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AMA meeting special section

In his opening address, AMA President J. James Rohack, MD, spelled out elements essential for health system reform. Turn to page 21 for House of Delegates coverage.

Stimulating EMR adoption

Hospital subsidies for doctors' EMRs are in flux now that federal funds are available.
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Teaching respect for obese patients

Education is key to remedying the bias patients feel some doctors have against them.
Professional Issues, page 10

Abortion amendment threatens reform's future
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Digital divide seen at hospitals serving poor
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Seeking a FAIR solution on out-of-network pay
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EMR school for doctors
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Liability premiums stay stable, but insurers warn this might not last

An overall dip in lawsuit frequency — 30% or more in some places — is the driving force behind premium moderation.

Amy Lynn Sorrel
AMNEWS STAFF

For the fourth straight year, medical liability insurance premiums have eased nationwide.

That's according to the annual *Medical Liability Monitor* survey, which showed 94% of premiums holding steady or dropping in 2009. Fifty-eight percent of premiums had no change, up from 50% in 2008. Another 36% of premiums fell, down from 43% last year.

While those figures are encouraging, physicians and insurance executives say premiums still must shrink from sky-high levels. Insurers expect improvements to continue into next year but are cautious of some potentially unfavorable trends suggesting that results could be short-lived.

"It does ease the pain, but the pain is still there because rates are still dramatically higher" than they were before rising in the early 2000s, said Robert D. Francis, chief operating officer of The Doctors Company, a Napa, Calif., physician-owned liability insurer that participated in the survey.

Meanwhile, jury awards are climbing steadily, counteracting the major premium reductions needed to get back to more reasonable pre-2000 levels, he said. "So we're getting to the end of the

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AMA INTERIM MEETING NEWS

PHOTO BY TED GRUDZINSKI/AMA

Physicians representing state and specialty medical societies gathered in Houston for the Interim Meeting of the AMA House of Delegates. The meeting is an opportunity for physicians to have their say.

Delegate vote refines AMA stance on system reform

Delegates rejected attempts to rescind AMA support of a U.S. House health reform bill and any new government-sponsored health insurance plan.

Doug Trapp
AMNEWS STAFF

Houston Hours of intense but civil discussion at the American Medical Association's Interim Meeting ended on Nov. 9 with the House of Delegates affirming its support for the leadership's actions on health system reform and strengthening the Association's reform policies.

Delegates adopted a 14-part substitute reform resolution that largely reaffirms existing AMA stances. It also formalizes some policies, such as AMA opposition to an independent Medicare commission with authority over payment policy. The resolution calls on the AMA to "actively and publicly" push several existing policies, such as physicians' rights to contract privately with patients.

AMA President-elect Cecil B. Wilson, MD, said the vote showed that the Board of Trustees correctly advocated on doctors' behalf in the time leading up to the meeting. "It's an affirmation of the AMA's position in

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Delegate vote refines AMA stance on system reform

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the health system reform debate."

Several state and specialty medical societies backed resolutions that would have rescinded AMA support for the Affordable Health Care for America Act, which the U.S. House of Representatives adopted Nov. 7. The AMA had announced its qualified support for the bill on Nov. 5 but did not endorse the entire measure.

The reference committee considering these resolutions did not recommend their approval, and the House of Delegates rejected proposed amendments with similar language.

David Cook is executive director and CEO of the Medical Assn. of Georgia, which led the coalition of medical societies that were critical of AMA support for the U.S. House bill. He said that despite the coalition's inability to redirect AMA policies, the society's leaders were satisfied they had a chance to present their arguments and help strengthen the policies.

"There's always going to be differences in any organization," Cook said after the meeting. "The important thing for an organization is that people are allowed to express their opinions and have a debate. We understand and respect the position that the House of Delegates took. We don't agree with that, but that's part of the democratic process."

Katie Orrico, director of the Washington, D.C., office of the American Assn. of Neurological Surgeons — another medical society in the coalition against U.S. House bill support — said her society's leaders also were pleased with the outcome of the meeting. "We feel that at this point it's certainly more constructive to try to work within the system to have the AMA represent our interests as opposed to just picking up our marbles and walking away."

Both Cook and Orrico said their societies would continue to advocate for their members' views.

Clarifying AMA support

Some delegates said during the meeting that the AMA did not go far enough in explaining its concerns about the U.S. House actions, which included passing a controversial public insurance option but moving a Medicare physician payment solution to a separate bill.

