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WIDE-ANGLE PHOTO BY PETER WYNN THOMPSON

The AMA House of Delegates, meeting in Chicago in June, took a wide-ranging look at key issues facing medicine today.

Call for revision

Delegates decry CMS no-pay list as unrealistic

Physicians said many conditions are not truly preventable and the initiative will expose doctors to additional liability.

DOUG TRAPP
AMNEWS STAFF

Chicago The AMA House of Delegates in June stood solidly against much of a Medicare initiative that would limit pay beginning Oct. 1 for up to 17 hospital-acquired conditions.

Under the program, Medicare still will pay for hospitalizations but no longer will reimburse facilities for the added cost of care for certain preventable conditions that patients develop during their stays. But delegates said the conditions on the Centers for Medicare & Medicaid Services' list are not always preventable, even if physi-

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AMA grades health plans on how they handle claims

The Association hopes to reduce the administrative costs and other obstacles doctors face in collecting from insurance companies.

EMILY BERRY
AMNEWS STAFF

Chicago The AMA has launched a campaign to fix a claims-payment system that doctors say requires them to spend precious time and their own money to get paid what they're owed by insurance companies.

As a starting point for its Cure the Claims campaign, the AMA released a report card at its Annual Meeting in June comparing the administrative accuracy and efficiencies of Medicare and several commercial payers. The report showed that insurers' claims payments are often late and inaccurate, explanations for denials are inconsistent, and payment rules are sometimes impossible to decipher.

"The AMA report card results clearly convey the daunting task confronting physicians and their staff, just to get paid for the services they have earned," said AMA Board of Trustees member William A. Dolan, MD, who introduced the initiative to members and delegates at the meeting.

Doctors sometimes spend as much as 14% of their total collections on claims administration, and the AMA wants to see the average lowered to 1%, Dr. Dolan said.

"While health insurers insist on high standards for physicians reporting medical claims, I'm afraid they hold themselves to a lower standard

Continued on next page

AMA meeting special section

In her inaugural address, incoming President Nancy H. Nielsen, MD, PhD, vowed to make the uninsured a priority. Coverage of the House of Delegates starts on page 25.

Medicare audit overreach?

Physicians say Medicare's "bounty hunters" are heavy-handed, but the program is going nationwide.
Government & Medicine, page 5

Book provides vaccine answers

Physicians may benefit from summaries of research as well as tips on communicating effectively with parents.
Health & Science, page 40

Colorado reforms include doctor rating standards
Government & Medicine, page 8

Mass. doctors sue, calling ranking program flawed
Professional Issues, page 13

Removing barriers to health IT
Opinion, page 38

Summer is time for Lyme
Health & Science, page 46

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AMA grades plans on how they handle claims processing

PHOTO BY PETER WYNN THOMPSON

"Physicians want to focus on caring for their patients, not fighting health insurance red tape that may delay, deny or shortchange payments for their services," AMA Trustee William A. Dolan, MD, said about the campaign.

Continued from preceding page

of accuracy for processing these claims," he said.

In some cases, health plans questioned the AMA's methodology in compiling the report card but also said they were analyzing the results to find ways to improve.

Eliminating, or at least reducing, the inefficiencies in the current billing system could save millions of dollars and time, freeing physicians to care for patients rather than worrying about getting paid by insurers. That could result in lower health insurance premiums and improve the quality of care doctors deliver, Dr. Dolan said.

"The current system is unacceptable," he said. "The health care system can no longer afford the cost of the current claims processing."

The National Health Insurer Report Card was based on data culled from 5 million claims billed electronically to Medicare and seven commercial health plans: Aetna, Humana, Cigna, WellPoint-owned Anthem Blue Cross Blue Shield, Coventry Health Care, Health Net, and UnitedHealth Group-owned UnitedHealthcare.

The AMA's analysis revealed that it is possible to reduce drastically or virtually eliminate the problems endemic in the health plans' claims-payment systems, because Medicare has done it in most cases, said Mark Rieger, CEO of National Healthcare Exchange Services, a physicians' claims service firm that provided the claims database for the report card project.

Improving claims processing

Cigna spokesman Joe Mondy said that the health plan disagreed with the way it was measured in some areas. For instance, it scored poorly for not listing the date a claim was received on one form when the date actually is disclosed on a different form. But, he said, the company shares the goal of improving the claims-processing system.

"There are some challenges, but it's the first year of the study, and hopefully we'll be able to work with the AMA in refining the methods so it's more meaningful in the future," he said.

A spokeswoman for UnitedHealthcare, Cheryl Randolph, said the health insurance giant was proud to have done well under some measures in the scorecard, including having a low rate of denials and being third best for payment timeliness.

"While we fully accept our accountability in terms of ensuring claims are paid accurately and on time, we believe that physicians and their billing services also share in that responsibility and have opportunities to facilitate their performance," she wrote in a statement. "In order for claims to be processed as efficiently and promptly as possible, both insurers and physicians need to strive for accuracy and timeliness. For example, data show there is often a significant lag time between when services are provided and physician claims are submitted."

Peter V. Lee, executive director for national health policy for the Pacific Business Group on Health, asked doctors to take responsibility for health care costs by holding down their own costs. The group is a nonprofit consortium of business leaders advocating for transparency in health care pricing and accurate, useful quality information for patients.

Lee said business leaders are beginning to understand how critical it is for doctors and other health professionals to be paid correctly and quickly, and are demanding it of health plans.

"That doesn't mean paying claims blindly," he added.

Marcy Zwelling, MD, a primary care physician from Los Alamitos, Calif., and a delegate for the California Medical Assn., said the AMA's campaign isn't the only answer to physicians' frustrations over billing, claims and reimbursement.

She said she has gone to a cash-based practice and no longer deals with insurance companies. She encouraged doctors who could afford it to make the same leap.

"It took a lot of courage for me to say no," she said. "But it's better [now]."

