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PHOTO BY PETER WYNN THOMPSON
Arl Van Moore Jr., MD, a radiologist from North Carolina, was among the physicians heard at AMA's 156th Annual Meeting.

AMA meeting special section

Medicare payment reform and pay-for-performance were among top action items.
6 pages of coverage start on page 11

Short on support

As physicians further embrace technology, it's getter harder to find someone to maintain it.
In Business, page 17

Health IT bill advances in Senate
Government & Medicine, page 5

States, CME adding cultural competency
Professional Issues, page 8

Take practice's pulse before adding physicians
Business, page 19

Doing what's best to prepare for the worst
Opinion, page 21

Cancer's age wave
Health & Science, page 24

CLASSIFIED ADVERTISING – PAGE 26

Delegates seek more oversight of retail clinics

The AMA House tries to ensure the clinics don't get special treatment from regulators and insurance companies, and don't compromise quality of care.

Pamela Lewis Dolan
AMNEWS STAFF

Chicago Citing concerns that retail-based clinics may be too much retail and not enough clinic, the AMA House of Delegates at its Annual Meeting last month approved resolutions that call for an investigation into the growing industry.

During testimony before the reference committee addressing medical practice, many AMA members expressed concerns with patients getting prescriptions written and filled under the same retail roof.

"Maybe MinuteClinic should change its name to Nurse Kiosk," quipped Raj Lal, MD, a thoracic surgeon from Oak Brook, Ill., referring to one of the largest retail clinic chains, now owned by Providence, R.I.-based CVS Caremark Corp.

Continued on next page

AMA launches pre-election push on plight of uninsured

Action on SCHIP is to be followed by the release of a national health policy agenda and an advertising campaign on the insurance access problem.

David Glendinning
AMNEWS STAFF

Chicago The American Medical Association House of Delegates last month voted in favor of strengthening children's health care and began formulating a broad health care agenda in advance of an election year expected to focus heavily on the uninsured.

At their Annual Meeting, delegates approved an AMA policy calling for the reauthorization of the State Children's Health Insurance Program before it expires at the end of September. They also called for a commitment from Congress of $60 billion over five years in SCHIP funding. This amount would allow the program to maintain its current level of coverage and enroll the remainder of children who are eligible but not insured.

AMA delegates and board members described covering children's health care as a vital first step in tackling the problem of the uninsured.

"Congress must find a way to pay for the millions of children SCHIP will protect," said Samantha Rosman, MD, a pediatrician and AMA board member. "This spending on children's health is a sound investment in our nation's future."

Delegates were unanimous in their support for reauthorizing SCHIP, but some argued against placing a specific price tag on the effort. Although $60 billion is considered by many experts to be the amount needed to cover all eligible kids, some physicians warned the AMA against locking itself into a specific figure when funding projections could change.

But the AMA board felt strongly that this figure was the amount required to ensure health coverage for every eligible child, Dr. Rosman said.

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AMA launches pre-election push on plight of uninsured

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President Bush and some lawmakers are calling for a much smaller SCHIP appropriation. After negotiations in Washington, this means the final amount could fall in the middle.

Delegates also considered other resolutions on the issue of the uninsured and underinsured. They adopted principles to guide the evaluation of health insurance coverage adequacy. For example, to pass AMA muster, insurance pools designed to enable access to coverage must offer several age-appropriate options, follow the same guidelines as those of federal health employee plans, and assist lower-income and sicker patients with high costs.

Preparing for 2008

Next year is expected to be a busy one on the issue of health access for the uninsured, and the AMA is preparing to have its say in the debate.

At the Annual Meeting, the AMA board gave a sneak peek at a national health care policy agenda it is putting together. When completed by late August, it will serve as the Association's official set of policies on a range of health care issues that could arise in the election year and beyond.

"This is the season to have these ideas heard by the American public we serve and their leaders," said AMA Trustee Cecil B. Wilson, MD. The AMA will deliver the final agenda to the White House, Congress and major political parties.

Although the package is not finalized, a discussion draft distributed at an Annual Meeting forum referenced the problem of the uninsured at the top of the "health care environment" category. Promoting such reforms as reconfiguration of tax benefits on the federal and state level, the AMA will try to help ensure fair coverage and access to care for both insured people and the uninsured. The agenda also is expected to cover the topics of clinical excellence, public health, practice viability and physician education.

> The AMA board will decide by fall how it will evaluate candidates' health reform plans against Association policies.

This fall, the AMA will launch a three-year "Voice for the Uninsured" media and education campaign aimed at bringing more public attention to the uninsured. Using advertisements and grassroots advocacy, the AMA hopes to put pressure on Congress to pass legislation on the issue.

Several of the planned ads feature actual doctors and uninsured patients who are trying to deal with the lack of insurance, on top of the patients' medical needs. The theme of the campaign — "Because one out of seven is 45 million too many" — is based on statistics for the number of uninsured.

Ads and other outreach tools will direct people to a Web site *(http://www.voicefortheuninsured.org/)* where they can share concerns and find information on how to contact lawmakers and candidates. The AMA board will decide by fall on how it will evaluate candidates' health reform plans against Association policies and share its assessments with members.

The house considered other policies on the uninsured, but delegates felt some went too far or needed study.

Delegates rejected a resolution that would have added publicly funded universal access to health insurance to the AMA's list of options to consider in the national health system reform debate. Opponents said the proposal was against AMA principles.

"Once we put 'publicly funded universal access to health insurance' on our approved list, we've now given cover to all politicians who wish to construct a single-payer system," said Alan W. Harmon, MD, a gastroenterologist and delegate from Jacksonville, Fla.

Other physicians said the AMA should at least acknowledge the option of publicly funded universal health care if it is going to remain an active player in the debate.

