

*decisions. Further, it is the AOA's position that roles within the "team" framework must be clearly defined, through established protocols and signed agreements, so physician involvement in patient care is sought when a patient's case dictates. Only proper attention to each of these considerations will ensure that the care being provided by non-physician clinicians is safe, effective, and of the highest quality.*

## **OBESITY—HEALTH PLANS SHOULD REVIEW BENEFITS FOR TREATMENT OF**

**WHEREAS**, obesity is increasing at alarming rates in the US, with more than 25% of adult Americans now considered obese; and

**WHEREAS**, in some population sub-groups, the percentage of individuals with a Body Mass Index (BMI) greater than 40 exceeds 10%; and

**WHEREAS**, along with this increase in the prevalence of obesity has come a rise in the incidence and occurrence of obesity-related co-morbid conditions, such as type 2 diabetes and cardiovascular disease; and

**WHEREAS**, numerous studies have shown that obesity treatments using nutritional counseling, behavioral therapy to improve diet and physical activity levels can lead to weight losses; now, therefore, be it

**RESOLVED**, that all health plans be requested to include nutritional counseling and physical conditioning as a benefit for members of all ages for the prevention and treatment of obesity. 2003

## **OBESITY IN CHILDREN**

**WHEREAS**, the number of obese children and adolescents in the United States has risen over the past four decades; and

**WHEREAS**, obesity related health problems are a major medical cost in the United States and add to premature morbidity and mortality; and

**WHEREAS**, according to *Healthy People 2010*, efforts to maintain a healthy weight should start early in childhood and continue throughout adulthood before obesity is established; and

**WHEREAS**, *Healthy People 2010* seeks to reduce the proportion of children and adolescents who are overweight or obese; now, therefore, be it

**RESOLVED** that the American Osteopathic Association (AOA) support programs which advocate physical fitness and good nutrition for children and families. 2001

## **OBESITY, TREATMENT OF**

**WHEREAS**, the unrelenting increase in the prevalence of obesity in the United States is a major risk factor for several chronic diseases, including hypertension, dyslipidemia, diabetes, cardiovascular disease, sleep apnea, osteoporosis and some cancers; and

**WHEREAS**, recent studies demonstrate that dietary modification and enhanced physical activity may delay or prevent the transition from impaired glucose tolerance to type 2 diabetes mellitus and provide relevant treatment paradigms for patients with the metabolic syndrome; and

**WHEREAS**, education and training will be critical to ensure that physicians have the knowledge and skills necessary to properly treat patients with obesity; and

**WHEREAS**, The Pharmacy Benefit Management Institute reports that drugs used to treat obesity have been excluded as a reimbursed benefit by more than 80% of employer sponsored insurance plans, according to a sample of 375 companies representing almost 12 million beneficiaries; and

**WHEREAS**, legislation to require health insurance coverage for weight loss programs is under consideration in many states including – Georgia, Hawaii, Maryland, Montana and Virginia; and

**WHEREAS**, lack of reimbursement for weight management, physical activity, dietary counseling, and pharmaceutical agents for intervention constitutes a major barrier for access to treatment; and

**WHEREAS**, the high prevalence and epidemic trend of this medical condition has serious implications for United States health care costs; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association recognize obesity as a disease, and that obesity treatment and prevention requires a chronic care model, by encouraging research at AOA medical schools; and, be it further

**RESOLVED**, that the American osteopathic Association endorse continued curriculum enhancement for osteopathic students, interns, and residents to receive specific training in obesity education and approve continuing medical education for physicians with established practices; and, be it further

**RESOLVED**, that that the American Osteopathic Association support efforts to close the gap between current and desirable practice patterns, by soliciting grants to collect and study the extent to which obesity treatment and prevention services are covered by third party insurers and advocate for adequate coverage for obesity treatment and prevention; and, be it further

**RESOLVED**, that the American Osteopathic Association develop comprehensive efforts, commensurate with available funding, to disseminate knowledge to the treating community, media, legislature and employer groups directed at controlling the obesity epidemic by improving treatment access and encouraging physical activity in the United States. 2002

## **OCCUPATIONAL SAFETY AND HEALTH ACT (OSHA) STANDARDS**

**WHEREAS**, the Occupational Safety and Health Act (OSHA) standards as they now stand are felt to be an excessive burden on practicing physicians; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association requests the U.S. Department of Labor reconsider its penalty structure and conduct a cost benefit analysis of how OSHA standards affect the escalating cost of healthcare. 1991; *revised* 1996, 2001

## **OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) REGULATIONS**

**WHEREAS**, OSHA through its general-duty clause, which obligates all employers to provide work places that are free from recognized hazards causing or likely to cause death or serious physical harm to employees, has assessed fines against physicians and healthcare providers; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association urge that the Occupational Safety and Health Administration (OSHA) emphasize education and training to create a safe work place rather than assessing punitive fines. 1992; *revised* 1997, 2002

## **OFFICE BASED SURGERY**

RESOLVED, that the attached Policy Statement on Office-Based Surgery be approved:

### **OFFICE-BASED SURGERY**

#### **Background**

A number of surgical procedures that were once only performed in hospitals or ambulatory surgery facilities can now be performed in a physician's office. It is estimated that within five years at least 10 million surgical procedures will be performed in doctors' offices each year. The AOA recognizes that a majority of these procedures are performed in a safe and effective manner; however, the complexity of the services and procedures being performed in physician offices is increasing at unprecedented levels. This increase is due in part to advances in technology, ease in scheduling, patient comfort, and cost. Some argue that technology, modern anesthesia agents, and laparoscopic techniques make many in-office surgical procedures possible. In addition, many argue that office-based surgery is easier to schedule and more comfortable for patients than surgery performed in a hospital. Perhaps most significant, however, is the reported cost savings for office-based surgery compared to surgery performed in a hospital. One study reported that the cost of an inguinal hernia repair done in an office setting was \$895 compared to \$2,237 for the same procedure in the hospital. Unfortunately cost may be the main driving force behind the increase in office-based surgical procedures due to the fact that many procedures performed in an office setting are elective and, therefore, paid directly by the patient.

These advantages, however, may be outweighed by the potential harm to patients precipitated by the lack of regulations of office-based surgery. Unlike hospitals and licensed ambulatory surgical centers, office-based surgery facilities are, for the most part, not regulated by federal, state or local laws. Currently, only five states have regulations or laws governing surgery performed in an office setting. Without adequate regulations, office-based surgery may be conducted in offices with limited or outdated equipment, inadequately trained personnel, little or no established patient safety standards, and no accreditation requirements.

This lack of oversight can result in fatal consequences for patients, as is evident by a number of stories documenting tragic outcomes following office-based surgery. For example, a 28 year old woman died after undergoing breast augmentation surgery. During the surgery, the woman developed malignant hyperthermia and appropriate emergency medications such as Dantrolene were not available in the office setting. By the time she was transferred to an emergency room her temperature was 107 degrees. Similarly, a 50 year old man in Florida suffered respiratory arrest and subsequently died while undergoing facial cosmetic surgery in his physician's office. The patient's cause of death was reported as hypoxic brain damage.

While there are a number of stories reported by the media of tragic outcomes following office-based surgery, the actual number of morbidity and mortality following office-based surgery is hard to determine because reporting adverse events is not mandatory in every state. A number of reports that have been published documented unsettling results. For example, in a survey of 1,200 plastic surgeons, 95 deaths were reported in nearly 500,000 liposuction procedures. Since 1986, at least 41 deaths and over 1,200 injuries have occurred during cosmetic surgery in Florida. Closed malpractice claims in Florida have also identified 830 deaths and approximately 4,000 injuries associated with office-based medical care occurring between 1990 and 1999. Finally,

since Florida's Board of Medicine imposed mandatory reporting requirements on physicians performing office-based surgery, 20 adverse incidents and five deaths were reported in a five month period.

Without proper attention to patient care, the rapid growth of office-based surgery is likely to be accompanied by increased reports of adverse events similar to those described above. Office-based surgery, however, can be a safe and viable option for many patients and many types of surgery. The AOA believes that the key is ensuring that basic principles of patient safety are not lost in technological advancements and that surgery performed in an office setting is as safe for patients as surgery performed in hospitals and ambulatory care centers. It is simply not logical to perform surgery with anesthesia in a physician's office without having the same resources that would be present for the same procedures in a hospital or ambulatory surgery facility.

Unfortunately, this is the current state of surgery in many physicians' offices.

### **Need for Office-Based Surgery Rule Development**

**The states have taken various approaches to the issue of office-based surgery regulation. The North Carolina Medical Board surveyed a subset of their licensees on this issue. Licensees who renewed their licenses online were required to complete a questionnaire dealing with office-based surgery. In essence, licensees were asked their opinions on the necessity of formal rules governing surgery performed in physicians' offices. Based in part on these survey results, the Board determined that formal rules were not appropriate for their state. Instead, the Board adopted guidelines for office-based surgery.**

*The AOA supports state licensing boards in surveying their licensees or researching the issue of office-based surgery regulation to determine if office-based surgery rule development is necessary.*

### **Classification of Office-Based Surgery**

Office-based surgical procedures are usually classified based on the level of anesthesia used. Typically the procedures are classified into three groups: Level 1, 2, and 3 or Class A, B, and C. While not uniform, these classifications are often referred to by state medical boards and state legislators, therefore, understanding the different levels is an important basis for a discussion of office-based surgery. First, Level 1 surgical procedures are minor procedures performed under topical, local, or infiltration block anesthesia without preoperative sedation. Second, Level 2 surgical procedures are minor or major procedures performed in conjunction with oral, parenteral or intravenous sedation or under analgesic or dissociative drugs. Finally, Level 3 surgical procedures utilize general anesthesia or major conduction block anesthesia and require the support of bodily functions.

*The AOA believes that Level 1 and Level 2 procedures are acceptable to be performed in an office-based setting. However, Level 3 procedures should only be performed in an office setting that has been accredited by an accreditation organization such as the AOA, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), or the Accreditation Association for Ambulatory Health Care (AAAHC).*

## **Physicians and Staff in the Office-Based Surgical Facility**

One of the reasons for the large number of adverse consequences associated with office-based surgery is the fact that many individuals, both physicians and non-physicians, performing office-based surgery lack the expertise to perform the surgery and administer the anesthesia in the first place. For example, in 1997, non-plastic surgeons performed 50% of the 250,000 liposuction procedures. These individuals included dermatologists, primary care physicians, emergency physicians, and in some cases unlicensed individuals representing themselves as licensed physicians. In addition, two Florida ophthalmologists and one anesthesiologist have placed advertisements for breast augmentation surgery. Several dentists have also been identified as performing hair transplants and liposuction procedures. While no single medical discipline has a monopoly on proper qualifications for performing office-based surgery, such incidents may spur state licensing boards to consider instituting licensure by specialty or board certification as opposed to an unlimited scope of practice.

The background and training of the staff present during an office-based surgical procedure is crucial. The physician or health care provider doing the operation must be qualified to perform that specific procedure, the anesthesia must be administered and monitored properly, and the patient must receive appropriate care especially in case of an emergency.

*It is the AOA's position that surgery performed in a physician's office must be done by a physician or health care provider qualified by education and training to perform that specific procedure. In addition, only health care providers who have completed the appropriate education and training, examination, and certification and are regulated by a state agency to administer anesthesia may administer anesthesia in an office-based surgical facility. The AOA further believes that the physician administering the anesthesia or supervising the administration of the anesthesia must be physically present in the office-based surgical facility during the surgery and immediately available until the patient has been discharged from anesthesia care. In case of an emergency, personnel with training in advanced resuscitative techniques should be immediately available until all patients are discharged.*

## **Equipment Required**

Equipment used in office-based surgery must be kept in excellent working condition and replaced as necessary. However, concerns have been raised regarding such equipment. A 1999 report by the New York State Senate Committee on Investigations, Taxation, and Government Operations showed that outdated anesthesia equipment that would not pass inspection in a hospital was being used in physicians' offices.

The type of monitoring equipment required in office-based settings depends on the type of anesthesia used and individual patient needs. However, every facility must have emergency supplies immediately available, including emergency drugs and equipment appropriate for cardiopulmonary resuscitation. This includes a defibrillator, difficult airway equipment, and drugs and equipment necessary for the treatment of malignant hyperthermia.

**It is the AOA's position that office-based surgical facilities must have the appropriate medications, equipment, and monitors necessary to perform the surgery and administer the anesthesia in a safe manner. The equipment and monitors must be maintained, tested, and inspected according to the manufacturer's specifications.**

#### **Transfer Agreement**

**Recent events in Florida and elsewhere have shown that emergencies occasionally arise during surgery which require patients to receive a level of care higher than that available in the office-based setting. Provisions must be in place to provide this care in a more comprehensively outfitted and staffed facility should it be needed.**

*The AOA feels that physicians and health care providers who perform surgery in an office setting must have a written protocol in place for transfer to an accredited hospital within proximity to the office when extended or emergency services are needed to protect the health or well-being of the patients.*

#### **Adverse Incident Reporting**

**Adverse events that may occur in office-based surgical facilities include patient deaths, cardiorespiratory events, anaphylaxis or adverse drug reactions, infections, and bleeding episodes. Reporting of adverse incidents to an appropriate state entity is an important patient safety measure.**

*The AOA supports reporting of adverse incidents related to surgical procedures performed in an office setting to a state entity, as required and appropriate, provided that these disclosures will be considered confidential and protected from discovery or disclosure.*

#### **Regulation of Office-Based Surgery**

Unlike hospitals and ambulatory surgery centers, office-based surgical facilities currently have little or no oversight by federal, state, or local laws. Even basic safety precautions pertaining to emergencies, fire, drugs, staff, training, and unanticipated patient transfers that are taken for granted in hospitals and ambulatory surgery centers may not exist in office surgery facilities. This lack of oversight thwarts common sense. Since states and state licensing boards have a constitutional obligation to protect the public's health, they need to regulate office-based surgery facilities to ensure that patients undergoing surgery in these facilities receive the same standard of care as patients undergoing surgery in ambulatory surgery centers or hospitals.

*The AOA supports the position that state medical licensing boards are the appropriate entity to create and implement regulations regarding office-based surgery.*

#### **Conclusion**

*The number and complexity of surgeries performed in office-based settings is likely to grow dramatically in the next few years. While a majority of these procedures can be performed in a safe and effective manner, the AOA firmly believes that steps must be taken to ensure that office-based surgery is as safe for patients as hospital- or ambulatory care center-based surgery. The AOA feels that, while Level 1 and Level 2 procedures are acceptable to be performed in the office, Level 3 procedures should only be performed in offices accredited by an appropriate accrediting*

*body. The physician or health care provider performing surgery in an office environment must be qualified to do the specific procedure he/she is performing. Only health care providers with an appropriate educational and training background and who are regulated by a state agency should administer anesthesia. It is also the AOA's position that appropriate physician oversight of anesthesia must be ensured. In case of emergency, personnel with training in advanced resuscitative techniques should be available and a transfer protocol should be in place. The AOA also strongly believes that office-based surgical facilities must use safe and appropriate equipment, monitors, and medications to perform surgery and administer anesthesia. Further, the AOA supports reporting of adverse incidents related to surgical procedures performed in an office setting to a state entity, as required and appropriate, provided that these disclosures will be considered confidential and protected from discovery or disclosure. Finally, it is the AOA's position that state medical licensing boards are the appropriate governing bodies to create and implement office-based surgery regulations. Properly addressing each of these areas will help to ensure that surgery performed in physicians' offices is safe and effective for patients. 2002*

## **OMT OF THE CERVICAL SPINE**

**RESOLVED**, that the Council on Scientific Affairs, in the hopes of advancing the science of osteopathic medicine call upon the House of Delegates to adopt the attached position paper.

Explanatory Statement: These recommendations are provided for osteopathic educators and physicians making decisions regarding the instruction of cervical spinal manipulation and the care of patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by a patient's physician. Like all reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the understanding that continued research is needed.

### **AMERICAN OSTEOPATHIC ASSOCIATION OSTEOPATHIC MANIPULATIVE TREATMENT OF THE CERVICAL SPINE**

#### **Background and Statement of Issue**

There has recently been an increasing concern about the safety of cervical spine manipulation. Specifically, this concern has centered on devastating negative outcomes such as stroke. This paper will present the evidence behind the benefit of cervical spine manipulation, explore the potential harm and make a recommendation about its use.

#### **Benefit**

Spinal manipulation has been reviewed in meta-analysis published as early as 1992, showing a clear benefit for low back pain. There is less available information in the literature about manipulation in regards to neck pain and headache, but the evidence does show benefit. There have been at least 12 randomized controlled trials of manipulative treatment of neck pain.

Some of the benefits shown include relief of acute neck pain, reduction in neck pain as measured by validated instruments in sub-acute and chronic neck pain compared with muscle relaxants or usual medical care. There is also short-term relief from tension-type headaches. Manipulation relieves cervicogenic headache and is comparable to commonly used first line prophylactic prescription medications for tension-

type headache and migraine. Meta-analysis of 5 randomized controlled trials showed that there was a statistically significant reduction in neck pain using a visual analogue scale.

## Harm

Since 1925, there have been approximately 275 cases of adverse events reported with cervical spine manipulation. It has been suggested by some that there is an under-reporting of adverse events. A conservative estimate of the number of cervical spine manipulations per year is approximately 33 million and may be as high as 193 million in the US and Canada. The estimated risk of adverse outcome following cervical spine manipulation ranges from 1 in 400,000 to 1 in 3.85 million manipulations. The estimated risk of major impairment following cervical spine manipulation is 6.39 per 10 million manipulations.

Most of the reported cases of adverse outcome have involved “Thrust” or “High Velocity/Low Amplitude” types of manipulative treatment. Many of the reported cases do not distinguish the type of manipulative treatment provided. However, the risk of a vertebrobasilar accident (VBA) occurring spontaneously, is nearly twice the risk of a VBA resulting from cervical spine manipulation.<sup>7</sup> This includes cases of ischemic stroke and vertebral artery dissection.

A concern has been raised by a recent report that VBA following cervical spine manipulation is unpredictable. This report is biased because all of the cases were involved in litigation. The nature of litigation can lead to inaccurate reporting by patient or provider. However, it did conclude that VBA following cervical spine manipulation is “idiosyncratic and rare”. Further review of this data showed that 25% of the cases presented with sudden onset of new and unusual headache and neck pain often associated with other neurologic symptoms that may have represented a dissection in progress.

In direct contrast to this concern of unpredictability, another recent report states that cervical spine manipulation may worsen preexisting cervical disc herniation or even cause cervical disc herniation. This report describes complications such as radiculopathy, myelopathy, and vertebral artery compression by a lateral cervical disc herniation. The authors concluded that the incidence of these types of complications could be lessened by rigorous adherence to published exclusion criteria for cervical spine manipulation. The current literature does not clearly distinguish the type of provider (i.e. M.D., D.O., D.C. or P.T.) or manipulative treatment (manipulation vs. mobilization) provided in cases associated with VBA. This information may help to understand the mechanism of injury leading to VBA, as there are differences in education and practice among the various professions that utilize this type of treatment.

## Comparison of Alternative Treatments

NSAIDs are the most commonly prescribed medications for neck pain. Approximately 13 million Americans use NSAIDs regularly.<sup>32</sup> 81% of GI bleeds related to NSAID use occur without prior symptoms.<sup>32</sup> Research in the United Kingdom has shown NSAIDs will cause 12,000 emergency admissions and 2,500 deaths per year due to GI tract complications.<sup>1</sup> The annual cost of GI tract complications in the US is estimated at \$3.9 billion, with up to 103,000 hospitalizations and at least 16,500 deaths per year. This makes GI toxicity from NSAIDs the 15<sup>th</sup> most common cause of death in the United States.

Epidural steroid injection is a popular treatment for neck pain. Common risks include subdural injection, intrathecal injection and intravascular injection. Subdural injection occurs in ~ 1% of procedures. Intrathecal injection occurs in ~ 0.6-10.9% of procedures. Intravascular injection is the most significant risk and occurs in ~ 2% of procedures and ~ 8% of procedures in pregnant patients. Cervical epidural abscess is rare, but has been reported in the literature.

