclear Medicine	115	0.0479%	58.48	30	88	1	1	0
40	American College of Nuclear Physicians	487	0.2029%	247.64	50	298	1	1	0
41	American College of Obstetricians and Gynecologists	7,814	3.2555%	3,973.41	6,834	10,807	11	10	+1
42	American College of Occupational and Environmental Medicine	2,233	0.9303%	1,135.48	497	1,632	2	1	+1
43	American College of Physician Executives	3,716	1.5482%	1,889.58	217	2,107	3	1	+2
44	American College of Physicians	29,111	12.1283%	14,802.92	6,083	20,886	21	8	+13
45	American College of Preventive Medicine	503	0.2096%	255.78	216	472	1	1	0
46	American College of Radiation Oncology	746	0.3108%	379.34	56	435	1	1	0
47	American College of Radiology	6,747	2.8109%	3,430.84	6,166	9,597	10	8	+2
48	American College of Rheumatology	1,002	0.4175%	509.52	396	906	1	1	0
49	American College of Surgeons	22,908	9.5440%	11,648.70	3,050	14,699	15	4	+11
50	American Gastroenterological Association	2,183	0.9095%	1,110.05	341	1,451	2	1	+1
51	American Geriatrics Society	1,465	0.6104%	744.95	155	900	1	1	0
52	American Institute of Ultrasound in Medicine	2,177	0.9070%	1,107.00	10	1,117	2	1	+1
53	American Medical Directors Association	1,699	0.7078%	863.94	65	929	1	1	0
54	American Medical Group Association	6,908	2.8780%	3,512.71	38	3,551	4	1	+3
55	American Orthopaedic Association	332	0.1383%	168.82	108	277	1	1	0
56	American Orthopaedic Foot and Ankle Society	422	0.1758%	214.59	53	268	1	1	0
57	American Pediatric Surgical Association	282	0.1175%	143.40	84	227	1	1	0
58	American Psychiatric Association	9,596	3.9979%	4,879.56	4,671	9,551	10	7	+3
59	American Roentgen Ray Society	3,313	1.3803%	1,684.66	21	1,706	2	1	+1
60	American Society for Aesthetic Plastic Surgery	574	0.2391%	291.88	3	295	1	1	0
61	American Society for Dermatologic Surgery	3,180	1.3249%	1,617.03	340	1,957	2	1	+1
62	American Society for Gastrointestinal Endoscopy	1,010	0.4208%	513.58	29	543	1	1	0
64	American Society for Surgery of the Hand	1,692	0.7049%	860.38	124	984	1	1	0
65	American Society for Therapeutic Radiology and Oncology	1,854	0.7724%	942.76	104	1,047	2	1	+1
66	American Society of Abdominal Surgeons	674	0.2808%	342.73	161	504	1	1	0
67	American Society of Addiction Medicine	1,739	0.7245%	884.28	123	1,007	2	1	+1
68	American Society of Anesthesiologists	509	0.2121%	258.83	145	404	1	1	0
69	American Society of Bariatric Physicians	668	0.2783%	339.68	144	484	1	1	0
70	American Society of Cataract and Refractive Surgery	8,800	3.6663%	4,474.79	6,719	11,194	12	9	+3
71	American Society of Clinical Oncology	265	0.1104%	134.75	1	136	1	1	0
72	American Society of Clinical Pathologists	2,418	1.0074%	1,229.55	148	1,378	2	1	+1
73	American Society of Colon and Rectal Surgeons	3,280	1.3665%	1,667.88	593	2,261	3	1	+2

No.	The 109 Specialty Societies Represented in the House of Delegates	Size in AMA Members ¹	Percent of AMA Memberships in All Specialty Societies ²	Allocated Ballots in Proposed System ³	Actual Ballots Cast through 12/31/04	Total Ballots using Allocation System ⁴	Delegates in Proposed System ⁵	Actual Delegates for I-04 ⁶	Difference between Actual I-04 and Proposal
74	American Society of Cytopathology	312	0.1300%	158.65	242	401	1	1	0
75	American Society of General Surgeons	474	0.1975%	241.03	28	269	1	1	0
76	American Society of Hematology	1,356	0.5649%	689.52	221	911	1	1	0
77	American Society of Maxillofacial Surgeons	1,277	0.5320%	649.35	100	749	1	1	0
78	American Society of Neuroimaging	150	0.0625%	76.27	55	131	1	1	0
79	American Society of Neuroradiology	288	0.1200%	146.45	22	168	1	1	0
80	American Society of Ophthalmic Plastic and Reconstructive Surgery	819	0.3412%	416.46	29	445	1	1	0
81	American Society of Plastic Surgeons	250	0.1042%	127.12	44	171	1	1	0
82	American Society of Retina Specialists	1,477	0.6154%	751.05	684	1,435	2	1	+1
83	American Thoracic Society	516	0.2150%	262.39	3	265	1	1	0
84	American Urological Association	1,770	0.7374%	900.04	120	1,020	2	1	+1
85	Association of Military Surgeons of the United States	3,472	1.4465%	1,765.51	1,842	3,608	4	3	+1
86	Association of University Radiologists	1,480	0.6166%	752.58	58	811	1	1	0
87	College of American Pathologists	262	0.1092%	133.23	2	135	1	1	0
88	Congress of Neurological Surgeons	2,154	0.8974%	1,095.31	3,061	4,156	5	4	+1
89	Contact Lens Association of Ophthalmologists	1,070	0.4458%	544.09	89	633	1	1	0
90	Infectious Diseases Society of America	271	0.1129%	137.80	8	146	1	1	0
91	International College of Surgeons - US Section	1,141	0.4754%	580.20	0	580	1	1	0
92	International Spinal Injection Society	1,067	0.4445%	542.57	53	596	1	1	0
93	National Association of Medical Examiners	566	0.2358%	287.81	0	288	1	1	0
94	North American Spine Society	250	0.1042%	127.12	64	191	1	1	0
95	Radiological Society of North America	1,294	0.5391%	658.00	224	882	1	1	0
96	Renal Physicians Association	4,462	1.8590%	2,268.92	134	2,403	3	1	+2
97	Society for Investigative Dermatology	757	0.3154%	384.93	232	617	1	1	0
98	Society for Vascular Surgery	264	0.1100%	134.24	9	143	1	1	0
99	Society of American Gastrointestinal Endoscopic Surgeons	628	0.2616%	319.34	73	392	1	1	0
100	Society of Critical Care Medicine	1,230	0.5124%	625.45	45	670	1	1	0
101	Society of Interventional Radiology	1,896	0.7899%	964.11	115	1,079	2	1	+1
102	Society of Laproendoscopic Surgeons	1,071	0.4462%	544.60	37	582	1	1	0
103	Society of Medical Consultants to the Armed Forces	2,530	1.0541%	1,286.50	0	1,287	2	1	+1
104	Society of Nuclear Medicine	157	0.0654%	79.83	29	109	1	1	0
105	Society of Radiologists in Ultrasound	388	0.1616%	197.30	0	197	1	1	0
106	Society of Thoracic Surgeons	1,212	0.5049%	616.30	367	983	1	1	0
107	The Endocrine Society	556	0.2316%	282.73	148	431	1	1	0
108	The Triological Society	259	0.1079%	131.70	12	144	1	1	0
109	United States and Canadian Academy of Pathology	1,698	0.7074%	863.43	62	925	1	1	0
	TOTALS	240,026	100.00%	122,053	82,307	204,360	266	192	+74

¹ The size (in number of AMA members) of each specialty society is drawn from data generated by the five-year reviews that specialty societies are required to undergo to retain representation in the AMA House. Consequently, the data on sizes of specialty societies do not relate to the same time period.

