AOA POSITION PAPERS

August 2005

The American Osteopathic Association's House of Delegates is the policy-making body of the osteopathic profession. Each year at its annual meeting, the House considers policy statements submitted by departments, bureaus, committees, divisional societies, affiliated societies, or the AOA Board of Trustees.

The full texts of policy statements adopted by the AOA House of Delegates are printed below. A short title for each statement has been adopted for ease of reference. By action of the AOA Board of Trustees in July, 1979, the AOA Committee on Health Related Policies will review all AOA policy guidelines relating to healthcare, health planning, and health delivery at least every five years and recommend affirmation, revision, or deletion to the AOA House of Delegates.

Note: Effective June 14, 2001, the Health Care Financing Administration (HCFA) agency was renamed. It is now the Center for Medicare and Medicaid Services (CMS).

COMMITTEE ON HEALTH RELATED POLICIES MISSION STATEMENT

WHEREAS, the Committee on Health Related Policies is responsible for reviewing American Osteopathic Association policies; and

WHEREAS, policies approved by the AOA House of Delegates will be published as official AOA policies; now, therefore, be it

RESOLVED, that American Osteopathic Association policies, which have not been subject to review within five years from their adoption date or last revision be automatically reviewed; and, be it further

RESOLVED, that in any AOA position statement the "Whereas" statements are considered as explanatory and only the "Resolved" statements will be published as official AOA policy. 1990; *revised* 1995; *reaffirmed* 2000, *revised* 2005

ABUSED PERSONS

WHEREAS, the American Osteopathic Association is aware that physical, emotional, and verbal abuse are serious public health problems, and that each year millions of Americans are victims of such abuse; and

WHEREAS, the AOA acknowledges that such abuse is very costly to society; now, therefore, be it

RESOLVED, that the American Osteopathic Association continues to encourage its membership to participate in programs designed for the treatment of the abused and the rehabilitation of the abuser; and, be it further

RESOLVED, that the AOA continues to encourage public health agencies to provide special training in: advocacy for abused persons; effective assessment and intervention techniques to assist those in abuse situations; legal procedures; special needs of young and elderly, building links with local shelters, and related community resources. 1982; *revised* 1987; *reaffirmed* 1992, 1997; revised 2002

ACUPUNCTURE

WHEREAS, osteopathic medicine is not limited in the use of any beneficial therapeutic or diagnostic modality; now, therefore, be it

RESOLVED, that the American Osteopathic Association recognizes that acupuncture may be a part of the armamentarium of qualified and licensed physicians. 1978; *reaffirmed* 1983; *revised* 1988, 1993; *reaffirmed* 1998, 2003

ADMINISTRATIVE RULE-MAKING PROCESS

WHEREAS, most enacted legislation is implemented through administrative regulations which often influence their ultimate effect; and

WHEREAS, the executive agencies have often surpassed the intent of Congress and the state legislatures in the manner in which such agencies have administered various laws; and

WHEREAS, the ultimate result of rulemaking has the effect of law; and

WHEREAS, it is in the interest of effective government that Congress and the state legislatures ensure that their intent has been followed in the rule-making process; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the concept of closer federal and state legislative scrutiny of the administrative rule-making process to more effectively monitor the development of regulations and insure their conformity with expressed legislative intent. 1986; *revised* 1992; *reaffirmed* 1997; revised 2002

ADOLESCENTS' BILL OF RIGHTS

WHEREAS, all states have specific legal provisions for adolescents to obtain confidential health care, particularly for mental health, substance abuse, and sexually related health needs; and

WHEREAS, these provisions are not known to most adolescents, their parents, and often even the medical providers; and

WHEREAS, new federal HIPAA regulations regarding confidentiality of adolescents receiving care in health care facilities and physician's offices are usually not understood by most adolescents, their parents, and sometimes even the medical providers; and

WHEREAS, some states, municipalities, medical facilities, and physicians' offices clearly post the "Patients' Bill of Rights"; now, therefore, be it

RESOLVED, that that the American Osteopathic Association advocate that all medical facilities that provide care for adolescents post an "Adolescents' Bill of Rights" which clearly articulates state and local applicable laws of consent and confidentiality regarding health care for adolescents who have not reached the age of majority. 2003

ADVANCE DIRECTIVES

WHEREAS, there is widespread consensus that healthcare costs must be controlled with minimal adverse impact on patients' autonomy and the quality of care; and

WHEREAS, well-informed, mentally competent patients should have the right and opportunity to decide for themselves what medical services they wish to receive or refuse; and

WHEREAS, it is recognized that significant healthcare costs can arise as a result of heroic and technological procedures, which, at times, may be futile and in direct opposition to the wishes of the patient; and

WHEREAS, by requiring that patients choose what medical treatments they wish to receive when joining healthcare plans, and requiring that these decisions be respected, it is

believed that the wishes of our patients will be better followed and the public will be better served; and

WHEREAS, research has shown that many patients would choose not to have certain procedures performed or heroic measures done, thereby significantly reducing costs while promoting patient autonomy; and

WHEREAS, by supporting these principles of patient autonomy, the American Osteopathic Association can reinforce the osteopathic profession's responsibility and desire to help control healthcare costs, while advancing its standing as the champion of patients' rights; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the concept of advance directives; and, be it further

RESOLVED, that the AOA proactively assist in introducing this concept into federal legislation. 1997, revised 2002

ADVERTISING--INFLAMMATORY AND UNETHICAL BY ATTORNEYS

WHEREAS, the osteopathic profession employs the highest ethical and professional standards among its members; and

WHEREAS, certain commercial messages on the media encourage, entice and skillfully attempt to persuade people to initiate unwarranted liability claims and suits; now, therefore, be it

RESOLVED, that the American Osteopathic Association continues to urge the American Bar Association to encourage its members who advertise to employ high ethical standards in their public advertisements. . 1989; *revised* 1994; *reaffirmed* 1999; *revised* 2004

AFFIRMATIVE ACTION

WHEREAS, osteopathic physicians have demonstrated a unique sensitivity and concern for the improvement of communities in which they serve, as evidenced by involvement not only in health, but also civic, social and welfare programs; and

WHEREAS, the osteopathic profession has recognized past inequities in our society related to opportunities for advancement of qualified women and minorities including, but not limited to; African Americans, Native Americans, Hispanic Americans and Asian Americans and has established nondiscriminatory policies throughout its organizational structure; and

WHEREAS, the members of the osteopathic profession continue to support affirmative action programs in the total integration of society; and

WHEREAS, the American Osteopathic Association acknowledges the need to continue efforts to recruit, encourage and otherwise support minorities entering the osteopathic profession; now, therefore, be it

RESOLVED, that the American Osteopathic Association reaffirms its commitment to the advancement and integration of qualified women and minorities including, but not limited to; African Americans, Native Americans, Hispanic Americans and Asian Americans into the osteopathic profession; and, be it further

RESOLVED, that the AOA promotes and endorses programs to encourage enrollment of qualified women and minority students in the colleges of osteopathic medicine and encourages their membership and full participation in the AOA and its affiliated organizations. *reaffirmed* 1979; *revised* 1983, 1988, 1994; *reaffirmed* 1999, *revised* 2004

AIRBAGS IN AUTOMOBILES

WHEREAS, the public does not always drive safely and use seat belts; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the ongoing efforts of the National Safety Council, the National Highway Traffic and Safety Administration, the National Transportation Safety Board, and other responsible safety organizations to educate the public regarding the proper use of safety belts, child safety seats and airbags; and, be it further

RESOLVED, that continued corporate development and research into safer airbags is needed, and, be it further

RESOLVED, that the AOA encourages the above-named organizations to educate the public regarding the potential dangers of airbags, and, be it further

RESOLVED, that responsible organizations continue to examine adult and child fatalities resulting from airbag deployment.

1993; *revised* 1998, 2003

AIRCRAFT EMERGENCY MEDICAL SUPPLIES

WHEREAS, airline travel is an extensive and widely used means of transportation; and

WHEREAS, illness and medical emergencies occur in flight; and

WHEREAS, this represents a unique situation in transportation in that there is isolation from medical facilities; and

WHEREAS, airlines are now required to carry diagnostic and emergency medical equipment or medications; and

WHEREAS, physicians are called upon to aid the ill as well as to diagnose and treat without immunity from liability or legal action; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) supports the concept that airlines, under the control of the Federal Aviation Administration, maintain a policy for adequately equipping commercial aircraft of greater than 19 seats with at least minimal diagnostic and emergency medical supplies; and, be it further

RESOLVED, that the AOA supports legislation that any physician providing emergency service while on a flight be immune from any liability or legal action. 1984; *revised* 1989, 1995; *reaffirmed* 2000, revised 2005

AIRLINE MEDICAL KITS

WHEREAS, the increasing trend in air travel portends the proportional increase in occurrence of such common ailments as fainting, dizziness, injury due to turbulence, breathing difficulties, heart attack and stroke; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the Federal Aviation Administration (FAA) Final Rules On Airline Emergency Equipment issued in 2001. 1998, *revised* 2003

ALCOHOL ABUSE

WHEREAS, the American Osteopathic Association, recognizes alcohol as one of the most frequently abused drugs in the United States; and

WHEREAS, alcoholism is an illness requiring treatment and rehabilitation through the assistance of a broad range of community health and social services; and

WHEREAS, alcohol affects directly or indirectly almost every person in America through vehicular, industrial and domestic losses of life, health, and property, as well as through its many other more subtle, but equally devastating economic, moral and social implications; and

WHEREAS, alcohol abuse by our nation's young people can have an especially devastating impact on their lives; now, therefore, be it

RESOLVED, that the American Osteopathic Association endorses local, state and federal legislation that would control the consumption and purchase of alcohol by individuals under the age of twenty-one; and, be it further

RESOLVED, that the AOA urges that alcohol abuse prevention and treatment programs be given a high national priority. 1974; *reaffirmed* 1978; *revised* 1983, 1988, 1994, 1997, 1999, 2004

ALCOHOL AND TOBACCO -- ADVERTISING BAN ON

WHEREAS, the American Osteopathic Association recognizes the value of promoting good health through proper diet and care for the body; and

WHEREAS, alcohol abuse and tobacco have short and/or long term deleterious effects on the human body; and

WHEREAS, alcohol and tobacco dependence are recognized by the AOA as disease processes; now, therefore, be it

RESOLVED, that the American Osteopathic Association endorses a ban on all advertising of tobacco and alcohol..1988; *revised* 1993; *reaffirmed* 1998; *revised* 2003

ANABOLIC ANDROGENIC STEROIDS AND SUBSTANCE ABUSE

WHEREAS, the deliberate abuse of performance enhancing substances or clinical manipulation of naturally occurring body substances, known as doping, and procedures to enhance sporting achievement, is threatening to ones health; and

WHEREAS, education of the medical, lay and athletic communities is necessary toward that end; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the efforts to eliminate the abuse of performance enhancing substances, know as doping, for the purpose of enhancing athletic performance or physical appearance; and, be it further

RESOLVED, that the AOA supports the concept that the use of banned substances for enhanced sporting performances should result in immediate ineligibility from competition, according to the rules of the appropriate governing federation; and, be it further

RESOLVED, that the AOA encourages education of athletes, the public and physicians of the dangers of these substances. 1989, *revised* 1994, 1999, *revised 2004*

ANIMALS IN MEDICAL RESEARCH

WHEREAS, osteopathic physicians support humane handling and treatment of all animals; and

WHEREAS, one of the basic tenets of osteopathic medicine is disease prevention; and

WHEREAS, the osteopathic profession always has been on the leading edge of medical research; and

WHEREAS, laboratory animals are needed to conduct much of this medical research; and

WHEREAS, without the use of laboratory animals, past achievements in both preventive and therapeutic care would not have been discovered; and

WHEREAS, without the use of laboratory animals, future advances in preventive and therapeutic care would be hampered dramatically; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the use of animals for valid medical research projects; and, be it further

RESOLVED, that the AOA supports the humane handling and treatment of such animals, and their ready availability from legitimate sources. 1990; *reaffirmed* 1995; *revised* 2000, *revised* 2005

ANTHRAX VICTIMS, GOVERNMENT RESPONSIBILITY OF HEALTHCARE

WHEREAS, anthrax has been unknown as a natural medical problem in the United States of America; and

WHEREAS, anthrax had only been seen as an occupational disease; and

WHEREAS, an intentional release of anthrax on the general public has caused illness; and

WHEREAS, victims of this weaponized biological weapon are still ill; and

WHEREAS, these victims no longer have health coverage and are responsible for their own care; and

WHEREAS, the reason they became ill is that they were victims of an attack where the victims were random; now, therefore, be it

RESOLVED, that victims of a biochemical terror attack are victims of a new age conflict against America; and, be it further

RESOLVED, that as victims of an attack against America, should be eligible for healthcare to be covered by the United States Government. 2004

ANTIBIOTICS—JUDICIOUS USE OF

WHEREAS, the use of antibiotics has greatly decreased the morbidity and mortality due to infectious diseases; and

WHEREAS, the American Osteopathic Association recognizes an excessive use of antibiotics; and

WHEREAS, inappropriate antibiotic prescriptions result in the increase in resistant organisms; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the following strategies for decreasing drug resistance:

1. Use of narrow spectrum antibiotics when indicated
2. Avoid using systemic antibiotics when a topical alternative will suffice
3. Educate the patient and the community on the appropriate use of antibiotics
4. Avoid the use of antibiotics for viral upper respiratory infections (URIs) unless associated with secondary bacterial infections
5. Improve diagnostic skills with educational workshops
6. Utilize evidence-based reports and recommendation from the Centers for Disease Control and Prevention (CDC)
7. Discourage the use of antibacterial products, except when medically indicated. 2002

ANTI-BULLYING LAW

WHEREAS, school tormentors are increasingly being linked to criminal acts in schools, and there has been an increase in violence in school; and

WHEREAS, the enactment of a nationwide anti-bullying provision would be benificial in hopes of cutting down on gestures, both written and verbal as well as physical, that a reasonable person should know would harm another student, damage another student's person or damage to the student's property; and

WHEREAS, this would also include the insult or demeaning of any student or group of students in such a way as to disrupt or interfere with the school's educational mission or the education of any student; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports anti-bullying policies enabling students to go to school in a peaceful manner without fear of tormenting or intimidating acts to themselves or others; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports a policy to prevent bullying in schools and provide treatment for those involved, thus furthering the cause of a peaceful education. 2002

ANTI-DISCRIMINATION

WHEREAS, there is discrimination against osteopathic physicians' participation as specialists in some plans; and

WHEREAS, osteopathic physicians continue to be excluded from professional practice in some healthcare institutions; now, therefore, be it

RESOLVED, that the American Osteopathic Association continues to be on record against such discrimination; and, be it further

RESOLVED, that the AOA supports the inclusion of osteopathic physicians in all healthcare delivery systems; and, be it further

RESOLVED, that the AOA opposes restraint of trade and supports the ability of all osteopathic physicians to practice freely in all institutions, as qualified by training and experience as recognized and prescribed by the AOA. 1987; *revised* 1992, 1997, 2002

ANY WILLING PROVIDER LEGISLATION

WHEREAS, most Americans have health care coverage through a third party entity; and

WHEREAS, many states have passed legislation to protect the freedom of choice that allows patients and physicians to enter into private contractual relationships for medical care; and

WHEREAS, those states do not allow closed panels that prohibit qualified and willing physicians from providing care for patients enrolled in the programs of those third parties; and

WHEREAS, the freedom of choice for patients and physicians (DO/MD) is in the best interest of both parties; and

WHEREAS, the Supreme Court of the United States upheld such legislation in the state of Kentucky in 2003; now, therefore, be it

RESOLVED that the American Osteopathic Association encourage and support the passage of legislation that will ensure the freedom of patients and physicians to enter into private contracts for health care services without regard to restrictions by any third party carrier; and, be it further

RESOLVED, that the AOA support legislation that will allow any qualified physician (DO/MD) to negotiate with any third party carrier the terms for service to be provided; and, be it further

RESOLVED that the AOA support legislation that will require any third party carrier to provide prompt and complete explanation to any requesting physician (DO/MD) whom it may deem unqualified. 2004

AOA HEALTH POLICY STATEMENT

Statement of Healthcare Policies and Principles
Executive Summary

The American Osteopathic Association (AOA) is dedicated to putting patients first and protecting the patient/physician relationship.

Guiding Policies and Principles

1. The American Osteopathic Association will work with Congress, the Administration, the states, and the private sector to ensure that Americans have access to the highest quality medical care in the world. Addressing the issue of professional liability insurance is central to this goal. The AOA will continue working to ensure that osteopathic physicians have the freedom to practice medicine.
2. The American Osteopathic Association will work with Congress and the Administration to implement provisions set forth in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173).
3. The American Osteopathic Association will work with Congress to ensure high priority consideration of the osteopathic graduate medical education program within physician workforce planning and financing legislation.
4. The American Osteopathic Association will work with Congress and the Administration to support research that advances medical science.

The Distinctiveness of the Osteopathic Physician

The osteopathic profession was founded more than 100 years ago on the basis that the osteopathic physician would treat the patient holistically. This is accomplished by the osteopathic physician using the traditional tools of medicine along with the additional modality of osteopathic manipulative treatment.

In general, there are four principles of osteopathic philosophy: (1) a person is comprised of body, mind and spirit; (2) the body is capable of self-regulation, self-healing and health maintenance; (3) the structure and function of the body are reciprocally related; and (4) rational medical treatment is based upon an understanding and integration of these three principles along with the use of evidence-based medicine.

Osteopathic manipulative treatment is a complement to the patient in an osteopathic physician's practice and treats both structure and function. When structure is improved, function is also improved; and when function is improved structure also improves. This process maintains and improves the body's self-regulation and healing. These philosophical and practice training commitments are the principles that distinguish osteopathic physicians (DO) from allopathic physicians (MD).

Primary Care and Under Served Communities

Since its inception in the late 1800s, more than 60% of osteopathic physicians practice in primary care fields. Unlike any other physician training paradigm, after completing osteopathic medical school, graduates are required to complete a one-year internship through which they gain experience in the areas of primary care and surgery. After completion of the internship, the osteopathic physician chooses to continue residency training in either primary care or in one of the 42 or more specialty and sub-specialty areas. All osteopathic physicians are grounded first in the primary care of patients.

Stemming from the principle of putting patients first, osteopathic physicians represent a significant portion of the physicians practicing in rural communities where attracting physicians is a common challenge. For example, while osteopathic physicians comprise a small percentage of the nation's physicians, they represent a significant percent of all the physicians practicing in rural, underserved areas. For many underserved communities, osteopathic physicians are the sole physicians providing complete healthcare within multiple county areas.

It is in the spirit of this distinctiveness that the American Osteopathic Association submits its statement on health care policies and principles:

1. **High Quality Medical Care – Health Systems Change, Access, Reliability, Patient Protections**: *The American Osteopathic Association strives to improve the quality and accessibility of healthcare services delivered to America's patients.*

a) <u>The Uninsured</u>

- The AOA supports universal healthcare coverage in which all Americans have access to health care coverage. Coverage can be provided through federal and state programs, private programs, or a combination of the two. Universal care should not be confused with single payer healthcare systems.
- The AOA supports the use of the tax code (tax credits and deductions), new purchasing agreements, and the limited expansion of existing federal and/or state programs (including Medicare, Medicaid, and SCHIP) to accomplish this goal.
- The AOA opposes the establishment of a single payer healthcare system in which the federal, state, or local government is the primary source of funding for healthcare services, excluding any existing federal or state programs, such as Medicare, Medicaid, and SCHIP.
- The AOA opposes attempts by the government to mandate healthcare coverage through a defined benefit or defined contribution program.
- The physician-patient relationship must be protected.
- Physicians, in cooperation with their patients, must maintain a high level of autonomy to control the healthcare services provided. Federal policies must not interfere with laws governing patient protections or healthcare rights.
- Policies should support the ability of physicians, hospitals, and other healthcare providers to provide care to patients. Physician compensation for care provided must not be jeopardized by federal, state, or local policies.

b) <u>Managed Care</u>

- The American Osteopathic Association first created a "Patient's Bill of Rights" in 1981 and has updated it continually to ensure the advancement of quality and consumer protections within the healthcare system. Built on the principle that patients have the right to humane and dignified treatment, the AOA's Patient's Bill of Rights is the foundation upon which the osteopathic medical profession continues to advance what America accepts as essential patient protections. Among these assurances are:

    1. The patient's right to secure medical treatment from the physician of one's choice. With more than 100 million patient visits per year made to

osteopathic physicians, millions of patients across the country make that choice daily, and must be empowered to continue to do so.

2. The patient's right to seek emergency department services based on the patient's belief that he/she is in medical peril. Known as the "prudent layperson" standard, the AOA believes that a health plan does not have the right to deny reimbursement to such patients and, therefore, we support the prohibition of health plans requiring "prior approval" for emergency medical services.
3. The patient's right to receive, in layman's terms, complete and current information about treatment options and the expected outcomes of each.
4. The patient's right to accept or reject treatment options after being fully informed by the physician. Integral to fully informing a patient, the AOA supports the patient's right to know the cost of the treatments. In addition, the AOA supports the patient's right to a free exchange of medical or benefit information with a physician. The AOA opposes any practice that would impede patient/physician communication either through contractual expression or by arbitrary termination of the physician as a provider.
5. The patient's right to expect that his/her medical records will be kept confidential and that these medical records be made available to the patient as guaranteed under the Health Insurance Portability and Accountability Act of 1996.

c) <u>Patient Safety</u>

The American Osteopathic Association is dedicated to improving the quality of the nation's healthcare delivery system. The AOA recognizes that medical errors and adverse events occur and is committed to reducing these occurrences.

The AOA believes that it is the current healthcare delivery system and not physicians alone that are the source of these events. We support the implementation of systemic procedures and policies that improve the quality of the healthcare delivery system.

The AOA supports the establishment of a databank designed to evaluate adverse events from across the country and produce reports designed to assist others in preventing similar occurrences. The reporting of such events could be either voluntary or mandatory, but the AOA believes that any information reported should be exempt from discovery and contain legal protections for all parties involved. Additionally, the AOA believes that all information reported should be exempted from discovery under the Freedom of Information Act (FOIA).

d) <u>Professional Liability Insurance Reform</u>

The American Osteopathic Association continues to seek solutions to reduce the high costs of professional liability insurance through the passage of tort reform legislation. The AOA supports the right of patients to be provided with legal redress when their employer-sponsored health insurers' treatment rules and coverage determinations cause them harm.

Like the physician community at-large, many osteopathic physicians have stopped delivering obstetrical care and other high-risk procedures because of exorbitant professional liability insurance premiums associated with delivering such care. The AOA believes that relief can be found in tort reforms such as limitations on non-

economic damage awards, equity on joint and several liability, limiting attorney contingency fees, periodic payments, reductions in statutes of limitation, and the reform of the collateral source rule.

The American Osteopathic Association recognizes that physicians are not alone in making treatment determinations for their patients. In the case of employer-sponsored health plans, which set forth treatment rules and coverage determinations, both patients and physicians must live and practice within a framework established by a healthcare plan, and not by a physician. Because of this leverage, third party payers and health plans are able to place controls on patient treatment. Once patient care is completed, physicians maintain the entire liability for these treatment decisions. The osteopathic profession believes that the responsibility for patient care decisions should be more equitably placed.

e) Women's Health

The American Osteopathic Association is dedicated to advancing federal policies that ensure appropriate attention to the unique medical needs of women. The AOA recognizes that women's health issues have not received adequate attention in the past. The osteopathic profession supports policies that ensure access to comprehensive care across a woman's life span, including prenatal care and preventive health services.

Therefore, the osteopathic profession supports increases in federal funding that (1) advance research into women's health issues, such as preventive measures and cures for breast and cervical cancer, osteoporosis, and cardiovascular disease in women; (2) improve the delivery of comprehensive quality healthcare to female patients of all ages; and (3) expand undergraduate and graduate medical education on women's issues.

f) Racial and Ethnic Disparities in Healthcare

Minority populations in America often experience difficulty in obtaining access to needed healthcare services. The AOA supports (1) initiatives that increase access to healthcare services for all Americans regardless of race or socioeconomic class; (2) efforts to expand outreach to culturally diverse populations, including enhancing research efforts and improving healthcare options in communities where incidents of certain healthcare conditions are more prevalent than in the community as a whole; (3) increased funding for programs targeted at minority populations, which decrease infant mortality rates and increase immunization and access to other preventive healthcare services; and (4) early intervention and treatment programs for minorities suffering from breast cancer, hypertension, diabetes, prostate cancer, alcoholism, and other diseases that disproportionately affect minority populations.

g) Prescribing

The American Osteopathic Association supports the ability of physicians to advocate on behalf of their patients without unfair or unwanted influence from outside agencies. The AOA believes that restrictive formularies and reimbursement policies that attempt to limit reimbursement, coverage, or other information about all available pharmaceutical treatment options violate the physician-patient relationship.

h) Non-Physician Clinicians

The American Osteopathic Association acknowledges the role of non-physician clinicians in the healthcare delivery system, but continues to advocate for direct

physician supervision. Attempts by non-physician clinician groups to expand their defined scope of practice beyond the accepted levels are opposed. Additionally, we strongly oppose attempts by any non-physician clinician group to place itself in a position of primary contact or serve as primary care providers.

i) HIV/AIDS

The AIDS crisis in Africa, the United States, and elsewhere has grown exponentially during the past twenty years and reverberations will continue to be felt around the world for decades to come. The American Osteopathic Association supports private and governmental efforts to address HIV/AIDS globally. Osteopathic physicians and osteopathic medical colleges provide medical expertise and financial support to assist distressed populations, particularly in Africa.

j) Regulatory Reform

The American Osteopathic Association is committed to reducing the regulatory burden placed upon physicians by Medicare and its contractors. The governing documents of Medicare currently exceed 130,000 pages and present a compliance quandary for physicians. The AOA believes that osteopathic physicians should be focused on patient care and not on complying with excessive federal mandates.

k) Office of the Surgeon General

The American Osteopathic Association supports the efforts of the Surgeon General, the nation's leading spokesperson on matters of public health, to protect and advance the health of the American people. The AOA will work with the Surgeon General and the staff of the Office of the Surgeon General to advocate for effective health promotion and disease prevention programs, participate in activities sponsored by the Office of the Surgeon General, and provide the expertise of osteopathic physicians.

2. Medicare and Medicaid: *The American Osteopathic Association strives to ensure that affordable, high quality medical care is available to all Americans, particularly vulnerable and uninsured populations such as senior and disabled Americans. As the Medicare and Medicaid programs ensure access to medical care for senior citizens, the disabled, children, and low-income individuals, the AOA supports these programs and pledges its cooperation in ensuring the continued availability of quality medical care at a reasonable cost.*

a) Medicare Physician Payments

The American Osteopathic Association supports legislative proposals to reform the Medicare physician payment formulas to reflect the costs of providing care and reduce the unpredictable nature of the current payment formulas. The current system, based largely upon projections and trends, should be altered to reflect actuarially sound data that limits the volatility of the formulas on a year-to-year basis.

Additionally, the AOA supports revisions to Medicare payment policies that reflect equity in payments for rural and urban providers.

b) Private Contracting

The osteopathic profession believes that physicians and Medicare beneficiaries have the right to contract privately for medical services otherwise covered by Medicare. The Balanced Budget Act of 1997 gives physicians this right. However, the law restricts the practical application of this right by mandating that physicians who enter

into private contracts with Medicare beneficiaries must opt out of the Medicare system for two years. The AOA supports legislative efforts that would make private contracting an immediate, viable option. The AOA supports the inclusion of specific patient protections in private contracting legislation.

c) **Medicaid/SCHIP**

The Medicaid program has made significant inroads into improving the quality of healthcare available to vulnerable Americans, such as indigent pregnant women and their dependent children, terminally ill, and disabled populations. The AOA supports the Medicaid program, but remains concerned that it is under funded. The AOA supports efforts by the federal government to work with the states to increase funding for Medicaid and ensure that a standard of high quality, accessible care is available to all Medicaid patients.

3. **Osteopathic Graduate Medical Education**: *The American Osteopathic Association is committed to working with Congress to ensure that osteopathic graduate medical education residency training positions are protected within federal law.*

Osteopathic and allopathic physicians are educated, trained and certified on separate but parallel tracks. Both physician professions have their own medical school accreditation entity, postgraduate training authority, and certification boards that are equally recognized by the U.S. Department of Education and the Centers for Medicare and Medicaid Services.

Given the distinct contribution to American healthcare made by osteopathic physicians, any graduate medical education reform must take special care to preserve and strengthen the osteopathic system of training physicians. Any reforms of the graduate medical education system must be made with a full understanding of their impact on the osteopathic graduate medical education system. Because osteopathic training is different, there is a true risk of inadvertent harm when federal legislators and regulators fail to recognize the impact of their reforms on the osteopathic graduate medical education system.

The AOA supports the investigation and debate of GME payment policies that reflect the contributions of parties other than the federal government. While the AOA believes that GME is an inherent 'public good' and that the federal government should continue to subsidize the training of physicians, we recognize that other parties benefit as well. To this end, we continue to encourage debate focused on the potential establishment of alternate GME financing mechanisms that rely upon all parties involved with a majority of funding continuing to be provided by the federal government.

The AOA Bureau of Osteopathic Education (BOE) reports to the Board of Trustees on behalf of its two subordinate councils: the Council on Postdoctoral Training (COPT) and the Council on Continuing Medical Education (CCME). The COPT has two subordinated committees: the Committee on Osteopathic Training Institutions (COPTI) and the Program and Trainee Review Committee (PTRC). With respect to the accreditation of osteopathic postdoctoral training institutions, the BOE is the final accrediting body. The Commission on Osteopathic College Accreditation (COCA), formerly the Bureau of Professional Education, is the entity within the AOA that is recognized by the U.S. Secretary of Education as the accreditation agency for colleges of osteopathic medicine (COMs) in the United States. With respect to the college accreditation function, the COCA is the final approval authority for COM accreditation standards and procedures and the COCA handbook.

a) **Osteopathic Postdoctoral Training Institutions**

Changes in the healthcare environment prompted the AOA Board of Trustees in 1995 to approve a new system for structuring and accrediting osteopathic GME, a system through which physicians are trained to practice medicine in all healthcare delivery environments.

The new osteopathic GME system is centered upon the Osteopathic Postdoctoral Training Institution (OPTI). Each OPTI is a consortium that includes one or more AOA-accredited osteopathic hospitals and at least one college of osteopathic medicine. OPTIs have the flexibility to provide opportunities for training in ambulatory healthcare facilities and non-traditional training sites that will be drawn into the many OPTI consortia. The OPTI system will encompass the osteopathic internship programs and the more than 500 residency programs already in place. With the goal of achieving the highest possible quality and efficacy in physician training, the OPTI draws on the strength of the traditional GME structure while adding to it the depth of the academic infrastructure and the variety of non-traditional training sites.

The osteopathic medical profession is committed to working with Congress and the U.S. Department of Health and Human Services to achieve the full implementation of its Osteopathic Postdoctoral Training Institutes consortia project.

4. **RESEARCH**: *The American Osteopathic Association is committed to advancing research within the osteopathic profession. It is also committed to working with Congress, the Administration, and private organizations to support research that benefits the advancement of medical science and the delivery of healthcare.*

The University of North Texas Health Science Center at Fort Worth-Texas College of Osteopathic Medicine houses the profession's Osteopathic Research Center. The Center conducts research on the effectiveness of osteopathic manipulative treatment (OMT), develops collaborative medicine, and trains students and clinicians in osteopathic research. 2005

ASSESSMENT AND REMEDIATION FOR PHYSICIANS--DEVELOPMENT OF

WHEREAS, the Federation of State Medical Boards of the United States (FSMB) developed *Recommendation*s for state medical boards on implementing measures to improve overall physician practice, enhancing the competence of practicing physicians and developing a system of markers to identify licensees warranting evaluation; and

WHEREAS, state medical boards are accountable to the public for ensuring that the physicians within their jurisdiction maintain a level of competence consistent with current professional knowledge and practice; and

WHEREAS, state medical boards should be responsible for developing and implementing methods to identify physicians who fail to provide quality care, as well as providing opportunities for improving physician practice in problematic areas; and

WHEREAS, while FSMB policy focuses on physician assessment and remediation tool for physicians, it does not suggest that all physicians be required to pass a formal registration or relicensure examination in order to continue practice; now, therefore, be it

RESOLVED, that the American Osteopathic Association opposes any efforts by any individual state agency to relicense physicians by any form of examination; and, be it further

RESOLVED, that the AOA and its state societies encourage state licensing boards to develop programs to enhance overall physicians' practices and develop an assessment and remediation tool for physicians to identify licensees warranting evaluation as delineated by the

FSMB in its "evaluation of quality of care and maintenance of competence" policy. 1990; *revised* 1995, 2000, *revised* 2005

ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD)

WHEREAS, primary care physicians diagnose and treat the patients with ADD/ADHD; and

WHEREAS, many of these patients are cared for totally by these primary care physicians; and

WHEREAS, insurance carriers either provide minimal or no services or support; and

WHEREAS, primary care physicians spend extended time diagnosing, counseling, calling/writing to educators, and advising both the patient and the family as to the care of this patient; now, therefore, be it

RESOLVED, that the American Osteopathic Association urge the insurance carriers to provide coverage for attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) patients by primary care physicians. 2005

BREAST-FEEDING EXCLUSIVITY

WHEREAS, the beneficial health effects of breastfeeding are widely acknowledged for infants, children, and their mothers; and

WHEREAS, the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American Academy of Family Practitioners and members of the American College of Osteopathic Pediatricians has provided useful guidelines to support breastfeeding; and

WHEREAS, the American College of Osteopathic Pediatricians, a member of the United States Breastfeeding Committee, agree that more needs to be done to support the Healthy People 2010 goals; and

WHEREAS, the Health and Human Services Blueprint for Action on Breastfeeding from the Surgeon General states: "Recent research also suggests that breastfeeding reduces the risk of chronic diseases among children, including diabetes, inflammatory bowel disease, allergies and asthma, and childhood cancer. Mothers also benefit from breastfeeding, including less postpartum bleeding, earlier return to pre-pregnancy weight, a possible reduced risk of ovarian cancer and premenopausal breast cancer, and positive hormonal, physical and psychosocial effects;" and

WHEREAS, an information gap exists concerning risks to the mother and infant associated with lack of breastfeeding; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the dissemination of information for the practicing physician about the health benefits associated with the duration and exclusivity of breastfeeding for six months. 2002

BREASTFEEDING, FRIENDLY WORKPLACE

WHEREAS, all physicians, whether they provide maternity or newborn care, have an opportunity to play a unique role in the promotion of breastfeeding; and

WHEREAS, there are numerous scholarly accounts of the benefits of breastfeeding; and

WHEREAS, the beneficial effects of breastfeeding have been described on the immune system, breastfed infants have increased intelligence and positive health outcomes are seen for both mother and infants; and

WHEREAS, most mothers are forced to return to the workplace after six weeks maternity leave; and

WHEREAS, the American Academy of Pediatrics and the World Health Organization recommend exclusive breastfeeding for four to six months; and

WHEREAS, breastfeeding an infant will improve the health of our country and reduce costs for medical care; and

WHEREAS, osteopathic physicians can serve as role models and take a leadership role in creating and supporting a breastfeeding friendly workplace; now, therefore, be it

RESOLVED, that the American Osteopathic Association urge its membership to take a role in providing a breastfeeding friendly workplace in their offices and hospitals. 2002

BREASTFEEDING—PROMOTION, PROTECTION AND SUPPORT OF

WHEREAS, all physicians, whether they provide maternity or newborn care, have an opportunity to play a unique role in the promotion of breastfeeding; and

WHEREAS, breastfeeding historically has been the societal norm in providing nutrition to infants; and

WHEREAS, there are numerous scholarly accounts of the benefits of breastfeeding; and

WHEREAS, the beneficial effects are known on the immune system, increased intelligence and positive health outcomes of both mother and infants; and

WHEREAS, over the last century, physicians have played a significant role in the mother's decision whether or not to breastfeed their infants; and

WHEREAS, current attitudes about nutrition for infants is molded in part by the manufacturers of human milk substitutes; and

WHEREAS, the American Academy of Pediatrics and the World Health Organization recommend exclusive breastfeeding for four to six months; and

WHEREAS, the American College of Osteopathic Pediatricians participates in the United States Breastfeeding Committee; and

WHEREAS, Healthy People 2010 challenges the American public to increase the rate of initiation and continuation of breastfeeding; now, therefore, be it

RESOLVED, that the American Osteopathic Association urge its membership to take a role in the protection, promotion and support of breastfeeding. 2002

BREASTFEEDING WHILE ON METHADONE MAINTENANCE

WHEREAS, methadone maintenance has been established as the standard of care for the addicted opiate dependent woman, and is associated with better maternal and fetal outcomes; and

WHEREAS, many health-care agencies and associations, publications from the Department of Health and Human Services and others have recommended breastfeeding while women are on methadone maintenance without restrictions regarding dosage, the only restriction being that the woman must be in stable recovery from all drug and alcohol abuse; and

WHEREAS, the literature on methadone levels in breast milk does not conclude that danger1ous amounts of methadone are expressed in breast milk or that there have been adverse experiences by women nursing while on methadone; now, therefore, be it

RESOLVED, that if women choose to breastfeed, then the American Osteopathic Association encourages exclusive breastfeeding by mothers in methadone maintenance who are in stable recovery from all drugs and alcohol abuse. 2003

BREASTFEEDING WOMEN --PROTECTING

WHEREAS, exclusive breastfeeding has been shown to be the preferred method of infant nutrition for the first six months of life; and

WHEREAS, the health benefits of breastfeeding have been supported by the United States Breastfeeding Committee, the American Academy of Pediatrics and the American College of Osteopathic Pediatricians; and

WHEREAS, the federal government has only recently provided protection to women breastfeeding on federal property; and

WHEREAS, some state and municipalities still do not allow a woman to breastfeed in a public space citing a violation of public decency laws; and

WHEREAS, the American College of Osteopathic Pediatricians and the American Osteopathic Association have provided strong support for breastfeeding; now, therefore, be it

RESOLVED, that the American Osteopathic Association encourage its members to contact their elected officials in support of legislation protecting the rights of breastfeeding women; and be it further

RESOLVED, that the American Osteopathic Association urge the Council on Federal Health Programs to add this issue to their legislative agenda. 2003

BROADBAND OVER POWER LINES (BPL)

WHEREAS, it has been proposed that broadband service be provided over power lines (BPL), and

WHEREAS, initial deployment of BPL has resulted in harmful interference to HF (1.7-80 MHz) frequencies; and

WHEREAS, federal/non-federal governmental entities and Amateur Radio Operators depend upon these frequencies for their communications; and

WHEREAS, these frequencies are vital in providing emergency communications when Public Safety VHF (30-300 MHz) and UHF (300 MHz-3 GHz) systems suffer failures during emergencies and disasters; and

WHEREAS, many other countries, such as Japan, have rejected BPL; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports efforts to eliminate interference to private and Public-Safety Radio Systems in order to ensure that citizens and emergency service providers preserve the ability to communicate in times of emergencies and disasters; and, be it further

RESOLVED, that this resolution be referred to the Council on Federal Health Programs for handling. 2004

CANCER

WHEREAS, the American Osteopathic Association reaffirms, by actions of its House of Delegates, its primary purpose to serve patients through competent healthcare delivery, current medical procedures and scientific research; and

WHEREAS, thousands of Americans, both victims and families, endure incalculable suffering each year because of cancer; and

WHEREAS, cancer is a widespread biological phenomenon with different incidence, appearances, and functioning; and

WHEREAS, the vastly complex nature of cancer requires a coordinated biomedical research effort of unprecedented dimensions; now, therefore, be it

RESOLVED, that the American Osteopathic Association recognizes, endorses, and approves the continuing efforts of the National Cancer Institute to develop means to reduce significantly the incidence of cancer and the suffering and death resulting from cancer; and, be it further

RESOLVED, that information gained from osteopathic and other research activities on the applications of the latest advances in cancer prevention, detection, early diagnosis and treatment be disseminated as rapidly as possible to the medical community and the public it serves. 1974; *reaffirmed* 1980, 1985; *revised* 1990, 1995, *reaffirmed* 2000, *revised* 2005

CARBONATED SOFT DRINKS IN SCHOOL

WHEREAS, numerous studies in medical journals have documented a significant increase in the consumption by children and adolescents of carbonated soft drinks and other non-nutritious beverages; and,

WHEREAS, four serious health issues have been linked to increased carbonated soft drink intake and the resulting decrease in dairy product intake in children over the past 20 years: 1) obesity (from the calories); 2) osteoporosis and bone fractures (from inadequate calcium intake); 3) enamel erosion and dental caries (due to the product's acidity); and 4) classroom behavioral issues (due to caffeine); and

WHEREAS, numerous school districts across the country are seeking or have in place lucrative commercial carbonated soft drink contracts with incentives tied to sales within their schools; and

WHEREAS, these contracts serve to augment school budgets but may create conflict in the promotion of a healthier diet; now, therefore, be it

RESOLVED, that the American Osteopathic Association encourage its physician members through articles in its publications and website and in communications to state societies to educate and caution their patients, school superintendents, and members of school boards across our nation as to the health consequences of carbonated soft drinks and urge them to eliminate these products in our school systems. 2001

CARDIOPULMONARY RESUSCITATION, TRAINING

WHEREAS, cardiopulmonary resuscitation (CPR) techniques have been proven as effective lifesaving measures; and

WHEREAS, CPR techniques should be familiar to as many members of the general public as can be interested; now, therefore, be it

RESOLVED, that the American Osteopathic Association strongly supports instruction in CPR to the general public; and, be it further

RESOLVED, that the AOA encourages member physicians to qualify as instructors in basic life support so as to enable them to teach cardiopulmonary resuscitation courses on a voluntary basis. 1980; *revised* 1985, 1990, 1995, 2000, *reaffirmed* 2005

CARDIOVASCULAR DISEASE AND WOMEN

WHEREAS, over 40 percent of all female deaths in America occur from cardiovascular disease (CVD), which includes coronary heart disease (CHD) and stroke; and

WHEREAS, CVD is a particularly important problem among minority women as the death rate due to CVD is substantially higher in black women than in white women; and

WHEREAS, each year CVD claimed the lives of more women than all forms of cancer combined; and

WHEREAS, the current obesity epidemic and lack of physical activity, along with associated diabetes, hypertension, and dyslipidemia are major factors in cardiovascular disease development; and

WHEREAS, misperceptions still exist that CVD is not a real problem for women, and

WHEREAS, the AOA and other osteopathic organizations and osteopathic physicians have participated in activities promoting women's cardiovascular health such as National Women's Health Week and National Women's Check-Up Day; now, therefore be it

RESOLVED, that the American Osteopathic Association encourage its members to participate in continuing medical education programs on CVD in women; and be it further

RESOLVED, that the AOA urge the state and specialty associations to offer CME on CVD in women, as part of their educational offerings; and, be it further

RESOLVED, that the AOA encourage its members to participate in national initiatives on women's health, especially cardiovascular health such as the National Heart, Lung, and Blood Institute's *The Heart Truth* (Red Dress) campaign; and, be it further

RESOLVED, that the AOA continue to recognize National Women's Health Week and National Women's Check-Up Day in the future; and be it further

RESOLVED, that the AOA, through its website, link to organizations whose mission is to educate patients and physicians on CVD. 2004

CENTERS FOR MEDICARE AND MEDICAID (CMS) COMMUNICATIONS WITH PHYSICIANS

WHEREAS, Medicare is continually issuing updated coding regulations that physicians and their staffs must use in order to obtain payment and to meet standards designed to curb program fraud and abuse; and

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) has now published on its website "essential coding information, the documentation guidelines for single and multi-system comprehensive evaluation and management services and the Correct Coding Initiative which sets Medicare standards for the bundling of services"; and

WHEREAS, communicating with physicians enhances the efficiency of the Medicare program by reducing the number of claims that have to be reprocessed because of errors or that have to be returned to physicians as unprocessable; and

WHEREAS, failure to provide physicians with necessary coding and billing information hampers the government's efforts to detect fraudulent and abusive practices by increasing the number of inadvertent coding and billing errors; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the distribution to all physicians, of thorough and current written information by all fiscal intermediaries on the correct preparation and coding of Medicare claims; and, be it further

RESOLVED, that the AOA supports the complete reasons for the rejection of any Medicare claims be communicated to the physician. 1999; *revised 2004*

CMS'S METHOD IN CALCULATING PATIENT SERVICES—A CHANGE IN

WHEREAS, the annual health care costs of Centers for Medicare and Medicaid Services (CMS) are placed into various categories; and

WHEREAS, these categories include hospital, nursing home, home health care, and physician services costs are calculated to determine annual expenditure for CMS; and

WHEREAS, the Physician Services category includes Direct Physician-Patient care costs, diagnostics testing costs and ancillary health care costs; and

WHEREAS, direct Physician-Patient care services costs are not known due to this type of grouping methodology; now, therefore, be it

RESOLVED, that the American Osteopathic Association endorses the proposal that the Centers for Medicare and Medicaid Services divide Physician Services into separate categories of Direct Physician Services and Referral Physician Services to provide the true expenditure of health services. 2003

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)--OPPOSITION TO CMS'S BEHAVIORAL OFFSET DECREASE IN PRACTICE EXPENSE VALUES

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) imposed an across-the-board behavioral offset to practice expense relative value units (RVUs) to account for anticipated increase in volume and intensity of services in response to payment reductions from the refinement of practice expenses RVUs; and

WHEREAS payment reductions more likely will lead to volume reductions, not increases; now, therefore, be it

RESOLVED, that the American Osteopathic Association opposes Centers for Medicare and Medicaid Services' policy to impose behavioral offset to physician services. 1998, *revised* 2003

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) POLICIES

WHEREAS, the American Osteopathic Association is increasingly concerned with government policies which restrict medical care of their patients; and

WHEREAS, policies frequently do not seem to protect the quality of care senior citizens obtain; and

WHEREAS, policies often conflict with what is considered to be appropriate medical care and treatment; and

WHEREAS, it is more difficult to change policies, rules and regulations once they are implemented; and

WHEREAS, often the policy is a directive from the Medicare carrier versus the Centers for Medicare and Medicaid Services (CMS); however, physicians are not always aware of this on implementation of the policy; now, therefore, be it

RESOLVED, that the American Osteopathic Association continue to inform state associations and their members on policies and rules being considered by the Centers for Medicare and Medicaid Services and/or other federal agencies on major patient/physician issues; and, be it further

RESOLVED, that the AOA encourage state associations provide their members with the information and take an active role in responding to CMS on policies and rules pertinent to their members, their practices and patients. 1998; *revised* 2003

CENTERS FOR MEDICARE AND MEDICAID (CMS)—REGULATORY REFORM

WHEREAS, the American Osteopathic Association represents osteopathic physicians in the United States; and

WHEREAS, physicians face significant state and federal regulatory requirements; and

WHEREAS, the quality of health care suffers due to excessive regulations that divert time and resources from patient services to fulfill administrative requirements; and

WHEREAS, the AOA opposes any effort at the state or federal level to interfere with the practice of medicine; and

WHEREAS, the AOA opposes the implementation of un-funded regulatory mandates; and

WHEREAS, physicians rely on Medicare carriers to provide explanations and guidance concerning Medicare policies and frequently carrier responses are inaccurate and unreliable; now, therefore, be it

RESOLVED, that the American Osteopathic Association remain committed to securing the enactment of comprehensive reforms that reduce the regulatory burden and allow physicians to dedicate the majority of their time to providing patient care; and, be it further

RESOLVED, that the Centers for Medicaid and Medicare Services (CMS) provide more physician education regarding Medicare policies, procedures, and regulations, particularly in rural and frontier areas; and, be it further

RESOLVED, that the AOA support actions that will hold carriers accountable for providing inaccurate information to physicians. 2003

CHELATION THERAPY

WHEREAS, chelation therapy utilizing *calcium disodium edetate* is currently labeled by the Food and Drug Administration and recognized by most physicians as medically acceptable only in the management of acute or chronic heavy metal poisoning; now, therefore, be it

RESOLVED, that pending the results of thorough, properly controlled studies, the American Osteopathic Association does not endorse chelation therapy as useful for other than its currently Food and Drug Administration approved and medically accepted uses. 1985; *revised* and *reaffirmed* 1990, 1995; *revised* 2000 (Referred in 2005)

CHILD ABUSE AND NEGLECT

WHEREAS, there are long-term negative effects that result from child abuse and neglect; and

WHEREAS, concerns about child abuse and neglect have led to increased federal, state and local efforts to address these problems; and

WHEREAS, all states have enacted criminal law provisions and mandatory reporting requirements and have strengthened child protective services to handle reports of abuse and neglect; and

WHEREAS, physicians are likely to detect child abuse and neglect; and

WHEREAS, the American Osteopathic Association recognizes child abuse and neglect as a national health problem; now, therefore, be it

RESOLVED, that the American Osteopathic Association urges its members to participate in a continuing national educational program relative to aspects of child abuse and neglect, to cooperate with state and local child protection agencies in reporting suspected child abuse and neglect cases, and to keep a vigilant eye toward recognizing maltreatment of children. 1974; *reaffirmed* 1980; *revised* 1985, 1990, 1995, 2000, 2005

CHILDREN ON AIRPLANES--RESTRAINTS

WHEREAS, numerous injuries have resulted from children not being securely positioned in airplane seats; and

WHEREAS, turbulence is the leading cause of nonfatal injury to aircraft passengers; now, therefore, be it

RESOLVED, that the American Osteopathic Association encourages the Federal Aviation Administration to develop guidelines on infant and child safety for air travel. 2002

CHILDREN'S SAFETY SEATS

WHEREAS, motor vehicle accidents continue to be a major cause of injuries and fatalities in children; and

WHEREAS, studies have demonstrated that child safety seat usage is effective in preventing fatalities and injuries when properly used; and

WHEREAS, numerous brands of child safety seats meeting the National Highway Traffic Safety Administration's Federal Motor Vehicle Safety Standard are on the market; and

WHEREAS, all 50 legislatures and the District of Columbia mandate child safety seat usage; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the enforcement of child safety seat statutes; and, be it further

RESOLVED, that the AOA recommends that its members educate their patients about the life-saving potential of child safety seats, encourage seat placement in the rear seat of passenger vehicles, and encourage the placement of infants in rear-facing seats until they are one year old or weigh more than twenty pounds; and, be it further

RESOLVED, that the AOA recommends education on dealer retrofit of new, available rear support harnesses for car seats. 1985; *revised* 1990; *reaffirmed* 1995; *revised* 2000, 2005

COLORECTAL CANCER SCREENING--REIMBURSEMENT FOR

WHEREAS, colorectal cancer (CRC) is the second leading cause of cancer deaths in the United States; and

WHEREAS, CRC affects women and men with equal frequency; and

WHEREAS, CRC is one of the most preventable and curable types of cancer, when detected early; and

WHEREAS, as many as 25,000 to 30,000 lives would be saved each year if men and women age 50 years and older were screened by colon examination every three to five years; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports colorectal cancer screening by all payers according to the American Cancer Society recommendations. 1998, *revised* 2003