The house tabled a resolution that would have added support for health care tax deductions to the AMA's policy on the uninsured, which now calls for tax credits to buy coverage. A measure to establish AMA guidelines for reviewing state health system reforms also was referred for more study.

The board will review the referred proposals and report back at the Interim Meeting in November. ◆

Delegates seek more oversight of retail clinics

Continued from preceding page

The AMA house adopted policy that calls for state and federal probes into a possible conflict of interest between the clinics and the pharmacies that own or host them. The new policy also opposes the waiving of state and federal regulations for retail clinics that do not comply with standards for medical practice facilities, and opposes the practice of insurers reducing or lowering co-pays to encourage the use of the clinics.

Members expressed concern that insurers and state regulators might be giving the clinics favorable treatment, placing traditional practices at a competitive disadvantage.

A year ago the AMA board acknowledged that retail health clinics were controversial but ultimately decided the clinics fit long-standing AMA policy that encourages "multiple entry points" into the health care system. It also developed guidelines that clinics must follow.

PHOTO BY PETER WYNN THOMPSON

Retail clinics would be fine if they were owned by doctors, said Robert Goldberg, DO, a physical medicine and rehabilitation specialist, "but they aren't."

In July 2006 there were approximately 90 clinics across the U.S. Today there are more than 400. As the clinics grow in popularity, some retailers, such as CVS Corp. and Walgreens, have stepped beyond the role of host and bought out entire chains.

Continued on page 4

Meeting Notes

Access to Care

ISSUE: Surgeons worry that non-physicians could encroach upon doctors of medicine and osteopathy when it comes to performing complex surgical procedures.

❒ **PROPOSED ACTION:** Adopt the definition of "surgery" developed by the American College of Surgeons. [*Adopted*]

ISSUE: Medicare Advantage plans are paid higher rates than fee-for-service plans, and private fee-for-service plans "deem" physicians as participants after filing one claim.

❒ **PROPOSED ACTION:** Seek to eliminate subsidies to Medicare Advantage and prohibit physician deeming without a contract. [*Adopted*]

ISSUE: Some physicians worry that the gulf between Medicare payments for primary care doctors and specialists is widening.

❒ **PROPOSED ACTION:** Recommend the voting representation on the AMA Relative Value Scale Update Committee, which suggests how much Medicare should value each service, be changed to include more primary care expertise. [*Referred for study*]

ISSUE: Physicians are concerned the National Quality Forum could supplant the Physician Consortium on Performance Improvement in developing quality measures.

❒ **PROPOSED ACTION:** Oppose any effort to expand the NQF in such a way and report on the forum's activities at the Interim Meeting. [*Adopted*]

ISSUE: The federal government could consider further limiting the prices paid for drugs, medical procedures and other services.

❒ **PROPOSED ACTION:** Oppose price controls in the health care industry and continue promoting market-based strategies to make health care affordable. [*Adopted*]

ISSUE: Immigrants and foreign visitors often lack health insurance.

❒ **PROPOSED ACTION:** Support legislation requiring the government pay physicians for federally mandated care, regardless of patient immigration status. [*Adopted*]

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Delegates seek more oversight of retail clinics

Continued from page 2

Some societies are already entrenched in fights over state governments considering waiving medical practice laws for retail clinics. Three Massachusetts medical societies are asking the Massachusetts Dept. of Public Health to hold public hearings before making a decision on MinuteClinic's request that it waive certain requirements, such as the size of the clinics and sanitation requirements.

The House of Delegates also opposed the practice of insurers lowering or waiving co-pays to encourage use of the clinics, 40% of which accept traditional health plans. Some plans, such as Blue Cross Blue Shield of Minnesota, have already begun waiving co-pays.

No other issue sparked as much discussion at the reference committee meeting. The majority of speakers favored an all-out opposition to retail-based clinics.

"Mayo Clinic, Cleveland Clinic, MinuteClinic? I don't think so," said Robert Goldberg, DO, a physical medicine and rehabilitation specialist from New York, who is also the president of the Medical Society of the State of New York.

Dr. Goldberg said the clinics would be fine if they were owned by doctors, "but they aren't."

Laws vary in each state regarding scope of practice and the role of physician assistants and nurse practitioners, who normally staff retail clinics without a physician on site. As part of its resolution, the AMA also resolved to work with state and specialty societies in developing guidelines and model legislation.

Other testimony dealt with concerns for patient safety and the implied conflict of interest between the clinics and the retailers who own and host them.

"The AMA is concerned that when patients go to retail-based clinics they get the same quality of care that they get in a physician's office," said board Trustee Peter W. Carmel, MD, a pediatric neurosurgeon from Newark, N.J.

When Rebecca Hafner, MD, a family physician from Minneapolis, stepped to the microphone, she admitted being nervous. Then she introduced herself as medical director for strategic alliance for MinuteClinic.

She said the testimony she was hearing was "all based on fear and unsubstantiated evidence."

In a prepared response to the AMA's action, MinuteClinic CEO Michael Howe said, "MinuteClinic follows nationally accepted, physician-developed treatment guidelines that ensure prescriptions are only issued when evidence-based testing demonstrates a need and where clinically appropriate."

Dr. Hafner said less than 50% of patients receive a prescription at all.

"Convenient care clinics have proliferated in retail settings throughout the country due to a widespread lack of access to high-quality, affordable health care in America," said Tine Hansen-Turton, executive director of the Convenient Care Assn., a trade group for the retail-based clinic industry, in a prepared statement.

"We are surprised that the AMA would take the position that it has, because so many physicians and other health care professionals have accepted this new model and see it as part of the solution to our broken health care system," she said.

Despite the overwhelming feelings against the clinics, the AMA board stopped short of calling for complete opposition.