² This figure is simply the size in AMA members divided by 240,026. A specialty society's proportion of the total AMA memberships in the 109 specialty societies that are represented in the AMA House determines what proportion of the allocated ballots would be awarded to that society.

³ Allocated ballots are ballots that are cast on behalf of AMA members who did not use the online balloting system to select a specialty society to represent them in the AMA House. Including fourth-year medical student members, a total of 129,743 eligible AMA members have not participated in the online balloting mechanism.

⁴ Total ballots are the sum of cast ballots and allocated ballots.

⁵ A delegate position would be allocated to a specialty society for each 1,000 total ballots (the sum of cast ballots and allocated ballots) or portion of 1,000 total ballots.

⁶ By action of the House, the number of delegate positions allotted to each specialty society for the 2004 Interim Meeting was frozen at the number for the 2003 Interim Meeting.

APPENDIX C - DELEGATE ALLOCATIONS: COMPARING STATE AND SPECIALTY SOCIETIES

	State Societies	Specialty Societies
Count of AMA members	a: AMA members who pay dues through a state are counted with that state. §2.111 b: Direct members (1) physicians are allocated to the state in which they have their preferred mailing address. §2.111 and (2) students are allocated to the state in which they attend medical school.	AMA members who have completed a ballot to select a specialty society are allocated to that society. §2.124 (As of December 31, 2004, 82,307 valid ballots had been cast, representing about 40.3% of 204,360 members eligible to cast ballots.)
Apportionment	1 per 1000 (or fraction) AMA members counted in that state. §2.111	1 per 1000 (or fraction) AMA members who cast a ballot for that specialty society. §2.124
Students	All medical students are allocated to a state society.	Only 4th year students are eligible to cast a ballot, so only those who exercise that right are allocated. §2.124 (As of December 31, 2004, 10,180 4th year students were eligible to cast ballots but only a single student had done so.)
Minimum number of delegates	1 delegate and 1 alternate without regard to number of AMA members in state.	1 delegate and 1 alternate without regard to number of ballots cast. §2.12
Additional delegates and unified membership	a: 1 extra delegate if 75% of state society members are AMA members. §2.112 b: 2 extra delegates if 100% of state society members are AMA members. §2.112 c: Societies adopting unified status will not lose delegates for first two years after becoming unified. §2.112	a: no similar provision for 75% threshold. b: 1 extra delegate if 100%. §2.122 c: No similar provision.
Retention of delegate	1-year grace period if membership decline warrants loss of delegate. §2.1111	No similar provision.
Retention of additional delegates	a: 1-year grace period for the delegate awarded for meeting 75% threshold. §2.1122 b: No provision for 100%.	a: Not applicable. b: No provision for 100%
Speaker (Vice Speaker)	A state society represented by the delegate elected to be Speaker (Vice Speaker) of the House of Delegates shall be entitled to an additional (i.e., replacement) delegate for the term of service of the Speaker (Vice Speaker). §2.123 Note: Per §4.402, the Speaker and Vice Speaker may not vote except by ballot (i.e., in elections).	A specialty society represented by the delegate elected to be Speaker (Vice Speaker) of the House of Delegates shall be entitled to an additional (i.e., replacement) delegate for the term of service of the Speaker (Vice Speaker). §2.123 Note: Per §4.402, the Speaker and Vice Speaker may not vote except by ballot (ie, in elections).

Note: References to Bylaws are given by citing the relevant section, §x.xx.

APPENDIX D - TOTAL POPULATION OF PHYSICIANS AND MEDICAL STUDENTS, AMA MEMBERSHIP AND DELEGATION SIZE BY STATE

State	Total Physician and Student Population*	2004 AMA Members	Total 2005 State Delegate Allocation†
Total	1,014,336	244,530	315
Alabama	11,845	4,487	5
Alaska	1,727	343	1
Arizona	16,283	3,045	4
Arkansas	6,988	2,317	3
California	114,426	19,578	23
Colorado	15,053	2,599	4
Connecticut	15,166	3,777	5
Delaware	2,604	927	3
District of Columbia	5,987	1,385	2
Florida	56,916	11,334	14

State	Total Physician and Student Population*	2004 AMA Members	Total 2005 State Delegate Allocation†
Georgia	24,052	5,512	7
Hawaii	4,898	1,217	2
Idaho	2,942	589	1
Illinois	44,876	13,524	16
Indiana	16,651	4,762	6
Iowa	8,082	2,916	4
Kansas	8,330	2,500	3
Kentucky	11,831	4,009	5
Louisiana	14,881	4,092	5
Maine	4,916	999	2
Maryland	27,724	4,283	5
Massachusetts	34,402	6,426	8
Michigan	34,773	10,373	13
Minnesota	17,475	5,047	7
Mississippi	6,600	3,934	6
Missouri	19,153	5,668	7
Montana	2,597	570	1
Nebraska	5,728	1,989	3
Nevada	5,562	1,070	2
New Hampshire	4,353	710	1
New Jersey	33,588	6,985	9
New Mexico	5,722	1,221	2
New York	91,646	18,297	23
North Carolina	26,541	6,986	8
North Dakota	1,986	782	1
Ohio	40,692	10,263	13
Oklahoma	8,962	5,159	8
Oregon	12,001	1,986	3
Pennsylvania	51,491	13,218	16
Puerto Rico	11,730	948	2
Rhode Island	4,656	922	2
South Carolina	12,057	4,075	5
South Dakota	2,197	976	1
Tennessee	18,927	4,944	6
Texas	60,735	17,627	21
Utah	6,311	1,830	2
Vermont	3,074	429	1
Virginia	25,433	6,264	7
Washington	20,302	3,416	5
West Virginia	5,919	1,892	3
Wisconsin	17,693	5,199	6
Wyoming	1,179	271	1
APO/FPO/Foreign	4,498	777	-

* - Total population includes residents, students and DOs

† - Total includes Guam (1) and Virgin Islands (1)

31. AUDITOR'S REPORT

HOUSE ACTION: FILED

The Consolidated Financials Statements for the years ended December 31, 2004 and 2003 and the Independent Auditor's report have been included in a separate booklet, titled "2004 Annual Report." This booklet is included in the handbook mailing to Members of the House of Delegates and will be discussed at the Reference Committee F hearing.