CO-MANAGEMENT OF A PATIENT

WHEREAS, the American Osteopathic Association considers an examination, history and physical by a D.O. or M.D. standard medical practice for patients prior to diagnosing and treating a patient; and

WHEREAS, evaluation of a patient's overall health status is imperative prior to any medical procedure/surgery; and

WHEREAS, follow-up care by a physician following a procedure is also considered standard medical practice; now, therefore, be it

RESOLVED, that the American Osteopathic Association's position on co-management of a patient, requires the patient to have an examination by the physician who will be performing the procedure; and, be it further

RESOLVED, that the physician providing the procedure be available for the follow-up care of the patient; and, be it further

RESOLVED, that if for any reason the physician providing the procedure cannot provide the pre- and post-procedural care to the patient, that he/she arrange for an osteopathic or allopathic physician to provide for the pre-procedural and post-procedural care. 2002, *revised* 2003

COMPULSIVE GAMBLING

WHEREAS, compulsive gambling is a recognized psychiatric disorder of impulse control in the Diagnostic and Statistical Manual of Mental Disorders (DSMIV); and

WHEREAS, the prevalence of persons afflicted with the disorder is increasing; and

WHEREAS, the true cost of pathologic gambling is enormous in personal and societal terms; and

WHEREAS, there has been little scientific interest and a paucity of resources devoted to this problem; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports research on compulsive gambling. 1998; *revised* 2003

CONDOM USAGE -- HEALTH EDUCATION

WHEREAS, condom usage is often taught by non-medical personnel; and

WHEREAS, condoms fail at times, with the resultant possibility of pregnancy and/or exposure to sexually transmitted diseases including Human Immunodeficiency Virus (HIV); now, therefore, be it

RESOLVED, that the American Osteopathic Association supports full disclosure of the risks and benefits of condom usage and the data on condom failure rates and causes of failure, whenever condom usage is taught. 1995; *revised* 2000, 2005

CONFIDENTIALITY OF PATIENT RECORDS

WHEREAS, the patient/physician relationship is one of the most intimate and important human relationships; and

WHEREAS, the ability of the physician to properly diagnose and treat the patient is predicated, to a significant degree, on the confidence of the patient in his physician and upon the physician's ability to obtain all relevant information from the patient; and

WHEREAS, the protection of privacy of the patient record is a tenet in the Hippocratic and Osteopathic Oaths; and

WHEREAS, increasing involvement by third parties in underwriting the costs of medical care has led to increasing invasion of patient medical records by entities such as Medicare, Medicaid and insurance companies; and

WHEREAS, the encroachment on the privacy of patient records is an inhibitor to patient freedom of expression and mitigates against the acquisition and retention of complete medical records; now, therefore, be it

RESOLVED, that the American Osteopathic Association opposes invasion of privacy of the patient record by any unauthorized person or agency; and, be it further

RESOLVED, that the AOA endorses reasonable programs which seek to protect patient/physician relationships and guarantee confidentiality of patient records.
1980; *revised* 1985, 1990, 1995; 2000, 2005

CPT CODE STANDARDIZED USAGE

WHEREAS, insurance companies and payers of healthcare services have utilized various codes for reimbursement of physician and other healthcare services; and

WHEREAS, insurance companies and managed care entities have been shown to indiscriminately substitute Current Procedural Terminology (CPT) codes causing either lack of payment, delay of payment and/or resulting changes in payment to physicians and healthcare providers; and

WHEREAS, the American Medical Association's (AMA) CPT code text is recognized as the national standard of coding for reimbursement of healthcare services for physicians by the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services (HHS), whose fee schedules most insurance companies have elected to parallel; and

WHEREAS, in the current CPT text, there are separate and distinctive CPT codes delineated for medical services, surgical services, anesthesia services and osteopathic manipulation services; now, therefore, be it

RESOLVED, that the American Osteopathic Association continue its involvement in the development of legislation that would mandate that all payers of healthcare services nationally solely utilize only CPT coding as delineated and as set forth by the current AMA CPT text for all medical services, surgical services, anesthesia services, and osteopathic manipulative services, respectively; and, be it further

RESOLVED, that the AOA continue its involvement in the development of legislation to prohibit payers of healthcare services from indiscriminately substituting CPT codes; and, be it further

RESOLVED, that the AOA work with recognized national insurance and managed care associations to expedite the streamlining of the billing process for osteopathic physicians nationwide. 1997; *revised* 2002

CRIMINAL LITIGATION FOR CLINICAL MISTAKES

WHEREAS, the threat of criminal prosecution for clinical mistakes could result in physicians being reluctant to treat the sickest patients; and

WHEREAS, access to care for patients who have a high risk of a bad outcome could be restricted; now, therefore, be it

RESOLVED, that the American Osteopathic Association opposes criminal prosecution of a physician whose clinical decisions were made without malice and in good faith. 1998, *revised* 2003

DEATH: RIGHT TO DIE

WHEREAS, the patient-physician relationship must be founded on mutual trust, cooperation, respect and informed consent; and

WHEREAS, the advice and medical opinion of the physicians involved in the care of a patient should be readily available to the patient or the patient's representative legally qualified for this purpose; and

WHEREAS, the decision as to what, if any, treatment is to be recommended or instituted for an individual patient is a matter of medical opinion; and

WHEREAS, any competent patient has the right to refuse treatment; now, therefore, be it

RESOLVED, that the decision to cease or omit treatment of a patient whose prognosis is terminal, or where, death is imminent, shall be based upon the wishes of the patient or his/her family or legal representative if the patient is incompetent to act on his/her own behalf as mandated by applicable law. 1979; *revised* 1984, 1989, 1995, 2000, 2005

DIABETICS CONFINED TO CORRECTIONAL INSTITUTIONS

WHEREAS, the incidence of diabetes mellitus is increasing in the general population and among inmates confined in correctional institutions; and

WHEREAS, the availability of American Diabetes Association approved diabetic meals and beverages for diabetic inmates is crucial to the successful treatment of diabetes mellitus; and

WHEREAS, proper nutrition, weight, weight management, and exercise are paramount in preventing diabetes mellitus; now, therefore, be it

RESOLVED, the American Osteopathic Association (AOA) supports the availability of American Diabetes Association (ADA) diabetic meals, beverages, and other diabetic interventions that follow ADA guidelines for all diabetic inmates, who are under the care of a licensed physician, and confined in correctional institutions. 2000, *revised 2005*

DIETARY SUPPLEMENTS

WHEREAS, since enactment of the *Dietary Supplement Health and Education Act of 1994* (DSHEA), makers of dietary supplements no longer have to test their products for purity, safety, or effectiveness before marketing them for human consumption; and

WHEREAS, there is a need to classify as drugs all dietary supplements that are precursors or metabolites of anabolic steroids; and

WHEREAS, under DSHEA, the Food and Drug Administration's (FDA) mandate is to remove unsafe ingredients and products from the market; now, therefore, be it

RESOLVED, that the American Osteopathic Association request the U.S. Congress to amend the Dietary Supplement Health and Education Act (DSHEA) so that dietary supplements will undergo pre-market safety and efficacy evaluation by the Food and Drug Administration. 2002

DIETARY SUPPLEMENTS AND HERBAL REMEDIES—USE OF

WHEREAS, the use of dietary supplements and herbal remedies has reached immense proportions in the United States; and

WHEREAS, osteopathic physicians recognize the need to work with their patients more effectively regarding the use of these substances; now, therefore, be it

RESOLVED, the American Osteopathic Association (AOA) supports modification of the Dietary Supplement Health and Education Act to require that dietary supplements and herbal remedies undergo Food and Drug Administration (FDA) approval, meet standards established by the U.S. Pharmacopeia, and meet FDA postmarketing requirements to report adverse events; and, be it further

RESOLVED, that the AOA encourage the FDA to educate the public about FDA's MedWatch program (or comparable program) and strongly encourage that such products meet the FDA reporting and labeling standards required for prescription drugs. 2000, *revised* 2005

DISABILITY MEDICINE

WHEREAS, the discipline of disability medicine incorporates disability evaluations, independent medical exams, impairment ratings, case management, and illness prevention; and

WHEREAS, there is an ever-increasing number of individuals in the nation's population that are developing real or perceived disabilities; and

WHEREAS, there is an ever-expanding array of federal and state regulatory requirements (such as the Americans with Disabilities Act, Family and Medical Leave Act), as well as disability evaluating systems and programs (such as the Social Security Disability System, state workers' compensation systems); and

WHEREAS, the majority of these evaluations are of a musculoskeletal nature; and

WHEREAS, osteopathic physicians are uniquely qualified to perform disability evaluations, impairment ratings, treat and manage disabled patients; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports education, training, and I involvement of osteopathic physicians and medical students in the discipline of disability medicine. 2002

DISCRIMINATION

WHEREAS, participation as a recognized provider in a managed care program is an economic necessity to many physicians in order to continue in the practice of medicine; and

WHEREAS, some insurance companies base their decision to include or exclude a physician on unknown criteria; and/or in an effort to side-step any willing provider laws; and

WHEREAS, many of these same insurance companies do not provide an avenue of due process for physicians to appeal exclusions or deselection; now, therefore, be it

RESOLVED, that the American Osteopathic Association actively pursue all reasonable avenues in support of its members who are discriminated against by insurance companies and excluded from participating in managed care programs; and, be it further

RESOLVED, that in those instances where there is no due process to discuss and mediate the exclusions, that the AOA petition organizations to present their credentialing criteria and deselection criteria, and to use those resources at its disposal to help obtain a fair and equitable solution to the problem and to include due process in all cases. 1995; *revised* 2000, 2005

DISCRIMINATION IN HEALTHCARE

WHEREAS, the American Osteopathic Association represents the nation's osteopathic physicians, many of whom practice in rural and underserved areas of the country; and

WHEREAS, recent studies have indicated that many minority and female patients are subjected to substandard medical diagnosis and treatment based upon race, ethnicity or gender; and

WHEREAS, these disparities may be occurring without a specific intent or effort overtly to mistreat patients solely on the basis; and

WHEREAS, the osteopathic profession does not condone or tolerate discrimination or bias in diagnosing and treating ailments by physicians based on their patient's race, ethnicity or gender; now, therefore, be it

RESOLVED, that the American Osteopathic Association hereby adopts a zero tolerance policy for all forms of patient discrimination; and, be it further

RESOLVED, that the AOA in concert with other healthcare organizations, the United States Surgeon General's office and the federal, state and local governments will continue to

monitor, correct and prevent any future negative bias towards one or more patient groups. 1999, *revised* 2004

DISPENSING OF MEDICATION BY PHYSICIANS

WHEREAS, the predoctoral education of all physicians includes training in pharmacology, and this educational process continues throughout the years of a physician's practice; and

WHEREAS, there may be compelling circumstances, including patient convenience and cost-effectiveness, when it serves the best interest of patients for physicians to dispense medications; and

WHEREAS, efforts have arisen to restrict, and in some cases, prohibit, the practice of dispensing prescription drugs by physicians to their patients; and

WHEREAS, there exist no data indicating widespread abuse of the practice of dispensing medications by physicians; and

WHEREAS, appropriate and effective mechanisms do exist within the states to discipline those who abuse the practice; now, therefore, be it

RESOLVED, that the American Osteopathic Association opposes any attempt by Congress, the federal government or state governments to restrict, prohibit or otherwise impede the prerogative of physicians to prescribe and dispense appropriate medications to their patients. 1987; *reaffirmed* 1992; *revised* 1997; reaffirmed 2002

DIVERSITY IN LEADERSHIP POSITIONS

WHEREAS, it is the duty of the American Osteopathic Association (AOA) to represent its membership; now, therefore, be it

RESOLVED, that the American Osteopathic Association support increased awareness of and encourage diversity in its leadership positions and encourage its divisional societies to do the same. 1999, *revised* 2004

DOMESTIC, FAMILY AND SCHOOL VIOLENCE EDUCATION

WHEREAS, domestic and family violence has an impact on the healthcare system of the United States across all age groups and patient populations; and

WHEREAS, the osteopathic profession has long been an advocate of patient centered and preventive care; and

WHEREAS, the AOA has adopted (1991) and reaffirmed (1996) a resolution to work with the federal and local government to develop programs to reduce violence and abuse of all kinds; and

WHEREAS, the AOA could serve to promote a nationwide initiative responsive to this societal need in healthcare education similar to the EPEC (Educating Physicians on End of Life Care) program; now, therefore, be it

RESOLVED, that the American Osteopathic Association seek funding to establish leadership in creating, promoting, distributing, and implementing curricula and educational resources aimed at improving the knowledge, attitudes and skills for student, resident and the practicing physician and physician extender communities in the area of domestic, family and school violence; be it further,

RESOLVED, that this effort include but not be limited to pre and post doctoral education, continuing medical education, community education, demonstration projects and efforts for dissemination of "best practices" in the area of domestic, family and school violence. 2001

DOMESTIC VIOLENCE--DEVELOPMENT OF PROGRAMS TO PREVENT

WHEREAS, domestic violence is a major public health concern; and

WHEREAS, domestic violence disrupts the root of our society, especially affecting children; now, therefore, be it

RESOLVED, that the American Osteopathic Association continues to support the efforts of the United States Department of Health and Human Services to develop and foster programs that prevent domestic violence. 1989; *revised* 1994, 1999; *reaffirmed 2004*

DRINKING/DRIVING

WHEREAS, a large percentage of the fatal traffic accidents in the United States each year involve alcohol; and

WHEREAS, drivers under the influence of alcohol in the United States cause accidents resulting in the loss of millions of dollars annually in medical expenses, damages to persons, property, and to loss of employment; and

WHEREAS, the deaths and losses caused by drivers under the influence of alcohol can be prevented through greater awareness of the problem by individuals and by society as a whole, and through enactment and more stringent enforcement of statutes prohibiting driving under the influence of alcohol; therefore, be it

RESOLVED, that the American Osteopathic Association pledges its support to law enforcement agencies in their efforts to enforce drinking/driving statutes; and be it further

RESOLVED, that the AOA encourages agencies in government and in the private sector to promote greater public awareness of the problem; and, be it further

RESOLVED, that the AOA encourages its members, through discussions with their patients and their communities, to actively assist in the effort by making the problem and its prevention more visible to the public. 1974; *revised* 1978; *reaffirmed* 1983; *revised* 1986, 1991, 1992, 1997; revised 2002

DRIVER INTOXICATION/ IMPAIRMENT

WHEREAS, administrative license revocation in some states has been shown to be effective in reducing alcohol fatalities and drunk driving; and

WHEREAS, driving while intoxicated, under the influence or impaired, often results in fatalities; now, therefore, be it

RESOLVED, that the American Osteopathic Association opposes the practice of driving while intoxicated, under the influence or impaired; and be it further

RESOLVED, that the American Osteopathic Association supports efforts and encourages its membership to educate their patients and the public about the dangers of driving while intoxicated, under the influence or impaired. 1994; *revised* 1996, 2001

DRUG EXPENDITURES--ELIMINATION OF RESTRICTIVE DRUG FORMULARIES

WHEREAS, managed care organizations and other restrictive drug formularies create a barrier between physician and patient; and

WHEREAS, these formularies may not provide the best treatment choices for the individual patient; and

WHEREAS, it is reasonable and prudent to contain costs of drug expenses; now, therefore, be it

RESOLVED, that the American Osteopathic Association advocates the removal of restrictive drug formularies. 1999; *reaffirmed 2004*

DRUG SAMPLES

WHEREAS, free samples of prescription drugs help patients who lack insurance coverage for medications or those who cannot afford medications and also help physicians determine whether a drug is appropriate for a patient before purchasing a prescription; now, therefore, be it.

RESOLVED, that the American Osteopathic Association encourages the pharmaceutical industry to continue the distribution of drug samples, and/or voucher to physicians, including those drugs whose patents have expired, and, be it further

RESOLVED, that the AOA petition the Food and Drug Administration to not limit the manufacturers' distribution of drug samples and/or vouchers; and be it further

RESOLVED, that the AOA continue to defend and support policies that allow osteopathic physicians to provide drug samples (including stock bottles or vouchers when appropriate) free-of-charge to patients. 1995; *reaffirmed* 1996; *revised* 2001

DRUG THERAPY SURVEYOR GUIDELINES FOR NURSING HOMES

WHEREAS, the American Osteopathic Association agrees that appropriate drug therapy is an important issue in the management of our long-term patients; and

WHEREAS, the Centers For Medicare and Medicaid Services (CMS) has recently developed drug therapy surveyor guidelines regarding inappropriate drug use in nursing facilities; and

WHEREAS, these guidelines contain significant flaws and may potentially result in adverse patient outcomes; and

WHEREAS, the judgment regarding appropriate use of drugs will be made by surveyors with limited clinical expertise in medical decision-making concerning pharmacotherapeutics; and

WHEREAS, the medical diagnosis and decision making should only be made by physicians; now, therefore, be it

RESOLVED, that the American Osteopathic Association stands opposed to the drug therapy surveyor guidelines for nursing facilities as currently written; and, be it further

RESOLVED, that the AOA recommends that these guidelines be rescinded and that any future drug therapy surveyor guidelines regarding inappropriate drug use in nursing facilities be developed in collaboration with professional organizations possessing clinical expertise in geriatrics and long-term care medicine. 1999; *revised 2004*

DRUGS, CURBING COUNTERFEIT FOR PATIENT SAFETY

WHEREAS, the Food and Drug Administration (FDA) estimates that counterfeit drugs comprise approximately 10% of the global medicine market, suggesting annual criminal sales in excess of 35 billion US dollars; and

WHEREAS, the number of investigations of possible counterfeit drugs by the FDA has increased from approximately five per year in the 1990's to more than 20 per year since 2000; and

WHEREAS, the effects on patients of counterfeit medicines are difficult to detect and quantify and are mostly hidden in public health statistics; and

WHEREAS, the FDA is advancing a range of safeguards from taking advantage of new track and trace technologies to follow drugs through the distribution chain to enhancing regulatory activity, increasing penalties for wrongdoing and heightening vigilance by health officials and consumers; and

WHEREAS, the FDA is developing a system that helps ensure reporting of counterfeit drugs, and that strengthens the ability of the FDA, other regulatory agencies and stakeholders to respond rapidly; and

WHEREAS, this system involves new steps to encourage physicians to report suspected counterfeit drugs to FDA's MEDWATCH System; now, therefore, be it

RESOLVED, that the American Osteopathic Association support the Food and Drug Administration's (FDA) efforts to educate osteopathic physicians on how to identify counterfeit drugs; and, be it further

RESOLVED that the AOA encourage osteopathic physicians to report counterfeit drugs through the FDA's Counterfeit Alert Network and encourage the education of D.O.'s on their role in identifying, minimizing exposure to and reporting of counterfeit drugs. 2005

DRUGS, NON-GENERIC

WHEREAS, Health Maintenance Organizations (HMOs) are making changes in formulary benefits to include only generics for the Medicare Choice patients; and

WHEREAS, although generic drugs are adequate in many cases, there are chronic conditions for which there is not current generic treatment; and

WHEREAS, patients may be harmed by inadequate treatment of certain conditions; and

WHEREAS, restricting formularies exclusively to generic drugs prevents selection of appropriate treatment protocols when such protocols include categories of drugs for which there is no generic substitute, which directly affects the health of patients; now, therefore, be it

RESOLVED, that the American Osteopathic Association's Council on Federal Health Programs promote the approval of non-generic drugs when they comprise the basis of the treatment protocols that are proven best practices; and, be it further

RESOLVED, that the Council through its national political influence urge the development and passage of legislation that will mandate that HMO's offering prescription drug coverage to Medicare beneficiaries provide for these essential medications. 2002

DRUGS, PRESCRIPTION DISCOUNTS—SENIORS

WHEREAS, some pharmaceutical companies currently offer low-income Medicare eligible patient discounts on their prescription drugs; and

WHEREAS, these Medicare eligible patient discounts are based on income limits and charge seniors a modest co-payment; and

WHEREAS, many Medicare eligible patients have no drug coverage at all; and

RESOLVED, that the American Osteopathic Association encourages pharmaceutical discount programs, and the cost of administration should be borne by the pharmaceutical industry. 2002

DRUGS, PRESCRIPTION—USE AMONG THE ELDERLY

WHEREAS, according to the U.S. Department of Health and Human Services, the elderly are at increased risk of complications from the effects of therapeutic agents; and

WHEREAS, these risks may be caused by the use of multiple, concurrent medications, the use of inappropriate medication, and the under-use of needed medication; and

WHEREAS, the American Osteopathic Association (AOA) supports primary care physicians overseeing the care and medication provided to their patients by other physicians as an important step in significantly reducing the potential problems of overmedication, under-medication, and/or harmful drug interactions; and

WHEREAS, AOA supports having only osteopathic and allopathic physicians prescribe or supervise prescriptions written by non-physician clinicians as another important step in significantly reducing the problems of overmedication, under-medication, and/or harmful drug interactions; and

WHEREAS, AOA supports shared responsibility among patients, caregivers, and physicians to ensure appropriate drug use; and

WHEREAS, AOA supports a Medicare prescription drug benefit program as an important step in removing the high cost of prescription drugs as one of the leading causes of inappropriate use of therapeutic agents among the elderly; now, therefore, be it

RESOLVED, that American Osteopathic Association work with osteopathic and allopathic physicians, the U.S. Congress, the U.S. Department of Health and Human Services, and other interested parties to assure the appropriate use of therapeutic agents among the elderly. 2002

DUAL DEGREES

WHEREAS, the DO degree in the United States is a full and complete medical degree; and

WHEREAS, the only accredited and authorized DO degrees are the Doctor of Osteopathy (DO), or the Doctor of Osteopathic Medicine (DO), as granted through an American college of osteopathic medicine, accredited by the Bureau of Professional Education of the AOA; and

WHEREAS, certain unaccredited medical schools outside of the United States seek to offer the MD degree to American trained DOs; now, therefore, be it

RESOLVED, that it is contrary to AOA policy to use a health related degree in a professional manner that is unearned or granted from a college or university that is not accredited by either the American Osteopathic Association or its allopathic equivalent. 1969; *reaffirmed* 1978; *revised* 1983, 1988; *reaffirmed* 1993; *revised* 1998; *revised* 2003

DUE PROCESS FOR ALLEGED IMPAIRED PHYSICIANS

WHEREAS, it is possible for a hospital administration to suspend the medical staff privileges of a physician or for a managed care organization or insurer to remove a physician from its approved provider panel based solely upon an assertion of impairment due to the existence of a presumed psychiatric diagnosis or an allegation of disruptive physician behavior; and

WHEREAS, it is possible for such an administrative decision to be made without a reasonable fact-finding hearing of the allegations or an appropriate clinical evaluation of the physician; and

WHEREAS, the assertion of physician impairment requires that there be actual or likely potential harm to patients; now, therefore, be it

RESOLVED, that the American Osteopathic Association adopt the policy that, except in the case of summary suspension necessary to protect patients from imminent harm, no adverse action be taken against the staff privileges of a physician by a hospital, managed care organization or insurer based on a claim of physician impairment without a suitable due process hearing in accordance with medical staff bylaws to determine the facts related to the allegations of impairment, and, where appropriate, a careful clinical evaluation of the physician. 1999; *reaffirmed 2004*

DUE PROCESS IN AGENCY DETERMINATIONS

WHEREAS, the principle of due process is fundamental to the American system; and

WHEREAS, federal and state agencies have increasingly been granted quasi-judicial powers in matters affecting the rights and/or property of individual citizens; and

WHEREAS, in some instances such powers have been conferred on a single individual, within an administrative agency, wherein such individual is given final authority for determinations affecting individual and property rights, without requirement of a formal hearing; and

WHEREAS, the American Osteopathic Association believes that granting such quasi-judicial powers, without the requirement that they be exercised only after a formal hearing, creates situations for potential discrimination, arbitrary and/or capricious decision making and denial of due process; now, therefore, be it

RESOLVED, that the American Osteopathic Association declares its opposition to any and all existing or proposed federal and state rules or procedures, and their underlying laws, which vest any administrative personality with final authority, in matters affecting the rights and/or property of individuals, where no provision is made for a prior, fair, formal hearing. 1982; *revised* 1987; *reaffirmed* 1992, 1997, 2002

DURABLE MEDICAL EQUIPMENT CLAIMS PROCESSING

WHEREAS, access to cost-effective healthcare has long been a concern of osteopathic physicians; and

WHEREAS, the ever-increasing burden of mandated paperwork has contributed significantly to the increasing cost of healthcare; and

WHEREAS, the federal government has announced its intent to reduce the amount of paperwork required of physicians; and

WHEREAS, the federal government has also recently regionalized claims processing for durable medical equipment; and

WHEREAS, this change requires physicians dispensing durable medical equipment to submit two claim forms instead of the current one form; now, therefore, be it

RESOLVED, that the American Osteopathic Association and its physicians remain committed to providing cost effective healthcare, and, be it further

RESOLVED, that the AOA supports a reexamination of federal policy regarding the processing of claims for durable medical equipment. 1993; *revised* 1998, 2003

ELECTRONIC HEALTH RECORDS

WHEREAS, the federal government will mandate the adoption of electronic health records for all physicians who see Medicare and Medicaid patients in the near future; and

WHEREAS, the cost of implementation and the information needed for implementation for the single, small, or rural medical offices will be very expensive; and

WHEREAS, once these regulations become mandatory, many physicians will not be able to comply with the regulations because of the added expense and additional knowledge required; and

WHEREAS, physicians will then be unable to continue to see Medicare & Medicaid patients in rural medical offices; now, therefore, be it

RESOLVED, that the American Osteopathic Association continue to advocate for Medicare and Medicaid patients having continued access to physicians for their medical care; and, be it further

RESOLVED, that the AOA continue to inform elected officials and regulatory agencies as to the potential impact that the financial burdens of adopting mandatory electronic health records would have on access of patients to physicians for their healthcare, especially in rural and small practices; and, be it further

RESOLVED, that the AOA advocate financial consideration or exemptions and programs that could offset the economic impact of mandatory electronic health records, so that patient care would not be adversely impacted. 2005

ELECTRONIC HEALTH RECORDS—IMPLEMENTATION OF

WHEREAS, in 1996 the Institute of Medicine launched a concerted effort to improve the nation's quality of care; and

WHEREAS, Health Information Technology has been shown to improve patient safety and reduce health care expenditures; and

WHEREAS, President George W. Bush has made it a priority to put an electronic health record (EHR) in the hands of every American by 2015; and

WHEREAS, President Bush, through Executive Order #13335, established the position of National Health Information Technology Coordinator and appointed David Brailer, M.D. as the first National Health Information Technology Coordinator; and

WHEREAS, Dr. Brailer is working on meeting the President's goal by encouraging the use of EHR's and developing standards to make the systems interoperable; and

WHEREAS, the interoperability will become functional through the public/private creation of Regional Health Information Organizations (RHIOs); now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the adoption of Health Information Technology and Regional Health Information Organizations that will include osteopathic principles and practice (OPP) terminology where and when it is needed to support care; and, be it further

RESOLVED, that the American Osteopathic Association encourages physicians to work toward the following goals, at a pace appropriate to their practices: The adoption and implementation of electronic health records (EHR); the adoption of e-prescribing, ideally integrated with the EHR; the adoption of systems providing clinical decision support; the choice of systems that comply with emerging national standards; the choice of systems from vendors that have achieved appropriate certification; the collection and use of clinical data for quality improvement; and the reporting of data of clinical quality measures to public warehouses. 2005

ELECTRONIC PRESCRIBING STANDARDS

WHEREAS, according to the Institute of Medicine report *To Err is Human,* many individuals suffer harm from medical errors each year; and

WHEREAS, handwritten prescriptions can be a significant source of these errors; and

WHEREAS, the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) has dictated that electronic prescribing (e-prescribing) standards be established; and

WHEREAS, the MMA standards must be applicable to numerous and varied clinical settings and specialties; and

WHEREAS, previous governmental mandates (i.e., HIPAA) have not allowed adequate time to test and implement the software and communications necessary to be compliant, and

WHEREAS, third parties are likely to underwrite or supply the hardware, software, or infrastructure of e-prescribing systems to make their use by physicians economically feasible; and

WHEREAS, the physician-patient relationship must be enhanced and unhindered by this new technology; and

WHEREAS, the use of such technology has induced its own health care errors in some instances; now, therefore, be it

RESOLVED, that the American Osteopathic Association support the following principles in its advocacy efforts relating to the development of electronic prescribing standards:

- **SAFETY:** Safety alerts should be prioritized and readily distinguishable from commercial messages; these messages should be allowed to be suppressed for efficiency.
- **PRIVACY:** Information on patients' medication should be current, comprehensive, and compliant with HIPAA.
- **TRANSPARENCY:** Third part involvement must be transparent and disclosed.
- **DESIGN:** Financial interests should not dictate the design of systems (i.e., all drugs should be available). Standards must require fail-safes in any system to prevent the introduction of new health care errors.
- **INTEGRATION:** Systems should be proven and should integrate with existing healthcare technology and existing workflow (i.e., download of patient data from EMR).
- **SCALABILITY:** Any standards should be broad-based and applicable to all healthcare delivery systems.
- **TIMING:** These standards should be in place at the earliest possible time to allow software vendors and practitioners adequate time to become compliant with said standards and perform all necessary testing prior to the implementation. 2004

EMERGENCY MEDICAL IDENTIFICATION--PROTOCOL AND GUIDELINES

WHEREAS, the American Osteopathic Association believes it is important to have a medical emergency identification system in place; and

WHEREAS, there are numerous systems which ensure that emergency medical identification programs exist; and

WHEREAS, current technology allows for the implementation of such systems; now, therefore, be it

RESOLVED, that the American Osteopathic Association support the concept of medical identification systems, and, be it further

RESOLVED, that osteopathic physicians encourage patients to participate in an emergency medical identification program. 1981; *reaffirmed* 1985; *revised* 1991, 1992; *reaffirmed* 1997; *revised* 2002

EMERGENCY MEDICAL SERVICES FOR CHILDREN, SUPPORT OF

WHEREAS, the Emergency Medical Services for Children (EMSC) program is a federal program that supports projects to expand and improve emergency medical care for children needing treatment for life-threatening illnesses and injuries; and

WHEREAS, the federal EMSC program funds pediatric emergency medical care improvement initiatives in every state, the District of Columbia, and five U.S. territories and assures a presence for children's concerns in state emergency medical services offices; and

WHEREAS, systems of care are not static and needs to be maintained and improved by the federal EMSC program to preserve and expand advances for children; now, therefore, be it

RESOLVED, that the American Osteopathic Association strongly supports full funding and reauthorization of the federal EMSC program. 2005

EMERGENCY ROOM REIMBURSEMENT FOR EMERGENCY ON-CALL PHYSICIANS

WHEREAS, there is an emergency room crisis throughout the United States due to the rapidly increasing numbers of patients using the emergency rooms; and

WHEREAS, on call and emergency room physicians are required to medically screen and stabilize patients due to the Emergency Treatment and Labor Act (EMTALA) with potential penalties to the physicians and the hospital if this does not occur; and

WHEREAS, physicians are required, in most cases, to take call to maintain their hospital staff privileges; and

WHEREAS, physicians provide unreimbursed care for out of network patients; now, therefore be it

RESOLVED, that the American Osteopathic Association urge legislators to amend Emergency Treatment and Labor Act (EMTALA) legislation to mandate that managed care plans reimburse the on call physician for providing care to patients with emergent needs, even if out-of-network, or service area; and, be it further

RESOLVED, that the American Osteopathic Association makes this a priority due to the unintended consequences that have resulted from EMTALA. 2001

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

WHEREAS, The Employee Retirement Income Security Act (ERISA) was implemented in 1976 to encourage large employers to provide employees with health insurance and other benefits; and

WHEREAS, the healthcare delivery system concerns and issues presently vary greatly from those prior to enactment of ERISA; and

WHEREAS, ERISA plans are those plans which normally command the most competitive insurance rates, yet are exempt from any responsibility or participation in state solutions to insure the uninsured, underinsured, and to offer plans with reasonable rates for small businesses and individuals who represent a large number of our uninsured and underinsured; and

WHEREAS, these exempt groups/plans stifled many states' ability to develop and implement healthcare reform, and as written, have accorded an unfair advantage to those who are protected by this Act; and

WHEREAS, the Departments of Insurance, in respective states, are prohibited from regulating plans under ERISA; now, therefore, be it

RESOLVED, that the American Osteopathic Association go on record supporting efforts to amend ERISA to allow states to take necessary steps or actions to require that these plans participate in healthcare reform initiatives; and be it further

RESOLVED, that the AOA actively support legislation to amend the ERISA law to eliminate the ERISA exemption status. 1996, *revised* 2001

END-OF-LIFE CARE

WHEREAS, many of our nation's children still succumb to a wide variety of morbid situations related to prematurity, congenital disabilities, trauma, violence, and cancer; and

WHEREAS, training in end-of-life issues including pain management, grief counseling, comfort care, and community resources for children and their families (including hospice) is sporadic in medical school and residency programs; now, therefore, be it

RESOLVED, that the American Osteopathic Association support the development, distribution and implementation of comprehensive curricula to train medical students, interns, residents and physicians in end-of-life issues, relating to children and their families. 2002

END-OF-LIFE CARE – USE OF PLACEBOS IN

WHEREAS, evidence based medicine is now available which assures exquisite symptom management for patients at end of life; and

WHEREAS, increasing numbers of patients at end of life are living with chronic and often under treated pain related to a terminal illness; and

WHEREAS, placebos have been shown to be detrimental to effective treatment of end of life pain; and

WHEREAS, appropriate pain management is of concern to all osteopathic physicians; now, therefore, be it

RESOLVED, that the attached position paper on Use of Placebos for Pain Management in End-of-Life Care be approved. 2004

USE OF PLACEBOS FOR PAIN MANAGEMENT IN END-OF-LIFE CARE

The issues of placebo usage, placebo effect and placebo abuse as they affect pain management are fraught with opinion, confusion, and misunderstanding. The placebo effect of medication can be a significant resultant action of any prescription. However, the substitution of a placebo in place of effective pain medication has been widely recognized as unethical, ineffective and potentially harmful. [1, 4, 5, 9, 10, 11, 15, 16] A number of organizations have advised against the use of placebo substitution, including the American Pain Society, Agency for Healthcare Policy and Research, World Health Organization, the Healthcare Facilities Accreditation Program, Joint Commission on Accreditation of Healthcare Organizations, Education on End-of-Life Care Project (co-sponsored by the American Medical Association), American Nursing Association, and the American Society of Pain Management Nurses.

This white paper describes the literature and rationale in support of the AOA's position on the controversial subject of the use of placebos for pain management in terminally ill patients.

I. Definition of Terms

A. Placebo, placebo substitution, placebo effect and nocebo response

A placebo is a substance presumed to be pharmacokinetically inert. Placebo substitution means the substitution of a physiologically inactive substance for a comparison with the physiologically active substance. Placebo effect is the positive psychosomatic response of an individual to a treatment; in contrast, the nocebo response is a negative psychosomatic response to

a treatment.[2] The placebo effect is an important adjunct in the treatment of symptoms. The alleviation of symptoms has an inherent positive psychological component; patients who perceive their symptoms to be relieved by the treatment and trust in their treating physician's treatment plan and/or prescription for the symptom relief are more likely to obtain relief. [4]

Placebo responses are necessary for controlled clinical trials in which the patient is informed that a placebo may indeed be utilized. Physiologic responses to placebo can be pleasant or unpleasant to the patient. An unpleasant effect attributable to administration of a placebo is called a "nocebo response". A pleasant effect is called a "positive placebo response". It has been noted that, "a positive placebo response simply speaks to the strength of an individual's central control processes (i.e., mind) to recruit their descending inhibitory system to block pain. The trained osteopathic physician knows that pain relief occurs both in the mind and in the body." [9] The basis of the placebo effect in a therapeutic physician-patient relationship also involves good communication skills as well as listening to the patient. [3, 7, 9]

To summarize, a placebo is a type of treatment, necessarily used in controlled clinical trials, that has no inherent physiological action yet is designed to mimic a therapy with a known active physiologic effect. Positive changes resulting from placebo administration would be due to expectations of success by the patient. Thus, the use of placebo effect is based on the patient's perception of the role of the placebo agent with symptom relief. The placebo response may be enhanced with a positive patient-physician relationship.

B. Addiction, substance abuse and dependence, tolerance, withdrawal and pseudo-addiction

Some physicians inappropriately justify using placebo in pain management to avoid "addicting" the patient. Addiction, as defined by the American Academy of Pain Medicine, "is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving." Actually, it is rare for a person to develop an addiction to pain medications. [15]

Substance abuse is defined as psychological and physical dependence on substances. Some physicians are concerned that prescribing narcotics may lead to substance abuse and therefore may attempt to use a placebo to assess whether the patient truly requires narcotics for pain relief. However, there is no scientific basis for using placebo in the assessment of the patient in pain who has or may have the potential for a substance abuse. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) [19], lists definitive criteria for diagnosis of psychological and physical dependence on substances. This text categorizes "Substance-Related Disorders" but does not utilize the term addiction; further, nowhere in the DSM-IV is placebo administration utilized with criteria for diagnosing and treating various forms of substance abuse. Substance dependence is defined as a cluster of cognitive, behavioral and physiological symptoms**.** The essential feature of a substance dependent individual is continuous use of the substance despite significant substance-related problems, such as deleterious effects on occupation, relationships, health, and others.

Physicians may become uncomfortable with requests for increased dosages of pain medications, fearing that a patient is manifesting a substance-related disorder. A better understanding of the concepts of tolerance, physical dependence, physiological dependence withdrawal symptoms and pseudo-addiction, may help physicians understand and more effectively treat these patients.

Tolerance represents a markedly diminished effect that can occur with continued use of most medications; the degree depends upon the daily dose and length of use. The need for medication titration, either due to development of tolerance or to incomplete responsiveness, is a part of routine medical care. Tolerance occurs due to compensatory changes in receptors and/or increased clearance resulting from induction of various metabolic pathways. The problem of tolerance should therefore be anticipated as a possible outcome in prescription pain medications.

Withdrawal is defined by the DSM-IV as a maladaptive behavioral change having physiological and cognitive concomitants, which occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged use of the substance, frequently inappropriately. Examples of withdrawal include the onset of seizures or delirium tremens in a newly abstinent alcohol chemically dependent individual.

Pseudo-addiction is the term used to describe the behavior of a patient in pain who is receiving an insufficient amount and/or an inappropriate dosing frequency of administration of the prescribed pain medication. In an effort to obtain relief, the patient in pain would request more frequent and/or increased medication. Such "drug seeking behavior" has been deemed as "proof" of "addiction." The reason for such requests is frequently that the patient is under-dosed, receiving too little of the medication and/or too long a delay between doses of the pain medication. In such instances, the patient receives inappropriate pain relief, which is not an appropriate criterion of a substance-abusing patient according to the DSM- IV.

II. Legal Considerations in the Use of Placebos in Pain Management

While there are no specific laws governing the use of placebos in any circumstance, there is a considerable amount of legislation regarding a patient's right to pain management. There are several state statutes that address this issue, some of which are based on the Federation of State Medical Boards' Model Guidelines for the Use of Controlled Substances for the Treatment of Pain. This document clarifies that legislative statutes accepting these guidelines understand the ongoing increased scientific knowledge of pain management, and thus have no need to modify legislation as the science of pain management changes. This document does not mention placebo usage. [16]

The American Bar Association (ABA) adopted a resolution concerning the promotion of pain management in all patients with chronic pain. This resolution states, "…that the American Bar Association urges federal, state and territorial governments to support fully the rights of individuals suffering from pain to be informed of, choose, and receive effective pain and symptom evaluation, management and ongoing monitoring as part of basic medical care, even if such pain and symptom management may result in analgesic tolerance, physical dependence or as an unintended consequence shorten the individual's life." [16] Placebo substitution for active pain medicine without informed consent on the part of the patients clearly violates the nature and substance of the ABA's position. Additionally, in two Supreme Court decisions regarding the right to assisted suicide, the court promoted the right of individuals to appropriate palliative care and pain management. [16]

While there is little case law concerning tort or administrative findings against physicians for inadequate pain management, this is likely to change in the near future. The main barrier to malpractice claims for inadequate pain management is use of the customary local standard to determine what constitutes ordinary care. The courts are steadily moving away from this standard to a national standard which uses clinical guidelines as the determinant of ordinary care. This is seen in the decision in the case of Noatske v. Oserhoh, where the court stated, "should customary medical practice fail to keep pace with development and advances in medical science, adherence to custom might constitute a failure to exercise ordinary care…" [10]

Guidelines developed by the Agency for Healthcare Policy and Research, now the Agency for Healthcare Research and Quality, the American Pain Society, the Healthcare Facilities Accreditation Program as well as the Joint Commission on Accreditation of Healthcare Organizations are good examples of sources the courts are using to determine ordinary practice. [1, 13, 17] These guidelines do not support the use of placebo in any fashion except in approved research studies when the appropriate patient informed consent has been obtained. Therefore, the physician thus cannot justify the use of placebo for pain management by attempting to diagnose "addiction" or with support from any of the above regulatory agencies. [10]

Furthermore, under California's elder abuse statute, a physician was successfully sued by the deceased's family for inadequate pain management at the end of life.[21]

III. Adverse Effects of Placebo Use

Pain is a universal experience and is subjective by nature. Despite the common colloquialism, "I feel your pain," no individual can truly experience another's pain. There are no laboratory tests or consistently reliable physical findings for assessment of pain. Patient self-report remains the gold standard for pain assessment. [14] Use of a placebo in place of an effective pain medication for attempting to determine whether the patient at end-of life is really in pain is under no circumstances appropriate.

There is a concern if a physician deceives the patient and substitutes a placebo treatment in the place of a known effective treatment without informing the patient. Deception has no place within the therapeutic relationship and is counter-productive. A physician may counsel a patient that "this treatment may be effective in treating your condition," but evidence-based medicine cannot guarantee a treatment outcome.

In this era of informed consent, deception of the patient poses many problems, including erosion of the trust individuals and society as a whole have for physicians. There are methods of using placebos and the placebo effect that do not involve deceit, e.g., clinical trials or the use of placebo as one of the trial agents for neurolytic block. This one narrow exception uses the placebo trial as part of the treatment selection for neurolytic blockade, a highly specialized procedure performed by a few skilled pain management physicians with appropriate informed consent.

Substituting placebo for accepted forms of pain treatment is under-treatment of the condition. Under-treatment of pain, as detailed in the American Bar Association's 2000 report, is an ongoing problem.[17] While there have been reports of placebo efficacy in pain management, placebo control of pain occurs in fewer patients and for shorter duration than active pain treatments. [8, 9, 16] It has also been argued that the prescription of an ineffective placebo in place of effective pain medication can act as a "suicidogen," whereby an individual in pain who is given inadequate medication for relief may be prompted to hasten his/her death.[11] In the clinical setting, substitution of a placebo for an active pain medication, even with the consent of the patient, is clinically suspect because better treatment alternatives exist and there are risks associated with the use of placebos. It is therefore inappropriate to substitute a placebo for a medication known to be effective in the treatment of a patient with the verified pain of a terminal illness.

Additionally, placebos are associated with side effects [5] and potentially precipitate hyperalgesia [18] or withdrawal in patients previously treated with pain medications.

IV. Summary

Exquisite management of end-of-life pain is a medical imperative. Use of a placebo in place of known effective pain medication for determining whether the patient is really in pain is under no circumstances appropriate. Use of placebos does not meet the accepted criteria to diagnose substance abuse, commonly referred to by some physicians as "addiction." There is no medical justification for the use of placebos to assess or treat pain at end of life.

The only appropriate use of a placebo in approved clinical research with informed consent.

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END OF LIFE CARE—POLICY STATEMENT ON

WHEREAS, recent events centering on end of life care issues have brought this topic sharply into the public consciousness for the American people; and

WHEREAS, the American Osteopathic Association House of Delegates has approved positions on various aspects of end of life care issues, but an all-encompassing position on end of life has not been proposed; and

WHEREAS, the principles of end of life care as approved by the American Osteopathic Association House of Delegates provides a framework for discussion; now, therefore, be it

RESOLVED, that the American Osteopathic Association approve the attached white paper on end of life care and encourage all osteopathic physicians to maintain competency in end of life care through educational programs such as the web-based osteopathic Education for Physicians on End of Life Care (Osteopathic EPEC) modules; and, be it further

RESOLVED, that the AOA encourage all osteopathic physicians to stay current with their individual state statutes on end of life care; and, be it further

RESOLVED, that the AOA encourage all osteopathic physicians to engage patients and their families in discussion and documentation of advance care planning regarding end of life decisions.

AMERICAN OSTEOPATHIC ASSOCIATION
END OF LIFE CARE

The osteopathic approach to care can be particularly beneficial at the end of life. Attending to the patient and family holistically is a key principle of osteopathic medicine. When there is nothing more that can be done to cure, there is always something that osteopathic physicians can do to comfort: management of a symptom, a treatment, a repositioning, a touch, a commitment to caring.

End of life decisions should be the result of the collaboration and mutual informing of the patient, the patient's family and the physicians, each sharing his or her own expertise to help the patient make the best possible decision, often in the worst possible circumstances.

Adults with decision-making capacity should be informed of their choices and that they have the legal and ethical right to make their own decisions about their end of life care, including the right to receive or refuse recommended life-sustaining or life-prolonging medical treatment. This position honors the patient's autonomy and liberty as guaranteed in the United States Constitution and the Patient Self-Determination Act. This right exists even when the physician disagrees with the patient's decisions.

Patients without decision-making capacity have the right to assurance that their previously executed instructive advance directives, such as living wills, and proxy directives (Durable Medical Power of Attorney -DMPOA) will be honored to guide others in delivering their health care. Advance directives delineate treatment options selected by an individual and enable decisions to be made by reviewing these documented wishes. The principle of "substituted judgment" allows for a proxy to speak for an individual who is unable to do so, based upon close personal knowledge of the incapacitated person. The principle of "best interests" (what the reasonable and informed patient would select) is invoked if the individual's wishes are not known. The over-riding issue is not what the family or friends want for the patient at end of life, but rather what would the patient want for himself or herself. If the patient were to awaken for only 15 minutes and be able to fully understand the circumstances, what decisions would the patient make? If the answer is unclear, society should choose life. If the answer is clear, it is unethical, except in extraordinary circumstances, not to follow the patient's wishes.

Creating ***advance directives*** (living wills or designating a Durable Medical Power of Attorney) is to be encouraged with non-crisis timing preferably in the setting of osteopathic primary care. Persons holding the DMPOA/proxy should make decisions in accordance with the patient's previously expressed preferences. Living wills document the desired treatments but leave much room for interpretation when the situation doesn't match the directives, so a combination may be best. If no DMPOA/proxy has been selected and no patient preference has been documented or expressed, decisions should be made based on the principle of "best interests". When there is disagreement, confusion or a request for another opinion, the use of an ethics committee is to be encouraged. Quality of life should be viewed from the patient's perspective in all these decisions because quality of life can only be self-determined. Extreme caution must be exercised when trying to determine what constitutes quality of life for another person as research has shown that patients consistently assess their quality of life to be better than their caregivers think the patients do. Unfortunately, no documentation or proxy designation can definitively prevent or curtail disagreements between family members.

Palliative care is always appropriate at the end of life. The osteopathic physician understands that physical suffering from pain; dyspnea and other end of life symptoms can be relieved with good osteopathic medical management. The patient may also need psychosocial and spiritual assistance to address suffering in those domains as well. Hospice and Palliative Care services provide invaluable

benefits to families and patients. The earliest possible involvement of hospice in the end of life care of patients should be encouraged.

The existence of a medical technology does not mandate its use. A physician is not required to provide ***futile medical care***. It may be difficult to determine that a requested treatment is actually futile. A life-prolonging treatment may allow a terminally ill patient to achieve an important life goal such as seeing a grandchild, but in other cases aggressive therapies serve only to prolong suffering and expense associated with the dying process. The physician should employ full disclosure and compassionate honesty in discussing a treatment's likely benefits and burdens. If agreement cannot be reached, a consultation with an ethics committee is appropriate. If an ethics committee is not available, it may be necessary to seek the assistance of a court-appointed guardian. When a patient and physician cannot align their goals and treatment approaches, a congenial transfer of care may be necessary. Patient abandonment is unethical.

Withholding or withdrawing life sustaining treatments are considered morally, legally, and ethically identical because the end results are the same. When the benefit of a palliative treatment is uncertain a time-limited trial is frequently advisable to help clarify prognosis. Offering treatment and then withdrawing it if it proves to be ineffective or burdensome is preferable to not offering the treatment at all.

Artificial nutrition and hydration may actually prolong the dying process. The use of artificial nutrition and hydration involves invasive medical procedures with potential side effects and complications. A decision to not provide or to discontinue this intervention may pose significant challenges to professional caregivers as well as to families. Physicians need to assist patients and families to understand the role of artificial nutrition and hydration at the end of life. Research has shown that dying patients do not experience hunger or thirst.

"Do Not Resuscitate/DNR" status is appropriate for patients who are dying from a primary illness or injury, or for whom cardiopulmonary resuscitation (CPR) would not be effective or for whom the burden of treatment outweighs the benefit. It is important to ensure that patients with DNR status receive all comfort care and appropriate treatments. A DNR status does not preclude treatment of correctable conditions. "Slow codes" (when full resuscitative efforts are not expended with the pretense that they are) are not appropriate as they represent an attempt to misrepresent, which is an ethical violation.

Irreversible loss of consciousness is particularly challenging. Patients determined to be in a persistent vegetative state are unconscious, but do not meet the criteria for brain death. They are not aware of nor are they able to meaningfully respond to their environment. The diagnosis can be difficult to determine and is usually made after the patient has been in this state for several (possibly as long as six) months. These patients may live extended periods of time. Whether or not this "life" is considered acceptable to the patient determines the type of support that is appropriate. The decision making approach is the same as that described for patients without decision-making capacity. The patient's constitutional right to self-determined life closure as expressed by an instructive advance directive or through a legally designated proxy must be upheld.

Physician assisted suicide is generally defined as a patient obtaining the assistance of a physician to secure the means to cause his/her own death. Physician assisted suicide is legal only as determined by specific state law. The request for physician-assisted suicide is frequently a call for help. Individuals may request physician-assisted suicide for reasons other than pain, e.g., inability to cope, fear of being a burden, or lack of control. The best alternative to physician-assisted suicide is physicians who are committed to providing excellence in end of life care and continuing to attend their dying patients. Community resources such as hospice programs should be made available to all patients. Hospice and palliative care principles are incongruent with physician assisted suicide and euthanasia.

Legal involvement to resolve end of life conflicts is sometimes inevitable, but is usually not the approach of choice. Legislative "remedies" including single-person and single-situation laws are also inappropriate. By far, the best approach to prevention/resolution of conflict is by documented advanced planning, good

communication, and the assistance of an ethics committee. Collection of "clear and convincing evidence" of the patient wishes as cited in a US Supreme Court decision, as well as the principles of "substituted judgment" and "best interests" discussed above apply to the decision-making process.