Rochester, N.Y., orthopedic surgeon William A. Dolan, MD, reference committee chair and a newly elected AMA trustee, said despite the dislike of retail clinics, "We have to treat them legally." He said a call for an all-out ban could result in an antitrust judgment similar to one by chiropractors in the 1980s when the AMA attempted a boycott of chiropractic services.

"I think it would be naïve to think that [fear of litigation] wasn't a factor," Dr. Carmel said. ◆

Quick growth in quick care

The number of retail-based clinics increased by almost 350% over the past year. Studies show there could be consumer demand for as many as 5,000 clinics over the next five years.

	Clinics
July 2006	90
December 2006	255
July 2007	400
December 2007 *	700
December 2008 *	1,500
2010 *	2,500

*PROJECTED
SOURCE: MARY KATE SCOTT, FOR THE CALIFORNIA HEALTHCARE FOUNDATION

Doctors who give disaster aid seek liability shield [PAGE 13]

AMA backs Medicare pay reform plan

Delegates also approved several restructuring policies that go beyond the physician reimbursement issue.

David Glendinning
AMNEWS STAFF

Chicago The AMA House of Delegates threw its support behind organized medicine's plan to push for at least two years of positive Medicare updates while it continues to work on more permanent reforms.

Delegates at the Annual Meeting backed a report from the AMA Board of Trustees that lays out the strategy, unveiled earlier this year by the AMA and 76 other medical organizations. Under the plan, Congress would eliminate the physician pay cuts expected in 2008 and 2009 but also would establish a "date certain" by which to overhaul the entire payment system.

Support from the house for this approach will allow the Association to maintain its focus while it and the other organizations navigate through a couple of politically tricky years, said AMA Trustee J. James Rohack, MD. "This reflects the reality that in our current legislative cycle, the Congress isn't ready yet to bite the apple," he said. "We feel that in asking for the two years, this gets us through the 2008 presidential elections."

The desired result is a permanent pay system that bases annual changes

Continued on page 13

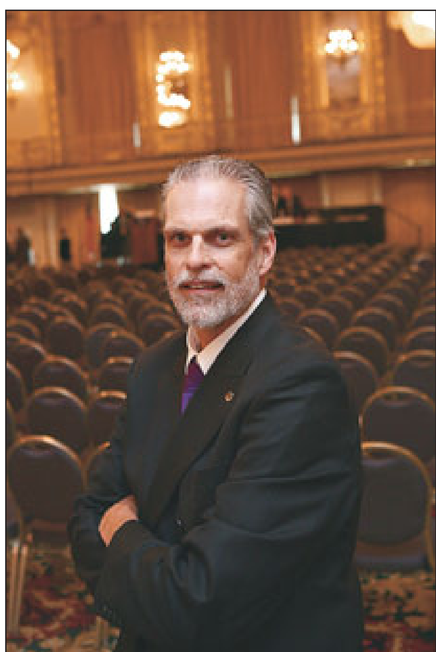

PHOTO BY PETER WYNN THOMPSON

Congress isn't yet ready to act, says AMA Trustee J. James Rohack, MD.

PHOTO BY PETER WYNN THOMPSON

More than 550 physicians representing geographic and specialty areas gathered in Chicago last month for the AMA Annual Meeting. Reimbursement issues — especially pay-for-performance initiatives — were much discussed.

AMA toughens P4P policy, vows to oppose problematic programs

The delegates' vote means the Association can aggressively act against deficient initiatives without waiting for state medical societies to weigh in.

David Glendinning
AMNEWS STAFF

Chicago The American Medical Association House of Delegates last month beefed up the AMA's policy on pay-for-performance programs by giving the Association freer rein to go after initiatives harmful to patients.

After intense debate, delegates at the Annual Meeting largely reaffirmed existing AMA policy on pay-for-performance but added language stating it would "actively oppose" any program that does not meet all of the Association's principles on the issue. First adopted two years ago, the principles maintain that programs must be voluntary, ensure quality of care, foster the patient-physician relationship, establish fair and accurate performance measures, and offer positive incentives — not penalties.

> "It is critical that physicians be at the table, or we will be on the table."
>
> **Richard M. Peer, MD, delegate**

During its 2005 Annual Meeting, the house voted to oppose programs that did not meet the principles. But by reaffirming this opposition and adding the word "actively," delegates this year agreed that the gloves should come off if the Association determines that a given public or private pay-for-performance initiative is in violation, said AMA Trustee J. James Rohack, MD.

"We interpret this to say that if we find a plan is being problematic, we can work with entities to try to correct that and don't need state societies' permission to come in," he said. "Sometimes, especially when we look at insurers that cross state boundaries, we will have to take action because of the implications that may affect all physicians."

The AMA already is claiming victory in heading off at least one public program that did not make the grade. Medicare's first attempt at a voluntary reporting program — considered by many to be a precursor to pay-for-performance — has been abandoned. It was replaced by a six-month pilot that uses new money for bonuses and uses measures developed by physicians. Dr. Rohack said that strong physician opposition to the initial plan was instrumental in that switch.

The new AMA policy is geared not only toward opposing undesirable programs. The house also voted for the Association to join other entities in developing new quality initiatives for the exclusive benefit of patients. These programs would need to preserve access to care and be free of third-party meddling with the patient-physician relationship in order to muster approval.

Not all pay-for-performance programs have proven

Continued on next page

Meeting Notes

Medical Practice

ISSUE: Insurers have implemented policies to fine physicians when patients chose to use out-of-network services.

❒ **PROPOSED ACTION:** "Vehemently oppose" any penalties insurance companies use against doctors when patients independently use out-of-network services. [*Adopted*]

ISSUE: The time psychiatric patients spend in emergency departments is steadily increasing, exacerbating ED crowding issues.