The AMA's show of support angered many members and created an image problem for the Association, said James E. Jarrett, MD, a head and neck surgeon and delegate from the Montana Medical Assn. "The image is that we have supported everything in the bill, whether we intended to or not."

Joseph P. Bailey Jr., MD, a rheumatologist and delegate from the Medical Assn. of Georgia, referred to an AMA news release applauding U.S. House adoption of reform legislation. "In my judgment, that's sort of like being in a lifeboat at sea and applauding the arrival of sharks in the water."

Other delegates, however, cited the AMA's qualified support of the U.S. House bill, noting that leaders appeared on national television to explain that position and that trustees held numerous teleconferences in advance of announcing the support.

Georgia delegates offered an amendment to the combined health system reform resolution that would have clarified that the AMA did not fully "endorse" the U.S. House bill. But the House of Delegates rejected the amendment by a 350-167 vote. Some attendees argued that the media and others would cite the clarification as evidence the House of Delegates did not support the AMA Board of Trustees, possibly damaging the Association's reputation.

Divide over the public option

Another hotly discussed resolution would have instructed the AMA Board of Trustees to determine whether to support reform legislation based on a list of 12 criteria. One of those criteria would have compelled the AMA to oppose any bill with a new publicly funded health insurance plan, including the U.S. House-passed measure. Fifteen state and specialty medical societies authored the resolution, which was not approved.

Nancy H. Nielsen, MD, PhD, AMA immediate past president, said she was troubled by the resolution's apparent rationale. She told delegates, "Do you all think that the board really didn't know this and that we didn't try to adhere to AMA policy?"

Much of the resolution's language was based on existing AMA policy, with one key exception being the proposed opposition to any new government-funded health plan. Delegates at the AMA Annual Meeting in June declined to take a firm stance on a public plan. Instead, the House of Delegates adopted policy supporting "health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice and universal access for patients."

The AMA's position on the public option isn't clear enough, said W. Jeff Terry, MD, chair of the delegation from the Medical Assn. of the State of Alabama. "We're just straddling the fence."

But delegates opposing the resolution said it would impede AMA leadership as it negotiated with Congress on reform legislation.

"I would not want to hamstring our policy decisions based on this one document," said delegate Lori Heim, MD, president of the American Academy of Family Physicians, which introduced resolutions supporting the Board of Trustees' positions. She said Congress may present a public health plan compatible with AMA policy. Other delegates said holding out for legislation that won't conflict with any AMA policy would brand the Association as an organization that always says "no." ◆

Resolution strengthens AMA health reform policies

The AMA House of Delegates on Nov. 9 adopted a 14-part resolution on health system reform in lieu of several proposed by state and specialty medical societies at the 2009 Interim Meeting. The resolution restates, strengthens and expands certain AMA policies on health reform legislation, including:

- That the AMA oppose an independent Medicare commission that would take Medicare payment policy control away from Congress and place it in the hands of unelected individuals.
- That the AMA actively and publicly support the right of patients and physicians to contract privately.
- That health insurance exchange plans be self-supporting and feature negotiated pay rates. Plans also must not require physician participation or restrict out-of-network access to doctors.
- That delegates support Association leadership in its efforts to promote AMA health system reform policies.
- That the AMA oppose redistributing Medicare pay among physicians based on unscientific outcomes, quality and risk-adjustment measurements. The AMA also opposes Medicare bonuses for one or more specialties being offset with cuts to other specialties.
- That eliminating health plans' preexisting condition denials also means ending inappropriate rescissions.

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Doctors, nurses can be disruptive, survey finds

Problem behavior persists a year after a Joint Commission crackdown, according to a survey of physician and nurse executives.
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Some specialists to see cuts in Medicare pay

Specialties involving heavy use of MRI and CT imaging will see particularly large reductions, prompting worry that some practices will close.
amednews.com/2009/gvl21116

Reform bills aimed at coverage shortages could fall short, insurers warn
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Reform on investors' minds as insurers report earnings
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Liability reform demos must include patient safety
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Ethics Forum: CME must be untainted — no matter who is paying
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Liability premiums stable, but insurers warn this might not last

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point where rates are going to keep coming down," Francis said.