## Provocative Tests

Provocative tests such as the DeKline test have been studied in animals and humans. This test and others like it were found to be unreliable for demonstrating reproducibility of ischemia or risk of injuring the vertebral artery.

#### Risk factors

VBA accounts for 1.3 in 1000 cases of stroke, making this a rare event. Approximately 5% of patients with VBA die as a result, while 75% have a good functional recovery. The most common risk factors for VBA are migraine, hypertension, oral contraceptive use and smoking. Elevated homocysteine levels, which have been implicated in cardiovascular disease, may be a risk factor for VBA.

A study done in 1999 reviewing 367 cases of VBA reported from 1966-1993 showed 115 cases related to cervical spine manipulation; 167 were spontaneous, 58 from trivial trauma and 37 from major trauma.

**Complications from cervical spine manipulation most often occur in patients who have had prior manipulation uneventfully and without obvious risk factors for VBA. “Most vertebrobasilar artery dissections occur in the absence of cervical manipulation, either spontaneously or after trivial trauma or common daily movements of the neck, such as backing out of the driveway, painting the ceiling, playing tennis, sneezing, or engaging in yoga exercises.” In some cases manipulation may not be the primary insult causing the dissection, but an aggravating factor or coincidental event.**

**It has been proposed that thrust techniques that use a combination of hyperextension, rotation and traction of the upper cervical spine will place the patient at greatest risk of injuring the vertebral artery. In a retrospective review of 64 medical legal cases, information on the type of manipulation was available in 39 (61%) of the cases. 51% involved rotation, with the remaining 49% representing a variety of positions including lateral flexion, traction and isolated cases of non-force or neutral position thrusts. Only 15% reported any form of extension.**

#### Conclusion

Osteopathic manipulative treatment of the cervical spine, including but not limited to High Velocity/Low Amplitude treatment, is effective for neck pain and is safe, especially in comparison to other common treatments. Because of the very small risk of adverse outcomes, trainees should be provided with sufficient information so they are advised of the potential risks. There is a need for research to distinguish the risk of VBA associated with manipulation done by provider type and to determine the nature of the relationship between different types of manipulative treatment and VBA.

Therefore, it is the position of the American Osteopathic Association that all modalities of osteopathic manipulative treatment of the cervical spine, including High Velocity/Low Amplitude, should continue to be taught at all levels of education, and that osteopathic physicians should continue to offer this form of treatment to their patients. 2004

## ONLINE MEDICINE

### AOA POLICY STATEMENT ONLINE MEDICINE

The identification and treatment of medical problems is no longer restricted to the doctor's office. The development of websites that allow consumers to receive medical information over the Internet is growing rapidly. Over 100 million Americans have utilized the Internet to answer medical questions; this information has had a profound effect

on how patients view their health.<sup>30</sup> There are a number of methods by which doctors are reaching their patients through this technology. Some doctors have utilized e-mail as a way to conduct online consultation; others are opting for medical software that is designed to help patients identify symptoms and narrow down diagnoses. However, each method poses its own difficulties for patients and doctors. The AOA recognizes the benefits of online technology to the medical field, and its ability to assist many patients who would not normally have access to medical care, but the AOA also acknowledges the special challenge for osteopathic physicians whose philosophy of a hands-on approach is hindered by the use of Internet technology. The AOA strives to put in place a policy that promotes wellness and safety for patients, and remains concerned over some practices that raise legal and ethical problems arising out of the use and misuse of online technology as a substitute for face-to-face care. The capabilities of the Internet offer many great opportunities to help doctors and patients, but it should always enhance an established doctor-patient relationship, not replace it.

## **Liability for Treatment and Diagnosis**

In a case where direct treatment and consultation through online technology might result in the appearance of a medical error, questions of liability are likely. The hospital, the doctor, or both could be subject to a medical malpractice suit.<sup>31</sup> Medical malpractice is any act or failure to act by a medical professional, resulting in harm, injury, distress, or death to a patient while under their care. As such, anything a physician may say or do can be used as evidence to establish the validity of a medical malpractice claim.

There is some concern that online consultation opens physicians up to liability by allowing them to make decisions about a patient's health without actually examining the patient. Doctors who are promoting online medical information or consultation are quick to distinguish their program from one that provides diagnoses over the web; however, it is not always clear where to draw the line. For example, one program, EasyDiagnosis.com, utilizes online software that allows consumers to select one major complaint or symptom, and then answer 20-25 questions related to that complaint.<sup>32</sup> The system supplies patients with a number of possible diagnoses ranked in order of probability.<sup>33</sup> The site does not recommend a course of treatment, and there is no e-mail access to doctors.

Doctors who support these programs seem to suggest that by not recommending a course of treatment, they are not practicing medicine online. This does not appear to be a safe assumption, especially when injured patients are contemplating a lawsuit. Doctors argue that the disclaimers on sites clearly state they are not giving out medical advice. However, given the current crisis surrounding liability insurance, taking such risks is not necessarily a prudent move for doctors already straining to hold on to their practices. Additionally, while disclaimers are a necessary policy, they do not protect patients from taking online information as gospel, and misapplying it to themselves. One solution is that online consultations should only occur after a previously established doctor-patient relationship.<sup>34</sup> However, it would be extremely difficult – if not impossible – to keep consumers who are not current patients from accessing a physician's web page without instituting extreme security measures.

### *Liability of Individuals*

Proponents argue that e-mail is a viable option for scheduling appointments, requesting prescription refills, and follow-up questions after an initial visit. However, it also raises the possibility of doctors extending the use of consultation through email or software to patients with whom they have no prior relationship. E-mail consultation has become a high-tech addition for computer-savvy doctors looking to address the overwhelming number of questions received regarding consumers' health concerns. Doctors can clarify treatment plans and provide guidance to consumers who are confused by the medical information that is already available online. Supporters see this technological advance as giving power to consumers through easily accessible information. The hope is that the resource will create better dialogue between doctors and patients.

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<sup>30</sup> P. Greg Gulick, *E-Health And The Future Of Medicine: The Economic, Legal, Regulatory, Cultural, And Organizational Obstacles Facing Telemedicine And Cybermedicine Programs*. 12 Alb. L.J. Sci & Tech. 351, 351 (2002).

<sup>31</sup> *Id.*

<sup>32</sup> Tyler Chin, *Web Site Lets Patients Narrow Diagnosis on Their Own*, American Medical News, June 10, 2002. ([http://www.ama-assn.org/sci-pubs/amnews/pick\\_02/bisb0610.htm](http://www.ama-assn.org/sci-pubs/amnews/pick_02/bisb0610.htm)).

<sup>33</sup> *Id.*

<sup>34</sup> Chin, *supra* note 3 at 5.

Another Internet-aided program that is particularly troublesome for individual doctors is called MyDoc.com. MyDoc.com is advertised as the “first fully-integrated, 24 hour online healthcare service providing everything from physician-directed assessment and treatment recommendations to prescriptions and follow-up care.”<sup>35</sup> This web-based service is targeted to individuals who are sick, or those responsible for caring for sick people; this means that the program is actually marketing itself to consumers without any contact with physicians who have actually seen the patient. MyDoc.com provides “symptom-based *diagnosis* (emphasis added) with the option of immediate on-line treatment by a board certified physician including prescription services.”<sup>36</sup>

This program may save consumers time, but clearly places their health at risk. Physicians who support this technology say that they are not giving diagnoses and therefore, they are not practicing medicine. However, advertising by MyDoc.com tells a different story. Licensed physicians monitor patients, and may request further information before diagnosing, but there is no requirement that the physicians actually see the patients.<sup>37</sup> Physicians may be risking a sanction in their respective states because of unsafe practice. On October 15, 2002, the Illinois Department of Professional Regulation (DPR) took action to stop the company from treating patients.<sup>38</sup> The DPR alleged that MyDoc.com violated Illinois law because the site was providing diagnosis and treatment without a prior physician-patient relationship and without physically examining the patient.<sup>39</sup> Furthermore, the DPR said MyDoc’s program violates the Illinois Medical Practice Act because persons not licensed as physicians were providing these services.<sup>40</sup>

### Liability for Companies

Both individual physicians and groups using these high tech methods of bringing health information to patients have cause for concern. The creators of the software for EasyDiagnosis.com developed and market their web-based software as an interactive medical decision-making software for consumers and health care providers.<sup>41</sup> The company warns that the “reliability of the program obviously depends on the information supplied by the physician and/or patient,” and provides a disclaimer that it is not making diagnoses, however, many patients could be easily misguided by such a program. The company even goes as far as to disclaim any liability for “misdiagnosis, damages, injury, or death occurring to any patient whose findings are entered herein.”<sup>42</sup> Disclaimers such as these are commonplace and necessary, but rarely shield a company from liability. Patients consistently look for the deep pockets, and EasyDiagnosis.com is an appealing target.

Some doctors started utilizing online technology believing it would be more time efficient; unfortunately, they are finding just the opposite.<sup>43</sup> While online technology has certainly emerged as a useful tool in health care, several studies have suggested deficiencies in the quality and usefulness of Internet-based health information for some purposes. One study, by the University of Michigan at Ann Arbor, found that e-mails did not help decrease the number of phone calls from patients, and missed appointments occurred just as frequently in the non-email group compared to the e-mail group.<sup>44</sup> Given the risks involved with treating, diagnosing, and prescribing medications

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<sup>35</sup> See <http://www.mydoc.com>

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

<sup>38</sup> Tyler Chin . *Firm Treating Strangers by Web Shut Out by Illinois Directive, State regulators move to ice online Consultation Company MyDoc.com*, American Medical News, November 4, 2002., Found at ([http://www.ama-assn.org/sci-pubs/amnews/pick\\_02/bise1104.htm](http://www.ama-assn.org/sci-pubs/amnews/pick_02/bise1104.htm)).

<sup>39</sup> *Id.*

<sup>40</sup> *Id.* see also 225 ILCS 60/1 et seq. (2002).

<sup>41</sup> See <http://www.easydiagnosis.com/about.html>.

<sup>42</sup> *Id.*

<sup>43</sup> Tyler Chin, *Patients E-mail-But They Still Keep Calling*, American Medical News, June 10, 2002.

([http://www.ama-assn.org/sci-pubs/amnews/pick\\_02/bil20610.htm](http://www.ama-assn.org/sci-pubs/amnews/pick_02/bil20610.htm)).

<sup>44</sup> *Id.*

without an established relationship, and the fact that studies undermine the quality of Internet-based health information, it is clear that the benefit of saving time does not outweigh the risks involved. A policy needs to be developed that supports patient safety over efficiency, and addresses the issues surrounding liability.

The AOA supports a policy that online consultation done without establishing a doctor-patient relationship, or without a licensed independent practitioner to receive the consultative opinion (who has established an appropriate relationship with the patient), is the practice of medicine, and does not meet an acceptable standard of medical practice. The absence of an appropriate established doctor-patient relationship may place physicians and the companies providing these services at risk for liability. A doctor-patient relationship can only be established through at least one face-to-face meeting. A consultation may occur when a licensed physician who has not met the patient in a face-to-face meeting is called upon to give his or her treatment advice to another licensed practitioner who is treating the patient within their scope of practice.

### Online Prescribing

One of the emerging issues within medical practice via the Internet is online prescribing, encompassing both the prescriptive power of doctors and the distributive power of pharmacists. Part of the difficulty in regulating the sale of pharmaceuticals on the Internet is the wide variety of federal agencies that have partial authority over online prescribing. One action the federal government has taken is to establish task forces to prosecute licensed physicians who distribute drugs without prescriptions across state lines.<sup>45</sup> Still, most of the regulation of online prescribing is left to states.

Under existing law in the majority of states, prescribing drugs to patients living or residing outside the state where physicians are licensed is considered the unlicensed practice of medicine.<sup>46</sup> Because prescription drugs can have potentially harmful side effects and dangerous contraindications when taken with other prescriptions or over-the-counter medications without proper instruction or follow-up, most states' laws require establishing a physician-patient relationship before prescribing drugs to patients. Unfortunately, state medicine boards cannot regulate or prevent all forms of online prescribing.

It is the AOA's position that prescription drugs should only be prescribed over the Internet by a physician who has been directly involved in the patient's physical evaluation, has knowledge of the patient's medical history, and has knowledge of the other medications that the patient is currently taking. Allowing a physician to diagnose, prescribe, and dispense medications to a patient via the Internet without having taken a history and completing a physical examination is unethical and places the patient in a position of unnecessary risk, and the physician in the position of unnecessary liability. The AOA therefore supports legislative and regulatory efforts that require establishing an appropriate doctor-patient relationship, as defined by the individual state boards of medicine and osteopathic medicine, before diagnosing and prescribing medicines online.

Several states have taken various approaches to regulating online prescribing.<sup>47</sup> **Colorado's** medical board disciplines doctors who prescribe medications without seeing patients, **Illinois** has passed a law requiring an Illinois pharmacy license for any Internet site that ships to patients in Illinois, and **Nevada's** Board of Medical Examiners

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<sup>45</sup> Gulick, *supra* note 1 at 368.

<sup>46</sup> American Medical Association, *Internet Prescribing* (1999) (<http://www.ama-assn.org/meetings/public/annual99/reports/onsite/bot/rtf/bot35.rtf>)

<sup>47</sup> Regulation through laws: **Arkansas, California, Illinois, Indiana, Nevada, New Hampshire, New York, Texas, and Virginia.** Teresa Floridi, *Online Pharmacies*, Issue Brief, Health Policy Tracking Service, July 1, 2002. Regulation through state boards: **Arizona, Colorado, Connecticut, Illinois, Nevada, New Jersey, Ohio, Texas, Washington, and Wyoming.** American Medical Association, *Internet Prescribing* (1999) <<http://www.ama-assn.org/meetings/public/annual99/reports/onsite/bot/rtf/bot35.rtf>>

prevents physicians from prescribing over the Internet unless they have seen the patient.<sup>48</sup> Also, some state attorneys general have taken action to prevent the sale of pharmaceuticals in their states.<sup>49</sup> However, before 1999, very few doctors or pharmacists have been punished for Internet prescribing.<sup>50</sup> Since 1999, **Arizona, California, Connecticut, Michigan, Missouri, Kansas, New Jersey, Pennsylvania, and Texas** have taken legal action against individuals and companies that conduct online dispensing of prescription drugs.<sup>51</sup>

### Actions Against Illegal Prescribing

#### **Cases are starting to emerge demonstrating the states' strong reaction towards prescribing drugs without first examining the patients.**

On May 28, 2002, California Governor Gray Davis announced that the California State Board of Pharmacy had fined pharmacists \$88 million for alleged violations of a California Internet prescription law passed 18 months previously. The law requires that Internet pharmacies fill prescriptions only after a patient receives a medical examination from a licensed California physician. The State of California alleged that over 3,500 prescriptions were written based on online patient questionnaires.<sup>52</sup>

On May 29, 2002, an Oklahoma doctor involved with the now-closed Nationpharmacy.com was sentenced by a U.S. District Court to 51 months in a federal prison, ordered to forfeit \$660,000 in illegal gains, and will likely have his medical license revoked in June after being convicted of the federal crime of conspiracy to distribute controlled drugs. The Department of Justice alleged that the doctor had been giving prescriptions for controlled drugs over the Internet to patients who had not undergone physical examinations.<sup>53</sup>

The states are not the only ones concerned about these cases; the private sector has also attempted to regulate prescribing over the Internet. Since 1999, the National Association of Boards of Pharmacy (NABP) Verified Internet Pharmacy Practice Sites has certified Internet pharmacies. Certification is available to pharmacies that follow the licensing requirements for their states and for each state to which they ship drugs.<sup>54</sup>

### **Licensure Concerns**

**While the majority of doctors who favor the use of online technology insist they are not practicing medicine by engaging in Internet-based consultations, others have argued to the contrary. If the pro-Internet doctors who use this technology are found to be practicing medicine, then they may face serious licensing issues. Since internet technology has allowed the practice of medicine across state and sometimes, international lines, several licensure problems can arise. A doctor who maintains a site in Illinois could easily reach patients who are accessing the system from another part of the country. In this case, there are questions as to where the doctor who maintains the site should be licensed; should a doctor be licensed in the state where he is located, or the state where the patient is accessing the information?**

Licensure of medical professionals and facilities was intended to accomplish several goals, but most importantly, establish an acceptable standard of care in the medical community that will ensure the welfare of the state's residents. The FSMB has remained true to this goal throughout the growth of telemedicine. Since 1994, at least 24 states have passed laws addressing licensure for physicians utilizing telemedicine technology; these are: **Alabama, Arizona,**

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<sup>48</sup> American Medical Association, *supra* note 30.

<sup>49</sup> P. Greg Gulick, *supra* note 1 at 369.

<sup>50</sup> Naftali Bendavid, *Prescriptions via Internet Pose Dangers*, Chicago Tribune, June 16, 1999, at A1.

<sup>51</sup> Teresa Floridi, *Online Pharmacies*, Issue Brief, Health Policy Tracking Service, July 1, 2002.

<sup>52</sup> Arent Fox Kintner Plotkin & Kahn, PLLC, *Penalties Handed Down in Internet Prescription Cases*, June 16, 2002. (See <http://www.arentfox.com>).

<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

**California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Indiana, Illinois, Kansas, Mississippi, Montana, Nevada, New Mexico, North Carolina, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Utah, and West Virginia.**<sup>55</sup> In 1996, the FSMB adopted model legislation to require doctors who want to practice medicine across state lines by means of internet technology to obtain a special license with reduced price, examination, and credentialing requirements.<sup>56</sup> So far, only six states from the above list enacted legislation consistent with the FSMB, these are: **Alabama, California, Montana, Oregon, Tennessee, and Texas.**<sup>57</sup>

In 2000, the FSMB adopted model guidelines stating they expect “physicians who provide medical care, electronically or otherwise to maintain acceptable standards of practice.”<sup>58</sup> Therefore, in a case where direct treatment and consultation through online technology results in poor outcomes, the hospital, the doctor, or both could be professionally liable, and possibly risk losing their licenses.<sup>59</sup>

Licensing groups have looked at several options such as the use of a consulting exception to the licensing law, endorsement of physicians in other states with equivalent standards, and limited licensure to name a few.<sup>60</sup> In effect, a particular state would recognize the out-of-state license if equivalent standards for licensing existed between the states.<sup>61</sup> Many states are skeptical about allowing a special license for the practice of medicine across state lines via the Internet. Opponents argue that doctors should have a full and unrestricted license in every state in which they practice. They fear that limited licenses will lead many out-of-state doctors to be less qualified to practice in a state than their in-state counterparts.<sup>62</sup> Alternatively, disallowing special or consultant licensure could be construed as interfering with the power of states to regulate health care workers and a barrier to interstate commerce. The U.S. Constitution permits states the authority to regulate activities that affect the health, safety, and welfare of their citizens, including the regulation of physicians’ activity.<sup>63</sup> However, opponents to this type of regulation could argue that limiting or controlling physician licensure when physicians are practicing interstate is a *violation* of the Constitution because it places a restraint on interstate trade. While the argument presents an interesting defense, courts have not yet addressed the issue of whether a state’s decision to limit the practice of medicine in their state to physicians licensed in that state is in fact a restraint on trade.

The question of what constitutes a legal practice of medicine is in many ways left up to each state’s interpretation. Still, most states still require full licensure in the practicing state.<sup>64</sup> **Indiana** and **Texas** specifically include electronic consultations in their definition of what constitutes the “practice of medicine”. In Indiana, consultations with a doctor through “electronic communications” on a “regular, routine, and non-episodic basis” are considered to be the practice of medicine.<sup>65</sup> Consequently, in order for a doctor located outside the state of Indiana to consult with a patient within the state, the doctor must be licensed to practice medicine in Indiana. The definition in Texas works somewhat differently. In Texas, any type of patient care, including interpreting an x-ray through the use of internet-technology devices, is the practice of medicine. However, doctors located in a state other than Texas may provide episodic

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<sup>55</sup> Stephanie Norris, *Telehealth*. Issue Brief: Health Policy Tracking Service, December 31, 2001. (<http://www.hpts.org>).

