HOUSE OF DELEGATES’ REFERENCE COMMITTEE DESCRIPTIONS:

- Committee on Professional Affairs (300 series)
  This reference committee reviews and considers matters relating to osteopathic health care facilities, advocacy, legislation, membership and conventions.

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RESOLVED, that the Bureau of Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H300-A/14 TRAINING -- EXTENDED RELEASE-LONG ACTING (ER/LA) OPIOID RISK EVALUATION AND MITIGATION STRATEGY (REMS)

The AOA encourages osteopathic physicians whose practice includes the prescribing of Extended Release-Long Acting (ER/LA) Opioids to complete ER/LA Opioid Risk Evaluation and Mitigation Strategy (REMS) training to ensure that ER/LA opioids are prescribed, when indicated, in a manner that enhances patient well-being and does not contribute to individual or public harm. 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________


RESOLVED, that the Bureau of Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H301-A/14 MEDICAL WEBSITES AND SMARTPHONES / TABLET COMPUTER APPS TO DIAGNOSE ILLNESS – USE OF

The American Osteopathic Association (AOA) recognizes the values that health information websites and apps provide patients and encourages their use for patients to gain information about their health, and will encourage its members to recommend patients use evidence-based resources so that they may continue to actively engage in their own health care. The AOA should actively educate patients on the importance of seeing a physician when ill or injured and in need of a medical diagnosis, and that patients not allow recommendations from these medical websites or applications to be used as a basis for delaying, or as a substitute for, evaluation and treatment by a physician. 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H305-A/14 FLU PANDEMIC – OSTEOPATHIC TREATMENT OF

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
the following policy be REAFFIRMED:

H305-A/14 FLU PANDEMIC – OSTEOPATHIC TREATMENT OF
The American Osteopathic Association supports the active utilization of osteopathic
manipulative treatment, along with other recognized and approved medical interventions, in the
treatment of flu pandemics and other infectious outbreaks; and will conduct programs to
disseminate appropriately training in osteopathic manipulative treatment. 2009; reaffirmed as
amended 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE _____________________________
RESOLVED, that the Bureau of Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H306-A/14  DIRECT-TO-CONSUMER MARKETING OF HEALTH SCREENING AND TESTING
The American Osteopathic Association is against unnecessary exams and testing marketed directly to consumers and encourages its members to educate their patients and follow the US Preventive Services Task Force Guidelines WHEN APPROPRIATE. 2009; reaffirmed 2014

Explanatory Statement:

ACTION TAKEN ____________________

DATE ____________________________
SUBJECT: H307-A/14 NEW BORN HIV TESTING

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H307-A/14 NEW BORN HIV TESTING
American Osteopathic Association policy recommends HIV testing immediately with expeditious reporting of results of newborns whose mothers’ HIV status is unknown and where clinically indicated. 2003, reaffirmed 2009; reaffirmed as amended 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
following policy be SUNSET:

H313-A/14 CDC – HIV PROPOSED RULE CHANGE

The American Osteopathic Association voices its concern and opposition to the Centers for
Disease Control and Prevention (CDC) proposed rule-making change on 42 CFR Part 34 to
remove human immunodeficiency virus (HIV) testing as a requirement for immigrants and
refugees; and, through its resources encourages members and the public to investigate and
comment on the proposed rule-making. 2009; referred 2014

Explanatory Statement:
This policy is no longer needed. On November 2, 2009, the Department of Health and Human
Services (HHS) and Centers for Disease Control and Prevention (CDC) published a final rule that
removes HIV (Human Immunodeficiency Virus) infection from the list of communicable diseases of
public health significance. As a result, HIV infection will not prevent non-U.S. citizens from entering
the United States. Further, HIV testing will no longer be required for U.S. immigration medical

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

**H314-A/14  INFLUENZA IMMUNIZATION FOR HEALTH CARE WORKERS AND EDUCATORS**

The American Osteopathic Association strongly supports and recommends influenza vaccinations for all health care workers and educators according to current guidelines of the Centers for Disease Control and Prevention. 2009; reaffirmed as amended 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau of Membership recommend that the following policy be reaffirmed:

H316-A/14  DUE PROCESS FOR ALLEGED IMPAIRED PHYSICIANS

It is the policy of the American Osteopathic Association that, except in the case of summary suspension necessary to protect patients from imminent harm, no adverse action be taken against the staff privileges of a physician by a hospital, managed care organization or insurer based on a claim of physician impairment without a suitable due process hearing in accordance with medical staff bylaws to determine the facts related to the allegations of impairment, and, where appropriate, a careful clinical evaluation of the physician. 1999; reaffirmed 2004; 2009; 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H317-A/14 DRUG FORMULARIES

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFECTED:

H317-A/14 DRUG FORMULARIES

The American Osteopathic Association (AOA) supports drug formularies which allow for an expeditious appeal process with a further peer to peer review option. 1999; reaffirmed 2004; 2009; reaffirmed as amended 2014

Explanatory Statement:

ACTION TAKEN ___________________

DATE ___________________________
RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
the following policy be REAFFIRMED:

H318-A/14  HOME-BASED CARE FOR FRAIL ELDERLY

The American Osteopathic Association encourages all parties with economic and clinical
responsibility to develop programs and systems to assist the frail elderly patient population and
provide appropriate access to healthcare services. 1999; revised 2004; reaffirmed 2009;
reaffirmed as amended 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED:

H319-A/14  HEALTH CARE COSTS IN LONG TERM SERVICES AND SUPPORT

The American Osteopathic Association reaffirms its commitment to the development and implementation of programs that improve the efficiency of long term services and support and ensure the delivery of quality care. 1984; revised 1989; reaffirmed 1994; revised 1999; reaffirmed 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be SUNSET:

H320-A/14 IMMUNIZATION REGISTRIES
The American Osteopathic Association encourages physicians to participate in the development of immunization registries in their communities and to use such registries in their practices.
1999; revised 2004; reaffirmed 2009; 2014

Explanatory Statement:
A new resolution was developed - CLINICAL DATA REGISTRIES AND QUALIFIED CLINICAL DATA REGISTRIES - for presentation to the HOD to encompass other public and private clinical data registries in addition to immunization registries.