❒ **PROPOSED ACTION:** Work with other stakeholders to study the issue and develop recommendations regarding the national scope of the psychiatric bed shortage problem and its impact on the nation's emergency and general medicine resources, including ED overcrowding. [*Adopted*]

ISSUE: As more physicians move toward adoption of health information technology, they find the buying decision challenging because so many options are available.

❒ **PROPOSED ACTION:** Use the AMA Web site and Association publications to educate physicians about issues to consider when purchasing health information technology systems, including ensuring that there is adequate technical support. [*Adopted*]

ISSUE: Health care spending continues to rise more quickly than wages and inflation.

❒ **PROPOSED ACTION:** A host of strategies, including reducing preventable disease, improving efficiencies in health care delivery, reducing nonclinical costs that do not add to the value of patient care and improving health-related decision-making processes. [*Adopted*]

PHOTO BY TED GRUDZINSKI

Outdated or incorrect listings "place physicians at a disadvantage," said board Trustee Peter W. Carmel, MD.

AMA collecting complaints on insurer directories

Doctors say insurance plans often fail to update physician listings.

PAMELA LEWIS DOLAN
AMNEWS STAFF

Chicago Physicians can drop an insurance plan, move, retire, change practices or even die, and their information will remain the same in the insurer's directory, say doctors who are fed up with the inaccuracies in insurance plan physician directories.

At its Annual Meeting, The AMA House of Delegates approved a resolution calling for the Association to solicit and compile complaints by members regarding inaccuracies contained in health plan directories.

The House also resolved to have the AMA collect the physician complaints and make them available to members upon request.

Board Trustee Peter W. Carmel, MD, a pediatric neurosurgeon from Newark, N.J., said when inaccuracies occur, "it places physicians at a disadvantage when his area of expertise is not listed or is not correct."

"We believe these inaccuracies are financially mandated by the insurers … to show they have a larger spectrum of providers than they actually do," said Peter Kaufman, MD, a gastroenterologist from Bethesda, Md. He said the inaccuracies have caused gastroenterologists serious problems when patients seek out specialists, and the physician's specialty is not listed or is wrong.

Dr. Kaufman went on to say he has seen physicians listed in directories up to two years after they have died.

AMA policy states health plans "must promptly remove the physician's name from marketing materials and directory of participating doctors upon termination of that physician's contract with the plan."

But many of the inaccuracies occur when group practices sign multiyear contracts, and the groups do not inform the plans when someone leaves mid-contract, said Mohit Ghose, spokesman for America's Health Insurance Plans. "We would encourage physicians to provide timely updates. I really don't think this has anything to do with intentional misrepresentation for marketing purposes."

The AMA policy also states plans should make the directories available through multiple media sources, including the Internet. Many have, according to Ghose. He said many directories have gotten better since going online, which made it possible for changes to be made as soon as a physician's status within the plan changed. ◆

AMA vows to oppose problematic P4P plans

Continued from preceding page

deleterious to patient care, Dr. Rohack said. He pointed to an Integrated Healthcare Assn. project engineered in part by the late Ronald Bangasser, MD, a California family physician and AMA delegate, as one example of an initiative that has received good marks.

Some physicians are not convinced that organized medicine can chart a clear path to positive pay-for-performance. AMA trustees and supporters on the issue had to hold back several attempts to have the Association reject the concept completely.

A number of resolutions cited recent studies showing that pay-for-performance has failed to improve patient outcomes and has even been linked to access problems. Because programs tend to redirect health care dollars and prompt some doctors to avoid seeing patients who will lower their quality scores, tying payment to performance can actually make health quality worse, several physicians said.

"Organized medicine cannot keep prescribing a medication that doesn't work, and that's what pay-for-performance is," said Peter E. Lavine, MD, an orthopedic surgeon and alternate delegate from Washington, D.C.

Some delegates proposed that the AMA try to bring about an immediate stop to all existing public and private pay-for-performance programs until it could determine whether an acceptable initiative is even possible. Otherwise, physicians would simply be standing by as payers continue to roll out programs that endanger patients and degrade quality while boosting profits for insurance companies and revenues for the government, they said.

But following a theme expressed in recent years by AMA trustees, opponents of making such an about-face on the issue warned that it would give physicians a bad name and tie their hands as they attempted to negotiate for improvements.

"Can you imagine the publicity if the AMA changes course and walks away from pay-for-performance? The press may well say that doctors are not interested in improving quality, only improving their bottom line," said Richard M. Peer, MD, a vascular surgeon and delegate from Buffalo, N.Y. "It is critical that physicians be at the table, or we will be on the table."

In the end, delegates urging a more moderate approach prevailed, but they indicated strategies might change if developing initiatives take a turn for the worse.

The new policy authorizes an annual AMA report investigating new and existing programs. The first report is due at November's Interim Meeting. ◆

Doctors who give disaster aid seek liability shield

Delegates push for legislative changes requiring plaintiffs to show malicious intent.

Amy Lynn Sorrel
AMNEWS STAFF

Chicago The AMA House of Delegates wants to bolster civil and criminal liability protections for physicians assisting during officially declared disasters or emergencies. The move would let doctors answer the call for help without fearing their medical judgment will be questioned.

A patchwork of federal and state laws immunize volunteer doctors from liability for certain negligence that might occur while treating patients in catastrophic situations, according to a Board of Trustees report presented at the Annual Meeting. Those laws typically do not cover misconduct, and there is no protection from criminal charges.

Delegates voted to have the AMA develop and give to state medical societies model legislation that would automatically shield eligible doctors — whether they volunteer or already work in the area — from civil and criminal liability when they are treating patients in response to a declared disaster. The AMA also will push to enhance existing laws by replacing the traditional negligence standard with one requiring plaintiffs to show that bad faith, malice or deliberate intent to harm a patient was involved.