<sup>56</sup> *Id.*

<sup>57</sup> *Id.*

<sup>58</sup> Federation of State Medical Boards, Special Committee on Professional Conduct and Ethics. *Model Guidelines for The Appropriate Use of the Internet in Medical Practice* Found at ([http://www.fsmb.org/Policy%20Documents%20and%20White%20Papers/internet\\_use\\_guidelines.htm](http://www.fsmb.org/Policy%20Documents%20and%20White%20Papers/internet_use_guidelines.htm)).

<sup>59</sup> *Id.*

<sup>60</sup> Ross Silverman, *The Changing Face of Law and Medicine in the New Millennium: Regulating Medical Practice in the Cyber Age*, 26 Am. J.L. and Med. 255 (2000).

<sup>61</sup> *Id.*

<sup>62</sup> Norris, *supra* note 11.

<sup>63</sup> *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982).

<sup>64</sup> Norris, *supra* note 11.

<sup>65</sup> *Id.* See Ind. Code Ann. 25-22.5-1-1.1(a)(4)(A) & (B) (Michie 1999).

consultation along side another doctor who practices in the same medical specialty as long as the doctor licensed in Texas supervises the patient.<sup>66</sup>

**California** has taken another approach by allowing physicians to practice consultation through online technology as long as they are licensed in one of the fifty states; however, there are some restrictions. The physician must obtain verbal and written consent from the patient who must be informed of all the risks involved in online consultation.<sup>67</sup> Unlike **Indiana** and **Texas**, **California's** laws seem to promote the use of online technology. The statute requiring informed patient consent does not apply to phone or e-mail consultations.<sup>68</sup> Instead, the law seems to protect only those patients who communicate through other computerized means. A second statute in **California** specifically allows consultation from a doctor licensed and located in another state as long as the consultation does not suggest a place to meet patients, and as long as there is a primary care physician who is ultimately responsible, licensed in the state of California.<sup>69</sup>

Often, state laws vary greatly in regards to the use of online technology, and the requirement that physicians obtain a full-unlimited license from each state to practice medicine via the Internet is perceived as overly restrictive. This is particularly relevant to physicians practicing in rural markets and medically underserved areas that are aided through the advancements in online technology. The AOA believes a physician should be licensed in all states in which they practice, and therefore, recommends a policy that decreases licensure barriers that limit access to care, while maintaining necessary health and safety protections.

**The AOA supports and recommends a policy that provides for the practice of medicine via the Internet and that State Medical Boards grant reciprocity for licensure between fellow State Medical Boards whose license regulating the practice of medicine via the Internet, meets equivalent licensing standards.**

## Reimbursement

The added cost of online consultations and Internet-based software has sparked an interest in reimbursement for online services. In the past, many doctors provided online consultation free of charge during its start-up phase, but they have realized that the cost, which is not covered by many insurance carriers, must be passed on to patients.<sup>70</sup> However, survey data suggests that patients are willing to foot the bill for the service; 90% of those polled want online communication with their doctors, and 37% said that they were willing to pay for it. The price can be high; e-mail consultation can range from \$20-\$25 per consultation.<sup>71</sup> Additionally, consumers could pay \$25 for an annual subscription to medical software that would give patients a list of possible diagnoses for a set of symptoms.<sup>72</sup>

Still, states are realizing that as costs for these services increase, fewer people can afford the option. As a result, legislative interest in policies that address reimbursement for online services has been growing. Some states, such as **California** and **Texas**, have begun reimbursement programs of their own. One statute in **California** recognizes an intent to support the practice of medicine via the Internet as a legitimate avenue for a patient to access medical care without in person contact.<sup>73</sup> The law authorizes the Medi-Cal program to reimburse consultations utilizing online methods as long as those consultations are done other than by fax or phone.<sup>74</sup> On a federal level, the Balanced Budget Act of 1997 allowed Medicare payments for medical consultation via an online system for those in rural areas. However, the amount of coverage was subject to Medicare co-payments and deductibles.<sup>75</sup> In 2000, President Clinton signed a law that expanded reimbursement in this area. The law will cover rural areas *and* existing Medicare demonstration sites. In addition, the law creates more eligible online services that can be billed to Medicare. E-mail consultation between a doctor and patient is not covered. The bill became effective on October 1, 2001.

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<sup>66</sup> Gulick, *supra* note 1 at 366. See Tex. Occ. Code Ann. 151.056(b)(1)

<sup>67</sup> Cal. Bus. & Prof. Code 2290.5(a)(1)& (b)(c) (West 1990 & Supp. 2002).

<sup>68</sup> *Id.* at 2290.5(a)(1).

<sup>69</sup> Cal. Bus. & Prof. Code 2060 (West 1999 & Supp. 2002)

<sup>70</sup> Tyler Chin. *Online Consultation: What is it Worth?* American Medical News, June 10, 2002. ([http://www.ama-assn.org/sci-pubs/amnews/pick\\_02/bisa0610.htm](http://www.ama-assn.org/sci-pubs/amnews/pick_02/bisa0610.htm)).

<sup>71</sup> *Id.*

<sup>72</sup> Chin, *supra* note 3.

<sup>73</sup> Cal. Wel. & Inst. 14132.72 (a) (West 2001).

<sup>74</sup> *Id.* at 14132.72(d)

<sup>75</sup> Rubin, *supra* note 7.

Advocates of online consultation expect that more insurers will expand coverage for these services when they recognize that demand is steadily increasing. Currently, very few insurers are agreeing to this arrangement. Blue Shield of California and First Health Group pay their physicians a small amount for consultations, but Medem, a web service started by the American Medical Association, expects patients to pay the full cost for its consultations.<sup>76</sup>

The AOA supports a policy that encourages more state action and legislation supporting the reimbursement by insurance and other third-party reimbursement for appropriate services utilizing online technology, online consultations, and Internet-based health programs.

### **Privacy Issues**

Privacy is a huge concern when looking at programs utilizing on-line medical technology. Since large amounts of data are being transmitted both within and out-of-state, medical professionals need to be particularly vigilant and attentive to patients' privacy rights. In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA).<sup>77</sup> It includes a provision that is meant to protect the privacy of patients whose identifiable health information is transmitted by electronic means. The Act also allows for the preemption of any less stringent state laws regarding privacy. This means that if a state passes any law that effects patient's privacy and it does not meet a higher federal standard, that law will not be controlling.<sup>78</sup> As a result, hospitals and medical professionals need to be very careful when implementing such programs.

The AOA supports a policy that acknowledging the importance of maintaining patients' privacy and encourages states to adopt strict standards and procedures to protect any medical information that is transmitted through electronic means.

### **Conclusion**

*While the American Osteopathic Association recognizes the ever-expanding nature of medicine and the growth in the practice of online technology in the health care field, it equally recognizes the need to protect patients from dangerous practices that may compromise their health and safety. To this end, the AOA supports a policy that will set limits on treatment, diagnosis, and prescribing over the Internet allowing such practice only when a clear doctor-patient relationship has been established. Furthermore, because licensure is greatly affected by individuals practicing medicine via the Internet, the AOA supports and recommends a policy that State Medical Boards issue a license for the practice of medicine via the Internet, and that State Medical Boards grant reciprocity for such licensure between fellow State Medical Boards whose license regulating the practice of medicine via the Internet meets equivalent licensing standards. In addition, the AOA supports a policy that encourages more state action and legislation supporting the reimbursement by insurance and other third-party providers for appropriate services utilizing online technology, online consultations, and Internet-based health programs. The AOA supports a policy acknowledging the maintenance of patients' privacy and encouraging states to adopt strict standards and procedures to protect the confidentiality of any medical information that is transmitted through electronic means. 2003*

## **ONSITE LAB WORK NO.1**

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<sup>76</sup> Rita Rubin. *The Virtual Doctor Will See You Now, But Have Your Credit Card Ready*, USA Today, June 10, 2002. (<http://www.usatoday.com/usatonline>).

<sup>77</sup> 42 U.S.C. 1320d-2

<sup>78</sup> Silverman, *supra* note 26.

**WHEREAS**, many managed care companies deny the performance and remuneration for CLIA approved on-site laboratory tests and other appropriate diagnostic tests and instead require referral to off-site providers for these basic laboratory tests and diagnostic procedures; and

**WHEREAS**, these practices can result in delays in diagnosis and treatment; and

**WHEREAS**, these delays in diagnosis and treatment could be harmful to patients; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports the adoption of national legislation which enables the physician to perform and be compensated for CLIA certified in-office laboratory tests; and, be it further

**RESOLVED**, that the AOA supports the adoption of national legislation which enables the physician to perform and be appropriately compensated for medically indicated on-site diagnostic procedures. 1999; *reaffirmed* 2004

## **ON SITE LAB WORK- NO. 2**

**WHEREAS**, many managed care companies routinely prohibit the performance of reasonable on-site diagnostic tests and require referral to off-site providers for these diagnostic tests; and

**WHEREAS**, these practices can result in unnecessary delays in diagnosis and treatment of patient's condition and illness; and

**WHEREAS**, these delays in diagnosis and treatment can have serious deleterious effects on the patient's health; now, therefore be it

**RESOLVED**, that the American Osteopathic Association work with federal and state governments to enact legislation that requires healthcare plans to pay for appropriate on-site testing at a rate equal to the highest rate paid for the same service to off site providers. 2001

## **OPIOID/OPIATE MEDICATION, LONG-ACTING**

**WHEREAS**, the Drug Enforcement Agency (DEA) has made efforts to establish guidelines for the administration of Opioids/Opiates and other controlled substances; and

**WHEREAS**, the DEA and other state and federal agencies have sought the advice and consent of pain specialist, anesthesiologists and other "specialists" in the development of these standards; and

**WHEREAS**, the treatment of pain and pain management represents a major component of an osteopathic physicians practice; and

**WHEREAS**, the American College of Osteopathic Family Physicians (ACOFP) Board of Governors has approved a policy opposing any federal law or regulation that attempts to limit the ability of family physicians to legally prescribe, administer, or dispense controlled substances; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association adopt the following policy on Long-Acting Opioid/Opiate Medication on behalf of the entire osteopathic profession.

### Long-Acting Opioid/Opiate Medication

It is a right of all patients to have access to medically appropriate intervention and/or treatment of acute and chronic pain. It is the right of all physicians, to provide medically appropriate intervention and treatment modalities that will achieve safe and effective pain control for all their patients.

As patient advocates and physicians, we believe that it is in the best interest of all patients not to confine, or seek to regulate opioid/opiate medications by limiting their use to a small number of selected specialties of medicine. This would also extend to modalities now developed, or yet to be developed, such as long-acting opioid/opiate preparations. These exclusionary strategies will limit access for patients with medical indications for therapy, complicate delivery of care, and add to pain and suffering of patients in all areas of our country. 2005

#### **ORGAN DONATION AND TRANSPLANTATION INITIATIVES—COMMITMENT TO**

**WHEREAS**, organ donation and transplantation efforts mobilize medical resources in the battle against a myriad of life-threatening diseases; and

**WHEREAS**, public education and outreach concerning the benefits of organ donation and transplantation are vital in the campaign to maximize the effectiveness of current medical treatments; and

**WHEREAS**, public and private sector initiatives, such as those of the United Network for Organ Sharing and the Office of the Surgeon General, have paved the way for improved patient access to organ and tissue reserves; and

**WHEREAS**, the American Osteopathic Association has had policy encouraging organ donor identification since 1988 and is seeking to further its efforts to provide physician leadership to advocate patient interests in this area; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association affirms its support for organ donation and transplantation programs at local and national levels; and, be it further

**RESOLVED**, that the AOA direct its End-of-Life Care Advisory Committee to develop physician and public education programs to advance the cause of organ donation and transplantation; and, be it further

**RESOLVED**, that the AOA Board of Trustees, the House of Delegates, their families, and members of the profession be urged to volunteer personally as organ donors, and in turn, actively encourage their patients to do the same; and, be it further

**RESOLVED**, that the AOA encourage osteopathic divisional and specialty organizations, osteopathic medical colleges, and other members of the osteopathic family to develop organ donation programs in their states and organizations. 2001

#### **ORGAN DONATION—OPPOSITION TO FINANCIAL INCENTIVES FOR ORGAN DONORS**

**WHEREAS**, the US Department of Health and Human Services has documented an ongoing shortage of organ donors; and

**WHEREAS**, medical leaders have been charged with the quest to develop new and innovative ways for achieving organ donor goals; and

**WHEREAS**, financial incentives have been criticized as an ineffective and potentially dangerous solution to increase organ donor rates; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association states its opposition to direct payment or other financial reimbursement in exchange for donation of human organs and tissue; and be it further

**RESOLVED**, that the osteopathic medical profession investigate other, more ethical alternatives to raising organ donor identification rates while preserving its first duty to protecting patient interests. 2002

## **ORGAN DONOR IDENTIFICATION**

**WHEREAS**, the AOA has committed itself to raising awareness of and access to organ donation and transplantation resources; and

**WHEREAS**, government reports have documented an ongoing shortage of available organs and eligible donors; and

**WHEREAS**, appropriate counseling by primary care physicians has been shown to favorably impact the process of identifying potential organ donors; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association encourages osteopathic physicians to discuss organ donation options with their outpatients as well as their inpatients; and, be it further

**RESOLVED**, that all physicians honor the policies of their designated Organ Procurement Organization in achieving optimal organ donor identification goals. 2002

Explanatory Statement: The US Department of Health and Human Services designates local and regional Organ Procurement Organizations (OPO) to work directly with healthcare facilities. Since OPO policies vary, it is important that physicians understand they must still follow state and federal guidelines in identifying potential organ donors. The Bureau of Healthcare Facilities Accreditation supports physicians being encouraged to discuss organ donation with their patients and agrees that all physicians should honor the policies of their Organ Procurement Organization in achieving optimal organ donor identification goals. The Bureau does not agree with adding organ donation preferences as a required part of primary care assessment procedures. The Bureau currently has several accreditation requirements related to organ procurement issues within its Accreditation Requirements for Healthcare Facilities.

## **OSTEOPATHIC GRADUATE MEDICAL EDUCATION**

**WHEREAS**, the future of osteopathic medicine relies on the continuing osteopathic intern and residency programs for graduates of osteopathic medical colleges; and

**WHEREAS**, many of the osteopathic graduate medical training programs are residing in community hospital settings; and

**WHEREAS**, financial incentives are lacking for these hospitals; and

**WHEREAS**, Medicare and Medicaid are cutting back on funding for graduate medical education; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association urge its member physicians to support hospitals which provide osteopathic internships, residencies and fellowships which are an integral part of osteopathic medical education. 1998 *revised* 2003

## **OSTEOPATHIC GRADUATE MEDICAL EDUCATION FUNDING**

**WHEREAS**, the future of the osteopathic profession lies in its ability to continually improve the quality Graduate Medical Education (GME) programs that present the profession as a profession based on excellence; and

**WHEREAS**, the present and future growth and maintenance of membership in osteopathic organizations are in part based on the continued growth and viability of quality GME programs; and

**WHEREAS**, the continuing of separate and distinct AOA accredited GME programs are essential in promoting the participation of active membership in osteopathic organizations; and

**WHEREAS**, the majority of funding of GME is funded by federal government programs such as Medicare, Medicaid and other federal and state programs; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association will continue efforts that encourage support and awareness of osteopathic GME programs within governmental entities. 1994; *revised* 1999, *revised* 2004

### **OSTEOPATHIC LICENSING**

**WHEREAS**, osteopathic medicine is a philosophically distinct and educationally separate school of medicine rather than simply an individual discipline within medicine; and

**WHEREAS**, Pluralism has worked well in credentialing osteopathic and allopathic physicians, and should continue; and

**WHEREAS**, the examinations of the National Board of Osteopathic Medical Examiners, Inc., are the only examinations which integrate osteopathic principles and practices throughout; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association reaffirms its position that the only examinations able to fully evaluate the ability and competency of osteopathic physicians for licensure are the examinations developed by the National Board of Osteopathic Medical Examiners, Inc. 1982; *revised* 1987, 1992, 1997, 2002

### **OMT--OSTEOPATHIC MANIPULATIVE TREATMENT**

**WHEREAS**, osteopathic medicine is a profession with full practice rights; and

**WHEREAS**, the osteopathic manipulative treatment is an integral part of osteopathic medicine; and

**WHEREAS**, the word “therapy” is associated with therapists and other persons that have different levels of education, responsibility and breadth of practice; and

**WHEREAS**, the use of the term “osteopathic manipulative therapy” will give the false impression that: (1) DOs are therapists or, (2) therapists who are not fully trained DOs can perform this form of intervention; now, therefore, be it

**RESOLVED**, that in all forms of communication the term OMT shall always be “Osteopathic Manipulative Treatment.” 1999; *revised* 2004

### **OMT IN A PRE-PAID ENVIRONMENT--REIMBURSEMENT POLICIES FOR**

**WHEREAS**, Independent Practice Associations (IPAs) contracting for prepaid enrollment must offer a full range of covered benefits to those enrollees; and

**WHEREAS**, the Centers For Medicare And Medicaid Services (CMS) has adopted osteopathic manipulative treatment (OMT) as a separately identifiable, reimbursable, physician-provided service in both a fee-for-service and prepaid environment; and

**WHEREAS**, other forms of manipulation usually are a covered benefit; and

**WHEREAS**, osteopathic physicians are highly trained in the integration of expert, cost-effective and judicious application of osteopathic manipulative treatment when indicated and appropriate; and

**WHEREAS**, IPAs working under Primary Care Physician (PCP) capitation generally capitate their primary care providers for a defined set of PCP responsibilities and skills; and

**WHEREAS**, equivalent capitation needs to be given for equivalent scope of PCP responsibilities; and

**WHEREAS**, most allopathic physicians are not trained in the utilization of manipulative procedures; and

**WHEREAS**, chiropractic or physical therapy manipulation, when authorized, is considered a specialty procedure; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association work to ensure that osteopathic manipulative treatment in any prepaid health plan be recognized as a separate procedure; and, be it further

**RESOLVED**, that the AOA work to ensure that osteopathic manipulative treatment as a procedure applied by fully-licensed physicians and surgeons be considered unique; and, be it further

**RESOLVED**, that the AOA work to ensure that osteopathic manipulative treatment in any prepaid health plan be compensated as a special separate procedure, either by payment of additional capitation or on a fee-for-service basis without the need for prior authorization. 1995; *revised* 2000, 2005

### **OSTEOPATHIC MANIPULATIVE TREATMENT--REIMBURSEMENT FOR**

**WHEREAS**, osteopathic physicians are educated and trained for the full practice of medicine; and

**WHEREAS**, the rendering of osteopathic manipulative treatment (OMT) is a unique modality which only osteopathic physicians are qualified to offer patients; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association pursue any and all legal and legislative recourse to protect the rights of its member physicians to deliver approved and beneficial modalities of healthcare; and, be it further

**RESOLVED**, that the American Osteopathic Association object to any attempt by third party payors to deny or restrict reimbursement for osteopathic manipulative treatment when appropriately rendered; and, be it further

**RESOLVED**, that the AOA continue to oppose any attempt by third-party payers to interchange and/or combine osteopathic manipulative treatment codes with codes used to describe other forms of manual manipulative treatment therapy. 1986; *revised* 1991, 1992, 1997, *revised* 2002

### **OMT AND EVALUATION AND MANAGEMENT (E&M) ON THE SAME DAY OF SERVICE-- REIMBURSEMENT FOR**

**WHEREAS**, many managed care insurers do not reimburse osteopathic physicians for performing osteopathic manipulative treatment (OMT) and consider OMT as part of an office visit; and

**WHEREAS**, primary care physicians performing OMT in addition to evaluation and management (E&M) may not receive a higher capitated amount than other primary care physicians not performing OMT; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports remuneration for osteopathic manipulative treatment (OMT). 1998, *revised* 2003

### **OSTEOPATHIC MANIPULATIVE TREATMENT--SUPERVISION FOR**

**WHEREAS**, osteopathic physicians in-training have expressed concern regarding supervising attending physicians' (MD and DO) denial of their appropriate utilization of osteopathic diagnosis and osteopathic manipulative treatment (OMT) procedures; and

**WHEREAS**, the American Osteopathic Association's basic documents for internship and residency training programs provide for the appropriate integration of osteopathic diagnosis and OMT in patient care; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association strongly encourages all supervising physicians to foster the appropriate utilization of osteopathic diagnosis and osteopathic manipulative treatment by students, interns and residents assigned to them. 1997; reaffirmed 2002