ACTION TAKEN ____________________
DATE ______________________________
SUBJECT: H321-A/14 NATIONAL PRACTITIONER DATA BANK – MEMBERSHIP ACTION

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Membership recommend that the following policy be
REAFFIRMED:

H321-A/14 NATIONAL PRACTITIONER DATA BANK – MEMBERSHIP ACTION
The American Osteopathic Association believes that adverse membership actions which do not involve professional competence or conduct such as nonpayment of dues, CME deficiencies and other association matters shall not be reported to the National Practitioner Data Bank (NPDB) unless otherwise required by law; and that final actions of expulsion of members from the American Osteopathic Association shall, when all appeal mechanisms have been exhausted by the osteopathic physicians, be reported to the National Practitioner Data Bank. 1999; reaffirmed 2004; 2009; 2014

Explanatory Statement:

ACTION TAKEN _______________________

DATE ______________________________
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

H322-A/14  IMPORTATION OF MEDICATIONS

The American Osteopathic Association supports the importation of medications that may be imported under the authority of the US Food and Drug Administration and encourages its members to assist patients in utilizing the many programs that are available to provide patients with free or reduced cost medications. 2004; reaffirmed 2009; 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED:

H323-A/14 ANY WILLING PROVIDER LEGISLATION

The American Osteopathic Association encourages and supports the passage of legislation that will ensure the freedom of patients and physicians to enter into private contracts for health care services without regard to restrictions by any third party carrier; supports legislation that will allow any qualified physician (DO/MD) to negotiate with any third party carrier the terms for service to be provided; and supports legislation that will require any third party carrier to provide prompt and complete explanation to any requesting physician (DO/MD) whom it may deem unqualified. 2004; reaffirmed 2009; 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

**H324-A/14 USE OF THE TERM “PHYSICIAN” “DOCTOR” AND “PROVIDER” - TRUTH IN ADVERTISING**

The American Osteopathic Association (AOA) adopts as policy: (1) that AOA members DOs AND MDS are encouraged to use the terms “physician” or “doctor” to describe themselves, leaving other terms such as “practitioner,” “clinician,” or “provider” to be used by non-physician clinicians or to categorize health care professionals as a whole; (2) supports the appropriate use of credentials and professional degrees in advertisements; (3) supports mechanisms for physicians to report advertisements related to medical care that are false or deceptive; (4) opposes non-physician clinicians’ use of the title “physician” or “doctor” because such communication is likely to deceive the public by implying that the non-physician clinician is engaged in the unlimited practice of medicine; (5) opposes legislation that would expand the use of the term “physician” OR “DOCTOR” to persons other than USTrained DOs, and MDs; (6) supports policies that REQUIRE physicians and non-physician clinicians TO VERBALLY DISCLOSE THEIR DEGREES WHEN identifying themselves to their patients, AND WEAR A NAMETAG WHICH CLEARLY DISPLAYS THEIR DEGREE DURING ALL PATIENT ENCOUNTERS, noting their degree in both a verbal description as well as a visual identification by use of a nametag; (7) OPPOSES will not support legislation THAT, which would allow non-physician clinicians to be called “physicians;” (8) supports policies THAT reserving the title “physician” for USTrained DOs, and MDs who have established the integrity of their education, training, examination WHICH UNIQUELY PREPARE THEM for the unlimited practice of medicine; and (9) opposes the misuse of the title “doctor” by non-physician clinicians, in all communications and clinical settings because such use deceives the public by implying THAT the non-physician clinician’s education, training or credentialing is equivalent to a DO or MD. 2009; reaffirmed as amended 2014

Explanatory Statement:
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

**H325-A/14 PHYSICALLY ACTIVE VIDEO GAMES – (EXERGAMING HEALTH) BENEFITS**

The American Osteopathic Association recommends: (1) osteopathic physicians should be aware of the potential benefits of exergaming; (2) physicians should consider recommending exergaming as a component of a person’s exercise program or when situational circumstances prohibit other types of exercise; and (3) additional research that demonstrates the benefits of exergaming. 2009; reaffirmed as amended 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED:

**H326-A/14  MEDICARE – PRESCRIPTION ASSISTANCE FOR MEDICARE PATIENTS**

The American Osteopathic Association supports legislation that will allow Medicare Part D recipients, who are in the “donut hole”, to utilize prescription discounts and vouchers. 2009; reaffirmed 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ____________________________
RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H327-A/14 ELECTRONIC PRESCRIBING

The American Osteopathic Association (AOA) supports electronic prescribing (e-prescribing) for non-scheduled pharmaceuticals.

The AOA supports e-prescribing for all scheduled pharmaceuticals on a voluntary basis without CMS reimbursement monetary penalty.

The AOA encourages pharmacies to utilize e-prescribing systems that are in compliance with state and federal law.

