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) **The Uninsured**

- 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) **Managed Care**

- 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 <u>managed care plans</u> 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 CRIMINAL CASES

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 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.

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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.

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.

<u>Medical Societies & Expert Witness Policies</u>

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.

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

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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.

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 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

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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)

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*

[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

out-of-state expert witnesses making them subject to disciplinary sanctions of the state licensing boards.

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

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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.

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 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