Former family physician and University of Chicago researcher Lawrence Casalino, MD, PhD, is working on a project similar to the AMA's report card. He said anonymous interviews with health plan executives for his research revealed that the people running claims-payment systems know they don't work well, and those systems could be improved if one company would take the first step.

"I don't think there's any disagreement that there's opportunity for improvement in the system," he said.

Dr. Casalino remembered the relentless frustration he and the other doctors in his group felt trying to be paid on time and accurately for their work.

"For 20 years I would go home with the uneasy feeling that I was leaving money on the table." ◆

The AMA's solution

The Cure the Claims campaign offers a prescription for addressing the cost of getting paid for care. Campaign materials outline ways for doctors and health plans to reduce wasted time and money spent on paying doctors.

How to fix it

- Physicians should submit claims quickly and accurately the first time.
- Health plans should pay in a timely manner and at the contracted rate.
- Plans should make available fee schedules, proprietary edits, payment policies and other payment information on their Web sites.
- Plans should standardize the language and reasons for claim denials to reduce ambiguity in the pay process.

What the fixes should do

- Reduce physicians' claim submission costs from the current 14% of collections to 1%.
- Reduce waste and inefficiency.

SOURCE: AMERICAN MEDICAL ASSOCIATION

Meeting Notes

Medical Practice

ISSUE: With more practices operating on a cash basis, physicians worry that some patients may not know the fees, or how they are expected to pay them.

❒ **PROPOSED ACTION:** The AMA is to adopt principles for a cash-based practice that include an appropriate fee schedule that is understandable and easily accessible to patients. Cash-based practices should encourage patients to have health insurance coverage for catastrophic illnesses. *[Adopted]*

ISSUE: Medicare rules prohibit patients from compensating physicians above and beyond what Medicare covers, which may discourage physician participation.

❒ **PROPOSED ACTION:** The AMA will immediately call upon Congress to remove fee limits under Medicare and to preempt state laws limiting charges for physicians. Progress is to be reported annually to the house. *[Adopted]*

ISSUE: Antiquated federal rules pose barriers to electronic prescribing.

❒ **PROPOSED ACTION:** The AMA will work with federal and private entities to update laws and rules that are roadblocks to e-prescribing, while maintaining a position that physician Medicare or Medicaid pay not be reduced for failing to adopt e-prescribing. The AMA will begin discussions with the Drug Enforcement Administration to allow e-prescribing of Schedule II drugs. *[Adopted]*

ISSUE: Physicians can't always access patient's preexisting prescriptions for controlled substances.

❒ **PROPOSED ACTION:** The AMA will support changes to state prescription drug monitoring programs to allow physicians real-time access to their patients' controlled substance prescriptions across state lines. *[Adopted]*

ISSUE: Physicians sometimes have limited knowledge of their rights under Medicare's Recovery Audit Contractor program.

❒ **PROPOSED ACTION:** The AMA will support a moratorium on the expansion of the RAC program and begin a physician education campaign. *[Adopted]*

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Delegates decry CMS no-pay list as unrealistic

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cians follow evidence-based guidelines. The effort threatens to increase defensive medicine, to drive up costs by requiring more tests upon admission, and to expose physicians to additional lawsuits, doctors said.

"This is a fundamentally flawed program about which our concerns cannot be expressed stringently enough," said AMA Board of Trustees member Steven J. Stack, MD, an emergency physician in Lexington, Ky.

The house adopted policy at its Annual Meeting calling on the AMA to oppose nonpayment of conditions that are not reasonably preventable with the application of well-developed evidence-based guidelines. The new policy asks the Association to inform physicians about the effort, to monitor practice changes resulting from the initiative, and to educate Congress, CMS and the public about its unintended consequences.

CMS, instructed by the Deficit Reduction Act of 2005, identified eight conditions for which Medicare would not pay beginning Oct. 1, 2008. CMS finalized that list in October 2007, but in April 2008 the agency called for nine additional conditions to be added. CMS accepted comments on the new proposal until June 13 and will respond to them in a final rule due on or before Aug. 1.

CMS should deny payment only if hospitals don't comply with evidence-based guidelines, the AMA says.

These efforts are an attempt to make Medicare a prudent purchaser of health care services, CMS Acting Administrator Kerry Weems said in April. A CMS spokeswoman said conservative estimates suggest $270 million in savings over five years.

Michael Greene, MD, an alternate delegate for the Medical Assn. of Georgia and a family physician in Macon, Ga., said the effort creates unrealistic expectations. "What these requirements do is not hold us to a standard of care. It holds us to a standard of perfection." For example, it's not reasonable to assume physicians can prevent all urinary catheter-associated infections — one condition on the no-pay list, he said.

The program will cause problems if it's not clear who is responsible for the patient developing the condition, said Louito Edje, MD, a family physician in Maumee, Ohio, and an AMA Organized Medical Staff Section member. "This potentially is divisive for the health care team."

The AMA also should be concerned that CMS will apply this philosophy to physician practices, said Richard Warner, MD, a psychiatrist in Shawnee Mission, Kan., and an alternate delegate for the Kansas Medical Society. "We need to put forward the strongest possible opposition to the continued growth of this approach."

In addition, the house adopted policy against allowing public or private insurers' payment practices to determine care standards. It instructed the AMA to study the initiative's impact on professional liability and its potential for micromanagement of physician decision-making.

AMA: Too many conditions

CMS should make a number of adjustments to the Medicare hospital-acquired conditions program, such as excluding eight conditions that do not meet the statutory requirement of being reasonably preventable, wrote AMA Executive Vice President and CEO Michael Maves, MD, MBA, in a June 13 letter to CMS.

For example, the program should not include delirium, which can have many potential causes and is common near the end of a patient's life. Seven other conditions aren't reasonably preventable, Dr. Maves wrote. These are: surgical site infections following certain elective procedures, *Staphylococcus aureus* septicemia, *Clostridium difficile*-associated disease, ventilator-associated pneumonia, deep vein thrombosis/pulmonary embolism, Legionnaire's disease and extreme aberrations in glycemic control.