The AOA supports the following principles in its advocacy efforts relating to the development of e-prescribing standards:

- SAFETY: Safety alerts should be prioritized and readily distinguishable from commercial messages; these messages should be allowed to be suppressed for efficiency.
- E-PRESCRIBING drugs should be listed with both generic and name brands.
- PRIVACY: Information on patients' medication should be current, comprehensive, accurate and maintained in compliance with HIPAA.
- TRANSPARENCY: Third party involvement must be transparent and disclosed TO THE PRESCRIBING PHYSICIAN AND PATIENT.
- DESIGN: Financial interests should not dictate the design of systems (i.e., all drugs should be available). Standards must require fail-safes in any system to prevent the introduction of new health care errors.
- INTEGRATION: Systems should be proven and should integrate with existing healthcare technology and existing workflow (i.e., download of patient data from EMR).
- SCALABILITY: Any standards should be broad-based and applicable to all healthcare delivery systems.
- TIMING: These standards should be in place at the earliest possible time to allow software vendors and practitioners adequate time to become compliant with said standards and perform all necessary testing prior to the implementation. 2004; reaffirmed as amended 2009; reaffirmed as amended 2014
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H328-A/14 CARDIOVASCULAR DISEASE AND WOMEN

The American Osteopathic Association: (1) encourages its members to participate in continuing medical education programs on cardiovascular disease (CVD) in women; (2) urges osteopathic state and specialty associations to offer CME on CVD in women, as part of their educational offerings; (3) encourages its members to participate in national initiatives on women’s health, especially cardiovascular health such as the National Heart, Lung, and Blood Institute’s The Heart Truth (Red Dress) campaign; (4) will continue to recognize National Women’s Health Week and National Women’s Check-Up Day; and (5) through its website, the AOA will link to organizations whose mission is to educate patients and physicians on CVD; and (6) encourages appropriately designed studies on contributors to CVD in women. 2004; 2009; reaffirmed as amended 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H329-A/14 HEALTHY WEIGHT FOR FAMILIES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H329-A/14 HEALTHY WEIGHT FOR FAMILIES

The American Osteopathic Association encourages participation of its members in personal health promotion; strongly recommends osteopathic medical schools incorporate personal health promotion as a part of their graded curriculum; strongly recommends participation of its members in outreach efforts to engage with local school districts in order to develop and improve wellness policy interventions to reduce childhood obesity; strongly recommends the state and specialty associations to collaborate with local school districts and major local employers to enhance wellness policy development, implementation, data assessment and improvements; encourages its members to participate in national and local initiatives on obesity; and, through its website, the AOA will link to the most up to date evidence on treating obesity.

Explanatory Statement:

ACTION TAKEN ________________

DATE __________________________
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED:

H330-A/14 ADMINISTRATIVE FEES

The American Osteopathic Association has determined that it is ethical for an osteopathic physician to charge patients fair and reasonable administrative fees as long as the patient is informed of these fees in advance, and the charging of administrative fees does not violate contractual or state law. 2004; 2009; reaffirmed as amended 2014
RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
the following policy be REAFFIRMED as AMENDED:

H331-A/14 END-OF-LIFE CARE – USE OF PLACEBOS IN

The AOA approves the attached position paper on Use of Placebos for Pain Management in
End-of-Life Care and will be updated according to the current literature. 2004; 2009; reaffirmed
as amended 2014

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

The placebo effect of medication can be a significant resultant action of any prescription.
However, the substitution of a placebo in place of effective pain medication has been widely
recognized as unethical, ineffective and potentially harmful. A number of
organizations have advised against the use of placebo substitution, including the American Pain
Society, Agency for Healthcare Policy and Research, World Health Organization, the
Healthcare Facilities Accreditation Program, Joint Commission on Accreditation of Healthcare
Organizations, Education on End-of-Life Care Project (co-sponsored by the American Medical
Association), American Nursing Association, and the American Society of Pain Management
Nurses.

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

I. Definition of Terms
A. Placebo, placebo substitution, placebo effect and nocebo response

A placebo is a substance presumed to be pharmacokinetically inert. Placebo substitution
means the substitution of a physiologically inactive substance for a comparison with the
physiologically active substance. Placebo effect is the positive psychosomatic response
of an individual to a treatment; in contrast, the nocebo response is a negative
psychosomatic response to a treatment. The placebo effect is an important adjunct in
the treatment of symptoms. The alleviation of symptoms has an inherent positive
psychological component; patients who perceive their symptoms to be relieved by the
treatment and trust in their treating physician’s treatment plan and/or prescription for
the symptom relief are more likely to obtain relief.

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

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

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

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

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

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

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

Withdrawal is defined by the DSM-V\(^\text{(14)}\) as a maladaptive behavioral change having physiological and cognitive concomitants, which occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged use of the substance, frequently inappropriately. Examples of withdrawal include the onset of seizures or delirium tremens in a newly abstinent alcohol chemically dependent individual.

Pseudo-addiction is the term used to describe the behavior of a patient in pain who is receiving an insufficient amount and/or an inappropriate dosing frequency of administration of the prescribed pain medication. In an effort to obtain relief, the patient in pain would request more frequent and/or increased medication. Such “drug seeking behavior” has been deemed as “proof” of “addiction.” The reason for such requests is frequently that the patient is under-dosed, receiving too little of the medication and/or too long a delay between doses of the pain medication. In such instances, the patient receives inappropriate pain relief, which is not an appropriate criterion of a substance-abusing patient according to the DSM-V\(^\text{(14)}\).

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

While there are no specific laws governing the use of placebos in any circumstance, there is a considerable amount of legislation regarding a patient’s right to pain management. There are several state statutes that address this issue, some of which are based on the Federation of State Medical Boards’ Model Guidelines for the Use of Controlled Substances for the Treatment of Pain\(^\text{(15)}\). This document clarifies that legislative statutes accepting these guidelines understand the ongoing increased scientific knowledge of pain management, and thus have no need to modify legislation as the science of pain management changes. This document does not mention placebo usage.