#### **OSTEOPATHIC MEDICINE—AUTONOMY OF**

**WHEREAS**, osteopathic medicine is a complete and distinct philosophy of medicine, serving the public for more than 100 years; and

**WHEREAS**, osteopathic medicine has attained its present status on the basis of merit and acceptance by the public; and

**WHEREAS**, osteopathic medicine and the osteopathic profession have developed appropriate liaisons with national, state, and local governments; and

**WHEREAS**, osteopathic profession has developed a system of medical education recognized by accrediting agencies and by institutions of higher learning; and

**WHEREAS**, the best interests of the health and welfare of the public and of the nation are best served by the continuance of a complete and distinct osteopathic profession; now, therefore, be it

**RESOLVED**, that the osteopathic profession in the interest of providing the best possible healthcare to the public shall maintain its status as a complete and distinct philosophy of medicine. 1959; *reaffirmed* 1965, 1974, 1980, 1985; *revised* 1990, 1996, 2001

#### **OSTEOPATHIC MEDICINE DEFINITION**

**RESOLVED**, that the following definition of osteopathic medicine, as revised by the AOA House of Delegates in 1998, be reaffirmed:

*Osteopathic Medicine*: A complete system of medical care with a philosophy that combines the needs of the patient with the current practice of medicine, surgery and obstetrics; that emphasizes the interrelationship between structure and function; and that has an appreciation of the body's ability to heal itself. 1991; *revised* 1992, 1997, 1998, *reaffirmed* 2003

#### **OSTEOPATHIC MUSCULOSKELETAL EVALUATION**

**WHEREAS**, an osteopathic musculoskeletal evaluation is an integral part of the physical examination; and

**WHEREAS**, the osteopathic musculoskeletal evaluation provides additional information regarding the health of the patient; now, therefore, be it

**RESOLVED**, that the osteopathic physician continue to utilize osteopathic musculoskeletal evaluation including the concepts of body unity, self-regulation, and structure-function interrelationships, to assess the patient's status and develop a plan of treatment. 1982; *reaffirmed* 1987; *revised* 1992, 1997, 2002

## **OSTEOPATHIC POSTDOCTORAL TRAINING IN ALL SPECIALTY AREAS**

**WHEREAS**, the American Osteopathic Association represents a school of medical practice; and

**WHEREAS**, this system of medicine contains its own colleges, hospitals, graduate medical education programs, specialty systems and OPTI programs; and

**WHEREAS**, osteopathic medical students must be instructed in programs taught by osteopathic physicians who appreciate and uphold the osteopathic philosophy and principles; now; therefore, be it

**RESOLVED**, that the osteopathic profession reaffirms itself as a complete profession of medicine and surgery; and, be it further

**RESOLVED**, that the AOA reaffirm its commitment to osteopathic postdoctoral training in all specialty areas. 1993; *revised* 1998, *revised* 2003

## **“OSTEOPATHY”-- USE OF THE TERM**

**WHEREAS**, osteopathy, as founded and named by Dr. Andrew Taylor Still, is the historical descriptor for this profession; and

**WHEREAS**, the use of the terms osteopathy and osteopathic medicine are appropriate when used to distinguish our form of healthcare from the allopathic model in the United States; and

**WHEREAS**, our distinct contributions to healthcare are being recognized by governmental agencies, third party carriers, healthcare agencies and the public; and

**WHEREAS**, healthcare reform is demanding that non-allopathic models of healthcare be promoted; and

**WHEREAS**, osteopathy/osteopathic medicine in the United States is the only complete and appropriate alternative to allopathic medicine; and

**WHEREAS**, osteopathy/osteopathic medicine is a complete system of healthcare in the United States and as such is much more holistic than medicine in the classical sense; and

**WHEREAS**, osteopathy is widely recognized outside the United States; and

**WHEREAS**, the practitioners of osteopathy outside the U.S. have a limited license allowing them to practice osteopathic diagnosis and treatment and precludes the practice of medicine, pharmacology, and surgery while working as a complement to standard medicine; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association (AOA) reaffirm its editorial policy of July 2000 to permit the use of the terms osteopathy and osteopathic medicine as interchangeable in the United States; and, be it further

**RESOLVED**, that the American Osteopathic Association institute a policy, both officially in our publications and individually on a conversational basis, to use the term “osteopathic physician and surgeon” in place of the word “osteopath”; the word “osteopath” being reserved for historical, sentimental and informal discussions only as well as for osteopaths educated outside the United States. 1994; *reaffirmed* 2000; *revised* 2005

## **PATIENT ACCESS IN RURAL AREAS**

**WHEREAS**, managed care enrollees in rural areas often have no local network physicians or hospitals to provide medical care; and

**WHEREAS**, some managed care enrollees must travel long distances to the nearest network physicians or hospitals; and

**WHEREAS**, healthcare plans should guarantee adequate access to providers in an enrollee's proximate area; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports legislation on the state and federal levels that would require all managed care health plans to have reasonably placed network physicians and hospital access; if the distance is unreasonable, the plans should pay for out of network services at no additional cost to the patient. 1995; *revised* 2000, 2005

#### **PATIENT CONFIDENTIALITY**

**WHEREAS**, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and HIPAA regulations place strict limitation upon a physician's use or disclosure of a patient's health information; and

**WHEREAS**, it has become the practice of some insurance companies to demand copies of complete medical records prior to reimbursement for physicians services; and

**WHEREAS**, this practice sometimes places the physicians in jeopardy of inadvertently violating legal and ethical requirements with respect to confidentiality; now, therefore, be it

**RESOLVED**, that in such cases where the physician is bound by law to protect patient confidentiality, the physician shall only be required to provide information that can be disclosed under law and where possible, the physician shall be allowed to submit narrative reports or only copies of the part of a medical record that is pertinent in lieu of a complete record. 1993; *reaffirmed* 1998; *revised* 2003

#### **PATIENT EDUCATION**

**WHEREAS**, patient education is an important component of the physician's responsibility to the patient; and

**WHEREAS**, the American Osteopathic Association plays a leadership role in advancing patient education through its participation in conferences on patient education, and its ongoing communications to its members in support of augmented patient education; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association reaffirms its commitment to the advancement of patient education to promote a better understanding of personal health and wellness.. 1983; *revised* 1988, 1993, 1998, 2003

#### **PATIENT INTERPRETERS**

**WHEREAS**, a federal rule has been published to mandate physicians provide an interpreter for patients who are not English proficient; and

**WHEREAS**, the Centers for Medicare and Medicaid Services (CMS) does not provide reimbursement for the interpreters; and

**WHEREAS**, few, if any other entities are expected to hire individuals to provide a service without reimbursement; and

**WHEREAS**, in some areas accessing an interpreter in a timely manner may be difficult; and

**WHEREAS**, the rule has a potential to reduce patients' access to be seen by a physician because of the mandated interpreter rule; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association support efforts to seek having the rule revised to eliminate the unfunded mandate of physicians to provide interpreters for patients; and, be it further

**RESOLVED**, that the AOA request the Centers for Medicare and Medicaid Services (CMS) to implement reasonable reimbursement directly to an interpreter. 2001

## **PATIENT-PHYSICIAN RELATIONS**

**WHEREAS**, recent political and judicial events have raised the question of restrictions upon the nature of medical information which a physician may discuss with a patient or person responsible for a patient; and

**WHEREAS**, in 1991, the Supreme Court in *Rust vs. Sullivan* upheld HHS regulations stating that a physician cannot legally inform a patient of all medical options related to family planning paid for by HHS Title X monies; and

**WHEREAS**, the essence of the patient-physician relationship rests upon a patient's confidence in the physician's ability and willingness to freely discuss, in complete privacy, any and all medical information which may have any bearing on the welfare of that patient; and

**WHEREAS**, the fundamentals of medical care rest on the right of a patient to complete medical information and the right and responsibility of a physician to provide that information, guided by the welfare of the patient above all other considerations, and in complete confidence; and

**WHEREAS**, any precedent allowing intrusion upon those rights in any regard, for any reason, is a direct attack on that relationship and therefore on the physician's ability to care for a patient; and

**WHEREAS**, such a precedent claims the right of the state to censor conversations held in the sanctity of the professional relationship; and

**WHEREAS**, such censorship is odious both to the American principle of freedom of speech and the millennia-old nature of the relationship between patient and physician; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association unalterably reject any claim of a right to censorship of professional communication, in any regard, and for any reason; and, be it further

**RESOLVED**, that the AOA work to secure enactment of legislation protecting these necessary rights of patients and physicians; and, be it further

**RESOLVED**, that the AOA continue to oppose any and all attempts to alienate the nature of the patient-physician relationship. 1991; *revised* 1996, 2001

## **PATIENT SAFETY**

**WHEREAS**, patient safety and quality of care have always been a concern of the American Osteopathic Association and its divisional societies; and

**WHEREAS**, levels of reimbursement to hospitals for patient care have been dramatically reduced due to cutbacks in Medicare and reductions by insurance companies and managed care entities; and

**WHEREAS**, there currently exists a concern for in-hospital patient safety as a result of staff shortages as well as the possible jeopardizing of patient recovery by premature discharges; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association and its state affiliates endorse a policy of patient safety in health care that encourages payers to provide adequate reimbursement so that hospitals can provide the best quality care in the safest of environments. 2002

## **PEDIATRIC DRUG TESTING**

**WHEREAS**, children are not "little adults"; and

**WHEREAS**, drugs used in pediatrics should have the same rigorous scientific studies that are required for the use of that drug in adults; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports legislation requiring all pharmaceutical companies to ensure all drugs with therapeutic benefits for children are tested for their use; and, be it further

**RESOLVED**, that all new drugs to be studied in children at the same time, or soon after, the drug is approved for use in adults. 2003

#### **PEDIATRIC PSYCHIATRIC CARE**

**WHEREAS**, pediatric psychiatric issues are becoming an increasing part of a primary care physician's practice; and

**WHEREAS**, the general public, school security services and physicians are seeing and reporting an increasing number of disturbances in children and adolescents which threaten the lives of family members and our community; and

**WHEREAS**, many insurance providers are refusing or providing minimal reimbursement for counseling and psychiatric care; and

**WHEREAS**, primary care physicians are not adequately trained to handle this burden; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association (AOA) support the development of educational programs to assist primary care physicians to identify and initiate appropriate support; and, be it further

**RESOLVED**, that the AOA encourage insurance providers to adequately reimburse counseling and psychiatric care deemed necessary by the patient's primary care physician. 2005

#### **PEER REVIEW**

**WHEREAS**, the American Osteopathic Association has always fostered and encouraged peer review, both through voluntary mechanisms and, since 1972, through Federal Peer Review Programs; and

**WHEREAS**, the AOA wishes to reaffirm its commitment to peer review regardless of federal policy or program changes; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association hereby affirms its commitment to promote and facilitate peer review among and through its members; and, be it further

**RESOLVED**, that the AOA believes that the voluntary hospital peer review process remains the most natural and appropriate vehicle through which to effect institutional peer review; and, be it further

**RESOLVED**, that all review under the peer review organization program of osteopathic diagnosis and therapeutics be performed by osteopathic physicians. 1981; *revised* 1983, 1987, 1992; reaffirmed 1994, 1999; (*referred in 2004*)

#### **PEER REVIEW BY EQUAL CREDENTIALING**

**WHEREAS**, the American Osteopathic Association supports peer review of osteopathic physicians by osteopathic physicians; and

**WHEREAS**, peer review takes place in both hospital and outpatient settings; and

**WHEREAS**, various entities, including the Centers for Medicare and Medicaid Services (HFCA), managed care organizations, third party payors, and workers' compensation programs often use peer review for determination in reimbursement decisions; and

**WHEREAS**, osteopathic specialty training is unique due to its osteopathic philosophy;  
and

**WHEREAS**, the AOA is the recommended certifying body for osteopathic postdoctoral training programs; and

**WHEREAS**, non-osteopathically trained physicians lack the additional education provided in osteopathic postdoctoral training; now, therefore be it

**RESOLVED**, that the American Osteopathic Association supports peer review of osteopathic physicians by other osteopathic physicians who have earned the same AOA certification credentials. 1996; *(to be considered in 2005)*

### **PEER REVIEW OF OSTEOPATHIC MANIPULATIVE TREATMENT**

**WHEREAS**, many insurers carriers have claims for the service of OMT “peer reviewed” by health care providers that are either not trained or who are inadequately trained in Osteopathic Principles and Practices; and

**WHEREAS**, osteopathic physicians are highly trained in the integration of expert, cost effective and judicious application of osteopathic manipulative treatment when indicated and appropriate; and

**WHEREAS**, most allopathic physicians are untrained in the utilization of osteopathic manipulative procedures; and

**WHEREAS**, chiropractors and physical therapists are untrained in the integration of osteopathic manipulative treatment and the unlimited practice of medicine and surgery; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association pursue any and all legal and legislative recourse to assure that the peer review of claims regarding the provision of OMT procedures may only be conducted by a qualified osteopathic physician; and, be it further

**RESOLVED**, that the only health care providers qualified to review OMT procedures are licensed osteopathic physicians. 2003

### **PEER REVIEWERS**

**WHEREAS**, osteopathic physicians acting as medical directors of insurers may make coverage decisions which affect the financial ability of patients to receive appropriate medical treatment; and

**WHEREAS**, osteopathic physicians acting as expert witnesses during trial may provide incomplete or inaccurate testimony which ultimately affects a practicing physician's ability to practice good and appropriate medical care of a patient without fear of legal jeopardy; and

**WHEREAS**, osteopathic physicians acting as hired peer reviewers for insurers, may give inappropriate or incomplete evaluations of medical records, which denies payment for further medically necessary patient treatment, and may cause other osteopathic physicians to avoid treating future patients with that insurer, thus affecting patient access to care; and

**WHEREAS**, the above actions of such osteopathic physicians can adversely affect and alter the clinical course and ultimate outcome of a patient's care by other physicians now, therefore, be it

**RESOLVED**, that the American Osteopathic Association adopt the position that osteopathic physicians acting as medical directors, expert witnesses, or peer reviewers, and affecting patient treatment, outcome of care and access to care, are practicing osteopathic medicine; and, be it further

**RESOLVED**, that the AOA pursue this clarification of defining osteopathic medicine through regulation or legislation and would require that only peers will be in the position to determine action (if necessary) to be taken. 1999; (*referred in 2004*)

#### **PHARMACEUTICAL PACKAGING/ ENVIRONMENTAL RESPONSIBILITY**

**WHEREAS**, the general public is becoming much more environmentally concerned; and  
**WHEREAS**, it is obvious to the members of the American Osteopathic Association that packaging of samples and promotional products by the pharmaceutical companies is often superfluous and unnecessary; and

**WHEREAS**, the unnecessary packaging is a source of expense for both the cost of production and disposal that is ultimately borne by the general public; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports environmentally responsible packaging of samples. 1991, *reaffirmed* 1994, 1999; *revised* 2004

#### **PHARMACEUTICALS--SUPPORT EFFORTS TO ENCOURAGE THE PROPER DISPOSAL OF UNUSED AND EXPIRED**

**WHEREAS**, pharmaceuticals can be an accidental health threat, illegally diverted, or used by others; and

**WHEREAS**, the United States has experienced an increase in prescription narcotic drug overdoses; and

**WHEREAS**, deaths from narcotic prescription drugs have surpassed those from illegal drugs in many states; and

**WHEREAS**, pharmaceuticals can contaminate the environment, damage sewage treatment plants or septic systems; now, therefore, be it

**RESOLVED**, that the AOA work with the appropriate regulatory/environmental and public health agencies to encourage the development of educational materials for the public on the dangers of keeping unused and expired pharmaceuticals in their possession; and, be it further

**RESOLVED**, that such materials also include education on the proper disposal of unused and expired pharmaceuticals. 2004

#### **PHARMACIES/PHARMACEUTICAL COMPANIES PARTNERSHIP**

**WHEREAS**, pharmaceutical companies may enter into agreements with pharmacy chains to conduct disease care management programs, now, therefore, be it

**RESOLVED**, that the American Osteopathic Association opposes any expansion in the scope of practice for pharmacists or pharmacy chains as a result of these agreements; and, be it further

**RESOLVED**, that the AOA work to ensure that the physician-patient relationship is protected. 1999; *revised* 2004

#### **PHYSICAL FITNESS AND SPORTS**

**WHEREAS**, the lack of physical fitness among Americans contributes to a decline of human and financial resources; and

**WHEREAS**, substantial evidence supports the belief that serious, chronic health problems, such as cardiorespiratory and lower back disabilities, begin in childhood and adolescence; and

**WHEREAS**, studies show that a relationship exists between quality physical education of children and the physical activity habits of adults; and

**WHEREAS**, lifetime physical activity is learned individual behavior; and

**WHEREAS**, the American Osteopathic Association and President's Council on Physical Fitness and Sports defines physical fitness as the ability to carry out daily tasks with vigor and awareness, without undue fatigue and with ample energy to enjoy leisure time pursuits and to meet emergencies; physical fitness is essential for safe and effective performance in physical activity, such as household chores, work, physical recreation, sports, and in improved health and intellectual performance; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association joins with the President's Council on Physical Fitness and Sports to strongly urge all school districts to provide daily physical education and structured physical activity for all children for grades K-12, and in addition, the AOA and the President's Council on Physical Fitness and Sports recommends that schools emphasize the following areas:

1. Every pupil should be evaluated for physical fitness at least twice a year;
2. Every pupil should have a visual posture check, body composition screening assessment and routine vision and hearing screening with appropriate follow-up;
3. Pupils found not to be physically fit should be given appropriate attention;
4. Disabled students should be included in all appropriate physical activities.