CMS should consider excluding high-risk patients from the effort and should determine how preventable these conditions are, Dr. Maves wrote. The agency should factor in the extra costs of complying with this program — including screenings and tests — in the physician pay formula.

A better approach would be for CMS to ask hospitals to comply with evidence-based care guidelines and deny payment only if these standards were not followed, Dr. Maves wrote. Under such a system, Medicare still would pay for the additional care required if the standards were followed and a patient still developed one of the conditions. ◆

Medical students helped the voice of the uninsured be heard [PAGE 29]

AMA House of Delegates

■ COVERAGE FROM THE 157TH ANNUAL MEETING, JUNE 14–18 IN CHICAGO ■

PHOTO BY TED GRUDZINSKI

Reflecting on a year of challenges

Wrapping up his year as AMA president, Ron Davis, MD, gave an inspirational and emotional speech during the opening session of the Annual Meeting. He spoke of his battle with pancreatic cancer and what it's like for a doctor to be a patient. Dr. Davis, who briefly donned a Detroit Red Wings cap to celebrate his home state team's Stanley Cup championship, also urged physicians to leave a legacy for the next generation.

Physicians demand greater oversight of doctors of nursing

Delegates also voted for increased supervision of midwifery practice.

AMY LYNN SORREL
AMNEWS STAFF

Chicago Citing patient safety concerns, members of the AMA House of Delegates protested the unregulated expansion of doctors of nursing practice and urged organized medicine to ensure transparency in and supervision of their role in medical care.

The outcry comes amid concerns about a shortage of primary care physicians and a surge in DNP programs.

The National Board of Medical Examiners this fall plans to offer a voluntary DNP certification test based on the medical licensing exam. In addition, many nursing schools and other health care professional training programs have incorporated doctorate degrees and used the titles "resident" and "doctor" despite their nonphysician status.

Delegates said patients could wind up confused and have their treatment compromised because DNPs and other advanced practice professionals do not share the same level of knowledge and training as licensed physicians. Delegates also worried the movement could lead to other scope-of-practice expansions.

In response, delegates at the AMA Annual Meeting in June passed a resolution calling on the Association to advocate that professionals in a clinical setting clearly identify their qualifications and degrees to patients. Delegates directed the AMA to develop model state legislation to that effect and to support other state legislative efforts to make it a felony for nonphysician health care professionals to misrepresent themselves as physicians.

"This is not to impugn [nurses'] training and important contributions to the care team. But in an era of transparency, we have to insist on complete openness in the qualifications and licensure of all caregivers," said AMA Board of Trustees member Steven J. Stack, MD. "Patients have a right to know."

The house also adopted policy that DNPs must prac-

Continued on next page

Guidelines target safety of medical tourists

With patients increasingly considering overseas trips for care, new principles outline how they should be protected.

KAREN CAFFARINI
AMNEWS STAFF

Chicago Acknowledging that lower costs are luring a growing number of patients abroad for medical treatment, the AMA's House of Delegates adopted nine new guiding principles at its Annual Meeting to ensure the safety of those medical tourists.

The principles — which the AMA said were the first of their kind — provide steps that the organization said should be considered by patients, employers, insurers and others when coordinating medical travel.

"Medical tourism is in its infancy, although it is growing very fast. It is still too early to determine whether the risks outweigh the advantages. We need to address this issue in its initial stage," said W.J. Terry, MD, a Mobile, Ala., urologist and member of the AMA Council on Medical Service.

In 2006, an estimated 150,000 Americans received medical care overseas, nearly half of which was for necessary surgeries, according to Josef Woodman, author of a book on medical tourism. Overseas procedures can cost 20% less than the price of the same procedure in the U.S. It also was pointed out in the council's report that a growing number of foreign hospitals and clinics are owned, managed or affiliated with American universities or health care systems, including the Cleveland and Mayo clinics.

The principles state that medical travel should be a choice, not a requirement, for patients and that patients need to be informed of the medical and legal risks of travel. The principles also state that financial incentives for medical travel should not restrict care given to patients, and be used only for facilities accredited by internationally recognized bodies such as the Joint Commission International or the International Society for Quality in Health Care.

In addition, follow-up care for patients back in the United States should be arranged prior to travel and patient information transferred between overseas and the U.S. should conform to HIPAA guidelines.

AMA President-elect J. James Rohack, MD, said the cost of care in

Continued on next page

Meeting Notes

Access to Care

ISSUE: More procedures are being performed in ambulatory surgical centers because of cost and quality benefits, but varying state regulations pose barriers to the doctor-owned facilities.

❒ **PROPOSED ACTION:** Review data on the effectiveness of ambulatory surgical centers and advocate for federal and state legislation aimed at removing obstacles such as certificate-of-need laws. *[Adopted]*

ISSUE: Physicians are concerned that the shortage of psychiatric services and beds is gravely impacting emergency department crowding and boarding.

❒ **PROPOSED ACTION:** Support efforts to facilitate access to both inpatient and outpatient psychiatric services and care for mental illnesses and substance use disorders. Also, address the psychiatric work force shortage and provide adequate reimbursement for the care of patients with mental illnesses. At next year's Annual Meeting, the House of Delegates will get a report on the effectiveness of the measures implemented. *[Adopted]*

ISSUE: Health plans are denying claims for physician-directed treatment of gender identity disorder.

❒ **PROPOSED ACTION:** The AMA supports public and private health insurance coverage for physician-recommended treatment of gender identity disorder. *[Adopted]*

More oversight of doctors of nursing

Continued from preceding page

tice under physician supervision and as part of a coordinated medical team. Delegates voted to oppose the NBME's participation in any DNP exam and directed the AMA to refrain from producing test questions.