"[Liability protection] should never be a question when people need help and have help available," said AMA board Trustee William A. Hazel Jr., MD.

A case brought in the Hurricane Katrina aftermath has raised concerns that doctors might think twice about volunteering in disaster situations, knowing they could face criminal charges for their decisions. The Louisiana attorney general is investigating New Orleans otolaryngologist Anna Maria Pou, MD, and two nurses for allegedly killing patients with lethal doses of pain drugs. Dr. Pou and the nurses deny the allegations.

In extraordinary emergencies, "normal procedures are not available to doctors and they are left only with their good-faith judgment," Dr. Pou's lawyer, Richard T. Simmons Jr., said at the AMA meeting.

No formal charges have been filed against Dr. Pou. But faced with defending possible criminal and civil charges, Simmons said he found no guidelines on how to address the case in the context of a disaster. ◆

PHOTO BY PETER WYNN THOMPSON

Doctors' "medical judgment should only be questioned if there is malice involved," said attorney Richard T. Simmons Jr.

AMA backs Medicare pay reform

Continued from page 11

in physician rates on the Medicare Economic Index, a measure of the increases in doctors' costs of providing care. The two years of immediate relief also would be based on the MEI.

Some delegates warned, however, that simply moving from the sustainable growth rate formula to one based on the MEI would be a good first step but not the solution to all of physicians' Medicare payment problems.

"We thought the SGR was good at one time, and the MEI could also come back to bite us in the future," said Marcy Zwelling, MD, an internist and delegate from Los Alamitos, Calif.

Instead of simply exchanging one problem-prone formula with another, Medicare should be transformed into a program of defined contributions, rather than defined benefits, Dr. Zwelling said. Under such a concept, which the AMA supports, Medicare would pay a set amount for a beneficiary's care and give him or her the choice of how to spend that money.

A more specific proposal for Medicare defined contribution plans was included in a separate Council on Medical Service report, which explored several strategies to strengthen Medicare that go beyond the physician payment issue. Delegates approved the proposal, which would transition the system to one that requires beneficiaries to pay the difference between the premiums for the benefits they select and what the government offers as its set share.

The house also approved recommendations in the report to implement a single cost-sharing structure for beneficiaries and restructure Medicare's age-eligibility requirements. Such bold reforms would be necessary to ensure that Medicare survives the increasing strain on its finances, while maintaining many of its core features, the council said.

The house referred for further review two recommendations that would have called for combining Medicare's hospital and doctor trust funds and phasing in a high annual deductible for all Medicare services.

The aim in combining the Medicare Part A and Part B trust funds is to make the program more efficient by better targeting funding depending on medical needs. For example, if more spending were needed for physician services, and that translated into less demand for hospital care, funds could be allocated accordingly.

But this move might prove difficult, because the physician side of the program is voluntary, while the hospital side is mandatory for anyone who signs up for Medicare, said Richard W. Whitten, MD, an internist and delegate from Kent, Wash.

The concept of a high annual deductible aims to encourage beneficiaries to use Medicare services only when they truly need them. But some physicians, such as Larry S. Fields, MD, a family physician and delegate from Flatwoods, Ky., worried that this could create a barrier to needed care.

"The high deductible causes you a problem with people not seeking care until it's too late," he said.

The AMA Board of Trustees will report back on these two issues at the Interim Meeting in November. ◆

PHOTO BY PETER WYNN THOMPSON

The MEI may not be the final answer, said Delegate Marcy Zwelling, MD.

Meeting Notes

Other Actions

ISSUE: Apologizing to patients for unexpected outcomes could improve physician-patient communication and help reduce lawsuits.

❒ **PROPOSED ACTION:** Create an AMA policy allowing physicians to make apologies, confessions of regret or admissions of error to patients or families regarding adverse events, without those statements being admissible in court, and push for state and federal legislative advocacy. [*Adopted*]

ISSUE: Physicians are frustrated that antitrust laws put them at a disadvantage when negotiating payment contracts with a consolidated managed care industry.

❒ **PROPOSED ACTION:** Bolster advocacy for federal legislative changes that would let independent doctors, as a group, negotiate with insurers for reasonable reimbursements without threat of antitrust violations. [*Study and report back at the Interim Meeting*]

ISSUE: New AMA leadership

RESULTS: Nancy H. Nielsen, MD, PhD, an internist from Buffalo, N.Y., was selected president-elect. Rochester, N.Y., orthopedic surgeon and clinical professor William A. Dolan, MD, was elected to a four-year term on the AMA Board of Trustees. Re-elected to the board were: Cyril M. Hetsko, MD, an internist and clinical professor of medicine at the University of Wisconsin; Edward L. Langston, MD, a family physician from Lafayette, Ind., who also will serve as board chair; Rebecca J. Patchin, MD, an anesthesiologist and pain management specialist from Riverside, Calif.; Samantha L. Rosman, MD, a third-year pediatric resident in Boston; and Chris DeRienzo, a Duke University medical student.

ISSUE: AMA 2006 finances

RESULT: In 2006, the AMA posted a $30.1 million operating profit, marking the seventh consecutive year it has finished in the black. That is up from a $28.1 million operating profit in 2005.

ISSUE: AMA membership dues

RESULT: Delegates voted not to raise dues. Regular members will continue to pay $420 annually. Dues will stay at $315 for physicians in their second year of practice, $280 for military physicians, $210 for physicians in their first year of practice, $45 for residents and $20 for medical students.

Meeting Notes

Public Health

ISSUE: Patients run out of medication when health plans limit them to a one- or three-month supply defined as 30 or 90 days.

❒ **PROPOSED ACTION:** Urge health plans to define a one-month supply as at least 31 days and a three-month one as a minimum of 93 days. [*Adopted*]

ISSUE: Payers' reimbursement for vaccine, particularly for newer inoculations, is inadequate.