1991; *revised* 1996, 2001

## **PHYSICAL FITNESS PROGRAM**

**WHEREAS**, multiple studies have been performed by professional research teams demonstrating the positive effects of preventive physical fitness programs; and

**WHEREAS**, the osteopathic profession has always, on a philosophical and practical basis, provided osteopathic healthcare on the premise of prevention-fitness as a part of its comprehensive approach; and

**WHEREAS**, the osteopathic profession realizes the importance of neuromusculoskeletal systems as the primary systems through which we can promote positive fitness levels; and

**WHEREAS**, the increased fitness levels which are derived through the proper use of the neuromusculoskeletal systems, through fitness, can also provide major visceral effects which yield positive general body homeostasis; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association believes that preventing and decreasing chronic disease can be accomplished through sound physical fitness programs which are performed on a regular basis, by responsible patients in cooperation with their osteopathic physicians; and, be it further

**RESOLVED**, that the AOA work to encourage school systems to implement regular mandatory physical education programs through all grade levels. 1981; *reaffirmed* 1986; *revised* 1991, 1992; *reaffirmed* 1997, revised 2002

## **PHYSICIAN ADMINISTERED OMT**

**WHEREAS**, the Physician's Current Procedural Terminology (CPT) book includes code numbers and descriptions for osteopathic manipulative treatment (OMT); and

**WHEREAS**, the OMT CPT codes in the book specifically state physician applied; and

**WHEREAS**, the term physician should be limited to doctors of osteopathic medicine (DO) and doctors of allopathic medicine (MD); now, therefore, be it

**RESOLVED**, that the American Osteopathic Association actively oppose the use of Osteopathic Manipulative Treatment (OMT)/ Current Procedural Terminology (CPT) codes by groups other than fully-licensed osteopathic and allopathic physicians and that the AOA work diligently to reverse such policies, wherever they exist, that allow non-physicians to utilize OMT/CPT codes for reimbursement.. 1994; *revised* 1999, 2004

### **PHYSICIAN ASSISTED SUICIDE--AOA POSITION**

**WHEREAS**, government and courts are seriously discussing physician assisted suicide and considering legislation to establish policy on this issue; and

**WHEREAS**, state legislators and courts are seriously considering laws to allow physician assisted suicide; and

**WHEREAS**, physician assisted suicide is unnecessary as terminally and chronically ill patients can be treated with palliative and drug therapy to relieve pain and suffering and improve their quality of life; and

**WHEREAS**, the osteopathic physician oath states, it is their responsibility to preserve health and life of their patients and further, they will give no deadly drugs to any though it may be asked; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association provide information on the care of the terminally ill to physicians and the public; and, be it further

**RESOLVED**, that the AOA provide osteopathic physicians with continuing medical education on palliative and drug therapy utilized to provide patients with an improved quality of life; and, be it further

**RESOLVED**, that the osteopathic medical colleges consider including in their curriculum, a specific course of study on pain management and palliative treatment of the terminally and chronically ill, specifically addressing the goals, objectives and value of hospice care; and, be it further

**RESOLVED**, that continuing medical education programs include information and resources for physicians on supportive care valuable to their patients, including, but not limited to hospice care; and, be it further

**RESOLVED**, that the osteopathic profession take a leadership role in providing the public information on the alternatives to physician assisted suicide and the potential abuse of this kind of public policy, both morally and economically; and, be it further

**RESOLVED**, that the AOA oppose legislation to legalize or mandate physician assisted suicide. 1997; reaffirmed 2002

### **PHYSICIAN COMPETENCY RETESTING**

**WHEREAS**, efforts are being made at a number of levels to encourage retesting of the competency of physician in practice; and

**WHEREAS**, several states have proposed mandatory testing as a condition of re-licensure; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association opposes any attempt by federal or state agencies to mandate re-certification or retesting, either as a condition of re-licensure, or as a requirement for receiving payment under a health benefits program; and be it further

**RESOLVED**, that the AOA will continue its voluntary efforts to address this issue of professional competency through the education of osteopathic physicians in their established core competencies. 1988; *reaffirmed* 1993; *revised* 1998, 2003

## **PHYSICIAN DEFINITION**

**WHEREAS**, certain sections of Titles 18 and 19 of the United States Code include in the definition of the term physician, providers other than complete physicians (DO or MD); and

**WHEREAS**, the continued expansion of the term physician has resulted in confusion on the part of the general public as to what services particular practitioners are qualified to provide; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association, endorses the position that only fully trained and licensed DOs and MDs be identified as physicians. 1984; *revised* 1987, 1988, 1993; *reaffirmed* 1998, 2003

## **PHYSICIAN FEES AND CHARGES**

**WHEREAS**, the American Osteopathic Association's Divisional Societies occasionally receive complaints from patients concerning the assessment of copy charges, charges for missed appointments and similar matters; and

**WHEREAS**, complaints which involve osteopathic physicians are sometimes referred to osteopathic societies by state and local medical associations; and

**WHEREAS**, it is difficult to mediate complaints without an established policy in order to assist both the physician and the patient; now, therefore, be it

**RESOLVED**, that the following policy on *Physician Fees and Charges* be approved:

### **PHYSICIAN FEES AND CHARGES**

#### **1. *Physician's Fees***

A physician's fees should be directly and solely based on the medical services provided to the patient, with due respect for:

- a. The difficulty and/or uniqueness of the services;
- b. The time, skill, and experience required;
- c. Customary fees charged for the same service in the same community;
- d. Overhead and professional liability costs.

#### **2. *Excessive Fees***

A physician should not collect excessive fees.

#### **3. *Reduced Fees***

A physician has the right to offer his/her services at a reduced fee, or without fee, when hardships exist or professional courtesy dictates, if he/she desires to do so.

#### **4. *Specialty Designation***

A fee should not be dependent upon a physician's specialty designation but upon the services provided. Any physician who provides a service for which he/she is properly trained has the right to charge the prevailing rate for such service, whether the service is performed by a family physician, a surgeon, an internist, or any other specialist.

#### **5. *Contingency Fees***

A physician's fees should be based directly on professional services rendered and not contingent on uncertain outcome. It is, therefore, deemed unethical for a physician to charge contingency fees.

**6. *Division of Fees***

Group practices and partnerships may ethically divide income based on service, contribution to the group, and/or contractual obligations.

**7. *Fee Splitting***

No physician may ethically split a fee to, or accept a fee from, another physician solely for the referral of a patient nor shall a physician accept payments from a hospital, clinic, laboratory, or other healthcare facility based upon patient referrals to that establishment. Surgeons may ethically engage other physicians to assist in the performance of a surgical procedure; however, the financial arrangements should be made known to the patient. This principle applies whether or not the assisting physician is the referring physician.

**8. *Referrals to Suppliers***

Physicians shall not accept payment of any kind from any source such as a hospital, clinic, laboratory, pharmaceutical company, device manufacturer, pharmacist or other healthcare provider or supplier, for referring patients to said facility or prescribing such entity's products. All referrals and prescriptions must be based on the patient's needs and sound medical decision-making, all in the patient's best interest.

**9. *Form Completion Charges***

A physician may make a clerical charge for completion of complex insurance forms.

**10. *Copying Charges***

A physician may charge the prevailing rate for the copying of patient records and postage incurred in mailing.

**11. *Missed Appointments***

A physician may ethically charge for missed appointments, or appointments cancelled less than 24 hours in advance, provided:

- a. The patient has been previously notified in writing of the policy;
- b. Utmost consideration is given to the patient, including the circumstances involved;
- c. The practice is resorted to infrequently;
- d. The physician's patient load is considered.

**12. *Delinquent Accounts***

Harsh or grossly commercialized collection practices are discouraged. If a physician has experienced problems dealing with patients who have delinquent accounts, he/she may properly request payment for service at the time of treatment, or may add interest or other late-payment charges in accordance with state and federal laws. The patient must be notified of such a policy in advance by one or more of the following:

- a. Posting a notice in the waiting room;
- b. Distribution of patient handbooks containing the policy;
- c. Notification by special letter;
- d. Notation of the policy on the billing statement before the charge is incurred.

The American Osteopathic Association encourages physicians to make exceptions to implementing these collection charges in case of financial hardship, after consultation with the involved patient.

The exception to waiving collection charges is the patient who receives payment for medical services from his/her insurance company, and then fails to make payment to the physician. In this case, all legal pressure may be brought to bear on the patient and the insurance company in order to discourage this practice, both by the insurance company and by the patient.

### **13. Legal Restrictions**

The foregoing statements are subject to any restrictions imposed by any state and federal laws or contractual obligations. 1998, *reaffirmed* 2003

## **PHYSICIAN HEALTH ASSISTANCE**

**WHEREAS**, a primary responsibility of the osteopathic profession is to assure competent care to patients by physicians; and

**WHEREAS**, this responsibility might occasionally be jeopardized by physicians who are impaired by psychiatric disorders, substance abuse (including alcoholism and drug dependence) and other incapacitating physical, mental and behavioral problems; and

**WHEREAS**, the osteopathic profession has an obligation to share in the responsibility to treat and rehabilitate the affected physician so that he can be restored to a useful and productive life; and

**WHEREAS**, frequently the affected physician is unable or unwilling to seek help; and

**WHEREAS**, it is essential that physicians recognize their ethical and social responsibility to assist their affected colleague; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports continued assistance in the rehabilitation of the affected osteopathic physicians through its Committee on Physician Health. 1973; *reaffirmed* 1978; *revised* 1983, 1988, 1993, 1998, 2003

## **PHYSICIAN INCENTIVES, TO UNDERSERVED AREAS**

**WHEREAS**, medicine continues to experience more non-physician providers delivering health care; and

**WHEREAS**, one reason given is to provide health care to underserved areas; and

**WHEREAS**, all U. S. citizens should have access to quality medical care by a physician; and

**WHEREAS**, areas are frequently underserved because of the debt physicians have on completing their medical education and training programs; and

**WHEREAS**, debt requires they locate in the most lucrative areas in order to repay student loans; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association focus attention on potential legislation to increase physician loan repayment programs and tax deductions or tax credits when initiating a practice in underserved areas to assist and assure an adequate supply of physicians in the future. 2005

## **PHYSICIAN NEGOTIATION RIGHTS**

**WHEREAS**, the McCarran-Ferguson Act of 1945 provides insurance organizations with an exemption from federal anti-trust statutes; and

**WHEREAS**, non-employed physicians are prohibited from collectively bargaining with insurance entities; and

**WHEREAS**, the intent of the McCarran-Ferguson Act was to promote competitive market behavior; and

**WHEREAS**, the finance of the McCarran-Ferguson Act did not envision this imbalance in negotiating positions that would occur 55 years after the passage of the act; and

**WHEREAS**, the market leverage currently enjoyed by health insurance organizations is detrimental to physicians and the patients they serve; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association aggressively pursue legislation to allow physicians to collectively bargain with third-party payers thereby promoting the spirit of competition by creating an equitable basis for negotiations between these parties. 2001

### **PHYSICIAN OFFICE LABORATORIES**

**WHEREAS**, a primary concern of osteopathic physicians is high quality medical care for all Americans; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association work to ensure that physician office laboratory certification be as non-intrusive into the practice of medicine as possible; and, be it further

**RESOLVED**, that the American Osteopathic Association supports the development and expansion of Waived Physician Office Laboratory testing; and, be it further

**RESOLVED**, that the American Osteopathic Association oppose unannounced inspections of any Physician Office Laboratory, whether it be waived, moderately complex, or complex as these inspections place an undue burden on the laboratory, the physician's office staff, and the physicians, which could result in compromised patient safety; and, be it further

**RESOLVED**, that the AOA seek assurances that access to any laboratory tests deemed medically necessary by the physician, not be limited by unnecessary regulations. 1990; *revised* 1995, 2000, 2005

### **PHYSICIAN PROFILES**

**WHEREAS**, physician profiles serve as a reservoir of physician practice information and can include a variety of information including, but not limited to, a physician's practice location, medical education, postgraduate training, board certification, license status, disciplinary information, criminal conviction history, and medical malpractice history; and

**WHEREAS**, historically information contained in physician profiles was used solely by licensing, disciplining, and employing authorities to screen and evaluate individual physicians; and

**WHEREAS**, consumer groups have advocated for the release of physician profiles to assist the public in choosing a physician; and

**WHEREAS**, the release of some information in physician profiles, such as malpractice and criminal histories, is inherently prejudicial, easily misinterpreted, and potentially damaging to a physician's practice; and

**WHEREAS**, any physician profile information released to the public should take into account the interests of the public in having access to information so that they can safely choose a physician and at the same time, the ability of the general public to appropriately interpret the information within physician profiles; and

**WHEREAS**, releasing physician profiles to the public is potentially subject to accuracy problems and could be very detrimental to a physician's practice; and

**WHEREAS**, state medical or osteopathic boards have traditionally licensed, regulated, and disciplined physicians practicing within their states and, therefore, are logically in the appropriate position to release physician profile information to the public; and

**WHEREAS**, compiling, maintaining, and releasing physician profile information to the public entails a substantial expense which should not be born solely by the source releasing the information; now, therefore, be it

**RESOLVED**, that it is the American Osteopathic Association's position that state medical or osteopathic boards, as the licensing and regulatory authorities for physicians, are the appropriate entities to collect, maintain, and disseminate physician profile information to the public; and, be it further

**RESOLVED**, that the AOA support the position that any legislation or regulations which mandate the release of physician profile information provide funding for the creation and maintenance of the profiling system without added expense to the physician; and, be it further

**RESOLVED**, that the AOA support the position that only physician profiles that incorporate all of the following five principles should be released to the public: fairness, relevancy, timeliness, accuracy, and reliability; and, be it further

**RESOLVED**, that the AOA oppose the inclusion of medical malpractice histories within physician profiles due to their susceptibility to misinterpretation and inherently prejudicial effect; and, be it further

**RESOLVED**, that the AOA support the position that before physician profiles are released to the public, every physician has the opportunity to verify the accuracy of the information and to contest any incorrect information before it is disseminated to the public; and, be it further

**RESOLVED**, that the AOA believes that the state licensing boards must include an appeal mechanism in their regulations that a physician may pursue if any information in his or her profile is inaccurate, and institute appropriate corrections. 2001

## **PHYSICIAN REIMBURSEMENT IN FEDERAL PROGRAMS**

**WHEREAS**, some states appear to be moving toward the implementation of managed care and/or a capitation reimbursement system for physician services in Medicaid; and

**WHEREAS**, such systems pose a potentially grave threat to osteopathic physicians through arbitrary and/or discriminatory exclusion from the delivery of care; and

**WHEREAS**, the osteopathic profession is committed to the containment of medical care costs, provided that the overall concern be for providing quality healthcare to the American public; now, therefore be it

**RESOLVED**, that the American Osteopathic Association recommends that educational programs for osteopathic medical students, interns, residents and practicing physicians should include utilization management and cost-effectiveness in the curricula; and, be it further

**RESOLVED**, that the osteopathic staff members of healthcare institutions should continue to improve utilization review programs for all patients, consistent with quality assurance and sound osteopathic medical practice; and, be it further

**RESOLVED**, that if states adopt managed care for capitated reimbursement systems for Medicaid, that they contain a provision to ensure the fullest participation of all physicians, ensuring best patient care and adequate compensation to all parties concerned, while preserving referral patterns as established by the osteopathic profession. 1986; *revised* 1991, 1992, 1997; reaffirmed 2002

## **PLASTIC BEVERAGE AND FOOD CONTAINER RECYCLING ACT**

**RESOLVED**, that the American Osteopathic Association supports conservational recycling. 1990, *revised* 1995; *reaffirmed* 2000 (*to be reviewed* 2006)

## **POSTGRADUATE COMPENSATION**

**WHEREAS**, hospitals with medical education programs often receive variable payments from Medicare on a per-resident basis; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association affirms its support for maintaining and enhancing the quality of teaching programs, and urges Congress to provide more equitable graduate medical education funding so hospitals and other healthcare delivery systems can provide competitive compensation for postgraduate training.

1990; *revised* 1995; *reaffirmed* 2000, *revised* 2005

## **POSTPARTUM DEPRESSION**

**WHEREAS**, ten percent of new mothers suffer from postpartum depression (PPD); and

**WHEREAS**, PPD affects women of all ages, economic status, and racial/ethnic backgrounds; and

**WHEREAS**, any woman who is pregnant, had a baby within the past few months, miscarried, or recently weaned a child from breastfeeding can develop PPD; and

**WHEREAS**, the number of children a woman has does not change her chances of getting PPD, with new mothers and women with more than one child having equal chances of getting PPD; and

**WHEREAS**, research has shown that women who have had problems with depression are more at risk for PPD than women who have not had a history of depression; and

**WHEREAS**, physicians need to be better educated on the signs and symptoms of PPD; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association encourage its members to participate in continuing medical education programs on postpartum depression (PPD); and, be it further

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

**RESOLVED**, that the AOA develop a speakers bureau on this subject which can be added to the AOA Speakers Bureau publication; and, be it further

**RESOLVED**, that the AOA endorse the use of screening tools and encourage the measurement of outcomes in their use; and, be it further

**RESOLVED**, that the AOA, through DO Online, link to organizations whose mission is to educate patients and physicians on PPD. 2003

## **PRACTICE RIGHTS OF OSTEOPATHIC PHYSICIANS**

**WHEREAS**, many governmental agencies and health insurance agencies are significantly increasing their civil and criminal fraud and abuse monitoring efforts; and

**WHEREAS**, many government agencies and health insurance agencies are utilizing coding, billing and documentation guidelines which are vague and ambiguous; and

**WHEREAS**, many osteopathic physicians' practice rights and practice security are being threatened by enforcement attempts, with little or no osteopathic peer review or oversight; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association and its component societies be encouraged to promote unity and the practice rights of osteopathic physicians, by establishing a specific Practice Rights agenda and support the development of seminars or other vehicles to carry out the following objectives:

1. Educate physicians as to the importance of compliance, risk management, at risk agreements with managed care, billing and coding, documentation, and fraud and abuse issues.
2. Assist in the establishment of guidelines to enhance these practice rights and safety in the areas of compliance, risk management, billing and coding documentation, and in fraud and abuse issues.
3. Identify supportive agencies, liability companies, and physicians with expertise in these issues.
4. Encourage government and insurance agencies to utilize only expert witnesses who are osteopathic physicians in peer review, fraud and abuse, civil and criminal cases involving osteopathic physicians and boards with “like osteopathic specialty”.
5. Develop and advise the leadership and state societies of the needs, trends, and issues of concern which will encourage unity, and enhance the practice rights of our fellow physicians; and, be it further

**RESOLVED**, that the AOA take steps to address the above listed issues at the national level. 1999; *revised* 2004

#### **PRE-AUTHORIZED MEDICAL/SURGICAL SERVICES -- DENIAL OF PAYMENT OF**

**WHEREAS**, many healthcare insurers require pre-authorization for some services and procedures performed by physicians in providing quality healthcare to patients; and

**WHEREAS**, exorbitant amounts of time and expense are wasted in obtaining pre-authorization from healthcare insurers for providing quality healthcare services to patients; and

**WHEREAS**, despite pre-authorization confirmation by a clerk, nurse, or other entity employed by the health insuring company, there is no guarantee for payment for the medical services or procedure in question; and

**WHEREAS**, in many instances, letters are sent out to physicians and sometimes even to patients by insurers indicating that the medical service or procedure requested has been approved but payment for said service is not guaranteed and subject to review; and

**WHEREAS**, such activities by healthcare insurers are unnecessarily cumbersome, needlessly interfering with the ability to provide quality medical care and most confusing to patients and healthcare subscribers; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association support legislation that would prohibit any healthcare insurer from retrospectively denying payment for any medical or surgical service or procedure that has already been pre-authorized by such health insurer; and, furthermore, any such letters by health insurers to physicians and patients indicating that the medical services/procedures that have been pre-authorized may not necessarily be compensated for should cease and desist. 1997; *revised* 2002

#### **PRESCRIPTION DRUGS—DIRECT CONSUMER ADVERTISING**

**WHEREAS**, the cost of prescription medicines are a leading cause of increasing health care costs and insurance in the United States; and

**WHEREAS**, pharmaceutical companies direct consumer advertising is a multibillion dollar a year industry; and

**WHEREAS**, advertising prescription medicines to the general public increases the overall marketing costs to pharmaceutical companies; and

**WHEREAS**, advertising prescription medicines may not be the most appropriate or cost effective way to inform patients about their health care; and

**WHEREAS**, prescription medicines may only be prescribed by osteopathic physicians and other licensed practitioners; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association (AOA) adopt policies to recommend pharmaceutical company direct to consumer advertising not be product specific; and, be it further

**RESOLVED**, that the AOA request that state and federal governments adopt policies or legislation to promote disease-specific public health education as the focus of direct to consumer advertising of prescription medicines to the general public. 2001; *revised* 2003, 2005

### **PRESCRIPTION DRUG SAMPLES**

**WHEREAS**, the practice of making sample prescription drugs conveniently available to the practicing physician has very significant medical and social value; and

**WHEREAS**, the incidence of diversion of sample drugs from pharmaceutical manufacturers is relatively insignificant; and

**WHEREAS**, such illegal diversion can be effectively deterred by appropriately severe criminal penalties and national record-keeping requirements; and

**WHEREAS**, any requirements for prior written request for sample drugs by physicians could effectively preclude sampling; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports the development of effective record-keeping requirements by the pharmaceutical manufacturers for distribution to physicians of prescription drug samples; and, be it further

**RESOLVED**, that the AOA supports the enactment of appropriate criminal penalties for those who illegally divert such samples; and, be it further

**RESOLVED**, that the AOA opposes any legislation which intends to restrict drug sampling by the physician; and, be it further

**RESOLVED**, that the AOA encourages pharmaceutical manufacturing companies to continue the effective practice of drug sampling. 1994; *revised* 1997, 2002

### **PRESCRIPTION OF DRUGS FOR OFF LABEL USES**

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

**WHEREAS**, there may be compelling circumstances when it serves the health interests of patients, for physicians to prescribe appropriate drugs; and

**WHEREAS**, medical indications for the usage of certain prescription drugs may be narrow in scope, due to the intricate federal drug approval process; and

**WHEREAS**, patient access to needed drugs might be hindered due to these limited label indications; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association believes it is appropriate for physicians to prescribe approved drugs for uses not included in their official labeling when they can be supported as accepted medical practice. 1995; *reaffirmed* 2000, 2005

## **PRESCRIPTION MEDICATIONS—OVERRIDES FOR**

**WHEREAS**, physicians and their patients know which medications work best for the patient; and

**WHEREAS**, many insurance providers have a restricted formulary which may change based on rebates from manufacturers; and