32. AMA DUES - 2006

HOUSE ACTION: RECOMMENDATION ADOPTED AND REMAINDER OF REPORT FILED

At its April meeting the Board of Trustees reviewed the 2006 dues recommendation. In October 2003, the AMA adopted 10 Strategic Membership initiatives to improve the value of AMA membership. As the AMA membership benefits portfolio is modified and enhanced, staff will continuously review dues pricing to ensure optimization.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

No change to the dues levels for 2006. That American Medical Association dues level for 2006 remain as follows:

Regular Members	\$420
Physicians in Their Second Year of Practice	\$315
Physicians in Military Service	\$280
Physicians in Their First Year of Practice	\$210
Physicians in Resident Training	\$45
Medical Students	\$20

Regular Physician Members of unified societies dues rebate for 2006 will be in the form of a reduced dues level of \$300.

33. SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES - FIVE-YEAR REVIEW

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

The Board of Trustees has completed its review of the specialty organizations seated in the House of Delegates which are scheduled to submit information and materials at the 2005 American Medical Association (AMA) Annual Meeting in compliance with the five-year review process directed by the House in Report A of the Council on Long Range Planning and Development (A-87) (Policy G-600.020, AMA Policy Database, and Section 8.50 of the AMA Bylaws).

Organizations are required to demonstrate continuing compliance with the guidelines established for admission to the House of Delegates. Also required is compliance with the five responsibilities of national medical specialty organizations as set out in the AMA policy statement and Section 8.70 of the AMA Bylaws.

The following organizations were reviewed for the 2005 Annual Meeting:

American Academy of Otolaryngic Allergy
 American College of Nuclear Physicians
 American College of Obstetricians and Gynecologists
 American College of Physicians
 American College of Preventive Medicine
 American College of Radiology
 American College of Surgeons
 American Society of Retina Specialists
 Society of Radiologists in Ultrasound

The above organizations were asked to submit materials in a format listing the guidelines/ requirements followed by the organization’s explanation of compliance. Each organization also submitted appropriate membership information. A summary of each group’s membership data is attached to this report (Exhibit A). Also attached is a summary of the guidelines for specialty admission to the House (Exhibit B) along with the five responsibilities of specialty organizations represented in the House (Exhibit C).

The material submitted indicates the reviewed organizations, with the exception of the Society of Radiologists in Ultrasound, continue to meet all guidelines and are in compliance with the five requirements of specialty organizations represented in the House. The Society of Radiologists in Ultrasound, because it has more than 500 members and only 25% (190 of 744) of its members belong to the AMA, is currently not in compliance with the guidelines for specialty representation. Under Section 8.54 of the AMA Bylaws, specialty societies found to be not in compliance with the current guidelines for representation in the House of Delegates have a grace period of one year to bring themselves into compliance. AMA staff will work with the Society of Radiologists in Ultrasound to help correct its AMA membership deficiency. At the 2006 AMA Annual Meeting (after the grace period), the Board will report back to the House with any appropriate actions as outlined in Section 8.55 of the Bylaws.

The Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

1. That the American Academy of Otolaryngic Allergy, American College of Nuclear Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Preventive Medicine, American College of Radiology, American College of Surgeons and the American Society of Retina Specialists retain representation in the AMA House of Delegates.
2. That the Society of Radiologists in Ultrasound be placed on a one-year grace period for review at the AMA’s 2006 Annual Meeting.

APPENDIX

Exhibit A - Summary Membership Information*

ORGANIZATION	AMA MEMBERSHIP WITH PERCENT OF TOTAL SOCIETY MEMBERSHIP
American Academy of Otolaryngic Allergy	606 of 1,266 (48%)
American College of Nuclear Physicians	127 of 302 (42%)
American College of Obstetricians and Gynecologists	6,256 of 25,508 (25%)
American College of Physicians	20,820 of 65,618 (32%)
American College of Preventive Medicine	314 of 843 (37%)
American College of Radiology	8,756 of 30,082 (29%)
American College of Surgeons	20,022 of 52,280 (38%)
American Society of Retina Specialists	587 of 1,314 (44%)
Society of Radiologists in Ultrasound	190 of 744 (25%)

* - Data files submitted by specialty societies and AMA membership numbers provided by AMA Data Services.

Exhibit B - Summary of Guidelines for Admission to the House

The following guidelines shall be utilized in evaluating specialty society applications for representation in the AMA House of Delegates (new specialty organization applications will be considered only at Annual Meetings of the House of Delegates):

1. The organization must not be in conflict with the Constitution and Bylaws of our AMA with regard to discrimination in membership.
2. The organization must:
 - (a) represent a field of medicine that has recognized scientific validity;
 - (b) not have board certification as its primary focus; and
 - (c) not require membership in the specialty organization as a requisite for board certification.

3. The organization must meet one of the following criteria:
 - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - (b) a specialty organization must demonstrate that it has a minimum of 250 AMA members and that thirty-five percent (35%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that thirty-five percent (35%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C - Responsibilities of National Medical Specialty Organizations

1. To cooperate with the AMA in increasing its AMA membership.
2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organization so that the delegate can properly represent the organization in the House of Delegates.
3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.
4. To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
5. To provide information and data to the AMA when requested.

34. UPDATE ON THE COMMISSION TO END HEALTH CARE DISPARITIES

HOUSE ACTION: FILED

This informational report is an update on the activities of the Commission to End Health Care Disparities that took place between July 2004 and May 2005. Other American Medical Association disparities activities are detailed in the Appendix.

COMMISSION TO END HEALTH CARE DISPARITIES

This group of 30 state, specialty and national medical societies evolved from a Federation task force, which was initially convened in October 2003. The second meeting of this task force was held in April 2004 and was led jointly by the AMA and the National Medical Association. The number of organizations committed to this initiative

increased from 24 at the initial meeting to 37 in 2004 and the task force decided to formalize into a more permanent organization. The Commission to End Health Care Disparities held its first meeting in July 2004. At that time, committees and committee leadership were formalized, a mission and vision statement was approved unanimously, and strategic project planning started.

In January 2005, the AMA formally announced the creation of the Commission at a press event in Washington, DC. In addition, member organizations were requested to formally train their leadership in cultural competency training through self-study CD-ROM and web-based programs, which were provided by the Commission staff. To date, 11 organizations have committed to this training. A baseline assessment of the organizations of the Commission is currently being conducted to identify member programs and policies that are directed at health care disparities.