Families of patients living with a terminal illness also have needs: the need to understand the dying process, the need to have cultural and religious differences understood and respected, the need to process grief. The osteopathic physician understands the important contribution of the family to the patient's overall well being and includes the family in the palliative plan of care.

Patients living with a life threatening illness as well as those who are terminally ill have a right to ***relief of pain*** as well as relief of other physical symptoms. Fear of regulatory scrutiny should never be a deterrent to the prescription of adequate doses of analgesic medications. State licensing boards of medicine and pharmacy should provide assurance to physicians that this care is appropriate and protected under the law. Osteopathic colleges and graduate medical education programs are encouraged to review curriculae in order that adequate education in osteopathic pain management is provided to osteopathic trainees at all levels of their education. Physicians in practice will want to avail themselves of educational opportunities such as Osteopathic-EPEC to stay current in pain management and other aspects of end of life care. Osteopathic physicians should always assure their patients that they will provide safe and comfortable dying. Alternatively, patients may elect to suffer significant pain so that they remain alert and engaged until death. In every circumstance, patient autonomy for decision-making must be upheld.

The ***over-riding principle at end of life*** is the same as at all other decision points in life; cure sometimes, comfort always. Osteopathic physicians, through their holistic approach, are well suited to provide quality end of life care. DO's are in a unique position to provide important leadership in enhancing end of life care in the United States. There is no finer gift that osteopathic physicians can give than to provide excellent care through all phases of life and no one is better suited to the task.

Nota bene: In an area as sensitive as end of life, no white paper can address all scenarios and permutations. It should be understood that this white paper presents general guidelines, and osteopathic physicians will always tailor appropriate management to the needs of their individual patients and families. 2005

ENVIRONMENTAL HEALTH

WHEREAS, continued pollution of the environment poses the imminent hazard of widespread injury to the community health; and

WHEREAS, the federal government has been confronted with health and environmental threats caused by the manufacturing, processing, and disposing of certain toxic substances; and

WHEREAS, the federal government has assumed the leadership and responsibility for developing and enforcing standards to control such environmental hazards; now, therefore, be it

RESOLVED, that the American Osteopathic Association strongly encourages the federal government to increase its efforts to promote standards which will prevent human suffering and death from environmental threats and hazards; and, be it further

RESOLVED, that the AOA reaffirms its commitment to support governmental agencies' efforts in eradicating environmentally related health risks. 1970; *revised* 1978; *reaffirmed* 1983; *revised* 1988; *reaffirmed* 1993; *revised* 1998, 2003

ENVIRONMENTAL RESPONSIBILITY--WASTE MATERIALS

WHEREAS, medical offices produce an enormous amount of waste; and

WHEREAS, some of this waste could be recycled; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the recycling of all recyclable non-medical waste. 1995; *revised* 2000, *revised* 2005

ENVIRONMENTAL TOXINS AND OUR CHILDREN'S HEALTH

WHEREAS, the American Osteopathic Association and its affiliate organizations have always advocated for the preservation of health and the practice of preventive medicine in the interest of public health; and

WHEREAS, across America growing numbers of individuals are suffering from disease states such as asthma, chronic lung disease and cancers, as well as learning and behavioral disabilities; and

WHEREAS, biomedical research is asking compelling questions about the health risks of an ever-increasing number of untested chemicals in our environment; and

WHEREAS, of the 3000 high production volume chemicals in use in this country today, only 43% have been even minimally tested and only about 10% have been thoroughly tested to examine their potential effects on children's health and development; and

WHEREAS, the importance of informed research has been shown effective in creating new public policy affecting the public health; now, therefore, be it

RESOLVED, that the American Osteopathic Association support public policy efforts on a national, state and local level, to assure adequate funding and research priority for evidenced based assessment of potential environmental toxins; and, be it further

RESOLVED, that the American Osteopathic Association encourage governmental agencies to adopt a proactive approach to implementing the results of such research in the interest of public health of current and future generations of Americans. 2002

ETHICAL AND SOCIOLOGICAL CONSIDERATIONS FOR MEDICAL CARE

WHEREAS, it has become a national problem in how to deal with the spiraling costs of supporting a huge and rapidly growing population of aged citizens whose lives are being prolonged, if not always enriched, by scientific and environmental advances which have added years to the average American's lifespan; and

WHEREAS, medicine's remarkable achievements in research laboratories, operating rooms, intensive and emergency care units, clinics and other professional workplaces have led to increased costs of medical care; and

WHEREAS, the growth of hospital costs have increased at such a rate that priorities are being evolved for patient access to such care; and

WHEREAS, the interpretation and application of medical ethics have been in the undisputed province of the medical profession; and

WHEREAS, practicing physicians must deal daily with social and ethical questions regarding the care of their patients; and

WHEREAS, at the present time the reality of the individual physician's devotion to the welfare of patients is encompassed in many questions of ethics, equity and public policy; now, therefore, be it

RESOLVED, that the Congress and the Department of Health and Human Services be encouraged to consult with the osteopathic and allopathic medical professions to determine the necessary, proper and acceptable role of government in ethical and sociological matters. 1985; *reaffirmed* 1990, 1995, 1997; revised 2002

EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES

WHEREAS, the American Osteopathic Association represents the nation's osteopathic physicians; and

WHEREAS, the AOA supports the development of new Evaluation and Management Current Procedural Terminology (CPT) code definitions being undertaken by the CPT Editorial Panel and designed to alleviate the documentation burden caused by the current documentation requirements; and

WHEREAS, the current versions of E&M guidelines represent tedious, and overly burdensome documentation for physicians; and

WHEREAS, prepayment audits delay proper and timely payments for services rendered; now, therefore be it

RESOLVED, that the American Osteopathic Association:

1. Opposes the use of patients' confidential medical records as an accounting instrument.
2. Opposes the use of checklist documentation ratings that diminish and fail to express the complexity of medical decision-making.
3. Advocates the use of an independent profession/specialty matched medical peer review process for physicians identified as outliers.
4. Opposes the continuation of random pre-payment audits of E&M claims.
5. Advocates that any auditing of outpatient medical records be conducted on a retrospective post-payment basis.
6. Opposes the CMS practice that requires physicians to repay alleged over-payments before all appeal remedies have been exhausted.
7. Advocates immunity from Medicare sanctions for physicians voluntarily participating in the pilot testing of E&M guidelines.
8. Advocates that CMS develop educational programs that help physicians identify mistakes or misunderstandings with their coding so as to avoid civil penalties. 2003

EXECUTIONS IN CAPITAL CRIMES <u>CRIMINAL CASES</u>

WHEREAS, various jurisdictions impose the death penalty; and

WHEREAS, the American Osteopathic Association has a specific code of ethical conduct; and

WHEREAS, this code of conduct prevents a physician from doing any harm or giving any medication to a patient that would be deemed harmful; now, therefore, be it

RESOLVED, that the American Osteopathic Association deems it an unethical act for any osteopathic physician to deliver or be required to deliver a lethal injection for the purpose of execution in capital crimes. 1995; *revised* 2000, 2005

EXPERT WITNESS

WHEREAS, expert witness testimony in medical liability cases serves to clarify and explain technical concepts and articulate professional standards care and is necessary for fair and complete trials; and

WHEREAS, professional liability insurance reform is the American Osteopathic Association's top legislative priority at the state and federal levels; and

WHEREAS, expert witnesses who provide testimony in medical liability cases have an effect on the professional liability insurance crisis in American; and

WHEREAS, the AOA believes expert testimony to be the practice of medicine; and

WHEREAS, state laws vary as to the qualifications necessary to become an expert witness; now, therefore, be it

RESOLVED, that the policy entitled Peer Review by Equal Credentialing adopted by the American Osteopathic Association (AOA) House of Delegates in 1996, and the policy entitled Peer Review of Osteopathic Manipulative Treatment adopted by the AOA House of Delegates in 2003 be deleted with the adoption of the following Expert Witness resolution; and be it further

RESOLVED, that the AOA adopt the attached policy paper as its position on expert witness. 2005

EXPERT WITNESS

The days when physicians would not testify against fellow colleagues because they did not want to break the code of silence previously associated with the profession are long gone.[1] Today, it is common practice for physicians to serve as medical experts in medical malpractice actions. The 1993 U.S. Supreme Court case, *Daubert v. Merrell Dow Pharmaceutical*, gave the Court an opportunity to establish guidelines for expert witness testimony. The Court concluded that expert witness testimony should be scientifically valid. Additionally, the Court said that testimony is valid if there has been peer review and general acceptance of the testimony.

Based on the Daubert decision, a trial court must determine if the opinion of the expert is reliable. In making that determination, the trial court may consider: (1) whether the theory or technique has been or can be tested; (2) whether the theory or technique has been proven by the peer review process or published within the scientific community; (3) the known rate of error, or the potential rate of error; (4) whether standards exist in the particular field or science from which the expertise comes; and (5) whether the theory or technique that is the subject of the opinion or testimony has been generally accepted by the particular scientific community. As a result of the Daubert decision, the medical community has developed guidelines for evidence-based medicine. Evidence-based medicine may be authenticated by three sources: (1) Large, controlled, randomized clinical trials; (2) Observational scientific studies; and (3) Consensus recommendations from a panel of recognized experts in the clinical or research field.[2]

There is a great deal of skepticism about the role of the physician-expert, and whether an expert's testimony is valid.[3] Some physicians travel the country routinely testifying in malpractice actions, and in many instances they are considered "hired guns" who will alter their opinions for the highest bidder.[4] Concern over speculative expert testimony has lead critics to call for stricter scrutiny of expert testimony and to appeal to professional organizations to take a more active role in monitoring physicians who give inaccurate testimony.[5]

Peer Review of Expert Witness Testimony

The integrity of both judicial and administrative proceedings regarding physicians and alleged medical malpractice depends in part on the honest, unbiased testimony of expert witnesses. Such testimony serves

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[1] Tanya Albert, *On the hot seat: Physician expert witnesses. With scrutiny high and the other side out to get the "hired gun," court appearances can be a trial for physicians who serve as expert witnesses,* American Medical News, April 8, 2002.

[2] http://cap.aoa-net.org/doc.cfm?ID=about&SaE912a0232=157521, accessed 10/29/04.

[3] Editorial Opinion, *Ensuring Accuracy in Medical Testimony, Calling Experts to Account,* American Medical News, September 16, 2002.

[4] Louise B. Andrew, M.D., J.D., *The Ethical Medical Expert Witness*, Journal of Medical Licensure and Discipline, Vol. 89 Number 3, Page 125, (2003).

[5] Tanya Albert, *California Court Throws Out "Speculative" Expert Testimony,* American Medical News, August 4, 2003.

to clarify and explain technical concepts and to articulate professional standards of care. To that end, the American Osteopathic Association has adopted the policy that "osteopathic physicians acting as medical directors, expert witnesses, or peer reviewers, and affecting patient treatment, outcome of care and access to care, are practicing osteopathic medicine." This statement suggests that expert witness testimony should be subject to peer review.

The introduction of a peer review requirement, however, presents an interesting question for osteopathic physicians: namely, should MDs be allowed to review the work of osteopathic physicians without the input of another DO? One of the important elements of osteopathic training is osteopathic manipulative treatment (OMT), a practice unique to the osteopathic profession. Because both DOs and MDs are licensed for the unlimited practice of medicine in all fifty states, members of either branch of the medical profession can generally testify concerning the actions of the members of the other branch of the profession. However, considering the uniqueness of osteopathic manipulative treatment, allopathic physicians will not likely have the education or training to determine if the actions of osteopathic physicians using OMT were within the appropriate standard of care.

The AOA supports a policy that peer review of osteopathic physicians should be limited to other osteopathic physicians whenever possible. Further when the standard of care involves a procedure unique to the osteopathic practice of medicine, such as OMT, then only osteopathic physicians should conduct peer review.

Medical Societies & Expert Witness Policies

Like many experts, a number of physicians believe that inaccurate expert testimony and opinion has added to out of control jury awards and, consequently, contributed to the growing medical liability insurance crisis. In August 2003, a group of lawyers and physicians formed the Coalition and Center for Ethical Medical Testimony.[6] Their goal is to identify physicians who falsify credentials, or mislead juries regarding the appropriate standard of care.[7] They suggest that professional medical organizations need to update their position statements to include a clearly defined section on disciplinary action through peer review if a member engages in false or egregious testimony.[8]

One association that has not only taken a position, but has already disciplined one of its members is the American Association of Neurological Surgeons (AANS). Under the AANS program a member of the specialty society may file a complaint against a fellow member based on his testimony as expert witness for either the plaintiff or the defense in a malpractice case. [9] The American Academy of Orthopedic Surgeons (AAOS) has also created a new expert witness program, which was recently unveiled during their annual meeting in March 2004.[10] The program has three components: education, advocacy, and potentially discipline. At the 2003 American Society of Anesthesiologists (ASA) House of Delegates meeting, a resolution was passed to implement an expert testimony program. The resolution provides for a "review of and action on complaints alleging irresponsible expert witness testimony given by an ASA member after October 15, 2003." Additionally, the Florida Medical Association (FMA) has initiated a system to track and punish physicians who provide fraudulent expert testimony against their colleagues.[11] To this end, the FMA created a peer review system that evaluates complaints about members' expert witness testimony.

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[6] Tanya Albert, *Group Aims to Weed Out Deficient Medical Expert Witnesses,* American Medical News, August 18, 2003.
[7] *Id.*
[8] Aubrey Milunsky, *Lies, Damned Lies, and Medical Experts: The Abrogation of Responsibility by Specialty Organizations and A Call for Action,* 18 Journal of Child Neurology 6 (June, 2003).
[9] Leigh Page, *Expert Witness Watchdog: Amid Complaints, AANS Defenders Say the Program is Necessary, Fair*, Modern Physician, August 2003.
[10] AAOS Online Bulletin, *AAOS Initiates Expert Witness Program*, available at http://www.aaos.org/wordhtml/bulletin/feb04/fline1.htm.
[11] Steve Ellman, *Testimony*, Vol. 03, No. 6-25, Pg. 11.

In addition to the previously described medical societies, other medical organizations that track and monitor their member testimonies include the North American Spine Society and the American College of Obstetricians and Gynecologists.[12] The American College of Obstetricians and Gynecologists has developed "affirmation" and "qualifications" documents that spell out to members the responsibilities and obligations of expert witnesses.[13] Finally, Both the American College of Emergency Physicians and the American College of Surgeons mandate that their members submit transcripts of depositions and testimony.

> Consistent with the AOA's policy that expert testimony constitutes the practice of medicine, the failure to provide truthful testimony amounts to unprofessional conduct subject to peer review. It is the AOA's policy to support and encourage state osteopathic societies and/or specialty colleges, if possible, to develop and implement appropriate monitoring procedures and effective disciplinary measures for their member expert witnesses who provide fraudulent and misleading testimony. Furthermore, the AOA shall act as a clearinghouse for advice and support for any osteopathic society wishing to develop its own expert witness program designed to discipline physicians for unprofessional conduct relative to expert testimony. Moreover, state licensing laws should be updated to define unprofessional conduct in a manner that includes 'providing false or misleading information in the role of expert witness.'

Expert Testimony in the Court Room

State law varies as to the qualifications necessary to become an expert witness. In some states, merely a license to practice osteopathic or allopathic medicine is needed to become a medical expert.[14] Increasingly however, states' expert laws specify that physicians must have credentials beyond their medical licenses. Rules and regulations regarding expert testimony in medical malpractice actions are outlined in several states' statutes. These laws address the specific conditions that health care providers must meet in order to qualify as expert witnesses and give testimony during medical malpractice cases in front of a judge or jury. Each state has its own particular requirements including factors relating to licensure, duration of practice, specialization and type of health care provider.[15]

Licensed in the State

Ten states, **Alaska**, **Colorado, Connecticut, Delaware, Mississippi, New Hampshire, Ohio, Pennsylvania, and Virginia** specify in their laws that physicians acting as an expert witness must be licensed in the same state as the defendant.

Active Practice/Teaching

Thirteen states, **Alabama, Connecticut, Delaware, Illinois, Kansas, Louisiana, New Hampshire, Ohio, Pennsylvania, Tennessee, Texas, and Virginia** require physicians to be actively practicing medicine or teaching medicine at an accredited university in order to qualify as expert witnesses.

Board Certified and Practicing in the Specialty

Alaska and **Pennsylvania** mandate that expert witnesses be licensed and trained in the defendant's discipline, and certified by a board recognized by the state.[16] **Michigan** law goes even further stating that

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[12] AAOS Online Bulletin, *AAOS Launches Expert Witness Program*, available at http://www.aaos.org/wordhtml/bulletin/apr04/fline1.htm.

[13] Mary Ellen Schneider, *Expert Medical Witnesses: medical community targets false testimony. (Practice Trends),* OB GYN News, April 15th, 2004.

[14] Allen L. Lanstra, Jr., *McDougall v. Schanz: Distinguishing the Authorities of The Michigan Legislature And The Michigan Supreme Court to Establish Rules of Evidence.* 2000 L. Rev. M.S.U.-D.C.L. 857, 865 (2002).

[15] *See* American Osteopathic Association, *Expert Testimony Qualifications By State Chart*, June, 2004 BSGA book (outlining the laws that apply to expert witnesses).

[16] §09.20.185 (1997)

expert witnesses must be licensed health professionals, practicing in a similar specialty, be board certified (if required by the specialty), and have clinical or academic experience in that specialty during the year preceding the action.[17] The **New Hampshire** expert witness legislation calls for board certification in a medical specialty substantially related to the medical injury claimed.[18] Finally, **Connecticut** law is more flexible. It states that an expert must be board certified by the appropriate American board in the same specialty but allows a non-board certified physician to testify if to the satisfaction of the court that he possesses sufficient training, experience and knowledge.[19]

Pretrial Certificates/Affidavits of Merit

Another technique employed by states to weed out frivolous claims and unnecessary expert testimonies are "certificates of merit" also known as "affidavits of merit." A certificate of merit is an affidavit, signed by the plaintiff's expert witness and attached to the original complaint, certifying that the expert witness is knowledgeable of the relevant facts of the case, is qualified to express an opinion on the merits of the case and certifying that there is a reasonable and meritorious cause for the filing of the action. Currently, 14 states require a physician to verify that a malpractice lawsuit has merit before it can be filed.[20] In addition, the certificate of merit officially states that the expert is qualified to make a determination of whether the defendant physician departed from the standard of care in treating the injured plaintiff.

Other Provisions

Aside from the more traditional criteria stated above, some states adopt a broader set of expert witness qualifications. **Idaho** statutes only require that expert witnesses have knowledge of community standards.[21] **Indiana** and **Louisiana** allow a medical review panel's testimony to qualify as expert testimony to establish a prima facie case.[22] **Nevada** requires that medical experts in its state practice or have practiced in an area similar to the practice related to the alleged malpractice.[23] **Rhode Island** only requires "training and education" to qualify as expert witnesses. **Pennsylvania** and **Illinois** permit retired physicians to serve as expert witnesses. Illinois allows retired physicians to testify if they can provide proof of attendance and completion of continuing education courses for three years previous to giving testimony

> *It is the AOA's position that an expert witness should not provide medical testimony that is false, misleading, or without medical foundation. The expert's testimony should be based on the guidelines set forth in the Daubert v. Merrell Pharmaceutical Supreme Court decision. Furthermore, an expert witness should have a current, unrestricted license to practice in the same state as the defendant physician. Preferably, the expert witness should be board certified in the same medical specialty as the defendant and the board should be one that is recognized by the state. The expert witness should be three (3) years removed from residency training, and should be engaged in active medical practice or teaching experience, or any combination thereof in the same specialty or subspecialty, for a period of no less than three (3) years prior to the date of the testimony. In cases where the physician serving as an expert witness has completed a forensic science, pediatric child abuse or other approved forensic fellowship and where the expert testimony specifically relates to that training, the requirement of being three (3) years removed from residency training is waived. Further, upon a showing of inability to find an in-state expert witness, the AOA encourages state licensing boards to grant temporary licensure to out-of-state expert witnesses making them subject to disciplinary sanctions of the state licensing boards.*

[17] §600.5056
[18] NH S.B. 452
[19] Conn. Gen. Stat. § 52-184c
[20] Tanya Albert, *Doctors can know accusers; ruling doesn't set precedent,* American Medical News, June 7, 2004.
[21] §679A.1 (1981)
[22] §34.18.8.4-6 (1975)
[23] §41A.800

Expert Testimony in Administrative and Disciplinary Hearings

Whereas traditional courts and juries have, for the most part, adopted requirements that expert testimony be used in medical malpractice cases, professional licensing boards have responded differently. Medical licensing boards work to police the actions of physicians by establishing and enforcing the standards of medical care within their communities, frequently without the aid of expert testimony.[24] This is because in most administrative settings the judge is trier of both fact and law. Expert testimony is taken to assist the judge as the trier of fact, but it is not required.[25] In some settings, experts will testify only by deposition, whereas in others live testimony is always needed. Additionally, it is possible that the review panel can provide opinion evidence.

Policy Behind Adopting a Requirement for Expert Testimony in Administrative Hearings

The expert testimony requirement serves three main purposes. First, expert testimony protects the defendant's right to review rather than allowing a professional board to base its decision only on its own expertise.[26] Second, having expert testimony in the record makes it easier for the defendant to challenge the evidence used to support the professional board's claim.[27] Finally, many courts recognize that members of a professional board are not necessarily qualified to make a medical opinion, and do not want to put a defendant's license at risk under those circumstances. However, most jurisdictions, even those who require expert testimony, often can decide *when* to apply the requirement. Consequently, states have a tendency to modify or soften their rules concerning the admission of expert testimony in administrative hearings.[28]

Compensation and Disclosure Requirements

In addition to peer review and strengthened expert witness qualifications, the unregulated compensation an expert witness may charge for medical testimony has contributed to the "hired gun" perception. Exorbitant compensation for expert witness testimony dilutes the integrity of the medical profession and erodes the credibility of all physicians. As it stands now, expert witnesses charge anywhere from $300 to $800 dollars an hour for their initial work alone. Consequently, there is an incentive for an expert witness to tailor his or her testimony to the needs of the attorney who is paying them.[29]

> *The AOA supports and recommends a policy that prohibits an expert witness from accepting compensation that is contingent on the outcome of the case. Furthermore, the compensation of the expert witness must be proportionate to* **the** *time, level of expertise and effort given for preparing and attending court appearances. The AOA further supports a policy that imposes mandatory disclosure to the court and opposing parties of the qualifications of the expert witness, access to copies of all publications authored by the witness in the preceding ten (10) years, and access to transcripts from all cases in which the witness has testified as an expert witness in the preceding four (4) years.*

Conclusion

The strict monitoring and discipline of physician expert testimony through peer review will greatly diminish the introduction of false, misleading, and biased testimony. Therefore the AOA supports and encourages all osteopathic societies to update their position statements to include a clearly defined

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[24] Timothy P. McCormack, *Expert Testimony and Professional Licensing Boards: What is Good , What is Necessary, and the Myth of the Majority-Minority Split.* 53 Me. L. Rev. 139, 144 (2001)

[25] Daniel Solomon, *Medical Expert Testimony in Administrative Hearings*, 17 J. NAALJ 285 (1997).

[26] McCormack, *supra* note 23 at 147

[27] *Id.*

[28] *Id.* at 187

[29] Tanya Albert, *On the hot seat: Physician expert witnesses. With scrutiny high and the other side out to get the "hired gun," court appearances can be a trial for physicians who serve as expert witnesses,* American Medical News, April 8, 2002.

section on disciplinary action through peer review if a member engages in false or egregious testimony.

It is the AOA's policy that the dissemination of expert testimony constitutes the practice of medicine; fraudulent expert testimony should be subject to disciplinary action by state licensing boards. The AOA supports a policy that peer review of osteopathic physicians should be limited to other osteopathic physicians whenever possible. Further when the standard of care involves a procedure unique to the osteopathic practice of medicine, such as OMT, then only osteopathic physicians should conduct peer review.

Consistent with the AOA's policy that expert testimony constitutes the practice of medicine, the failure to provide truthful testimony amounts to unprofessional conduct subject to peer review. It is the AOA's policy to support and encourage state osteopathic societies and/or specialty colleges, if possible, to develop and implement appropriate monitoring procedures and effective disciplinary measures for their member expert witnesses who provide fraudulent and misleading testimony. Furthermore, the AOA shall act as a clearinghouse for advice and support for any osteopathic society wishing to develop its own expert witness program designed to discipline physicians for unprofessional conduct relative to expert testimony.

In addition, the AOA supports a policy encouraging states to strengthen their expert witness qualifications. It is the AOA's position that an expert witness should not provide medical testimony that is false, misleading, or without medical foundation. The expert's testimony should be based on the guidelines set forth in the Daubert v. Merrell Pharmaceutical Supreme Court decision. Furthermore, an expert witness should have a current, unrestricted license to practice in the same state as the defendant physician. Preferably, the expert witness should be board certified in the same medical specialty as the defendant and the board should be one that is recognized by the state. The expert witness should be three (3) years removed from post-graduate training, and should be engaged in active medical practice or teaching experience, or any combination thereof in the same specialty or subspecialty, for a period of no less than three (3) years prior to the date of the testimony. In cases where the physician serving as an expert witness has completed a forensic science, pediatric child abuse or other approved forensic fellowship and where the expert testimony specifically relates to that training, the requirement of being three (3) years removed from residency training is waived. Further, upon a showing of inability to find an in-state expert witness, the AOA encourages state licensing boards to grant temporary licensure to out-of-state expert witnesses making them subject to disciplinary sanctions of the state licensing boards.

The AOA supports and recommends a policy that prohibits an expert witness from accepting compensation that is contingent on the outcome of the case. Furthermore, the compensation of the expert witness must be proportionate to the time and effort given for preparing and attending court appearances. The AOA further supports mandatory disclosure to the court and opposing parties of the qualifications of the expert witness, access to copies of all publications authored by the witness in the preceding ten (10) years, and access to transcripts from all cases in which the witness has testified as an expert witness in the preceding four (4) years.

The AOA believes that adoption of these policies will improve the quality of expert testimony in lawsuits alleging medical malpractice, and thus improve the civil justice system. In addition, professionally accurate, honest and unbiased testimony will result in better and fairer outcomes. 2005

EXPLANATION OF BENEFITS FORM

WHEREAS, the Explanation of Benefits (EOB) forms provided by the insurance companies and other payers to medical providers and patients should clearly explain what services are covered under a policy, what services are not covered, what portion of a bill the insurance company is paying and what part of the bill is the responsibility of the patient; and

WHEREAS, even experienced accounts receivable specialists cannot always understand the explanations provided under current EOBs; and

WHEREAS, a confusing EOB can contribute to misunderstanding and promote ill feelings between the provider of services, the patients, and third party payers; and

WHEREAS, currently each payer uses their own proprietary format to report the claims benefit determination; now, therefore, be it

RESOLVED, that the American Osteopathic Association work with Congress and individual public and private payers to develop the standard Explanation of Benefits form; and, be it further

RESOLVED, that this standardized form should clearly state information such as the patient's name, the insured's name, the patient's date of birth, the date of service, the CPT code submitted, the amount charged, the amount allowed, the amount discounted, the amount of co-pay, the deductible amount, the withhold amount, and the payment to the physician. 1999; *revised* 2004

FAMILY, SUPPORT OF

WHEREAS, osteopathic physicians recognize the importance and value of family interaction; and

WHEREAS, families may include both parents in one household, or in divided homes, extended family including step-parent, grand-parent, guardian, foster, or other care taker; and

WHEREAS, the amount of time families spend together has been declining for over a decade; now, therefore, be it

RESOLVED, that the American Osteopathic Association recommend that their members support families by encouraging families to do the following:

1. try to eat at least one meal per day together, using healthful nutritional guidelines
2. a set time be spent together as a family to help with school work and include reading to and with children
3. limiting non-educational use of television, computer and video game to no more than 2 hours per day
4. limiting exposure to violence
5. engaging in a healthy lifestyle that includes exercise. 2005

FAMILY AND MEDICAL LEAVE ACT (FMLA) DOCUMENTATION

WHEREAS, the Family and Medical Leave Act (FMLA) allows employees to take time off from their job for various reasons; and

WHEREAS, the FMLA allows employers to require medical certification of illness or disability; and

WHEREAS, the FMLA sets no standard for this certification; and

WHEREAS, a wide range of report forms and information is requested for this certification; and

WHEREAS, some of the employer required reports intrude on the patient's privacy and require information beyond that needed to establish illness or disability; now, therefore, be it

RESOLVED, that the American Osteopathic Association will work with patient advocacy groups and other similar groups to develop uniform documentation requirements that provide adequate information for employers but protect the patient's right to privacy. 2002

FIRE PREVENTION--TEACHING OF

WHEREAS, the National Safety Council reports that fire is a leading cause of accidental death in the United States; and

WHEREAS, each season has its own special fire hazards thus making fire prevention an all-year-round concern; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports fire prevention education. 1988; *revised* 1993, 1998, 2003

FIREARM SAFETY

WHEREAS, firearms are involved in a number of preventable deaths of children and adolescents; and

WHEREAS, a number of these deaths are intentional, either homicide or suicide; and

RESOLVED, that the American Osteopathic Association supports and encourages strategies such as secure storage and the use of safety locks for eliminating the inappropriate access to firearms by children and adolescents; and, be it further

RESOLVED, that the AOA supports and encourages all physicians to educate families in the safe use and storage of firearms. 1994; *revised* 1999, 2004

FIREARMS-- COMMITTING A CRIME WHILE USING A FIREARM

RESOLVED, that the American Osteopathic Association supports the position that persons convicted of a crime involving a firearm be prosecuted to the full extent of the law. 1994; *revised* 1996, 2001

FIREARMS--EDUCATION FOR USERS

WHEREAS, the American Osteopathic Association is concerned about deaths that occur in the United States as the result of misuse of firearms; and

WHEREAS, the AOA recognizes the extreme high cost of medical care and rehabilitation to treat the injuries and disabilities resulting from firearms; now, therefore be it

RESOLVED, that the American Osteopathic Association supports education involving firearm safety and the inherent risk and responsibility of ownership. 1990; *reaffirmed* 1995, 2000, 2005

FLAME-RETARDANT CLOTHING FOR CHILDREN—SLEEPING OR LOUNGING

WHEREAS, there have been requests from American College of Osteopathic Pediatrician (ACOP) members to cause manufacturers to produce only flame retardant sleep and lounge clothing; and

WHEREAS, the ACOP strongly feels that by causing the manufacturer's of such clothing to be flame retardant that it would save lives of many children who die yearly of smoke inhalation and/or burns; and

WHEREAS, the law (The Federal Flammable Fabrics Act of 1967) previously was in effect but is no longer and should be reinstated; and

WHEREAS, inhalational injury may cause pulmonary conditions such as hypoxemia, asphyxia, carbon monoxide poisoning, central nervous system injury and even death; and

WHEREAS, fire and burn related injuries are the third most common cause of unintentional injury deaths in the USA per year at 6000 per year, and ONE-THIRD of these are from injuries involved in infant sleepwear; these burns averaged 30% of the body and averaged a 70- day stay in the hospital; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports legislation to cause manufacturers to produce only flame retardant sleep and lounge clothing for infant and children. 2002

FLUORIDATION

WHEREAS, fluoridation is a public health program that benefits people of all ages, is safe and is cost effective, and

WHEREAS, a vast body of scientific literature endorses water fluoridation as a safe means of reducing the incidence of tooth decay, and

WHEREAS, only 62.2% of the US population served by public water systems have access to fluoridated water, now therefore be it

RESOLVED, that the American Osteopathic Association supports the fluoridation of fluoride-deficient public water supply. 2004

FORMULARY CHANGES

WHEREAS, it has become a common practice for health insurers and managed care plans to utilize a restricted pharmaceutical formulary; and

WHEREAS, it is also common for the pharmaceutical agents on the formulary to be changed; and

WHEREAS, it is common for financial criteria to be used in determining which agents are available on the formula; and

WHEREAS, these frequent changes in the formulary require patients to be switched from one medication to another; and

WHEREAS, at times it may not be medically advisable for the patient's medication to be changed; and

WHEREAS, in the case of antidepressants, psychotropic medications, and other narrow therapeutic window drugs, it may be dangerous for patients to change medications; now, therefore, be it

RESOLVED, that the American Osteopathic Association educate healthcare insurers and managed care companies on the potential dangers of formulary substitutions. 2002

GENDER DISCRIMINATION

WHEREAS, gender discrimination against physicians and medical students cannot be tolerated by the osteopathic profession; and

WHEREAS, all osteopathic physicians are fully qualified physicians and should be treated equally; and

WHEREAS, not all existing medical facilities within both osteopathic and allopathic institutions provide equally for both male and female osteopathic physicians and medical students; now, therefore, be it

RESOLVED, that the American Osteopathic Association require all of its recognized training institutions, both osteopathic and allopathic, to provide equally for their male and female physicians and students. 1992; *revised* 1997, 2002

GENERIC DRUGS

WHEREAS, generic drug substitution has been increasingly promoted by government and other third-party payors; and

WHEREAS, current Food and Drug Administration (FDA) standards for generic drugs allow for medically significant variance in the bioavailability and therapeutic effect of such substituted drugs; and

WHEREAS, recent revelations regarding shortcomings in FDA's testing and approval process for generic drugs now cast grave doubts upon the safety and effectiveness of all generic drugs not manufactured by the branded drug companies; now, therefore, be it

RESOLVED, that the American Osteopathic Association urges the FDA to strengthen its inspection and approval procedures and equivalency standards to ensure that generic drugs approved by the FDA are therapeutically equivalent to the brand drug for which they are to be substituted; and, be it further

RESOLVED, that the AOA opposes mandatory generic substitution programs that remove control of the treatment program from the physician; and, be it further

RESOLVED, that until the FDA has effected such policies, standards and procedures, consistent with its distinguished and longstanding stewardship of drug safety and effectiveness, the AOA opposes the mandatory use of generic drugs. 1990; *reaffirmed* 1995, 1997; revised 2002

GENETIC MANIPULATION OF FOOD PRODUCTS—CONSUMERS RIGHT TO KNOW

WHEREAS, food products continue to be genetically manipulated; and

WHEREAS, the latest trend is to transfer animal genes to plants, or to transfer genes between different types of plants; and

WHEREAS, products resulting from these gene transplants are being sold to the consumer without any notification that they have been genetically manipulated; and

WHEREAS, genetic manipulation may affect the beneficial value of the products; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports efforts that require that genetically manipulated food products be identified as such in order to inform consumers of any alterations. 2000, *revised* 2005

GENETIC TESTING

WHEREAS, the human genome project and genetic testing have contributed advances in medical knowledge; and

WHEREAS, such advances hold great promise for the future in diagnosis, management and treatment of the human condition; and

WHEREAS, such knowledge can also provide the basis for unethical and discriminatory behavior; and

WHEREAS, the American Osteopathic Association asserts that access to healthcare should not be restricted on the basis of genetic testing; and

WHEREAS, the AOA asserts that discrimination in employment on the basis of genetic testing should be prohibited; and

WHEREAS, the AOA asserts that health insurance policies, healthcare plans, and health maintenance organizations should be prohibited from restricting or denying coverage or raising premiums on the basis of genetic testing; now, therefore, be it

RESOLVED, that the American Osteopathic Association support the public interest in prohibiting discrimination in employment, insurance coverage, and access to care on the basis of genetic information. 1997; *revised* 2002

GERIATRIC HEALTHCARE

WHEREAS, the geriatric population of the United States has increased dramatically, requiring more emphasis on the medical needs of the elderly; and

WHEREAS, the healthcare needs of the elderly often differ from those of other patients; and

WHEREAS, the osteopathic physician plays a major role in planning and providing high quality healthcare to the elderly; now, therefore, be it

RESOLVED, that the American Osteopathic Association, osteopathic medical schools, and appropriate training programs support innovative approaches to instruction in end-of-life care and geriatric medicine . 1960; *reaffirmed* 1978, 1983; *revised* 1988, 1993, 1998, 2003

GERIATRICS--LOSS OF LIABILITY INSURANCE COVERAGE FOR PRACTITIONERS OF

WHEREAS, medical demographics project the aging of the American population such that the population over the age of 60 is expected to significantly increase; and

WHEREAS, this significantly increased over age 60 demographic will require substantial medical care and resources; and

WHEREAS, many osteopathic physicians are making career commitments for care of this aging population, which include specialized residency and fellowship training; and

WHEREAS, such specialized training often focuses on the very different way in which post-hospital care is now being provided, such that nursing homes are utilized as rehab centers and medical step down units in addition to long term care centers; and

WHEREAS, this medical care utilization of nursing homes increasingly demands the expertise of a hospital intensivist knowledge base; and

WHEREAS, those osteopathic physicians who commit to such a career often may not have an outpatient office, in keeping with their hospital based practice; and

WHEREAS, some medical liability insurers have, without fair notice to the medical community, made an industry decision to refuse coverage of <u>any kind at any price</u> for those physicians who do not have an outpatient office based practice and whose practice includes nursing home care of any kind; and

WHEREAS, such an industry decision will profoundly impair quality and access to medical care for an increasing population who desperately need such care; and

WHEREAS, this industry decision will adversely impact those physicians who want to provide geriatric care by effectively and completely restraining their trade; now, therefore, be it

RESOLVED, that the American Osteopathic Association stand publicly as opposed to any medical liability insurance industry policy which excludes offering coverage to a whole class of appropriate medical practice and work to have such a policy rescinded; and, be it further

RESOLVED, that the AOA coordinate its efforts with other organizations similarly opposed to this medical liability insurance industry policy in order to enhance success; and, be it further

RESOLVED, that the AOA advocate its opposition to those legislative and governmental entities who have impact on allowing the medical liability insurance industry to restrain trade; and, be it further

RESOLVED, that the AOA investigate this issue for its national implications and to intervene as appropriate. 2003

GIFTS TO PHYSICIANS FROM INDUSTRY

WHEREAS, we believe in the ethical, moral and philosophical integrity of our members; and

WHEREAS, pharmaceutical companies may provide physicians with free gifts despite a growing number of counter-campaigns by physicians, hospitals, organizations, such as the Pharmaceutical Research and Manufacturers of America (PhRMA), the American Medical Association (AMA) and, more recently, the Office of the Inspector General (OIG) of the United States; and

WHEREAS, the AOA House of Delegates, at its July 2002 meeting in Chicago, passed a resolution strengthening the AOA Code of Ethics in this regard; now, therefore, be it

RESOLVED, that the American Osteopathic Association adopt the following "guide to Section 17 of the AOA Code of Ethics as follows:

1. *Physicians' responsibility is to provide appropriate care to patients. This includes*

   determining the best pharmaceuticals to treat their condition. This requires that physicians educate themselves as to the available alternatives and their appropriateness so they can determine the most appropriate treatment for an individual patient. Appropriate sources of information may include journal articles, continuing medical education programs, and interactions with pharmaceutical representatives.

2. It is ethical, and may be in the best interest of their patients for osteopathic physicians to meet with pharmaceutical companies and their representatives for the purpose of product education, such as, side effects, clinical effectiveness and ongoing pharmaceutical research.

3. Pharmaceutical companies may offer gifts to Physicians from time to time. *The use of a product or service based solely on the receipt of a gift shall be deemed unethical.*

4. When a physician provides services to a pharmaceutical company, it is appropriate to receive compensation. However, it is important that compensation be in proportion to the services rendered. Compensation should not have the substance or appearance of a relationship to the physician's use of the employer's products in patient care; and, be it further

RESOLVED, that the American Osteopathic Association distribute this information to students of osteopathic medicine and osteopathic physicians. 1991, *revised* 1994, 1999, 2003

GOOD SAMARITAN ACTS (HOLD HARMLESS AGREEMENT) PERFORMED ON COMMERCIAL AIRCRAFT

WHEREAS, an individual who volunteers to use his or her professional knowledge and expertise to assist a fellow individual suffering an acute medical event is referred to as a Good Samaritan; and,

WHEREAS, the training and/or expertise of the Good Samaritan may or may not be in the specialist field appropriate to the particular medical event; and,

WHEREAS, the Good Samaritan acts with good faith and within the bounds of his or her professional competence to alleviate suffering and minimize harm; and,

WHEREAS, the request or acceptance of a fee or remuneration for such an act changes the encounter from a Good Samaritan relationship to a formal doctor/patient encounter with acceptance of full clinical liability for the consequences of the actions; and,

WHEREAS, the American Osteopathic Association has previously approved a resolution and gone on record supporting national legislation providing for a Good Samaritan Act; and,

WHEREAS, the AOA believes that a Good Samaritan shall be held harmless and not liable for damages resulting from an inflight medical emergency unless the individual is negligent or willfully does wrong; now, therefore, be it

RESOLVED, that the American Osteopathic Association strongly recommends that all countries establish Good Samaritan (Hold Harmless) laws for medical care rendered on commercial aircraft and urges all airlines to provide liability coverage for such Good Samaritan acts, for qualified practitioners. 2001

GOVERNMENT INTERVENTION IN PRIVATE PRACTICE

WHEREAS, the practice of osteopathic medicine and surgery requires independent decisions and actions; and

WHEREAS, these decisions and actions may not always parallel the opinions of any other single physician reviewer; and

WHEREAS, it is not appropriate for a third party to penalize any practicing physician based on review by a single physician; now, therefore, be it

RESOLVED, that the American Osteopathic Association strongly recommends that any intervention by third party payers (Medicare, Medicaid and other third-party insurers), shall not penalize any physician without proper peer review and opportunity for appeal, without prejudice or penalty; and be it further

RESOLVED, that the AOA encourage the continued availability of judicial review of claims of Part B Medicare and other third-party payers. 1985; *revised* 1990, 1994; *reaffirmed* 1999; *revised* 2004

GRADUATE MEDICAL EDUCATION-FEDERAL FUNDING FOR

WHEREAS, the indirect medical adjustment payment is determined by the inpatient settings of a hospital-specific percentage amount based on the ratio of interns and residents per bed added to the payment for each admission; and

WHEREAS, the indirect medical adjustment payment was developed to compensate teaching institutions for their higher costs associated with teaching; and

WHEREAS, there is an increasing shift in the volume and complexity of outpatient surgical procedures that are performed in a free-standing and/or ambulatory surgical setting; and

WHEREAS, in its 1997 Annual Report to Congress, the Medicare Payment Advisory Commission (MedPAC) recognized that current Medicare policy requiring payments to be made

only to hospitals discourages training in an ambulatory setting and that this requirement exists despite the expressed need for physicians to receive more training to practice in ambulatory settings; and

WHEREAS, in its 1997 Annual Report to Congress, the MedPAC supports alternative methods to encourage training outside of the hospital, including to permit all training time to be counted for the purposes of either direct or indirect payments; and

WHEREAS, the Institute of Medicine (Committee On Implementing a National Graduate Medical Education Trust Fund, April 1997) recommends that residency training time in ambulatory sites should count toward indirect medical education (IME) payments in the same way that it does for direct medical education (DME) payments; now, therefore, be it

RESOLVED, that the American Osteopathic Association support the concept that when the federal government provides for direct reimbursement of the costs of graduate medical education in ambulatory settings, that such reimbursement should be provided on an equal basis for both primary care and specialty training programs, including surgical training. 1999; *reaffirmed* 2004

GRADUATE MEDICAL EDUCATION (GME) FUNDING FOR RESIDENCY PROGRAMS USING VOLUNTEER FACULTY

WHEREAS, the Balanced Budget Act of 1997 (BBA) contained provisions intended to both encourage training of residents in rural and underserved areas and in non-hospital settings; and

WHEREAS, Congressional intent was to increase the amount of training in non-hospital settings, which more closely resembled the types of environments physicians' would ultimately practice in; and

WHEREAS, Congress determined that the Federal government should encourage the training of future physicians in the types of medical practices they will work in upon completion of their residencies by allowing hospitals to receive Medicare Indirect Medical Education (IME) payments in addition to Direct Graduate Medical Education (DGME) payments for time residents spent in non-hospital training sites; and

WHEREAS, recent rule-making by the Centers for Medicare and Medicaid Services (CMS) has eliminated the ability of physicians in non-hospital sites to volunteer their services to postgraduate training programs; and

WHEREAS, actions being taken by CMS go against Congressional intent; and

WHEREAS, the one-year moratorium established in Section 713 of the Medicare Prescription Drug Modernization and Improvement Act (MMA) (Public Law 108-173) allowing continuation of IME payments for osteopathic and allopathic residents in family medicine postgraduate training programs who are training in non-hospital sites without regard to the financial arrangement between the hospital and the supervisory physician expired on December 31, 2004; and

WHEREAS, if CMS policy is not changed, hospitals will be forced to train all residents in the hospital setting or eliminate programs further limiting the quality of education provided to osteopathic physicians; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) supports the enactment of federal legislation that increases and adequately finances the training of osteopathic residents in ambulatory non-hospital sites; and, be it further

RESOLVED, that the AOA calls upon grassroot efforts to contact U. S. Senators and Representatives, and the Centers for Medicare and Medicaid Services to take the necessary steps

to allow hospitals to utilize volunteer faculty without funding decreases by Medicare; and, be it further

RESOLVED, that the AOA supports the enactment of federal legislation that clarifies Congressional intent as established in the Balanced Budget Act of 1997, allowing teaching hospitals and physicians in non-hospital sites to enter into educational agreements to train osteopathic residents regardless of financial arrangement. 2005

GRADUATE OSTEOPATHIC MEDICAL EDUCATION PROGRAMS

WHEREAS, it is important for graduates of colleges of osteopathic medicine to have adequate sites for graduate medical education in appropriate American Osteopathic Association approved training sites; and

WHEREAS, the osteopathic profession does not currently have the capacity to train all of the graduates of colleges of osteopathic medicine in AOA-approved training sites; and

WHEREAS, the osteopathic profession depends on qualified postdoctoral programs, for the training of osteopathic physicians; and

WHEREAS, the training of osteopathic physicians depends on the availability of all types of hospital settings for this experience; and

WHEREAS, qualified programs are approved and utilized for this purpose in a variety of hospitals with different financial bases; and

WHEREAS, certain hospitals with previously qualified training programs have expressed an intention of not continuing these programs; now, therefore, be it

RESOLVED, that the American Osteopathic Association, as a matter of policy, opposes any federal or state law or regulation that would prevent the development of additional osteopathic graduate medical education programs or training positions; and, be it further

RESOLVED, that the American Osteopathic Association continue to take all measures possible to prevent the termination of distinctive osteopathic training programs. 1997; revised 2002

HEALTHCARE COSTS

WHEREAS, the provision of healthcare of the highest quality is the primary mission of osteopathic physicians and osteopathic hospitals; and

WHEREAS, promulgation of programs which contain healthcare costs but do not lower the quality of such care are consistent with the objectives of osteopathic physicians and osteopathic hospitals; now, therefore, be it

RESOLVED, that the American Osteopathic Association reaffirms its commitment to the development and implementation of programs which encompass healthcare cost containment, and assures the quality of such care. 1984; *revised* 1989; *reaffirmed* 1994; *revised* 1999; *reaffirmed* 2004

HEALTHCARE DELIVERY SYSTEMS

WHEREAS, healthcare delivery has always been the main concern of the osteopathic physician; and

WHEREAS, there has been a rapid expansion of healthcare delivery systems which limit the patient's free choice of physicians and place cost containment above quality of care; and

WHEREAS, there is a need to provide more information to osteopathic physicians and patients about the full consequences of such delivery systems; now, therefore, be it

RESOLVED, that the American Osteopathic Association continues to have as a high priority the education of osteopathic physicians and the general public as to the importance of continued availability of osteopathic services in all healthcare delivery systems. 1987; *reaffirmed* 1992; *revised* 1997, 2002

HEALTH CARE DISPARITIES

WHEREAS, health care disparities exist in United States and most greatly affect underrepresented minorities, including African Americans, Hispanic Americans, Asian Americans, Native Americans Pacific Islanders, and individuals of disadvantaged backgrounds; and

WHEREAS, there is a need for organized medicine to develop strategies to address health care disparities among minorities and to prepare culturally competent physicians; now, therefore, be it

RESOLVED, that the American Osteopathic Association adopts the following Position Statement on Minority Health Disparities:

POSITION STATEMENT ON MINORITY HEALTH DISPARITIES

The minority healthcare crisis in America stems from a multitude of factors. In particular, healthcare disparities most greatly affect underrepresented minorities, which include African-Americans, Hispanic-Americans, Asian-Americans, Native Americans and Pacific Islanders. In order to effectively create positive change, certain questions must be addressed. These include, but are not limited to**:** Which minorities are most affected by disease-specific illness? Why do these disparities exist? What can be done to eliminate them? Will a concerted effort to increase awareness and education about health-care disparities result in improved delivery of quality healthcare?

There is a need for the osteopathic profession and all of organized medicine to develop strategies which address health care disparities among minorities and prepare culturally competent physicians. Guidance should be offered to educate practicing physicians and trainees to better resolve known disparities and serve diverse populations. Efforts must be made to assure cultural competency and to identify and overcome language and other barriers to delivering health care to minorities.

Healthcare disparities include differences in health coverage, health access and quality of care. Health disparities result in morbidity and mortality experienced by one population group in relation to another.

Cultural competency is a set of academic and personal skills that allow one to understand and appreciate cultural differences among groups. The better a healthcare professional understands a patient's behavior, values and other personal factors, the more likely that patient will receive effective, high quality care.

Racial and ethnic healthcare disparities caused by problems with access to, and utilization of, quality care may be alleviated through improvements in the cultural competency skills of physicians. Healthcare disparities may also be alleviated through effective recruitment of underrepresented minorities into health professions schools.

The Centers for Disease Control, in conjunction with the U.S. Department of Health and Human Services, created an Office of Minority Health in 1985. Through this collaboration, the Racial and Ethnic Approaches to Community Health Act (REACH) was designed to identify and eliminate disparities in a number of major areas. Disparities in access to care as well as quality of care in these areas result in poorer outcomes for racial and ethnic minorities.
The identified areas of disparity include: 1) infant mortality; 2) breast and cervical cancer screening and malignancy; 3) cardiovascular and cerebrovascular disease; 4) diabetes; 5) HIV/AIDS; and 6) child and adult immunizations. In addition, serious disparities exist in the provision of care for mental health problems, substance abuse and suicide prevention.
The American Osteopathic Association calls for the following actions to be taken to address minority health disparities and to improve cultural competency of its physician members:

1) The creation of a forum to increase physician knowledge on racial and ethnic healthcare needs, including disparities in the areas listed above;
2) The elimination of provider stereotypical beliefs that may play a role in clinical decision-making;
3) The evaluation and analysis of medical information which would permit the targeting of populations who are at greatest risk;
4) The identification of new methods to involve physician members in the communities in which they serve;
5) The identification and integration of available resources to better serve minority communities, including houses of worship, schools and local government;
6) The inclusion of cultural competency training throughout the continuum of osteopathic education;
7) The development of strategies to actively recruit underrepresented minority physicians into the profession in both primary care and subspecialties;
8) The development of approaches to encourage all physicians to provide care to underserved minority populations;
9) The adoption of strategies to assist physicians to effectively communicate with their patients, addressing translation and other barriers to patient understanding.