**WHEREAS**, many of these plans require the physician to request an approval for maintenance and time-consuming; and

**WHEREAS**, insurance companies have made this process excessively time-consuming; and

**WHEREAS**, it is detrimental to quality patient care to keep changing medications; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association support legislative efforts to:

- 1) decrease the hold time for physicians and staff for requesting approval from insurance pharmacy plans,
- 2) require insurance pharmacy plans to allow patients to continue receiving the medications for which they are prescribed and are in good control.
- 3) make it easier for a physician to request an approval. 2005

## **PRESCRIPTION PLANS-- RESTRICTIVE**

**WHEREAS**, patients are increasingly relying on insurance plans and managed care plans that have prescription drug programs to obtain necessary, prescribed medications; and

**WHEREAS**, the rapidly increasing prices of many pharmaceuticals effectively prevent their use without the assistance of these plans; and

**WHEREAS**, patients and their employers, when purchasing such insurance, spend substantial premiums to include these drug plans in their benefit packages; and

**WHEREAS**, insurance companies and managed care organizations market these prescription plans to their customers without emphasizing their restrictions and limitations; and

**WHEREAS**, patients and their physicians often find out about the restrictive nature of the prescription plans only after attempting to fill a needed, prescribed medication; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association, through its Division of State Government Affairs, urge state legislatures to pass laws that would:

1. Mandate that insurance companies and managed care organizations use the term limited prescription plan, limited paid prescription plan, or similar terminology, in their marketing of such products to their customers, unless such plans pay for all prescription pharmaceuticals currently recognized by the FDA as safe and effective; and
2. Require truth in advertising and prohibit insurance companies and managed care organizations marketing such plans from restricting their reimbursement for pharmaceuticals to formularies or other devices intended to limit patient and physician choice to a narrow list of approved medications; and
3. Prohibit these companies from mandating the use of generic drugs to the exclusion of proprietary pharmaceuticals. 1998, *revised* 2003

## **PRIMARY CARE PHYSICIANS--TRAINING REAFFIRMATION**

**WHEREAS**, for more than a century of public service, the osteopathic profession has merited deserved recognition for its tradition of training primary care physicians; and

**WHEREAS**, the proportions of primary care physicians to those in other specialties are decreasing in the face of an urgent need for primary care physicians particularly in inner cities and rural areas; and

**WHEREAS**, studies reveal an ever widening need for primary care in many sectors of the nation; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association reaffirm its commitment to train competent and compassionate primary care physicians to meet projected national needs. 1992; *reaffirmed* 1997; revised 2002

## **PROFESSIONAL ASSOCIATION BY DOs**

**WHEREAS**, it is the policy of the American Osteopathic Association to encourage loyalty and unity within the osteopathic profession; and

**WHEREAS**, that policy is best served by membership in the AOA, its divisional societies, and organizations outside of the osteopathic profession whenever such membership is necessary to the member's professional development; now, therefore, be it

**RESOLVED**, that in order to maintain the essential role of the osteopathic profession as an independent scientific school of medicine and to prevent the extinction of the osteopathic profession by direct attack or absorption, osteopathic physicians should support and sustain their profession by maintaining active membership in the American Osteopathic Association and other affiliated associations; and, be it further

**RESOLVED**, that it is not the policy of the AOA to directly or indirectly restrict or restrain any individual member's freedom of choice with respect to professional associations. 1979; *reaffirmed* 1984; *revised* 1989; *reaffirmed* 1995; *revised* 2000, 2005

## **PROFESSIONAL LIABILITY INSURANCE REFORM**

**WHEREAS**, physicians throughout the United States must have sufficient professional liability insurance and/or coverage; and

**WHEREAS**, in litigation, courts have been awarding ever increasing monetary judgments; and

**WHEREAS**, all of the above conditions are causing an increase in healthcare cost; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association continues support of professional liability insurance reform that includes the following six principles:

1. Limitations on non-economic damages
  - a. including provisions that afford states the opportunity to maintain or establish laws governing limitations on non-economic damages;
2. Periodic payment of future expenses or losses;
3. Offsets for collateral sources;
4. Joint and several liability reform;
5. Limitations on attorney contingency fees; and
6. Establishment of uniform statutes of limitations. 1985; *revised* 1990, 1993, 1998, 2003

## **PROFESSIONAL LIABILITY REFORM**

**WHEREAS**, the current medical liability crisis continues to have a significant negative impact upon the health care delivery system and continues to reduce patient access to quality health care; and

**WHEREAS**, osteopathic physicians across the nation continue to face difficulties in securing affordable professional liability insurance coverage; and

**WHEREAS**, osteopathic physicians are forced to limit the services they offer their patients, relocate their practices, or retire as a result of unavailable and unaffordable professional liability insurance; and

**WHEREAS**, the AOA has made professional liability insurance reform its top legislative priority at both the Federal and state levels; and

**WHEREAS**, over the past three years the AOA Council on Federal Health Programs and the Bureau of State Government Affairs has implemented comprehensive strategies aimed at achieving the enactment of comprehensive professional liability insurance reforms; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association reaffirm professional liability insurance reform as its top legislative priority at both the Federal and state levels; and, be it further

**RESOLVED**, that the AOA implement programs to increase the involvement of its members and the patients they serve in this effort; and, be it further

**RESOLVED** that, the AOA continue to devote significant personnel and financial resources to achieve the enactment of professional liability insurance reforms adopted and ratified by this House of Delegates; and, be it further

**RESOLVED**, that the AOA approve a \$150,000 special allocation to fund patient-focused grassroots activities, participate in national and local media campaigns, and produce advocacy materials for AOA members, specialty colleges, and other affiliated groups.

Explanatory Statement: This policy will allow the AOA to continue pursuing the enactment of comprehensive reforms at both the Federal and state level by providing resources to establish a patient advocacy website, participate in advertising campaigns, and participate in other activities throughout the year.

### Patient Advocacy Website

Lawmakers continue to urge the AOA to involve our patients in this effort. While we have attempted to do this through informing our members and providing information for dissemination to their patients, this is simply not enough. We propose the establishment of a patient advocacy website, which allows our patients to utilize a central resource to express their support for our legislative priorities. The website will be named according to its mission and will allow the AOA and its members to include our patients in the professional liability insurance reform debate, as well as future issues. The cost of establishing this website is approximately \$20,000. Annual maintenance fees will be approximately \$6,000 to \$8,000.

### Advertising Campaigns

One of the most effective manners of conveying a position is through purchased advertisements. Over the past two years the AOA has run ads in Waco, TX, Las Vegas, NV, and several in Washington urging lawmakers to support PLI reforms. We have received numerous compliments from our friends for these efforts. Additionally, these advertisements raise the profile of the AOA and solidify our presence as a “player” in this and other debates. We request \$120,000 over the next year to continue this activity. \$50,000 of this will be contributed to a physician consortium, including the American Medical Association, the American College of Surgeons, and the American Association of Neurological Surgeons. The consortium has developed radio and

television advertisements that can be personalized for each participating organization and run in targeted states. The remaining \$70,000 will enable the AOA to run print advertisements in local and national newspapers, magazines, and other publications and/or participate in advertising campaigns with other physician groups.

#### Advocacy Materials for Osteopathic Physicians

In an effort to increase the involvement of our members we request \$10,000 to produce advocacy materials for our members. These materials will inform our members and their patients of the new website as well as provide them with display materials for their offices. 2003

### **PROFESSIONAL ORGANIZATION—PHYSICIANS CHOOSING TO WHICH THEY BELONG**

**WHEREAS**, some employers pay professional association dues as a part of the employment benefits for their physician employees; and

**WHEREAS**, in many cases the employer chooses to pay the dues for the physician in the allopathic medical associations and does not give the physician their choice of medical associations; and

**WHEREAS**, many osteopathic physicians would prefer to belong to an osteopathic medical associations instead of an allopathic medical association; and

**WHEREAS**, in essence this is requiring the physician to belong to an association against their choice as a condition of their employment; and

**WHEREAS**, these osteopathic physicians wish to have their employer pay dues to their osteopathic medical association in the same way as that of their allopathic colleagues; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association (AOA) supports all physicians having the right to choose which medical associations they join, even when the employer is paying the membership fees; and, be it further

**RESOLVED**, that the AOA provide the physician with a letter template stating their desire to have dues paid to an osteopathic medical association. 2005

### **PROVIDER--USE OF TERM TO DESCRIBE PHYSICIANS**

**WHEREAS**, physicians undergo an extended period of education and training; and

**WHEREAS**, physicians pursue continuing medical education throughout their careers to remain current in their profession; and

**WHEREAS**, the relationship between physicians and their patients is central to the delivery of healthcare; and

**WHEREAS**, healthcare insurers and systems, hospitals, government entities and others involved in, but peripheral to, the patient-physician relationship, indiscriminately use the term “provider” as an all inclusive label in contracts, insuring agreements, print and media advertising, signage, rules, regulations and policies; and

**WHEREAS**, the term “provider” is not appropriate to physicians, and is a label which wrongly and unfairly diminishes the professional stature of physicians, and ultimately undermines the patient-physician relationship; and

**WHEREAS**, the use of the term “provider” to describe physicians erodes trust between physicians and those organizations which employ the term because of the disrespect it connotes, and

**WHEREAS**, the use of the term “provider” further blurs the distinction between physicians and non-physician healthcare providers; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association discourages the use of the term “provider” to describe its members, and urges any organization which employs the term to describe physicians by their proper, professional titles of either, “physician” or “doctor”. 1999; *revised* 2004

#### **PUBLIC HEALTH SERVICE, AOA SUPPORT**

**WHEREAS**, the United States Public Health Service Commissioned Corps is one of the uniformed services of the United States; and

**WHEREAS**, the Commissioned Corps supplies medical personnel, including osteopathic physicians, for agencies providing comprehensive health services; and

**WHEREAS**, the Commissioned Corps is a mobile force designed to rapidly provide personnel to deal with a wide range of medical emergencies, including natural disasters and rapid examination of refugees; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association recognizes the contribution of the PHS Commissioned Corps to the healthcare of the United States; and, be it further

**RESOLVED**, that the AOA supports the continued existence of the United States Public Health Service Commissioned Corps. 1981; *revised* 1986; *reaffirmed* 1991, 1992, 1997, 2002

#### **REPRODUCTIVE ISSUES -- COUNSELING FEMALE PATIENTS ON**

**WHEREAS**, osteopathic physicians have traditionally provided a large percentage of primary medical care in the United States; and

**WHEREAS**, osteopathic physicians strive to present their patients with the most knowledgeable, conscientious and confidential personal health advice available; and

**WHEREAS**, osteopathic physicians are frequently asked questions about controversial aspects of reproductive issues; and

**WHEREAS**, recent legislation and courtroom decisions have threatened to limit the osteopathic physician's ability to counsel their patients on reproductive issues; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association take whatever actions are necessary to ensure that osteopathic physicians can continue to offer their patients complete, objective, informed advice in a confidential manner on all aspects of reproductive issues. 1992; *reaffirmed* 1997; *revised* 2002

#### **RESIDENCY TRAINING SLOTS**

**WHEREAS**, the Medicare Balanced Budget Act of 1997 has severely restricted Medicare funding for graduate medical education; and

**WHEREAS**, the emphasis of much patient care has changed from an inpatient to an outpatient setting; and

**WHEREAS**, managed care organizations are gaining market share as a system of healthcare for patients and HMOs are one type of managed care delivery system requiring licensure in the states; and

**WHEREAS**, graduate medical education trains physicians in a variety of patient care settings while providing access to high quality care to patients and their communities; now, therefore, be it

**RESOLVED**, that HMOs be encouraged by the appropriate state agency to provide funding for GME training programs; and, be it further

**RESOLVED**, that state societies be encouraged to introduce and support the enactment of the Physician Education Advancing Community Health (PEACH) program model legislation developed by the Bureau of State Government Affairs to effect changes in funding GME training programs. 1999; *revised* 2004

#### **RURAL HEALTHCARE PAYMENT EQUITY**

**WHEREAS**, the osteopathic profession traditionally has been committed to serving the rural population of the United States; and

**WHEREAS**, there is evidence that the healthcare needs of Americans living in many rural areas often go unmet; and

**WHEREAS**, there are inadequate levels of reimbursement under federal and other health programs; and

**WHEREAS**, the gap between urban and rural payment rates for identical services has exacerbated the maldistribution of physicians in urban versus rural areas; and

**WHEREAS**, the urgency of improving access to quality medical care for rural Americans warrants higher payments for such care; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association endorses equity in reimbursement for rural physicians as part of the strategy to increase the availability of quality healthcare in rural areas. 1988; *revised* 1993; *reaffirmed* 1998, 2003

#### **RURAL HEALTH CLINICS--LOCATION AND QUALITY OF CARE**

**WHEREAS**, the goal of providing healthcare services to people living in rural areas of the United States is admirable; and

**WHEREAS**, some rural areas of the United States already have physicians who provide healthcare services to the medically underserved population; and

**WHEREAS**, many rural health clinics (RHCs), operated by large healthcare organizations, establish their facilities adjacent to private physicians' medical facilities rather than locating in other areas devoid of medical facilities; and

**WHEREAS**, the quality of care provided to the medically underserved population should be the highest priority of the RHC rather than profits; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports the concept that federal and state tax dollars should not be used to support rural health clinics that choose to locate within the vicinity of an established, private physician's healthcare facility rather than other sites within medically underserved areas.

1999; *revised* 2004

#### **RURAL SITES AND UNDERSERVED/INNER CITY AREAS—OSTEOPATHIC EDUCATION**

**WHEREAS**, the knowledge and training of osteopathic medical students is greatly enhanced by rural settings, and rural education assists in the recruitment of new physicians to rural areas; and

**WHEREAS**, inner city medical training is also beneficial and rewarding, and more importantly, is generally considered as an underserved area; and

**WHEREAS**, the AOA encourages predoctoral and postdoctoral osteopathic medical education in underserved areas, including both rural and inner-city areas; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association encourage clinical rotations in underserved areas, including rural office/hospital settings as well as inner city office/hospital settings, by osteopathic medical students and graduates during their respective predoctoral and postdoctoral education programs. 2001

#### **RURAL AND URBAN PRACTICES, DISPARITIES BETWEEN**

**WHEREAS**, current physician work adjustment factors result in severe inequities between rural and urban localities under the Medicare physician fee schedule; and

**WHEREAS**, there are currently 43 Medicare localities which have a physician work adjuster below 1.000; and

**WHEREAS**, “physician work” is defined by Centers for Medicare and Medicaid Services (CMS) as the amount of time, skill, and intensity a physician puts into a patient visit, and

**WHEREAS**, this definition of “physician work” is not influenced by location; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports federal legislation that would establish a minimum physician work geographic cost-of-practice index value for physicians’ services of 1.000. 2002

#### **RURAL SITES--OSTEOPATHIC EDUCATION IN**

**WHEREAS**, some predominately rural states do not have the benefit of an osteopathic medical school and osteopathic hospital with physicians and students being trained in their state; and

**WHEREAS**, some states realize a shortage of physicians in rural communities; and

**WHEREAS**, exposure to medical practice in a rural setting would give the student and physician a broadened scope of expertise and rural awareness; and

**WHEREAS**, the rural exposure would assist in the recruitment of new physicians to rural areas; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association encourage clinical rotations in rural settings by osteopathic medical students and graduates during their respective predoctoral and postdoctoral education programs.1990; *revised* 1995, 2000, 2005

#### **SALE OF HEALTH-RELATED PRODUCTS AND DEVICES**

**WHEREAS**, the physician-patient relationship is based on trust in the physicians and in the high ethical standards of the medical profession; and

**WHEREAS**, physicians must be ever mindful of their duty to honor that trust and never derive monetary gain from an abuse of the patient-physician relationship; and

**WHEREAS**, it is unethical for a physician to exploit the physician-patient relationship in any manner whatsoever; and

**WHEREAS**, the AOA expects its members to observe principles of scientific medicine in the recommendation of all health-related products or devices; now, therefore, be it

**RESOLVED**, that it is appropriate for physicians to derive reasonable monetary gain from the sale of health-related products or devices that are both supported by rigorous scientific testing or authoritative scientific data and, in the opinion of the physician, are medically necessary or will provide a significant health benefit; and, be it further

**RESOLVED**, that it is inappropriate and unethical for physicians to use their physician/patient relationship to attempt to involve any patient in a program for the patient to

distribute health related products or devices in which distribution results in a profit for the physician. 1999; *revised* 2004

### **SCHOOL BASED HEALTH EDUCATION--PROMOTION**

**WHEREAS**, school-based health education is an essential key in providing sound health standards for youth and a lasting guide through adolescence and maturity; and

**WHEREAS**, such aforementioned education is best developed through programs that meet the Centers for Disease Control and Prevention definition of comprehensive school health education; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association continues to urge the state legislatures to enact measures establishing programs that meet with the Centers for Disease Control and Prevention definition of comprehensive school health education. 1992; *reaffirmed* 1997, *revised* 2002

### **SEAT BELT LAWS—PRIMARY ENFORCEMENT**

**WHEREAS** the use of seat belts by the drivers and passengers in automobiles reduces the morbidity and mortality of those involved in accidents; and

**WHEREAS**, the U.S. Transportation Secretary is urging state legislatures from around the country to pass primary enforcement seat belt laws; and

**WHEREAS**, a National Highway Traffic Safety Administration (NHTSA) study, *Crash Outcome Data Evaluation System (CODES)*, found that the average inpatient costs for crash victims who were not using seat belts were 55 percent higher than for those who were belted; and

**WHEREAS**, the most recent figures indicate that 73 percent of passenger vehicle occupants who were totally ejected from the vehicle were killed, and that through the use of seat belts, only 1 percent of the occupants reported to have been using restraints were totally ejected, compared with 30 percent of unrestrained occupants; and

**WHEREAS**, the osteopathic philosophy places an emphasis on prevention of illness and injury; and

**WHEREAS**, the osteopathic profession is dedicated to health promotion for the patients it serves; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association endorse the passage of primary enforcement seat belt laws in every state. 2005

### **SECOND OPINION, SURGICAL CASES**

**WHEREAS**, state health agencies, insurance companies and the Centers For Medicare & Medicaid Services (CMS) have instituted programs to underwrite the cost of second surgical opinions for elective surgical procedures; and

**WHEREAS**, such entities call upon the American Osteopathic Association and its affiliated organizations for guidance in developing lists of osteopathic physicians who may participate in such programs; now, therefore, be it

**RESOLVED**, that members of the American Osteopathic Association who are board certified, or board eligible in the same surgical specialty and qualified by their training and experience as evidenced by their hospital privileges to render a second surgical opinion in any given case, be recognized and utilized as qualified and reimbursed by entities underwriting such opinions; and, be it further

**RESOLVED**, that this resolution in no way advocates the institution of any mandatory second surgical opinion programs, by any entity. 1980; *revised* 1985, 1990; *reaffirmed* 1995; *revised* 2000, 2005

## **SEXUAL HARASSMENT**

**WHEREAS**, the occurrence of sexual harassment is receiving national attention with resultant protective measures initiated in many sectors; and

**WHEREAS**, such awareness should serve as impetus for widespread legislative and social measures to curtail sexual harassment; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association urges the enactment of appropriate legislation to eliminate all sexual harassment in the full spectrum of life. 1992; *reaffirmed* 1997, revised 2002

## **SLEEP DISORDERS—PROMOTING THE UNDERSTANDING AND PREVENTION OF**

**WHEREAS**, a significant amount of Americans suffer from sleep disorders, and millions more suffer intermittent sleep problems related to pain, stress, anxiety, depression, and other ailments; and

**WHEREAS**, sleep-related disorders affect members of every race, socioeconomic class and age group, the majority of which remain undiagnosed and untreated; and

**WHEREAS**, sleep affects mood, reaction times, alertness, memory, and motor skills and takes an enormous toll on health, safety, and productivity; and

**WHEREAS**, it is important that patients and physicians understand the importance of sleep and its impact on health; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association (AOA) support programs that promote education and understanding of sleep and its impact on health; and be it further

**RESOLVED**, that the AOA encourage osteopathic physicians to educate their patients about sleep disorders, and the importance of sleep and its impact on health. 2005