Florida saw significant rate reductions, as much as 22% in some regions. But it topped the charts again this year with the highest rates nationwide for internists, general surgeons and ob-gyns, at $57,859, $191,422 and $201,808, respectively. The *Monitor* asked carriers to report manual rates as of July 1 for mature claims-made policies with $1 million/$3 million limits for those specialties.

But increases have slowed significantly. Only 6% of premiums nationally went up in 2009 — down from 7% in 2008 and 16% in 2007 — with nearly all premium hikes under 10%.

Competition also was up. No company withdrew from any state, and more than 10% of survey participants began writing business in new states.

Treading lightly

Insurers are proceeding cautiously, however, given past experience.

An overall dip in the frequency of lawsuit filings — 30% or more in some parts of the country — remains the driving force behind the premium moderation, said Lawrence E. Smarr, president and CEO of the Physician Insurers Assn. of America, a trade group for doctor-owned and -operated liability companies.

■ See more from the annual survey of medical liability premiums online.
amednews.com/2009/prl21123

"But we've seen this happen before in the 1980s, when claims unexpectedly dropped off, and it was followed by a rapid rise" that culminated in the spikes of the 2000s, he said. "For this reason, insurers are being very cautious and taking reductions only when they are truly justified."

For now, the decline in claims appears to be drowning out a rise in severity and litigation expenses, said Joseph M. Inwald, editor of the *Monitor's* 2009 results and president of Inwald Consulting Services, a Michigan-based insurance consulting firm.

But frequency is leveling off or rising in some areas, and if claims costs catch up to or outpace lawsuit filings, it could pressure insurers to raise premiums to keep up, Inwald warned.

When asked by the *Monitor*, some insurers said "never event" reporting and electronic medical records could trigger more claims.

Francis said tort reform has contributed significantly to the drop in frequency, although its staying power remains questionable, causing some insurers to hold back on cuts until reforms are confirmed by the courts. Premiums did not decline as precipitously in Illinois and Georgia, he noted, where damage caps are being challenged in the states' highest courts.

Still, some say the survey results indicate tort reform's success.

The premium cuts Ohio physicians saw in 2009 and the preceding three years coincided with a series of reforms lawmakers passed from 2002 to 2005, including a $350,000 noneconomic damage cap, said Tim Maglione, senior director of government relations for the Ohio State Medical Assn. Claims since have dropped 34% statewide, and three times the number of companies are now competing, compared with earlier in the decade.

"Is medical liability insurance still very expensive for many specialties? Yes," Maglione said. "But all these things add up to what we think is a really good case study for the cause and effect between a state legislature enacting meaningful tort reform and a more stable insurance marketplace for physicians."

In states without tort reform, patient safety improvements have helped moderate premiums, Francis said. But AMA Chair-elect Ardis Dee Hoven, MD, said the recent stability "will be short-lived in states without meaningful medical liability reform." The AMA is seeking inclusion of medical liability reforms in federal comprehensive health system reform.

A House bill that would eliminate certain antitrust exemptions for liability insurers could hurt their ability to share data and effectively price premiums, the PIAA's Smarr said.

Insurers "will have to be more conservative in pricing policies because more uncertainty means more risk, and that translates to higher prices for doctors." ◆

Clarification

The Nov. 2 article, "AMA's flu site 1st to link to care after rating symptoms," gave an unclear date for the start of the online flu assessment tool by Microsoft, which includes information from the Emory University School of Medicine. The idea for the site was developed in December 2008; the site was launched Oct. 7, 2009. Also, what was described as the Emory site is actually run by Microsoft. ◆

Delegates support review of marijuana's schedule I status [PAGE 22]

AMA House of Delegates

■ COVERAGE FROM THE 63RD INTERIM MEETING, NOV. 7–10 IN HOUSTON ■

PHOTOS BY TED GRUDZINSKI / AMA

The doctors are in the house

Health reform took center stage at the Interim Meeting of the AMA House of Delegates, held earlier this month in Houston. Delegates also took action on A(H1N1) influenza, gay rights, medical marijuana and resident work hours.

"Don't ask, don't tell" said to hurt patient care; repeal urged

The House of Delegates also said a lack of marriage rights contributes to health care disparities that affect gay families.

KEVIN B. O'REILLY
AMNEWS STAFF

Houston The American Medical Association came out in favor of ending the "don't ask, don't tell" law that requires gays in the military to hide their sexual orientation from their physicians and others. Delegates to the AMA Interim Meeting said the policy threatens the physician-patient relationship and compromises the medical care of gay patients in the military.