❒ **PROPOSED ACTION:** Intensify efforts to advocate that manufacturers and distributors make affordable and quickly deliver to physicians vaccines recommended by the Centers for Disease Control and Prevention. Recommend payers reimburse vaccination costs and related expenses. [*Adopted*]

ISSUE: Influenza vaccine distribution appears inequitable.

❒ **PROPOSED ACTION:** Study the impact of vaccine contracting by retail and other nongovernmental establishments. Continue efforts to educate those in the supply chain that physicians who serve high-risk patients should receive flu vaccine supplies in a timely and equitable manner. [*Adopted*]

ISSUE: Is banning men who have had sex with men at least once since 1977 from donating blood an outdated policy?

❒ **PROPOSED ACTION:** Rescind this policy in hopes of increasing the donor pool without elevating the risk of transmitting infections, given that highly sensitive and specific screening tests are available. [*Referred for study*]

ISSUE: Few women who have sex with women receive safer-sex education from physicians. They are also less likely to receive recommended cancer screenings.

❒ **PROPOSED ACTION:** Educate physicians about the need for this population to have regular health screenings for sexually transmitted infections and cancer. Support partner organizations in raising awareness among women who have sex with women of the need for regular health care and safer-sex practices. [*Adopted*]

ISSUE: No federal-level offices are dedicated to men's health.

❒ **PROPOSED ACTION:** Encourage the Dept. of Health and Human Services to establish a men's health office. [*Adopted*]

Overlap seen in human, animal medicine

Physicians hope closer ties between the disciplines will improve global health.

VICTORIA STAGG ELLIOTT
AMNEWS STAFF

Chicago As part of providing care for cancer patients, neuropsychiatrist Carol Tavani, MD, walks the wards of the Christiana Care Health System in Wilmington, Del., with a registered therapy dog. Patients have benefited from the canine's presence. But when the animal developed cancer, it benefited from the same technology — interventional radiology, thoracic surgery and chemotherapy — used to treat human carcinomas.

"[The dog] is now a cancer survivor seeing cancer patients," Dr. Tavani said.

This example is one of the many connections between human and animal medical care that improve the health of both. In recognition of this intersection and in hope of gaining even more from it, the AMA adopted policy at its June meeting committing to work with the American Veterinary Medical Assn. and calling for more collaboration.

PHOTO BY TED GRUDZINSKI

Carol Tavani, MD, takes a cancer-surviving canine to visit human cancer patients.

"We can accomplish more to improve health worldwide than we can alone," said AVMA President Roger K. Mahr, DVM.

In addition, the AMA will support joint educational programs between veterinary and human medical schools and cross-species disease surveillance. The organization also endorses the development of diagnostic methods, medicines and vaccines to control diseases that jump species.

"You think of all the diseases that affect us both. There's such a great need for this kind of relationship," said Raymond Dieter Jr., MD, a surgeon.

Meeting attendees said stronger ties were important for several reasons. Knowledge gained from animal medicine can improve human health and vice versa. Most notably, many outbreaks, such as pandemic influenza, originate in animals, and detection of pathogens in various species can be key to tracking and control of outbreaks in humans. Animals are often the source of food-borne outbreaks.

"With threats of cross-species disease transmission and pandemic in our global health environment, the time has come for the human and veterinary medical professions to work closer together for the greater protection of the public health in the 21st century," said AMA Trustee Duane M. Cady, MD.

Monitoring animal health has led to the discovery that certain environmental contaminants, such as lead or mercury, can be unhealthy for humans. AMA President Ronald M. Davis, MD, for instance, is investigating the effect of secondhand smoke on pets. Dr. Davis will be a keynote speaker at the "One Medicine" focus session at the July AVMA convention in Washington, D.C.

The AMA's action is the latest move toward strengthening the ties between those who work on animal and human health issues. The AVMA launched the "One Health Initiative Task Force" in April. The Centers For Disease Control and Prevention, which has had veterinarians on staff for many years, also created the National Center for Zoonotic, Vector-Borne and Enteric Diseases, in order to bring experts in animal medicine under one roof.

"The CDC has long embraced this approach," said Abigail Shefer, MD, who represented the U.S. Public Health Service at the Annual Meeting. "Joint AMA and AVMA tactical and strategic planning will greatly enhance public health communications and education." ◆

AMA concerned about video games' impact on youth

Delegates call for a review of the rating system but stop short of calling overuse an addiction.

VICTORIA STAGG ELLIOTT
AMNEWS STAFF

PHOTO BY PETER WYNN THOMPSON

"Naming this problem as a disease would remove some of the pejorative implications of it," said Melvyn Sterling, MD, an internist from Orange, Calif.

Chicago The video game rating system needs to be improved to allow parents to know why games receive the ratings they do and to lead to informed decision-making about which ones their children will be permitted to use, according to a report from the AMA's Council on Science and Public Health. These recommendations were adopted as policy at last month's Annual Meeting.

"We would like to see a ratings system that better alerts parents to the content of the video game and recommended age of the player, so they can decide whether or not their child should be playing it," said AMA President Ronald M. Davis, MD.

About 70% to 90% of those younger than 18 play video games. In response to studies suggesting that this activity can increase aggression in the short term and suspicions that it may contribute to the obesity epidemic, the AMA wants to increase awareness of the need to monitor and restrict video game and Internet use among children and adolescents. The organization also wants to encourage research into the long-term impact, both good and bad, and a determination of safe limits for screen time.

"The recognition of this as a problem by the medical community is only in its infancy, and the research follows rather than precedes recognition that something is a problem," said Thomas Allen, MD, a psychiatrist from Towson, Md., speaking for MedChi, the Maryland State Medical Society.