## **SMOKING CESSATION**

**WHEREAS**, cigarette smoking substantially increases the risk of cardiovascular disease, including ischemic heart disease, arteriosclerosis, hypertension, pulmonary disease and throat and lung cancers; and

**WHEREAS**, smoking during pregnancy increases risk of miscarriage, stillbirth, and low weight infants; and

**WHEREAS**, exposure to secondhand smoke contributes to lower respiratory tract infections in infants and children, and new cases of asthma in children; and

**WHEREAS**, smoking may be the single most preventable cause of premature death in the United States; and

**WHEREAS**, the American Osteopathic Association has a policy supporting counseling patients on the health risks of smoking; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association support third-party coverage of evidence-based approaches for the treatment of smoking cessation and nicotine withdrawal. 1998; *revised* 2003

## **SMOKING-TOBACCO PRODUCTS**

**WHEREAS**, cigarette smoking has been identified as a chief preventable cause of death in our society; and

**WHEREAS**, smoking is a major cause of cancer, heart and lung disease; and

**WHEREAS**, cigarettes and other forms of tobacco are addicting; and

**WHEREAS**, the pharmacologic and behavioral processes that determine tobacco addiction are similar to those which determine addiction to drugs such as heroin and cocaine; and

**WHEREAS**, the unrestricted use of tobacco in public and the workplace sends a mixed message to the youth of this country concerning the social acceptance of smoking and drug use; and

**WHEREAS**, involuntary smoking from secondary smoke has shown to have detrimental effects on health; and

**WHEREAS**, educating the American people of the health risks associated with smoking is a vital component of the effort to prevent disease by reducing cigarette use; and

**WHEREAS**, tobacco use by children is associated with chronic and recurrent medical problems; and

**WHEREAS**, the American Osteopathic Association members, as important role models for both children and adults, should be encouraged not to smoke or use tobacco products in the presence of their patients; and

**WHEREAS**, men, women and children continue to smoke, despite the abundance of educational health programs focused on the life threatening circumstances of smoking; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports a comprehensive education campaign on the hazards of smoking beginning at the elementary school level; and, be it further

**RESOLVED**, that physicians be encouraged to inquire into tobacco use and exposure as part of both prenatal visits and every appropriate health supervision visit; and, be it further

**RESOLVED**, that the AOA strongly recommends that all federal and state health agencies continue to take positive action to discourage the American public from using cigarettes and other tobacco products; and, be it further

**RESOLVED**, that the AOA encourages its members to discuss the hazards of tobacco use with their patients; and, be it further

**RESOLVED**, that the AOA encourages the elimination of federal subsidies and encourages increased taxation of tobacco products at both federal and state levels; that monies from the additional taxation could be earmarked for smoking-reduction programs and research for prevention of tobacco-related diseases; that municipal, state and federal executive agencies and lawmakers enact clean-indoor air acts, a total ban on tobacco product advertising, opposes cigarette vending machines in general and supports federal legislation to limit access to cigarette machines to minors, and the elimination of free distribution of cigarettes in the United States; and that grades K -12 should be encouraged to incorporate a curricular component that has been proven effective in preventing tobacco usage in its health education curriculum; and, be it further

**RESOLVED**, that the AOA urges the development of anti-tobacco educational programs targeted to all members of society, with the ultimate goal of achieving a tobacco-free nation. 1990; *revised* 1995, 1997; revised 2002

## **SPACE STATION--INTERNATIONAL**

**WHEREAS**, since before the dawn of the space age, members of the American Osteopathic Association, in conjunction with physicians and scientists worldwide, have participated in the explosion in the knowledge base of human physiology and medicine; and

**WHEREAS**, a significant amount of this knowledge and experience is the direct result of the contributions and research performed in the unique aviation and space environs; and

**WHEREAS**, the quantum leaps in knowledge so vital to the future improvement of the human condition can be immensely assisted by research that cannot be duplicated in earth's terrestrial environment; and

**WHEREAS**, the knowledge and products yielded from National Aeronautics And Space Administration's (NASA) International Space Station, combined with the pioneering team efforts of global partners, will provide important medical and life style improvements; and

**WHEREAS**, the expectation of reduced international political tension and stabilizing world economies increase the possibilities for the reallocation of government funding; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association endorses the sustained funding of NASA's participation in the International Space Station. 1992; *revised* 1995, 2000, 2005

## **SPECIALTY CERTIFICATION, OSTEOPATHIC MEMBERSHIP OF DOs**

**WHEREAS**, the value of the board certification credential to the public is enhanced by requiring that board certified physicians adhere to the standards set forth in the AOA's code of ethics, satisfy appropriate continuing medical education requirements and have an active license to practice osteopathic medicine, all of which are required of AOA members; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association continue to condition AOA specialty board certification upon AOA membership and encourages membership in its practice affiliates as well as state and local osteopathic associations. 1979; *reaffirmed* 1984; *revised* 1990; *reaffirmed* 1995, 2000, *revised* 2005

## **SPINAL MANIPULATION LEGISLATION OR REGULATION**

**WHEREAS**, in recent years, state legislation has been introduced that would establish a set number of educational and/or clinical hours necessary to perform spinal manipulation; and

**WHEREAS**, this legislation is an attempt to restrict the practice of spinal manipulation by certain allied health professionals; and

**WHEREAS**, this legislation often times does not exclude osteopathic physicians from its restrictive requirements; and

**WHEREAS**, an osteopathic physician receives training in osteopathic principles and practices (OPP) throughout the osteopathic medical education continuum; and

**WHEREAS**, an osteopathic physician is trained in osteopathic manipulative treatment (OMT) within his or her osteopathic medical education, which includes instruction in all forms of manipulation, including spinal; and

**WHEREAS**, an osteopathic physician is licensed for the full and unlimited practice of medicine; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association opposes all legislation or regulatory changes that could be interpreted to exclude osteopathic physicians from the right to practice spinal manipulation, and all other forms of osteopathic manipulative treatment; and, be it further

**RESOLVED**, that the AOA works with legislators and state licensing boards to preserve the osteopathic profession's right to establish and maintain standards of practice of osteopathic manipulative treatment. 1999; *revised* 2004

#### **STATE LICENSURE OF MCO MEDICAL DIRECTORS**

**WHEREAS**, in recent years, the growth of managed care organizations (MCOs) has brought about serious changes in the way care is provided to patients; and

**WHEREAS**, medical treatments in a managed care atmosphere must usually be approved prior to their render; and

**WHEREAS**, medical directors of MCOs generally make the final determination of the necessity of a particular treatment for a patient with respect to his or her knowledge of the particular case as well as the standards of care established by the health plan; and

**WHEREAS**, any treatment decision which is the final determinate of a patient's care should come from a thorough understanding of contemporary medicine with regards to that care; and

**WHEREAS**, protecting the public is of paramount importance; and

**WHEREAS**, the public deserves the assurance that physicians making the ultimate medical decisions on their health have met the minimum standards of their state through licensure; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports legislation or regulations that would require all managed care organization (MCO) medical directors to be fully-licensed physicians of the state where the care is being provided; and, be it further

**RESOLVED**, that the AOA supports state medical boards' rights to oversee and discipline any medical director of an MCO licensed as a physician in their state. 1999; *reaffirmed* 2004

#### **STATES -- EMERGING**

**WHEREAS**, the American Osteopathic Association through its regional managers has established a program to strengthen osteopathic societies in the emerging states; and

**WHEREAS**, this program has proven and continues to be very effective; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association through its committee structure and departmental staff continue to support the emerging states program so that the osteopathic profession is strengthened nationwide. 1976; *reaffirmed* 1981; *revised* 1986, 1991, 1996, 2001

#### **STATES -- EMERGING: ASSISTANCE BY OTHER STATES AND THE AOA**

**WHEREAS**, there are many states with low DO physician population and/or limited organizational structures; and

**WHEREAS**, the concept of assistance to emerging states by larger or more organized states has been a successful means to improve organizational effectiveness in emerging states; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association encourages liaison between state organizations whether formal or informal; and, be it further

**RESOLVED**, that the AOA supports assistance to emerging state organizations. 1979; *revised* 1984, 1989; *reaffirmed* 1994; *revised* 1999; *reaffirmed* 2004

## **STUDENT LOAN INTEREST DEDUCTIONS**

**WHEREAS**, the elimination of student loan interest deductions by the U.S. Congress has placed undue hardships upon osteopathic medical school graduates as well as other graduates; and

**WHEREAS**, the reduction and future elimination of student loan interest payment tax deductions will discourage promising candidates from entering the osteopathic profession; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association aggressively petition Congress to reinstate tax laws governing student loan interest tax deductions regardless of when the loan was incurred; and, be it further

**RESOLVED**, that the AOA and appropriate affiliated organizations communicate pertinent tax deduction laws to its members. 1989; *revised* 1994, 1999; *reaffirmed* 2004

## **SUBSTANCE ABUSE**

**WHEREAS**, substance abuse is a significant health problem in the United States today; and

**WHEREAS**, physicians are ultimately responsible for the medical management of substance abusers who seek, or are referred for, medical treatment; and

**WHEREAS**, total community education relative to substance abuse is essential to the alleviation of the problem; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association encourages its members, to maintain current knowledge of addictive substances with a high potential for abuse, and of appropriate treatment techniques, and supports health and law enforcement agencies in their efforts to eliminate substance abuse, urges all members of the osteopathic profession to participate in the care and rehabilitation of persons suffering from substance abuse and recognizes appropriate proclamations dedicated to "Drug Abuse Prevention Month". 1978; *revised* 1983, 1988, 1993, 1998, 2003

## **SUDDEN INFANT DEATH**

**WHEREAS**, the American Osteopathic Association recognizes sudden infant death syndrome as a tragic phenomenon; and

**WHEREAS**, when an infant dies suddenly, with no medical explanation, the parents are often unjustly accused of negligence; and

**WHEREAS**, existing sudden infant death syndrome counseling, information, and educational programs may be inadequate; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association urges continued research into causes and prevention of sudden infant death syndrome; and, be it further

**RESOLVED**, that information based on current medical literature be made available to the public on the nature of sudden infant death syndrome and proper counseling be available to families who lose infants to this disease. 1974; *reaffirmed* 1980, 1985; *revised* 1990, 1995, 2000 *reaffirmed* 2005

## **SUDDEN INFANT DEATH SYNDROME**

**WHEREAS**, Sudden Infant Death Syndrome (SIDS) is the leading cause of infant mortality between 1 month and 1 year of age in the United States, responsible for thousands of deaths annually; and

**WHEREAS**, recent epidemiologic and physiologic evidence has implicated the prone sleeping position as a potential risk factor for SIDS; and

**WHEREAS**, several countries including Australia, New Zealand, Britain and the Netherlands have significantly reduced deaths from SIDS after mounting a national campaign to discourage the prone sleeping position; and

**WHEREAS**, the U.S. Public Health Service and other organizations are mounting intensive national campaigns to promote the supine sleeping position in healthy infants; now, therefore, be it

**RESOLVED**, that that the American Osteopathic Association supports the U.S. Public Health Service's campaigns by encouraging its members to educate the parents and care-givers of young infants to place healthy infants to sleep on their backs. . 1994; *revised* 1999, 2004

### **SUPPORT OF LITERACY PROGRAMS**

**WHEREAS**, an elemental strength of democratic society is a free flow of information and exchange of opinion; and

**WHEREAS**, the vitality and progress of such democracy is reflected in decisions rendered by its citizens based on information available to all; and

**WHEREAS**, the ability to read and write usually is a requisite for the full exercise of citizenship and a recognition of its obligations; and

**WHEREAS**, illiteracy in the United States is unacceptable; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports programs which promote literacy in the United States. 1990; *revised* 1995; *reaffirmed* 2000, *revised* 2005

### **TAKE BACK LAWS**

**WHEREAS**, osteopathic physicians believe in a level playing field between physicians and insurers; and

**WHEREAS**, insurance carriers now limit the time period that a physician is allowed to bill for services rendered; and

**WHEREAS**, an insurer can request or demand money back from physicians for overpayment of a claim for an indefinite period of time; now, therefore, be it

**RESOLVED**, that American Osteopathic Association calls upon the U.S. Congress to pass federal legislation which subjects all parties to the same terms and time frame for billing, payment and appeal. 2002

### **TANNING DEVICES**

**WHEREAS**, tanning devices may cause harmful effects from high intensity UVA exposure; and

**WHEREAS**, appropriate tanning device requirements accompanied by public education on this subject is in the common interest; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association endorses appropriate governmental action to impose those safety precautions which are needed regarding the use of tanning devices. 1990; *revised* 1995, 2000. *reaffirmed* 2005

## **TAX CREDITS FOR HEALTH PROFESSION SHORTAGE AREAS**

**WHEREAS**, the distribution of physicians to rural and other underserved communities has decreased in the past decade; and

**WHEREAS**, financial incentives have proven effective in encouraging physicians to pursue practice opportunities; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association (AOA) support the establishment of tax credits for physicians who practice full time in federally designated health professions shortage areas (HPSAs) or Medicare defined physician scarcity areas and federally and/or state designated underserved areas; and, be it further

**RESOLVED**, that these tax credits be available, on a sliding scale, to physicians who provide services on a part-time basis in these communities. 2005

## **TAXATION-OPPOSITION TO GROSS RECEIPTS OR HEALTHCARE PROVIDER TAXES BY GOVERNMENTAL BODIES**

**WHEREAS**, osteopathic physicians have long provided free or reduced cost healthcare to indigent patients; and

**WHEREAS**, this society as a whole must share the moral obligation of providing the costs of such care; and

**WHEREAS**, it is grossly unfair to ask physicians to share the burden alone through the use of a tax that singles them out and shows no equality or concern for them or the well being of their families; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association opposes taxation by any state, subdivision or federal government that is levied only on healthcare providers; and, be it further

**RESOLVED**, that the AOA encourages the divisional societies to take a similar position. 1993; *revised* 1998, 2003

## **TEACHING CHILDREN AND ADOLESCENTS ABOUT MEDICINES--TEN GUIDING PRINCIPLES FOR**

**WHEREAS**, the American Osteopathic Association encourages activities that will help children, through adolescence, become active participants in the process of using medicines including all types, both prescription and non-prescription, to the best of their abilities; and

**WHEREAS**, the AOA recognizes that children of the same age vary in development, experience, and capabilities; and

**WHEREAS**, children learn by example; now, therefore, be it

**RESOLVED**, that the American osteopathic Association endorses the United States Pharmacopeia (USP) position statement of the following "Ten Guiding Principles for Teaching Children and Adolescents About Medicines:"

1. Children, as users of medicines, have a right to appropriate information about their medicines that reflects the child's health status, capabilities, and culture.
2. Healthcare providers and health educators should communicate directly with children about their medicines.
3. Children's interests in medicine should be encouraged, and they should be taught how to ask questions of healthcare providers, parents, and other caregivers about medicines and other therapies.
4. The actions of parents and other caregivers should show children appropriate use of medicines.

5. Children, their parents, and their healthcare providers should negotiate the gradual transfer of responsibility for medicine use in ways that respect parental responsibilities and the health status and capabilities of the child.
6. Children's medicine education should take into account what children want to know about medicines, as well as what health professionals think children should know.
7. Children should receive basic information about medicines and their proper use as a part of school health education.
8. Children's medicine education should include information about the general use and misuse of medicines, as well as about the specific medicines the child is using.
9. Children have a right to information that will enable them to avoid poisoning through the misuse of medicines.
10. Children asked to participate in clinical trials (after parents' consent) have a right to receive appropriate information to promote their understanding before assent and participation. 1999; *reaffirmed* 2004

### **TEENAGE SEXUALITY, CONTRACEPTION, AND THE MEDIA**

**WHEREAS**, more than 85 percent of teenagers have first coitus prior to seeking professional advice about pregnancy prevention or sexually transmitted diseases; and

**WHEREAS**, the teenage pregnancy rate in the U.S. has been found to be two to five times higher than other developed countries; and

**WHEREAS**, the consequences of unprotected coitus, including unwanted pregnancy and exposure to STDs, are not well understood or are taken for granted by the teenage population; and

**WHEREAS**, print/electronic media powerfully influences teenagers' sexual attitudes, values and beliefs; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association adopts the following policy:

#### **TEENAGE SEXUALITY, CONTRACEPTION AND THE MEDIA**

1. Osteopathic physicians should facilitate and encourage open discussion between adolescent patients and their families on the effects of the media on sexual behavior.
2. Osteopathic physicians and the AOA should assist and encourage the print/electronic media to use public service announcements that (a) promote abstinence, and (b) educate on the proper use, risk and failure rate of condoms and other forms of contraception.
3. Osteopathic physicians and the AOA should assist and encourage the print/electronic media to consider that when broadcasting advertisements for non-prescription contraceptives, guidelines should be used to ensure that the content of these advertisements is factual, educational and focused on responsible sexual behavior and decision-making.
4. Osteopathic physicians and the AOA should assist and encourage the print/electronic media to influence programs aimed at adolescents, to air advertisements and public service announcements that conform to the "Guide to Responsible Sexual Content" in Television, Film and Music; and, be it, further

**RESOLVED**, that the American Osteopathic Association enlists the support of this policy by Congress and the office of the President of the United States, and encourages the proposal of federal legislation for the purpose of promoting the use of these guidelines by the broadcast industry.

### ***Teenage Sexuality***

#### ***Guide to Responsible Sexual Content in Television, Film and Music***

In film, television, and music, sexual messages are becoming more explicit in dialogue, lyrics and behavior. Unfortunately, too often these messages contain unrealistic, inaccurate, and misleading information which young people accept as fact.

Following are some suggestions for the presentation of responsible sexual content:

- Recognize sex as a healthy and natural part of life.
- Parent and child conversations about sex are important and healthy and should be encouraged.
- Demonstrate that not only the young, unmarried, and beautiful have sexual relationships.
- Not all affection and touching must culminate in sex.
- Portray couples as having sexual relationships with feelings of affection, love and respect for one another.
- Consequences of unprotected sex should be discussed or shown.
- Miscarriage should not be used as a dramatic convenience for resolving an unwanted pregnancy.
- Use of contraceptives should be indicated as a normal part of a sexual relationship.
- Avoid associating violence with sex or love.
- Rape should be depicted as a crime of violence, not one of passion.
- The ability to say no should be recognized and respected.