COMMITTEES

Data/Information Gathering Advisory Committee

The data committee has completed a survey on "Quality Health Care for Minorities: Understanding Physicians' Experiences," which had been mailed to a nationally representative sample of almost 2000 primary care physicians. The aim of the survey was to learn what characteristics of a physician's experience and environment can lead to engagement in addressing health care disparities. Early results indicate that many physicians now perceive health care disparities to be a problem and have become actively engaged in attempting to address this problem. Over the next two to three months the data committee will continue to analyze the survey responses to determine what recommendations it can provide for the other Commission committees.

Workforce Diversity Committee

This committee was charged with the goal of increasing the number of racial and ethnic minorities in the workforce. The committee, in partnership with the Association of American Medical Colleges (AAMC), has chosen to follow the recommendations of the Sullivan Commission report and is working in consultation with Dr. Louis Sullivan. The committee's initial project is a survey of medical school admissions committees to determine the extent of minority participation on these committees. The racial and ethnic composition and that of their corresponding student bodies will be assessed. The survey of the schools will begin in June, with results to be tabulated by the middle/end of the summer. The results will be used to inform the second-phase questionnaire of a subset of the medical schools, which will also look at the racial and ethnic composition of the schools' faculty.

Education and Training Advisory Committee

This committee is currently reviewing physician training programs on cultural competency and health disparities. It is in the process of preparing a formal assessment of four CD-ROM/Web-based programs on these topics that were reviewed at the January 2005 Commission meeting. The assessments will be used by the Commission members to provide direction for assisting the Commission organizations with their leadership training in cultural competence.

Professional Awareness Committee

The Professional Awareness Committee is working with AMA staff on the production of a disparities speakers kit. This kit will contain a Power Point presentation and fact sheets on factors that contribute to racial and ethnic health care disparities, data on their prevalence, and strategies to overcome them. A 20-minute video/CD with authenticated voices of both physicians and minority patients accompanies the fact sheets and Power Point presentation.

MEMBER ORGANIZATIONAL SURVEY

Twenty-four of the 37 member organizations have responded to the request for a survey on their programs and policies related to health disparities. Fifteen of the 24 organizations have targeted health care disparities as a key issue for their members in 2004, with cultural competency (12), health literacy (12), and health care access (12) as the primary areas of focus. The most common types of health care disparities being targeted are: racial/ethnic (17), socioeconomic (11), and rural (6). Only 4 of the 24 organizations have conducted an assessment of membership needs and interests in the area of health disparities. A large majority (19/24) stated that their organization is currently involved with programs/activities involving physician education and training regarding health disparities.

Fifty percent of the organizations that responded to our survey reported that their organization is currently active in legislative programs to address health disparities, with the majority (11) being at the federal level. Thirteen organizations have developed or are in the process of developing policies or resolutions related to the reduction of health disparities.

Only three medical societies have conducted an assessment of the assets of their own organizations with regard to the elimination of health disparities.

FUTURE PLANS

Partnership with Office of Minority Health

Both the Commission to End Health Care Disparities and the Department of Health and Human Services (DHHS) are committed to improving disease prevention and health promotion among minority patients. The DHHS has proposed that the Commission partner with it in a National Screening Day for Minorities. A specific day will be designated annually for the promotion of disease screenings of minority patients. A tool kit containing fact sheets, screening aids, and promotional materials will be developed and distributed on the web. A press event announcing the Commission-DHHS partnership would be held in conjunction with the next Commission meeting.

Commission-Wide Project

Commission staff are in the process of preparing a proposal aimed at reducing racial and ethnic health disparities in small- to medium-sized group practices through a system change model. Experts in system change, cultural competence, patient-centered care, and language barriers will inform the project. Commission members will serve as external advisors to the project and as direct links with the local chapter of their member state and specialty organizations through which project participants will be recruited. Practices will form collaboratives around one or more chronic diseases that will use clinical performance measures for quality improvement. The Commission has initiated talks with various funders including the Robert Wood Johnson Foundation. The grant will be submitted in June, with an anticipated start date of December 2005.

Committee Projects

Education and Training

The education and training committee will be researching optimal incentives for physicians that will lead to action for disparity reduction in their practices. Specifics have not yet been formulated.

Data

This committee is now developing a follow-up project to its 2004 survey that will use a series of phone interviews and physician practice site visits to identify specific barriers to achieving quality care for minority patients and promising practices that have the potential to improve the care that is being provided. The Commission organizations will use the findings of this project to develop education and training initiatives, promote health system changes, and guide an advocacy agenda.

Workforce Diversity

Town Hall Meeting on Workforce Pipeline

The Town Hall Meeting to increase the workforce diversity pipeline will be a working meeting resulting in recommendations and an action plan. The underlying theme for the meeting will be the role of professional organizations in addressing workforce issues. The targeted date for the meeting is Fall 2006.

Second Language as a Requirement in Medical Schools

The workforce committee concurred that one mechanism of addressing the language barriers that contribute to racial and ethnic health care disparities would be to integrate foreign language training into the medical school curriculum. A proposal on this topic will be prepared to be vetted by the Association of American Medical Colleges and the Licensing Committee on Medical Education by October 2005.

Professional Awareness

The Committee is in the process of developing a Speakers Bureau. These individuals will be available nationwide to use the speaker's kit for talks on health care disparities.

APPENDIX - AMA ACTIVITIES ON HEALTH CARE DISPARITIES

Language

The language gap between physicians and non-English speaking patients is an increasingly significant issue in health care delivery. Physicians who receive federal funds (Medicare and Medicaid) are mandated to provide language access services for all persons with limited English proficiency (LEP). On the basis of concern about the need for guidance on language barriers for physicians nationally, the American Medical Association is dedicated to identifying effective and feasible solutions. The language initiative currently being undertaken by the AMA is a three-step process.

Phase 1

Nine focus groups of 8-10 physicians, nurses and office managers each will be convened. Participants for the groups will be selected from practices in areas with greater than 100% growth in the non-English speaking population. The participants will be recruited from specialties in primary care (2/3) and other specialty (1/3) practices in the following groupings: focus groups of physicians who are actively seeking ways of addressing the language barriers in their practice, those for whom their practices have found effective methods of addressing these barriers, and a mixture of participants from both groups will be convened. The groups will:

- Review the tools used by physicians to communicate with their limited English proficiency patients from medical practices with established language access service programs.
- Identify the elements that render the systems cost-effective and could be replicated in similar practice settings.
- Solicit suggestions for the ideal language access service, excluding interpreters, from those physicians who have not yet addressed the problem of language access services in their practices.
- Identify a cost threshold for purchasing language access services for the medical practice among these physicians.
- We anticipate that the focus groups and report will be completed mid summer 2005.

Phases 2 and 3, in which a prototype language access service is identified and purchased in bulk for AMA members (at a reduced cost) and a pilot testing of this tool is planned for the fall and winter of 2005-2006.