The American Bar Association (ABA)\(^\text{(16)}\) adopted a resolution concerning the promotion of pain management in all patients with chronic pain. This resolution states, “…that the American Bar Association urges federal, state and territorial governments to support fully the rights of individuals suffering from pain to be informed of, choose, and receive effective pain and symptom evaluation, management and ongoing monitoring as part of basic medical care, even if such pain and symptom management may result in analgesic tolerance, physical dependence or as an unintended consequence shorten the individual’s life.”\(^\text{(16)}\) Placebo substitution for active pain medicine without informed consent on the part of the patients clearly violates the nature and substance of the ABA’s position. Additionally, in two Supreme Court decisions regarding the right to assisted suicide, the court promoted the right of individuals to appropriate palliative care and pain management.\(^\text{(17, 18)}\)

While there is little case law concerning tort or administrative findings against physicians for inadequate pain management, this is likely to change in the near future. The main barrier to malpractice claims for inadequate pain management is use of the customary local standard to determine what constitutes ordinary care. The courts are steadily moving away from this standard to a national standard which uses clinical guidelines as the determinant of ordinary care. This is seen in the decision in the case of Nowatske v. Oserloh, where the court stated, “should customary medical practice fail to keep pace with development and advances in medical science, adherence to custom might constitute a failure to exercise ordinary care…”\(^\text{(19)}\)
Guidelines developed by the Agency for Healthcare Policy and Research, now the Agency for Healthcare Research and Quality (1), the American Pain Society, (7) the Healthcare Facilities Accreditation Program (20), as well as the Joint Commission on Accreditation of Healthcare Organizations (21) are good examples of sources the courts are using to determine ordinary practice. These guidelines do not support the use of placebo in any fashion except in approved research studies when the appropriate patient informed consent has been obtained. Therefore, the physician thus cannot justify the use of placebo for pain management by attempting to diagnose “addiction” or with support from any of the above regulatory agencies.

Furthermore, under California’s elder abuse statute, (22) a physician was successfully sued by the deceased’s family for inadequate pain management at the end of life. (21)

III. Adverse Effects of Placebo Use

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

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

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

Substituting placebo for accepted forms of pain treatment is under-treatment of the condition. Under-treatment of pain, as detailed in the American Bar Association’s 2000 report, is an ongoing problem. (22) While there have been reports of placebo efficacy in pain management, placebo control of pain occurs in fewer patients and for shorter duration than active pain treatments. (4, 7, 26) It has also been argued that the prescription of an ineffective placebo in place of effective pain medication can act as a “suicidogen,” whereby an individual in pain who is given inadequate medication for relief may be prompted to hasten his/her death. (4-6) In the clinical setting, substitution of a placebo for an active pain medication, even with the consent of the patient, is clinically suspect because better treatment alternatives exist and there are risks associated with the use of placebos. It is therefore inappropriate to substitute a placebo for a medication known to be effective in the treatment of a patient with the verified pain of a terminal illness.

Additionally, placebos are associated with side effects (43) and potentially precipitate hyperalgesia (42) or withdrawal in patients previously treated with pain medications.

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

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

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21. National Pharmaceutical Council and Joint Commission on Accreditation of Healthcare
24. Portenoy RK. Contemporary Diagnosis and Management of Pain in Oncologic and AIDS
    for Physicians on End-of-Life Care (EPEC) Curriculum: The EPEC Project. The Robert
27. Compton P, Athanasos P, Elashoff D. Withdrawal hyperalgesia after acute opioid physical

Explanatory Statement:
Striking out statement on page 2 (lines 20-21) and corresponding reference. All remaining references
have been checked and revised editorially.

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H332-A/14 MINORITIES IN THE OSTEOPATHIC PROFESSION – COLLECTING DATA

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED:

H332-A/14 MINORITIES IN THE OSTEOPATHIC PROFESSION – COLLECTING DATA

The American Osteopathic Association (AOA) will: (1) include optional questions relating to race, ethnicity, and socioeconomic status as part of the data collected from physicians in membership records; (2) encourage the American Association of Colleges of Osteopathic Medicine (AACOM), individual osteopathic medical colleges, osteopathic residency programs, state associations and specialty colleges to submit existing data on minority representation in the osteopathic profession to the AOA; (3) encourage all osteopathic organizations to work with and respond to future inquiries from the AOA on this and similar matters; (4) distribute all of the information gathered through this initiative only as non-identifiable or aggregate demographic data; and (5) encourage all specialty colleges to establish committees to address training, fellowship, cultural competency and service issues related to underrepresented minorities (including but not limited to Hispanic/Latino Ethnicity, Black/African American, Native American, Alaska Native and Hawaiian/Pacific Islander) and to work collaboratively with the AOA to programs implement with multi-cultural impact. 2004; reaffirmed 2009; reaffirmed as amended 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
WHEREAS, the House of Delegates referred H-333-A/2014 OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) OF THE CERVICAL SPINE to the Bureau of Osteopathic Clinical Education and Research (BOCER) to review and update as some of the information provided in support of the position statement was out of date and needed citations; and

WHEREAS, the BOCER reviewed referred resolution H-333 - A/2014 and developed an updated position statement; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED as AMENDED:

H333-A/14 OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) OF THE CERVICAL SPINE

The American Osteopathic Association, in the hopes of advancing the science of osteopathic medicine adopts the following position (2004; reaffirmed 2009 [Editor’s note: This policy has been referred to as some of the information is out of date and needs citations - 2014]).

(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. 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. MD, DO, DC or PT) 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. 81% of GI bleeds related to NSAID use occur without prior symptoms. 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. The annual cost of GI tract complications in the US is estimated at $3.9 billion, with up to 103,000 hospitalizations and at least 16,500 deaths per year. This makes GI toxicity from NSAIDs the 15th most common cause of death in the United States.
Epidural steroid injection is a popular treatment for neck pain. Common risks include subdural injection, intrathecal injection and intravascular injection. Subdural injection occurs in ~1% of procedures. Intrathecal injection occurs in ~0.6-10.9% of procedures. Intravascular injection is the most significant risk and occurs in ~2% of procedures and ~8% of procedures in pregnant patients. Cervical epidural abscess is rare, but has been reported in the literature.