2005

HEALTHCARE FRAUD

WHEREAS, the Center for Medicare and Medicaid Services (CMS) alleges $23 billion in "fraudulent" Medicare claims; and

WHEREAS, CMS has included denied claims in this amount; and

WHEREAS, the broad brush and label of fraudulent claims does not seem to separate from fraudulent claims those claims based upon innocent error or mistake; and

WHEREAS, the regulatory definition of "fraud" is too broad and inclusive in that it incorporates a variety of actions as "fraudulent" which are in no way related to billings for services not rendered; and

WHEREAS, current CMS regulations are difficult to understand because of their volume and contradictions and thereby create an atmosphere wherein honest billing or record keeping mistakes can easily be made, but not otherwise forgiven; and

WHEREAS, the American Osteopathic Association is concerned about the preservation of high quality patient care within a trusting atmosphere of the patient-physician relationship; now, therefore, be it

RESOLVED, that the American Osteopathic Association request the Center for Medicare and Medicaid Services (CMS) redefine its definition of "fraud" to include only those claims for services billed intentionally to defraud the government; and, be it further

RESOLVED, that the AOA further request CMS to omit from the definition of "fraud" any mistake on the submitted claim as well as any difference between CMS and the physician regarding the level of service, based on the CPT code; and, be it further

RESOLVED, that the AOA request CMS to disclose to the public and the medical community the actual amount of "fraud" in dollars, based on the reasonable definition of "fraud" omitting all denied claims and all honest mistakes by physicians and the Medicare carriers; and, be it further

RESOLVED, that the AOA strongly oppose the use of law enforcement agencies and auditors to enter physicians' offices without prior request, warning or due process under the law for the purpose of confiscating records. 1999; *revised 2004*

HEALTH CARE INSURANCE OPTIONS

WHEREAS, there is existing law mandating that employers offer an HMO to employees; and

WHEREAS, employers are not required to offer a "fee for service" insurance; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports legislation that will require employers to include traditional indemnity insurance as one of their choices for health insurance for their employees where existing law mandates employers to offer an HMO to their employees. 1986; *revised* 1991, 1992, 1997; revised 2002

HEALTHCARE PROVIDERS RIGHT OF CONSCIENCE

WHEREAS, the American Osteopathic Association Committee on Ethics, after deliberation has determined that it is unethical for an osteopathic physician to impose his/her conscience on a patient without offering that patient other treatment options; now, therefore, be it

RESOLVED, that all osteopathic physicians are ethically bound to inform patients of available options with regard to treatment; and, be it further

RESOLVED, that if an osteopathic physician has an ethical, moral or religious belief that prevents him or her from providing a medically-approved service, they should recuse themselves from the case and refer the patient to another provider. 2003

HEALTHCARE, REGULATION OF

WHEREAS, there is an increased cost of healthcare delivered, both in real dollars and as a percentage of gross domestic product; and

WHEREAS, these increased costs are due in part to the following three factors:

(1) many new high technologies, high cost healthcare services have been developed and broadly utilized;

(2) the cost of providing inpatient care has continued to rise at a rate exceeding the general rate of inflation;

(3) the growth of federal regulation, which has paralleled government participation in financing healthcare services, has enormously increased the total cost of healthcare delivered; now, therefore, be it

RESOLVED, that the American Osteopathic Association policy with respect to regulation in healthcare is as follows:

1. The need for any new regulation must demonstrate that access to or the quality of healthcare will be improved by the proposed regulatory action and that the claimed improvement can be accomplished at an acceptable cost to the public.
2. In all matters where the health profession has demonstrated its capacity for quality self-regulation, government at all levels should not impose additional or preemptive regulation.
3. Where the need for regulation has been demonstrated, it should emanate from the lowest applicable level of government.
4. Where there is a demonstrated necessity for regulation of healthcare, such regulation must be drawn and implemented in such a way as to promote pluralism and preserve the free enterprise system in healthcare. 1981; *revised* 1986, 1992; *reaffirmed* 1997; *revised* 2002

HEALTHCARE THAT WORKS FOR ALL AMERICANS

WHEREAS, many forces in health care today work to impede Osteopathic physicians in their quest to provide quality, cost-efficient health care to their communities; and

WHEREAS, these impediments include the professional liability insurance crisis, the more than 40 million uninsured, and the barriers insurance companies place on access to Osteopathic physicians, training institutions, and Osteopathic manipulative services; and

WHEREAS, legislation has been introduced to provide a nationwide public debate about improving the ability of every American to obtain quality, affordable healthcare; and

WHEREAS, many national health care organizations have agreed to work to facilitate this public debate and implementation of changes to our current system; now, therefore, be it

RESOLVED, that the American Osteopathic Association's Council on Federal Health Programs have a priority goal to encourage the US Congress for passage of legislation to further the national health care debate; and, be it further

RESOLVED, that this public debate address the major issues that threaten the ability of Osteopathic physicians to provide quality, cost-efficient health care to their communities, including the availability of affordable health insurance for all citizens, inclusion of Osteopathic physicians, training institutions, and Osteopathic manipulative services on insurance company reimbursement, and the fundamental question of Professional Liability Tort Reform; and, be it further

RESOLVED, that follow up activity assures that Congress enacts the appropriate legislation that assures the accomplishments of the above-listed goals. 2003

HEALTH CLINICS—FEDERALLY FUNDED

WHEREAS, federally funded health clinics require a nurse practitioner or physician assistant be a part of the staff; and

WHEREAS, this requirement has been detrimental in areas where there is a shortage of nurse practitioners and physician assistants; and

WHEREAS, it has prevented physicians from serving in the clinics as they do not have a physician to share coverage; and

WHEREAS, the rule has no study to demonstrate improved health care because of a nurse practitioner or physician assistant in the clinics; and

WHEREAS, the requirement has had a detrimental effect on some clinics and/or potential clinics; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports eliminating the requirement to have a nurse practitioner or physician assistant in federally funded health clinics; and, be it further

RESOLVED, that the AOA supports instead, adequate staffing for the physicians providing medical care in the clinics; and, be it further

RESOLVED, that the AOA take steps necessary to eliminate the present requirement. 2002

HEALTHY LIFE STYLES

WHEREAS, many of the effects of unhealthy personal life styles are known, and the detrimental effects are projected to cost billions of healthcare dollars paid by society; and

WHEREAS, the promotion of healthy life style is an investment in a healthier society and a less costly healthcare treatment system for tomorrow; now, therefore, be it

RESOLVED, that the American Osteopathic Association promotes guidelines for healthy life styles and will continue to work with Congress and related healthcare agencies to develop those guidelines. 1992; *revised* 1997, 2002

HEALTHY PEOPLE 2010

WHEREAS, the promotion of healthy life styles is an investment in a healthier society and a less costly healthcare treatment system for tomorrow; and

WHEREAS, "Healthy People 2010: National Health Promotion and Disease Prevention Objectives" presents a national prevention strategy to increase the quality and years of healthy life and the elimination of racial and ethnic disparities in health status, now, therefore, be it

RESOLVED, that the American Osteopathic Association supports "Healthy People 2010." 1998, *revised* 2003

HEALTHY WEIGHT FOR FAMILIES

WHEREAS, childhood, adolescent and adult obesity is now epidemic in the United States affecting 30.5 percent adults and 15 percent of children; and

WHEREAS, obesity is accompanied by an increased prevalence of metabolic syndrome, type 2 diabetes, cardiovascular and cerebrovascular disease, as well as other diseases; and

WHEREAS, these co-morbid diseases increase mortality rates significantly; and

WHEREAS, the medical expenditures for obesity is estimated at $47.5 billion (2001); and

WHEREAS, quality of care data reflects a need for both immediate and long-term quality improvement in the management of obesity and its co-morbid diseases; and

WHEREAS, the American Osteopathic Association, other osteopathic organizations and osteopathic physicians have participated in activities promoting healthy lifestyles; now, therefore be it

RESOLVED, that the American Osteopathic Association encourages participation of its members in personal health promotion; and, be it further

RESOLVED, that the AOA encourages participation of its members in continuing medical education (CME) programs on obesity in all ages and ethnic groups; and, be it further

RESOLVED, that the AOA urge the state and specialty associations to offer Continuing Medical Education obesity programs in all age groups and ethnic groups, as part of their educational offerings; and, be it further

RESOLVED, that the AOA encourage its members to participate in national and local initiatives on obesity; and, be it further

RESOLVED, that the AOA, through its website, link to organizations whose mission is to educate patients and physicians on obesity. 2004

HEART ATTACK SAFETY ACT

WHEREAS, heart attacks are the number one cause of death among adults in the United States; and

WHEREAS, there is currently no national system to direct the public to the best available facility for treatment of chest pain; and

WHEREAS, there are no broadly accepted criteria that represent the best practice for the treatment of chest pain; and

WHEREAS, hospitals may designate themselves as specializing in the treatment of chest pain without any accreditation; and

WHEREAS, the American Osteopathic Association supports efforts to improve the quality of health care; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) support the adoption of standards and criteria that will raise the quality of hospitals who treat chest pain; and, be it further

RESOLVED, that the AOA support the "Heart Attack Safety Act" of 2005 introduced by Senator DeWine of Ohio as S1277. 2005

HOME-BASED CARE FOR FRAIL ELDERLY

WHEREAS, the U.S. population is aging; and

WHEREAS, the frail elderly are a significant and growing component of the Medicare population; and

WHEREAS, the frail elderly are physically restricted in their ability to access normal outpatient care services; and

WHEREAS, the home-bound frail elderly often enter the healthcare system via an Emergency Medical Services (EMS) call and/or a trip to the emergency room; and

WHEREAS, the lack of continuity of care for the frail elderly results in a disproportionate component of total Medicare expenditures; and

WHEREAS, at-risk managed care plans could benefit from taking a leading role in proactive programs to improve the health of frail elderly; now, therefore, be it

RESOLVED, that the American Osteopathic Association encourage all parties with economic and clinical responsibility to develop programs and systems to improve the frail elderly patient population and provide appropriate access to healthcare services. 1999; *revised* 2004

HOME HEALTHCARE ABUSE

WHEREAS, the cost of home healthcare is a rapidly escalating component of Medicare costs; and

WHEREAS, the physician, in signing orders for such services and attesting to the fact that the services are necessary and the patient is home-bound, is assuming medical and legal responsibility for the accuracy of these statements; and

WHEREAS, in actuality the home healthcare plan for the patient is often developed by the home health agency and presented to the physician for signature; and

WHEREAS, the physician, in signing orders for home healthcare, is usually not aware of the Medicare costs involved in the proposed plan and the possibility of other options that may be preferable for patient management and cost control; now, therefore, be it

RESOLVED, that the American Osteopathic Association encourage and assist its members to become more aware of the cost of home healthcare and the increased responsibility of the physician; and, be it further

RESOLVED, that the AOA support ongoing efforts of the medical profession, Department of Health and Human Services, the Attorney General's office, and Congress to prevent abuse of home health services under the Medicare program. 1997; revised 2002

HOSPICE-- SUPPORT FOR

WHEREAS, Hospice and palliative care are developing fields of medical specialization in the United States and globally; and

WHEREAS, Hospice and palliative care treat the psychosocial, spiritual, and physical problems of patients and their families who are living with serious complex progressive and life threatening illness; and

WHEREAS, Hospice and palliative care utilize a holistic interdisciplinary model of care which is directed by the patients personal attending physician; and

WHEREAS, the goal of hospice and palliative care is the worldwide relief of pain and suffering for patients at the end of life; and

WHEREAS, Hospice and palliative care firmly oppose physician assisted suicide and euthanasia; and

WHEREAS, the Hospice model of care has been shown to provide high patient satisfaction concurrently with cost effectiveness; now, therefore, be it

RESOLVED, that the American Osteopathic Association endorses the practice of hospice and palliative care medicine and supports the organizations dedicated to education and provision of this care. 1993; *reaffirmed* 1998*, revised* 2003

HOSPICE CARE PROGRAMS

WHEREAS, the American Osteopathic Association recognizes that the hospice concept is an alternative approach to providing humanitarian care for the terminally ill and their families; and

WHEREAS, traditional medical care is directed toward cure or control of disease in individual patients, and palliative care in consonance with patients' desires; and

WHEREAS, hospice care focuses on caring not curing; now, therefore, be it

RESOLVED, that the American Osteopathic Association continues to encourage its membership to participate in the hospice care program; and, be it further

RESOLVED, that the AOA strongly urges the United States Congress to continue to include hospice care as a benefit under Medicare and Medicaid; and that it strongly urges the health insurance industry to include hospice care as a benefit. 1982; *revised* 1987, 1992; *reaffirmed* 1997; *revised* 2002

HOSPITALISTS

WHEREAS, the American Osteopathic Association members are strongly committed to providing comprehensive medical care to patients; and

WHEREAS, the osteopathic profession's philosophy is based on a continuum of care for patients; and

WHEREAS, the trust and confidence of a patient is important in the development of a strong physician/patient relationship; which instills patient confidence and enhances medical compliance; now, therefore, be it

RESOLVED, that the American Osteopathic Association strongly opposes any attempt by a third-party payer, business, institution or government to mandate a patient be seen and managed by any individual, in any setting, by hospitalists or any one other than the patient's physician. 1999; *revised* 2004

HUMAN CLONING

WHEREAS, the federal government is debating the ethics of human cloning; and

WHEREAS, there is a significant impact on the public and medical community; now, therefore, be it

RESOLVED, that the American Osteopathic Association closely monitor debate on the ethics of human cloning; and, be it further

RESOLVED, that the state osteopathic associations receive up-to-date information on this issue from the AOA to share with their members; and, be it further

RESOLVED, that the AOA take a leadership role in bringing the osteopathic and allopathic medical communities, researchers, scientists, and ethicists together to discuss and develop a policy on the issue prior to passage of legislation may adversely affect patients and/or medical research. 1998; *revised* 2003

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

WHEREAS, HIV infection is one of the greatest public health crisis of our times and affects all segments of our society; and

WHEREAS, HIV is transmitted primarily through sexual contact, exposure to infected blood, from mothers to neonate, and IV drug abuse; and

WHEREAS, the design and implementation of effective prevention programs is an essential but complicated goal; and

WHEREAS, HIV has precipitated unique sociopolitical problems in our society often resulting in fear and discrimination; and

WHEREAS, physicians occupy a unique position by providing care to those afflicted by the disease, as well as serving as educational resources for both their patients and their communities; now, therefore, be it

RESOLVED, that physicians should, in accordance with the American Osteopathic Association's Code of Ethics, provide basic care for those at risk and those infected with Human Immunodeficiency Virus HIV, including serologic testing, basic diagnosis and treatment of the infection and its complications in an atmosphere of compassion and nondiscrimination; and, be it further

RESOLVED, that osteopathic physicians recognize their professional and ethical obligations to care for such patients as they care for all patients; and, be it further

RESOLVED, that osteopathic physicians in their important role as humanitarian resources to their patients, families, and communities, provide candid, effective nonjudgmental

preventive education for those at risk, and serve as effective resources for their patients' families and loved ones; and, be it further

RESOLVED, that osteopathic physicians should be educational resources for those at negligible risk in an effort to promote enlightened attitudes in places of work, our schools, and communities in general. 1992; *revised* 1996, 2001

HIV--APPROVAL OF THE DISTRIBUTION OF STERILE SYRINGES AND NEEDLES TO I.V. DRUG ABUSERS

WHEREAS, intravenous (I.V.) drug abusers have a high potential for contracting hepatitis and HIV/AIDS which are life-threatening and life-taking; and

WHEREAS, these diseases are communicable under certain conditions and have infected other persons who are not I.V. drug abusers; and

WHEREAS, some cities in the United States, as well as foreign countries, embarked on a trial program of supplying sterile syringes and needles to I.V. drug abusers in an attempt to reduce the significantly high rate of hepatitis and HIV/AIDS; and

WHEREAS, certain cities in the U.S. who approved the concept of supplying sterile needles and syringes have documented drastic reductions in the spread of hepatitis and HIV/AIDS; and

WHEREAS, many I.V. drug abusers have never been introduced to, or taken advantage of, a health system or provider who gives an alternative option for treatment of drug addiction; and

WHEREAS, a certain number of I.V. drug abusers who receive sterile syringes and needles might avail themselves of treatment; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the distribution of sterile syringes and needles to I.V. drug abusers to help abate the spread of hepatitis and HIV/AIDS and improve access to the legitimate healthcare system. 1998; *revised* 2003

HUMAN IMMUNODEFICIENCY VIRUS (HIV)--POSITIVE STATUS AS A DISABILITY

WHEREAS, a positive HIV test, in itself, is not considered a basis for disability at the present time under most disability insurance contracts; and

WHEREAS, there is increasing pressure by the public and governmental bodies to require physicians to disclose the fact that they are HIV positive to their patients; and

WHEREAS, such disclosure can have a devastating impact on the physician's practice resulting in the loss of patients and privileges; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports efforts to require all disability insurance contracts to recognize HIV positive status as a disability for all physicians, regardless of specialty, provided that the physician can demonstrate that this status has caused a significant loss of patients, income or privileges. 1992; *revised* 1997; reaffirmed 2002

HIV TESTING--CLINICAL AND PUBLIC HEALTH APPLICATION OF

WHEREAS, HIV testing is important to identify, manage, and prevent HIV infection; and HIV testing in clinical settings should be voluntary, confidential, and associated with pre- and post-test counseling; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports widespread application of HIV testing in the clinical setting particularly for those at risk for HIV infection as determined by physician evaluation; and, be it further

RESOLVED, that the American Osteopathic Association supports continued anonymous testing and counseling programs in public health facilities to maximize individual participation; and, be it further

RESOLVED, that the AOA supports mandatory HIV testing only for source patients, in cases of rape or incest, or in cases of an accidental exposure in patients who are at risk for HIV/AIDS; and, be it further

RESOLVED, that the AOA supports the following recommendation of the American College of Osteopathic Obstetricians and Gynecologists:

A. Healthcare Workers

1. Healthcare workers have a minimal risk of acquiring HIV infection from patients; however, this risk is much greater than the extremely remote possibility of transmission to patients.

2. Properly used universal precautions are effective in the prevention of transmission of bodily fluids between healthcare workers and patients and diminish the risk of infection. Serologic testing of patients and/or healthcare workers for the purposes of infection control does not prevent the transmission of HIV infection nor enhance the effectiveness of universal precautions. The AOA supports and encourages patients who know they are HIV positive to inform their physician that they are HIV positive prior to receiving medical care.

3. The AOA opposes mandatory testing of patients and healthcare workers as there is no scientific data supporting the efficacy of such testing in the prevention of HIV transmission in the healthcare setting. Should any state or the federal government legislate mandatory HIV testing for any group, the AOA is opposed to any such legislation which does not include the entire population because such legislation discriminates against certain groups. The AOA affirms the right of HIV-infected individuals to practice their occupations in a manner which does not present any identifiable risk of transmission of disease and pledges itself to promote the ability of these individuals to continue productive careers so long as they can do so responsibly and safely.

4. The AOA supports programs for effective education and implementation of universal precautions in all healthcare settings.

B. Public and Patient Education

1. Although studies have demonstrated an improved awareness of HIV infection and its modes of transmission, myths and misconceptions persist.

2. The AOA supports public education programs that provide accurate, up-to-date and clearly stated information regarding HIV transmission. The AOA urges increased governmental appropriations for implementing public health measures to assist in halting the increasing incidence of HIV and AIDS.

3. Primary care physicians occupy a central role in education of patients regarding preventative healthcare in general and are in an ideal position to serve a central role in HIV prevention.

4. The AOA encourages all osteopathic physicians to be knowledgeable in HIV risk evaluations and to incorporate candid and nonjudgmental assessment of related risk behaviors in routine patient care.

C. Medical Education

1. Osteopathic medical students and physicians in training are particularly vulnerable to the socioeconomic consequences of occupationally acquired HIV infection. The osteopathic profession bears a unique responsibility to provide for their maximum protection and social well being.

All osteopathic medical schools and postdoctoral training programs should make available: life, health and disability insurance including coverage for occupationally acquired HIV infection; effective education and training in AIDS, infection control and universal precautions. 1991; *revised* 1992; *reaffirmed* 1997, *revised* 2003

ICD-9 CODES FOR LABORATORY TESTS, ASSIGNMENT OF

WHEREAS, the Balanced Budget Act requires physicians to assign acceptable diagnosis codes utilizing the ICD-9 system for each laboratory test ordered in their practice of medical care; and

WHEREAS, health insurance companies which provide coverage for Medicare recipients have been permitted the latitude of determining the medical necessity of laboratory tests, thus, indirectly practicing medicine; and

WHEREAS, this policy and practice of medical necessity oversight has created an unnecessary burden and increased paper work for ordering physicians, and in addition, has placed increased risk for financial loss and liability on physicians practicing in good faith; and

WHEREAS, this unnecessary burden and paperwork requirement has lessened that amount of time available for direct patient care by physicians; now, therefore, be it

RESOLVED, that the American Osteopathic Association adopt the policy that the use of single ICD-9 codes should suffice to justify the ordering of laboratory tests, if those tests are ordered as part of the evaluation of a disease process or in the context of an already known disease; and, be it further

RESOLVED, that the AOA communicate this policy to the Centers for Medicare and Medicaid Services, the Department of Health and Human Services, health insurance companies, and to the U.S. Congress. 1998, *revised* 2003

IMMUNIZATIONS

WHEREAS, the American Osteopathic Association urges active immunization of children and adults as recommended by the Centers for Disease Control and Prevention to prevent the resurgence of childhood diseases and control the spread of other infectious diseases, now; therefore, be it

RESOLVED, that the American Osteopathic Association supports the Centers for Disease Control and Prevention in its efforts to achieve a high compliance rate among infants, children and adults by encouraging osteopathic physicians to immunize patients of all ages when appropriate. 1993; *revised* 1998, 2003

IMMUNIZATIONS—AVAILABILITY OF

WHEREAS, national vaccine programs are beset by production shortages, under funding, and distribution inequities; and

WHEREAS, children who are not immunized are at risk for preventable disease and represent potential reservoir of such diseases; and

WHEREAS, children whose immunizations are not current or are incomplete represent a potential threat to the health and the security of the nation; now, therefore, be it

RESOLVED, that the American Osteopathic Association, along with other healthcare agencies that provide care for children, advocate that the U.S. Department of Health and Human Services assume responsibility to ensure adequate availability and effective distribution of all recommended childhood vaccines. 2003

IMMUNIZATIONS--INSURANCE COVERAGE FOR

WHEREAS, immunization represents one of the most cost-effective means of disease prevention; and

WHEREAS, lack of insurance coverage for immunization constitutes a significant barrier to protection from vaccine-preventable diseases; and

WHEREAS, many states do not have laws requiring regulated third-party carriers to provide immunization coverage; now, therefore, be it

RESOLVED, that the American Osteopathic Association endorse a requirement for regulated third-party carriers to provide full coverage for all immunizations as recommended by the Centers for Disease Control (CDC). 1996; *revised* 2001

IMMUNIZATION REGISTRIES

WHEREAS, every child needs multiple vaccinations by age five, to be fully immunized; and

WHEREAS, the American Osteopathic Association has policies in support of immunization; and

WHEREAS, lack of accurate immunization records represents a major reason for missed opportunities to vaccinate; and

WHEREAS, immunization registries offer a cost-saving solution that ensures access to accurate immunization records at every visit, enables automated assessment of immunization needs, permits automated generation of reminder/recall messages when children are due or late for immunizations; and

WHEREAS, the National Vaccine Advisory Committee continues to recommend the development of a national network of community and state population-based immunization registries, which are able to share information and maintain privacy and confidentiality; now, therefore, be it

RESOLVED, that the American Osteopathic Association encourages physicians to participate in the development of immunization registries in their communities and to use such registries in their practices. 1999; *revised* 2004

INFANT WALKER (MOBILE)—BAN ON THE MANUFACTURE AND SALE OF

WHEREAS, the use of mobile infant walkers is associated with a considerable risk of injury or death; and

WHEREAS, walkers do not help a child learn to walk; and

WHEREAS, they can delay normal motor and mental development; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the ban on the manufacture and sale of mobile infant walkers. 2003

INFLUENZA VACCINE

WHEREAS, the United States has experienced a shortage of flu vaccine in recent years; and

WHEREAS, few companies are manufacturing flu vaccine; and

WHEREAS, distribution of influenza vaccine is overseen by the Centers for Disease Control and Prevention only during crises; and

WHEREAS, year after year entities, other than physicians, receive vaccine first; and

WHEREAS, physicians with a physician-patient relationship are in the best position to determine the high risk patients who need the influenza vaccine; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) work with federal and state governmental agencies to ensure that high risk patients are provided their influenza vaccinations first, as a public safety measure. 2005

INSURANCE CARRIERS, PATIENT ACCESSIBILITY OF DIAGNOSTIC SERVICES

WHEREAS, many insurance companies and managed care entities have restricted the availability of diagnostic services to "approved providers" only; and

WHEREAS, this can limit the accessibility to diagnostic services by placing obstacles for the patient and additional co-pays; and

WHEREAS, timely diagnostic services data can enhance patient comfort and outcomes; now, therefore, be it

RESOLVED, that the American Osteopathic Association work with the state health insurance regulators and health insurance companies to allow physicians the option of providing diagnostic services at the same reimbursement level that the insurance carrier has contracted with its other approved providers. 2003

INTERNATIONAL OSTEOPATHIC MEDICINE

WHEREAS, the American Osteopathic Association (AOA) has increasing numbers of members active in the international medical community; and

WHEREAS, the osteopathic physician trained and educated in the United States receives the degree doctor of osteopathy (DO), or doctor of osteopathic medicine (DO); and

WHEREAS, osteopathic medicine, as a separate school of healing arts has been articulated and developed in the United States; and

WHEREAS, it is the obligation of the osteopathic profession, its physicians and scientists dedicated to the advancement of medical truths and the improvement of human life, to share fundamental medical knowledge and practice with legitimate and fully trained physicians throughout the world; now, therefore, be it

RESOLVED, that the American Osteopathic Association will:

1. Do all things necessary to ensure the continued advancement of osteopathic medicine in the United States through research, education and health care delivery;
2. Actively offer assistance and guidance, upon request, to nations wishing to provide

for the licensure and practice rights of osteopathic physicians trained in colleges of osteopathic medicine accredited by the AOA;

3. Endorse institutions or programs from other countries, which have been accredited by the AOA and designate themselves on diplomas, or similar documents, as colleges of osteopathy, colleges of osteopathic medicine, or otherwise identify themselves as osteopathic medical institutions;
4. Assist upon request legitimate institutions of other countries in the development of colleges of osteopathic medicine or osteopathic graduate medical education programs when such entities clearly demonstrate the capacity to be accredited by the AOA;
5. Recognize continuing medical education programs in other countries only when such programs are organized for awarding credit to fully trained physicians (DO/MD), and such programs meet the continuing medical education requirements of the AOA;
6. Establish a policy that AOA members may teach osteopathic manipulative treatment to individuals who have, or will have upon graduation, the full, unlimited scope of medical practice to apply said skills.
7. Promote, on request, osteopathic medical education that meets AOA accreditation standards in those institutions outside of the United States that provide for such instruction, and where feasible, actively promote full medical practice rights for graduates of AOA accredited institutions in that country.

1985; *reaffirmed* 1990; *revised* 1996, 2001

INTRACTABLE AND/OR CHRONIC NON-MALIGNANT PAIN

WHEREAS, osteopathic physicians have a duty and a responsibility to treat patients suffering from intractable and/or chronic non-malignant pain; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) supports the enactment of legislation concerning the administration of controlled substances to persons experiencing intractable and/or chronic non-malignant pain substantially conforming to the attached definitions and requirements; and, be it further

RESOLVED, that the American Osteopathic Association advocate and promote to students, residents, fellows and practicing physicians educational resources regarding addictive disorders, diversion awareness and monitoring and appropriate referral resources, as well as the prevention and treatment of pain disorders.

Definitions:

A. Intractable and/or chronic non-malignant pain means a pain state in which the cause of the pain cannot be removed or otherwise definitively treated and which in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending physician and one or more physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain. Chronic non-malignant pain may be associated with a long-term incurable or intractable medical condition or disease.

Requirement:

A. Notwithstanding any other provision of law, a physician may prescribe or administer controlled substances to a person in the course of the physician's treatment of the person for a diagnosed condition causing intractable and/or chronic non-malignant pain. This includes patients with chemical dependency and/or substance abuse history if chronic non-malignant pain exists and controlled substance management is indicated.

physician hypervigilance in screening for drugs of abuse, as well as the presence of the treatment medication in these patients is necessary.

B. No physician shall be subject to disciplinary action (by the state medical board) for appropriately prescribing or administering controlled substances in the course of treatment of a person for intractable pain and/or chronic non-malignant pain.

C. No physician shall be subject to criminal prosecution (by state or federal agencies) for appropriately prescribing or administering medically necessary controlled substances in the course of treatment of a person for intractable pain and/or chronic non-malignant pain.

D. This section shall not authorize a physician to prescribe or administer controlled substances to a person the physician knows to be using drugs or substances for non-therapeutic purposes.

E. This section does not affect the power (of the state medical board) to deny, revoke, or suspend the license of any physician who fails to keep accurate records of purchases and disposal of controlled substances, writes false or fictitious prescriptions for controlled substances, or prescribes, administers, or dispenses in violation of state controlled substances act.

Explanatory Statement: Recent court decisions in multiple states have criminalized civil malpractice litigation. This has resulted in subsequent incarceration and/or other imposed criminal sentencing. Therefore, the previously adopted AOA language supporting appropriate, medically necessary pain management needs to be revisited. Furthermore, the term intractable pain is ambiguous as to the source. A policy on hospice related pain exists and is supportive of palliative care, including opiate and/or controlled substance management for terminally ill patients. This defines intractable pain in the terminally ill, but further clarification is necessary for chronic non-malignant pain. Chronic non-malignant pain might also necessitate opiate and/or controlled substance management for patients when other interventions have been inadequate. Opiate and/or controlled substance management in treating chronic non-malignant pain patients in those with substance abuse disease issues is now supported as a standard of care by the medical literature. Such patients require physician hypervigilance as part of this standard of care. 2005

INVESTMENT TAX

WHEREAS, from time to time, there are proposals to enact a tax on investment income of associations exempt under 501{c}(6) of the IRS code; and

WHEREAS, associations with the 501{c}(6) designation would be subject to such a tax on unrelated business income tax (UBIT) as to dividends, capital gains and/or interest income on reserve and current operation funds; and

WHEREAS, these associations' reserve funds are based on a projected two (2) year operation cost, plus inflation, and for unexpected losses that may occur; and

WHEREAS, dues represent only 33 percent of many associations' total revenue; and

WHEREAS, these associations' boards of trustees are entrusted to seek a reserve in order to help the associations weather bad years; and

WHEREAS, these associations do not, nor do they intend to compete with other entities, for profit or otherwise; and

WHEREAS, these associations provide for the Continuing Medical Education (CME) to the physicians and furthers public education, thereby enhancing the quality care for the population it serves; now, therefore, be it

RESOLVED, that it is the responsibility of all osteopathic associations with 501{c}(6) tax status to urge their state legislators, U.S. senators and congressmen, to defeat any proposed tax on unrelated business income tax (UBIT) as to dividends, capital gains and/or interest income on reserves and current operational funds, under the 501{c}(6) tax status. 1999; *revised 2004*

LATEX ALLERGY

WHEREAS, latex allergy is a documented and well known medical condition; and

WHEREAS, healthcare providers are at a significant risk of developing latex allergy and suffer from its consequences secondary to repeated exposure; and

WHEREAS, given the sometimes urgent and emergent care necessitated by patients without the opportunity on behalf of healthcare providers to procure non-latex products; and

WHEREAS, healthcare workers, as part of their duty, will use latex containing products, regardless of known allergy or product warning; now, therefore, be it

RESOLVED, that the American Osteopathic Association strongly encourages hospitals and other healthcare facilities to provide non-latex alternatives in areas of patient care. 1999; *revised* 2004

LICENSURE OF INTERNS AND RESIDENTS

WHEREAS, it is the responsibility of the individual state medical boards to ensure public health and safety; and

WHEREAS, it is necessary for credentials to be verified to ensure that each physician's education and training meets necessary standards to maintain the public health and safety; and

WHEREAS, certain instances have arisen where physicians in post-graduate training programs have been practicing medicine without the verification of all credentials and/or the verification of satisfactory participation in prior programs; and

WHEREAS, state medical boards have the ability and means to verify the credentialing of physicians in intern and residency programs; and

WHEREAS, licensing of such physicians by state medical boards would further allow for the reporting of any disciplinary action against these physicians; now, therefore, be it

RESOLVED, that the American Osteopathic Association recommends that all state licensing boards implement a mechanism to ensure that osteopathic physicians who are eligible for licensure and are in intern or residency programs within each board's state have satisfied all necessary credentialing requirements for licensure. 1998; *revised* 2003

LONG-TERM CARE

WHEREAS, Americans should be able to prepare appropriately for the provision of long-term care without fear of financial destitution in the final years of their lives, at the expense of their children; and

WHEREAS, the non-institutionalized, and spouses should be entitled to retain income and assets sufficient to live independently and provide for their own healthcare needs at the end of their able-bodied years; now, therefore be it

RESOLVED, that the American Osteopathic Association supports: (1) to the extent possible that Americans should plan to cover long-term care expenses through tax-favored savings and the purchase of private long-term care insurance, (2) through modifications to the Internal Revenue Code, the Congress should encourage employers to offer long-term care insurance to employees, particularly younger individuals who would benefit from lower premiums; and (3) tax-favored savings plans for medical expenses ought to be available for

individuals, including the purchase of long-term care insurance. 1990; *reaffirmed* 1995; *revised* 2000, 2005

MAIL ORDER PHARMACY

WHEREAS, insurers are constantly seeking methods to lower the cost of pharmaceuticals; and

WHEREAS, the use of mail order pharmacy has found favor as a method of reducing health care costs; and

WHEREAS, some mail order pharmacy providers deliver medications directly to the patient's residence; and

WHEREAS, when the prescription is delivered to the patient's residence the prescribing physician does not know if the medication has been delivered or whether it has been subjected to environmental extremes that will adversely affect its potency; and

WHEREAS, in some cases the patient's safety depends on medication being received by the patient with unimpaired efficacy; and

WHEREAS, delayed receipt of these medications may contribute to adverse outcomes; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) opposes pharmaceutical programs that require all medications be delivered to the patient's residence as failing to act in the best interests of the patient; and, be it further

RESOLVED, that maintenance medication prescriptions may be obtainable at a pharmacy at the patient's discretion. 2004

MAMMOGRAPHY—ACCESSIBILITY

WHEREAS, statistics from the Centers for Disease Control and Prevention reveal that a significant number of American women will develop breast cancer; and

WHEREAS, mammograms are an essential element in early detection of breast cancer; and

WHEREAS, many women do not have the financial resources to secure mammograms or understand the necessity of such evaluation; and

WHEREAS, mammography has become one of the most important methods for the early detection of breast cancer; and

WHEREAS, the American Cancer Society as well as other organizations recommend that annual mammography be performed on all women over the age of 40 years; and

WHEREAS, Medicare reimbursement is allowed only for women who qualify; now, therefore be it

RESOLVED, that the American Osteopathic Association urges adoption of measures to improve the access to mammography as indicated. 1992; *revised* 1997, 2002

MANAGED CARE--ALL PRODUCTS CLAUSES

WHEREAS, many managed care organizations (MCOs) require physician participation in every plan, or "product," that the MCO offers; and

WHEREAS, an "all products/all products developed in the future" clause in a physician's managed care contract binds the physician to participation in every plan, product or future products to be developed that the MCO offers; and

WHEREAS, the use of all products/all products developed in the future" clauses significantly reduces the ability of the physician to control the amount of risk he or she assumes in his or her practice by taking away control of the number of plans in which he or she participates; and

WHEREAS, the use of all products/all products developed in the future" clauses increases the ability of a dominant MCO in a particular geographical area to maintain its control of the market, thereby decreasing competition and patient choice; and

WHEREAS, all products/all products developed in the future" clauses can be utilized by a MCO in order to keep poorly-run HMOs or other plans operative, thereby increasing risks to patients; and

WHEREAS, legislation has been and will continue to be introduced at the state level that would prohibit the use of all products/all products developed in the future" clauses; and

WHEREAS, state regulatory agencies have begun and will continue to closely scrutinize the use of all products/all products developed in the future" clauses; now, therefore, be it

RESOLVED, that the American Osteopathic Association and state osteopathic societies oppose the use of all products/all products developed in the future" clauses in physician managed care contracts; and, be it further

RESOLVED, that the AOA actively oppose the use of any other clauses that may limit the ability of the physician to choose the plans in which he or she participates; and, be it further

RESOLVED, that the AOA educate its members on the potential risks of all products/all products developed in the future" clauses and the importance of identifying such clauses in contracts prior to their signing; and, be it further

RESOLVED, that the AOA support both state and federal legislation as well as regulatory agency regulations and rulings to prohibit the use of all products/all products developed in the future" clauses in physician managed care contracts. 2000, *revised* 2005

MANAGED CARE ORGANIZATIONS--OSTEOPATHIC DISCRIMINATION BY

WHEREAS, osteopathic physicians are being discriminated against when attempting to participate in managed care organizations based on their medical training and board certification; and

WHEREAS, established licensed osteopathic physicians who have been in practice for years cannot reasonably be expected to close their practices, return to and complete additional multi-year residency training, obtain specialty board certification and create new medical practices for the sole purpose of participating in managed care organizations; and

WHEREAS, this discrimination will literally force many osteopathic physicians into early retirement or bankruptcy, eroding this nation's foundation of primary care physicians; now, therefore, be it

RESOLVED, that the American Osteopathic Association is opposed to discrimination against osteopathic physicians by managed care organizations; and, be it further

RESOLVED, that federal and state legislation must clearly state that any and all managed care organizations, and insurance companies must accept as sufficient professional credentials all licenses properly granted by state boards of medicine or osteopathic medicine, and all specialty certifications granted by boards approved by the AOA or American Board of Medical Specialists. 1993; *revised* 1998, 2003

MANAGED CARE--PHYSICIAN-PATIENT RELATIONSHIP AND

WHEREAS, some osteopathic physicians may feel pressured by managed care plans to be particularly mindful of financial costs involved in providing patient care; and

WHEREAS, the welfare of patients must be placed first by osteopathic physicians; and

WHEREAS, financial conflicts between patient and a health plan and/or physician must be resolved in the best interest of the patient; now, therefore, be it

RESOLVED, that it be reaffirmed that it is the responsibility of the osteopathic physician to advocate for the rights of his/her patients, regardless of any contractual relationship; and, be it further

RESOLVED, that the osteopathic physician-patient relationship shall not be altered by any system of healthcare practice, including managed care entities, which may place economic considerations above the interest of patients. 1998, *reaffirmed* 2003

MANAGED CARE PLANS--SERVICE, ACCESS AND COSTS IN

WHEREAS, managed care plans have been criticized for creating barriers to convenient, flexible, service-oriented care; and

WHEREAS, current compensation models in managed care provide minimal incentives for individual service excellence; and

WHEREAS, consumers are demanding increasing levels of service, access and choice; and

WHEREAS, providing increasing levels of service and choice represent tangible increased costs to employers and managed care organizations; and

WHEREAS, in the current premium environment, at-risk managed care organizations and delegated medical groups are unable to assume further increases in level of risk; and

WHEREAS, balanced consumer models should combine increasing access and choice with consumer accountability for determining the added value of these attributes; and

WHEREAS, managed care needs to be re-engineered to empower consumers and incentivize individual practitioners to provide high levels of service excellence; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports efforts to combine open access and open formulary models with expanded use of variable co-pays that reflect the full added costs of these programs; and be it further

RESOLVED, that the AOA supports efforts to design benefits that align consumer needs and accountability and individual physician incentives to meet consumer needs. 1999; *revised* 2004

MANAGED CARE REFERRALS

WHEREAS, the current method of referrals for specialty care required by most managed care organizations is both cumbersome and time consuming; and

WHEREAS, this process affects quality care by limiting its access; now, therefore be it

RESOLVED, that the American Osteopathic Association supports and promotes legislation that enables patients access to medical specialist by direct referral from the primary care physicians without precertification by the managed care company. 2001

MANAGED HEALTHCARE SYSTEMS--FREEDOM OF CHOICE

WHEREAS, the majority of osteopathically oriented hospitals are independent and are of less than 250-bed capacity; and

WHEREAS, the majority of osteopathic teaching programs are based in these hospitals; and

WHEREAS, the economic viability and survival of osteopathically-oriented hospitals and training programs is vital to the osteopathic profession; and

WHEREAS, the unique and special features of hospital-based osteopathic healthcare are delivered best in osteopathic hospitals; and

WHEREAS, current economic trends have resulted in the emergence and rapid growth of managed healthcare systems; and

WHEREAS, the selective contracting policies of these systems often discriminate against small, independent hospitals and in particular, against osteopathic hospitals and physicians; and

WHEREAS, these same policies effectively deny patients freedom of choice with regards to osteopathic oriented hospital care; now, therefore, be it

RESOLVED, that the Board of Trustees of the American Osteopathic Association through the Committee on Socioeconomic Affairs assist state osteopathic medical associations in drafting of legislation which provides for freedom of choice of providers; and, be it further

RESOLVED, that the AOA work with managed healthcare entities to: (1) offer high quality healthcare to all patients, which includes osteopathic benefits to all enrollees, and allow osteopathic physicians, if they wish, to be included on the health plans' specialty panels for osteopathic manipulative treatment; (2) permit freedom of choice of hospital and doctors; (3) permit the patient to make economic decisions involving his healthcare; (4) do not exclude certain physicians and hospitals from honest competition for any segment of the marketplace; (5) do not force physicians on a contracting hospital staff to join that hospital's managed care entity and thereby lead to closed hospital staffs; (6) will not exclude DOs on the basis of degree or AOA certification or training; and (7) afford all physicians appropriate hearing and appeal processes. 1988; *revised* 1993, 1994, 1999; 2004 (referred)

MANDATORY ASSIGNMENT

WHEREAS, the existing system permitting physicians to make assignment decisions on a patient-by-patient basis is effective; and

WHEREAS, patients must be provided freedom of choice of physicians; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the right of physicians to accept assignments of payments on a case by case basis. 1988; *revised* 1993; *reaffirmed* 1998, *revised* 2003

MANDATORY PARTICIPATION IN MEDICARE

WHEREAS, some states now require mandatory participation in the Medicare and Medicaid programs as a prerequisite for medical licenses; now, therefore, be it

RESOLVED, that the American Osteopathic Association oppose any legislation that requires mandatory participation of physicians in Medicare or Medicaid programs as a basis for licensure. 1994; *revised* 1996, 2001

MATERNAL AND CHILD HEALTHCARE BLOCK GRANTS

WHEREAS, the American Osteopathic Association is dedicated to improving maternal and child health, and especially infant mortality; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports government expenditures for maternal and child healthcare block grants and the efficient use of resources; and, be it further

RESOLVED, that the AOA supports the maintaining or increasing funding levels for the maternal and child healthcare block grants. 1988; *revised* 1993, 1998, 2003, 2004

MD DEGREE--FALSE QUALIFICATION STANDARDS AND ADVERTISING FOR

WHEREAS, from time to time, inaccurate descriptions are made from various sources regarding the osteopathic medical profession and the Doctor of Osteopathy or Doctor of Osteopathic Medicine degree; and

WHEREAS, false information about the osteopathic profession and its degrees, at times, may be intentionally expressed or disseminated to undermine or demean the profession; now, therefore, be it

RESOLVED, that the American Osteopathic Association will remain vigilant for any false or erroneous information that many undermine the integrity of the profession of osteopathic medicine in the United States; and, be it further

RESOLVED, that the AOA will work with the Federation of State Medical Boards (FSMB) and its constituent boards to inform them of attempts to misrepresent the practice of osteopathic in the United States or to misrepresent the education leading to the degree Doctor of Osteopathy or Doctor of Osteopathic Medicine. 1998, *revised* 2003

MEDICAID, INDEPENDENT PROGRAM OVERSIGHT

WHEREAS, a number of states have imposed formulary restrictions and Prior Authorization programs on their respective Medicaid programs, for a variety of stated reasons including cost effectiveness and efficacy; and

WHEREAS, often these programs are under the oversight of state employees whose objectivity may be overly influenced by state budgets; and

WHEREAS, physician/provider advisory boards to these bureaucratic agencies may have no binding authority; now, therefore, be it

RESOLVED, that the American Osteopathic Association work with Congress to require that state Medicaid programs have an independent Advisory Committee to create and manage any preferred drug list; and, be it further

RESOLVED, that this Advisory Committee should have practicing physician/provider members representing those healthcare professionals with independent practice rights in the state and who shall have the authority to determine the medications that shall comprise a preferred drug list. 2004

MEDICAID PHARMACEUTICAL BENEFITS

WHEREAS, Medicaid was approved by Congress and signed into law in 1965 to provide healthcare to indigent patients; and

WHEREAS, one of the benefits received by Medicaid is prescription drug medications; and

WHEREAS, the federal government may contemplate decentralizing Medicaid funds thereby allowing more discretion in the state's use of these funds; and

WHEREAS, some states artificially restrict the number of pharmaceutical products, limiting the number which can be prescribed and thereby have an adverse effect upon the patient; and

WHEREAS, many patients suffering from chronic illnesses require more than the restricted formulary amount of medications; and

WHEREAS, restricting the physician in treating Medicaid patients in this manner will create a discriminatory healthcare system; and

WHEREAS, quality medical care includes skilled and appropriate diagnosis on the part of the physician teamed with the appropriate protocols for patient wellness which includes medicines, drugs and therapeutics; now, therefore, be it

RESOLVED, that the American Osteopathic Association take appropriate action including but not limited to informing federal and state government agencies of the need to assure that inequities do not exist in the medical treatment of Medicaid patients. 1996; *revised* 2001

MEDICAID PRIOR AUTHORIZATION PROGRAMS—EXPANSION OF

WHEREAS, Medicaid programs throughout the country are expanding their list of prescription drugs that undergo prior authorization, requiring doctors to use generics, or the least expensive brand-name drugs for their Medicaid patients; and

WHEREAS, state Medicaid programs are expecting to achieve savings in the millions of dollars through expanded prior authorization programs; and

WHEREAS, the expansion of prior authorization policy is affecting thousands of Medicaid patients, causing unnecessary side effects, more trips to the pharmacy to pick up medications, emergency room visits, etc; and

WHEREAS, this policy would no doubt inflate the cost of emergency room bills due to changes in medication, as well as increase the administrative costs for doctors, posing unnecessary financial burdens which will undoubtedly lead to healthcare access problems for Medicaid patients; now, therefore, be it

RESOLVED, that the American Osteopathic Association promote and encourage state association/specialty societies to pursue sound policies on the composition of an expanded prior authorization program to ensure quality care of Medicaid patients, as well as the protection of physicians, to include but not be limited to: directing the appropriate state regulatory agency to promulgate rules governing the development, implementation, and administration of the expanded program for prior authorization of prescription drugs in the Medicaid program, and requesting that the regulatory agency hold a public hearing on the draft rules and provide a period for written public comment on the rules; and, be it further

RESOLVED, that in those states where Medicaid prior authorization programs do not exist, the AOA work with the state societies to prevent the implementation of prior authorization programs; and, be it further

RESOLVED, that the AOA promote and encourage state association/specialty societies to work with the regulatory agency to administer the prior authorization program in a way that minimizes the burden on healthcare practitioners and patients in accessing optimal drug therapy. 2001

MEDICAL INSURANCE COVERAGE FOR SURGERY IN CASES OF CHRONIC GINGIVITIS

WHEREAS, many insurance companies will not reimburse for diagnosis involving teeth and gums; and

WHEREAS, there are systematic diseases associated with chronic gingival infection, i.e. bacteremia, cardiac valvular disease, septic arthritis, general debility and aggravation of diabetes mellitus; and

WHEREAS, lack of insurance coverage for diseases of teeth and gums can result in worsening of systematic diseases for patients who cannot afford out of pocket expenditures; now, therefore, be it

RESOLVED, that the American Osteopathic Association support the concept that medical insurance coverage should include medical and surgical treatment of chronic gingivitis for those patients with comorbid conditions. 2001

MEDICAL MALPRACTICE CRISIS

WHEREAS, malpractice insurance is paramount for obtaining and maintaining hospital privileges; and

WHEREAS, malpractice insurance rates are on the rise; and

WHEREAS, malpractice carriers may drop physicians based on claims regardless of fault, settlement, or outcome; and

WHEREAS, malpractice lawsuits are often settled to avoid cost of litigation, knowing a victory could cost more than the settlements; and

WHEREAS, malpractice judgments are often determined by juries who do not understand medicine and medical care; and

WHEREAS, physicians are prematurely retiring due to the expense and frustration caused by malpractice lawsuits or threat of them; and

WHEREAS, the loss of many established physicians has and will affect the short and long term quality of medicine; now, therefore, be it

RESOLVED, that the American Osteopathic Association support appropriate legislation to ban arbitrarily dropping physician's malpractice coverage and allow meaningful appeals processes; and, be it further

RESOLVED, that the AOA petition malpractice carriers to inform insured physicians at least 90 days prior to a potential termination or rate increase. 2001

MEDICAL PROCEDURE PATENTS

WHEREAS, medical procedure patents delay, restrict, and inhibit the free-flow of information and inhibit innovation in medical science; and

WHEREAS, medical procedure patents pose a threat to the availability, quality, and cost of healthcare; and

WHEREAS, physicians have a tradition and ongoing responsibility to advance medical science; and should resist any processes that inhibit the advances of medical science; and

WHEREAS, medical procedure patents will place physicians in jeopardy of litigation, thus discouraging the use of state-of-the-art medical procedures; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports measures that restrict medical procedure patents. 1995; *reaffirmed* 2000, *revised* 2005

MEDICAL RECORDS--POLICY/ GUIDELINES FOR THE MAINTENANCE, RETENTION, AND RELEASE OF

WHEREAS, the American Osteopathic Association should create standards for confidentiality involving patient medical records in the possession of osteopathic physicians; and

WHEREAS, the federal government and most states have enacted statutes that authorize patient access to medical records; and

WHEREAS, these statutes vary; now, therefore, be it

RESOLVED, that osteopathic physicians shall become familiar with the applicable laws, rules, or regulations on retention of records and patient access to medical records in their states; and, be it further

RESOLVED, that the following Policy/ Guidelines for the Maintenance, Retention, and Release of Medical Records be approved as amended:

POLICY/GUIDELINES FOR THE MAINTENANCE, RETENTION, AND RELEASE OF MEDICAL RECORDS

A. ***Release of Records****:* The record is a confidential document involving the osteopathic physician-patient relationship and shall not be communicated to any other person or entity without the patient's prior written consent, unless required by law. Notes made in treating a patient are primarily for the osteopathic physician's own use and constitute his or her personal property. Under The Health Insurance Portability and Accountability Act of 1996 (HIPAA), patients have the right to request access to review and copy certain information in their medical records. In addition, HIPAA provides patients with the right to request an amendment to health information in their medical records. HIPAA also provides patients with the right to request an "accounting of disclosures" of their protected health information. Upon written request of the patient, an osteopathic physician shall provide a copy of, or a summary of, the record to the patient or to another physician, an attorney, or other person or entity authorized by the patient as provided by law. Medical information shall not be withheld because of an unpaid bill for medical services.