EPoCH (Educating Physicians on Controversies and Challenges in Health) Web Streaming Program

The Unit on Medicine and Public Health is developing a series of five-minute informational web streaming programs targeted to primary care physicians. The objective is to engage physicians by informing them about the challenges and controversies at the interface of clinical medicine and public health and to link physicians with the strategies to address these issues. The first of several episodes will address topics in health care disparities. Episode 1 will be a broad overview of health care disparities and strategies for physicians to reduce these within their own practices. Subsequent topics will include: disparities in immunizations, is obesity a disease, STD vaccines for adolescents, and how to address language barriers in your practice.

White House Conference on Aging Mini-Conference

The AMA is hosting a mini-conference on Health Literacy and Health Disparities for the planning committee of the 2005 White House Conference on Aging (WHCoA). The goal of the mini-conference is to develop policies in these areas for consideration by the full WHCoA meeting in October 2005. The mini-conference will take place in July 2005 in Chicago and will be co-hosted by the Blue Cross Blue Shield Association. The morning session will be composed of three expert panel discussions. In the afternoon, the 18-20 participants (experts in the fields of health literacy and health disparities) will break up into small groups on one of the three topics listed below:

- Improving communications for better understanding.
- Patient safety and drug benefit; reducing risks of medication errors.
- Incentives to improve quality through patient centered primary care.

Twelve speakers are in the process of being identified.

Roadmaps on Immunizations

The roadmap “Improving Immunizations: Addressing Racial and Ethnic Populations, A Primer for Physicians” will be released in late May 2005. This four booklet primer contains background on the issue, recommendations and resources for physicians, and illustrative case presentations for improving health care delivery in racial and ethnic populations. Funding has been provided by Adventis.

Quality Unit

Project “EQUIP”

The AMA is a partner on a three-year, \$1.5 million grant received by the Alliance of Chicago Community Health Services (Chicago Alliance), called Enhancing Quality in Patient Care (EQUIP). The EQUIP Project was one of a hundred proposals funded out of 600 submitted to AHRQ. EQUIP is a quality improvement initiative in which a network of 23 federally-qualified community health centers in Chicago propose to integrate AMA/Consortium measures into an electronic health record system (EHRS) being installed at their sites. AMA staff participating on this grant will lend expertise on performance measure integration and data element validation. This collaborative effort will enable the development of a data registry to aggregate data for clinical and system quality improvement and assess the results of interventions to reduce disparities. The community health centers serve as safety net facilities to Chicago’s most vulnerable populations.

Project “Advance”

The AMA is collaborating with the Chicago Alliance and the Health Research and Education Trust (HRET), the research unit of the American Hospital Association. Together, the three participating organizations plan to link standardized clinical data from the AMA/Consortium performance measures with standardized demographic data. HRET has been the leader in the creation and testing of a framework for collecting data on patients’ race, ethnicity, and primary language. To date, this framework has only been tested in the hospitals.

Medical Education

A questionnaire survey of all Liaison Committee on Medical Education-accredited medical schools (126) is being conducted to obtain the following information: (1) what topics related to cultural competence/health disparities are included in the formal curriculum; and (2) how much time is devoted to teaching in these areas. Once the survey data have been analyzed, schools with mature programs will be identified for follow-up interview. The interviews will address the following topics: (1) what teaching methods are used; (2) what faculty participate in the teaching; and (3) what barriers exist to ensuring that learners acquire the desired skills/competencies. Through the survey and the interviews, as well as other methods (e.g., a comprehensive literature review) model programs will be identified, and this information shared with other schools.

Ethics Group

The AMA's Ethics Group is involved in several initiatives to help physicians eliminate racial and ethnic health care disparities. At the 2005 Annual Meeting, the Council on Ethical and Judicial Affairs is presenting a report entitled "Racial and Ethnic Health Care Disparities" that examines the ethical implications of health care disparities and outlines recommendations for physician action. The Ethics Group has also initiated Project REACH, a national effort to bolster and extend the mission of free clinics to provide health care for the uninsured. Through Project REACH, the AMA has given grants to student-founded free clinic programs at five medical schools. The Ethical Force Program, led by the Institute for Ethics at the AMA, has received funding from the Connecticut Health Foundation and California Endowment to develop a consensus report and performance evaluation toolkit on the topic of Patient-Centered Communication. These products will outline performance expectations and guidance for health care organizations, including hospitals and physician practices, to help these organizations better communicate with patient populations that may be vulnerable to ineffective communication within the health care system. With funding from the Commonwealth Fund, the Ethical Force Program is also conducting a series of hospital site visits to learn what "promising practices" are being implemented to improve patient-centered communication with certain vulnerable populations. On behalf of the Commission to End Health Care Disparities, the Institute for Ethics at the AMA conducted the physician survey, "Quality Health Care for Minorities: Understanding Physicians' Experiences." Early results of this survey indicate that many physicians now perceive health care disparities to be a problem and have become actively engaged in attempting to address them. Finally, the AMA's Ethics Group is continuing to conduct research and disseminate information on levels of trust that minority populations have in the medical profession and what can be done to increase trust.

**35. MEDICARE PHYSICIAN PAYMENT
(RESOLUTION 207, A-04)**

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF
RESOLUTION 231 AND RESOLUTION 207 (A-04) AND
REMAINDER OF REPORT FILED**

At the 2004 Annual Meeting, the House of Delegates referred Resolution 207, introduced by the New York delegation, which calls for the American Medical Association to petition Congress and the Centers for Medicare and Medicaid Services (CMS) for an immediate increase in Medicare payments to physicians to equal the 10.6% increase in the payment rate that was given to the Medicare managed care organizations as a result of the Medicare Modernization Act (MMA).

This report explains the current forecast for updates to Medicare physician payment rates and the major campaign that has been launched by the AMA and the Federation to replace the forecast payment cuts with positive updates and avert a meltdown in seniors' access to care. The report also explains the context for the funding increases included in the MMA for managed care plans. The report concludes that the AMA should continue its aggressive effort to prevent the forecast payment cuts and replace the unsustainable spending target with updates that reflect annual increases in physicians' practice costs.

2005 MEDICARE TRUSTEES REPORT

The 2005 Medicare Trustees Report forecasts that physicians will experience payment cuts of 26% from 2006 through 2011. During the same period, the Trustees predict that the government's conservative measure of inflation in medical practice costs, called the Medicare Economic Index or MEI, will increase by 15%.

The cuts are the product of a formula called the Sustainable Growth Rate (SGR) which was enacted in the Balanced Budget Act of 1997. Although the SGR produced positive payment updates for its first couple years, multiple efforts by Congress and the Administration aimed at revising the formula so that it would not lead to steep pay cuts have failed to stem the current unsustainable forecast for Medicare physician payment rates.

The first of the six consecutive steep pay cuts--a reduction of 4.3%--is slated to go into effect on January 1, 2006, 192 calendar days (and even fewer legislative days) after the conclusion of this Annual Meeting. Under the SGR, Medicare payment rates to physicians have already fallen far below inflation in practice costs. If payment rates are cut in 2006, then during the five-year period from 2002 through 2006 Medicare rates will have fallen 16% below the MEI. By 2014, more than 30 states face cuts of more than a billion dollars.