The report, however, stopped short of urging that Internet and video game addiction be included as a formal category in the revised *Diagnostic and Statistical Manual of Mental Disorders*. Rather, the AMA document will be forwarded for consideration to the American Psychiatric Assn. and other specialty societies involved in the revision.

"There's nothing here saying that this is a complex physiologic disease state akin to alcoholism or other substance use disorders, so it doesn't get to have the word 'addiction' attached to it," said New York psychiatrist Stuart Gitlow, MD, MPH, representing the American Society of Addiction Medicine. ◆

Schools urged to plan response for kids' anaphylaxis

AMA wants at-risk kids, and those who care for them, to be prepared.

Victoria Stagg Elliott
AMNEWS STAFF

Chicago Students at risk for anaphylaxis should be allowed access to epinephrine or other appropriate medications, and schools should have emergency-response plans to deal with this possible circumstance. School personnel who initially respond to an incident should be allowed to administer the necessary medications, according to a report from the AMA's Council on Science and Public Health, adopted as policy at last month's Annual Meeting.

"An epinephrine injection at the first sign of a reaction is critical," said AMA Trustee Rebecca J. Patchin, MD. "All states should have laws that allow children to protect themselves by carrying lifesaving tools like epinephrine or other prescribed medication."

The organization took this stand because anaphylaxis, though relatively rare, can be deadly if not dealt with immediately. Also, a growing number of children have allergies and asthma and are at risk, but barriers remain to ensuring they receive proper care.

"As a parent of two kids who have had anaphylaxis, I have to say you can raise them up as little kids. You can try to take care of them. But the moment they enter the school system you have no control over what happens," said Mohamed Khan, MD, PhD, who, as chair of the council, presented the report. "Depending on the school district, they can be in great danger."

Only 32 states have laws that allow students to carry epinephrine, which is the usual treatment, and some states have laws preventing school personnel from administering it. In addition, educational institutions may not necessarily be prepared to react appropriately to this type of emergency. According to data from the Centers for Disease Control and Prevention, most schools have medical emergency response plans, but many have never practiced them.

"It's very important that these procedures are in place and children can be protected," said Dr. Khan. "There are some legal changes that need to be made and some training that needs to occur at schools."

The AMA's recommendations apply from preschool to 12th grade and call for individual students known to be at risk to have a personalized emergency plan developed in conjunction with a physician. In addition, the organization wants more research to lead to improved understanding of the causes, epidemiology and treatment of anaphylactic reactions.

Experts say the hesitation about prompt action for children at risk for anaphylaxis is the fact that the preferred drug is injected. In a related action, the AMA intends to study the best way to improve care of children with diabetes in schools. ◆

Board Trustee Chris DeRienzo, a fourth-year student at Duke University School of Medicine in North Carolina, said access to care for the uninsured is a national problem the student section wants to address. "We hope to make these screenings a tradition at AMA meetings."

Delivering care

More than 100 children and adults from one underserved Chicago neighborhood received free health care screenings June 15, courtesy of AMA student and physician members. John Vasudevan, MD, a new medical school graduate and member of the Medical Student Section, helped organize the service event held at The Gap Community Center. "The object of this health fair was not only to provide a snapshot of health but to emphasize the importance of regular follow-up care," he said. Some 30 students participated in the Chicago service project, along with four physician volunteers. Student chapters across the country plan to organize additional screenings to draw attention to the uninsured issue.

PHOTOS BY KEVIN WEINSTEIN

Parents of eligible children were encouraged to sign up for the State Children's Health Insurance Program and were given information about community clinics that provide routine care. Medical student Meera Sheffrin helps Ana Sanchez with enrollment paperwork.

Meeting Notes

Medical Education

ISSUE: Some physicians remain skeptical of the need for the U.S. Medical Licensing Examination clinical skills test.

❒ **PROPOSED ACTION:** Study potential mechanisms for independent oversight of physician licensing exams, with a report due at the 2008 Annual Meeting. [*Adopted*]

ISSUE: Resident physicians may hesitate to report work-hour violations for fear of retaliation against them or their programs.

❒ **PROPOSED ACTION:** Urge the Accreditation Council for Graduate Medical Education and the American Osteopathic Assn. to alter the resident duty-hour violation reporting system to better protect whistle-blowers. [*Referred for study*]

ISSUE: Federal money for graduate medical education is capped, and regulatory changes threaten further restrictions to GME funding.

❒ **PROPOSED ACTION:** Collaborate with other stakeholders and advocate for a stable GME funding stream and push for more GME positions. [*Adopted*]

ISSUE: Concern that nonphysicians may call themselves board certified.

❒ **PROPOSED ACTION:** Communicate concerns to the National Board of Public Health Examiners and other stakeholders about NBPHE plans to create "board certification" for those who complete a master's in public health. Physicians believe the certification would be misleading. [*Adopted*]

ISSUE: Some worry that Office of Inspector General guidelines and revised Accreditation Council for Continuing Medical Education guidelines are impacting commercial CME money negatively.

❒ **PROPOSED ACTION:** A recent study said no, but continued monitoring on the impact of CME guidelines, standards and regulations on the delivery of CME at the state level is needed. Continued monitoring of trends in CME financing and availability also is needed. [*Adopted, with a report due back at the 2009 Annual Meeting*]

CEJA to study how ethics may shift during disasters

Delegates also commented on treating STD patients' sex partners without an exam.

Kevin B. O'Reilly
AMNEWS STAFF

Chicago After disasters such as Hurricane Katrina and the tsunami following the Indian Ocean earthquake, physicians say they need ethical guidance on triage and other matters in catastrophic situations.

More than 20 delegates expressed their concerns to the Council on Ethical and Judicial Affairs at the AMA Annual Meeting last month.