"We're talking about quality of care and excellence," said delegate Ted E. Epperly, MD, of Boise, Idaho, president-elect of the American Academy of Family Physicians. While advanced nursing education can help facilitate better patient care, the NBME exam would "give an implicit legitimacy that DNPs are subject to the same eyes of the medical board that credentials doctors," despite the differences in education, he said.

More doctors of nursing expected

The DNP degree requires two years of schooling versus five to seven years for medical training. About 200 nursing schools are expected to offer the program by 2015.

Dr. Epperly warned that patients may not be able easily to discern whether they are being treated by a "doctor doctor" or a "doctor nurse."

Such a scenario could prove dangerous should a patient experience an acute condition, said delegate Neil Winston, MD, an emergency medicine physician from Chicago.

Because of such risks, alternate delegate Donald W. Hatton, MD, an internist from Lawrence, Kan., and chair of the board of governors of the American College of Physicians, said "we need a team-based approach where nurses are in collaborative practice with physicians."

But some delegates feared that pursuing criminal actions could have unintended consequences. Such efforts "might lead to a movement to have additional practitioners certified by law," said Albuquerque, N.M., nephrologist Steven Kanig, MD, speaking on his own behalf.

Representatives of the American Nurses Assn. who testified in opposition to the proposed policies said their goal is to improve patient care, not add confusion.

"We are trying to work together in a spirit of cooperation to fill the gaps [in medical care]," particularly in rural areas, said Eileen S. Carlson, RN, associate director of the ANA's government affairs department. Increased supervision requirements could harm access to care, nurses said.

Tackling other scope-of-practice issues, delegates adopted two resolutions demanding more oversight of midwifery practice.

Fearing a host of patient safety risks associated with home births, such as unexpected complications, delegates voted to have the AMA support state legislation calling for physician and regulatory oversight of midwifery. Twenty-one states license certified professional midwives to deliver babies without requiring formal nursing training or physician supervision, and a number of states pursued similar legislation in 2008.

PHOTO BY PETER WYNN THOMPSON

Ted E. Epperly, MD, president-elect of the AAFP, warned that the exam would "give an implicit legitimacy that DNPs are subject to the same eyes of the medical board that credentials doctors," despite differences in education.

A second resolution says the AMA will advocate for state legislation recognizing that the safest settings for deliveries are accredited freestanding birthing centers or hospital-based birthing units that meet American Academy of Pediatrics and American College of Obstetricians and Gynecologists standards.

"We are all trying to find the best, high-quality ways to provide care," said Erin E. Tracy, MD, a Stoneham, Mass., ob-gyn and ACOG delegate. "Giving licenses to those without adequate training is not the answer." ◆

Medical tourists

Continued from preceding page

the U.S. needs to be addressed and the uninsured need to get coverage so that every American can get the health care he or she needs at home.

But, "until there is significant action at home, patients with limited resources may turn elsewhere for care. It is important that U.S. patients have access to credible information and resources so that the care they receive abroad is safe and effective," Dr. Rohack said.

Michael Rosenberg, MD, a cosmetic surgeon and delegate from New York, pointed out that some companies entice medical tourists with five-star hotels and other perks. He asked that the AMA seek legislation or regulations that would prevent insurance companies, employers or other entities from providing such incentives to their subscribers.

"The fact that insurance companies are incentivizing patients with beaches, five-star hotels, even cash kickbacks, I find distasteful," added Michael Simon, MD, an alternate delegate for the American Society of Anesthesiologists.

Their appeal that the resolution be amended to include this regulation was denied.

AMA GUIDELINES FOR PATIENTS GOING OVERSEAS FOR CARE

- Medical care outside the U.S. should be voluntary.
- Financial incentives to go outside the U.S. for care should not inappropriately limit diagnostic and therapeutic alternatives, or restrict treatment or referral options.
- Financial incentives should be used only for care at institutions accredited by recognized international accrediting bodies.
- Local follow-up care should be coordinated and financing arranged to ensure continuity of care.
- Coverage for travel outside the U.S. for care must include the costs of follow-up care upon return.
- Patients should be informed of rights and legal recourse before traveling outside the U.S. for care.
- Patients should have access to physician licensing and outcomes data, as well as facility accreditation and outcomes data.
- Transfer of patient medical records should be consistent with HIPAA guidelines.
- Patients should be provided with information about the potential risks of combining surgical procedures with long flights and vacation activities.

SOURCE: "MEDICAL CARE OUTSIDE THE UNITED STATES," AMA COUNCIL ON MEDICAL SERVICE REPORT 1 (A–08), AS ADOPTED

"We need to address the safety aspect for the patient. But the AMA feels patients should be able to go to the doctor they want where they want," Dr. Terry said.

To ensure that insurers and others that facilitate medical tourism adhere to the nine new principles, the AMA will introduce model legislation for consideration by state lawmakers. ◆

Increasing use of Tasers prompts safety review

Physicians want more safety information about the stun guns.

Victoria Stagg Elliott
AMNEWS STAFF

Chicago In response to concerns about the expanding use of Tasers and their possible impact on health, the AMA's Council on Science and Public Health will gather scientific data on injuries and deaths that may be connected to these electronic control devices for a future report, according to policy adopted at the AMA's June meeting.

"There remains controversy around the safety of Tasers," said AMA Board of Trustees member Steven J. Stack, MD. "Further study is in order to ensure that Tasers present the least possible harm to the people being subdued."

Delegates are seeking this report because Tasers are increasingly used beyond law enforcement.

"Tasers are being used in some school settings and health care settings without any knowledge of the consequences," said Carol Berkowitz, MD, speaking for the American Academy of Pediatrics.

Some people are stunned by the devices as part of the how-to-use training. Background checks are required, but the devices can be legally carried as concealed weapons in many jurisdictions. A version is available to the public in nine colors, including two shades of pink.

"I would caution everyone about arming the world with Tasers. We need the science, and I hope we don't end up killing more people than protecting them," said Robert E. McAfee, MD, a former AMA president and general surgeon from Portland, Maine.