Provocative Tests

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

Risk Factors

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

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

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

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

Conclusion

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

Therefore, it is the position of the American Osteopathic Association that all modalities of osteopathic manipulative treatment of the cervical spine, including High Velocity/Low Amplitude, should continue to be taught at all levels of education, and that osteopathic physicians should continue to offer this form of treatment to their patients.
Background and Statement of Issue
Treating chronic pain continues to be an important health issue for osteopathic physicians. Chronic pain affects over 100 million Americans over the age of 18 and negatively impacts their quality of life. In addition, it costs $600 billion a year in healthcare costs and loss of productivity. Back and neck pain are two leading causes of chronic pain and they are amongst the leading causes of people living with disabilities in the United States (U.S.) as well as worldwide. More specifically, back and neck pain are ranked in the top 8 diseases and injuries in the U.S. regarding years lived with disability (YLDs) and in the top 6 globally. Cervical spine manipulation is one option for treating back and neck pain.

Concerns continue to arise regarding the safety of cervical spine manipulation. Specifically, concerns center on the potential development of serious adverse events such as stroke and cervical artery dissection after spinal manipulation. Since spinal manipulation is an option available to osteopathic physicians to incorporate into the care of their patients, it is important to examine these concerns and develop a position on the issue. This paper will present the evidence behind the benefit of cervical spine manipulation, explore the potential harms and make a recommendation about its use.

Benefit
Spinal manipulation has been reviewed in various systematic reviews and meta-analyses over the past three decades. The majority of the studies conducted on spinal manipulation focus on low back pain for which the evidence has shown spinal manipulation has clear benefits. For neck pain, however, there are fewer studies and the findings vary, but there is some evidence that conclude spinal manipulation benefits patients presenting with neck pain. This evidence indicates that the benefits of spinal manipulation include relief of acute neck pain, and reduction in neck pain as measured by validated instruments in sub-acute and chronic neck pain compared with muscle relaxants or usual medical care. Bronfort et al. specifically concluded that for patients with chronic neck pain, there is moderate evidence that (1) manipulation and mobilization are superior to general practitioner management in the short term, (2) high-technology exercise results in more pain improvement than manipulation in the long term for a mix of patients with acute and chronic pain, and (3) mobilization is superior to physical therapy and general medical care and similar to manipulation in both the short and long term.

Benefits of spinal manipulation for areas beyond the low back and neck include 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.

Harm
Overall
The literature presents varying conclusions on the harms of spinal manipulative treatment (SMT). In a 2017 review of risks associated with spinal manipulation, 46% percent of the studies reviewed found spinal manipulation to be safe, 42% percent were neutral (did not find harm/benefit); and the remaining 12% percent concluded that spinal manipulation was unsafe because of the possibility of serious adverse events. Nevertheless, the existence of any adverse effect should not be trivialized.

Studies have noted that there are two types of adverse effects as a result of SMT. The first type is considered to be mild adverse events that are short-term and non-serious such as dizziness, fatigue, and muscle soreness/discomfort. These side effects occur in 23-83% of patients.
The second type of adverse events is more serious and includes cervical artery dissection, stroke, spinal cord injuries, and other serious conditions outcomes related to vertebrobasilar accidents (VBAs). Currently, much of the literature discusses vertebrobasilar insufficiency or vertebrobasilar ischemia (VBI) which is a type of VBA and is often determined to be the link to the more serious adverse events. Nonetheless, serious adverse events are seen as a rarity, and it is estimated that they occur in the range of every 20,000 to 250,000,000 manipulation performed.7,18-27

Most of the reported cases of adverse outcomes have involved thrust or High Velocity/Low Amplitude (HVLA) types of manipulative treatment.18,25 Unfortunately, many of the reported cases do not distinguish the type of manipulative treatment provided.

VBAs
VBAs account for 1.3 in 1000 cases of stroke, making them a rare event. Approximately 5% of patients with a VBA die as a result, while 75% have a good functional recovery.28 The most common risk factors for VBAs are migraine, hypertension, oral contraceptive use and smoking.29 Elevated homocysteine levels, which have been implicated in cardiovascular disease, may be a risk factor for a VBA.30

The risk of a VBA occurring spontaneously, is nearly twice the risk of a VBA resulting from cervical spine manipulation.14 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.31

A study in 2002 conducted by Haldeman et al., reported that a VBA following cervical spine manipulation was unpredictable.14 The authors, however, concluded that a VBA following cervical spine manipulation was “idiosyncratic and rare”. Further review of the 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.32

Complications from cervical spine manipulation most often occur in patients who have had prior manipulation uneventfully and without obvious risk factors for a VBA.14 “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.”21 In some cases manipulation may not be the primary culprit for causing the dissection, but an aggravating factor or coincidental event.32

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. Fifty-one percent (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.32

Cervical Artery Dissection (CAD)
CAD occurs at a rate of 2.9 per 100,000 individuals every year in the general population, and a large majority (89%) of the individuals diagnosed with CAD have no symptoms or no significant disability that prohibits them from being productive within the following three months of the event.33 Among those with symptoms, headaches and neck pain are the
predominant symptoms for CAD. This creates a dilemma for physicians because cervical spine manipulation is often sought to treat these medical issues. Thus, it is difficult to determine if manipulation causes CAD or if CAD existed at the time of treatment.