B. ***Records Upon Retirement or Departure from a Group:*** A patient's records may be necessary to the patient in the future not only for medical care but also for employment, insurance, litigation, or other reasons. When an osteopathic physician retires or dies, patients shall be timely notified and urged to find a new physician and shall be informed that, upon authorization, records will be sent to the new physician. Records which may be of value to a patient and which are not forwarded to a new physician shall be retained consistent with the privacy requirements under federal and/or state laws and regulations, either by the treating osteopathic physician, or such other person lawfully permitted to act as a custodian of the records. The patients of an osteopathic physician who leaves a group practice must be notified that the osteopathic physician is leaving the group. It is unethical to withhold the address of the departing osteopathic physician if requested by the patient or his or her authorized designee. If the responsibility for notifying patients falls to the departing osteopathic physician rather than to the group, the group shall not interfere with the discharge of these duties by withholding patient lists or other necessary information.

C. *Sale of medical practice*: In the event that an estate of, or the practice of an osteopathic physician's medical practice is to be sold, the assets of such practice or estate, both hard and liquid, should be transferred in a mutually agreeable manner consistent between seller and buyer. If medical records of the estate or of the practicing physician are included in such sale they should be transferred between seller and buyer in accordance with state and federal guidelines to remain compliant with the confidentiality rules and regulations which govern the security of such records, allowing the buyer to have the opportunity to continue caring for those patients.

> *All active patients should be notified that the osteopathic physician (or the estate) is transferring the practice to another physician who will retain custody of their records and that at their written request, within a reasonable time as specified in the notice, the records or copies will be sent to any other physician of their choice. Rather than destroy the records of a deceased osteopathic physician, it is better that they be transferred to a practicing physician who will retain them consistent with privacy requirements under federal and/or state laws and regulations and subject to requests from patients that they be sent to another physician. A reasonable charge may be assessed for the cost of*

duplicating records. Any sale of a medical practice should conform to IRS and federal guidelines.

D. ***Retention of Records****:* Osteopathic physicians have an obligation to retain patient records. The following guidelines are offered to assist osteopathic physicians in meeting their ethical and legal obligations:

(1) Medical considerations are the principal basis for deciding how long to retain medical records. For example, operative notes and chemotherapy records should always be part of the patient's chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether an osteopathic physician would want the information if he or she were seeing the patient for the first time.

(2) If a particular record no longer needs to be kept for medical reasons, the osteopathic physician should check state laws to see if there is a requirement that records be kept for a minimum length of time. Most states will not have such a provision. If they do, it will be part of the statutory code or state licensing board.

(3) In all cases, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice claims. The statute of limitations may be three or more years, depending on the state law. State medical associations and insurance carriers are the best resources for this information. If a patient is a minor, the statute of limitations for medical malpractice claims may not begin to run until the patient reaches the age of majority.

(4) Whatever the statute of limitations, an osteopathic physician should measure time from the last personal professional contact with the patient.

(5) The records of any patient covered by Medicare or Medicaid must be kept in accordance with the respective regulations.

(6) In order to preserve confidentiality when discarding old records, all documents should be destroyed. Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity. 1998; *revised* 2003

MEDICAL ERRORS--REDUCING AND IMPROVING PATIENT HEALTH

WHEREAS, the 2001 report of the Institute of Medicine (IOM) has resulted in numerous state initiatives and proposed federal and state legislation; and

WHEREAS, the IOM report calls for immediate action to improve care over the next decade and offers a comprehensive strategy to do so; and

WHEREAS, the IOM report also calls on the U.S. Department of Health and Human Services (HHS) to monitor and track quality improvements in six key areas: safety, effectiveness, responsiveness to patients, timeliness, efficiency, and equity; and

WHEREAS, the American Osteopathic Association has issued a position paper stating that “it generally supports the IOM’s recommendations to bolster nationwide efforts to improve patient care” , and

WHEREAS, the AOA should support expanded activities to identify and address system failures that lead to medical errors; now, therefore, be it

RESOLVED, that the American Osteopathic Association adopt the following guiding principles to assist state associations and specialty organizations in the formulation of local state policy for reporting adverse events:

*Reporting systems must be non-punitive.

*Focus must be on identifying opportunities for improvement and preventing and correcting systems failures—not on individual or organizational fault.
*Reporting systems must have the capability to comprehensively analyze, aggregate and distribute useful information for improvement and prevention to providers.
*Confidentiality protections for patients, healthcare professionals, and healthcare organizations and protection of information from discovery are essential.
*Reporting systems should facilitate the sharing of patient safety information among other healthcare organizations.
*Systems must not duplicate or be in conflict with other required reporting to minimize administrative burdens on providers. A state-level system must have the ability to form collaborative relationships with any potential federally mandated reporting requirements.
*Must be premised on a clear definition of reasonable reporting requirements, based on due process.
*Pilot project should be instituted to review the components and utility of the collected data. 2001

MEDICARE

WHEREAS, the American Osteopathic Association continues to endorse Medicare as a necessary mechanism for assuring access to quality healthcare for older Americans; and

WHEREAS, Medicare has not completely fulfilled its promise to those covered to make all necessary services available, in that many Medicare beneficiaries have unreasonably been denied needed services solely to effect program cost containment; now, therefore, be it

RESOLVED, that the American Osteopathic Association declares its continued support of the Medicare program, the continued availability of quality medical care at a reasonable cost and comprehensive Medicare reform to ensure that Medicare beneficiaries receive necessary services. 1966; *reaffirmed* 1978; *revised* 1983, 1988, 1993, 1998, 2003

MEDICARE AND MEDICAID ABUSE

WHEREAS, the American Osteopathic Association recognizes that there has been abuse of the Medicare and Medicaid programs by some providers as well as recipients; and

WHEREAS, such practices are harmful to patient welfare and adversely affect the total cost of the federal programs; and

WHEREAS, the AOA is dedicated to fostering the delivery of quality healthcare and the observance of the highest moral, ethical, and practice standards by its members; and

WHEREAS, the AOA's obligation to promote the public health includes the obligation to use all of its resources to assist all appropriate governmental efforts to abolish any fraud and abuse by providers as well as recipients; now, therefore, be it

RESOLVED, that the American Osteopathic Association continues to pledge its full cooperation and support of all reasonable and appropriate efforts by the federal government and the states to stop all fraud and abuse of Medicare and Medicaid. 1977; *revised and reaffirmed* 1982; *revised* 1987; *reaffirmed* 1992, 1997, 2002

MEDICARE COVERAGE FOR DIABETES & LIPID SCREENING—LACK OF

WHEREAS, diabetes and lipid disorders can lead to serious medical complications before symptoms arise; and

WHEREAS, Medicare will not reimburse for screening lab tests for these diseases; and

WHEREAS, it is not only quality patient care, but also saves tax dollars by preventing expensive treatment of these complications; now, therefore, be it

RESOLVED, that the American Osteopathic Association support dialogue with the Centers for Medicare and Medicaid Services (CMS) and Congress to encourage Medicare to reimburse the fee of screening tests for diabetes and dyslipidemia. 2001

MEDICARE AND MEDICAID--ETHICAL PHYSICIAN ARRANGEMENTS

WHEREAS, fraud and abuse of the Medicare and Medicaid programs are harmful to patients, physicians and federal taxpayers; and

WHEREAS, the American Osteopathic Association is committed to the highest standards of ethics in the delivery of healthcare; and

WHEREAS, the AOA has long supported efforts to stop fraud and abuse of the Medicare and Medicaid programs; and

WHEREAS, the Inspector General of the U.S. Department of Health and Human Services (HHS) has issued safe harbor regulations outlining the acceptable legal and ethical arrangements under Medicare and Medicaid law; now, therefore, be it

RESOLVED, that the American Osteopathic Association inform its members regarding the safe harbor rules as put forward by the HHS Inspector General. 1992; *revised* 1997; *reaffirmed* 2002

MEDICARE CLAIMS CODING – CMS COMMUNICATIONS WITH PHYSICIANS

WHEREAS, Medicare is continually issuing updated coding regulations that physicians and their staffs must use in order to obtain payment and to meet standards designed to curb program fraud and abuse; and

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) has now twice published "essential coding information, the documentation guidelines for single and multi-system comprehensive evaluation and management services and the Correct Coding Initiative which sets Medicare standards for the bundling of services" without funding the distribution of that information to physicians; and

WHEREAS, communicating with physicians enhances the efficiency of the Medicare program by reducing the number of claims that have to be reprocessed because of errors or that have to be returned to physicians as unprocessable; and

WHEREAS, failure to provide physicians with necessary coding and billing information hampers the government's efforts to detect fraudulent and abusive practices by increasing the number of inadvertent coding and billing errors; now, therefore, be it

RESOLVED, that the American Osteopathic Association leadership meet with Centers for Medicare and Medicaid Services officials to request that CMS require its fiscal intermediaries to provide thorough, current, written information on the preparation and coding of Medicare claims to all physicians prior to the implementation of any new policies or programs. 1999

MEDICARE/MEDICAID--DISPROPORTIONATE FUNDING AND REIMBURSEMENT OF PEDIATRIC ADOLESCENT CARE

WHEREAS, osteopathic medical care for the physical, emotional and spiritual well-being of children and adolescents is a high priority concern of the American Osteopathic Association; and

WHEREAS, it is critical that the osteopathic medical community communicate this positive support and message to the youth of America; and

WHEREAS, needy and underserved children are located in or near urban areas and rural/remote areas; and

WHEREAS, Medicare/Medicaid reform will most likely call for a reduction in the Disproportionate Share Hospital funding through new mechanisms for entitlement programs; and

WHEREAS, this reduction in funding will most likely cause a relative deprivation of funding to children's hospitals and pediatric departments in community hospitals; now, therefore, be it

RESOLVED, that the American Osteopathic Association adopt and support policy that children's hospitals and pediatric services at community hospitals be exempted from any reduction in Disproportionate Share Hospitals reimbursement from Medicare/Medicaid; and, be it further

RESOLVED, that AOA work with the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS) to address this issue prior to final rule making by CMS, HHS and individual states. 1997, revised 2002

MEDICARE—EQUITABLE REIMBURSEMENT

WHEREAS, all Medicare beneficiaries have paid into the Medicare system; and

WHEREAS, the present Medicare reimbursement system has resulted in some providers no longer serving Medicare patients; and

WHEREAS, the present Medicare reimbursement system has resulted in uneven access to benefits in the Medicare Choice program; now, therefore, be it

RESOLVED, that the American Osteopathic Association requests the President of the United States and Congress to take immediate action to revise the current Medicare reimbursement system to ensure fair and equitable access to health care for all Medicare beneficiaries. 2003

MEDICARE FEE SCHEDULE—CONVERSION FACTOR FOR

WHEREAS, dramatic reduction in Medicare reimbursement as a result of lowering their conversion factor threatens seniors' access to quality physician services; and

WHEREAS, the sustainable growth rate (SGR) should be replaced with a new factor that more fully accounts for changes in the costs of providing physicians' services; and

WHEREAS, the SGR exacerbates Medicare's problem of paying different amounts for the same service depending on the geographic location where the service is provided; now, therefore, be it

RESOLVED, that the American Osteopathic Association will continue to support federal legislation that replaces the sustainable growth rate (SGR) system with an annual update based on reliable factors influencing the unit costs of efficiently providing physician services. 2002

MEDICARE FEE SCHEDULE--COMPETITIVE BIDDING (AUCTIONS)

WHEREAS, on January 30, 1997, the Centers for Medicare and Medicaid Services (CMS) announced the creation of the Medicare Managed Care Competitive Pricing Demonstration pilot project for the implementation of competitive bidding (auctions) amongst insurance carriers as the means for establishing future Medicare reimbursement fee schedules; and

WHEREAS, the utilization of competitive bidding as the method for establishing future Medicare payment rates will result in the decreased rendition and delivery of quality medical services to Medicare beneficiaries; now, therefore, be it

RESOLVED, that the American Osteopathic Association is opposed to the utilization of competitive bidding as the method for establishing future Medicare reimbursement fee schedules, and, be it further

RESOLVED, that the AOA support federal legislation that opposes the use of competitive bidding as the method for establishing future Medicare payment rates. 1997; revised 2002

MEDICARE INTERMEDIARY DENIAL LETTERS

WHEREAS, the doctor-patient relationship is built on mutual respect and trust; and

WHEREAS, Medicare intermediary denial letters (issued to patients) often pit the patient against the physician and seriously damage the doctor-patient relationship; now, therefore, be it

RESOLVED, that the American Osteopathic Association calls upon the Centers For Medicare And Medicaid Services (CMS) to involve osteopathic physicians in the development of screening parameters including osteopathic structural diagnoses and manipulative treatments. 1990; *revised* 1995, 2000, 2005

MEDICARE LAW AND RULES

WHEREAS, access to quality medical care is vital to the citizens of the United States of America; and

WHEREAS, one of the fastest rising costs of medical care is in administration; and

WHEREAS, one of the reasons for the increase in administrative costs is bureaucratic processes which require more information and lead to cumbersome rules; and

WHEREAS, when citizens become eligible for Medicare coverage, their freedom of choice of care is restricted and the complexity of receiving such care is increased; now, therefore, be it

RESOLVED, that Medicare regulations that restrict a patient's freedom, as well as assess punitive damages to physicians, be challenged; and, be it further

RESOLVED, that administrative burdens placed on both the patient and physician be reduced. 1995; *revised* 2000, 2005

MEDICARE'S LIMITING CHARGE/RBRVS SYSTEM

WHEREAS, osteopathic physicians are united in opposing legislation or policies which are designed to divide physicians into two opposing groups under Medicare (participating and non-participating physicians); and

WHEREAS, all physicians are entitled to equal treatment under the law; and

WHEREAS, the limiting charge equals 115 percent of the non-participant fee schedule amount; now, therefore, be it

RESOLVED, that the American Osteopathic Association opposes Medicare's limiting charge ceiling. 1989; *revised* 1993, 1998, 2003

MEDICARE—PAYMENT FOR X-RAY INTERPRETATION BY

WHEREAS, the Centers for Medicare and Medicaid Services, (CMS) is contemplating rules that would limit payment for x-ray interpretation to physicians in certain specialties; and

WHEREAS, physicians in many different specialties are qualified and routinely perform and interpret diagnostic x-ray studies; and

WHEREAS, in rural and other areas of the country radiologists are not readily available to interpret x-rays; and

WHEREAS, if implemented by CMS, these rules would have a detrimental effect on the timeliness and availability of diagnostic x-ray services potentially delaying diagnosis and treatment of the patient; and

WHEREAS, the American Osteopathic Association, (AOA) recognizes that although some physicians become residency trained in radiology giving them special expertise in interpreting x-ray studies; physicians trained in many other specialties receive x-ray interpretation training; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the policy that physicians of many different specialties possess the training and knowledge to appropriately interpret x-rays and this knowledge is not limited to any particular physician specialty; and, be it further

RESOLVED, that the AOA will communicate this policy to the Centers for Medicare and Medicaid Services, (CMS) through the AOA Washington office. 2005

MEDICARE—PHYSICIAN PAYMENT

WHEREAS, the American Osteopathic Association (AOA) represents osteopathic physicians in the United States; and

WHEREAS, physicians face significant reductions in Medicare payments in 2004 and beyond; and

WHEREAS, the use of the Sustainable Growth Rate (SGR) formula in physician reimbursement is poor policy and threatens patient access to physician services; and

WHEREAS, physicians are the only providers in the Medicare program subject to the volatile SGR system; and

WHEREAS, the current formula penalizes physicians for volume increases that they cannot control and that the government actively promotes through new coverage decisions, quality improvement activities and other initiatives that are not reflected in the update formula; now, therefore, be it

RESOLVED, that the American Osteopathic Association:

1. Supports the replacement of the current SGR payment formula with a less volatile formula similar to the approach used for other providers, and
2. Supports legislative and regulatory action that prevents future payment reductions and establishes reimbursement formulas that adequately compensate osteopathic physicians for their services. 2003

MEDICARE PREVENTIVE MEDICAL SCREENING

WHEREAS, the Medicare program does not cover sufficient routine preventive medical services in the form of screening exams; and

WHEREAS, this preventative care allows for early detection of diseases and ultimately saves lives and decreases medical costs; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports coverage of Medicare recipients for routine preventive medical services.

1995; *reaffirmed* 2000, *revised* 2005

MEDICARE PHYSICIAN REIMBURSEMENT FOR OSTEOPATHIC MANIPULATIVE TREATMENT

WHEREAS, in certain carrier regions Medicare physician reimbursement policy evaluates osteopathic manipulative treatment as an integral component of an office visit and provides reimbursement only for the office visit; and

WHEREAS, any other medical specialty in most instances where manipulation is indicated would refer the patient to a practitioner skilled in manipulative treatment, thus incurring additional charges to Medicare; and

WHEREAS, such Medicare regulations are both inequitable to the osteopathic physician providing manipulative treatment and not in conformance with stated Medicare objectives to provide medical care at responsible costs; now, therefore, be it

RESOLVED, that the American Osteopathic Association, advocate for nationwide consistency in Medicare physicians reimbursement policy, as it relates to OMT and E&M service, leading to reimbursement for osteopathic manipulative treatment as a separately identifiable procedure from the office visit in all carrier regions. 1991; *revised* 1996, 2001

MEDICARE POLICIES

WHEREAS, the U.S. House of Representatives and Senate have introduced legislation to decrease unnecessary paperwork and add safeguards to assure fairness to physicians; and

WHEREAS, the Center for Medicare and Medicaid Services (CMS) is working with physician groups to decrease physician concerns and compliance issues with the Medicare program; and

WHEREAS, CMS has committed to reducing unnecessary rules and regulations which physicians are expected to adhere to; and

WHEREAS, the policies and procedures of Medicare carriers continue to complicate the physician's ability to care for patients; and

WHEREAS, the policies and procedures vary from carrier to carrier; and

WHEREAS, those policies can make it difficult for Medicare patients in one state to have the care provided in another state; and

WHEREAS, uniform policies and procedures for all carriers would ensure Medicare patients receive consistent care; and

WHEREAS, one set of policies and procedures would give the CMS more control over utilization and cost of the Medicare program; and

WHEREAS, a set of uniform policies and procedures by carriers would allow CMS to be more consistent in their goals and objectives; now, therefore, be it

RESOLVED, that the American Osteopathic Association encourages the establishment of policies and procedures by the Center for Medicare and Medicaid Services (CMS) for carriers, physicians and other providers; and, be it further

RESOLVED, that the AOA initiate steps to encourage the CMS to move toward one set of policies and procedures for all Medicare patients and the physicians providing medical care. 2002

MEDICARE PRESCRIPTION DRUG COVERAGE

WHEREAS, the Medicare Modernization Act was approved by Congress and signed into law in 2003 to provide Medicare prescription drug coverage; and

WHEREAS, not all "covered drugs" will be covered by the prescription drug plans (PDP) or Medicare Advantage Plans (MA-PD) and each plan may develop a formulary and/or tiered formulary; and

WHEREAS, according to the U.S. Department of Health and Human Services, the elderly are at increased risk of complications from the effects of therapeutic agents; and

WHEREAS, these risks may be increased by the change(s) in patients' medications by the restricted formulary; and

WHEREAS, restricting the physician in treating Medicare patients in this manner will create unnecessary patient complications and place undue stress upon the healthcare system; and

WHEREAS, the American Osteopathic Association works with osteopathic physicians, the U.S. Congress, the U.S. Department of Health and Human Services and other interested parties to assure that the elderly are provided with the highest quality of care; now, therefore, be it

RESOLVED, that the American Osteopathic Association seek opportunities to work in collaboration with other professional organizations possessing clinical expertise in geriatrics and long-term care medicine to develop and or refine guidelines that ensure the highest quality of care for these patients through the judicious use of formularies. 2005

MEDICARE PRESCRIPTION DRUGS

WHEREAS, all Medicare beneficiaries have paid into the Medicare system at an equal rate; and

WHEREAS, the present Medicare reimbursement system has resulted in some providers no longer serving Medicare patients; and

WHEREAS, the present Medicare reimbursement system has resulted in uneven access to benefits in the Medicare Choice program; and

WHEREAS, the present Medicare reimbursement system does not pay for most prescription drugs; now, therefore, be it

RESOLVED, that the American Osteopathic Association requests the U.S. Congress and the administration to take immediate action to revise the current Medicare benefits to ensure fair and equitable access to healthcare that includes equitable prescription drug benefits for all Medicare beneficiaries. 2004

MEDICARE RECOVERY AUDIT CONTRACTORS

WHEREAS, the American Osteopathic Association, (AOA) supports the proper coding and payment of claims; and

WHEREAS, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) required the Centers for Medicare and Medicaid Services, (CMS) to carry out a demonstration project using Medicare Recovery Audit Contractors, (MRAC); and

WHEREAS, the purpose of this demonstration project is to retrospectively review payment of claims for accuracy; and

WHEREAS, the MRAC is required to review claims for both underpayment and overpayment; and

WHEREAS, CMS has based payment to the MRAC only on the value of overpaid claims found; and

WHEREAS, this creates a clear incentive for the MRAC to find overpaid claims and ignore underpaid claims; now, therefore, be it

RESOLVED, that the American Osteopathic Association communicate to Centers for Medicare and Medicaid Services (CMS) its concern about the Medicare Recovery Audit Contractors (MRAC) payment methodology. 2005

MEDICARE REIMBURSEMENT FAIRNESS

WHEREAS, Medicare is a national entitlement program for all eligible Americans regardless of where they reside; and

WHEREAS, Medicare taxes are uniform nationwide; and

WHEREAS, the current reimbursement rates for Medicare risk contracts are based on the historical fee-for-service fees and rewards inefficient systems with the higher reimbursement rates at the expense of more efficient systems; and

WHEREAS, this method of determining rates results in taxpayers in regions with historically more efficient healthcare utilization, effectively subsidizing reimbursement in those regions with less efficient healthcare utilization; and

WHEREAS, Medicare beneficiaries in regions reimbursed at lower rates may receive substantially fewer benefits (e.g., prescription coverage, vision, etc.) than do beneficiaries in other regions; and

WHEREAS, the physicians and hospitals serving Medicare beneficiaries in regions reimbursed at lower rates have fewer dollars to invest in new services and programs for the elderly; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the concept of equitable Medicare funding and benefits for all Medicare beneficiaries; and, be it further

RESOLVED, that the AOA make every effort to convince the Centers for Medicare and Medicaid Services (CMS) to make more equitable payment for Medicare services provided under Medicare risk contracts. 1997; *revised* 2002

MEDICARE SKILLED NURSING ADMITTING REQUIREMENTS

WHEREAS, patient screening is required prior to nursing home admission prohibiting admissions that would occur directly from the patient's home environment without interruption or undue hospitalization; and

WHEREAS, this policy of a three-day hospital admission prior to transfer to a skilled nursing facility admission would no doubt increase the cost of medical care in most, if not all, cases and poses unnecessary financial burden to the Medicare system; and

WHEREAS, Medicare Health Maintenance Organizations currently do not require a three-day stay

for discharge to a skilled nursing facility (SNF); now, therefore, be it

RESOLVED, that the American Osteopathic Association encourage Congress to eliminate the three-day hospital admission requirement for Medicare coverage for skilled nursing admissions nationwide. 1997; *revised* 2002

MEDICARE USER FEES

WHEREAS, recent proposals my administrations of both political parties have included Medicare user fees; and

WHEREAS, the proposals are not user fees but a significant new tax entirely at odds with congressional leaders' goal of reducing or holding the line on taxes; and

WHEREAS, physicians are now asked to pay for the privilege of dealing with Medicare's extensive paperwork and low payments, further increasing the burden; and

WHEREAS, these proposals create an unfair financial onus on medical group practices; now, therefore, be it

RESOLVED, that the American Osteopathic Association opposes any legislation that would establish Medicare user fees. 1998, *revised* 2003

MEDICATION FOR INDIGENT PATIENTS

WHEREAS, the high cost of prescription drugs poses an economic burden upon indigent patients; and

WHEREAS, a win-win solution for indigent patients with chronic diseases, who require daily maintenance medication, and the pharmaceutical industry is possible; and

WHEREAS, at least 30 days prior to the expiration date on the medication to treat chronic diseases, the pharmaceutical industry could ship them to volunteer distribution centers where they would be processed and provided to indigent patients on the basis of financial need; and

WHEREAS, the pharmaceutical industry should receive a form of indemnification protection, from the federal government for this specific activity, in return for their donation of these medications to indigent patients; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the U.S. Congress' approval for a form of indemnification protection for those pharmaceutical companies that donate near-expired maintenance medication to volunteer distribution centers for distribution to indigent patients on the basis of financial need. 2001

MEDICATIONS—PRIOR AUTHORIZATION FOR

WHEREAS, the process for prior authorizations for medications required by many managed care organizations causes unnecessary delays in the proper treatment of patients; and

WHEREAS, this delay may have a detrimental effect on the healthcare of our patients; now, therefore, be it

RESOLVED, that the American Osteopathic Association evaluate and recommend alternatives to prior authorizations for medications; and, be it further

RESOLVED, that the American Osteopathic Association promote legislation that supports these alternatives. 2001

MILITARY MEDICAL READINESS

WHEREAS, the osteopathic profession is in support of maintaining medical readiness in the United States; and

WHEREAS, this support is clearly evidenced by the many osteopathic physicians who have been, and are, committed to careers in the military; and

WHEREAS, the United States Department of Defense is seeking to improve military medical readiness in a number of ways; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports efforts by the Department of Defense which encourage the voluntary participation of osteopathic physicians in the military and improves the military medical readiness of America. 1987; *revised* 1992; *reaffirmed* 1997. 2002

MINORITY HEALTH AND GRADUATE MEDICAL EDUCATION

WHEREAS, the American Osteopathic Association recognizes a disparity between the level of access to healthcare between minority and non-minority populations; and

WHEREAS, although heart disease is recognized as the number one cause of death in the U.S. for all races, it disproportionately affects (i.e., on the average of 50 percent higher cause of deaths per 100,000 resident population for minority populations than for non-minority populations): Black men and women; Hispanic men; and Native American men (yet such groups receive less medical treatment than non-minority groups); and

WHEREAS, certain preventable diseases are more prevalent in minority populations than in non-minority populations, such as: cerebrovascular diseases; chronic liver disease/cirrhosis; HIV; and diabetes mellitus (i.e., black women have a 900 percent higher HIV cause of death rate per 100,000 resident population than white women); and

WHEREAS, the AOA recognizes an under representation of U.S. citizen minorities in osteopathic and allopathic medical schools; and

WHEREAS, minority populations in the U.S. collectively make up over 20 percent of the U.S. population, and only 18 percent of osteopathic and 30 percent of allopathic medical school enrolled students are comprised of such population groups; and

WHEREAS, furthermore, broken down by race, (Breakdown is by race, percentage of national population, and enrollment percentage at osteopathic (O) and allopathic (A) medical schools respectively: Black-12.1-3.3 (0)-7.4(A); Hispanic-9.0-3.7 (O)-6.0(A); Asian-2.8-10.3 (O)-16.1(A); and Native American-0.8-0.7 (O)-0.5(A) there is an even greater disproportionate under representation ratio between each respective minority group's total population and its respective percentage of the U.S. population on the whole in relation to racial group representation at osteopathic and allopathic medical schools; and

WHEREAS, 52 percent of patients seen in the practices of African Americans are black, while only 9 percent of the patients are black in non-African American practices; and

WHEREAS, among Latino physicians, 54 percent of patients in their practices are Latino, but only 20 percent of patients are Latino in non-Latino practices; and

WHEREAS, communities with high populations of African Americans and Latinos are four times as likely as other areas to suffer from physician shortages; and,

WHEREAS, regardless of race, economic standing is a powerful indicator of access to healthcare as illustrated by the fact that in 1994 only 25 percent of those with cumulative family income below $14,000 annually had health insurance, while 78 percent of families with incomes between $25,000 and $35,000 had health insurance; and 93 percent of families with incomes above $55,000 per year had health insurance; and

WHEREAS, these economic indicators for the same year indicate that while 74 percent of the White population had private health insurance, only 52 percent of the African American population and 49 percent of the Hispanic population also had private healthcare coverage; and

WHEREAS, at the same time 17 percent of Whites, 26 percent of Blacks and 33 percent of Latinos were not insured, and nearly four times more African Americans and more than twice as many Hispanics than Whites received their healthcare through Medicaid; now, therefore, be it

RESOLVED, that the American Osteopathic Association will encourage the development of internal programs to address: the disproportionate incidence of heart diseases and certain preventable diseases in minority populations and lack of proper medical treatment of such diseases for such groups; the pervasive lack of adequate healthcare in minority communities; and the under representation of minority populations in osteopathic and allopathic medical schools; and, be it further

RESOLVED, that the AOA will work towards the elimination of such disparities within its colleges of osteopathic medicine and encourage federal/state governments, academia and the healthcare industry to develop programs to eliminate the aforementioned medical and academic disparities between minority and non-minority groups in the U.S. 1996; 2001

MULTIPLE PRESCRIPTION PROGRAMS

WHEREAS, the abuse and misuse of legitimate prescription drugs is an ongoing concern which demands continual attention by state and federal governments, the profession and private industry; and

WHEREAS, several states have adopted mandatory use of multiple (usually triplicate) prescription forms for the dispensing of certain drugs scheduled under federal and state controlled substance acts; and

WHEREAS, such programs impose duplicate and potentially expensive regulations on already highly regulated drugs; now, therefore, be it

RESOLVED, that the American Osteopathic Association oppose any mandatory multiple prescription program; and, be it further

RESOLVED, that the AOA support more effective cost-efficient approaches for dealing with prescription drug abuse; and, be it further

RESOLVED, that the AOA continue to cooperate with the pharmaceutical industry, law enforcement and government agencies to stop prescription drug abuse as a threat to the health and well-being of the American public. 1989; *revised* 1994; *reaffirmed* 1999, 2004

NATIONAL CLINICAL TRIALS REGISTRY

WHEREAS, multiple entities are performing research on medications and patient care and it is difficult to access this information; and

WHEREAS, many of the results are not available for public review; and

WHEREAS, evidence-based medicine is an important result of published research; and

WHEREAS, many of the research studies have faults including, but not limited to, entities such as small number of patients, not double-blinded, not significant time for evaluation, unexpected high mortality and morbidity; and sponsors may try to conceal this information; and

WHEREAS, available review of all completed and published medical research would allow appropriate evaluation of all results by all interested parties; and

WHEREAS, formation of a National Clinical Trials Registry that is easily accessible via electronic database would improve medical therapy and patient care; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports establishment of a National Clinical Trials Registry of all evidence-based medical research, and that it be funded by research sponsors. 2005

NATIONAL PRACTITIONER DATA BANK

WHEREAS, the AOA is on record as opposing the establishment of a National Practitioner Data Bank; and

WHEREAS, the original fears of the House of Delegates appear to be substantiated by new provisions implemented by Congress, requiring inclusion of adverse actions; and

WHEREAS, a complaint does not necessarily indicate fault, error, or malpractice; and

WHEREAS, trivial complaints resulting in negative findings, and encoded as a permanent record against the physician will impugn the reputation of the physician; and

WHEREAS, a National Practitioner Data Bank has been established and the amount and type of data collected have gone beyond the scope of significant professional matters, and the distribution of this information is widespread; and

WHEREAS, neither a time limit for retention of data, nor any limit for reporting actions has been indicated; now, therefore, be it

RESOLVED, that the American Osteopathic Association reaffirm its opposition to the existence of a National Practitioner Data Bank; and, be it further

RESOLVED, that since such a data bank does exist that the AOA Council on Federal Health Programs employ its resources to persuade the National Practitioner Data Bank to 1) limit required reports to significant findings relative to professional matters, 2) establish a maximum time limit of five (5) years for retention of data, 3) record as an action only a settlement that exceeds $50,000, 4) eliminate inclusion of interns and residents who perform their services properly under the supervision of an attending physician; and, be it further

RESOLVED, that the AOA urge the United States Congress to amend the National Practitioner Data Bank law to mandate that all federal confidentiality protections accorded to the bank supersede state discovery or open-record laws. 1991; *revised* 1993, 1998, 2003

NATIONAL PRACTITIONER DATA BANK--MEMBERSHIP ACTION

WHEREAS, in 1991 the American Osteopathic Association went on record as opposing the establishment of a National Practitioner Data Bank; and

WHERESAS, such a data bank does now exist; and

WHEREAS, a professional society of physicians which engages in professional review activity through a formal peer review process for the purpose of furthering quality healthcare is required to report adverse membership actions to the National Practitioner Data Bank; and

WHEREAS, the Committee on Ethics and the Committee on Membership of the AOA engage in such review and make recommendations regarding membership actions to the AOA Board of Trustees; now, therefore, be it

RESOLVED, that adverse membership actions which do not involve professional competence or conduct such as nonpayment of dues, CME deficiencies and other association matters shall not be reported to the National Practitioner Data Bank; and, be it further

RESOLVED, that final actions of expulsion of members from the American Osteopathic Association shall, when all appeal mechanisms have been exhausted by the osteopathic physicians, be reported to the National Practitioner Data Bank. 1999; *reaffirmed* 2004

NEWBORN AND INFANT HEARING SCREENS

WHEREAS, hearing loss continues to be a common birth defect in America; and

WHEREAS, legislation was enacted to provide funds for state grants to develop infant hearing screening and intervention programs; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports adequate funding for universal hearing screening and intervention for newborns and infants. 1995; *revised* 2000, 2005

NEW BORN HIV TESTING

WHEREAS, it is estimated that more than 40,000 persons in the United States contract HIV infection each year; and

WHEREAS, the number of women testing positive for HIV has been increasing; and

WHEREAS, perinatal transmission from mother to child accounts for 91% of all cases of pediatric AIDS in United States; and

WHEREAS, a national standard of care for routine universal prenatal HIV testing with right of refusal has been established, but up to 25 percent of pregnant women do not undergo prenatal HIV testing; and

WHEREAS, children continue to be born with HIV infection in United States each year; and

WHEREAS, a recent medical study (NEJM;1998;339:1409) demonstrated that 25 – 40% of newborn HIV infections can be prevented if antiretroviral therapy is given only to the newborn within the first 24 – 48 hours of life; now, therefore, be it

RESOLVED, that the American Osteopathic Association adopt a policy recommending universal HIV testing immediately with expeditious reporting of results of all newborns whose mothers' HIV status is unknown and where clinically indicated. 2003

NON-PHYSICIAN CLINICIANS

WHEREAS, non-physician clinicians can be categorized into one of the three following groups: midlevel medical professionals who are meant to work under the supervision of or in collaboration with physicians, non-physician independent traditional professionals who practice independently within specialty areas, and alternative medicine providers who follow and independently practice alternative therapies; and

WHEREAS, non-physician clinicians are gaining increased licensure and practice privileges in areas that were once only held by physicians including, but not limited to, prescribing drugs and medical or surgical treatments, practicing autonomously, performing surgery, and being reimbursed by all types of third-party payors; and

WHEREAS, non-physician clinicians are gaining even more expansive privileges than they already possess; and

WHEREAS, patient safety is the foremost concern when addressing issues of expanding scopes of practice for any healthcare profession; and

WHEREAS, patient safety and state laws mandate that physicians meet a minimum threshold of education, post-graduate training, examination, and regulation for an unlimited license to practice medicine; and

WHEREAS, many of these non-physician clinician professions are undertaking tasks that overlap with physician practice without being required to meet the equivalent threshold of education, post-graduate training, examination, and regulation established for physicians by state licensing boards; now, therefore, be it

RESOLVED, that the American Osteopathic Association adopt the attached policy paper as its position on non-physician clinicians including appropriate onsite supervision. 2000, *revised 2005*

Policy Statement
NON-PHYSICIAN CLINICIANS
(July 2005)

The American Osteopathic Association recognizes nurse practitioners, physician assistants, certified nurse midwives, certified registered nurse anesthetists, chiropractors, naturopaths, acupuncturists, homeopaths, optometrists, podiatrists, psychologists, pharmacists, physical therapists, occupational therapists and numerous other non-physician clinicians have unique and valid roles in providing healthcare. In recent years, the growth of these non-physician clinicians has been significant. This growth is due in part to public demand, an expanded healthcare market, changes in state laws regarding these professions, and an increase in the number of non-physician clinicians being trained.

As non-physician clinicians seek new roles in the delivery of healthcare, the AOA feels it is important to look at the growth of healthcare professions in a historical context. The practice of medicine or "healing" expanded in the 18th and early 19th centuries into many different areas, to a point where there were almost two dozen competing medical systems in use in the 1840s. As allopathic medicine grew in popularity, validity**,** strength, and number, it slowly became the prevailing medical practice in the United States. Licensure laws in the 1890s began to set standards into place for medical practice, providing patients with protection from those who offered less-than-adequate care. In 1910 Abraham Flexner, a medical education reformer, wrote *Medical Education in the United States and Canada*, a study which exposed the inadequacies of a large number of medical schools in the U.S. The report stimulated the closing of a large number of medical schools, both osteopathic and allopathic schools.

Those schools and professions wishing to remain viable had to be able to establish and implement standards to ensure extensive education, training, examination, and licensure for the level of care being provided. Through time, only osteopathic and allopathic medicines' curricula, training, examinations and licensure have been established as the two models for the unlimited practice of medicine.

Throughout medicine's history, the osteopathic profession and the AOA have worked tirelessly to ensure the medical care being provided to patients is safe, effective, and of the highest quality. To facilitate this need and its responsibility as a profession, the AOA has historically instituted the highest standards across its medical landscape. For example, in 1902, the AOA first adopted standards for the approval of osteopathic colleges and began conducting on-site evaluations in 1903. In 1936, the AOA held its first inspection and approval of osteopathic hospitals for the training of interns. In 1952 and continuing through today, the AOA has been recognized as the accrediting body for osteopathic education by the U.S. Office of Education, Department of Health, Education and Welfare. In 1967, the AOA was recognized by the National Commission on Accrediting as the accrediting agency for colleges of osteopathic medicine, which continues under its successor, the Council for Higher Education Accreditation (CHEA). Maintaining this recognition requires that osteopathic criteria and standards are continually being reviewed and updated to meet strict guidelines.

The osteopathic profession, through the AOA, has repeatedly shown its standards for education, training, and examination to be appropriate for the unlimited practice of medicine. State medical boards have reinforced this finding by recognizing osteopathic education, post-graduate training, examination, and – in those states with such a requirement– board certification for licensure of the unlimited practice of medicine.

Today, non-physician clinicians are seeking expanded scopes of practice and other increased rights – into areas traditionally reserved for physicians. Many non-physician clinicians have succeeded in attaining new rights in a number of these areas. Specifically, non-physician clinicians have succeeded in increasing their autonomy, scopes of practice, prescriptive rights, and direct reimbursement from third party payors. However, there are disturbing inconsistencies in the manner in which these rights have been expanded.

Patient Care and Safety

The practice of medicine and the quality of medical care are the responsibility of properly licensed physicians. As the DO/MD medical model has proven its ability to provide professionals with complete medical education and training, their leadership in such an approach is logical and most appropriate. Further, the states' medical boards confirm the appropriateness of the medical model by utilizing it for medical licensure requirements.

Non-physicians are currently seeking roles that increasingly overlap with the activities of a physician. Too often at the state level, expanded rights of non-physician clinicians become "turf battles" with other professions – including physicians – where political maneuvering and other personal biases lead to decisions on non-physician clinician practice rights that directly affect patients' lives. Such a formula for making these decisions is not based on empirical evidence proving patient safety, but rather the professional aspirations of non-physician clinicians and their ability to persuade state and federal legislatures and regulatory authorities. Public policy dictates patient safety and proper patient care should be foremost in mind when the issues encompassing expanded practice rights for non-physician clinicians – autonomy, scopes of practice, prescriptive rights, liability and reimbursement, among others – are addressed.

In the healthcare marketplace, a physician's board certification may be considered one of the highest standards an individual physician can achieve in a particular specialty or subspecialty. Today, many hospitals and managed care organizations are requiring board certification for employment of physicians. In addition, state medical boards are likewise beginning to look at increasing the number of postgraduate training years required for physician licensure. While these higher standards are being placed on physicians, the same scrutiny is not faced by non-physician clinicians, in spite of the fact that at the same time they are asking for and receiving increased scopes of practice.

However, many non-physician clinician professions themselves are beginning to recognize the need for proper instruction and training levels in the education of their professionals. For example, many of these professions are moving towards master's level requirements for accreditation purposes, and some are requiring continuing education for licensure purposes. As professions seek expanded roles in the delivery of healthcare, these professions' educational

curricula, training, examination, and licensure should likewise expand to match the level of care they wish to provide patients within the "team" framework.

The AOA supports the "team" approach to medical care, with the physician as the leader of that team. The AOA further supports the position that patients should be made clearly aware at all times whether they are being treated by a non-physician clinician or a physician. The AOA recognizes the growth of non-physician clinicians and supports their rights to practice within the scope of the relevant state statutes. However, it is the AOA's position that new roles for non-physician clinicians may be granted after appropriate processes and programs are established in all of the following four areas: education, training, examination, and regulation. It is further the AOA's stance that non-physician clinicians may be allowed to expand their rights only after it is proven they have the ability to provide healthcare within these new roles safely and effectively.

Independent Practice

Certain non-physician clinician professional groups, including some groups who traditionally have worked under the supervision of physicians, such as nurses, are currently seeking roles in the delivery of healthcare without any physician involvement. These individuals and groups seek to completely separate their role from that of a physician, with little to no supervision, referral, collaboration or contact whatsoever. Many of these roles sought increasingly overlap with the traditional activity of physicians. This lack of physician involvement, again, does not appropriately attend to patient safety or proper patient care.

As patient safety and proper patient care must be the foremost concern of any healthcare professional, all non-physician clinicians should recognize and refer those patient cases that require knowledge beyond their training. Just as a family practice physician will refer a patient to a specialist when his or her illness or injury is beyond the physician's scope of expertise, so too must any non-physician clinician call upon a physician when a patient's condition warrants such action. To ignore the physician's role as the leader of the "team" approach in the delivery of healthcare is to compromise the patient's safety.

As the physician is the leader of the "team" approach to medical care, the roles for all members of the team need to be clearly defined and understood, through established protocols or written agreements. The AOA feels non-physician clinician professions that have traditionally been under the supervision of physicians must retain physician involvement in patient care. Those non-physician clinician professions that have traditionally remained independent of physicians must involve physicians in patient care when warranted. All non-physician clinicians must refer a patient to a physician when the patient's condition is beyond the non-physician clinician's scope of expertise.

Liability

Patient safety mandates that those physicians who act as supervisors must exercise due care within this "team" approach to healthcare delivery. It is crucial to understand the delegation of duties by a physician to a non-physician

clinician does not equate with the delegation of liability. Physicians, as leaders of the "team," should be held liable for the acts of those they supervise or work in collaboration with, if they fail to provide adequate and reasonable supervision.

Conversely, in the "team" model to healthcare, holding a supervising physician liable does not exonerate the non-physician clinician from liability. Non-physician clinicians are accountable for the adverse treatment decisions they make. In legal terms, both the non-physician clinician (for the adverse medical treatment) and the physician (for failure to provide adequate supervision) would be named defendants to a malpractice suit. Because these non-physician clinicians can not shield themselves from liability, those working under the supervision of or in collaboration with physicians should obtain their own individual malpractice insurance.

The AOA endorses the view that physician liability for non-physician clinician actions should be reflective of the quality of supervision being provided and should not exonerate the non-physician clinician from liability.

For those non-physician clinicians who desire to practice autonomously without any form of physician supervision or collaboration, there should be a corresponding exclusive, personal liability. This is because the physician would no longer operate in a supervisory capacity and therefore should not be held accountable for the acts of the independent provider. Liability for treatment decisions should be placed on the individual or institution responsible for providing the treatment, and not default onto the physician.

It is the AOA's position that non-physician clinicians acting autonomously of physicians should be held to the equivalent degree of liability as that of a physician. Within this independent practice framework, the AOA further believes that non-physician clinicians should be required to obtain malpractice insurance in those states that currently require physicians to possess malpractice insurance.

Educational Standards

As the osteopathic profession has continually proven its ability to meet and exceed standards necessary for the unlimited practice of medicine, non-physician clinician professions should also meet educational, training, examination, and regulation standards for the roles they seek. Current standards may not exist and may need to be formulated.

Non-physician clinician professional standards should be implemented, reviewed, and validated for the roles they currently fill as well as for the roles being sought. Once education, training, examination, and regulation are all proven effective, either through documented studies or other empirical means, expanded roles may be granted within the "team" framework.

The review and validation of non-physician clinician standards may need to come from an objective, independent body. Possible sources of this review may be the U.S. Department of Education, an accrediting agency that it recognizes, or CHEA. Alternatively, a national advisory board on health profession issues could be utilized, as is suggested in the Pew Commission

Taskforce on Health Care Workforce Regulation's 1998 report, *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation*. The taskforce recommends the creation of a national advisory body to study existing scopes of practice, competency requirements, and other professional matters for all health professions and establish clear guidelines in each of these areas. However, this board would strictly serve an advisory function and its guidelines would not be binding. That is, the individual state licensing boards would still possess the exclusive authority to license and discipline its medical personnel. The individual states could choose to incorporate the guidelines into state law, but this decision would be within the sole discretion of the states.

The AOA holds the position that education, training, examination and regulation must all be documented and reflective of the expanded scopes of practice being sought by non-physician clinicians. The AOA recognizes there may be a need for an objective, independent body to review and validate non-physician clinician standards.

Conclusion

As DOs/MDs have proven and continue to prove the efficacy of their education, training, examinations, and regulation for the unlimited practice of medicine, it is the AOA's firm conviction that only holders of DO and MD degrees be licensed for medicine's unlimited practice. The AOA feels the education, training, examination and regulation necessary and proven effective for the unlimited practice of medicine validate the physician's role the leader of the "team" approach for the delivery of medical care. As non-physician clinicians seek wider roles, standards of education, training, examination, and regulation must all be adopted to protect the patient and ensure that proper patient care is being given. The AOA recognizes these standards may need to come from an objective, independent organization. Liability considerations for non-physician clinicians should appropriately be shared between those parties making treatment decisions, and those non-physician clinicians who act autonomously of physicians should be held completely liable for the outcomes of those decisions. Further, it is the AOA's position that roles within the "team" framework must be clearly defined, through established protocols and signed agreements, so physician involvement in patient care is sought when a patient's case dictates. Only proper attention to each of these considerations will ensure that the care being provided by non-physician clinicians is safe, effective, and of the highest quality.

OBESITY—HEALTH PLANS SHOULD REVIEW BENEFITS FOR TREATMENT OF

WHEREAS, obesity is increasing at alarming rates in the US, with more than 25% of adult Americans now considered obese; and

WHEREAS, in some population sub-groups, the percentage of individuals with a Body Mass Index (BMI) greater than 40 exceeds 10%; and

WHEREAS, along with this increase in the prevalence of obesity has come a rise in the incidence and occurrence of obesity-related co-morbid conditions, such as type 2 diabetes and cardiovascular disease; and

WHEREAS, numerous studies have shown that obesity treatments using nutritional counseling, behavioral therapy to improve diet and physical activity levels can lead to weight losses; now, therefore, be it

RESOLVED, that all health plans be requested to include nutritional counseling and physical conditioning as a benefit for members of all ages for the prevention and treatment of obesity. 2003

OBESITY IN CHILDREN

WHEREAS, the number of obese children and adolescents in the United States has risen over the past four decades; and

WHEREAS, obesity related health problems are a major medical cost in the United States and add to premature morbidity and mortality; and

WHEREAS, according to *Healthy People 2010*, efforts to maintain a healthy weight should start early in childhood and continue throughout adulthood before obesity is established; and

WHEREAS, *Healthy People 2010* seeks to reduce the proportion of children and adolescents who are overweight or obese; now, therefore, be it

RESOLVED that the American Osteopathic Association (AOA) support programs which advocate physical fitness and good nutrition for children and families. 2001

OBESITY, TREATMENT OF

WHEREAS, the unrelenting increase in the prevalence of obesity in the United States is a major risk factor for several chronic diseases, including hypertension, dyslipidemia, diabetes, cardiovascular disease, sleep apnea, osteoporosis and some cancers; and

WHEREAS, recent studies demonstrate that dietary modification and enhanced physical activity may delay or prevent the transition from impaired glucose tolerance to type 2 diabetes mellitus and provide relevant treatment paradigms for patients with the metabolic syndrome; and

WHEREAS, education and training will be critical to ensure that physicians have the knowledge and skills necessary to properly treat patients with obesity; and

WHEREAS, The Pharmacy Benefit Management Institute reports that drugs used to treat obesity have been excluded as a reimbursed benefit by more than 80% of employer sponsored insurance plans, according to a sample of 375 companies representing almost 12 million beneficiaries; and

WHEREAS, legislation to require health insurance coverage for weight loss programs is under consideration in many states including – Georgia, Hawaii, Maryland, Montana and Virginia; and

WHEREAS, lack of reimbursement for weight management, physical activity, dietary counseling, and pharmaceutical agents for intervention constitutes a major barrier for access to treatment; and

WHEREAS, the high prevalence and epidemic trend of this medical condition has serious implications for United States health care costs; now, therefore, be it

RESOLVED, that the American Osteopathic Association recognize obesity as a disease, and that obesity treatment and prevention requires a chronic care model, by encouraging research at AOA medical schools; and, be it further

RESOLVED, that the American osteopathic Association endorse continued curriculum enhancement for osteopathic students, interns, and residents to receive specific training in obesity

education and approve continuing medical education for physicians with established practices; and, be it further

RESOLVED, that that the American Osteopathic Association support efforts to close the gap between current and desirable practice patterns, by soliciting grants to collect and study the extent to which obesity treatment and prevention services are covered by third party insurers and advocate for adequate coverage for obesity treatment and prevention; and, be it further

RESOLVED, that the American Osteopathic Association develop comprehensive efforts, commensurate with available funding, to disseminate knowledge to the treating community, media, legislature and employer groups directed at controlling the obesity epidemic by improving treatment access and encouraging physical activity in the United States. 2002

OCCUPATIONAL SAFETY AND HEALTH ACT (OSHA) STANDARDS

WHEREAS, the Occupational Safety and Health Act (OSHA) standards as they now stand are felt to be an excessive burden on practicing physicians; now, therefore, be it

RESOLVED, that the American Osteopathic Association requests the U.S. Department of Labor reconsider its penalty structure and conduct a cost benefit analysis of how OSHA standards affect the escalating cost of healthcare. 1991; *revised* 1996, 2001

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) REGULATIONS

WHEREAS, OSHA through its general-duty clause, which obligates all employers to provide work places that are free from recognized hazards causing or likely to cause death or serious physical harm to employees, has assessed fines against physicians and healthcare providers; now, therefore, be it

RESOLVED, that the American Osteopathic Association urge that the Occupational Safety and Health Administration (OSHA) emphasize education and training to create a safe work place rather than assessing punitive fines. 1992; *revised* 1997, 2002

OFFICE BASED SURGERY

RESOLVED, that the attached Policy Statement on Office-Based Surgery be approved:

OFFICE-BASED SURGERY

Background

A number of surgical procedures that were once only performed in hospitals or ambulatory surgery facilities can now be performed in a physician's office. It is estimated that within five years at least 10 million surgical procedures will be performed in doctors' offices each year. The AOA recognizes that a majority of these procedures are performed in a safe and effective manner; however, the complexity of the services and procedures being performed in physician offices is increasing at unprecedented levels. This increase is due in part to advances in technology, ease in scheduling, patient comfort, and cost. Some argue that technology, modern anesthesia agents, and laparoscopic techniques make many in-office surgical procedures possible. In addition, many argue that office-based surgery is easier to schedule and more comfortable for patients than surgery performed in a hospital. Perhaps most significant, however, is the reported cost savings for office-based surgery compared to surgery performed in a hospital. One study reported that the

cost of an inguinal hernia repair done in an office setting was $895 compared to $2,237 for the same procedure in the hospital. Unfortunately cost may be the main driving force behind the increase in office-based surgical procedures due to the fact that many procedures performed in an office setting are elective and, therefore, paid directly by the patient.