The military reserves the power to inspect service members' medical records for combat readiness purposes. So any mention of their sexual orientation could result in discharge under the federal law governing the military's policy on gays, known as "don't ask, don't tell."

The law puts gays in the military and their physicians in an untenable situation, said Wisconsin Medical Society delegate Paul A. Wertsch, MD, who brought the issue

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The "don't ask, don't tell" law is "hurting people, it's making doctors lie, it's having patients not get proper care and it's hurting the military," says Dr. Wertsch, a family physician, who brought the issue before the house.

No flu shot mandate for doctors; hand sanitizer pushed

The AMA will study if there's any benefit from requiring all health professionals to receive influenza vaccine.

KEVIN B. O'REILLY
AND DAMON ADAMS
AMNEWS STAFF

Houston The AMA House of Delegates rejected a proposal to mandate vaccinations for health care professionals but approved other policy to prevent the spread of seasonal flu and influenza A(H1N1).

A resolution by the Infectious Diseases Society of America said the AMA should back universal seasonal and H1N1 flu immunizations unless health professionals have medical contraindications or religious objections. In October, New York state announced that it was requiring all health professionals to get the H1N1 immunization, but the mandate was suspended later that month due to vaccine shortages.

DR. BUTERA

"It is our ethical duty to do no harm and prevent transmission of disease to patients," said Michael L. Butera, MD, an alternate delegate who spoke on behalf of IDSA. "Despite educational efforts, we have 40% to 70% immunization rates that are woefully inadequate." Mandates may be "the only way to achieve" the goal of universal vaccination, he said.

But delegates balked at the idea of a vaccination mandate, saying that requirements should be a last resort and can be counterproductive if implemented poorly. The house directed the AMA to study the ethical and scientific intricacies of the issue further.

Delegates said hand sanitizer dispensers should be available in well-trafficked areas and urged large gathering places to develop plans in line with Centers for Disease Control and Prevention recommendations.

Physicians briefed on H1N1

During a session at the Interim Meeting, two CDC officials briefed delegates on the latest epidemiological data on H1N1 and how best to manage the disease. They addressed hospitalization rates, vaccine availability, dosing and vaccine testing.

Most cases of H1N1 have not required hospital care. But the highest hospitalization rates have been for

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Delegates support review of marijuana's schedule I status

A change could make it easier for researchers to test potential medical uses and develop a drug delivery form safer than smoking.

Kevin B. O'Reilly
AMNEWS STAFF

Houston It is time to re-examine whether marijuana should be legally categorized as a schedule I drug, the AMA House of Delegates said at its Interim Meeting.

The goal of such a review is to facilitate "the conduct of clinical research and development of cannabinoid-based medicines and alternate delivery methods," says the newly adopted house policy.

The current scheduling "limits the access to cannabinols for even research — it is very difficult," said AMA Board of Trustees member Edward L. Langston, MD, a Lafayette, Ind., family physician. "We believe there should be a scientific review of cannabinols in the treatment of pain and other issues. ... We support research on the use of cannabinols for medical use."

Scientists researching marijuana's medical properties must get the Drug Enforcement Administration's approval every step of the way, and the sole legal national source of cannabis for scientific purposes is the National Institute on Drug Abuse. A number of bureaucratic hurdles apply to cannabis research that do not impede other drug investigations, said a report from the AMA Council on Science and Public Health.

Previously, the AMA called for more medical research on marijuana but balked at questioning its placement in the DEA schedule. The science council originally recommended retaining marijuana's schedule I status, but delegates objected in reference committee testimony.

"Schedule I is very appropriate for heroin and other noxious substances that have no place in medicine, but cannabinoids are useful drugs," said Melvyn Sterling, MD, a palliative care doctor and California Medical Assn. delegate who spoke on his own behalf. "There is compelling research that cannabinoids are helpful in treating the spasticity associated with multiple sclerosis and in persistent nausea associated with chemotherapy, and they may have other uses yet undiscovered. Why are they undiscovered? Because it's a schedule I drug."

Though delegates called for reviewing whether marijuana fits into schedule I, the house's new policy said the recommendation "should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug."

"Cannabinoids are useful drugs," says Melvyn Sterling, MD, a California palliative care physician.