Limitations of Studies and Concerns with Pre-manipulation Screening
Due to the design of studies (case reports or retrospective surveys), infrequent reporting of adverse events, and the rare occurrence of many of the more serious complications, it is difficult to determine a causal relationship between SMT and the serious adverse effect. Thus the lingering question of whether or not pre-existing pathologies may have existed prior to the patient receiving SMT remains.18,26,34

In Malone et al., the authors reported that cervical spine manipulation may worsen preexisting cervical disc herniation or even cause cervical disc herniation.26 This report describes complications such as radiculopathy, myelopathy, and vertebral artery compression by a lateral cervical disc herniation. The incidence of these types of complications could be lessened by rigorous adherence to published exclusion criteria for cervical spine manipulation.26,35

Another noteworthy point to highlight is that the 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 serious adverse effects. This information may help to understand the mechanism of injury leading to serious adverse effects, as there are differences in education and practice among the various professions that utilize this type of treatment. It is duly noted that the osteopathic approach strictly limits the “thrust”, which is more commonly referred to as “impulse” in osteopathic practicums, to the physiologic barrier as opposed to the chiropractic approach may extend to the parasympathetic space.

Additionally, pre-manipulation screening tools, that might be used to identify a patient’s risk for VBA and cervical artery dissection have been widely criticized because they have been found to be unreliable and difficult to validate. These studies have examined the DeKleyn’s test and others like it and determined the tests are unreliable for demonstrating reproducibility of ischemia or risk of injuring the vertebral artery. For this reason, researchers and groups such as the Bone and Joint Decade Task Force on Neck Pain and Its Associated Disorders recommend that all health care providers conduct a thorough patient history, physical examination and patient self-assessment to rule out certain pre-existing conditions.13,44

Alternative Treatments
Non-steroidal anti-inflammatory drugs (NSAIDs)
NSAIDs such as ibuprofen and aspirin are the most commonly prescribed medications for neck pain. More than 30 million people worldwide use NSAIDs regularly. In fact, 5% of all medical visit outcomes in the U.S. include a prescription for NSAIDS. NSAIDs offer temporary relief, but long-term use, gender, age, strength of dose as well as consumption of multiple medications simultaneously may be associated with serious risks affecting the gastrointestinal (GI), renal and cardiovascular systems. Eighty-one percent (81%) of GI bleeds related to NSAID use occur without prior symptoms. 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. The annual cost of GI tract complications in the U.S. is estimated at $3.9 billion, with up to 103,000 hospitalizations and at least 16,500 deaths per year therein making GI toxicity from NSAIDs the 15th most common cause of death in the United States.

Epidural steroid injections
Epidural steroid injections (ESIs) are a popular treatment for neck pain.\textsuperscript{50} Complications to ESIs generally occur because of needle placement or drug administration. Common risks associated with needle placement include subdural injection, intrathecal injection and intravascular injection.\textsuperscript{51} Subdural injection occurs in ~ 1\% of procedures, intrathecal injection occurs in ~ 0.6-10.9\% of procedures, and intravascular injection, the most significant risk, occurs in ~ 2\% of procedures.\textsuperscript{51} Other risks include cervical epidural abscess, dural puncture, spinal cord trauma, infection, hemotoma, nerve damage, vascular injury and cerebral vascular or pulmonary embolus.\textsuperscript{52,53} Complications that may arise from drug administration include osteoporosis, Cushing’s syndrome, avascular necrosis of bone, and steroid myopathy. While complications due to needle placement or administration of steroids are rare, they have been reported in the literature.\textsuperscript{52,53}

Conclusion
Osteopathic manipulative treatment of the cervical spine, including but not limited to HVLA treatment, is effective for low back and neck pain and is safe. Because of the rarity of serious adverse events, trainees and practicing physicians should be provided with sufficient information so they are advised of the potential risks and able to communicate the potential risks to their patients. Prior to recommending cervical spine manipulations, physicians should conduct a thorough patient exam and medical history review to try to identify any preexisting conditions that may indicate the patient is at risk for a serious adverse event. Additionally, it is recognized that there is a need for research to distinguish the risk of VBA and CAD associated with manipulation done by specific provider types as well as research to determine the nature of the relationship between the different types of manipulative treatment and VBA and CAD.

It is the position of the American Osteopathic Association that all modalities of osteopathic manipulative treatment of the cervical spine, including HVLA, 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. Physicians should use a combination of medical history reviews and physical exams, diagnostic studies, and best judgment to determine if a patient has any pre-existing conditions that place the patient at risk of suffering a serious adverse event.

Special Acknowledgements
In crafting the updated Position Statement, the Bureau of Osteopathic Clinical Education and Research (BOCER) would like to thank the Osteopathic Manipulation Medicine and Osteopathic Manipulative Treatment (OMM/OMT) Research Task Force for its input, and a special thank you to Hollis King, DO, PhD, who served as an outside contributor.

References


Explanatory Statement:

ACTION TAKEN _________________________

DATE ________________________________
RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H334-A/14 RIGHT TO PRIVately CONTRACT
The American Osteopathic Association supports the fundamental right of physicians to privately contract with patients without penalties and regardless of payor, within the framework of free market principles and seeks changes in statutes and regulations that will allow physicians individually and as defined groups to negotiate fair contracts with private sector and public sector health plans. 2009; reaffirmed 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau of Membership recommend that the following policy be
REAFFIRMED as AMENDED:

H336-A/14 PROMOTING DIVERSITY IN AOA MEMBERSHIP AND
LEADERSHIP

The American Osteopathic Association reaffirms its commitment to promote the advancement
and integration of qualified women and underrepresented minorities (including, but not limited
to Hispanic/Latino Ethnicity, Black/African Americans, Native American/Alaska Natives, and
Hawaiian/Pacific Islanders) into the osteopathic profession; endorses programs to encourage
increased enrollment of these groups at colleges of osteopathic medicine; and will work to
identify and encourage qualified individuals from these groups for participation in those
osteopathic affiliate and national activities which foster leadership opportunities. reaffirmed
reaffirmed as amended 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H337-A/14 ABUSE OF PERFORMANCE ENHANCING SUBSTANCES AND PROCEDURES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