These advantages, however, may be outweighed by the potential harm to patients precipitated by the lack of regulations of office-based surgery. Unlike hospitals and licensed ambulatory surgical centers, office-based surgery facilities are, for the most part, not regulated by federal, state or local laws. Currently, only five states have regulations or laws governing surgery performed in an office setting. Without adequate regulations, office-based surgery may be conducted in offices with limited or outdated equipment, inadequately trained personnel, little or no established patient safety standards, and no accreditation requirements.

This lack of oversight can result in fatal consequences for patients, as is evident by a number of stories documenting tragic outcomes following office-based surgery. For example, a 28 year old woman died after undergoing breast augmentation surgery. During the surgery, the woman developed malignant hyperthermia and appropriate emergency medications such as Dantrolene were not available in the office setting. By the time she was transferred to an emergency room her temperature was 107 degrees. Similarly, a 50 year old man in Florida suffered respiratory arrest and subsequently died while undergoing facial cosmetic surgery in his physician's office. The patient's cause of death was reported as hypoxic brain damage.

While there are a number of stories reported by the media of tragic outcomes following office-based surgery, the actual number of morbidity and mortality following office-based surgery is hard to determine because reporting adverse events is not mandatory in every state. A number of reports that have been published documented unsettling results. For example, in a survey of 1,200 plastic surgeons, 95 deaths were reported in nearly 500,000 liposuction procedures. Since 1986, at least 41 deaths and over 1,200 injuries have occurred during cosmetic surgery in Florida. Closed malpractice claims in Florida have also identified 830 deaths and approximately 4,000 injuries associated with office-based medical care occurring between 1990 and 1999. Finally, since Florida's Board of Medicine imposed mandatory reporting requirements on physicians performing office-based surgery, 20 adverse incidents and five deaths were reported in a five month period.

Without proper attention to patient care, the rapid growth of office-based surgery is likely to be accompanied by increased reports of adverse events similar to those described above. Office-based surgery, however, can be a safe and viable option for many patients and many types of surgery. The AOA believes that the key is ensuring that basic principles of patient safety are not lost in technological advancements and that surgery performed in an office setting is as safe for patients as surgery performed in hospitals and ambulatory care centers. It is simply not logical to perform surgery with anesthesia in a physician's office without having the same resources that would be present for the same procedures in a hospital or ambulatory surgery facility. Unfortunately, this is the current state of surgery in many physicians' offices.

Need for Office-Based Surgery Rule Development

The states have taken various approaches to the issue of office-based surgery regulation. The North Carolina Medical Board surveyed a subset of their licensees on this issue. Licensees who renewed their licenses online were required to complete a questionnaire

dealing with office-based surgery. In essence, licensees were asked their opinions on the necessity of formal rules governing surgery performed in physicians' offices. Based in part on these survey results, the Board determined that formal rules were not appropriate for their state. Instead, the Board adopted guidelines for office-based surgery.

The AOA supports state licensing boards in surveying their licensees or researching the issue of office-based surgery regulation to determine if office-based surgery rule development is necessary.

Classification of Office-Based Surgery

Office-based surgical procedures are usually classified based on the level of anesthesia used. Typically the procedures are classified into three groups: Level 1, 2, and 3 or Class A, B, and C. While not uniform, these classifications are often referred to by state medical boards and state legislators, therefore, understanding the different levels is an important basis for a discussion of office-based surgery. First, Level 1 surgical procedures are minor procedures performed under topical, local, or infiltration block anesthesia without preoperative sedation. Second, Level 2 surgical procedures are minor or major procedures performed in conjunction with oral, parenteral or intravenous sedation or under analgesic or dissociative drugs. Finally, Level 3 surgical procedures utilize general anesthesia or major conduction block anesthesia and require the support of bodily functions.

The AOA believes that Level 1 and Level 2 procedures are acceptable to be performed in an office-based setting. However, Level 3 procedures should only be performed in an office setting that has been accredited by an accreditation organization such as the AOA, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), or the Accreditation Association for Ambulatory Health Care (AAAHC).

Physicians and Staff in the Office-Based Surgical Facility

One of the reasons for the large number of adverse consequences associated with office-based surgery is the fact that many individuals, both physicians and non-physicians, performing office-based surgery lack the expertise to perform the surgery and administer the anesthesia in the first place. For example, in 1997, non-plastic surgeons performed 50% of the 250,000 liposuction procedures. These individuals included dermatologists, primary care physicians, emergency physicians, and in some cases unlicensed individuals representing themselves as licensed physicians. In addition, two Florida ophthalmologists and one anesthesiologist have placed advertisements for breast augmentation surgery. Several dentists have also been identified as performing hair transplants and liposuction procedures. While no single medical discipline has a monopoly on proper qualifications for performing office-based surgery, such incidents may spur state licensing boards to consider instituting licensure by specialty or board certification as opposed to an unlimited scope of practice.

The background and training of the staff present during an office-based surgical procedure is crucial. The physician or health care provider doing the operation must be qualified to perform that specific procedure, the anesthesia must be administered and monitored properly, and the patient must receive appropriate care especially in case of an emergency.

It is the AOA's position that surgery performed in a physician's office must be done by a physician or health care provider qualified by education and training to perform that specific procedure. In addition, only health care providers who have completed the appropriate education and training, examination, and certification and are regulated by a state agency to administer anesthesia may administer anesthesia in an office-based surgical facility. The AOA further believes that the physician administering the anesthesia or supervising the administration of the anesthesia must be physically present in the office-based surgical facility during the surgery and immediately available until the patient has been discharged from anesthesia care. In case of an emergency, personnel with training in advanced resuscitative techniques should be immediately available until all patients are discharged.

Equipment Required

Equipment used in office-based surgery must be kept in excellent working condition and replaced as necessary. However, concerns have been raised regarding such equipment. A 1999 report by the New York State Senate Committee on Investigations, Taxation, and Government Operations showed that outdated anesthesia equipment that would not pass inspection in a hospital was being used in physicians' offices.

The type of monitoring equipment required in office-based settings depends on the type of anesthesia used and individual patient needs. However, every facility must have emergency supplies immediately available, including emergency drugs and equipment appropriate for cardiopulmonary resuscitation. This includes a defibrillator, difficult airway equipment, and drugs and equipment necessary for the treatment of malignant hyperthermia.

It is the AOA's position that office-based surgical facilities must have the appropriate medications, equipment, and monitors necessary to perform the surgery and administer the anesthesia in a safe manner. The equipment and monitors must be maintained, tested, and inspected according to the manufacturer's specifications.

Transfer Agreement

Recent events in Florida and elsewhere have shown that emergencies occasionally arise during surgery which require patients to receive a level of care higher than that available in the office-based setting. Provisions must be in place to provide this care in a more comprehensively outfitted and staffed facility should it be needed.

The AOA feels that physicians and health care providers who perform surgery in an office setting must have a written protocol in place for transfer to an accredited hospital within proximity to the office when extended or emergency services are needed to protect the health or well-being of the patients.

Adverse Incident Reporting

Adverse events that may occur in office-based surgical facilities include patient deaths, cardiorespiratory events, anaphylaxis or adverse drug reactions, infections, and bleeding episodes. Reporting of adverse incidents to an appropriate state entity is an important patient safety measure.

The AOA supports reporting of adverse incidents related to surgical procedures performed in an office setting to a state entity, as required and appropriate, provided that these disclosures will be considered confidential and protected from discovery or disclosure.

Regulation of Office-Based Surgery

Unlike hospitals and ambulatory surgery centers, office-based surgical facilities currently have little or no oversight by federal, state, or local laws. Even basic safety precautions pertaining to emergencies, fire, drugs, staff, training, and unanticipated patient transfers that are taken for granted in hospitals and ambulatory surgery centers may not exist in office surgery facilities. This lack of oversight thwarts common sense. Since states and state licensing boards have a constitutional obligation to protect the public's health, they need to regulate office-based surgery facilities to ensure that patients undergoing surgery in these facilities receive the same standard of care as patients undergoing surgery in ambulatory surgery centers or hospitals.

The AOA supports the position that state medical licensing boards are the appropriate entity to create and implement regulations regarding office-based surgery.

Conclusion

The number and complexity of surgeries performed in office-based settings is likely to grow dramatically in the next few years. While a majority of these procedures can be performed in a safe and effective manner, the AOA firmly believes that steps must be taken to ensure that office-based surgery is as safe for patients as hospital- or ambulatory care center-based surgery. The AOA feels that, while Level 1 and Level 2 procedures are acceptable to be performed in the office, Level 3 procedures should only be performed in offices accredited by an appropriate accrediting body. The physician or health care provider performing surgery in an office environment must be qualified to do the specific procedure he/she is performing. Only health care providers with an appropriate educational and training background and who are regulated by a state agency should administer anesthesia. It is also the AOA's position that appropriate physician oversight of anesthesia must be ensured. In case of emergency, personnel with training in advanced resuscitative techniques should be available and a transfer protocol should be in place. The AOA also strongly believes that office-based surgical facilities must use safe and appropriate equipment, monitors, and medications to perform surgery and administer anesthesia. Further, the AOA supports reporting of adverse incidents related to surgical procedures performed in an office setting to a state entity, as required and appropriate, provided that these disclosures will be considered confidential and protected from discovery or disclosure. Finally, it is the AOA's position that state medical licensing boards are the appropriate governing bodies to create and implement office-based surgery regulations. Properly addressing each of these areas will help to ensure that surgery performed in physicians' offices is safe and effective for patients. 2002

OMT OF THE CERVICAL SPINE

RESOLVED, that the Council on Scientific Affairs, in the hopes of advancing the science of osteopathic medicine call upon the House of Delegates to adopt the attached position paper.

Explanatory Statement: These recommendations are provided for osteopathic educators and physicians making decisions regarding the instruction of cervical spinal manipulation and the care of patients. As such, they cannot substitute for the individual judgment

brought to each clinical situation by a patient's physician. Like all reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the understanding that continued research is needed.

AMERICAN OSTEOPATHIC ASSOCIATION
OSTEOPATHIC MANIPULATIVE TREATMENT
OF THE CERVICAL SPINE

Background and Statement of Issue

There has recently been an increasing concern about the safety of cervical spine manipulation. Specifically, this concern has centered on devastating negative outcomes such as stroke. This paper will present the evidence behind the benefit of cervical spine manipulation, explore the potential harm and make a recommendation about its use.

Benefit

Spinal manipulation has been reviewed in meta-analysis published as early as 1992, showing a clear benefit for low back pain. There is less available information in the literature about manipulation in regards to neck pain and headache, but the evidence does show benefit. There have been at least 12 randomized controlled trials of manipulative treatment of neck pain.

Some of the benefits shown include relief of acute neck pain, reduction in neck pain as measured by validated instruments in sub-acute and chronic neck pain compared with muscle relaxants or usual medical care. There is also short-term relief from tension-type headaches. Manipulation relieves cervicogenic headache and is comparable to commonly used first line prophylactic prescription medications for tension-type headache and migraine. Meta-analysis of 5 randomized controlled trials showed that there was a statistically significant reduction in neck pain using a visual analogue scale.

Harm

Since 1925, there have been approximately 275 cases of adverse events reported with cervical spine manipulation. It has been suggested by some that there is an under-reporting of adverse events. A conservative estimate of the number of cervical spine manipulations per year is approximately 33 million and may be as high as 193 million in the US and Canada. The estimated risk of adverse outcome following cervical spine manipulation ranges from 1 in 400,000 to 1 in 3.85 million manipulations. The estimated risk of major impairment following cervical spine manipulation is 6.39 per 10 million manipulations.

Most of the reported cases of adverse outcome have involved “Thrust” or “High Velocity/Low Amplitude” types of manipulative treatment. Many of the reported cases do not distinguish the type of manipulative treatment provided. However, the risk of a vertebrobasilar accident (VBA) occurring spontaneously, is nearly twice the risk of a VBA resulting from cervical spine manipulation.[7] This includes cases of ischemic stroke and vertebral artery dissection.

A concern has been raised by a recent report that VBA following cervical spine manipulation is unpredictable. This report is biased because all of the cases were involved in litigation.
The nature of litigation can lead to inaccurate reporting by patient or provider. However, it did conclude that VBA following cervical spine manipulation is “idiosyncratic and rare”. Further review of this data showed that 25% of the cases presented with sudden onset of new and unusual headache and neck pain often associated with other neurologic symptoms that may have represented a dissection in progress.

In direct contrast to this concern of unpredictability, another recent report states that cervical spine manipulation may worsen preexisting cervical disc herniation or even cause cervical disc herniation. This report describes complications such as radiculopathy, myelopathy, and vertebral artery compression by a lateral cervical disc herniation. The authors concluded that the incidence of these types of complications could be lessened by rigorous adherence to published exclusion criteria for cervical spine manipulation. The current literature does not clearly distinguish the type of provider (i.e. M.D., D.O., D.C. or P.T.) or manipulative treatment (manipulation vs. mobilization) provided in cases associated with VBA. This information may help to understand the mechanism of injury leading to VBA, as there are differences in education and practice among the various professions that utilize this type of treatment.

Comparison of Alternative Treatments

NSAIDs are the most commonly prescribed medications for neck pain. Approximately 13 million Americans use NSAIDs regularly.[32] 81% of GI bleeds related to NSAID use occur without prior symptoms.[32] Research in the United Kingdom has shown NSAIDs will cause 12,000 emergency admissions and 2,500 deaths per year due to GI tract complications.[i] The annual cost of GI tract complications in the US is estimated at $3.9 billion, with up to 103,000 hospitalizations and at least 16,500 deaths per year. This makes GI toxicity from NSAIDs the 15th most common cause of death in the United States.

Epidural steroid injection is a popular treatment for neck pain. Common risks include subdural injection, intrathecal injection and intravascular injection. Subdural injection occurs in ~ 1% of procedures. Intrathecal injection occurs in ~ 0.6-10.9% of procedures. Intravascular injection is the most significant risk and occurs in ~ 2% of procedures and ~ 8% of procedures in pregnant patients. Cervical epidural abscess is rare, but has been reported in the literature.

Provocative Tests

Provocative tests such as the DeKline test have been studied in animals and humans. This test and others like it were found to be unreliable for demonstrating reproducibility of ischemia or risk of injuring the vertebral artery.

Risk factors

VBA accounts for 1.3 in 1000 cases of stroke, making this a rare event. Approximately 5% of patients with VBA die as a result, while 75% have a good functional recovery. The most common risk factors for VBA are migraine, hypertension, oral contraceptive use and smoking. Elevated homocysteine levels, which have been implicated in cardiovascular disease, may be a risk factor for VBA.

A study done in 1999 reviewing 367 cases of VBA reported from 1966-1993 showed 115 cases related to cervical spine manipulation**;** 167 were spontaneous, 58 from trivial trauma and 37 from major trauma.

Complications from cervical spine manipulation most often occur in patients who have had prior manipulation uneventfully and without obvious risk factors for VBA. "Most vertebrobasilar artery dissections occur in the absence of cervical manipulation, either spontaneously or after trivial trauma or common daily movements of the neck, such as backing out of the driveway, painting the ceiling, playing tennis, sneezing, or engaging in yoga exercises." In some cases manipulation may not be the primary insult causing the dissection, but an aggravating factor or coincidental event.

It has been proposed that thrust techniques that use a combination of hyperextension, rotation and traction of the upper cervical spine will place the patient at greatest risk of injuring the vertebral artery. In a retrospective review of 64 medical legal cases, information on the type of manipulation was available in 39 (61%) of the cases. 51% involved rotation, with the remaining 49% representing

a variety of positions including lateral flexion, traction and isolated cases of non-force or neutral position thrusts. Only 15% reported any form of extension.

Conclusion

Osteopathic manipulative treatment of the cervical spine, including but not limited to High Velocity/Low Amplitude treatment, is effective for neck pain and is safe, especially in comparison to other common treatments. Because of the very small risk of adverse outcomes, trainees should be provided with sufficient information so they are advised of the potential risks. There is a need for research to distinguish the risk of VBA associated with manipulation done by provider type and to determine the nature of the relationship between different types of manipulative treatment and VBA.

Therefore, it is the position of the American Osteopathic Association that all modalities of osteopathic manipulative treatment of the cervical spine, including High Velocity/Low Amplitude, should continue to be taught at all levels of education, and that osteopathic physicians should continue to offer this form of treatment to their patients. 2004

ONLINE MEDICINE

AOA POLICY STATEMENT
ONLINE MEDICINE

The identification and treatment of medical problems is no longer restricted to the doctor's office. The development of websites that allow consumers to receive medical information over the Internet is growing rapidly. Over 100 million Americans have utilized the Internet to answer medical questions; this information has had a profound effect on how patients view their health.[30] There are a number of methods by which doctors are reaching their patients through this technology. Some doctors have utilized e-mail as a way to conduct online consultation; others are opting for medical software that is designed to help patients identify symptoms and narrow down diagnoses. However, each method poses its own difficulties for patients and doctors. The AOA recognizes the benefits of online technology to the medical field, and its ability to assist many patients who would not normally have access to medical care, but the AOA also acknowledges the special challenge for osteopathic physicians whose philosophy of a hands-on approach is hindered by the use of Internet technology. The AOA strives to put in place a policy that promotes wellness and safety for patients, and remains concerned over some practices that raise legal and ethical problems arising out of the use and misuse of online technology as a substitute for face-to-face care. The capabilities of the Internet offer many great opportunities to help doctors and patients, but it should always enhance an established doctor-patient relationship, not replace it.

Liability for Treatment and Diagnosis

In a case where direct treatment and consultation through online technology might result in the appearance of a medical error, questions of liability are likely. The hospital, the doctor, or both could subject to a medical malpractice suit.[31] Medical malpractice is any act or failure to act by a medical professional, resulting in harm, injury, distress, or death to a patient while under their care. As such, anything a physician may say or do can be used as evidence to establish the validity of a medical malpractice claim.

There is some concern that online consultation opens physicians up to liability by allowing them to make decisions about a patient's health without actually examining the patient. Doctors who are promoting online medical information or consultation are quick to distinguish their program from one that provides diagnoses over the web; however, it is not always clear where to draw the line. For example, one program, EasyDiagnosis.com, utilizes online software that allows consumers to select one major complaint or symptom, and then answer 20-25 questions related

[30] P. Greg Gulick, *E-Health And The Future Of Medicine: The Economic, Legal, Regulatory, Cultural, And Organizational Obstacles Facing Telemedicine And Cybermedicine Programs.* 12 Alb. L.J. Sci & Tech. 351, 351 (2002).
[31] *Id.*

to that complaint.[32] The system supplies patients with a number of possible diagnoses ranked in order of probability.[33] The site does not recommend a course of treatment, and there is no e-mail access to doctors.

Doctors who support these programs seem to suggest that by not recommending a course of treatment, they are not practicing medicine online. This does not appear to be a safe assumption, especially when injured patients are contemplating a lawsuit. Doctors argue that the disclaimers on sites clearly state they are not giving out medical advice. However, given the current crisis surrounding liability insurance, taking such risks is not necessarily a prudent move for doctors already straining to hold on to their practices. Additionally, while disclaimers are a necessary policy, they do not protect patients from taking online information as gospel, and misapplying it to themselves. One solution is that online consultations should only occur after a previously established doctor-patient relationship.[34] However, it would be extremely difficult – if not impossible – to keep consumers who are not current patients from accessing a physician's web page without instituting extreme security measures.

Liability of Individuals

Proponents argue that e-mail is a viable option for scheduling appointments, requesting prescription refills, and follow-up questions after an initial visit. However, it also raises the possibility of doctors extending the use of consultation through email or software to patients with whom they have no prior relationship. E-mail consultation has become a high-tech addition for computer-savvy doctors looking to address the overwhelming number of questions received regarding consumers' health concerns. Doctors can clarify treatment plans and provide guidance to consumers who are confused by the medical information that is already available online. Supporters see this technological advance as giving power to consumers through easily accessible information. The hope is that the resource will create better dialogue between doctors and patients.

Another Internet-aided program that is particularly troublesome for individual doctors is called MyDoc.com. MyDoc.com is advertised as the "first fully-integrated, 24 hour online healthcare service providing everything from physician-directed assessment and treatment recommendations to prescriptions and follow-up care."[35] This web-based service is targeted to individuals who are sick, or those responsible for caring for sick people; this means that the program is actually marketing itself to consumers without any contact with physicians who have actually seen the patient. MyDoc.com provides "symptom-based *diagnosis* (emphasis added) with the option of immediate on-line treatment by a board certified physician including prescription services."[36]

This program may save consumers time, but clearly places their health at risk. Physicians who support this technology say that they are not giving diagnoses and therefore, they are not practicing medicine. However, advertising by MyDoc.com tells a different story. Licensed physicians monitor patients, and may request further information before diagnosing, but there is no requirement that the physicians actually see the patients.[37] Physicians may be risking a sanction in their respective states because of unsafe practice. On October 15, 2002, the Illinois Department of Professional Regulation (DPR) took action to stop the company from treating patients.[38] The DPR alleged that MyDoc.com violated Illinois law because the site was providing diagnosis and treatment without a prior physician-patient relationship and without physically examining the patient.[39] Furthermore, the DPR said MyDoc's program violates the Illinois Medical Practice Act because persons not licensed as physicians were providing these services.[40]

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[32] Tyler Chin, *Web Site Lets Patients Narrow Diagnosis on Their Own,* American Medical News, June 10, 2002. (http://www.ama-assn.org/sci-pubs/amnews/pick_02/bisb0610.htm).
[33] *Id.*
[34] Chin, *supra* note 3 at 5.
[35] *See* http://www.mydoc.com
[36] *Id.*
[37] *Id.*
[38] Tyler Chin . *Firm Treating Strangers by Web Shut Out by Illinois Directive, State regulators move to ice online Consultation Company MyDoc.com*, American Medical News, November 4, 2002., Found at (http://www.ama-assn.org/sci-pubs/amnews/pick_02/bise1104.htm).
[39] *Id.*
[40] *Id.* see also 225 ILCS 60/1 et seq. (2002).

Liability for Companies

Both individual physicians and groups using these high tech methods of bringing health information to patients have cause for concern. The creators of the software for EasyDiagnosis.com developed and market their web-based software as an interactive medical decision-making software for consumers and health care providers.[41] The company warns that the "reliability of the program obviously depends on the information supplied by the physician and/or patient," and provides a disclaimer that it is not making diagnoses, however, many patients could be easily misguided by such a program. The company even goes as far as to disclaim any liability for "misdiagnosis, damages, injury, or death occurring to any patient whose findings are entered herein."[42] Disclaimers such as these are commonplace and necessary, but rarely shield a company from liability. Patients consistently look for the deep pockets, and EasyDiagnosis.com is an appealing target.

Some doctors started utilizing online technology believing it would be more time efficient; unfortunately, they are finding just the opposite.[43] While online technology has certainly emerged as a useful tool in health care, several studies have suggested deficiencies in the quality and usefulness of Internet-based health information for some purposes. One study, by the University of Michigan at Ann Arbor, found that e-mails did not help decrease the number of phone calls from patients, and missed appointments occurred just as frequently in the non-email group compared to the e-mail group.[44] Given the risks involved with treating, diagnosing, and prescribing medications without an established relationship, and the fact that studies undermine the quality of Internet-based health information, it is clear that the benefit of saving time does not outweigh the risks involved. A policy needs to be developed that supports patient safety over efficiency, and addresses the issues surrounding liability.

The AOA supports a policy that online consultation done without establishing a doctor-patient relationship, or without a licensed independent practitioner to receive the consultative opinion (who has established an appropriate relationship with the patient), is the practice of medicine, and does not meet an acceptable standard of medical practice. The absence of an appropriate established doctor-patient relationship may place physicians and the companies providing these services at risk for liability. A doctor-patient relationship can only be established through at least one face-to-face meeting. A consultation may occur when a licensed physician who has not met the patient in a face-to-face meeting is called upon to give his or her treatment advice to another licensed practitioner who is treating the patient within their scope of practice.

Online Prescribing

One of the emerging issues within medical practice via the Internet is online prescribing, encompassing both the prescriptive power of doctors and the distributive power of pharmacists. Part of the difficulty in regulating the sale of pharmaceuticals on the Internet is the wide variety of federal agencies that have partial authority over online prescribing. One action the federal government has taken is to establish task forces to prosecute licensed physicians who distribute drugs without prescriptions across state lines.[45] Still, most of the regulation of online prescribing is left to states.

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[41] *See* http://www.easydiagnosis.com/about.html.
[42] *Id.*
[43] Tyler Chin, *Patients E-mail-But They Still Keep Calling,* American Medical News, June 10, 2002. (http://www.ama-assn.org/sci-pubs/amnews/pick_02/bil20610.htm.
[44] *Id.*
[45] Gulick, *supra* note 1 at 368.

Under existing law in the majority of states, prescribing drugs to patients living or residing outside the state where physicians are licensed is considered the unlicensed practice of medicine.[46] Because prescription drugs can have potentially harmful side effects and dangerous contraindications when taken with other prescriptions or over-the-counter medications without proper instruction or follow-up, most states' laws require establishing a physician-patient relationship before prescribing drugs to patients. Unfortunately, state medicine boards cannot regulate or prevent all forms of online prescribing.

> It is the AOA's position that prescription drugs should only be prescribed over the Internet by a physician who has been directly involved in the patient's physical evaluation, has knowledge of the patient's medical history, and has knowledge of the other medications that the patient is currently taking. Allowing a physician to diagnose, prescribe, and dispense medications to a patient via the Internet without having taken a history and completing a physical examination is unethical and places the patient in a position of unnecessary risk, and the physician in the position of unnecessary liability. The AOA therefore supports legislative and regulatory efforts that require establishing an appropriate doctor-patient relationship, as defined by the individual state boards of medicine and osteopathic medicine, before diagnosing and prescribing medicines online.

Several states have taken various approaches to regulating online prescribing.[47] **Colorado's** medical board disciplines doctors who prescribe medications without seeing patients, **Illinois** has passed a law requiring an Illinois pharmacy license for any Internet site that ships to patients in Illinois, and **Nevada's** Board of Medical Examiners prevents physicians from prescribing over the Internet unless they have seen the patient.[48] Also, some state attorneys general have taken action to prevent the sale of pharmaceuticals in their states.[49] However, before 1999, very few doctors or pharmacists have been punished for Internet prescribing.[50] Since 1999, **Arizona, California, Connecticut, Michigan, Missouri, Kansas, New Jersey, Pennsylvania, and Texas** have taken legal action against individuals and companies that conduct online dispensing of prescription drugs.[51]

Actions Against Illegal Prescribing

Cases are starting to emerge demonstrating the states' strong reaction towards prescribing drugs without first examining the patients.

> On May 28, 2002, California Governor Gray Davis announced that the California State Board of Pharmacy had fined pharmacists $88 million for alleged violations of a California Internet prescription law passed 18 months previously. The law requires that Internet pharmacies fill prescriptions only after a patient receives a medical examination from a licensed California physician. The State of California alleged that over 3,500 prescriptions were written based on online patient questionnaires.[52]

> On May 29, 2002, an Oklahoma doctor involved with the now-closed Nationpharmacy.com was sentenced by a U.S. District Court to 51 months in a federal prison, ordered to forfeit $660,000 in

[46] American Medical Association, *Internet Prescribing* (1999) (http://www.ama-assn.org/meetings/ public/annual99/reports/onsite/bot/rtf/bot35.rtf)

[47] Regulation through laws: **Arkansas, California, Illinois, Indiana, Nevada, New Hampshire, New York, Texas, and Virginia**. Teresa Floridi, *Online Pharmacies*, Issue Brief, Health Policy Tracking Service, July 1, 2002. Regulation through state boards: **Arizona, Colorado, Connecticut, Illinois, Nevada, New Jersey, Ohio, Texas, Washington, and Wyoming**. American Medical Association, *Internet Prescribing* (1999) <http://www.ama-assn.org/meetings/ public/annual99/reports/onsite/bot/rtf/bot35.rtf>

[48] American Medical Association, *supra* note 30.

[49] P. Greg Gulick, *supra* note 1 at 369.

[50] Naftali Bendavid, *Prescriptions via Internet Pose Dangers*, Chicago Tribune, June 16, 1999, at A1.

[51] Teresa Floridi, *Online Pharmacies*, Issue Brief, Health Policy Tracking Service, July 1, 2002.

[52] Arent Fox Kintner Plotkin & Kahn, PLLC, *Penalties Handed Down in Internet Prescription Cases*, June 16, 2002. (*See* http://www.arentfox.com).

> illegal gains, and will likely have his medical license revoked in June after being convicted of the federal crime of conspiracy to distribute controlled drugs. The Department of Justice alleged that the doctor had been giving prescriptions for controlled drugs over the Internet to patients who had not undergone physical examinations.[53]

The states are not the only ones concerned about these cases; the private sector has also attempted to regulate prescribing over the Internet. Since 1999, the National Association of Boards of Pharmacy (NABP) Verified Internet Pharmacy Practice Sites has certified Internet pharmacies. Certification is available to pharmacies that follow the licensing requirements for their states and for each state to which they ship drugs.[54]

Licensure Concerns

While the majority of doctors who favor the use of online technology insist they are not practicing medicine by engaging in Internet-based consultations, others have argued to the contrary. If the pro-Internet doctors who use this technology are found to be practicing medicine, then they may face serious licensing issues. Since internet technology has allowed the practice of medicine across state and sometimes, international lines, several licensure problems can arise. A doctor who maintains a site in Illinois could easily reach patients who are accessing the system from another part of the country. In this case, there are questions as to where the doctor who maintains the site should be licensed; should a doctor be licensed in the state where he is located, or the state where the patient is accessing the information?

Licensure of medical professionals and facilities was intended to accomplish several goals, but most importantly, establish an acceptable standard of care in the medical community that will ensure the welfare of the state's residents. The FSMB has remained true to this goal throughout the growth of telemedicine. Since 1994, at least 24 states have passed laws addressing licensure for physicians utilizing telemedicine technology; these are: **Alabama, Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Indiana, Illinois, Kansas, Mississippi, Montana, Nevada, New Mexico, North Carolina, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Utah,** and **West Virginia**.[55] In 1996, the FSMB adopted model legislation to require doctors who want to practice medicine across state lines by means of internet technology to obtain a special license with reduced price, examination, and credentialing requirements.[56] So far, only six states from the above list enacted legislation consistent with the FSMB, these are: **Alabama, California, Montana, Oregon, Tennessee,** and **Texas**.[57]

In 2000, the FSMB adopted model guidelines stating they expect "physicians who provide medical care, electronically or otherwise to maintain acceptable standards of practice."[58] Therefore, in a case where direct treatment and consultation through online technology results in poor outcomes, the hospital, the doctor, or both could be professionally liable, and possibly risk losing their licenses.[59]

Licensing groups have looked at several options such as the use of a consulting exception to the licensing law, endorsement of physicians in other states with equivalent standards, and limited licensure to name a few.[60] In effect, a particular state would recognize the out-of-state license if equivalent standards for licensing existed between the states.[61] Many states are skeptical about

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[53] *Id.*
[54] *Id.*
[55] Stephanie Norris,. *Telehealth*. Issue Brief: Health Policy Tracking Service, December 31, 2001. (http:www.hpts.org).
[56] *Id.*
[57] *Id.*
[58] Federation of State Medical Boards, Special Committee on Professional Conduct and Ethics. *Model Guidelines for The Appropriate Use of the Internet in Medical Practice* Found at (http://www.fsmb.org/Policy%20Documents%20and%20White%20Papers/internet_use_guidelines.htm).
[59] *Id.*
[60] Ross Silverman, *The Changing Face of Law and Medicine in the New Millennium: Regulating Medical Practice in the Cyber Age,* 26 Am. J.L. and Med. 255 (2000).
[61] *Id.*

allowing a special license for the practice of medicine across state lines via the Internet. Opponents argue that doctors should have a full and unrestricted license in every state in which they practice. They fear that limited licenses will lead many out-of-state doctors to be less qualified to practice in a state than their in-state counterparts.[62] Alternatively, disallowing special or consultant licensure could be construed as interfering with the power of states to regulate health care workers and a barrier to interstate commerce. The U.S. Constitution permits states the authority to regulate activities that affect the health, safety, and welfare of their citizens, including the regulation of physicians' activity.[63] However, opponents to this type of regulation could argue that limiting or controlling physician licensure when physicians are practicing interstate is a *violation* of the Constitution because it places a restraint on interstate trade. While the argument presents an interesting defense, courts have not yet addressed the issue of whether a state's decision to limit the practice of medicine in their state to physicians licensed in that state is in fact a restraint on trade.

The question of what constitutes a legal practice of medicine is in many ways left up to each state's interpretation. Still, most states still require full licensure in the practicing state. [64] **Indiana** and **Texas** specifically include electronic consultations in their definition of what constitutes the "practice of medicine". In Indiana, consultations with a doctor through "electronic communications" on a "regular, routine, and non-episodic basis" are considered to be the practice of medicine.[65] Consequently, in order for a doctor located outside the state of Indiana to consult with a patient within the state, the doctor must be licensed to practice medicine in Indiana. The definition in Texas works somewhat differently. In Texas, any type of patient care, including interpreting an x-ray through the use of internet-technology devices, is the practice of medicine. However, doctors located in a state other than Texas may provide episodic consultation along side another doctor who practices in the same medical specialty as long as the doctor licensed in Texas supervises the patient.[66]

California has taken another approach by allowing physicians to practice consultation through online technology as long as they are licensed in one of the fifty states; however, there are some restrictions. The physician must obtain verbal and written consent from the patient who must be informed of all the risks involved in online consultation.[67] Unlike **Indiana** and **Texas**, **California's** laws seem to promote the use of online technology. The statute requiring informed patient consent does not apply to phone or e-mail consultations.[68] Instead, the law seems to protect only those patients who communicate through other computerized means. A second statute in **California** specifically allows consultation from a doctor licensed and located in another state as long as the consultation does not suggest a place to meet patients, and as long as there is a primary care physician who is ultimately responsible, licensed in the state of California.[69]

Often, state laws vary greatly in regards to the use of online technology, and the requirement that physicians obtain a full-unlimited license from each state to practice medicine via the Internet is perceived as overly restrictive. This is particularly relevant to physicians practicing in rural markets and medically underserved areas that are aided through the advancements in online technology. The AOA believes a physician should be licensed in all states in which they practice, and therefore, recommends a policy that decreases licensure barriers that limit access to care, while maintaining necessary health and safety protections.

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[62] Norris, *supra* note 11.
[63] Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982).
[64] Norris, *supra* note 11.
[65] *Id.* See Ind. Code Ann. 25-22.5-1-1.1(a)(4)(A) & (B) (Michie 1999).
[66] Gulick, *supra* note 1 at 366. See Tex. Occ. Code Ann. 151.056(b)(1)
[67] Cal. Bus. & Prof. Code 2290..5(a)(1)& (b)(c) (West 1990 & Supp. 2002).
[68] *Id.* at 2290.5(a)(1).
[69] Cal. Bus. & Prof. Code 2060 (West 1999 & Supp. 2002)

The AOA supports and recommends a policy that provides for the practice of medicine via the Internet and that State Medical Boards grant reciprocity for licensure between fellow State Medical Boards whose license regulating the practice of medicine via the Internet, meets equivalent licensing standards.

Reimbursement

The added cost of online consultations and Internet-based software has sparked an interest in reimbursement for online services. In the past, many doctors provided online consultation free of charge during its start-up phase, but they have realized that the cost, which is not covered by many insurance carriers, must be passed on to patients.[70] However, survey data suggests that patients are willing to foot the bill for the service; 90% of those polled want online communication with their doctors, and 37% said that they were willing to pay for it. The price can be high; e-mail consultation can range from $20-$25 per consultation.[71] Additionally, consumers could pay $25 for an annual subscription to medical software that would give patients a list of possible diagnoses for a set of symptoms.[72]

Still, states are realizing that as costs for these services increase, fewer people can afford the option. As a result, legislative interest in policies that address reimbursement for online services has been growing. Some states, such as **California** and **Texas**, have begun reimbursement programs of their own. One statute in **California** recognizes an intent to support the practice of medicine via the Internet as a legitimate avenue for a patient to access medical care without in person contact.[73] The law authorizes the Medi-Cal program to reimburse consultations utilizing online methods as long as those consultations are done other than by fax or phone.[74] On a federal level, the Balanced Budget Act of 1997 allowed Medicare payments for medical consultation via an online system for those in rural areas. However, the amount of coverage was subject to Medicare co-payments and deductibles.[75] In 2000, President Clinton signed a law that expanded reimbursement in this area. The law will cover rural areas *and* existing Medicare demonstration sites. In addition, the law creates more eligible online services that can be billed to Medicare. E-mail consultation between a doctor and patient is not covered. The bill became effective on October 1, 2001.

Advocates of online consultation expect that more insurers will expand coverage for these services when they recognize that demand is steadily increasing. Currently, very few insurers are agreeing to this arrangement. Blue Shield of California and First Health Group pay their physicians a small amount for consultations, but Medem, a web service started by the American Medical Association, expects patients to pay the full cost for its consultations.[76]

The AOA supports a policy that encourages more state action and legislation supporting the reimbursement by insurance and other third-party reimbursement for appropriate services utilizing online technology, online consultations, and Internet-based health programs.

Privacy Issues

Privacy is a huge concern when looking at programs utilizing on-line medical technology. Since large amounts of data are being transmitted both within and out-of-state, medical professionals need to be particularly vigilant and attentive to patients' privacy rights. In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA).[77] It includes a provision that is meant to protect the privacy of patients whose identifiable health information is transmitted by electronic means. The Act also allows for the preemption of any less stringent state laws regarding privacy. This means that if a state passes any law that effects patient's privacy and it does not meet a

[70] Tyler Chin. *Online Consultation: What is it Worth?* American Medical News, June 10, 2002. (http://www.ama-assn.org/sci-pubs/amnews/pick_02/bisa0610.htm.
[71] *Id.*
[72] Chin, *supra* note 3.
[73] Cal. Wel. & Inst. 14132.72 (a) (West 2001).
[74] *Id.* at 14132.72(d)
[75] Rubin, *supra* note 7.
[76] Rita Rubin. *The Virtual Doctor Will See You Now, But Have Your Credit Card Ready,* USA Today, June 10, 2002. (http://www.usatoday.com/usatonline).
[77] 42 U.S.C. 1320d-2

higher federal standard, that law will not be controlling. [78] As a result, hospitals and medical professionals need to be very careful when implementing such programs.

> The AOA supports a policy that acknowledging the importance of maintaining patients' privacy and encourages states to adopt strict standards and procedures to protect any medical information that is transmitted through electronic means.

Conclusion

While the American Osteopathic Association recognizes the ever-expanding nature of medicine and the growth in the practice of online technology in the health care field, it equally recognizes the need to protect patients from dangerous practices that may compromise their health and safety. To this end, the AOA supports a policy that will set limits on treatment, diagnosis, and prescribing over the Internet allowing such practice only when a clear doctor-patient relationship has been established. Furthermore, because licensure is greatly affected by individuals practicing medicine via the Internet, the AOA supports and recommends a policy that State Medical Boards issue a license for the practice of medicine via the Internet, and that State Medical Boards grant reciprocity for such licensure between fellow State Medical Boards whose license regulating the practice of medicine via the Internet meets equivalent licensing standards. In addition, the AOA supports a policy that encourages more state action and legislation supporting the reimbursement by insurance and other third-party providers for appropriate services utilizing online technology, online consultations, and Internet-based health programs. The AOA supports a policy acknowledging the maintenance of patients' privacy and encouraging states to adopt strict standards and procedures to protect the confidentiality of any medical information that is transmitted through electronic means. **2003**

ONSITE LAB WORK NO.1

WHEREAS, many managed care companies deny the performance and remuneration for CLIA approved on-site laboratory tests and other appropriate diagnostic tests and instead require referral to off-site providers for these basic laboratory tests and diagnostic procedures; and

WHEREAS, these practices can result in delays in diagnosis and treatment; and

WHEREAS, these delays in diagnosis and treatment could be harmful to patients; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the adoption of national legislation which enables the physician to perform and be compensated for CLIA certified in-office laboratory tests; and, be it further

RESOLVED, that the AOA supports the adoption of national legislation which enables the physician to perform and be appropriately compensated for medically indicated on-site diagnostic procedures. 1999; *reaffirmed* 2004

ON SITE LAB WORK- NO. 2

WHEREAS, many managed care companies routinely prohibit the performance of reasonable on-site diagnostic tests and require referral to off-site providers for these diagnostic tests; and

WHEREAS, these practices can result in unnecessary delays in diagnosis and treatment of patient's condition and illness; and

[78] Silverman, *supra* note 26.

WHEREAS, these delays in diagnosis and treatment can have serious deleterious effects on the patient's health; now, therefore be it

RESOLVED, that the American Osteopathic Association work with federal and state governments to enact legislation that requires healthcare plans to pay for appropriate on-site testing at a rate equal to the highest rate paid for the same service to off site providers. 2001

OPIOID/OPIATE MEDICATION, LONG-ACTING

WHEREAS, the Drug Enforcement Agency (DEA) has made efforts to establish guidelines for the administration of Opioids/Opiates and other controlled substances; and

WHEREAS, the DEA and other state and federal agencies have sought the advice and consent of pain specialist, anesthesiologists and other "specialists" in the development of these standards; and

WHEREAS, the treatment of pain and pain management represents a major component of an osteopathic physicians practice; and

WHEREAS, the American College of Osteopathic Family Physicians (ACOFP) Board of Governors has approved a policy opposing any federal law or regulation that attempts to limit the ability of family physicians to legally prescribe, administer, or dispense controlled substances; now, therefore, be it

RESOLVED, that the American Osteopathic Association adopt the following policy on Long-Acting Opioid/Opiate Medication on behalf of the entire osteopathic profession.

Long-Acting Opioid/Opiate Medication

It is a right of all patients to have access to medically appropriate intervention and/or treatment of acute and chronic pain. It is the right of all physicians, to provide medically appropriate intervention and treatment modalities that will achieve safe and effective pain control for all their patients.

As patient advocates and physicians, we believe that it is in the best interest of all patients not to confine, or seek to regulate opioid/opiate medications by limiting their use to a small number of selected specialties of medicine. This would also extend to modalities now developed, or yet to be developed, such as long-acting opioid/opiate preparations. These exclusionary strategies will limit access for patients with medical indications for therapy, complicate delivery of care, and add to pain and suffering of patients in all areas of our country. 2005

ORGAN DONATION AND TRANSPLANTATION INITIATIVES—COMMITMENT TO

WHEREAS, organ donation and transplantation efforts mobilize medical resources in the battle against a myriad of life-threatening diseases; and

WHEREAS, public education and outreach concerning the benefits of organ donation and transplantation are vital in the campaign to maximize the effectiveness of current medical treatments; and

WHEREAS, public and private sector initiatives, such as those of the United Network for Organ Sharing and the Office of the Surgeon General, have paved the way for improved patient access to organ and tissue reserves; and

WHEREAS, the American Osteopathic Association has had policy encouraging organ donor identification since 1988 and is seeking to further its efforts to provide physician leadership to advocate patient interests in this area; now, therefore, be it

RESOLVED, that the American Osteopathic Association affirms its support for organ donation and transplantation programs at local and national levels; and, be it further

RESOLVED, that the AOA direct its End-of-Life Care Advisory Committee to develop physician and public education programs to advance the cause of organ donation and transplantation; and, be it further

RESOLVED, that the AOA Board of Trustees, the House of Delegates, their families, and members of the profession be urged to volunteer personally as organ donors, and in turn, actively encourage their patients to do the same; and, be it further

RESOLVED, that the AOA encourage osteopathic divisional and specialty organizations, osteopathic medical colleges, and other members of the osteopathic family to develop organ donation programs in their states and organizations. 2001

ORGAN DONATION—OPPOSITION TO FINANCIAL INCENTIVES FOR ORGAN DONORS

WHEREAS, the US Department of Health and Human Services has documented an ongoing shortage of organ donors; and

WHEREAS, medical leaders have been charged with the quest to develop new and innovative ways for achieving organ donor goals; and

WHEREAS, financial incentives have been criticized as an ineffective and potentially dangerous solution to increase organ donor rates; now, therefore, be it

RESOLVED, that the American Osteopathic Association states its opposition to direct payment or other financial reimbursement in exchange for donation of human organs and tissue; and be it further

RESOLVED, that the osteopathic medical profession investigate other, more ethical alternatives to raising organ donor identification rates while preserving its first duty to protecting patient interests. 2002

ORGAN DONOR IDENTIFICATION

WHEREAS, the AOA has committed itself to raising awareness of and access to organ donation and transplantation resources; and

WHEREAS, government reports have documented an ongoing shortage of available organs and eligible donors; and

WHEREAS, appropriate counseling by primary care physicians has been shown to favorably impact the process of identifying potential organ donors; now, therefore, be it

RESOLVED, that the American Osteopathic Association encourages osteopathic physicians to discuss organ donation options with their outpatients as well as their inpatients; and, be it further

RESOLVED, that all physicians honor the policies of their designated Organ Procurement Organization in achieving optimal organ donor identification goals. 2002

Explanatory Statement: The US Department of Health and Human Services designates local and regional Organ Procurement Organizations (OPO) to work directly with healthcare facilities. Since OPO policies vary, it is important that physicians understand they must still follow state and federal guidelines in identifying potential organ donors. The Bureau of Healthcare Facilities Accreditation supports physicians being encouraged to discuss organ donation with their patients and agrees that all physicians should honor the policies of their Organ Procurement Organization in achieving optimal organ donor identification goals. The Bureau

does not agree with adding organ donation preferences as a required part of primary care assessment procedures. The Bureau currently has several accreditation requirements related to organ procurement issues within its Accreditation Requirements for Healthcare Facilities.