Last year, the American College of Physicians adopted policy supporting a review of marijuana's schedule I classification. By this article's deadline, the DEA had not responded to *American Medical News* inquiries on the AMA's action. The Food and Drug Administration cited an interagency memo reflecting policy of the DEA, the Office of National Drug Control Policy and the FDA stating that the agencies "do not support the use of smoked marijuana for medical purposes." ◆

Student to student

Tiffany C. Nelson, a medical student at the University of Texas Medical Branch, shows high school student Brandon Scott one aspect of medical professionals' work during a Nov. 5 visit to Jack Yates Senior High School in Houston. About 90 medical students and physicians, including AMA President J. James Rohack, MD, spoke to more than 2,500 students at four schools as part of the AMA's Doctors Back to School, a program that encourages minorities to pursue careers in medicine.

PHOTOS BY TED GRUDZINSKI/AMA

Keep hands off the handhelds, drivers urged

Delegates said the use of cell phones and other devices while on the road distracts drivers and endangers public safety.

Kevin B. O'Reilly
AMNEWS STAFF

Houston A year after calling for a ban on driving while texting, the American Medical Association stepped up its attack on distracted driving. Any use of handheld devices while driving should be against the law, according to policy the AMA House of Delegates adopted at its Interim Meeting.

"We want your hands on the steering wheel," said AMA Board of Trustees member Edward L. Langston, MD, a Lafayette, Ind., family physician. "There's a growing body of data that's very definitive on the dangerous diversion of attention when using handheld devices. ... We're very supportive of legislation to deal with this."

The house is not seeking a ban on hands-free phone chatter behind the wheel, though studies have found that the cognitive distraction of holding a conversation — not encumbered hands — is what endangers drivers. Dr. Langston said that as more research on cell phones and driving emerges, the AMA may revisit its position.

Delegates said the use of cell phones and other devices on the road is getting out of hand and endangering drivers and others.

"I drive about 500 miles a week, and I regularly see people texting and talking on two different devices simultaneously," said Richard Pieters Jr., MD, a radiation oncologist and delegate who spoke on behalf of the Massachusetts Medical Society. "It is a very serious public health problem."

No state bans hands-free cell phone use, but six states and the District of Columbia bar holding the phone while driving. Texting while driving is against the law in 19 states and the District of Columbia. Drivers are four times more likely to crash when talking on a cell phone than when they are not, studies have found. ◆

Meeting Notes

Other Actions

ISSUE: The growing popularity of computed tomography and other imaging tests is exposing patients to increasing cumulative amounts of ionizing radiation, with unclear effects on lifetime cancer risk.

❒ **PROPOSED ACTION:** Work with specialty societies to devise a common format to track individual patients' cumulative radiation exposure and develop related physician performance measures. *[Adopted]*

ISSUE: Physicians too often fail to spot cases of child abuse and neglect.

❒ **PROPOSED ACTION:** Develop a comprehensive strategy to help educate doctors about how to detect, report and treat the mistreatment of children while reducing conflicts with child protective services. *[Adopted]*

ISSUE: Forty state medical boards ask about physicians' history of mental illness, potentially discouraging doctors from seeking appropriate treatment for psychiatric disorders.

❒ **PROPOSED ACTION:** Work with the Federation of State Medical Boards and others to develop less discriminatory application language that is consistent with boards' mission to protect public health. *[Adopted]*

No flu shot mandate for physicians

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children through age 4, said Anthony E. Fiore, MD, MPH, a medical epidemiologist in the CDC Influenza Division. Among hospitalized adults, 70% have an underlying medical condition. If a patient appears to have the virus, treatment should be started as soon as possible. "We encourage people not to delay treatment awaiting laboratory confirmation."

Physicians and other health care professionals need to take precautions to make sure they don't get sick, said Michael Bell, MD, associate director for infection control at the CDC Division of Healthcare Quality Promotion. Most exposure risk in hospitals is from sick workers, not patients. He cited an example of a resident at an Ohio hospital who infected 166 people with the virus.

To prevent the spread of H1N1 in physician practices, sick workers should stay home, and ill patients should be kept away from noninfected patients. Dr. Bell recommended vaccination for doctors and their staffs, saying it doesn't make sense to put patients at risk by skipping shots.

Health care personnel who develop a fever and respiratory symptoms should be excluded from work for at least 24 hours after the fever subsides, the CDC said. Workers who develop acute respiratory symptoms without fever should be allowed to work unless assigned to areas with severely immunocompromised patients. In those cases, workers should be reassigned temporarily or excluded from work for seven days from the onset of symptoms.