Only physicians face these steep cuts. Payments for most other Medicare providers, including hospitals, nursing homes, and home health agencies, are based on annual increases in their costs. For 2006, therefore, current law provides for increases for most other Medicare provider groups, whereas physicians face a cut of more than 4%.

An AMA survey of 5,486 physicians conducted during February and March 2005 demonstrated that continuing pay cuts to physicians could seriously impair seniors' access to medical care. The survey found that if payments are cut in 2006:

- more than one-third of physicians (38%) will decrease acceptance of new Medicare patients;
- more than one-half (54%) of physicians will defer information technology purchases;
- a majority (53%) of physicians will be less likely to participate in Medicare Advantage plans;
- one-quarter (24%) of physicians will close satellite offices and/or discontinue rural outreach services (29%); and
- one-third of physicians (34%) will discontinue nursing home visits.

SGR CAMPAIGN

At the 2004 Interim Meeting, the House of Delegates adopted Policy H-390.855 (AMA Policy Database), "Replacement of Sustainable Growth Rate System," which states that the AMA continues to assign a top priority to the prevention of further Medicare payment cuts due to the SGR system and seeks replacement of the SGR system with payment updates that reflect increases in the cost of medical practice. The AMA understands the magnitude of the problem and has been aggressively lobbying both the Administration and Congress to try to avert these cuts. Working closely with the national medical specialty societies, state medical associations, and other leading medical organizations, the AMA launched a major campaign to increase awareness of the problem and build support for a solution. At the State Legislation meeting, National Advocacy Conference, and through Federation conference calls, grassroots alerts and the Patients Action Network, the AMA has been educating physicians and patients on the pay cut problem and providing materials to help them advocate on the issue to the Administration and their Members of Congress.

Materials developed include talking points, frequently asked questions, charts, a map with state impacts, a poster for physician offices and a pocket card that fits in a physician lab coat. All of these materials have been posted to the AMA web site and regularly updated to reflect the most recent information available from the Medicare Trustees, CMS, and the Medicare Payment Advisory Commission (MedPAC). Also, the physician survey data described above were presented at a media backgrounder that was covered in the *New York Times*, Reuters, and several Beltway publications read by Members of Congress and their staff.

The Administration could significantly reduce the cost of legislation to address the pending patient access crisis by removing the cost of physician-administered drugs from its SGR calculations. The latest information provided to Congress by the HHS Secretary indicates that removing these costs from the SGR, retroactive to the SGR base year of 1996-97, would lead to a positive update in 2006 and avert the forecast cuts. Using an SGR research fund with contributions from 33 national medical specialty societies and state medical associations, the AMA obtained a legal opinion from a former General Counsel for CMS' predecessor agency, the Health Care Financing Administration (HCFA), which made a compelling case that CMS has the authority to remove drugs from the SGR. Through meetings with senior Administration officials and by intensifying advocacy with Congress, the AMA has been relentless in seeking to convince the Administration to remove physician-administered drugs from the SGR pool.

MedPAC has recommended that the SGR be replaced with a system that would provide for annual updates reflecting annual increases in practice cost inflation. On May 12, 2005, H.R. 2356, the "Preserving Patient Access to Physicians Act of 2005," was introduced by Reps. Clay Shaw (R-FL) and Ben Cardin (D-MD), and would repeal the SGR and replace it with updates based on the MEI as recommended by MedPAC. On May 19, 2005, S. 1081, also titled the "Preserving Patient Access to Physicians Act of 2005," was introduced by Sens. Jon Kyl (R-AZ) and Debbie Stabenow (D-MI). The Senate bill would replace the forecast cuts with a 2.7% increase in 2006 and an MEI

update in 2007. Sens. Jim Talent (R-MO) and Jon Corzine (D-NJ) also signed on as original cosponsors of S. 1081. The AMA worked closely with the sponsors and cosponsors of the House and Senate bills to help secure their introduction, and is now engaged with the state and specialty societies in a major effort to help garner additional cosponsors for these two bills.

MEDICARE ADVANTAGE PAYMENTS

One of the main objectives that Congress and the Administration hoped to achieve in the MMA was to increase the availability of Medicare private plan options throughout the country. For this reason, the private plan options, which the MMA named "Medicare Advantage," were funded generously. Although studies have shown that Medicare pays significantly more for beneficiaries enrolled in Medicare Advantage plans than it would pay if these same beneficiaries were enrolled in the Medicare fee-for-service (FFS) program, the Administration has noted that patients enrolled in Medicare Advantage have lower out-of-pocket expenses than those in Medicare FFS. The Administration has also reported that Medicare Advantage plans have used the additional funding provided by the MMA to expand their networks and improve their benefits, and that there is significant interest among private plans in offering the new Medicare PPO options slated to start in 2006.

With only about 12% of Medicare beneficiaries enrolled in Medicare Advantage plans and more than 85% in the FFS program, it costs the government much more to increase FFS payment rates than Medicare Advantage rates. Recent estimates from the Congressional Budget Office (CBO) indicate that legislation to adopt the MedPAC recommendation to repeal the SGR and replace it with updates based on the MEI would cost more than \$150 billion over the next 10 years. The cost of a 10.6% increase in physician payment rates--especially in contrast to the currently forecast 4.3% cut--would likely be more than double the cost of the MedPAC recommendation.

DISCUSSION

MedPAC has been recommending for several years that the SGR be repealed and that Medicare physician payment updates reflect increases in their practice costs. AMA Policy H-390.855 also calls for the SGR to be replaced with payment updates based on increases in physicians' practice costs. After a major effort by the AMA and with the AMA's strong support, legislation has been introduced in both Houses of Congress that would base payment updates on the MEI. It would be much more difficult to justify tying physician payment updates to Medicare managed care updates than to the MEI, and this strategy could potentially jeopardize support for addressing the SGR problem. Moreover, the managed care payment rates are subject to change themselves and may well be reduced. The Board believes that the AMA has a much better chance of averting the forecast payment cuts and achieving positive updates by continuing our current strategy of seeking updates that are based on inflation in medical practice costs.

In the current political environment where the Administration and Congress are attempting to reduce the federal budget deficit, averting the forecast 26% payment reductions is itself a formidable challenge. The CBO score for preventing physician payment reductions has caused significant concern on Capitol Hill, and this apprehension has been heightened by recent statements from the Administration regarding rising spending for Part B services and forecast increases in Part B premiums.

In this environment, the Board believes that it would be better for the AMA to stay focused on addressing the urgent situation with the FFS physician payment updates and continue to seek a new update system tied to increases in physicians' practice costs. To change tactics and seek parity with Medicare's private plan options instead of tying pay updates to medical practice cost increases is highly unlikely to produce the needed results.