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*Reproduced by permission of Pediatrics. 1996; revised 2001*

### **TELEMARKETING -- HEALTHCARE**

**WHEREAS**, patients make difficult decisions regarding their health and general welfare; and

**WHEREAS**, patients are listed, without their permission or knowledge, on contact lists which are readily available to telemarketers and advertisers; and

**WHEREAS**, solicitations to patients may be misleading; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports the federal trade commission's "national do not call registry" as well as Congressional efforts to regulate the healthcare telemarketing industry by putting an end to unwanted solicitations.. 1999; *revised 2004*

### **THIRD-PARTY PAYERS AND UTILIZATION REVIEW FIRMS--ACCOUNTABILITY**

**WHEREAS**, utilization review criteria are sometimes withheld from the physicians that are being reviewed; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association support the disclosure of the origin of utilization review criteria used by third-party payers. . 1994; *revised 1999, 2004*

### **TIMELY ACCESS TO ANCILLARY FACILITIES**

**WHEREAS**, access to medical care and its ancillary services, especially in rural areas, is frequently limited; and

**WHEREAS**, managed care organizations contract with laboratories and diagnostic imaging centers outside of reasonable geographic accessibility; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association exert its influence to insure that managed care organizations will provide a full range of medical services, if available, within the service area of its subscribers. 2001

#### **TOBACCO CONTROL—THE FRAMEWORK CONVENTION ON**

**WHEREAS**, globally, smoking causes 4 million deaths annually, and the percentage of deaths from tobacco use is projected to double from 6% in 1990 to 12.3% in 2020; and

**WHEREAS**, 1 in 10 deaths worldwide are caused by smoking-related diseases; and

**WHEREAS**, currently, there are 1.1 billion smokers in the world, with 80% of smokers living in developing countries; and

**WHEREAS**, the majority of tobacco related deaths will occur in developing countries, with 70% of all deaths from tobacco use occurring in developing countries by the year 2030; and

**WHEREAS**, tobacco companies spend billions of dollars annually on both direct and indirect advertising of tobacco products, and since smoking by women in developing countries is currently at 7%, making women and girls prime advertising targets; and

**WHEREAS**, advertising is also aimed at young people in developing countries through sports sponsorships, promotional items, entertainment sponsorships, and free cigarette samples at events frequented by young people; and

**WHEREAS**, U.S. advertising by tobacco companies also target women and minority communities in magazines, newspapers, and billboards; and

**WHEREAS**, The World Health Organization (WHO) began the Tobacco Free Initiative in 1998 to reduce tobacco use by strengthening global initiatives, and includes the development of an international treaty on tobacco control called the Framework Convention on Tobacco Control (FCTC); and

**WHEREAS**, the FCTC will consider negotiations on a wide range of issues including, advertising; promotion and sponsorship of tobacco products; smuggling of tobacco products; cessation and treatment; tobacco price and tax policies; passive smoking; sale of duty-free tobacco products; tobacco product regulation, including testing and reporting of ingredients and the ability to require tobacco product modification; information exchange; health education and research; and agricultural policies; and

**WHEREAS**, the American Osteopathic Association has an extensive policy discouraging the use of tobacco products in the United States because of its adverse effect on health and recommending federal and state legislation to discourage its use; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association support the efforts of international health agencies in eliminating smoking from their societies, and encourage the United States to use its experience in tobacco control to help developing countries with this health issue; and, be it further

**RESOLVED**, that the American Osteopathic Association support the public health initiatives of the World Health Organization for tobacco control by promoting the Framework Convention on Tobacco Control (FCTC) and encourage the federal government to work towards the development and adoption of this international treaty. 2001

#### **TOBACCO SETTLEMENT FUNDS**

**WHEREAS**, all 50 states reached a large settlement agreement with the tobacco companies; and

**WHEREAS**, this Master Settlement Agreement places no restrictions on how the states can use the settlement funds; and

**WHEREAS**, there are numerous competing demands for the funds including both health related and non-health related items; and

**WHEREAS**, some states allocate the funds for non-health related items such as education, childhood development, tobacco communities and growers, and road improvement; and

**WHEREAS**, the tobacco settlement fund was caused by a growing concern for the dangers of tobacco use which is a health-related matter; and

**WHEREAS**, states have plans to allocate the tobacco settlement funds for healthcare services such as tobacco use prevention, biomedical research, hospital charity care, programs for the uninsured, Medicaid enhancement, and state children's health insurance programs (SCHIPs); now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports the use of the tobacco settlement fund for health-related items to include health care services, education and research only. 2000, *revised* 2005

#### **TOBACCO USE IN FILMS**

**WHEREAS**, the tobacco industry promotes the use of tobacco products in films; and

**WHEREAS**, although the Motion Picture Association of America has a voluntary rating system to rate films, they have no current system to quantify smoking in the film media; and

**WHEREAS**, consumer groups and health organizations have shown the harmful effects of tobacco; and

**WHEREAS**, the American Osteopathic Association and other healthcare associations have petitioned in support of presidential and congressional initiatives to ban all forms of tobacco advertising, especially to children; and

**WHEREAS**, it is estimated that approximately 3,000 people in the United States, mostly children, begin smoking each day and approximately 1000 will die from tobacco use related deaths; and

**WHEREAS**, tobacco product use depicted in films usually enhances the product and does not depict its adverse consequences on health; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association encourages the Motion Picture Association of America to measure, monitor and reduce the use of tobacco products in films. 2003

#### **TOBACCO USE STATUS-REPORTING IN THE MEDICAL RECORD**

**WHEREAS**, tobacco use is the nation's number one preventable health problem; and

**WHEREAS**, physician intervention has shown to improve cessation, and primary care clinicians are uniquely poised to assist patients who use tobacco, as they have extraordinary access to this population; and

**WHEREAS**, tobacco users cite a physician's advice to quit as an important motivator for attempting to stop; and

**WHEREAS**, physicians must have a systematic approach to identify patient tobacco use status; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports the Agency for Healthcare Research and Quality's (AHRQ) guideline on tobacco use cessation that specifically

recommends a method of identifying patients tobacco use status on each visit to increase the likelihood of physician intervention with their patients who use tobacco. 1999; *revised* 2004

### **TORT REFORM**

**WHEREAS**, professional liability insurance premiums are in an upward spiral; and  
**WHEREAS**, some physicians have been forced to move to states with affordable malpractice coverage or to close their practices altogether; and

**WHEREAS**, the resultant lack of availability of health care has the potential to cause harm to all Americans; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association support and encourage its divisional societies to support legislation for tort reform to include the following points:

- A cap on non-economic damages
- A uniform statute of limitations
- Collateral source payment offsets
- Periodic payment of future damages
- Joint and several liability reforms
- Limitation of plaintiff attorney contingency fees; and be it further

**RESOLVED**, that the AOA support and encourage legislation in all states to increase the standards in professional liability cases to “clear and convincing.” 2002

### **TUBERCULOSIS MEDICAL TRAINING**

**WHEREAS**, tuberculosis is on the increase in the United States; and

**WHEREAS**, the AIDS epidemic and other multiple factors have resulted in new cases of tuberculosis and the emergence of new multi-drug resistant strains of tuberculosis; and

**WHEREAS**, prior to this resurgence of tuberculosis, laxity in the prevention and treatment of this disease has occurred; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association urges the United States Department of Health and Human Services to formulate new programs to educate physicians, healthcare workers and the public on the prevention and treatment of tuberculosis; and, be it further

**RESOLVED**, that the AOA supports tuberculosis prevention programs carried out by the Centers for Disease Control and Prevention (CDC), The National Institutes of Health (NIH) and other organizations and encourages the use of the CDC's core curriculum on tuberculosis by osteopathic physicians who treat patients diagnosed with tuberculosis or are at high risk for tuberculosis disease or infection. 1993; *revised* 1998; *reaffirmed* 2003

### **UNIFORM BILLING**

**WHEREAS**, the percentage of time spent for billing compared to that of actual treating of patients has increased; and

**WHEREAS**, the actual cost for billing has also increased; and

**WHEREAS**, third-party payers require billing to be done in many different ways which leads to confusion and delay in payment; and

**WHEREAS**, the availability of a uniform electronic billings system would enhance physician use of such a system; now, therefore, be it

**RESOLVED** that the American Osteopathic Association supports a uniform standard for electronic billing to be used by the healthcare industry; and, be it further

**RESOLVED**, that the AOA opposes charging a fee or other penalty to physicians for the reimbursement claims that they submit for care provided to Medicare and Medicaid patients. 1993; *revised* 1998, 2003

#### **UNIFORM PATHWAY OF LICENSING OF OSTEOPATHIC PHYSICIANS**

**WHEREAS**, the United States Medical Licensing Examination presents a challenge for osteopathic physicians to have a distinctive osteopathic examination and licensure; and

**WHEREAS**, osteopathic medicine is a separate and complete medical profession and its members should be licensed to indicate this distinction; and

**WHEREAS**, licensure, while an individual state process, should have uniformity throughout the nation to protect the quality and integrity of osteopathic licensure and the public's interest; now, therefore, be it

**RESOLVED**, that the examination of the National Board of Osteopathic Medical Examiners must remain as an avenue for the licensure of osteopathic physicians; and, be it further

**RESOLVED**, that the American Osteopathic Association supports a uniform pathway of licensing osteopathic physicians through the mechanisms of the National Board of Osteopathic Medical Examiners. 1991; *revised* 1993, 1998, 2003

#### **UNIFORMED SERVICES: ENDORSEMENT OF PHYSICIANS SERVING IN THE UNIFORMED SERVICES**

**WHEREAS**, the osteopathic profession has the highest regard for our men and women in uniform; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association will continue to assist the Surgeons General of the US and the American public in maintaining and assuring the highest quality of healthcare by its representatives in the uniformed services; and, be it further

**RESOLVED**, that the AOA recognize the 40th anniversary of osteopathic physicians being commissioned in the military. 1985; *revised* 1990, 1995; 2000, 2005

#### **UNINSURED—ACCESS TO HEALTH CARE**

**WHEREAS**, the cost of health insurance coverage annually increases at a rate sufficient to negatively impact access to basic health care coverage and ultimately prevent those who are unable to obtain insurance from seeking quality health care services; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports federal and state efforts to increase access to affordable health care coverage through initiatives that expand coverage to the uninsured through the efficient use of both private and public resources; and, be it further

**RESOLVED**, that the American Osteopathic Association supports efforts to reform programs such as Medicaid, Medicare, and State Child Health Insurance Program (SCHIP) to provide coverage to populations that would otherwise lack health care coverage and ultimately, access to needed health care services. 2003

## **UNIONIZATION OF PHYSICIANS**

**WHEREAS**, in response to the increased power third-party payers have over osteopathic physicians and patient care, physicians are seeking a unified voice to represent their interests in contract negotiations; and

**WHEREAS**, it has become increasingly difficult for physicians to negotiate contracts that recognize their need for clinical autonomy in making treatment decisions on behalf of patients; and

**WHEREAS**, interpretations of federal and state antitrust laws currently prohibit physicians, who are otherwise competitors, from negotiating as a group with third-party payers; and

**WHEREAS**, federal labor law exempts only non-supervisory, employed physicians from the federal antitrust laws and allows them to engage in collective bargaining with their employer; and

**WHEREAS**, only a small percentage of physicians represented by the AOA are covered by this labor law exception to the federal antitrust laws and would be permitted to engage in collective bargaining; and

**WHEREAS**, through unionization the public's perception of the professionalism of physicians could be irreversibly damaged; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association does not, at this time, believe that physician unionization is a viable solution to the problems physicians face today; and, be it further

**RESOLVED**, that the AOA actively pursue efforts to create an open and constructive dialogue between physicians and third-party payers with the goal of improving the practice environment for osteopathic physicians through joint negotiations; and, be it further

**RESOLVED**, that the AOA monitor the unionization movement; and, be it further

**RESOLVED**, that the AOA support federal efforts to seek appropriate antitrust reforms. 1999; *revised* 2004

## **URGING STANDARD POLICIES FOR CERTIFYING INDIGENT PATIENTS FOR FREE PHARMACEUTICALS**

**WHEREAS**, many major drug companies have established procedures whereby physicians may request certain medications at no cost for indigent patients; and

**WHEREAS**, the procedures required of the physician in requesting such medications varies among the pharmaceutical companies in factors such as eligibility criteria, amount and type of paper work required, approval time, and method of distribution of the medication; and

**WHEREAS**, these variances create an encumbrance on both physicians and patients often resulting in deserving patients not receiving the medicine, or only after a medically unacceptable delay; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association urges the Pharmaceutical Industry, through the Pharmaceutical Research and Manufacturers of America, to develop standard and uniform policies and procedures for certifying indigent patients for free medication programs, including a method whereby the patients, once approved, could receive the appropriate medicine more expeditiously in compliance with state dispensing regulations. 1996; *revised* 2001

## **UNIFORMED SERVICES PHYSICIANS REQUIRING AND ASSIGNED TO CIVILIAN RESIDENCY PROGRAMS—AOA SUPPORT OF ALL OSTEOPATHICALLY TRAINED**

**WHEREAS**, the American Osteopathic Association has been fully supportive of osteopathic physicians serving in the uniformed services of the United States for many decades; and

**WHEREAS**, these osteopathic physicians serving in the uniformed services and represented by the Association of Military Osteopathic Physicians and Surgeons, supported the AOA and its postgraduate training programs; and

**WHEREAS**, the uniformed services osteopathic interns/PGY1 residents should be able to receive expeditious AOA approval of Federally funded training in residency programs sponsored under the uniformed services umbrella in both military and civilian institutions; now therefore, be it

**RESOLVED** that the American Osteopathic Association continue to monitor, assist and support all osteopathic physicians who receive graduate medical education (GME) through the uniformed services process, removing barriers to osteopathic graduate medical education approval. 1998; *revised* 2004

### **VACCINE DILEMMA**

**WHEREAS**, there has been a growing shortage of certain immunizations; and

**WHEREAS**, manufacturers have recently supplied non-physicians with significant amounts of vaccine; now, therefore, be it

**RESOLVED** that the American Osteopathic Association contact manufacturers of vaccines to encourage rapid increase in vaccine supply and to distribute these vaccines preferentially to physicians, healthcare facilities, and healthcare agencies. 2001

### **VACCINE SHORTAGES**

**WHEREAS**, the vaccine program in the United States is extremely fragile and vulnerable at this time; and

**WHEREAS**, the United States has had severe shortages of certain vaccines in recent years; and

**WHEREAS**, the reason given for the shortages are; fewer companies are manufacturing vaccine because of poor reimbursement and because of the increased liability to the manufacturer; and

**WHEREAS**, vaccine shortages carry a high risk to the public's health; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association take the necessary steps to establish a coalition to meet with federal legislators and the Centers for Disease Control & Prevention on this critical issue of vaccine shortage; and, be it further

**RESOLVED**, that the meeting include discussion on increased reimbursement for vaccines to encourage increased manufacturing; and, be it further

**RESOLVED**, that steps be taken to give manufacturers of vaccine immunity from lawsuits because of complications which are not due to negligence; and, be it further

**RESOLVED**, that the public be provided information on potential side effects and complications of vaccines so they are fully informed and responsible for their decision to be immunized. 2005

## **VACCINES FOR CHILDREN PROGRAM**

**WHEREAS**, Section 1928 of the Social Security Act was enacted so that children could receive vaccinations as a part of routine health care, supporting the reintegration of vaccination into primary health care; and

**WHEREAS**, the Vaccines for Children (VFC) program provides immunizations in their primary physician's office for children who are uninsured, Medicaid recipients Native Americans, and Alaska Natives; and

**WHEREAS**, children who are underinsured, that is, they have health insurance but it does not cover routine immunizations, may not receive immunizations in their private physician's office, but must go to a participating federally qualified health clinic or rural health clinic; and

**WHEREAS**, this creates many missed immunization opportunities, in direct opposition to the goals of the Program; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association (AOA) supports legislative action to authorize the expansion of the Vaccines for Children (VFC) Program to include immunizations to all underinsured children, in keeping with the original goals of the program. 2005

## **VETERANS ADMINISTRATION CREDENTIALING OF NON-PHYSICIAN PROVIDERS**

**WHEREAS**, the Veterans Administration (VA) operates one of the largest health care delivery systems in the country; and

**WHEREAS**, decisions made by the VA are duplicated within other payment systems; and

**WHEREAS**, a lack of consistent policy exist in the credentialing of non-physicians within the VA system; and

**WHEREAS**, any non-physician provider may be credentialed within the VA system up to the extent of their license; and

**WHEREAS**, there is no consistency in state licensure requirements for non-physician providers; and

**WHEREAS**, under current VA policy a non-physician provider may be granted sweeping privileges within the VA based upon a minority of state laws; and

**WHEREAS**, this creates a decrease in the quality of care provided to our nation's veterans; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association (AOA) support the establishment of well-defined credentialing and privileging criteria within the Veterans Administration (VA) that prohibits non-physician providers with expanded scope of practice rights in a minority of states from demanding such privileges in the VA system; and, be it further

**RESOLVED**, that the AOA support the establishment of a consistent requirement for the privileging of non-physician providers in the VA system. 2005

## **VETERANS—HEALTH CARE FOR U.S.**

**WHEREAS**, U.S. Veterans from World II, Korea, and Vietnam are reaching the age when multiple disabilities from chronic diseases are causing them to seek health services from veterans hospitals and clinics; and

**WHEREAS**, many Veterans are living on fixed incomes that do not provide enough funds to purchase private health insurance plans; and

**WHEREAS**, the federal government has instituted an “income means” test as a way to cut back funding for Veterans causing the ranks of Americans without adequate health insurance to swell; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports adequate health care funding by the federal government to take care of all U.S. Veterans at veteran’s hospitals and clinics or alternate health care sites. 2003

#### **VETERANS HOSPITALS AND CLINICS-OMT IN**

**WHEREAS**, osteopathic physicians are trained to utilize Osteopathic Manipulative Treatment (OMT) in the diagnosis and treatment of patients; and

**WHEREAS**, OMT is recognized by a majority of third-party payors for reimbursement purposes; and

**WHEREAS**, OMT is a physician administered health care service which is beneficial and cost-effective; and

**WHEREAS**, current national VA policy recognizes osteopathic treatment and CPT coding for OMT; and

**WHEREAS**, osteopathic physicians working in some veterans healthcare facilities have not been permitted by the director of their local facility to utilize OMT for diagnosis and treatment of patients and to document the findings in medical records; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association requests that the Department of Veterans Affairs Research and resolve this problem so that osteopathic physicians will be able to document the finds and provide OMT in all departments of veterans affairs healthcare facilities. 2003

#### **VIOLENCE--DEVELOPMENT OF PROGRAMS TO REDUCE**

**WHEREAS**, violence of all kinds has a devastating effect on its victims and society; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association urges its members as well as governmental agencies to continue to develop and expand educational and preventative programs to reduce violence and abuse of all kinds, including those of a sexual and/or domestic nature. 1991; *revised* 1996, 2001

#### **VIOLENCE IN THE ENTERTAINMENT MEDIA**

**WHEREAS**, there continues to be an increase in the portrayal of violence in the entertainment media; and

**WHEREAS**, the entertainment media has a demonstrated impact on children's attitudes and learned behavior; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association opposes the presentation of gratuitous violence in the entertainment media. 1977; *revised* 1982, 1987, 1992; *reaffirmed* 1997; *revised* 2002

#### **VOTING DAY—AOA SUPPORTS VOTING DAY POLICY**

**WHEREAS**, if every healthcare provider and healthcare facility would initiate a policy to allow their employees time off during working hours to participate in voting, the political voices of healthcare professionals would be heard; now, therefore, be it

**RESOLVED**, the American Osteopathic Association encourages all osteopathic physicians to adopt voting policies in their workplaces that would allow their employees time off during working hours to participate in voting for local, state, and national elections. 1991; *revised* 1996, 2001

### **WOMEN'S CONTRACEPTIVE COVERAGE LEGISLATION**

**WHEREAS**, some of the traditional indemnity plans and preferred provider organizations (PPOs) fail to cover any of the most commonly used forms of contraception for women; and

**WHEREAS**, the exclusion of contraceptive coverage of insuring companies is discriminatory against women and their health; and

**WHEREAS**, coverage for such services not only facilitates the health of the woman using the contraceptive but aids in alleviating the problem of unintended pregnancy in this country; and

**WHEREAS**, millions of unintended pregnancies occur in the United States every year; and

**WHEREAS**, unintended pregnancy causes both an economic and emotional strain on women and their families; and

**WHEREAS**, avoiding unintended pregnancy can relieve a large percentage of the abortions performed in this country every year as well as the number of children born into economically distressed households; and

**WHEREAS**, the use of contraceptives by women is a safe and effective way of avoiding unintended pregnancy and maintaining the health of the woman using the contraceptive; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association supports health insurance coverage for Federal Food and Drug Administration (FDA)-approved contraceptive services to women of child-bearing age; and, be it further

**RESOLVED**, that the AOA supports language which would maintain co-payment for contraceptive services at a cost no higher than the normal set level of co-payment for any other prescription. 1999; *revised* 2004

### **YOUNG PHYSICIANS**

**WHEREAS**, the needs of physicians who are recent graduates or new in practice are unique and different than the needs of physicians who have been in practice for many years; and

**WHEREAS**, these physicians, known as “young physicians”, need a forum in which they can organize, share ideas, and plan events to meet their distinct and emerging needs; and

**WHEREAS**, a progressive transition from the Bureau of Interns/Residents to the Council of Young Physicians promotes the sharing of mutual ideas and goals in a seamless fashion; now, therefore, be it

**RESOLVED**, that the American Osteopathic Association shall define the category of “young physician” as a physician who has graduated from an osteopathic medical school and that this designation shall apply for a period of ten (10) years following the graduation; and, be it further

**RESOLVED**, that the chair of the Bureau of Interns/Residents will serve as the liaison for the Council of Young Physician; and, be it further

**RESOLVED**, that the AOA continue to support and assist the Council of Young Physicians to address the needs of young osteopathic physicians of the United States. 1999; *revised* 2004