Daniel P. Edney, MD, a Vicksburg, Miss., internist, said he had volunteered to serve in four world-class disasters but that Hurricane Katrina differed in that physicians also were victims of the catastrophe who had to choose between fleeing with their families and remaining behind.

"We have the dilemma of deciding, 'Do I stay irrespective of what help I can provide?' " Dr. Edney said. "Especially when we reach the point where staying is futile in terms of benefiting patients, yet when I leave I'm abandoning the patient."

Other delegates said public authorities, not necessarily physicians, manage disaster response operations and that any ethical guidance should take that into account.

CEJA member Dudley M. Stewart Jr., MD, said the council "would like to develop guidelines consistent with the basic principles of medical ethics but take into consideration some of the exigencies of emergency situations." A central conflict, he said, is between the doctor's traditional responsibility to individual patients versus the population-based medicine that takes priority during disasters.

Delegates at the forum also discussed expedited partner therapy, the practice of treating sex partners of patients with sexually transmitted diseases without examining or counseling them. The Centers for Disease Control and Prevention has recommended such therapy for adult heterosexual couples with chlamydia or gonorrhea. Randomized controlled trials have found that the practice, also known as patient-delivered partner therapy, has reduced reinfection rates.

But the practice raises ethical concerns, according to CEJA member Hilary Fairbrother, MD, because "it turns patients into pseudo-physicians and relies on them to explain things accurately to their partners." Many delegates said treating a patient without an examination increases the risk of adverse events. Others with public health backgrounds said asymptomatic partners often are very reluctant to seek treatment and that partner therapy is effective.

PHOTO BY TED GRUDZINSKI

One unique aspect of Katrina was that physicians were also victims of the wide-ranging national disaster, said Daniel P. Edney, MD.

The day before CEJA held its open forum, about 25 disability activists from Chicago-based Feminist Response in Disability Activism and Not Dead Yet protested outside the Annual Meeting at the Hilton Chicago. The groups are upset about the medical ethics of the "Ashley X" case in Seattle. A CEJA report relevant to the Ashley case that deals with pediatric decision-making was withdrawn from consideration at the Annual Meeting because several late-arriving comments from specialty societies could not adequately be incorporated into the council's recommendations. The report likely will be presented for consideration at the AMA Interim Meeting in November. ◆

Anti-discrimination policy expanded to transgendered

The addition will allow the AMA to publicly oppose discrimination against transgender physicians, just as it would oppose inequities based on age, race or gender.

Kevin B. O'Reilly
AMNEWS STAFF

Chicago Transgender physicians, medical students and patients should not be discriminated against, the AMA's House of Delegates said at its Annual Meeting here last month.

The Association voted to modify 13 of its policies relating to human rights, medical staff and medical education to add gender identity to the list of characteristics such as race, sex and age that should be protected from discrimination.

The house also recommended that the Council on Ethical and Judicial Affairs add similar language to its policies on civil rights and physician-patient relationships.

The AMA Advisory Committee on Gay, Lesbian, Bisexual, and Transgender Issues, established in 2004, identified relevant policies and recommended the changes.

R. Nick Gorton, MD, is an openly transgender physician who said he was lucky to come out in a tolerant environment. He testified, however, about a transgender medical student whose school attempted to force him to leave when he announced his gender identity. It was only after outside intervention that the medical school even agreed to print the student's new legal male name on his diploma.

"Without policy opposing such discrimination, the AMA could not publicly support this student and condemn the school's actions," said Dr. Gorton, speaking as an individual.

AMA Trustee Steven J. Stack, MD, said he hopes that recognizing the challenges transgender physicians and patients face can have a larger impact.

"We want to be a thought leader in being as inclusive as possible," Dr. Stack said. Not including gender-identity language in AMA policy was an oversight, he added, "and we're happy to have it corrected." ◆

PHOTO BY PETER WYNN THOMPSON

Not every transgender physician experiences the tolerant environment he had, said R. Nick Gorton, MD.

Meeting Notes

Medical Ethics

ISSUE: Medical device industry representatives often advise physicians about company equipment, many times during surgery, but the AMA had no ethical policy governing this activity.

❒ **PROPOSED ACTION:** A new ethical opinion calling on physicians to prevent industry representatives from breaching patient confidentiality, to assure that their hospitals have mechanisms to verify reps' credentials, and to tell patients if a representative is present during a procedure and explain that person's role. [*Adopted*]

ISSUE: Are physicians still obliged to uphold medical ethics when they are serving in nonclinical roles?

❒ **PROPOSED ACTION:** An ethical opinion saying that physicians are still bound by their medical ethical obligations to the extent that their nonclinical roles — practicing health law or working as a health care journalist, for example — rely on medical experience, perspective or training. [*Adopted*]

ISSUE: What should physicians do to avoid conflicts of interest relating to their ownership stake in a health facility?

❒ **PROPOSED ACTION:** Update existing ethical opinion to clarify that physician ownership must not be contingent on a specified volume of referrals and that doctors should disclose their financial interests when advising their patients. [*Referred for study*]

ISSUE: Some patients have reported trouble filling prescriptions, especially for the emergency contraceptive pill marketed as Plan B, because pharmacists refused to fill the orders on the grounds of conscience.

❒ **PROPOSED ACTION:** That the AMA prepare a report on reported delays and recommend ways to make sure patients' legally valid prescriptions are filled in a timely fashion. [*Adopted*]

ISSUE: The implantation of rice-grain-sized radio frequency identification tags in humans as a way to store medical information is likely to expand, but poses safety and ethical concerns.

❒ **PROPOSED ACTION:** Inform patients about the uncertainties associated with RFID tags, ensure that any information stored on the devices is secure and support further safety and efficacy research. [*Adopted*]