RECOMMENDATION

The Board recommends that the following be adopted in lieu of Resolution 207 (A-04) and the remainder of this report be filed:

1. That American Medical Association Policy H-390.855, "Replacement of Sustainable Growth Rate System," be reaffirmed.
2. That our AMA send all members of Congress a letter, signed by all willing members of the Federation, urging them to enact legislation replacing Medicare's sustainable growth rate reimbursement formula with a system based on appropriate updates.

**36. STRENGTHENING, EXPANDING, AND PROMOTING FOUNDATION
AND MEDICAL SOCIETY SCHOLARSHIP PROGRAMS
(RESOLUTIONS 616 AND 617, I-04)**

**HOUSE ACTION: RECOMMENDATION ADOPTED
(RESOLUTIONS 616 AND 617, I-04 NOT ADOPTED) AND
REMAINDER OF REPORT FILED**

This report is in response to Resolutions 616 and 617, which were referred to the Board of Trustees by the House of Delegates at the American Medical Association 2004 Interim Meeting. Both resolutions relate to scholarship programs.

BACKGROUND

Resolution 616, "Strengthening AMA Foundation and State Foundation Scholarship Programs," introduced by the Medical Student Section (MSS), calls for the AMA to (1) ask state medical society foundations and the AMA Foundation to encourage donors to pool their funds with others to endow large scholarships; (2) ask the AMA Foundation to work with state medical societies and their foundations to ensure that scholarship funds are disbursed directly to the student and not to the medical school; (3) ask the AMA Foundation to work with state medical societies and their foundations to make scholarship programs direct-application at the medical school level; and (4) ask the AMA Foundation to compile and distribute a list of fundraising "best practices" that have been shown to be effective in raising funds for medical scholarships.

Resolution 617, "Expanding and Promoting State Medical Society Scholarship Programs," also introduced by the MSS, calls for the AMA to (1) work with state medical societies and their associated Foundations to ensure that information about all scholarships they offer is readily available online; (2) strongly urge each state medical society to add a voting medical student representative to its Foundation Board of Directors or other appropriate governing body; (3) collect and propagate model bylaws changes from state Foundations that have added medical students to their Board of Directors; and (4) urge all state foundations to consider converting any loan programs they may have into scholarship programs and provide information to said foundations on how other states have achieved this conversions.

The Board of Trustees provided the recommendations in Resolutions 616 and 617 to the AMA Foundation for its consideration.

DISCUSSION

The implementation of the recommendations in Resolutions 616 and 617 must respect the legal separation and independent identity of medical societies from the foundations with which they may be associated. Also, many existing scholarship and loan programs were established based on continuing restrictions on the use of the funds, e.g., limiting assistance to loans; limiting assistance to students in specific schools, specialties or geographic areas, and/or requiring that assistance be given to students selected by a medical school.

As noted below, the AMA Foundation has informed AMA staff that the Foundation has already or will take action to adopt most of the recommendations from Resolutions 616 and 617.

Resolution 616

The Board has been advised that the AMA Foundation now offers donors the option of pooling funds for scholarship purposes, through the National Scholarship, with a minimum \$10,000 award. Four of these scholarships will be awarded in 2005. For the AMA Alliance medical school fundraising program, the Foundation requires that it receive the name of the student recipient from the medical school before sending a check, which is made out to both the student and the medical school. This program has also been recently changed so that a minimum \$1,000 scholarship is awarded. The AMA Foundation will continue working with the Deans for selection of applicants, since the number of medical schools and scholarships is so great and the process is resource-intensive. Deans receive grant applications to complete for each student nominee. The AMA Foundation is compiling a list of its own practices to make available online with a request for others to contribute their best practices to this online resource. Medical societies and their foundations will be notified when this online resource is available.

Resolution 617

The Board has also been advised that the AMA Foundation has an online listing of available scholarships and will actively solicit information from others as requested in this resolution. Information on scholarships compiled by the MSS and provided to the Foundation will be considered by the Foundation for inclusion in this online listing. The proposed changes in the bylaws of the AMA Foundation will result in the addition of a medical student to its board. The bylaw changes to effect this action will be publicly available. Finally, converting loan programs into scholarship programs, as outlined in the fourth recommendation under this resolution, could be accomplished if doing so accords with the wishes of the donors. The AMA Foundation does not have any loan program at this time.

RECOMMENDATION

Based on the requirement to respect the legal separation and independent identity of medical societies and their affiliated foundations, and the actions being taken by the AMA and AMA Foundation, the Board of Trustees recommends that Resolutions 616 and 617 (I-04) not be adopted, and that the remainder of this report be filed.

**37. IMG SECTION BYLAWS
(RESOLUTION 11, A-04)**

**HOUSE ACTION: RECOMMENDATION ADOPTED
IN LIEU OF RESOLUTION 11 (A-04) AND
REMAINDER OF REPORT FILED**

INTRODUCTION

Resolution 11 (A-04), "Redefining IMG Section Membership," which was introduced by the International Medical Graduates Section and referred to the Board of Trustees for decision, asked that our American Medical Association modify its bylaws so that all IMG members of the Association are defined as members of the IMG Section, while continuing to allow provisional membership for IMGs who are not yet AMA members.

Prior to the Board's discussion, the International Medical Graduates (IMG) Section Governing Council reconsidered Resolution 11 and IMG Section election bylaws. The Governing Council recommended:

1. That all IMG members of the AMA be defined as members of the IMG Section.
2. That all IMG Section members who are AMA members be allowed to vote in the election of members of the IMG Section Governing Council but that, at the IMG Section Annual Meeting, only those IMG Section members who are AMA members, and who attend that meeting, be allowed to elect Governing Council members to specific offices (Chair, Vice Chair, etc).

BACKGROUND

The AMA allows IMGs to join the AMA if they are certified by the Educational Commission for Foreign Medical Graduates (ECFMG) or licensed in a US jurisdiction.

Currently, any AMA member physician who wishes to join the AMA-IMG Section does so by telling the IMG Section that he or she wishes to become a member of the Section. In contrast, the Medical Student Section, Resident and Fellow Section and Young Physicians Section automatically define AMA members who are medical students, residents or fellows, or young physicians, as members of those respective sections. The Organized Medical Staff Section and Section on Medical Schools work on a representative model--medical staffs and medical schools designate delegates to those Sections.

Non-AMA members and IMGs who are not yet ECFMG-certified can also join the IMG Section for up to one year as non-voting members. These "provisional" members dropped from the IMG Section if they haven't joined the AMA within one year of joining the IMG Section.

At present, there are 4,300 members of the IMG Section. Of this number, 2,710 are AMA members. The total IMG population in the US is about 216,000, with 34,765 AMA members.