More widespread use also means more questions about whether these devices are overused and how dangerous they might be. The Commission for Public Complaints Against The Royal Canadian Mounted Police, a government-created independent agency, issued a report last month supporting continued use. But, because of public concern raised by several related deaths, the Canadian report urged Taser use be restricted to experienced officers.

The report also found Tasers were most likely to be used on unarmed males aged 20 to 39 who had been drinking alcohol. The document recommended the stunning devices only be used on people who were combative and presented a risk of inflicting death or grievous bodily harm. Medical attention should always be sought afterward.

In the scientific realm, several prospective studies have failed to find any negative cardiac impact, but case reports have documented a handful of associated injuries. A paper in the November 2007 *Annals of Emergency Medicine* reported details of a police officer who was stunned during training and sustained spinal fractures from the severe, Taser-induced muscle contractions. This possibility is included in the safety information accompanying the device.

"We need to let the public know that they are not as undangerous as they think," said Corliss Varnum, MD, a family physician from Oswego, N.Y., and a representative of the Medical Society of the State of New York.

Delegates were particularly concerned about Taser use outside of law enforcement, and the possibility that the devices could be used to control children or the mentally ill.

"Tasers have now been implicated in several deaths, and those with mental illness seem to be 'Tasered' with disproportionate frequency," said David Fassler, MD, a child and adolescent psychiatrist from Burlington, Vt., speaking for the American Academy of Child & Adolescent Psychiatry.

"When used properly," said Steve Tuttle, vice president of communications for the manufacturer, TASER International, "medical and law enforcement experts have concluded that Taser technology is among the most effective use-of-force interventions available to law enforcement officers to halt violent situations that pose a safety risk."

Statements on the company Web site indicate that 71 wrongful death and injury lawsuits brought against the company have been dismissed. ◆

Doctors oppose mandatory drug reporting laws

Delegates worry these kinds of regulations will make patients hesitate to seek help.

Victoria Stagg Elliott
AMNEWS STAFF

Chicago Physicians should not be required to report to police information about patients who test positive on drug screens, according to policy adopted at the American Medical Association's June meeting.

"Physicians take an oath to first serve their patients," said AMA Board of Trustees member Steven J. Stack, MD. "We're not in the business of law enforcement. It's a violation of our confidentiality agreement."

Hawaii requires health professionals who treat drivers from a car crash to report results of any medical test that reveals intoxication or drug impairment. Tennessee considered, but did not pass, a similar bill earlier this year.

"A drug screen is an important part of a medical workup," said Stuart Gitlow, MD, MPH, a psychiatrist from New York who was speaking for the American Society of Addiction Medicine. "The result of that type of regulation is that doctors don't perform drug screens, and the patient doesn't receive the necessary treatment or follow-up."

Physicians said such laws interfere with the patient-physician relationship.

"Mandatory reporting discourages treatment and discourages patients from coming in," said Lynn Parry, MD, a Denver neurologist who represented the Colorado Medical Society. "The law doesn't prohibit you from reporting if you think there's a danger to the public, but it shouldn't mandate it. That's a very important distinction."

Some argued, however, that required reporting of test results may be appropriate in situations such as car crashes in which drugs may have played a role.

"We need to not only look out for our patient, but the patient who could be down the hall who was also injured," said Sandeep Krishnan, a third-year medical student at the University of Missouri, Kansas City, who represented the Missouri State Medical Assn. "There's actually harm that could happen from not reporting."

PHOTO BY PETER WYNN THOMPSON

There's an important distinction between allowing reporting and mandating it, Dr. Lynn Parry told a panel.

Opponents noted that other routes can be used to obtain this information and legal mandates were unnecessary. A spokeswoman for the National Council of State Legislatures said there are common ways to gain access to test results if legal action results and this evidence is needed.

The resolution also called for the AMA to promote education of physicians on the importance of referring patients with positive screens for relevant care.

In related action, the AMA voiced support for "The Surgeon General's Call to Action to Prevent and Reduce Underage Drinking" and voted to continue participating in programs to raise awareness and increase screening, diagnosis and treatment of substance use disorders. ◆

Meeting Notes
Public Health

ISSUE: Questions have been raised about the role high-fructose corn syrup may play in escalating obesity rates. A review suggested that increasing consumption of all forms of sugar may be involved, but that high-fructose corn syrup could not be singled out.

❒ **PROPOSED ACTION:** Encourage independent research into the effects of high-fructose corn syrup and recommend that people limit consumption of all caloric sweeteners. *[Adopted]*

ISSUE: Research indicates that recommended levels for vitamin D are too low and deficiencies in this substance may play a role in development of chronic diseases.

❒ **PROPOSED ACTION:** Urge the Institute of Medicine to re-examine recommended daily intake values for vitamin D. *[Adopted]*

ISSUE: Many hospitals require physicians to sign a written version of verbal orders within 48 hours, but physicians regard this as a waste of time and lacking evidence that it benefits patients.

❒ **PROPOSED ACTION:** Request from appropriate federal agencies evidence supporting this policy, and, if there is none, ask for the requirement to be rescinded. *[Adopted]*

ISSUE: Many blood-banking organizations regard the lifetime ban on blood donations from men who have had sex with men since 1977 as no longer necessary to keep supplies safe. It also may be discriminatory and stigmatizing.

❒ **PROPOSED ACTION:** Recognize that a five-year deferral is supportable by science. *[Adopted]*

ISSUE: Those living with chronic medical conditions are more likely to be injured or die during a disaster or in its aftermath. This may be due in part to a lack of access to usual medications.

❒ **PROPOSED ACTION:** Recommend patients maintain an emergency pharmaceutical reserve and always carry a detailed list of their medications. *[Adopted]*

ISSUE: Studies have not found "abstinence-only" education to be effective, but state and federal funding supports it.