DR. FIORE

DR. BELL

Meanwhile, CDC officials on Nov. 12 said about 22 million Americans had been sickened by H1N1 and about 4,000 had died, including 540 children. About 42 million doses of vaccine have been created.

"The amount coming out will increase rapidly in the next few weeks," Dr. Fiore said.

In a Nov. 10 letter to doctors, Food and Drug Administration Commissioner Margaret A. Hamburg, MD, said no serious adverse events attributed to the vaccine had emerged in clinical trials on more than 3,600 patients. She encouraged physicians to report any vaccine-related problems to the Vaccine Adverse Event Reporting System.

Colette R. Willins, MD, a family physician in Westlake, Ohio, and a delegate for the American Academy of Family Physicians, was among the physicians at the AMA Interim Meeting who voiced frustration about not receiving H1N1 vaccines yet.

"They keep telling us to watch for it," she said. "I can't even get my staff vaccinated." ◆

Nap time mandate for on-call residents rejected

Delegates support tracking studies of how resident fatigue affects patient safety, but they say medicine — not politicians — should devise duty-hour rules.

KEVIN B. O'REILLY
AMNEWS STAFF

Houston A mandated five-hour nap time for medical residents on call could worsen patient safety by disrupting the continuity of care, the AMA House of Delegates said in a report adopted at its Interim Meeting.

The AMA will urge the Accreditation Council for Graduate Medical Education to reject a protected sleep period proposed by an Institute of Medicine report published in December 2008. That and other changes proposed by the IOM come with an estimated $1.5 billion price tag and would be difficult to implement, according to AMA Council on Science and Public Health recommendations the house adopted.

"There is a growing body of information exploring sleep deprivation and care and safety issues, particularly in residents, but there is a belief that it's not complete enough to support the restrictive hours that the Institute of Medicine had recommended," said AMA Board of Trustees member Edward L. Langston, MD, a Lafayette, Ind., family physician who in the past served on the ACGME board of directors.

Delegates also said the AMA should work to keep control of duty-hour decisions in the hands of the ACGME and free from the intervention of politicians, Joint Commission or Centers for Medicare & Medicaid Services.

"Addressing the rules and regulations around the training of physicians in various disciplines should reside with the profession," Dr. Langston said.

Surgeons have been especially outspoken about the effect of duty-hour rules on training.

"There really should not be further tinkering with work-hour restrictions," said AMA Trustee Peter W. Carmel, MD, a Newark, N.J., pediatric neurosurgeon, in reference committee testimony. "Our colleagues in Europe are suffering with the fact that they have such restrictions on work hours that they cannot train neurosurgeons the way they should be trained. ... They turn out neurosurgeons who cannot pass the board of the American Board of Neurological Surgery."

PHOTO BY TED GRUDZINSKI / AMA

Students oppose the five-hour nap rule for residents, says Michael Best of the Medical Student Section.

Medical students also backed the AMA's stance on required sleep. "We strongly oppose the five-hour nap time rule until such a time as there are clear data to suggest the benefits of that policy," said Michael Best, a regional medical student delegate who spoke on behalf of the Medical Student Section.

The AMA will continue to study the evidence on the effect of work-hour restrictions on physician training and patient care. The ACGME is reviewing its regulations and could propose new rules in February 2010. ◆

Better data protection needed from Blues

New AMA policy says the national insurer needs to expand its offer of credit protection for doctors whose information was on a stolen laptop.

DAMON ADAMS
AMNEWS STAFF

Houston The BlueCross BlueShield Assn. should expand credit protection and increase identity theft insurance to physicians affected when a laptop computer containing doctors' personal information was stolen from an employee's car, according to policy adopted by the American Medical Association House of Delegates.

The new policy calls for the Blues association to offer at least five years of credit protection for all affected physicians, offer more than one company for protection, raise the amount of ID theft insurance and publicly report confirmed cases of identity theft.

The national Blues plan also should provide affected physicians easy access to credit-monitoring reports without cost, and give legal protection and indemnification to doctors for any losses resulting from the breach.

> "It's really unconscionable that you could be so negligent in handling someone's data."
>
> **Michael Simon, MD**

"It's really unconscionable that you could be so negligent in handling someone's data," said Michael Simon, MD, a Poughkeepsie, N.Y., anesthesiologist and alternate delegate for the American Society of Anesthesiologists, who spoke on his own behalf in committee testimony.