**H337-A/14 ABUSE OF PERFORMANCE ENHANCING SUBSTANCES AND PROCEDURES**

The American Osteopathic Association: (1) supports efforts to eliminate the abuse of performance enhancing substances, known as doping, for the purpose of enhancing athletic performance or physical appearance; (2) supports the efforts of the United States Anti-Doping Agency (USADA) and its program in accordance with the World Anti-Doping (WADA) code and the WADA International Standards (IST) to protect clean athletes and ensure their rights to compete on a fair and level playing field, free from the pressures of performance enhancing drugs; and (3) encourages education of athletes, the public and physicians of the dangers of these substances. 1989, revised 1994, 1999, revised 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau of Membership recommend that the following policy be
REAFFIRMED:

H338-A/14  DIVERSITY IN LEADERSHIP POSITIONS

The American Osteopathic Association (AOA) supports legislative and other efforts to ensure adequate funding of behavioral health services in the state and will support actions, including federal, state or local legislation or regulation, that improve access to and continuity of behavioral health care services in local communities and that maintain stability of established patient-physician relationships. The AOA will request similar support on a national level by way of the Helping Families in Mental Health Crisis Act of 2015 (HR 2646). 2016

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H339-A/14  TOBACCO USE STATUS – REPORTING IN THE MEDICAL RECORD

The American Osteopathic Association supports the Agency for Healthcare Research and Quality’s (AHRQ) U.S. PREVENTIVE SERVICES TASK FORCE (USPSTF) guideline on tobacco use cessation that specifically recommends a method of identifying tobacco use status on each patient visit to increase the likelihood of physician intervention with their patients who use tobacco. 1999; revised 2004; reaffirmed 2009; 2014

Explanatory Statement:
The policy is consistent with current USPSTF guidelines.

RESOLVED, that the Bureau on Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H344-A/14 SURPRISED MEDICAL BILL COSTS INCURRED BY PATIENTS FOR SERVICES NOT COVERED BY THEIR INSURANCE

The American Osteopathic Association (AOA) will advocate for hospitals and other sites of medical services to inform patients in advance of scheduled procedures, who the service providers involved in their care will be and whether or not those providers are covered IN NETWORK AND COVERED by the patients’ insurance. The AOA supports providing patients with an estimate of all the costs of their procedure as well as the identity of all ancillary providers that will be participating in their care in advance of the procedure if they are personally responsible for assuring payment for these services. The AOA strongly supports giving patients the opportunity to select ancillary providers who are covered IN NETWORK AND COVERED by their insurance so that they are not exposed UNKNOWINGLY RESPONSIBLE FOR MEDICAL EXPENSES AND to medical BILLS for which they are not prepared. 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy be REAFFIRMED:

H345-A/14 ELECTRONIC MEDICAL RECORD (EMR) – STUDENT ACCESS AND USE

The American Osteopathic Association will work with the American Association of Colleges of Osteopathic Medicine and the American Osteopathic Association of Medical Informatics to promote the opportunity for medical students to document and practice order entry in EMRs at facilities where osteopathic medical students are trained. 2014

Explanatory Statement:
SUBJECT: H346-A/14 TESTOSTERONE THERAPY: LONG TERM EFFECT ON HEALTH

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
the following policy be REAFFIRMED:

H346-A/14 TESTOSTERONE THERAPY: LONG TERM EFFECT ON HEALTH

The American Osteopathic Association requests that the National Institutes of Health fund
independent research of the long term risk/benefits of testosterone therapy, 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau on Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H348-A/14 COMPENSATION TIED TO PATIENT SATISFACTION SURVEYS – OSTEOPATHIC PHYSICIAN

The American Osteopathic Association opposes the principle that any participation in patient satisfaction surveys with have a significant minimal impact on osteopathic physician's compensation payment. 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
WHEREAS, the costs of biologics are a significant factor in rising drug prices, accounting for
38 percent of U.S. prescription drug spending, and 70 percent of drug spending growth
between 2010 and 2015; and

WHEREAS, entrance of biosimilars onto drug markets have significant potential to reduce
drug prices and help contain spending growth, yet only 12 biosimilars have been FDA
approved; and

WHEREAS, the development and marketing of biosimilars should be encouraged, but
additional consideration should be given to protecting patient; because biosimilars are
developed with living organisms, they vary more significantly from their reference
product than a chemical-based generic drug would; and

WHEREAS, physicians should maintain discretion over patient treatment plans and when
therapies may be substituted in consideration of a patient’s condition and circumstance; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports policies that
strengthen the biosimilar market while preserving physician authority over patient care
and protecting patient safety, be it further

RESOLVED, that the AOA will advocate for policies relating to the granting of
“interchangeable” status to drugs that (1) requires manufacturers to study and
demonstrate to the FDA that alternating between a reference product and proposed
interchangeable biosimilar has no meaningful impact on patient safety or drug efficacy;
(2) that physicians maintain autonomy to designate which biologic or biosimilar product
is dispensed to patients; and (3) only permit drug substitutions upon approval of the
physician ordering the drug.

References
Drugs” December 26, 2018.

Explanatory Statement.

ACTION TAKEN _____________________

DATE _____________________________
WHEREAS, the United States is the only industrialized nation with a rising maternal mortality rate; and

WHEREAS, it is estimated that over 60% of the pregnancy related deaths are preventable; and

WHEREAS, findings from state maternal mortality review committees reveal a growing number of maternal deaths linked to cardiovascular disease, cardiomyopathy, and overdose and suicide, with many of these deaths occurring during the postpartum period.

WHEREAS, African American Women are 3-4 more times likely to die of pregnancy related complication; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports (1) the important work of maternal mortality review committees; (2) work with state and specialty medical societies to advocate for state and federal legislation establishing Maternal Mortality Review Committees; and (3) work with state and specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees.