❒ **PROPOSED ACTION:** Urge that mandates for "abstinence-only" instruction end and that money be redirected to comprehensive sex education. *[Referred]*

Meeting Notes

Medical Ethics

ISSUE: To better halt the spread of chlamydia and gonorrhea, the Centers for Disease Control and Prevention recommends expedited partner therapy, in which doctors give patients antimicrobials for their sex partners. The practice, while effective, may undermine informed consent and continuity of care, and violate state laws.

❒ **PROPOSED ACTION:** New ethical policy saying doctors should only use EPT if they believe a patient's partner would otherwise not seek treatment. *[Adopted]*

ISSUE: Some hospitals have asked medical staff members to provide personal financial information as part of conflict-of-interest policies apparently aimed at shutting out doctors who work for competitors.

❒ **PROPOSED ACTION:** A Board of Trustees report recommending that only physicians seeking to serve in a hospital leadership position be required to disclose employment, ownership or financial interests, or leadership positions at another hospital. Also, the information requested should be no different from that requested of nonphysicians. *[Adopted]*

ISSUE: Treating peer physicians poses special challenges to clinical objectivity and confidentiality.

❒ **PROPOSED ACTION:** New policy saying doctors should not hesitate to treat peers in emergencies, but should beware of the risk of biased treatment recommendations, take care to respect privacy, and share decision-making as they would with other patients. *[Adopted]*

AMA OKs palliative sedation for terminally ill

The seldom-used technique is deemed ethical because the aim is to relieve intractable symptoms, not hasten death.

Kevin B. O'Reilly
AMNEWS STAFF

PHOTO BY PETER WYNN THOMPSON

Palliative sedation "is part of the skill set of physicians who take care of patients at the end of life," said Dr. H. Rex Greene, a CEJA member.

Chicago When all else fails to control patients' pain at the end of life, it is appropriate for physicians to sedate such patients to unconsciousness, according to new ethical policy adopted at the AMA Annual Meeting in June.

The rarely employed practice of palliative or terminal sedation is sometimes perceived as speeding the dying process, leading critics to dub it a form of physician-assisted suicide. But evidence of such a hastening effect is lacking, according to a Council on Ethical and Judicial Affairs report adopted by the House of Delegates.

"These are unusual circumstances that require us to urgently relieve these symptoms by sedating patients to unconsciousness," said CEJA member H. Rex Greene, MD, a Lima, Ohio, oncologist and palliative medicine specialist. "This is not intended to end life."

The ethical opinion says physicians are obligated to offer palliative sedation as a last resort when "symptoms cannot be diminished through all other means of palliation, including symptom-specific treatments." Such symptoms include pain, shortness of breath, dyspnea, nausea and vomiting. Between 5% and 35% of hospice patients have intractable symptoms in the last week of life, according to a 2000 *Annals of Internal Medicine* study.

Doctors should consult with a multidisciplinary team or a palliative care expert to determine that sedation to unconsciousness is the right course of treatment, the policy says. The rationale for the sedation should be documented in the medical record, and patients or their surrogates should consent to the procedure.

Physicians also should talk with patients about whether the sedation will be intermittent or constant, and whether to withdraw or withhold other life-sustaining treatments.

Treating patient pain

The policy draws the line at using palliative sedation to combat emotional distress some terminally ill patients experience at the end of life. These symptoms are better addressed with social and spiritual supports, the CEJA opinion stated. Lastly, palliative sedation "must never be used to intentionally cause a patient's death."

The policy "protects patients from inappropriate use of palliative sedation," said California delegate Melvyn Sterling, MD, a palliative care specialist. "It provides guidance to hospitals that might otherwise be reluctant to allow this to occur, and it provides protection to the entire health care team involved, who might otherwise allow terrible suffering to occur."

The American Academy of Hospice and Palliative Medicine and the American Academy of Pain Medicine support the use of palliative sedation to unconsciousness. The AMA opposes euthanasia and physician-assisted suicide as being "fundamentally incompatible with the physician's role as healer."

Delegates also directed the AMA to study alternatives to "do not resuscitate" orders. The resolution said DNR terminology "is both confusing and misleading to patients and families because of the negativism in wording, which suggests that something is being denied, and the implication that all care, including comfort measures, is to be withheld."

Alternatives to be studied include "allow natural death," "limitations of emergency treatment" and "physician orders for life-sustaining treatment." In panel testimony, most delegates agreed the study was needed, but others said altering the terminology will do little to make talking with patients and families easier.

"If we think changing the name changes the task, then we are deluding ourselves," said Michael A. Williams, MD, a delegate for the American Academy of Neurology. "There is no form we can have that will make the complex challenges of this go away." ◆

Delegates explore on-call coverage, at-home genetic tests

A shortage of specialists taking call at hospitals sparks debate at CEJA forum.

Kevin B. O'Reilly
AMNEWS STAFF

Chicago Most hospitals are struggling to find specialists to provide emergency on-call coverage, and many are paying a stipend to attract them.

But are physicians obligated to take call? Is it OK for hospitals to mandate medical staff to do so? Should hospitals compensate some doctors for taking call but not others?

These are some of the questions delegates examined at the Council on Ethical and Judicial Affairs open forum at the AMA's Annual Meeting in June.

Nearly three-quarters of hospitals say they have inadequate on-call coverage, according to a 2006 American College of Emergency Physicians report. Neurosurgeons, orthopedic surgeons, trauma surgeons, ob-gyns, ophthalmologists and dermatologists are some of the specialists hospitals have trouble getting to take call. More than a third of hospitals now pay specialists, usually surgeons, to provide on-call coverage, ACEP says.

Constance Powell, MD, a Portland, Ore., psychiatrist and alternate delegate for the American Psychiatric Assn., said many physicians used to feel compelled to take call by the unwritten social contract between doctors and society. In exchange for working strenuous hours, physicians were rewarded with excellent pay and high social esteem, Dr. Powell said.

DR. POWELL

"Now, society has changed the social contract with physicians," she said. "We feel ambivalent about asking for money for giving care, as though there is something wrong with that."