Dr. Simon and other delegates said the measures are necessary to protect physicians from thieves. "They can now set up a practice using your name and number on paper and send out bills," Dr. Simon said.

A file containing unencrypted, identifying information for every physician nationwide who contracts with a BlueCross BlueShield-affiliated insurance plan was on the stolen employee-owned computer.

The Blues association told affiliated plans one week after the Aug. 25 theft. But the 39 member plans did not start informing the affected 850,000 doctors until October. Connecticut Attorney General Richard Blumenthal is investigating the data breach and whether the delay in notifying physicians violated state law. In a statement Nov. 9, Blumenthal also said affected physicians should get at least two years of credit monitoring and protection.

The Blues said it would provide a free year of credit monitoring only for those doctors listed in the file whose Social Security number is also their National Provider Identifier or tax identification number.

Blues spokesman Jeff Smokler said the association is working with the AMA to address physicians' concerns. It has contacted the Centers for Medicare & Medicaid Services to ensure that the agency knows which physician IDs have been compromised in case fraudulent billing is suspected. After the laptop was reported stolen, he said, the delay in getting the word to doctors was a result of "the way we're set up."

"We regret that this unfortunate and rare occurrence took place, and we are working to rectify the situation as swiftly and responsibly as possible," Smokler said. "We take very seriously our commitment to our provider partners and are committed to working with the AMA to protect physicians' information and to prevent such a security breach from happening again."

The new AMA policy also says insurers should store personal information about physicians and other health care professionals electronically only in encrypted form to reduce the chance of a data security breach. If a breach occurs, insurers should notify physicians immediately.

The AMA will study the problems of such breaches and report back at its Annual Meeting in June 2010. ◆

Are doctors responsible for controlling costs?

A CEJA open forum explored the role of physicians in an age of ever-rising medical spending.

Kevin B. O'Reilly
AMNEWS STAFF

Houston In the debate over health insurance reform, proposals to control rising costs have focused on systemic changes such as redesigning the payment system, prioritizing primary care and comparing the effectiveness of medical interventions.

But what obligation does the individual physician have to appropriately use scarce medical dollars? And how can that responsibility be squared with doctors' duty to advocate for the welfare of their patients?

These were some of the questions delegates explored at the Council on Ethical and Judicial Affairs open forum held at the AMA's Interim Meeting in November.

Health care costs account for 16% of U.S. gross domestic product. That level of spending "represents an enormous burden for individuals, employers and other payers at the state and federal levels," said CEJA member Susan D. Goold, MD, an Ann Arbor, Mich., internist. She said it is critical for doctors to examine what part they play in rising costs.

DR. GOOLD

"The physician's pen is the most expensive medical device out there," Dr. Goold said. "Our orders pretty much control what happens to patients. We have a big role in what happens to health care spending."

Some delegates said the fear of medical liability lawsuits drives doctors to order costly interventions.

"Until we end up with a solution to the malpractice problem so that patients can be adequately compensated when they are injured without throwing all kinds of blame or harassment on physicians, we're going to have overutilization," said John A. Seibel, MD, an Albuquerque, N.M., endocrinologist and a delegate for the American Assn. of Clinical Endocrinologists.

PHOTO BY TED GRUDZINSKI / AMA

Doctors are "doing everything they can to keep the malpractice costs down," says John A. Seibel, MD.

Shifting responsibilities

Others challenged the notion that rising medical spending is a baleful trend.

"Increased spending on health care is good for this country," said Leon Reinstein, MD, a Baltimore physical medicine and rehabilitation specialist and a delegate for American Academy of Physical Medicine and Rehabilitation. "Two-thirds of health care spending goes into wages. These people don't put their money into mattresses. They buy houses, they buy cars, they spend money. You can't say the sky is falling just because we're spending more money on health care; the question is how to spend that money wisely."

Others said they want ethical guidance on how to balance obligations to individual patients and to society.

"I'm troubled by the ethical policy that says the responsibility is only to the patient in front of you," said Neil H. Brooks, MD, a Vernon Rockville, Conn., family physician and a delegate for the American Academy of Family Physicians. "Every moment I am with a patient, I'm also responsible to other patients. When I'm with the family with a mom who has cancer and they want one more CT scan, I somehow have to be involved in these decisions about the use of resources. I don't think it's ethical for me not to."