MEMBERSHIP BYLAWS

There is a significant difference between the AMA membership rates of IMGs and US medical graduates (USMGs). Sixteen percent of IMGs are members of the AMA while 23% of USMGs are AMA members. Currently, only the 4,300 IMG Section members receive newsletters and e-mails from the AMA targeted towards IMGs. Over 32,000 IMG members of the AMA do not receive communications which focus on AMA efforts to support IMGs.

Modifying the membership bylaws of the IMG Section to include all IMGs who are members of the AMA will increase communication to all IMGs. Increasing communication will help counter negative perceptions and help member retention and recruitment efforts.

Increased communication is expected to increase IMG participation in AMA and IMG Section activities. Some IMGs who are interested in leadership roles may hesitate to get involved in organized medicine because they believe they lack experience in the US. The IMG Section provides those members with mentors who understand the challenges IMGs face and who can guide and encourage their leadership development.

The Board also discussed the option of provisional membership for IMGs who are not AMA members. The purpose of provisional membership is to encourage IMGs to join the AMA. However, the success of provisional membership has been difficult to accurately measure and has proven time-consuming for staff. Therefore, the Board believes that provisional membership should be discontinued.

Communicating with a larger audience will increase costs. Sending additional newsletters will increase costs by approximately \$25,000 per year. However, staff would no longer have to maintain a separate database of IMG members, which would save approximately \$7500 in clerical staff time. While the increased costs are significant, they must be weighed against the possibility of increasing member retention.

Finally, modifying the IMG Section membership bylaws would make its bylaws consistent with those of the MSS, RFS and YPS. Therefore, the BOT supports amending the IMG Section bylaws so that all IMG members of the AMA will be defined as members of the IMG Section. Because this item was "referred for decision," the Board's decision is forwarded through this report to the Council on Constitution and Bylaws for draft language.

ELECTION BYLAWS

The request for a change in election bylaws was not part of Resolution 11 (I-04), but the IMG Section Governing Council communicated its request to the BOT to consider changing the election bylaws at the same time as the membership bylaws.

Currently, the IMG Section Governing Council is elected at the IMG Section Annual Meeting only by those IMG Section members attending that meeting who are members of the AMA. Typically, about 40 IMG Section members attend and vote at the Annual Meeting.

The IMG Section Governing Council believes that a larger number of IMG members should be able to participate in Governing Council elections. The Council proposes that all members of the IMG Section who are AMA members be allowed to vote in elections of members of the Governing Council. To minimize costs, candidates would be presented in the Spring *AMA Voice* for IMGs and members would be able to vote online. The Council does not propose any change in eligibility requirements for candidates--only IMG Section members who are AMA members can run for the IMG Section Governing Council. It suggests that all IMG Section members who are members of the AMA be allowed to elect members to the Governing Council at large. Then, the IMG Section members who are AMA members and attend the IMG Annual Meeting would elect members to specific positions on the Governing Council (Chair, Vice Chair, etc). This is unlike any elections conducted elsewhere within the AMA; however it is similar in part to other AMA elections. The Women Physicians Congress allows all members to vote in its elections. Members of the Board of Trustees and some Councils are elected "at large" to the Board or Council and then the Board or Council elects its officers.

The Board realizes this is a significant change and has a number of consequences. The major positive consequence is that it would give members more of a sense of participation and influence.

Another consequence is that most voters would have to make their decision solely on written personal statements and curriculum vitae--they will not have a chance to meet the candidates. This may mean that some voters will determine whom to vote for based on characteristics such as ethnicity, state, specialty, etc. However, the Board recognizes that voting based on such characteristics probably already occurs.

In addition, many members of the IMG Section may be unfamiliar with the responsibilities of various Governing Council officers such as the Chair, Vice Chair, and Delegate. Although the Section can define and describe these positions, most members will not gain the understanding of these positions that the members who attend IMG meetings will gain.

The IMG Section Governing Council believes that the benefits of allowing broader participation in the IMG Section Governing Council election outweigh the risks. The Council also believes that the risks will be reduced by allowing the AMA members of the IMG who attend the IMG Section Annual Meeting to elect Governing Council members into specific offices. The members attending the Annual Meeting will likely have more experience in the IMG Section and therefore have a better understanding of the various positions on the Governing Council. They also will have the opportunity to meet the candidates and can better determine which members are best suited for the various positions on the Governing Council.

The Board discussed this proposal at length. The Board believes that the IMG Section should be allowed to amend its election bylaws and should report its experiences to the Board. The Board suggests this proposal be reviewed for its positive and negative consequences in three years.

RECOMMENDATION

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 11 (A-04) and the remainder of this report be filed:

That the AMA Bylaws be amended to provide that all IMG Section members who are AMA members be allowed to vote in the election of members of the IMG Section Governing Council and that, at the IMG Section Annual Meeting, only those IMG Section members who are AMA members and who attend that meeting be allowed to elect Governing Council members to specific offices (Chair, Vice Chair, Secretary, Delegate, Alternate Delegate, At-Large Member, Resident Member) and that this election process be reviewed three years after its final approval by the House of Delegates.

38. AMA ACTIVITIES SUPPORTING FREE CLINIC PROGRAMS

HOUSE ACTION: FILED

Recommendation 6 of American Medical Association Board of Trustees Report 17-A-04, "Licensure and Liability for Senior Physician Volunteers," asked that our AMA reaffirm Policy H-160.940 and Policy H-160.953 supporting free clinics and report, at the 2005 Annual Meeting, on the status of efforts by the AMA to support free clinic programs.

This informational report responds to that mandate.

STATUS

AMA staff have been working on several projects that support free clinic programs:

Reaching Equitable Access to Care for Health (REACH) (www.ama-assn.org/go/reach), a program run by the Ethics Group, is designed to promote physician volunteerism, support clinics in local communities, and foster an ethic of service among the next generation of physicians. Since 2004, REACH has provided grants to medical student and faculty teams for health promotion and disease prevention projects designed and run by medical students at student-led free clinics.

The AMA Professional Relations area has also promoted free clinic activities. The Senior Physicians Group (www.ama-assn.org/go/spg) has been updating its list of licensure and liability laws that affect physician volunteers and promotes volunteer opportunities through its newsletter. The Medical Student Section (www.ama-assn.org/go/mss) has created a web site listing resources for medical students who wish to create a free clinic at their medical school.

AMA staff has also publicized changes in federal law that provide liability immunity for volunteer physicians at free clinics. The changes, which were passed as Section 194 of the Health Insurance Portability and Accountability Act (HIPAA), now constitute the Free Clinics Federal Tort Claims Act (FTCA) Medical Malpractice Program.

Recently, AMA formed a staff a working group to coordinate efforts on AMA projects that benefit the uninsured. The working group includes representatives from the Ethics Group, Professional Standards, Professional Relations, Socioeconomic Policy Development, Integrated Marketing Strategy and the AMA Foundation. These groups are exploring opportunities to increase public awareness of AMA efforts to address the problem of the uninsured through increasing insurance coverage and access to care. The working group will report on its activities regularly to AMA leadership.