Some delegates told CEJA that hospitals often lack the equipment required to provide specialized care, making it a burden to be on call. Others said that increasing specialization makes them uncomfortable taking call for other surgical areas, especially given higher liability risks associated with emergency care.

Even when doctors taking call get paid, it is often not enough to make up for the sleepless nights, said Marvin S. Kaplan, MD, a Newport Beach, Calif., general surgeon and alternate delegate for the California Medical Assn. "Many younger physicians don't feel automatically obliged to be on call for emergencies and volunteer their services."

Delegates also examined the ethical implications of direct-to-consumer mail-order kits that can determine paternity or tell patients whether their DNA puts them at increased risk of certain diseases.

"Does this constitute a dangerous disturbance of the patient-physician relationship?" asked Kavita Shah, a medical student member of CEJA. "On one hand, patients get knowledge. On the other hand, will patients turn to pamphlets for information rather than their physicians?"

Many delegates said genetic testing often can be misleading and should be offered only within the context of physician-patient relationships, and when clinical or family history warrants testing. ◆

Delegates respond to rising student debt

The Association wants medical schools to tell students why their tuition is going up and whether incentives were involved in their loans.

Emily Berry
AMNEWS STAFF

Chicago The AMA House of Delegates is asking medical schools to deal more openly with medical students when it comes to student loans, tuition hikes and the schools' spending.

The house agreed to support medical school policies that require financial aid officers to disclose any incentives they have received from lenders in exchange for designation as a "preferred lender."

Medical students need to know when the people advising them have a stake in the lending process, said Peter Ragusa, a medical student at the University of Minnesota and an alternate delegate from the Medical Student Section.

Being pushed to borrow from a lender who isn't offering the best terms isn't just a matter of a few more dollars of interest, he said. "Medical debt is a major factor in specialty choice."

The AMA will also support standardized disclosures by medical schools explaining the reasons for tuition increases and the use of income generated by them.

Supporters said the schools shouldn't see medical students as cash cows who can be tapped to fund schools' needs beyond the cost of educating them.

Meanwhile, the house asked the AMA to study potential solutions to reducing medical students' debt.

"The medical student debt crisis imposes great strain on their psychological, economic welfare and also greatly restricts their choices in specialties or areas of medicine upon graduation," said Verner Stillner, MD, an alternate delegate for the Alaska State Medical Assn. and a psychiatrist from Juneau, Alaska. "We strongly support the AMA pursuing long-term solutions in this crisis."

Relief for growing debt cannot come soon enough, medical students told committee members.

"When I graduate, I will have accumulated nearly a quarter of a million dollars in debt, and that's from a state school," Ragusa said.

The average debt load carried by doctors leaving medical school reached $140,000 in 2007. Debt is already driving some prospective students out of medicine, or away from primary care specialties, delegates testified. ◆

PHOTO BY PETER WYNN THOMPSON

"Medical debt is a major factor in specialty choice," said University of Minnesota student Peter Ragusa.

PHOTOS BY PETER WYNN THOMPSON

Taking the message out to the ball game

About 350 medical students and residents took the AMA's Voice for the Uninsured campaign to a Chicago White Sox baseball game on June 13. Outside the stadium, resident and then AMA Board of Trustees member Chris DeRienzo, MD, joined those who handed out pocket cards, spoke to fans about the crisis of the uninsured and encouraged adults to vote in November with the issue in mind. The AMA group was acknowledged on the stadium scoreboard, and a TV ad about the uninsured campaign played on the Jumbotron.

Meeting Notes

Medical Education

ISSUE: There are no standards to define pain medicine specialists.

❒ **PROPOSED ACTION:** Encourage interested parties to join to define scope of practice and define appropriate credentialing of pain specialists. *[Adopted]*

ISSUE: There remains a disparity in pay and advancement opportunities between female and male physicians.

❒ **PROPOSED ACTION:** Encourage specialty and state societies to find solutions to gender disparity, support doctors in balancing work and life, train women physicians in leadership and contract negotiations, and publicize best practices. *[Adopted]*

ISSUE: Some residency programs will not accept graduates of international medical schools.

❒ **PROPOSED ACTION:** Ask the Accreditation Council for Graduate Medical Education to make IMG status a prohibited discrimination. *[Adopted]*

ISSUE: Residency programs vary in leave time and whether time off results in repeating training.

❒ **PROPOSED ACTION:** Ask the ACGME to standardize leave under the Family and Medical Leave Act, and to encourage the American Board of Medical Specialties to standardize absence policies. *[Adopted]*

Delegates seek to change law on organ donor incentives

The proposal would make it legal to conduct ethically designed pilot studies of payments for cadaveric donations.

Kevin B. O'Reilly
AMNEWS STAFF

Chicago With the United Network for Organ Sharing waiting list approaching 100,000, the AMA's House of Delegates voted in June to put the prospect of paying organ donors high on its legislative agenda.

Six years ago, the house approved studying benefits and harms of financial incentives for cadaveric organ donation. But even testing the idea on a demonstration basis is illegal under the 1984 National Organ Transplant Act, which bans "valuable consideration" in exchange for organ donation. The change would not apply to living organ donors.

"If there are other ways to increase the supply of transplantable organs and do it in an ethical way … it is worthwhile to at least study," said AMA Board of Trustees member Joseph P. Annis, MD.

Alternate delegate Gerald A. Wilson, MD, a Columbia, S.C., general surgeon, said that in his work with the state organ procurement organization, he has encountered families of donors who ask for financial help with burial expenses.

"By law, we're prohibited from doing that," said Dr. Wilson, who introduced the resolution adopted by the house. "We cannot put a price on tissue or human life, but there is a need to see if it's possible to increase the number of organ donors."

As many as 7,000 patients die while on the waiting list, and since 1988, 75,000 have died waiting for a donor organ, according to the resolution.

Since 1981, AMA delegates on multiple occasions have adopted or reaffirmed policy calling for pilot studies of ways to increase organ donation.