OSTEOPATHIC GRADUATE MEDICAL EDUCATION

WHEREAS, the future of osteopathic medicine relies on the continuing osteopathic intern and residency programs for graduates of osteopathic medical colleges; and

WHEREAS, many of the osteopathic graduate medical training programs are residing in community hospital settings; and

WHEREAS, financial incentives are lacking for these hospitals; and

WHEREAS, Medicare and Medicaid are cutting back on funding for graduate medical education; now, therefore, be it

RESOLVED, that the American Osteopathic Association urge its member physicians to support hospitals which provide osteopathic internships, residencies and fellowships which are an integral part of osteopathic medical education. 1998 *revised* 2003

OSTEOPATHIC GRADUATE MEDICAL EDUCATION FUNDING

WHEREAS, the future of the osteopathic profession lies in its ability to continually improve the quality Graduate Medical Education (GME) programs that present the profession as a profession based on excellence; and

WHEREAS, the present and future growth and maintenance of membership in osteopathic organizations are in part based on the continued growth and viability of quality GME programs; and

WHEREAS, the continuing of separate and distinct AOA accredited GME programs are essential in promoting the participation of active membership in osteopathic organizations; and

WHEREAS, the majority of funding of GME is funded by federal government programs such as Medicare, Medicaid and other federal and state programs; now, therefore, be it

RESOLVED, that the American Osteopathic Association will continue efforts that encourage support and awareness of osteopathic GME programs within governmental entities. 1994; *revised* 1999, *revised* 2004

OSTEOPATHIC LICENSING

WHEREAS, osteopathic medicine is a philosophically distinct and educationally separate school of medicine rather than simply an individual discipline within medicine; and

WHEREAS, Pluralism has worked well in credentialing osteopathic and allopathic physicians, and should continue; and

WHEREAS, the examinations of the National Board of Osteopathic Medical Examiners, Inc., are the only examinations which integrate osteopathic principles and practices throughout; now, therefore, be it

RESOLVED, that the American Osteopathic Association reaffirms its position that the only examinations able to fully evaluate the ability and competency of osteopathic physicians for licensure are the examinations developed by the National Board of Osteopathic Medical Examiners, Inc. 1982; *revised* 1987, 1992, 1997, 2002

OMT--OSTEOPATHIC MANIPULATIVE TREATMENT

WHEREAS, osteopathic medicine is a profession with full practice rights; and

WHEREAS, the osteopathic manipulative treatment is an integral part of osteopathic medicine; and

WHEREAS, the word "therapy" is associated with therapists and other persons that have different levels of education, responsibility and breadth of practice; and

WHEREAS, the use of the term "osteopathic manipulative therapy" will give the false impression that: (1) DOs are therapists or, (2) therapists who are not fully trained DOs can perform this form of intervention; now, therefore, be it

RESOLVED, that in all forms of communication the term OMT shall always be "Osteopathic Manipulative Treatment." 1999; *revised 2004*

OMT IN A PRE-PAID ENVIRONMENT--REIMBURSEMENT POLICIES FOR

WHEREAS, Independent Practice Associations (IPAs) contracting for prepaid enrollment must offer a full range of covered benefits to those enrollees; and

WHEREAS, the Centers For Medicare And Medicaid Services (CMS) has adopted osteopathic manipulative treatment (OMT) as a separately identifiable, reimbursable, physician-provided service in both a fee-for-service and prepaid environment; and

WHEREAS, other forms of manipulation usually are a covered benefit; and

WHEREAS, osteopathic physicians are highly trained in the integration of expert, cost-effective and judicious application of osteopathic manipulative treatment when indicated and appropriate; and

WHEREAS, IPAs working under Primary Care Physician (PCP) capitation generally capitate their primary care providers for a defined set of PCP responsibilities and skills; and

WHEREAS, equivalent capitation needs to be given for equivalent scope of PCP responsibilities; and

WHEREAS, most allopathic physicians are not trained in the utilization of manipulative procedures; and

WHEREAS, chiropractic or physical therapy manipulation, when authorized, is considered a specialty procedure; now, therefore, be it

RESOLVED, that the American Osteopathic Association work to ensure that osteopathic manipulative treatment in any prepaid health plan be recognized as a separate procedure; and, be it further

RESOLVED, that the AOA work to ensure that osteopathic manipulative treatment as a procedure applied by fully-licensed physicians and surgeons be considered unique; and, be it further

RESOLVED, that the AOA work to ensure that osteopathic manipulative treatment in any prepaid health plan be compensated as a special separate procedure, either by payment of additional capitation or on a fee-for-service basis without the need for prior authorization. 1995; *revised* 2000, 2005

OSTEOPATHIC MANIPULATIVE TREATMENT--REIMBURSEMENT FOR

WHEREAS, osteopathic physicians are educated and trained for the full practice of medicine; and

WHEREAS, the rendering of osteopathic manipulative treatment (OMT) is a unique modality which only osteopathic physicians are qualified to offer patients; now, therefore, be it

RESOLVED, that the American Osteopathic Association pursue any and all legal and legislative recourse to protect the rights of its member physicians to deliver approved and beneficial modalities of healthcare; and, be it further

RESOLVED, that the American Osteopathic Association object to any attempt by third party payors to deny or restrict reimbursement for osteopathic manipulative treatment when appropriately rendered; and, be it further

RESOLVED, that the AOA continue to oppose any attempt by third-party payers to interchange and/or combine osteopathic manipulative treatment codes with codes used to describe other forms of manual manipulative treatment therapy. 1986; *revised* 1991, 1992, 1997, *revised* 2002

OMT AND EVALUATION AND MANAGEMENT (E&M) ON THE SAME DAY OF SERVICE-- REIMBURSEMENT FOR

WHEREAS, many managed care insurers do not reimburse osteopathic physicians for performing osteopathic manipulative treatment (OMT) and consider OMT as part of an office visit; and

WHEREAS, primary care physicians performing OMT in addition to evaluation and management (E&M) may not receive a higher capitated amount than other primary care physicians not performing OMT; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports remuneration for osteopathic manipulative treatment (OMT). 1998, *revised* 2003

OSTEOPATHIC MANIPULATIVE TREATMENT--SUPERVISION FOR

WHEREAS, osteopathic physicians in-training have expressed concern regarding supervising attending physicians' (MD and DO) denial of their appropriate utilization of osteopathic diagnosis and osteopathic manipulative treatment (OMT) procedures; and

WHEREAS, the American Osteopathic Association's basic documents for internship and residency training programs provide for the appropriate integration of osteopathic diagnosis and OMT in patient care; now, therefore, be it

RESOLVED, that the American Osteopathic Association strongly encourages all supervising physicians to foster the appropriate utilization of osteopathic diagnosis and osteopathic manipulative treatment by students, interns and residents assigned to them. 1997; reaffirmed 2002

OSTEOPATHIC MEDICINE—AUTONOMY OF

WHEREAS, osteopathic medicine is a complete and distinct philosophy of medicine, serving the public for more than 100 years; and

WHEREAS, osteopathic medicine has attained its present status on the basis of merit and acceptance by the public; and

WHEREAS, osteopathic medicine and the osteopathic profession have developed appropriate liaisons with national, state, and local governments; and

WHEREAS, osteopathic profession has developed a system of medical education recognized by accrediting agencies and by institutions of higher learning; and

WHEREAS, the best interests of the health and welfare of the public and of the nation are best served by the continuance of a complete and distinct osteopathic profession; now, therefore, be it

RESOLVED, that the osteopathic profession in the interest of providing the best possible healthcare to the public shall maintain its status as a complete and distinct philosophy of medicine. 1959; *reaffirmed* 1965, 1974, 1980, 1985; *revised* 1990, 1996, 2001

OSTEOPATHIC MEDICINE DEFINITION

RESOLVED, that the following definition of osteopathic medicine, as revised by the AOA House of Delegates in 1998, be reaffirmed:

Osteopathic Medicine: A complete system of medical care with a philosophy that combines the needs of the patient with the current practice of medicine, surgery and obstetrics; that emphasizes the interrelationship between structure and function; and that has an appreciation of the body's ability to heal itself. 1991; *revised* 1992, 1997, 1998, *reaffirmed* 2003

OSTEOPATHIC MUSCULOSKELETAL EVALUATION

WHEREAS, an osteopathic musculoskeletal evaluation is an integral part of the physical examination; and

WHEREAS, the osteopathic musculoskeletal evaluation provides additional information regarding the health of the patient; now, therefore, be it

RESOLVED, that the osteopathic physician continue to utilize osteopathic musculoskeletal evaluation including the concepts of body unity, self-regulation, and structure-function interrelationships, to assess the patient's status and develop a plan of treatment. 1982; *reaffirmed* 1987; *revised* 1992, 1997, 2002

OSTEOPATHIC POSTDOCTORAL TRAINING IN ALL SPECIALTY AREAS

WHEREAS, the American Osteopathic Association represents a school of medical practice; and

WHEREAS, this system of medicine contains its own colleges, hospitals, graduate medical education programs, specialty systems and OPTI programs; and

WHEREAS, osteopathic medical students must be instructed in programs taught by osteopathic physicians who appreciate and uphold the osteopathic philosophy and principles; now; therefore, be it

RESOLVED, that the osteopathic profession reaffirms itself as a complete profession of medicine and surgery; and, be it further

RESOLVED, that the AOA reaffirm its commitment to osteopathic postdoctoral training in all specialty areas. 1993; *revised* 1998, *revised* 2003

"OSTEOPATHY"-- USE OF THE TERM

WHEREAS, osteopathy, as founded and named by Dr. Andrew Taylor Still, is the historical descriptor for this profession; and

WHEREAS, the use of the terms osteopathy and osteopathic medicine are appropriate when used to distinguish our form of healthcare from the allopathic model in the United States: and

WHEREAS, our distinct contributions to healthcare are being recognized by governmental agencies, third party carriers, healthcare agencies and the public; and

WHEREAS, healthcare reform is demanding that non-allopathic models of healthcare be promoted; and

WHEREAS, osteopathy/osteopathic medicine in the United States is the only complete and appropriate alternative to allopathic medicine; and

WHEREAS, osteopathy/osteopathic medicine is a complete system of healthcare in the United States and as such is much more holistic than medicine in the classical sense; and

WHEREAS, osteopathy is widely recognized outside the United States; and

WHEREAS, the practitioners of osteopathy outside the U.S. have a limited license allowing them to practice osteopathic diagnosis and treatment and precludes the practice of medicine, pharmacology, and surgery while working as a complement to standard medicine; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) reaffirm its editorial policy of July 2000 to permit the use of the terms osteopathy and osteopathic medicine as interchangeable in the United States; and, be it further

RESOLVED, that the American Osteopathic Association institute a policy, both officially in our publications and individually on a conversational basis, to use the term "osteopathic physician and surgeon" in place of the word *"*osteopath*"*; the word "osteopath*"* being reserved for historical, sentimental and informal discussions only as well as for osteopaths educated outside the United States. 1994; *reaffirmed* 2000; *revised* 2005

PATIENT ACCESS IN RURAL AREAS

WHEREAS, managed care enrollees in rural areas often have no local network physicians or hospitals to provide medical care; and

WHEREAS, some managed care enrollees must travel long distances to the nearest network physicians or hospitals; and

WHEREAS, healthcare plans should guarantee adequate access to providers in an enrollee's proximate area; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports legislation on the state and federal levels that would require all managed care health plans to have reasonably placed network physicians and hospital access; if the distance is unreasonable, the plans should pay for out of network services at no additional cost to the patient. 1995; *revised* 2000, 2005

PATIENT CONFIDENTIALITY

WHEREAS, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and HIPAA regulations place strict limitation upon a physician's use or disclosure of a patient's health information; and

WHEREAS, it has become the practice of some insurance companies to demand copies of complete medical records prior to reimbursement for physicians services; and

WHEREAS, this practice sometimes places the physicians in jeopardy of inadvertently violating legal and ethical requirements with respect to confidentiality; now, therefore, be it

RESOLVED, that in such cases where the physician is bound by law to protect patient confidentiality, the physician shall only be required to provide information that can be disclosed under law and where possible, the physician shall be allowed to submit narrative reports or only copies of the part of a medical record that is pertinent in lieu of a complete record. 1993; *reaffirmed* 1998; *revised* 2003

PATIENT EDUCATION

WHEREAS, patient education is an important component of the physician's responsibility to the patient; and

WHEREAS, the American Osteopathic Association plays a leadership role in advancing patient education through its participation in conferences on patient education, and its ongoing communications to its members in support of augmented patient education; now, therefore, be it

RESOLVED, that the American Osteopathic Association reaffirms its commitment to the advancement of patient education to promote a better understanding of personal health and wellness.. 1983; *revised* 1988, 1993, 1998, 2003

PATIENT INTERPRETERS

WHEREAS, a federal rule has been published to mandate physicians provide an interpreter for patients who are not English proficient; and

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) does not provide reimbursement for the interpreters; and

WHEREAS, few, if any other entities are expected to hire individuals to provide a service without reimbursement; and

WHEREAS, in some areas accessing an interpreter in a timely manner may be difficult; and

WHEREAS, the rule has a potential to reduce patients' access to be seen by a physician because of the mandated interpreter rule; now, therefore, be it

RESOLVED, that the American Osteopathic Association support efforts to seek having the rule revised to eliminate the unfunded mandate of physicians to provide interpreters for patients; and, be it further

RESOLVED, that the AOA request the Centers for Medicare and Medicaid Services (CMS) to implement reasonable reimbursement directly to an interpreter. 2001

PATIENT-PHYSICIAN RELATIONS

WHEREAS, recent political and judicial events have raised the question of restrictions upon the nature of medical information which a physician may discuss with a patient or person responsible for a patient; and

WHEREAS, in 1991, the Supreme Court in Rust vs. Sullivan upheld HHS regulations stating that a physician cannot legally inform a patient of all medical options related to family planning paid for by HHS Title X monies; and

WHEREAS, the essence of the patient-physician relationship rests upon a patient's confidence in the physician's ability and willingness to freely discuss, in complete privacy, any and all medical information which may have any bearing on the welfare of that patient; and

WHEREAS, the fundamentals of medical care rest on the right of a patient to complete medical information and the right and responsibility of a physician to provide that information, guided by the welfare of the patient above all other considerations, and in complete confidence; and

WHEREAS, any precedent allowing intrusion upon those rights in any regard, for any reason, is a direct attack on that relationship and therefore on the physician's ability to care for a patient; and

WHEREAS, such a precedent claims the right of the state to censor conversations held in the sanctity of the professional relationship; and

WHEREAS, such censorship is odious both to the American principle of freedom of speech and the millennia-old nature of the relationship between patient and physician; now, therefore, be it

RESOLVED, that the American Osteopathic Association unalterably reject any claim of a right to censorship of professional communication, in any regard, and for any reason; and, be it further

RESOLVED, that the AOA work to secure enactment of legislation protecting these necessary rights of patients and physicians; and, be it further

RESOLVED, that the AOA continue to oppose any and all attempts to alienate the nature of the patient-physician relationship. 1991; *revised* 1996, 2001

PATIENT SAFETY

WHEREAS, patient safety and quality of care have always been a concern of the American Osteopathic Association and its divisional societies; and

WHEREAS, levels of reimbursement to hospitals for patient care have been dramatically reduced due to cutbacks in Medicare and reductions by insurance companies and managed care entities; and

WHEREAS, there currently exists a concern for in-hospital patient safety as a result of staff shortages as well as the possible jeopardizing of patient recovery by premature discharges; now, therefore, be it

RESOLVED, that the American Osteopathic Association and its state affiliates endorse a policy of patient safety in health care that encourages payers to provide adequate reimbursement so that hospitals can provide the best quality care in the safest of environments. 2002

PEDIATRIC DRUG TESTING

WHEREAS, children are not "little adults"; and

WHEREAS, drugs used in pediatrics should have the same rigorous scientific studies that are required for the use of that drug in adults; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports legislation requiring all pharmaceutical companies to ensure all drugs with therapeutic benefits for children are tested for their use; and, be it further

RESOLVED, that all new drugs to be studied in children at the same time, or soon after, the drug is approved for use in adults. 2003

PEDIATRIC PSYCHIATRIC CARE

WHEREAS, pediatric psychiatric issues are becoming an increasing part of a primary care physician's practice; and

WHEREAS, the general public, school security services and physicians are seeing and reporting an increasing number of disturbances in children and adolescents which threaten the lives of family members and our community; and

WHEREAS, many insurance providers are refusing or providing minimal reimbursement for counseling and psychiatric care; and

WHEREAS, primary care physicians are not adequately trained to handle this burden; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) support the development of educational programs to assist primary care physicians to identify and initiate appropriate support; and, be it further

RESOLVED, that the AOA encourage insurance providers to adequately reimburse counseling and psychiatric care deemed necessary by the patient's primary care physician. 2005

PEER REVIEW

WHEREAS, the American Osteopathic Association has always fostered and encouraged peer review, both through voluntary mechanisms and, since 1972, through Federal Peer Review Programs; and

WHEREAS, the AOA wishes to reaffirm its commitment to peer review regardless of federal policy or program changes; now, therefore, be it

RESOLVED, that the American Osteopathic Association hereby affirms its commitment to promote and facilitate peer review among and through its members; and, be it further

RESOLVED, that the AOA believes that the voluntary hospital peer review process remains the most natural and appropriate vehicle through which to effect institutional peer review; and, be it further

RESOLVED, that all review under the peer review organization program of osteopathic diagnosis and therapeutics be performed by osteopathic physicians. 1981; *revised* 1983, 1987, 1992; reaffirmed 1994, 1999; *(referred in 2004)*

PEER REVIEW BY EQUAL CREDENTIALING

WHEREAS, the American Osteopathic Association supports peer review of osteopathic physicians by osteopathic physicians; and

WHEREAS, peer review takes place in both hospital and outpatient settings; and

WHEREAS, various entities, including the Centers for Medicare and Medicaid Services (HFCA), managed care organizations, third party payors, and workers' compensation programs often use peer review for determination in reimbursement decisions; and

WHEREAS, osteopathic specialty training is unique due to its osteopathic philosophy; and

WHEREAS, the AOA is the recommended certifying body for osteopathic postdoctoral training programs; and

WHEREAS, non-osteopathically trained physicians lack the additional education provided in osteopathic postdoctoral training; now, therefore be it

RESOLVED, that the American Osteopathic Association supports peer review of osteopathic physicians by other osteopathic physicians who have earned the same AOA certification credentials. 1996; *(to be considered in 2005)*

PEER REVIEW OF OSTEOPATHIC MANIPULATIVE TREATMENT

WHEREAS, many insurers carriers have claims for the service of OMT "peer reviewed" by health care providers that are either not trained or who are inadequately trained in Osteopathic Principles and Practices; and

WHEREAS, osteopathic physicians are highly trained in the integration of expert, cost effective and judicious application of osteopathic manipulative treatment when indicated and appropriate; and

WHEREAS, most allopathic physicians are untrained in the utilization of osteopathic manipulative procedures; and

WHEREAS, chiropractors and physical therapists are untrained in the integration of osteopathic manipulative treatment and the unlimited practice of medicine and surgery; now, therefore, be it

RESOLVED, that the American Osteopathic Association pursue any and all legal and legislative recourse to assure that the peer review of claims regarding the provision of OMT procedures may only be conducted by a qualified osteopathic physician; and, be it further

RESOLVED, that the only health care providers qualified to review OMT procedures are licensed osteopathic physicians. 2003

PEER REVIEWERS

WHEREAS, osteopathic physicians acting as medical directors of insurers may make coverage decisions which affect the financial ability of patients to receive appropriate medical treatment; and

WHEREAS, osteopathic physicians acting as expert witnesses during trial may provide incomplete or inaccurate testimony which ultimately affects a practicing physician's ability to practice good and appropriate medical care of a patient without fear of legal jeopardy; and

WHEREAS, osteopathic physicians acting as hired peer reviewers for insurers, may give inappropriate or incomplete evaluations of medical records, which denies payment for further medically necessary patient treatment, and may cause other osteopathic physicians to avoid treating future patients with that insurer, thus affecting patient access to care; and

WHEREAS, the above actions of such osteopathic physicians can adversely affect and alter the clinical course and ultimate outcome of a patient's care by other physicians now, therefore, be it

RESOLVED, that the American Osteopathic Association adopt the position that osteopathic physicians acting as medical directors, expert witnesses, or peer reviewers, and affecting patient treatment, outcome of care and access to care, are practicing osteopathic medicine; and, be it further

RESOLVED, that the AOA pursue this clarification of defining osteopathic medicine through regulation or legislation and would require that only peers will be in the position to determine action (if necessary) to be taken. 1999; *(referred in 2004)*

PHARMACEUTICAL PACKAGING/ ENVIRONMENTAL RESPONSIBILITY

WHEREAS, the general public is becoming much more environmentally concerned; and

WHEREAS, it is obvious to the members of the American Osteopathic Association that packaging of samples and promotional products by the pharmaceutical companies is often superfluous and unnecessary; and

WHEREAS, the unnecessary packaging is a source of expense for both the cost of production and disposal that is ultimately borne by the general public; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports environmentally responsible packaging of samples. 1991, *reaffirmed* 1994, 1999; *revised* 2004

PHARMACEUTICALS--SUPPORT EFFORTS TO ENCOURAGE THE PROPER DISPOSAL OF UNUSED AND EXPIRED

WHEREAS, pharmaceuticals can be an accidental health threat, illegally diverted, or used by others; and

WHEREAS, the United States has experienced an increase in prescription narcotic drug overdoses; and

WHEREAS, deaths from narcotic prescription drugs have surpassed those from illegal drugs in many states; and

WHEREAS, pharmaceuticals can contaminate the environment, damage sewage treatment plants or septic systems; now, therefore, be it

RESOLVED, that the AOA work with the appropriate regulatory/environmental and public health agencies to encourage the development of educational materials for the public on the dangers of keeping unused and expired pharmaceuticals in their possession; and, be it further

RESOLVED, that such materials also include education on the proper disposal of unused and expired pharmaceuticals. 2004

PHARMACIES/PHARMACEUTICAL COMPANIES PARTNERSHIP

WHEREAS, pharmaceutical companies may enter into agreements with pharmacy chains to conduct disease care management programs, now, therefore, be it

RESOLVED, that the American Osteopathic Association opposes any expansion in the scope of practice for pharmacists or pharmacy chains as a result of these agreements; and, be it further

RESOLVED, that the AOA work to ensure that the physician-patient relationship is protected. 1999; *revised* 2004

PHYSICAL FITNESS AND SPORTS

WHEREAS, the lack of physical fitness among Americans contributes to a decline of human and financial resources; and

WHEREAS, substantial evidence supports the belief that serious, chronic health problems, such as cardiorespiratory and lower back disabilities, begin in childhood and adolescence; and

WHEREAS, studies show that a relationship exists between quality physical education of children and the physical activity habits of adults; and

WHEREAS, lifetime physical activity is learned individual behavior; and

WHEREAS, the American Osteopathic Association and President's Council on Physical Fitness and Sports defines physical fitness as the ability to carry out daily tasks with vigor and awareness, without undue fatigue and with ample energy to enjoy leisure time pursuits and to meet emergencies; physical fitness is essential for safe and effective performance in physical activity, such as household chores, work, physical recreation, sports, and in improved health and intellectual performance; now, therefore, be it

RESOLVED, that the American Osteopathic Association joins with the President's Council on Physical Fitness and Sports to strongly urge all school districts to provide daily physical education and structured physical activity for all children for grades K-12, and in addition, the AOA and the President's Council on Physical Fitness and Sports recommends that schools emphasize the following areas:

1. Every pupil should be evaluated for physical fitness at least twice a year;
2. Every pupil should have a visual posture check, body composition screening assessment and routine vision and hearing screening with appropriate follow-up;
3. Pupils found not to be physically fit should be given appropriate attention;
4. Disabled students should be included in all appropriate physical activities.

1991; *revised* 1996, 2001

PHYSICAL FITNESS PROGRAM

WHEREAS, multiple studies have been performed by professional research teams demonstrating the positive effects of preventive physical fitness programs; and

WHEREAS, the osteopathic profession has always, on a philosophical and practical basis, provided osteopathic healthcare on the premise of prevention-fitness as a part of its comprehensive approach; and

WHEREAS, the osteopathic profession realizes the importance of neuromusculoskeletal systems as the primary systems through which we can promote positive fitness levels; and

WHEREAS, the increased fitness levels which are derived through the proper use of the neuromusculoskeletal systems, through fitness, can also provide major visceral effects which yield positive general body homeostasis; now, therefore, be it

RESOLVED, that the American Osteopathic Association believes that preventing and decreasing chronic disease can be accomplished through sound physical fitness programs which are performed on a regular basis, by responsible patients in cooperation with their osteopathic physicians; and, be it further

RESOLVED, that the AOA work to encourage school systems to implement regular mandatory physical education programs through all grade levels. 1981; *reaffirmed* 1986; *revised* 1991, 1992; *reaffirmed* 1997, revised 2002

PHYSICIAN ADMINISTERED OMT

WHEREAS, the Physician's Current Procedural Terminology (CPT) book includes code numbers and descriptions for osteopathic manipulative treatment (OMT); and

WHEREAS, the OMT CPT codes in the book specifically state physician applied; and

WHEREAS, the term physician should be limited to doctors of osteopathic medicine (DO) and doctors of allopathic medicine (MD); now, therefore, be it

RESOLVED, that the American Osteopathic Association actively oppose the use of Osteopathic Manipulative Treatment (OMT)/ Current Procedural Terminology (CPT) codes by groups other than fully-licensed osteopathic and allopathic physicians and that the AOA work diligently to reverse such policies, wherever they exist, that allow non-physicians to utilize OMT/CPT codes for reimbursement.. 1994; *revised* 1999, 2004

PHYSICIAN ASSISTED SUICIDE--AOA POSITION

WHEREAS, government and courts are seriously discussing physician assisted suicide and considering legislation to establish policy on this issue; and

WHEREAS, state legislators and courts are seriously considering laws to allow physician assisted suicide; and

WHEREAS, physician assisted suicide is unnecessary as terminally and chronically ill patients can be treated with palliative and drug therapy to relieve pain and suffering and improve their quality of life; and

WHEREAS, the osteopathic physician oath states, it is their responsibility to preserve health and life of their patients and further, they will give no deadly drugs to any though it may be asked; now, therefore, be it

RESOLVED, that the American Osteopathic Association provide information on the care of the terminally ill to physicians and the public; and, be it further

RESOLVED, that the AOA provide osteopathic physicians with continuing medical education on palliative and drug therapy utilized to provide patients with an improved quality of life; and, be it further

RESOLVED, that the osteopathic medical colleges consider including in their curriculum, a specific course of study on pain management and palliative treatment of the

terminally and chronically ill, specifically addressing the goals, objectives and value of hospice care; and, be it further

RESOLVED, that continuing medical education programs include information and resources for physicians on supportive care valuable to their patients, including, but not limited to hospice care; and, be it further

RESOLVED, that the osteopathic profession take a leadership role in providing the public information on the alternatives to physician assisted suicide and the potential abuse of this kind of public policy, both morally and economically; and, be it further

RESOLVED, that the AOA oppose legislation to legalize or mandate physician assisted suicide. 1997; reaffirmed 2002

PHYSICIAN COMPETENCY RETESTING

WHEREAS, efforts are being made at a number of levels to encourage retesting of the competency of physician in practice; and

WHEREAS, several states have proposed mandatory testing as a condition of re-licensure; now, therefore, be it

RESOLVED, that the American Osteopathic Association opposes any attempt by federal or state agencies to mandate re-certification or retesting, either as a condition of re-licensure, or as a requirement for receiving payment under a health benefits program; and be it further

RESOLVED, that the AOA will continue its voluntary efforts to address this issue of professional competency through the education of osteopathic physicians in their established core competencies. 1988; *reaffirmed* 1993; *revised* 1998, 2003

PHYSICIAN DEFINITION

WHEREAS, certain sections of Titles 18 and 19 of the United States Code include in the definition of the term physician, providers other than complete physicians (DO or MD); and

WHEREAS, the continued expansion of the term physician has resulted in confusion on the part of the general public as to what services particular practitioners are qualified to provide; now, therefore, be it

RESOLVED, that the American Osteopathic Association, endorses the position that only fully trained and licensed DOs and MDs be identified as physicians. 1984; *revised* 1987, 1988, 1993; *reaffirmed* 1998, 2003

PHYSICIAN FEES AND CHARGES

WHEREAS, the American Osteopathic Association's Divisional Societies occasionally receive complaints from patients concerning the assessment of copy charges, charges for missed appointments and similar matters; and

WHEREAS, complaints which involve osteopathic physicians are sometimes referred to osteopathic societies by state and local medical associations; and

WHEREAS, it is difficult to mediate complaints without an established policy in order to assist both the physician and the patient; now, therefore, be it

RESOLVED, that the following policy on *Physician Fees and Charges* be approved:

PHYSICIAN FEES AND CHARGES

1. Physician's Fees

A physician's fees should be directly and solely based on the medical services provided to the patient, with due respect for:

a. The difficulty and/or uniqueness of the services;
b. The time, skill, and experience required;
c. Customary fees charged for the same service in the same community;
d. Overhead and professional liability costs.

2. Excessive Fees

A physician should not collect excessive fees.

3. Reduced Fees

A physician has the right to offer his/her services at a reduced fee, or without fee, when hardships exist or professional courtesy dictates, if he/she desires to do so.

4. Specialty Designation

A fee should not be dependent upon a physician's specialty designation but upon the services provided. Any physician who provides a service for which he/she is properly trained has the right to charge the prevailing rate for such service, whether the service is performed by a family physician, a surgeon, an internist, or any other specialist.

5. Contingency Fees

A physician's fees should be based directly on professional services rendered and not contingent on uncertain outcome. It is, therefore, deemed unethical for a physician to charge contingency fees.

6. Division of Fees

Group practices and partnerships may ethically divide income based on service, contribution to the group, and/or contractual obligations.

7. Fee Splitting

No physician may ethically split a fee to, or accept a fee from, another physician solely for the referral of a patient nor shall a physician accept payments from a hospital, clinic, laboratory, or other healthcare facility based upon patient referrals to that establishment. Surgeons may ethically engage other physicians to assist in the performance of a surgical procedure; however, the financial arrangements should be made known to the patient. This principle applies whether or not the assisting physician is the referring physician.

8. Referrals to Suppliers

Physicians shall not accept payment of any kind from any source such as a hospital, clinic, laboratory, pharmaceutical company, device manufacturer, pharmacist or other healthcare provider or supplier, for referring patients to said facility or prescribing such entity's products. All referrals and prescriptions must be based on the patient's needs and sound medical decision-making, all in the patient's best interest.

9. Form Completion Charges

A physician may make a clerical charge for completion of complex insurance forms.

10. Copying Charges

A physician may charge the prevailing rate for the copying of patient records and postage incurred in mailing.

11. Missed Appointments

A physician may ethically charge for missed appointments, or appointments cancelled less than 24 hours in advance, provided:

a. The patient has been previously notified in writing of the policy;

b. Utmost consideration is given to the patient, including the circumstances involved;

c. The practice is resorted to infrequently;

d. The physician's patient load is considered.

12. Delinquent Accounts

Harsh or grossly commercialized collection practices are discouraged. If a physician has experienced problems dealing with patients who have delinquent accounts, he/she may properly request payment for service at the time of treatment, or may add interest or other late-payment charges in accordance with state and federal laws. The patient must be notified of such a policy in advance by one or more of the following:

a. Posting a notice in the waiting room;

b. Distribution of patient handbooks containing the policy;

c. Notification by special letter;

d. Notation of the policy on the billing statement before the charge is incurred.

The American Osteopathic Association encourages physicians to make exceptions to implementing these collection charges in case of financial hardship, after consultation with the involved patient.

The exception to waiving collection charges is the patient who receives payment for medical services from his/her insurance company, and then fails to make payment to the physician. In this case, all legal pressure may be brought to bear on the patient and the insurance company in order to discourage this practice, both by the insurance company and by the patient.

13. Legal Restrictions

The foregoing statements are subject to any restrictions imposed by any state and federal laws or contractual obligations. 1998, *reaffirmed* 2003

PHYSICIAN HEALTH ASSISTANCE

WHEREAS, a primary responsibility of the osteopathic profession is to assure competent care to patients by physicians; and

WHEREAS, this responsibility might occasionally be jeopardized by physicians who are impaired by psychiatric disorders, substance abuse (including alcoholism and drug dependence) and other incapacitating physical, mental and behavioral problems; and

WHEREAS, the osteopathic profession has an obligation to share in the responsibility to treat and rehabilitate the affected physician so that he can be restored to a useful and productive life; and

WHEREAS, frequently the affected physician is unable or unwilling to seek help; and

WHEREAS, it is essential that physicians recognize their ethical and social responsibility to assist their affected colleague; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports continued assistance in the rehabilitation of the affected osteopathic physicians through its Committee on Physician Health. 1973; *reaffirmed* 1978; *revised* 1983, 1988, 1993, 1998, 2003

PHYSICIAN INCENTIVES, TO UNDERSERVED AREAS

WHEREAS, medicine continues to experience more non-physician providers delivering health care; and

WHEREAS, one reason given is to provide health care to underserved areas; and

WHEREAS, all U. S. citizens should have access to quality medical care by a physician; and

WHEREAS, areas are frequently underserved because of the debt physicians have on completing their medical education and training programs; and

WHEREAS, debt requires they locate in the most lucrative areas in order to repay student loans; now, therefore, be it

RESOLVED, that the American Osteopathic Association focus attention on potential legislation to increase physician loan repayment programs and tax deductions or tax credits when initiating a practice in underserved areas to assist and assure an adequate supply of physicians in the future. 2005

PHYSICIAN NEGOTIATION RIGHTS

WHEREAS, the McCarran-Ferguson Act of 1945 provides insurance organizations with an exemption from federal anti-trust statutes; and

WHEREAS, non-employed physicians are prohibited from collectively bargaining with insurance entities; and

WHEREAS, the intent of the McCarran-Ferguson Act was to promote competitive market behavior; and

WHEREAS, the finance of the McCarran-Ferguson Act did not envision this imbalance in negotiating positions that would occur 55 years after the passage of the act; and

WHEREAS, the market leverage currently enjoyed by health insurance organizations is detrimental to physicians and the patients they serve; now, therefore, be it

RESOLVED, that the American Osteopathic Association aggressively pursue legislation to allow physicians to collectively bargain with third-party payers thereby promoting the spirit of competition by creating an equitable basis for negotiations between these parties. 2001

PHYSICIAN OFFICE LABORATORIES

WHEREAS, a primary concern of osteopathic physicians is high quality medical care for all Americans; now, therefore, be it

RESOLVED, that the American Osteopathic Association work to ensure that physician office laboratory certification be as non-intrusive into the practice of medicine as possible; and, be it further

RESOLVED, that the American Osteopathic Association supports the development and expansion of Waived Physician Office Laboratory testing; and, be it further

RESOLVED, that the American Osteopathic Association oppose unannounced inspections of any Physician Office Laboratory, whether it be waived, moderately complex, or complex as these inspections place an undue burden on the laboratory, the physician's office staff, and the physicians, which could result in compromised patient safety; and, be it further

RESOLVED, that the AOA seek assurances that access to any laboratory tests deemed medically necessary by the physician, not be limited by unnecessary regulations. 1990; *revised* 1995, 2000, 2005

PHYSICIAN PROFILES

WHEREAS, physician profiles serve as a reservoir of physician practice information and can include a variety of information including, but not limited to, a physician's practice location, medical education, postgraduate training, board certification, license status, disciplinary information, criminal conviction history, and medical malpractice history; and

WHEREAS, historically information contained in physician profiles was used solely by licensing, disciplining, and employing authorities to screen and evaluate individual physicians; and

WHEREAS, consumer groups have advocated for the release of physician profiles to assist the public in choosing a physician; and

WHEREAS, the release of some information in physician profiles, such as malpractice and criminal histories, is inherently prejudicial, easily misinterpreted, and potentially damaging to a physician's practice; and

WHEREAS, any physician profile information released to the public should take into account the interests of the public in having access to information so that they can safely choose a physician and at the same time, the ability of the general public to appropriately interpret the information within physician profiles; and

WHEREAS, releasing physician profiles to the public is potentially subject to accuracy problems and could be very detrimental to a physician's practice; and

WHEREAS, state medical or osteopathic boards have traditionally licensed, regulated, and disciplined physicians practicing within their states and, therefore, are logically in the appropriate position to release physician profile information to the public; and

WHEREAS, compiling, maintaining, and releasing physician profile information to the public entails a substantial expense which should not be born solely by the source releasing the information; now, therefore, be it

RESOLVED, that it is the American Osteopathic Association's position that state medical or osteopathic boards, as the licensing and regulatory authorities for physicians, are the appropriate entities to collect, maintain, and disseminate physician profile information to the public; and, be it further

RESOLVED, that the AOA support the position that any legislation or regulations which mandate the release of physician profile information provide funding for the creation and maintenance of the profiling system without added expense to the physician; and, be it further

RESOLVED, that the AOA support the position that only physician profiles that incorporate all of the following five principles should be released to the public: fairness, relevancy, timeliness, accuracy, and reliability; and, be it further

RESOLVED, that the AOA oppose the inclusion of medical malpractice histories within physician profiles due to their susceptibility to misinterpretation and inherently prejudicial effect; and, be it further

RESOLVED, that the AOA support the position that before physician profiles are released to the public, every physician has the opportunity to verify the accuracy of the information and to contest any incorrect information before it is disseminated to the public; and, be it further

RESOLVED, that the AOA believes that the state licensing boards must include an appeal mechanism in their regulations that a physician may pursue if any information in his or her profile is inaccurate, and institute appropriate corrections. 2001

PHYSICIAN REIMBURSEMENT IN FEDERAL PROGRAMS

WHEREAS, some states appear to be moving toward the implementation of managed care and/or a capitation reimbursement system for physician services in Medicaid; and

WHEREAS, such systems pose a potentially grave threat to osteopathic physicians through arbitrary and/or discriminatory exclusion from the delivery of care; and

WHEREAS, the osteopathic profession is committed to the containment of medical care costs, provided that the overall concern be for providing quality healthcare to the American public; now, therefore be it

RESOLVED, that the American Osteopathic Association recommends that educational programs for osteopathic medical students, interns, residents and practicing physicians should include utilization management and cost-effectiveness in the curricula; and, be it further

RESOLVED, that the osteopathic staff members of healthcare institutions should continue to improve utilization review programs for all patients, consistent with quality assurance and sound osteopathic medical practice; and, be it further

RESOLVED, that if states adopt managed care for capitated reimbursement systems for Medicaid, that they contain a provision to ensure the fullest participation of all physicians, ensuring best patient care and adequate compensation to all parties concerned, while preserving referral patterns as established by the osteopathic profession. 1986; *revised* 1991, 1992, 1997; reaffirmed 2002

PLASTIC BEVERAGE AND FOOD CONTAINER RECYCLING ACT

RESOLVED, that the American Osteopathic Association supports conservational recycling. 1990, *revised* 1995; *reaffirmed* 2000 (*to be reviewed 2006*)

POSTGRADUATE COMPENSATION

WHEREAS, hospitals with medical education programs often receive variable payments from Medicare on a per-resident basis; now, therefore, be it

RESOLVED, that the American Osteopathic Association affirms its support for maintaining and enhancing the quality of teaching programs, and urges Congress to provide more equitable graduate medical education funding so hospitals and other healthcare delivery systems can provide competitive compensation for postgraduate training.

1990; *revised* 1995; *reaffirmed* 2000, *revised* 2005

POSTPARTUM DEPRESSION

WHEREAS, ten percent of new mothers suffer from postpartum depression (PPD); and

WHEREAS, PPD affects women of all ages, economic status, and racial/ethnic backgrounds; and

WHEREAS, any woman who is pregnant, had a baby within the past few months, miscarried, or recently weaned a child from breastfeeding can develop PPD; and

WHEREAS, the number of children a woman has does not change her chances of getting PPD, with new mothers and women with more than one child having equal chances of getting PPD; and

WHEREAS, research has shown that women who have had problems with depression are more at risk for PPD than women who have not had a history of depression; and

WHEREAS, physicians need to be better educated on the signs and symptoms of PPD; now, therefore, be it

RESOLVED, that the American Osteopathic Association encourage its members to participate in continuing medical education programs on postpartum depression (PPD); and, be it further

RESOLVED, that the AOA urge the state and specialty associations to offer CME on PPD as part of their educational offerings; and, be it further

RESOLVED, that the AOA develop a speakers bureau on this subject which can be added to the AOA Speakers Bureau publication; and, be it further

RESOLVED, that the AOA endorse the use of screening tools and encourage the measurement of outcomes in their use; and, be it further

RESOLVED, that the AOA, through DO Online, link to organizations whose mission is to educate patients and physicians on PPD. 2003

PRACTICE RIGHTS OF OSTEOPATHIC PHYSICIANS

WHEREAS, many governmental agencies and health insurance agencies are significantly increasing their civil and criminal fraud and abuse monitoring efforts; and

WHEREAS, many government agencies and health insurance agencies are utilizing coding, billing and documentation guidelines which are vague and ambiguous; and

WHEREAS, many osteopathic physicians' practice rights and practice security are being threatened by enforcement attempts, with little or no osteopathic peer review or oversight; now, therefore, be it

RESOLVED, that the American Osteopathic Association and its component societies be encouraged to promote unity and the practice rights of osteopathic physicians, by establishing a specific Practice Rights agenda and support the development of seminars or other vehicles to carry out the following objectives:

1. Educate physicians as to the importance of compliance, risk management, at risk agreements with managed care, billing and coding, documentation, and fraud and abuse issues.
2. Assist in the establishment of guidelines to enhance these practice rights and safety in the areas of compliance, risk management, billing and coding documentation, and in fraud and abuse issues.
3. Identify supportive agencies, liability companies, and physicians with expertise in these issues.
4. Encourage government and insurance agencies to utilize only expert witnesses who are osteopathic physicians in peer review, fraud and abuse, civil and criminal cases involving osteopathic physicians and boards with “like osteopathic specialty”.
5. Develop and advise the leadership and state societies of the needs, trends, and issues of concern which will encourage unity, and enhance the practice rights of our fellow physicians; and, be it further

RESOLVED, that the AOA take steps to address the above listed issues at the national level. 1999; *revised* 2004

PRE-AUTHORIZED MEDICAL/SURGICAL SERVICES -- DENIAL OF PAYMENT OF

WHEREAS, many healthcare insurers require pre-authorization for some services and procedures performed by physicians in providing quality healthcare to patients; and

WHEREAS, exorbitant amounts of time and expense are wasted in obtaining pre-authorization from healthcare insurers for providing quality healthcare services to patients; and

WHEREAS, despite pre-authorization confirmation by a clerk, nurse, or other entity employed by the health insuring company, there is no guarantee for payment for the medical services or procedure in question; and

WHEREAS, in many instances, letters are sent out to physicians and sometimes even to patients by insurers indicating that the medical service or procedure requested has been approved but payment for said service is not guaranteed and subject to review; and

WHEREAS, such activities by healthcare insurers are unnecessarily cumbersome, needlessly interfering with the ability to provide quality medical care and most confusing to patients and healthcare subscribers; now, therefore, be it

RESOLVED, that the American Osteopathic Association support legislation that would prohibit any healthcare insurer from retrospectively denying payment for any medical or surgical service or procedure that has already been pre-authorized by such health insurer; and, furthermore, any such letters by health insurers to physicians and patients indicating that the medical services/procedures that have been pre-authorized may not necessarily be compensated for should cease and desist. 1997; revised 2002

PRESCRIPTION DRUGS—DIRECT CONSUMER ADVERTISING

WHEREAS, the cost of prescription medicines are a leading cause of increasing health care costs and insurance in the United States; and

WHEREAS, pharmaceutical companies direct consumer advertising is a multibillion dollar a year industry; and

WHEREAS, advertising prescription medicines to the general public increases the overall marketing costs to pharmaceutical companies; and

WHEREAS, advertising prescription medicines may not be the most appropriate or cost effective way to inform patients about their health care; and

WHEREAS, prescription medicines may only be prescribed by osteopathic physicians and other licensed practitioners; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) adopt policies to recommend pharmaceutical company direct to consumer advertising not be product specific; and, be it further

RESOLVED, that the AOA request that state and federal governments adopt policies or legislation to promote disease-specific public health education as the focus of direct to consumer advertising of prescription medicines to the general public. 2001; *revised* 2003, 2005

PRESCRIPTION DRUG SAMPLES

WHEREAS, the practice of making sample prescription drugs conveniently available to the practicing physician has very significant medical and social value; and

WHEREAS, the incidence of diversion of sample drugs from pharmaceutical manufacturers is relatively insignificant; and

WHEREAS, such illegal diversion can be effectively deterred by appropriately severe criminal penalties and national record-keeping requirements; and

WHEREAS, any requirements for prior written request for sample drugs by physicians could effectively preclude sampling; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the development of effective record-keeping requirements by the pharmaceutical manufacturers for distribution to physicians of prescription drug samples; and, be it further

RESOLVED, that the AOA supports the enactment of appropriate criminal penalties for those who illegally divert such samples; and, be it further

RESOLVED, that the AOA opposes any legislation which intends to restrict drug sampling by the physician; and, be it further

RESOLVED, that the AOA encourages pharmaceutical manufacturing companies to continue the effective practice of drug sampling. 1994; *revised* 1997, 2002

PRESCRIPTION OF DRUGS FOR OFF LABEL USES

WHEREAS, the predoctoral education of all physicians includes training in pharmacology, and this educational process continues throughout the years of a physician's practice; and

WHEREAS, there may be compelling circumstances when it serves the health interests of patients, for physicians to prescribe appropriate drugs; and

WHEREAS, medical indications for the usage of certain prescription drugs may be narrow in scope, due to the intricate federal drug approval process; and

WHEREAS, patient access to needed drugs might be hindered due to these limited label indications; now, therefore, be it

RESOLVED, that the American Osteopathic Association believes it is appropriate for physicians to prescribe approved drugs for uses not included in their official labeling when they can be supported as accepted medical practice. 1995; *reaffirmed* 2000, 2005

PRESCRIPTION MEDICATIONS—OVERRIDES FOR

WHEREAS, physicians and their patients know which medications work best for the patient; and

WHEREAS, many insurance providers have a restricted formulary which may change based on rebates from manufacturers; and

WHEREAS, many of these plans require the physician to request an approval for maintenance and time-consuming; and

WHEREAS, insurance companies have made this process excessively time-consuming; and

WHEREAS, it is detrimental to quality patient care to keep changing medications; now, therefore, be it

RESOLVED, that the American Osteopathic Association support legislative efforts to:

1) decrease the hold time for physicians and staff for requesting approval from insurance pharmacy plans,
2) require insurance pharmacy plans to allow patients to continue receiving the medications for which they are prescribed and are in good control.
3) make it easier for a physician to request an approval. 2005

PRESCRIPTION PLANS-- RESTRICTIVE

WHEREAS, patients are increasingly relying on insurance plans and managed care plans that have prescription drug programs to obtain necessary, prescribed medications; and

WHEREAS, the rapidly increasing prices of many pharmaceuticals effectively prevent their use without the assistance of these plans; and

WHEREAS, patients and their employers, when purchasing such insurance, spend substantial premiums to include these drug plans in their benefit packages; and

WHEREAS, insurance companies and managed care organizations market these prescription plans to their customers without emphasizing their restrictions and limitations; and

WHEREAS, patients and their physicians often find out about the restrictive nature of the prescription plans only after attempting to fill a needed, prescribed medication; now, therefore, be it

RESOLVED, that the American Osteopathic Association, through its Division of State Government Affairs, urge state legislatures to pass laws that would:

1. Mandate that insurance companies and managed care organizations use the term limited prescription plan, limited paid prescription plan, or similar terminology, in their marketing of such products to their customers, unless such plans pay for all prescription pharmaceuticals currently recognized by the FDA as safe and effective; and
2. Require truth in advertising and prohibit insurance companies and managed care organizations marketing such plans from restricting their reimbursement for pharmaceuticals to formularies or other devices intended to limit patient and physician choice to a narrow list of approved medications; and
3. Prohibit these companies from mandating the use of generic drugs to the exclusion of proprietary pharmaceuticals. 1998, *revised* 2003

PRIMARY CARE PHYSICIANS--TRAINING REAFFIRMATION

WHEREAS, for more than a century of public service, the osteopathic profession has merited deserved recognition for its tradition of training primary care physicians; and

WHEREAS, the proportions of primary care physicians to those in other specialties are decreasing in the face of an urgent need for primary care physicians particularly in inner cities and rural areas; and

WHEREAS, studies reveal an ever widening need for primary care in many sectors of the nation; now, therefore, be it

RESOLVED, that the American Osteopathic Association reaffirm its commitment to train competent and compassionate primary care physicians to meet projected national needs. 1992; *reaffirmed* 1997; revised 2002

PROFESSIONAL ASSOCIATION BY DOs

WHEREAS, it is the policy of the American Osteopathic Association to encourage loyalty and unity within the osteopathic profession; and

WHEREAS, that policy is best served by membership in the AOA, its divisional societies, and organizations outside of the osteopathic profession whenever such membership is necessary to the member's professional development; now, therefore, be it

RESOLVED, that in order to maintain the essential role of the osteopathic profession as an independent scientific school of medicine and to prevent the extinction of the osteopathic profession by direct attack or absorption, osteopathic physicians should support and sustain their

profession by maintaining active membership in the American Osteopathic Association and other affiliated associations; and, be it further

RESOLVED, that it is not the policy of the AOA to directly or indirectly restrict or restrain any individual member's freedom of choice with respect to professional associations.

1979; *reaffirmed* 1984; *revised* 1989; *reaffirmed* 1995; *revised* 2000, 2005

PROFESSIONAL LIABILITY INSURANCE REFORM

WHEREAS, physicians throughout the United States must have sufficient professional liability insurance and/or coverage; and

WHEREAS, in litigation, courts have been awarding ever increasing monetary judgments; and

WHEREAS, all of the above conditions are causing an increase in healthcare cost; now, therefore, be it

RESOLVED, that the American Osteopathic Association continues support of professional liability insurance reform that includes the following six principles:

1. Limitations on non-economic damages
    a. including provisions that afford states the opportunity to maintain or establish laws governing limitations on non-economic damages;
2. Periodic payment of future expenses or losses;
3. Offsets for collateral sources;
4. Joint and several liability reform;
5. Limitations on attorney contingency fees; and
6. Establishment of uniform statutes of limitations. 1985; *revised* 1990, 1993, 1998, 2003

PROFESSIONAL LIABILITY REFORM

WHEREAS, the current medical liability crisis continues to have a significant negative impact upon the health care delivery system and continues to reduce patient access to quality health care; and

WHEREAS, osteopathic physicians across the nation continue to face difficulties in securing affordable professional liability insurance coverage; and

WHEREAS, osteopathic physicians are forced to limit the services they offer their patients, relocate their practices, or retire as a result of unavailable and unaffordable professional liability insurance; and

WHEREAS, the AOA has made professional liability insurance reform its top legislative priority at both the Federal and state levels; and

WHEREAS, over the past three years the AOA Council on Federal Health Programs and the Bureau of State Government Affairs has implemented comprehensive strategies aimed at achieving the enactment of comprehensive professional liability insurance reforms; now, therefore, be it

RESOLVED, that the American Osteopathic Association reaffirm professional liability insurance reform as its top legislative priority at both the Federal and state levels; and, be it further

RESOLVED, that the AOA implement programs to increase the involvement of its members and the patients they serve in this effort; and, be it further

RESOLVED that, the AOA continue to devote significant personnel and financial resources to achieve the enactment of professional liability insurance reforms adopted and ratified by this House of Delegates; and, be it further

RESOLVED, that the AOA approve a $150,000 special allocation to fund patient-focused grassroots activities, participate in national and local media campaigns, and produce advocacy materials for AOA members, specialty colleges, and other affiliated groups.

Explanatory Statement: This policy will allow the AOA to continue pursuing the enactment of comprehensive reforms at both the Federal and state level by providing resources to establish a patient advocacy website, participate in advertising campaigns, and participate in other activities throughout the year.

Patient Advocacy Website

Lawmakers continue to urge the AOA to involve our patients in this effort. While we have attempted to do this through informing our members and providing information for dissemination to their patients, this is simply not enough. We propose the establishment of a patient advocacy website, which allows our patients to utilize a central resource to express their support for our legislative priorities. The website will be named according to its mission and will allow the AOA and its members to include our patients in the professional liability insurance reform debate, as well as future issues. The cost of establishing this website is approximately $20,000. Annual maintenance fees will be approximately $6,000 to $8,000.

Advertising Campaigns

One of the most effective manners of conveying a position is through purchased advertisements. Over the past two years the AOA has run ads in Waco, TX, Las Vegas, NV, and several in Washington urging lawmakers to support PLI reforms. We have received numerous compliments from our friends for these efforts. Additionally, these advertisements raise the profile of the AOA and solidify our presence as a "player" in this and other debates. We request $120,000 over the next year to continue this activity. $50,000 of this will be contributed to a physician consortium, including the American Medical Association, the American College of Surgeons, and the American Association of Neurological Surgeons. The consortium has developed radio and television advertisements that can be personalized for each participating organization and run in targeted states. The remaining $70,000 will enable the AOA to run print advertisements in local and national newspapers, magazines, and other publications and/or participate in advertising campaigns with other physician groups.