Delegates also discussed "never events" — serious preventable adverse outcomes such as wrong-site surgery. Medicare recently stopped paying for some of these mistakes, joining a growing number of health plans. Many hospitals also have stopped billing for these errors, and 27 states require organizations to report when never events happen.

But many delegates asked CEJA to distinguish in its deliberations on ethics policy between true never events and complications, such as urinary tract infections, that are not always preventable despite the best efforts to adhere to evidence-based guidelines.

CEJA could present ethical opinions on these topics for delegates' consideration within the next 12 to 18 months. ◆

Meeting Notes

Medical Ethics

ISSUE: Industry funding of continuing medical education and CME faculty with financial conflicts may inappropriately influence educational content.

❒ **PROPOSED ACTION:** Develop ethical guidance advising that commercial support should be avoided when possible. Lay out principles for how to minimize financial conflicts and reduce the potential for bias. *[Referred]*

ISSUE: Kidney transplant chains have become more prevalent in recent years, raising questions about their propriety.

❒ **PROPOSED ACTION:** Examine the scientific feasibility and ethical implications of these new practices. *[Adopted]*

ISSUE: Some medical students and doctors post unprofessional content online.

❒ **PROPOSED ACTION:** Write ethical standards for physician professionalism online and incorporate them into the modernized AMA Code of Medical Ethics. *[Adopted]*

ISSUE: Illegal immigrants sometimes are discharged from American hospitals and repatriated to their home countries, where they get little or no medical care.

❒ **PROPOSED ACTION:** Develop ethical guidance advising doctors to refuse to sign discharge orders that would repatriate such patients involuntarily. *[Referred]*

Repeal of "don't ask, don't tell" urged

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before the house. "If you can't trust your doctor to tell the truth, you're not going to tell the truth," said Dr. Wertsch, whose son is gay. "If a doctor feels that by writing down the truth, he can get you in trouble, that's a bad situation."

The "don't ask, don't tell" law is "hurting people, it's making doctors lie, it's having patients not get proper care and it's hurting the military," said Dr. Wertsch, a family physician.

His original resolution asked the AMA to lobby the armed forces to change policy to protect the confidentiality of any disclosures regarding sexual orientation. But military physicians testified in reference committee that federal law governed the matter and the law is what needs to change. The committee strengthened the resolution to call for a complete repeal of the "don't ask, don't tell" law, and the house adopted it without debate.

"The AMA took the horse by the reins in doing what needed to be done to call for the repeal of something that creates such disparities and such health care risks," said Jennifer Chaffin, MD, a San Ramon, Calif., forensic psychiatrist who chairs the AMA Advisory Committee on Gay, Lesbian, Bisexual and Transgender Issues. Dr. Wertsch also serves on the committee.

Alexander Nicholson, executive director of Servicemembers United, which represents gays actively serving in the military and veterans, testified before the AMA reference committee. "This is yet another nail in the coffin of the flawed and outdated 'don't ask, don't tell' law," he said later, "It should send a strong message to those who continue to blindly claim that this policy works."

A July 2008 *Washington Post*-ABC News poll found that 75% of Americans back allowing gays to openly serve in the military.

After months of inaction and growing complaints from gay advocacy groups, President Barack Obama in October reaffirmed his campaign pledge to sign legislation allowing gays in the military to reveal their sexual orientation.

"President Obama has been clear ... that he is committed to repeal the 'don't ask, don't tell' policy," said Lt. Col. Jonathan Withington, a Dept. of Defense spokesman. "He has also been clear that he is committed to doing it in a way that is least disruptive to our troops, especially given that they have been simultaneously waging two wars for six years now."

Repeal of "don't ask, don't tell" is likely to be part of next year's Defense Dept. authorization bill, according to Rep. Barney Frank (D, Mass.), who is one of three openly gay members of Congress.

Marriage disparities

A separate AMA Council on Science and Public Health report found that gay families face a host of health disparities, such as unequal access to health insurance benefits, due to laws barring them from marriage.

"Exclusion from civil marriage contributes to health care disparities affecting same-sex households," said the council's report recommendation, which the house adopted.

The AMA's new policy — also adopted without house debate — commits the organization to working to reduce health disparities in gay families and supporting "measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households."

The policy does not call for repealing the Defense of Marriage Act — which denies federal benefits to same-sex partners — or for backing state-level attempts to give gays access to civil unions or legal marriage. ◆