Many delegates opposed any form of paying for organs, saying it could lead to exploitation of the poor and drive down donation rates.

"Organ donation is currently based on altruism, and it's a very brittle altruism," said Peter N. Bretan Jr., MD, a Novato, Calif., renal transplant surgeon. "Any perception we give forward that doesn't give the freedom to opt out or allows payment … will specifically hurt altruism and decrease altruism."

Dr. Bretan said reform efforts should focus on removing financial disincentives, not inducing donation with big-money offers.

But Thomas G. Peters, MD, a Jacksonville, Fla., transplant surgeon, argued that a regulated payment for cadaveric organ donation, similar to the death benefit given to the families of fallen soldiers, is ethically appropriate and could forestall grislier alternatives.

"This is a gratuity from America for service to Americans," Dr. Peters said during committee debate. Pushing again for the resolution on the house floor, he said "circumstances have gotten to the point that the lack of domestic cadaveric organs has driven a move to transplant tourism."

The AMA's Council on Legislation will propose language to change federal law in line with the adopted resolution and lobby Congress. ◆

Resident work hours stir passionate debate

Testimony from both sides ends with no changes to work hour limits, but the AMA will support making it easier to report violations.

Emily Berry
AMNEWS STAFF

Chicago Spontaneous applause from delegates followed testimony both in support of and opposition to further limits on resident work hours. But neither side won the endorsement of the AMA House of Delegates.

Instead, the AMA will encourage the Accreditation Council for Graduate Medical Education to continue studying the issue.

Delegates did agree that reporting work hour violations should not pose a threat to doctors' careers or training. The house approved a resolution encouraging the ACGME and American Osteopathic Assn. to "reduce barriers" to reporting violations.

However, some delegates testified before the AMA's Committee on Medical Education that the 80-hour weekly limit is hurting patients and doctors.

"We're very concerned with the culture we're creating," said Don Swikert, MD, a delegate and family physician from Edgewood, Ky.

Krystal Tomei, MD, a neurosurgery resident from Jersey City, N.J., in testimony before the committee and the full house, expressed concern that any further reductions to work hours would leave her and younger students unprepared. "I knew what I was getting into." ◆

PHOTO BY PETER WYNN THOMPSON
Krystal Tomei, MD

AMA clarifies plan on tax credits for insurance

Delegates rejected an attempt to keep tax–free HSA contributions along with tax credits.

Doug Trapp
AMNEWS STAFF

Chicago At a time when the presidential election has again put health system reform in the national spotlight, the AMA House of Delegates in June refined the Association's policy on increasing health insurance access.

Existing AMA policy, first approved a decade ago, calls for ending employees' federal income tax exemption for work-based coverage. That should happen, however, only after establishing a system of tax credits to help people buy health insurance. Related AMA policy also calls for expansion of health plan choices, more consistent health insurance regulation, guaranteed policy renewals, an individual insurance mandate for those earning more than 500% of the federal poverty level, and subsidies for medically high-risk people.

AMA policy adopted at the meeting further specifies that once tax credits are in place, employee exemptions for health insurance spending should end only for federal income taxes — not for state or federal payroll taxes, which include Medicare, Social Security and unemployment taxes. Although ending the exemption for payroll taxes would simplify administrative work for businesses — including physician practices — and increase Social Security and Medicare Part A revenues, it would disproportionately affect lower-income people and raise employers' payroll taxes, and would not provide additional revenue for health insurance tax credits.

The revised policy is neutral on state health insurance income tax exemptions but says that if states decide to end this exemption, they should spend the resulting revenue on tax subsidies for health coverage.

State and federal health insurance exemptions for employees and the self-employed were worth $200 billion in 2004, according to AMA Council on Medical Service figures based on a February 2004 article in *Health Affairs*. The employee federal income tax exemption made up $109 billion of that total.

Several delegates expressed concern over how health savings accounts would be affected by ending the tax exemption. Richard Warner, MD, a Kansas psychiatrist, offered an amendment to maintain tax-free HSA contributions after insurance tax credits are in place, but the house did not adopt it. Supporters of existing AMA policy noted it would provide refundable, advanceable tax credits for health insurance spending, including HSA contributions.

Delegates also clarified AMA policy on the tax deductibility of health insurance spending. Previous policy had called for deductibility of out-of-pocket medical expenses and insurance premiums, but the house rescinded it in favor of the tax credit plan. AMA policy still envisions people with lower incomes having more generous tax credits and easier access to them than wealthier people. The policy does not specify an income cutoff. ◆

Meeting Notes

Other Actions

ISSUE: State medical boards differ in their standards for restricting or revoking physicians' licenses.

❒ **PROPOSED ACTION:** Explore ways to establish principles for due process protections. *[Adopted]*

ISSUE: Whether primary care physicians have enough representation on the AMA/Specialty Society RVS Update Committee.

❒ **PROPOSED ACTION:** Maintain existing allocation of primary care seats on the committee and continue to support the RUC's work. Its efforts should include advocating for separate payment for physician services that do not require face-to-face interaction. *[Adopted]*

ISSUE: New AMA leadership

RESULT: Texas cardiologist J. James Rohack, MD, was named president-elect. Oklahoma neonatal-perinatal specialist Mary Anne McCaffree, MD, was elected to the Board of Trustees. Re-elected to the board were Colorado psychiatrist Jeremy A. Lazarus, MD, as speaker; Pennsylvania hand surgeon Andrew William Gurman, MD, as vice speaker; and Virginia orthopedic surgeon William A. Hazel Jr., MD. Board chair is Massachusetts obstetrician-gynecologist Joseph M. Heyman, MD; chair-elect is California anesthesiologist and pain management specialist Rebecca J. Patchin, MD; and secretary is Kentucky internist and infectious disease specialist Ardis Dee Hoven, MD.

ISSUE: AMA membership dues

RESULT: Dues will not be raised.