Advocacy Materials for Osteopathic Physicians

In an effort to increase the involvement of our members we request $10,000 to produce advocacy materials for our members. These materials will inform our members and their patients of the new website as well as provide them with display materials for their offices. 2003

PROFESSIONAL ORGANIZATION—PHYSICIANS CHOOSING TO WHICH THEY BELONG

WHEREAS, some employers pay professional association dues as a part of the employment benefits for their physician employees; and

WHEREAS, in many cases the employer chooses to pay the dues for the physician in the allopathic medical associations and does not give the physician their choice of medical associations; and

WHEREAS, many osteopathic physicians would prefer to belong to an osteopathic medical associations instead of an allopathic medical association; and

WHEREAS, in essence this is requiring the physician to belong to an association against their choice as a condition of their employment; and

WHEREAS, these osteopathic physicians wish to have their employer pay dues to their osteopathic medical association in the same way as that of their allopathic colleagues; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) supports all physicians having the right to choose which medical associations they join, even when the employer is paying the membership fees; and, be it further

RESOLVED, that the AOA provide the physician with a letter template stating their desire to have dues paid to an osteopathic medical association. 2005

PROVIDER--USE OF TERM TO DESCRIBE PHYSICIANS

WHEREAS, physicians undergo an extended period of education and training; and

WHEREAS, physicians pursue continuing medical education throughout their careers to remain current in their profession; and

WHEREAS, the relationship between physicians and their patients is central to the delivery of healthcare; and

WHEREAS, healthcare insurers and systems, hospitals, government entities and others involved in, but peripheral to, the patient-physician relationship, indiscriminately use the term "provider" as an all inclusive label in contracts, insuring agreements, print and media advertising, signage, rules, regulations and policies; and

WHEREAS, the term "provider" is not appropriate to physicians, and is a label which wrongly and unfairly diminishes the professional stature of physicians, and ultimately undermines the patient-physician relationship; and

WHEREAS, the use of the term "provider" to describe physicians erodes trust between physicians and those organizations which employ the term because of the disrespect it connotes, and

WHEREAS, the use of the term "provider" further blurs the distinction between physicians and non-physician healthcare providers; now, therefore, be it

RESOLVED, that the American Osteopathic Association discourages the use of the term "provider" to describe its members, and urges any organization which employs the term to describe physicians by their proper, professional titles of either, "physician" or "doctor". 1999; *revised* 2004

PUBLIC HEALTH SERVICE, AOA SUPPORT

WHEREAS, the United States Public Health Service Commissioned Corps is one of the uniformed services of the United States; and

WHEREAS, the Commissioned Corps supplies medical personnel, including osteopathic physicians, for agencies providing comprehensive health services; and

WHEREAS, the Commissioned Corps is a mobile force designed to rapidly provide personnel to deal with a wide range of medical emergencies, including natural disasters and rapid examination of refugees; now, therefore, be it

RESOLVED, that the American Osteopathic Association recognizes the contribution of the PHS Commissioned Corps to the healthcare of the United States; and, be it further

RESOLVED, that the AOA supports the continued existence of the United States Public Health Service Commissioned Corps. 1981; *revised* 1986; *reaffirmed* 1991, 1992, 1997, 2002

REPRODUCTIVE ISSUES -- COUNSELING FEMALE PATIENTS ON

WHEREAS, osteopathic physicians have traditionally provided a large percentage of primary medical care in the United States; and

WHEREAS, osteopathic physicians strive to present their patients with the most knowledgeable, conscientious and confidential personal health advice available; and

WHEREAS, osteopathic physicians are frequently asked questions about controversial aspects of reproductive issues; and

WHEREAS, recent legislation and courtroom decisions have threatened to limit the osteopathic physician's ability to counsel their patients on reproductive issues; now, therefore, be it

RESOLVED, that the American Osteopathic Association take whatever actions are necessary to ensure that osteopathic physicians can continue to offer their patients complete, objective, informed advice in a confidential manner on all aspects of reproductive issues. 1992; *reaffirmed* 1997; revised 2002

RESIDENCY TRAINING SLOTS

WHEREAS, the Medicare Balanced Budget Act of 1997 has severely restricted Medicare funding for graduate medical education; and

WHEREAS, the emphasis of much patient care has changed from an inpatient to an outpatient setting; and

WHEREAS, managed care organizations are gaining market share as a system of healthcare for patients and HMOs are one type of managed care delivery system requiring licensure in the states; and

WHEREAS, graduate medical education trains physicians in a variety of patient care settings while providing access to high quality care to patients and their communities; now, therefore, be it

RESOLVED, that HMOs be encouraged by the appropriate state agency to provide funding for GME training programs; and, be it further

RESOLVED, that state societies be encouraged to introduce and support the enactment of the Physician Education Advancing Community Health (PEACH) program model legislation developed by the Bureau of State Government Affairs to effect changes in funding GME training programs. 1999; *revised* 2004

RURAL HEALTHCARE PAYMENT EQUITY

WHEREAS, the osteopathic profession traditionally has been committed to serving the rural population of the United States; and

WHEREAS, there is evidence that the healthcare needs of Americans living in many rural areas often go unmet; and

WHEREAS, there are inadequate levels of reimbursement under federal and other health programs; and

WHEREAS, the gap between urban and rural payment rates for identical services has exacerbated the maldistribution of physicians in urban versus rural areas; and

WHEREAS, the urgency of improving access to quality medical care for rural Americans warrants higher payments for such care; now, therefore, be it

RESOLVED, that the American Osteopathic Association endorses equity in reimbursement for rural physicians as part of the strategy to increase the availability of quality healthcare in rural areas. 1988; *revised* 1993; *reaffirmed* 1998, 2003

RURAL HEALTH CLINICS--LOCATION AND QUALITY OF CARE

WHEREAS, the goal of providing healthcare services to people living in rural areas of the United States is admirable; and

WHEREAS, some rural areas of the United States already have physicians who provide healthcare services to the medically underserved population; and

WHEREAS, many rural health clinics (RHCs), operated by large healthcare organizations, establish their facilities adjacent to private physicians' medical facilities rather than locating in other areas devoid of medical facilities; and

WHEREAS, the quality of care provided to the medically underserved population should be the highest priority of the RHC rather than profits; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the concept that federal and state tax dollars should not be used to support rural health clinics that choose to locate within the vicinity of an established, private physician's healthcare facility rather than other sites within medically underserved areas.
1999; *revised* 2004

RURAL SITES AND UNDERSERVED/INNER CITY AREAS—OSTEOPATHIC EDUCATION

WHEREAS, the knowledge and training of osteopathic medical students is greatly enhanced by rural settings, and rural education assists in the recruitment of new physicians to rural areas; and

WHEREAS, inner city medical training is also beneficial and rewarding, and more importantly, is generally considered as an underserved area; and

WHEREAS, the AOA encourages predoctoral and postdoctoral osteopathic medical education in underserved areas, including both rural and inner-city areas; now, therefore, be it

RESOLVED, that the American Osteopathic Association encourage clinical rotations in underserved areas, including rural office/hospital settings as well as inner city office/hospital settings, by osteopathic medical students and graduates during their respective predoctoral and postdoctoral education programs. 2001

RURAL AND URBAN PRACTICES, DISPARITIES BETWEEN

WHEREAS, current physician work adjustment factors result in severe inequities between rural and urban localities under the Medicare physician fee schedule; and

WHEREAS, there are currently 43 Medicare localities which have a physician work adjuster below 1.000; and

WHEREAS, “physician work” is defined by Centers for Medicare and Medicaid Services (CMS) as the amount of time, skill, and intensity a physician puts into a patient visit, and

WHEREAS, this definition of “physician work” is not influenced by location; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports federal legislation that would establish a minimum physician work geographic cost-of-practice index value for physicians’ services of 1.000. 2002

RURAL SITES--OSTEOPATHIC EDUCATION IN

WHEREAS, some predominately rural states do not have the benefit of an osteopathic medical school and osteopathic hospital with physicians and students being trained in their state; and

WHEREAS, some states realize a shortage of physicians in rural communities; and

WHEREAS, exposure to medical practice in a rural setting would give the student and physician a broadened scope of expertise and rural awareness; and

WHEREAS, the rural exposure would assist in the recruitment of new physicians to rural areas; now, therefore, be it

RESOLVED, that the American Osteopathic Association encourage clinical rotations in rural settings by osteopathic medical students and graduates during their respective predoctoral and postdoctoral education programs.1990; *revised* 1995, 2000, 2005

SALE OF HEALTH-RELATED PRODUCTS AND DEVICES

WHEREAS, the physician-patient relationship is based on trust in the physicians and in the high ethical standards of the medical profession; and

WHEREAS, physicians must be ever mindful of their duty to honor that trust and never derive monetary gain from an abuse of the patient-physician relationship; and

WHEREAS, it is unethical for a physician to exploit the physician-patient relationship in any manner whatsoever; and

WHEREAS, the AOA expects its members to observe principles of scientific medicine in the recommendation of all health-related products or devices; now, therefore, be it

RESOLVED, that it is appropriate for physicians to derive reasonable monetary gain from the sale of health-related products or devices that are both supported by rigorous scientific testing or authoritative scientific data and, in the opinion of the physician, are medically necessary or will provide a significant health benefit; and, be it further

RESOLVED, that it is inappropriate and unethical for physicians to use their physician/patient relationship to attempt to involve any patient in a program for the patient to distribute health related products or devices in which distribution results in a profit for the physician. 1999; *revised* 2004

SCHOOL BASED HEALTH EDUCATION--PROMOTION

WHEREAS, school-based health education is an essential key in providing sound health standards for youth and a lasting guide through adolescence and maturity; and

WHEREAS, such aforementioned education is best developed through programs that meet the Centers for Disease Control and Prevention definition of comprehensive school health education; now, therefore, be it

RESOLVED, that the American Osteopathic Association continues to urge the state legislatures to enact measures establishing programs that meet with the Centers for Disease Control and Prevention definition of comprehensive school health education. 1992; *reaffirmed* 1997, *revised* 2002

SEAT BELT LAWS—PRIMARY ENFORCEMENT

WHEREAS the use of seat belts by the drivers and passengers in automobiles reduces the morbidity and mortality of those involved in accidents; and

WHEREAS, the U.S. Transportation Secretary is urging state legislatures from around the country to pass primary enforcement seat belt laws; and

WHEREAS, a National Highway Traffic Safety Administration (NHTSA) study, *Crash Outcome Data Evaluation System (CODES)*, found that the average inpatient costs for crash victims who were not using seat belts were 55 percent higher than for those who were belted; and

WHEREAS, the most recent figures indicate that 73 percent of passenger vehicle occupants who were totally ejected from the vehicle were killed, and that through the use of seat belts, only 1 percent of the occupants reported to have been using restraints were totally ejected, compared with 30 percent of unrestrained occupants; and

WHEREAS, the osteopathic philosophy places an emphasis on prevention of illness and injury; and

WHEREAS, the osteopathic profession is dedicated to health promotion for the patients it serves; now, therefore, be it

RESOLVED, that the American Osteopathic Association endorse the passage of primary enforcement seat belt laws in every state. 2005

SECOND OPINION, SURGICAL CASES

WHEREAS, state health agencies, insurance companies and the Centers For Medicare & Medicaid Services (CMS) have instituted programs to underwrite the cost of second surgical opinions for elective surgical procedures; and

WHEREAS, such entities call upon the American Osteopathic Association and its affiliated organizations for guidance in developing lists of osteopathic physicians who may participate in such programs; now, therefore, be it

RESOLVED, that members of the American Osteopathic Association who are board certified, or board eligible in the same surgical specialty and qualified by their training and experience as evidenced by their hospital privileges to render a second surgical opinion in any given case, be recognized and utilized as qualified and reimbursed by entities underwriting such opinions; and, be it further

RESOLVED, that this resolution in no way advocates the institution of any mandatory second surgical opinion programs, by any entity. 1980; *revised* 1985, 1990; *reaffirmed* 1995; *revised* 2000, 2005

SEXUAL HARASSMENT

WHEREAS, the occurrence of sexual harassment is receiving national attention with resultant protective measures initiated in many sectors; and

WHEREAS, such awareness should serve as impetus for widespread legislative and social measures to curtail sexual harassment; now, therefore, be it

RESOLVED, that the American Osteopathic Association urges the enactment of appropriate legislation to eliminate all sexual harassment in the full spectrum of life. 1992; *reaffirmed* 1997, revised 2002

SLEEP DISORDERS—PROMOTING THE UNDERSTANDING AND PREVENTION OF

WHEREAS, a significant amount of Americans suffer from sleep disorders, and millions more suffer intermittent sleep problems related to pain, stress, anxiety, depression, and other ailments; and

WHEREAS, sleep-related disorders affect members of every race, socioeconomic class and age group, the majority of which remain undiagnosed and untreated; and

WHEREAS, sleep affects mood, reaction times, alertness, memory, and motor skills and takes an enormous toll on health, safety, and productivity; and

WHEREAS, it is important that patients and physicians understand the importance of sleep and its impact on health; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) support programs that promote education and understanding of sleep and its impact on health; and be it further

RESOLVED, that the AOA encourage osteopathic physicians to educate their patients about sleep disorders, and the importance of sleep and its impact on health. 2005

SMOKING CESSATION

WHEREAS, cigarette smoking substantially increases the risk of cardiovascular disease, including ischemic heart disease, artherosclerosis, hypertension, pulmonary disease and throat and lung cancers; and

WHEREAS, smoking during pregnancy increases risk of miscarriage, stillbirth, and low weight infants; and

WHEREAS, exposure to secondhand smoke contributes to lower respiratory tract infections in infants and children, and new cases of asthma in children; and

WHEREAS, smoking may be the single most preventable cause of premature death in the United States; and

WHEREAS, the American Osteopathic Association has a policy supporting counseling patients on the health risks of smoking; now, therefore, be it

RESOLVED, that the American Osteopathic Association support third-party coverage of evidence-based approaches for the treatment of smoking cessation and nicotine withdrawal. 1998; *revised* 2003

SMOKING-TOBACCO PRODUCTS

WHEREAS, cigarette smoking has been identified as a chief preventable cause of death in our society; and

WHEREAS, smoking is a major cause of cancer, heart and lung disease; and

WHEREAS, cigarettes and other forms of tobacco are addicting; and

WHEREAS, the pharmacologic and behavioral processes that determine tobacco addiction are similar to those which determine addiction to drugs such as heroin and cocaine; and

WHEREAS, the unrestricted use of tobacco in public and the workplace sends a mixed message to the youth of this country concerning the social acceptance of smoking and drug use; and

WHEREAS, involuntary smoking from secondary smoke has shown to have detrimental effects on health; and

WHEREAS, educating the American people of the health risks associated with smoking is a vital component of the effort to prevent disease by reducing cigarette use; and

WHEREAS, tobacco use by children is associated with chronic and recurrent medical problems; and

WHEREAS, the American Osteopathic Association members, as important role models for both children and adults, should be encouraged not to smoke or use tobacco products in the presence of their patients; and

WHEREAS, men, women and children continue to smoke, despite the abundance of educational health programs focused on the life threatening circumstances of smoking; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports a comprehensive education campaign on the hazards of smoking beginning at the elementary school level; and, be it further

RESOLVED, that physicians be encouraged to inquire into tobacco use and exposure as part of both prenatal visits and every appropriate health supervision visit; and, be it further

RESOLVED, that the AOA strongly recommends that all federal and state health agencies continue to take positive action to discourage the American public from using cigarettes and other tobacco products; and, be it further

RESOLVED, that the AOA encourages its members to discuss the hazards of tobacco use with their patients; and, be it further

RESOLVED, that the AOA encourages the elimination of federal subsidies and encourages increased taxation of tobacco products at both federal and state levels; that monies from the additional taxation could be earmarked for smoking-reduction programs and research for prevention of tobacco-related diseases; that municipal, state and federal executive agencies and lawmakers enact clean-indoor air acts, a total ban on tobacco product advertising, opposes cigarette vending machines in general and supports federal legislation to limit access to cigarette machines to minors, and the elimination of free distribution of cigarettes in the United States; and that grades K -12 should be encouraged to incorporate a curricular component that has been proven effective in preventing tobacco usage in its health education curriculum; and, be it further

RESOLVED, that the AOA urges the development of anti-tobacco educational programs targeted to all members of society, with the ultimate goal of achieving a tobacco-free nation. 1990; *revised* 1995, 1997; revised 2002

SPACE STATION--INTERNATIONAL

WHEREAS, since before the dawn of the space age, members of the American Osteopathic Association, in conjunction with physicians and scientists worldwide, have participated in the explosion in the knowledge base of human physiology and medicine; and

WHEREAS, a significant amount of this knowledge and experience is the direct result of the contributions and research performed in the unique aviation and space environs; and

WHEREAS, the quantum leaps in knowledge so vital to the future improvement of the human condition can be immensely assisted by research that cannot be duplicated in earth's terrestrial environment; and

WHEREAS, the knowledge and products yielded from National Aeronautics And Space Administration’s (NASA) International Space Station, combined with the pioneering team efforts of global partners, will provide important medical and life style improvements; and

WHEREAS, the expectation of reduced international political tension and stabilizing world economies increase the possibilities for the reallocation of government funding; now, therefore, be it

RESOLVED, that the American Osteopathic Association endorses the sustained funding of NASA's participation in the International Space Station. 1992; *revised* 1995, 2000, 2005

SPECIALTY CERTIFICATION, OSTEOPATHIC MEMBERSHIP OF DOs

WHEREAS, the value of the board certification credential to the public is enhanced by requiring that board certified physicians adhere to the standards set forth in the AOA’s code of ethics, satisfy appropriate continuing medical education requirements and have an active license to practice osteopathic medicine, all of which are required of AOA members; now, therefore, be it

RESOLVED, that the American Osteopathic Association continue to condition AOA specialty board certification upon AOA membership and encourages membership in its practice affiliates as well as state and local osteopathic associations. 1979; *reaffirmed* 1984; *revised* 1990; *reaffirmed* 1995, 2000, *revised* 2005

SPINAL MANIPULATION LEGISLATION OR REGULATION

WHEREAS, in recent years, state legislation has been introduced that would establish a set number of educational and/or clinical hours necessary to perform spinal manipulation; and

WHEREAS, this legislation is an attempt to restrict the practice of spinal manipulation by certain allied health professionals; and

WHEREAS, this legislation often times does not exclude osteopathic physicians from its restrictive requirements; and

WHEREAS, an osteopathic physician receives training in osteopathic principles and practices (OPP) throughout the osteopathic medical education continuum; and

WHEREAS, an osteopathic physician is trained in osteopathic manipulative treatment (OMT) within his or her osteopathic medical education, which includes instruction in all forms of manipulation, including spinal; and

WHEREAS, an osteopathic physician is licensed for the full and unlimited practice of medicine; now, therefore, be it

RESOLVED, that the American Osteopathic Association opposes all legislation or regulatory changes that could be interpreted to exclude osteopathic physicians from the right to practice spinal manipulation, and all other forms of osteopathic manipulative treatment; and, be it further

RESOLVED, that the AOA works with legislators and state licensing boards to preserve the osteopathic profession's right to establish and maintain standards of practice of osteopathic manipulative treatment. 1999; *revised* 2004

STATE LICENSURE OF MCO MEDICAL DIRECTORS

WHEREAS, in recent years, the growth of managed care organizations (MCOs) has brought about serious changes in the way care is provided to patients; and

WHEREAS, medical treatments in a managed care atmosphere must usually be approved prior to their render; and

WHEREAS, medical directors of MCOs generally make the final determination of the necessity of a particular treatment for a patient with respect to his or her knowledge of the particular case as well as the standards of care established by the health plan; and

WHEREAS, any treatment decision which is the final determinate of a patient's care should come from a thorough understanding of contemporary medicine with regards to that care; and

WHEREAS, protecting the public is of paramount importance; and

WHEREAS, the public deserves the assurance that physicians making the ultimate medical decisions on their health have met the minimum standards of their state through licensure; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports legislation or regulations that would require all managed care organization (MCO) medical directors to be fully-licensed physicians of the state where the care is being provided; and, be it further

RESOLVED, that the AOA supports state medical boards' rights to oversee and discipline any medical director of an MCO licensed as a physician in their state. 1999; *reaffirmed* 2004

STATES -- EMERGING

WHEREAS, the American Osteopathic Association through its regional managers has established a program to strengthen osteopathic societies in the emerging states; and

WHEREAS, this program has proven and continues to be very effective; now, therefore, be it

RESOLVED, that the American Osteopathic Association through its committee structure and departmental staff continue to support the emerging states program so that the osteopathic profession is strengthened nationwide. 1976; *reaffirmed* 1981; *revised* 1986, 1991, 1996, 2001

STATES -- EMERGING: ASSISTANCE BY OTHER STATES AND THE AOA

WHEREAS, there are many states with low DO physician population and/or limited organizational structures; and

WHEREAS, the concept of assistance to emerging states by larger or more organized states has been a successful means to improve organizational effectiveness in emerging states; now, therefore, be it

RESOLVED, that the American Osteopathic Association encourages liaison between state organizations whether formal or informal; and, be it further

RESOLVED, that the AOA supports assistance to emerging state organizations.1979; *revised* 1984, 1989; *reaffirmed* 1994; *revised* 1999; *reaffirmed* 2004

STUDENT LOAN INTEREST DEDUCTIONS

WHEREAS, the elimination of student loan interest deductions by the U.S. Congress has placed undue hardships upon osteopathic medical school graduates as well as other graduates; and

WHEREAS, the reduction and future elimination of student loan interest payment tax deductions will discourage promising candidates from entering the osteopathic profession; now, therefore, be it

RESOLVED, that the American Osteopathic Association aggressively petition Congress to reinstate tax laws governing student loan interest tax deductions regardless of when the loan was incurred; and, be it further

RESOLVED, that the AOA and appropriate affiliated organizations communicate pertinent tax deduction laws to its members. 1989; *revised* 1994, 1999; *reaffirmed* 2004

SUBSTANCE ABUSE

WHEREAS, substance abuse is a significant health problem in the United States today; and

WHEREAS, physicians are ultimately responsible for the medical management of substance abusers who seek, or are referred for, medical treatment; and

WHEREAS, total community education relative to substance abuse is essential to the alleviation of the problem; now, therefore, be it

RESOLVED, that the American Osteopathic Association encourages its members, to maintain current knowledge of addictive substances with a high potential for abuse, and of appropriate treatment techniques, and supports health and law enforcement agencies in their efforts to eliminate substance abuse, urges all members of the osteopathic profession to participate in the care and rehabilitation of persons suffering from substance abuse and recognizes appropriate proclamations dedicated to "Drug Abuse Prevention Month". 1978; *revised* 1983, 1988, 1993, 1998, 2003

SUDDEN INFANT DEATH

WHEREAS, the American Osteopathic Association recognizes sudden infant death syndrome as a tragic phenomenon; and

WHEREAS, when an infant dies suddenly, with no medical explanation, the parents are often unjustly accused of negligence; and

WHEREAS, existing sudden infant death syndrome counseling, information, and educational programs may be inadequate; now, therefore, be it

RESOLVED, that the American Osteopathic Association urges continued research into causes and prevention of sudden infant death syndrome; and, be it further

RESOLVED, that information based on current medical literature be made available to the public on the nature of sudden infant death syndrome and proper counseling be available to families who lose infants to this disease. 1974; *reaffirmed* 1980, 1985; *revised* 1990, 1995, 2000 *reaffirmed* 2005

SUDDEN INFANT DEATH SYNDROME

WHEREAS, Sudden Infant Death Syndrome (SIDS) is the leading cause of infant mortality between 1 month and 1 year of age in the United States, responsible for thousands of deaths annually; and

WHEREAS, recent epidemiologic and physiologic evidence has implicated the prone sleeping position as a potential risk factor for SIDS; and

WHEREAS, several countries including Australia, New Zealand, Britain and the Netherlands have significantly reduced deaths from SIDS after mounting a national campaign to discourage the prone sleeping position; and

WHEREAS, the U.S. Public Health Service and other organizations are mounting intensive national campaigns to promote the supine sleeping position in healthy infants; now, therefore, be it

RESOLVED, that that the American Osteopathic Association supports the U.S. Public Health Service's campaigns by encouraging its members to educate the parents and care-givers of young infants to place healthy infants to sleep on their backs. . 1994; *revised* 1999, 2004

SUPPORT OF LITERACY PROGRAMS

WHEREAS, an elemental strength of democratic society is a free flow of information and exchange of opinion; and

WHEREAS, the vitality and progress of such democracy is reflected in decisions rendered by its citizens based on information available to all; and

WHEREAS, the ability to read and write usually is a requisite for the full exercise of citizenship and a recognition of its obligations; and

WHEREAS, illiteracy in the United States is unacceptable; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports programs which promote literacy in the United States. 1990; *revised* 1995; *reaffirmed* 2000, *revised* 2005

TAKE BACK LAWS

WHEREAS, osteopathic physicians believe in a level playing field between physicians and insurers; and

WHEREAS, insurance carriers now limit the time period that a physician is allowed to bill for services rendered; and

WHEREAS, an insurer can request or demand money back from physicians for overpayment of a claim for an indefinite period of time; now, therefore, be it

RESOLVED, that American Osteopathic Association calls upon the U.S. Congress to pass federal legislation which subjects all parties to the same terms and time frame for billing, payment and appeal. 2002

TANNING DEVICES

WHEREAS, tanning devices may cause harmful effects from high intensity UVA exposure; and

WHEREAS, appropriate tanning device requirements accompanied by public education on this subject is in the common interest; now, therefore, be it

RESOLVED, that the American Osteopathic Association endorses appropriate governmental action to impose those safety precautions which are needed regarding the use of tanning devices. 1990; *revised* 1995, 2000. *reaffirmed 2005*

TAX CREDITS FOR HEALTH PROFESSION SHORTAGE AREAS

WHEREAS, the distribution of physicians to rural and other underserved communities has decreased in the past decade; and

WHEREAS, financial incentives have proven effective in encouraging physicians to pursue practice opportunities; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) support the establishment of tax credits for physicians who practice full time in federally designated health professions shortage areas (HPSAs) or Medicare defined physician scarcity areas and federally and/or state designated underserved areas; and, be it further

RESOLVED, that these tax credits be available, on a sliding scale, to physicians who provide services on a part-time basis in these communities. 2005

TAXATION-OPPOSITION TO GROSS RECEIPTS OR HEALTHCARE PROVIDER TAXES BY GOVERNMENTAL BODIES

WHEREAS, osteopathic physicians have long provided free or reduced cost healthcare to indigent patients; and

WHEREAS, this society as a whole must share the moral obligation of providing the costs of such care; and

WHEREAS, it is grossly unfair to ask physicians to share the burden alone through the use of a tax that singles them out and shows no equality or concern for them or the well being of their families; now, therefore, be it

RESOLVED, that the American Osteopathic Association opposes taxation by any state, subdivision or federal government that is levied only on healthcare providers; and, be it further

RESOLVED, that the AOA encourages the divisional societies to take a similar position. 1993; *revised* 1998, 2003

TEACHING CHILDREN AND ADOLESCENTS ABOUT MEDICINES--TEN GUIDING PRINCIPLES FOR

WHEREAS, the American Osteopathic Association encourages activities that will help children, through adolescence, become active participants in the process of using medicines including all types, both prescription and non-prescription, to the best of their abilities; and

WHEREAS, the AOA recognizes that children of the same age vary in development, experience, and capabilities; and

WHEREAS, children learn by example; now, therefore, be it

RESOLVED, that the American osteopathic Association endorses the United States Pharmacopeia (USP) position statement of the following "Ten Guiding Principles for Teaching Children and Adolescents About Medicines:"

1. Children, as users of medicines, have a right to appropriate information about their medicines that reflects the child's health status, capabilities, and culture.
2. Healthcare providers and health educators should communicate directly with children about their medicines.
3. Children's interests in medicine should be encouraged, and they should be taught how to ask questions of healthcare providers, parents, and other caregivers about medicines and other therapies.
4. The actions of parents and other caregivers should show children appropriate use of medicines.
5. Children, their parents, and their healthcare providers should negotiate the gradual transfer of responsibility for medicine use in ways that respect parental responsibilities and the health status and capabilities of the child.
6. Children's medicine education should take into account what children want to know about medicines, as well as what health professionals think children should know.
7. Children should receive basic information about medicines and their proper use as a part of school health education.
8. Children's medicine education should include information about the general use and misuse of medicines, as well as about the specific medicines the child is using.
9. Children have a right to information that will enable them to avoid poisoning through the misuse of medicines.
10. Children asked to participate in clinical trials (after parents' consent) have a right to receive appropriate information to promote their understanding before assent and participation. 1999; *reaffirmed* 2004

TEENAGE SEXUALITY, CONTRACEPTION, AND THE MEDIA

WHEREAS, more than 85 percent of teenagers have first coitus prior to seeking professional advice about pregnancy prevention or sexually transmitted diseases; and

WHEREAS, the teenage pregnancy rate in the U.S. has been found to be two to five times higher than other developed countries; and

WHEREAS, the consequences of unprotected coitus, including unwanted pregnancy and exposure to STDs, are not well understood or are taken for granted by the teenage population; and

WHEREAS, print/electronic media powerfully influences teenagers' sexual attitudes, values and beliefs; now, therefore, be it

RESOLVED, that the American Osteopathic Association adopts the following policy:

TEENAGE SEXUALITY, CONTRACEPTION AND THE MEDIA

1. Osteopathic physicians should facilitate and encourage open discussion between adolescent patients and their families on the effects of the media on sexual behavior.

2. Osteopathic physicians and the AOA should assist and encourage the print/electronic media to use public service announcements that (a) promote abstinence, and (b) educate on the proper use, risk and failure rate of condoms and other forms of contraception.

3. Osteopathic physicians and the AOA should assist and encourage the print/electronic media to consider that when broadcasting advertisements for non-prescription contraceptives, guidelines should be used to ensure that the content of these advertisements is factual, educational and focused on responsible sexual behavior and decision-making.

4. Osteopathic physicians and the AOA should assist and encourage the print/electronic media to influence programs aimed at adolescents, to air advertisements and public service announcements that conform to the "Guide to Responsible Sexual Content" in Television, Film and Music; and, be it, further

RESOLVED, that the American Osteopathic Association enlists the support of this policy by Congress and the office of the President of the United States, and encourages the proposal of federal legislation for the purpose of promoting the use of these guidelines by the broadcast industry.

Teenage Sexuality

Guide to Responsible Sexual Content in Television, Film and Music

In film, television, and music, sexual messages are becoming more explicit in dialogue, lyrics and behavior. Unfortunately, too often these messages contain unrealistic, inaccurate, and misleading information which young people accept as fact.

Following are some suggestions for the presentation of responsible sexual content:

- Recognize sex as a healthy and natural part of life.
- Parent and child conversations about sex are important and healthy and should be encouraged.
- Demonstrate that not only the young, unmarried, and beautiful have sexual relationships.
- Not all affection and touching must culminate in sex.
- Portray couples as having sexual relationships with feelings of affection, love and respect for one another.
- Consequences of unprotected sex should be discussed or shown.
- Miscarriage should not be used as a dramatic convenience for resolving an unwanted pregnancy.
- Use of contraceptives should be indicated as a normal part of a sexual relationship.
- Avoid associating violence with sex or love.
- Rape should be depicted as a crime of violence, not one of passion.
- The ability to say no should be recognized and respected.

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TELEMARKETING -- HEALTHCARE

WHEREAS, patients make difficult decisions regarding their health and general welfare; and

WHEREAS, patients are listed, without their permission or knowledge, on contact lists which are readily available to telemarketers and advertisers; and

WHEREAS, solicitations to patients may be misleading; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the federal trade commission's "national do not call registry" as well as Congressional efforts to regulate the healthcare telemarketing industry by putting an end to unwanted solicitations.. 1999; *revised* 2004

THIRD-PARTY PAYERS AND UTILIZATION REVIEW FIRMS--ACCOUNTABILITY

WHEREAS, utilization review criteria are sometimes withheld from the physicians that are being reviewed; now, therefore, be it

RESOLVED, that the American Osteopathic Association support the disclosure of the origin of utilization review criteria used by third-party payers. . 1994; *revised* 1999, 2004

TIMELY ACCESS TO ANCILLARY FACILITIES

WHEREAS, access to medical care and its ancillary services, especially in rural areas, is frequently limited; and

WHEREAS, managed care organizations contract with laboratories and diagnostic imaging centers outside of reasonable geographic accessibility; now, therefore, be it

RESOLVED, that the American Osteopathic Association exert its influence to insure that managed care organizations will provide a full range of medical services, if available, within the service area of its subscribers. 2001

TOBACCO CONTROL—THE FRAMEWORK CONVENTION ON

WHEREAS, globally, smoking causes 4 million deaths annually, and the percentage of deaths from tobacco use is projected to double from 6% in 1990 to 12.3% in 2020; and

WHEREAS, 1 in 10 deaths worldwide are caused by smoking-related diseases; and

WHEREAS, currently, there are 1.1 billion smokers in the world, with 80% of smokers living in developing countries; and

WHEREAS, the majority of tobacco related deaths will occur in developing countries, with 70% of all deaths from tobacco use occurring in developing countries by the year 2030; and

WHEREAS, tobacco companies spend billions of dollars annually on both direct and indirect advertising of tobacco products, and since smoking by women in developing countries is currently at 7%, making women and girls prime advertising targets; and

WHEREAS, advertising is also aimed at young people in developing countries through sports sponsorships, promotional items, entertainment sponsorships, and free cigarette samples at events frequented by young people; and

WHEREAS, U.S. advertising by tobacco companies also target women and minority communities in magazines, newspapers, and billboards; and

WHEREAS, The World Health Organization (WHO) began the Tobacco Free Initiative in 1998 to reduce tobacco use by strengthening global initiatives, and includes the development of an international treaty on tobacco control called the Framework Convention on Tobacco Control (FCTC); and

WHEREAS, the FCTC will consider negotiations on a wide range of issues including, advertising; promotion and sponsorship of tobacco products; smuggling of tobacco products; cessation and treatment; tobacco price and tax policies; passive smoking; sale of duty-free tobacco products; tobacco product regulation, including testing and reporting of ingredients and

the ability to require tobacco product modification; information exchange; health education and research; and agricultural policies; and

WHEREAS, the American Osteopathic Association has an extensive policy discouraging the use of tobacco products in the United States because of its adverse effect on health and recommending federal and state legislation to discourage its use; now, therefore, be it

RESOLVED, that the American Osteopathic Association support the efforts of international health agencies in eliminating smoking from their societies, and encourage the United States to use its experience in tobacco control to help developing countries with this health issue; and, be it further

RESOLVED, that the American Osteopathic Association support the public health initiatives of the World Health Organization for tobacco control by promoting the Framework Convention on Tobacco Control (FCTC) and encourage the federal government to work towards the development and adoption of this international treaty. 2001

TOBACCO SETTLEMENT FUNDS

WHEREAS, all 50 states reached a large settlement agreement with the tobacco companies; and

WHEREAS, this Master Settlement Agreement places no restrictions on how the states can use the settlement funds; and

WHEREAS, there are numerous competing demands for the funds including both health related and non-health related items; and

WHEREAS, some states allocate the funds for non-health related items such as education, childhood development, tobacco communities and growers, and road improvement; and

WHEREAS, the tobacco settlement fund was caused by a growing concern for the dangers of tobacco use which is a health-related matter; and

WHEREAS, states have plans to allocate the tobacco settlement funds for healthcare services such as tobacco use prevention, biomedical research, hospital charity care, programs for the uninsured, Medicaid enhancement, and state children's health insurance programs (SCHIPs); now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the use of the tobacco settlement fund for health-related items to include health care services, education and research only. 2000, *revised* 2005

TOBACCO USE IN FILMS

WHEREAS, the tobacco industry promotes the use of tobacco products in films; and

WHEREAS, although the Motion Picture Association of America has a voluntary rating system to rate films, they have no current system to quantify smoking in the film media; and

WHEREAS, consumer groups and health organizations have shown the harmful effects of tobacco; and

WHEREAS, the American Osteopathic Association and other healthcare associations have petitioned in support of presidential and congressional initiatives to ban all forms of tobacco advertising, especially to children; and

WHEREAS, it is estimated that approximately 3,000 people in the United States, mostly children, begin smoking each day and approximately 1000 will die from tobacco use related deaths; and

WHEREAS, tobacco product use depicted in films usually enhances the product and does not depict its adverse consequences on health; now, therefore, be it

RESOLVED, that the American Osteopathic Association encourages the Motion Picture Association of America to measure, monitor and reduce the use of tobacco products in films. 2003

TOBACCO USE STATUS-REPORTING IN THE MEDICAL RECORD

WHEREAS, tobacco use is the nation's number one preventable health problem; and

WHEREAS, physician intervention has shown to improve cessation, and primary care clinicians are uniquely poised to assist patients who use tobacco, as they have extraordinary access to this population; and

WHEREAS, tobacco users cite a physician's advice to quit as an important motivator for attempting to stop; and

WHEREAS, physicians must have a systematic approach to identify patient tobacco use status; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports the Agency for Healthcare Research and Quality's (AHRQ) guideline on tobacco use cessation that specifically recommends a method of identifying patients tobacco use status on each visit to increase the likelihood of physician intervention with their patients who use tobacco. 1999; *revised* 2004

TORT REFORM

WHEREAS, professional liability insurance premiums are in an upward spiral; and

WHEREAS, some physicians have been forced to move to states with affordable malpractice coverage or to close their practices altogether; and

WHEREAS, the resultant lack of availability of health care has the potential to cause harm to all Americans; now, therefore, be it

RESOLVED, that the American Osteopathic Association support and encourage its divisional societies to support legislation for tort reform to include the following points:

- A cap on non-economic damages
- A uniform statute of limitations
- Collateral source payment offsets
- Periodic payment of future damages
- Joint and several liability reforms
- Limitation of plaintiff attorney contingency fees; and be it further

RESOLVED, that the AOA support and encourage legislation in all states to increase the standards in professional liability cases to "clear and convincing." 2002

TUBERCULOSIS MEDICAL TRAINING

WHEREAS, tuberculosis is on the increase in the United States; and

WHEREAS, the AIDS epidemic and other multiple factors have resulted in new cases of tuberculosis and the emergence of new multi-drug resistant strains of tuberculosis; and

WHEREAS, prior to this resurgence of tuberculosis, laxity in the prevention and treatment of this disease has occurred; now, therefore, be it

RESOLVED, that the American Osteopathic Association urges the United States Department of Health and Human Services to formulate new programs to educate physicians, healthcare workers and the public on the prevention and treatment of tuberculosis; and, be it further

RESOLVED, that the AOA supports tuberculosis prevention programs carried out by the Centers for Disease Control and Prevention (CDC), The National Institutes of Health (NIH) and other organizations and encourages the use of the CDC's core curriculum on tuberculosis by osteopathic physicians who treat patients diagnosed with tuberculosis or are at high risk for tuberculosis disease or infection. 1993; *revised* 1998; *reaffirmed* 2003

UNIFORM BILLING

WHEREAS, the percentage of time spent for billing compared to that of actual treating of patients has increased; and

WHEREAS, the actual cost for billing has also increased; and

WHEREAS, third-party payers require billing to be done in many different ways which leads to confusion and delay in payment; and

WHEREAS, the availability of a uniform electronic billings system would enhance physician use of such a system; now, therefore, be it

RESOLVED that the American Osteopathic Association supports a uniform standard for electronic billing to be used by the healthcare industry; and, be it further

RESOLVED, that the AOA opposes charging a fee or other penalty to physicians for the reimbursement claims that they submit for care provided to Medicare and Medicaid patients. 1993; *revised* 1998, 2003

UNIFORM PATHWAY OF LICENSING OF OSTEOPATHIC PHYSICIANS

WHEREAS, the United States Medical Licensing Examination presents a challenge for osteopathic physicians to have a distinctive osteopathic examination and licensure; and

WHEREAS, osteopathic medicine is a separate and complete medical profession and its members should be licensed to indicate this distinction; and

WHEREAS, licensure, while an individual state process, should have uniformity throughout the nation to protect the quality and integrity of osteopathic licensure and the public's interest; now, therefore, be it

RESOLVED, that the examination of the National Board of Osteopathic Medical Examiners must remain as an avenue for the licensure of osteopathic physicians; and, be it further

RESOLVED, that the American Osteopathic Association supports a uniform pathway of licensing osteopathic physicians through the mechanisms of the National Board of Osteopathic Medical Examiners. 1991; *revised* 1993, 1998, 2003

UNIFORMED SERVICES: ENDORSEMENT OF PHYSICIANS SERVING IN THE UNIFORMED SERVICES

WHEREAS, the osteopathic profession has the highest regard for our men and women in uniform; now, therefore, be it

RESOLVED, that the American Osteopathic Association will continue to assist the Surgeons General of the US and the American public in maintaining and assuring the highest quality of healthcare by its representatives in the uniformed services; and, be it further

RESOLVED, that the AOA recognize the 40th anniversary of osteopathic physicians being commissioned in the military. 1985; *revised* 1990, 1995; 2000, 2005

UNINSURED—ACCESS TO HEALTH CARE

WHEREAS, the cost of health insurance coverage annually increases at a rate sufficient to negatively impact access to basic health care coverage and ultimately prevent those who are unable to obtain insurance from seeking quality health care services; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports federal and state efforts to increase access to affordable health care coverage through initiatives that expand coverage to the uninsured through the efficient use of both private and public resources; and, be it further

RESOLVED, that the American Osteopathic Association supports efforts to reform programs such as Medicaid, Medicare, and State Child Health Insurance Program (SCHIP) to provide coverage to populations that would otherwise lack health care coverage and ultimately, access to needed health care services. 2003

UNIONIZATION OF PHYSICIANS

WHEREAS, in response to the increased power third-party payers have over osteopathic physicians and patient care, physicians are seeking a unified voice to represent their interests in contract negotiations; and

WHEREAS, it has become increasingly difficult for physicians to negotiate contracts that recognize their need for clinical autonomy in making treatment decisions on behalf of patients; and

WHEREAS, interpretations of federal and state antitrust laws currently prohibit physicians, who are otherwise competitors, from negotiating as a group with third-party payers; and

WHEREAS, federal labor law exempts only non-supervisory, employed physicians from the federal antitrust laws and allows them to engage in collective bargaining with their employer; and

WHEREAS, only a small percentage of physicians represented by the AOA are covered by this labor law exception to the federal antitrust laws and would be permitted to engage in collective bargaining; and

WHEREAS, through unionization the public's perception of the professionalism of physicians could be irreversibly damaged; now, therefore, be it

RESOLVED, that the American Osteopathic Association does not, at this time, believe that physician unionization is a viable solution to the problems physicians face today; and, be it further

RESOLVED, that the AOA actively pursue efforts to create an open and constructive dialogue between physicians and third-party payers with the goal of improving the practice environment for osteopathic physicians through joint negotiations; and, be it further

RESOLVED, that the AOA monitor the unionization movement; and, be it further

RESOLVED, that the AOA support federal efforts to seek appropriate antitrust reforms. 1999; *revised* 2004

URGING STANDARD POLICIES FOR CERTIFYING INDIGENT PATIENTS FOR FREE PHARMACEUTICALS

WHEREAS, many major drug companies have established procedures whereby physicians may request certain medications at no cost for indigent patients; and

WHEREAS, the procedures required of the physician in requesting such medications varies among the pharmaceutical companies in factors such as eligibility criteria, amount and type of paper work required, approval time, and method of distribution of the medication; and

WHEREAS, these variances create an encumbrance on both physicians and patients often resulting in deserving patients not receiving the medicine, or only after a medically unacceptable delay; now, therefore, be it

RESOLVED, that the American Osteopathic Association urges the Pharmaceutical Industry, through the Pharmaceutical Research and Manufacturers of America, to develop standard and uniform policies and procedures for certifying indigent patients for free medication programs, including a method whereby the patients, once approved, could receive the appropriate medicine more expeditiously in compliance with state dispensing regulations. 1996; *revised* 2001

UNIFORMED SERVICES PHYSICIANS REQUIRING AND ASSIGNED TO CIVILIAN RESIDENCY PROGRAMS—AOA SUPPORT OF ALL OSTEOPATHICALLY TRAINED

WHEREAS, the American Osteopathic Association has been fully supportive of osteopathic physicians serving in the uniformed services of the United States for many decades; and

WHEREAS, these osteopathic physicians serving in the uniformed services and represented by the Association of Military Osteopathic Physicians and Surgeons, supported the AOA and its postgraduate training programs; and

WHEREAS, the uniformed services osteopathic interns/PGY1 residents should be able to receive expeditious AOA approval of Federally funded training in residency programs sponsored under the uniformed services umbrella in both military and civilian institutions; now therefore, be it

RESOLVED that the American Osteopathic Association continue to monitor, assist and support all osteopathic physicians who receive graduate medical education (GME) through the uniformed services process, removing barriers to osteopathic graduate medical education approval. 1998; *revised* 2004

VACCINE DILEMMA

WHEREAS, there has been a growing shortage of certain immunizations; and

WHEREAS, manufacturers have recently supplied non-physicians with significant amounts of vaccine; now, therefore, be it

RESOLVED that the American Osteopathic Association contact manufacturers of vaccines to encourage rapid increase in vaccine supply and to distribute these vaccines preferentially to physicians, healthcare facilities, and healthcare agencies. 2001

VACCINE SHORTAGES

WHEREAS, the vaccine program in the United States is extremely fragile and vulnerable at this time; and

WHEREAS, the United States has had severe shortages of certain vaccines in recent years; and

WHEREAS, the reason given for the shortages are; fewer companies are manufacturing vaccine because of poor reimbursement and because of the increased liability to the manufacturer; and

WHEREAS, vaccine shortages carry a high risk to the public's health; now, therefore, be it

RESOLVED, that the American Osteopathic Association take the necessary steps to establish a coalition to meet with federal legislators and the Centers for Disease Control & Prevention on this critical issue of vaccine shortage; and, be it further

RESOLVED, that the meeting include discussion on increased reimbursement for vaccines to encourage increased manufacturing; and, be it further

RESOLVED, that steps be taken to give manufacturers of vaccine immunity from lawsuits because of complications which are not due to negligence; and, be it further

RESOLVED, that the public be provided information on potential side effects and complications of vaccines so they are fully informed and responsible for their decision to be immunized. 2005

VACCINES FOR CHILDREN PROGRAM

WHEREAS, Section 1928 of the Social Security Act was enacted so that children could receive vaccinations as a part of routine health care, supporting the reintegration of vaccination into primary health care; and

WHEREAS, the Vaccines for Children (VFC) program provides immunizations in their primary physician's office for children who are uninsured, Medicaid recipients Native Americans, and Alaska Natives; and

WHEREAS, children who are underinsured, that is, they have health insurance but it does not cover routine immunizations, may not receive immunizations in their private physician's office, but must go to a participating federally qualified health clinic or rural health clinic; and

WHEREAS, this creates many missed immunization opportunities, in direct opposition to the goals of the Program; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) supports legislative action to authorize the expansion of the Vaccines for Children (VFC) Program to include immunizations to all underinsured children, in keeping with the original goals of the program. 2005

VETERANS ADMINISTRATION CREDENTIALING OF NON-PHYSICIAN PROVIDERS

WHEREAS, the Veterans Administration (VA) operates one of the largest health care delivery systems in the country; and

WHEREAS, decisions made by the VA are duplicated within other payment systems; and

WHEREAS, a lack of consistent policy exist in the credentialing of non-physicians within the VA system; and

WHEREAS, any non-physician provider may be credentialed within the VA system up to the extent of their license; and

WHEREAS, there is no consistency in state licensure requirements for non-physician providers; and

WHEREAS, under current VA policy a non-physician provider may be granted sweeping privileges within the VA based upon a minority of state laws; and

WHEREAS, this creates a decrease in the quality of care provided to our nation's veterans; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) support the establishment of well-defined credentialing and privileging criteria within the Veterans Administration (VA) that prohibits non-physician providers with expanded scope of practice rights in a minority of states from demanding such privileges in the VA system; and, be it further

RESOLVED, that the AOA support the establishment of a consistent requirement for the privileging of non-physician providers in the VA system. 2005

VETERANS—HEALTH CARE FOR U.S.

WHEREAS, U.S. Veterans from World II, Korea, and Vietnam are reaching the age when multiple disabilities from chronic diseases are causing them to seek health services from veterans hospitals and clinics; and

WHEREAS, many Veterans are living on fixed incomes that do not provide enough funds to purchase private health insurance plans; and

WHEREAS, the federal government has instituted an "income means" test as a way to cut back funding for Veterans causing the ranks of Americans without adequate health insurance to swell; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports adequate health care funding by the federal government to take care of all U.S. Veterans at veteran's hospitals and clinics or alternate health care sites. 2003

VETERANS HOSPITALS AND CLINICS-OMT IN

WHEREAS, osteopathic physicians are trained to utilize Osteopathic Manipulative Treatment (OMT) in the diagnosis and treatment of patients; and

WHEREAS, OMT is recognized by a majority of third-party payors for reimbursement purposes; and

WHEREAS, OMT is a physician administered health care service which is beneficial and cost-effective; and

WHEREAS, current national VA policy recognizes osteopathic treatment and CPT coding for OMT; and

WHEREAS, osteopathic physicians working in some veterans healthcare facilities have not been permitted by the director of their local facility to utilize OMT for diagnosis and treatment of patients and to document the findings in medical records; now, therefore, be it

RESOLVED, that the American Osteopathic Association requests that the Department of Veterans Affairs Research and resolve this problem so that osteopathic physicians will be able to document the finds and provide OMT in all departments of veterans affairs healthcare facilities. 2003

VIOLENCE--DEVELOPMENT OF PROGRAMS TO REDUCE

WHEREAS, violence of all kinds has a devastating effect on its victims and society; now, therefore, be it

RESOLVED, that the American Osteopathic Association urges its members as well as governmental agencies to continue to develop and expand educational and preventative programs to reduce violence and abuse of all kinds, including those of a sexual and/or domestic nature. 1991; *revised* 1996, 2001

VIOLENCE IN THE ENTERTAINMENT MEDIA

WHEREAS, there continues to be an increase in the portrayal of violence in the entertainment media; and

WHEREAS, the entertainment media has a demonstrated impact on children's attitudes and learned behavior; now, therefore, be it

RESOLVED, that the American Osteopathic Association opposes the presentation of gratuitous violence in the entertainment media. 1977; *revised* 1982, 1987, 1992; *reaffirmed* 1997; *revised* 2002

VOTING DAY—AOA SUPPORTS VOTING DAY POLICY

WHEREAS, if every healthcare provider and healthcare facility would initiate a policy to allow their employees time off during working hours to participate in voting, the political voices of healthcare professionals would be heard; now, therefore, be it

RESOLVED, the American Osteopathic Association encourages all osteopathic physicians to adopt voting policies in their workplaces that would allow their employees time off during working hours to participate in voting for local, state, and national elections.1991; *revised* 1996, 2001

WOMEN'S CONTRACEPTIVE COVERAGE LEGISLATION

WHEREAS, some of the traditional indemnity plans and preferred provider organizations (PPOs) fail to cover any of the most commonly used forms of contraception for women; and

WHEREAS, the exclusion of contraceptive coverage of insuring companies is discriminatory against women and their health; and

WHEREAS, coverage for such services not only facilitates the health of the woman using the contraceptive but aids in alleviating the problem of unintended pregnancy in this country; and

WHEREAS, millions of unintended pregnancies occur in the United States every year; and

WHEREAS, unintended pregnancy causes both an economic and emotional strain on women and their families; and

WHEREAS, avoiding unintended pregnancy can relieve a large percentage of the abortions performed in this country every year as well as the number of children born into economically distressed households; and

WHEREAS, the use of contraceptives by women is a safe and effective way of avoiding unintended pregnancy and maintaining the health of the woman using the contraceptive; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports health insurance coverage for Federal Food and Drug Administration (FDA)-approved contraceptive services to women of child-bearing age; and, be it further

RESOLVED, that the AOA supports language which would maintain co-payment for contraceptive services at a cost no higher than the normal set level of co-payment for any other prescription. 1999; *revised* 2004

YOUNG PHYSICIANS

WHEREAS, the needs of physicians who are recent graduates or new in practice are unique and different than the needs of physicians who have been in practice for many years; and

WHEREAS, these physicians, known as "young physicians", need a forum in which they can organize, share ideas, and plan events to meet their distinct and emerging needs; and

WHEREAS, a progressive transition from the Bureau of Interns/Residents to the Council of Young Physicians promotes the sharing of mutual ideas and goals in a seamless fashion; now, therefore, be it

RESOLVED, that the American Osteopathic Association shall define the category of "young physician" as a physician who has graduated from an osteopathic medical school and that this designation shall apply for a period of ten (10) years following the graduation; and, be it further

RESOLVED, that the chair of the Bureau of Interns/Residents will serve as the liaison for the Council of Young Physician; and, be it further

RESOLVED, that the AOA continue to support and assist the Council of Young Physicians to address the needs of young osteopathic physicians of the United States. 1999; *revised* 2004