References

Explanatory Statement
Our nation has a rising maternal mortality rate. Mental health conditions, including suicide and overdose, are the leading cause of maternal mortality in a growing number of states. Other causes include pre-eclampsia, obstetrical hemorrhage, cardiovascular disease and cardiomyopathy. Not all states or the federal government collect data on maternal mortality. In some of states, where data is being collected and implementing best practices, they are showing a decrease in the maternal mortality rate. Maternal mortality review committees work to reduce preventable maternal deaths. Our nation has a rising maternal mortality rate. Mental health conditions, including suicide and overdose, are the leading cause of maternal mortality in a growing number of states. Other causes include pre-eclampsia, obstetrical hemorrhage, cardiovascular disease and cardiomyopathy. Not all states or the federal government collect data on maternal mortality. In some of states, where data is being collected and
implementing best practices, they are showing a decrease in the maternal mortality rate. Maternal mortality review committees work to reduce preventable maternal deaths.

ACTION TAKEN _____________________

DATE _____________________________
WHEREAS, Medicaid is the largest single payer of maternity care in the United States, covering 42.6 percent of births and playing a critical role in ensuring healthy moms and babies; and

WHEREAS, Medicaid is a women’s health success story and is the pathway to jobs and financial stability for women and girls. Girls enrolled in Medicaid as children are more likely to attend college, and Medicaid coverage during pregnancy and a newborn’s first year of life increases the likelihood that the child will experience upward mobility; and

WHEREAS, Medicaid pregnancy coverage lapses at the end of the month after 60-days postpartum; and

WHEREAS, the postpartum period is simultaneously a time of vulnerability and maternal health risk, and a transition period with often unmet maternal health needs; and

WHEREAS, findings from state maternal mortality review committees reveal a growing number of maternal deaths linked to cardiovascular disease, cardiomyopathy, and overdose and suicide, with many of these deaths occurring during the postpartum period; and

WHEREAS, federal legislation has been introduced in 2019 to extend Medicaid coverage to 12 months postpartum; now, therefore be it

RESOLVED, that the American Osteopathic Association support and actively work toward enactment of state legislation, Section 1115 waiver applications, and federal legislation to extend Medicaid coverage to 12-months postpartum.

References


Explanatory Statement

ACTION TAKEN ________________________

DATE ______________________________
WHEREAS, a “new physician in practice” is not defined in the American Osteopathic Association’s (AOA) Constitution and Bylaws; and

WHEREAS, there are conflicting descriptions of a “new physician in practice” referenced in the AOA Constitution, Article VIII, Section C.; and

WHEREAS, the need for osteopathic leadership among new physicians in practice is reflected by the growth of the profession and the increasing numbers of new physicians in practice, while also investing in leadership development for DOs who will one day lead the osteopathic medical profession; now, therefore be it

RESOLVED, that the American Osteopathic Association define a new physician in practice as a “physician is no more than 5 years past the completion of postdoctoral training with no more than 2 years gap in enrollment in an ACGME-approved postdoctoral training program.”

Explanatory Statement
There is no absolute definition of a New Physician in Practice; however, there are two references to New Physician in Practice contained in the AOA Constitution. Article VIII, Section C. states, “…an osteopathic physician who has completed his/her postdoctoral training within the last five years or graduated from a college of osteopathic medicine approved by the Commission on Osteopathic College Accreditation within the last 10 years…”

It should be noted that the resolution definition is intended to be inclusive of post graduate osteopathic physicians in fellowships.

ACTION TAKEN _____________________

DATE _____________________________
WHEREAS, 87 rural hospitals closed from January 2010 through August 2018; and

WHEREAS, on average 30 U.S. hospitals shutdown each year, with an increase expected this year; and

WHEREAS, a larger share of the consumer health market gives merged providers more pricing power; and

WHEREAS, increases in hospital market consolidation have been demonstrated as leading to an increase in the price for hospital care; and

WHEREAS, providers that merged in concentrated markets experienced price increases of 20 percent or more since 2006; and

WHEREAS, an analysis of 2005-2012 Medicare fee-for-service claims and enrollment data for the effect of cardiology market structure on utilization and health outcomes showed that an increase in consolidation leads to statistically and economically significant increases in negative health outcomes for patients; and,

WHEREAS, that the American Osteopathic Association is concerned about the impact of hospital mergers and the consolidation of health systems on patients’ access to quality and affordable care in rural and urban communities; now, therefore be it

RESOLVED, that the American Osteopathic Association opposes further consolidations of hospitals and health systems that are absent of sufficient legal safeguards in place to protect patients’ access to quality and affordable care and physicians’ ability to negotiate equitable relationships with hospitals and payors.

References
1. 82 Rural Hospital Closures: January 2010 – Present,” UNC, Cecil G. Sheps Center for Health Services Research; National Rural Health Association.


Explanatory Statement

ACTION TAKEN _______________________

DATE _____________________________
WHEREAS, multiple factors contribute to the rising cost of drugs in the United States; and

WHEREAS, consolidation in the pharmacy benefit manager (PBM) market has led to a power imbalance that favors PBMs and other corporate members in the drug supply chain, at the expense of individual consumers; and

WHEREAS, regulatory oversight of PBMs is currently limited at the federal level and in a majority of states;

WHEREAS, a lack of transparency and misaligned incentives have resulted in increased drug prices for consumers and large profits for PBMs; now, therefore be it

RESOLVED, that the resolution and following white paper be adopted as the policy of the American Osteopathic Association with respect to increased governmental regulation of pharmacy benefit managers.

PHARMACY BENEFIT MANAGERS – INCREASED REGULATION OF

BACKGROUND
The rising cost of drugs is a major concern in the U.S., where consumers pay two to six times more for prescription drugs than the rest of the world\(^1\). Between 2007 and 2017, drug spending in the U.S. increased by 40%, an increase largely attributable to existing drugs rather than new drugs entering the market\(^2\). Increased drug prices have resulted in patient noncompliance, with sometimes fatal consequences, as patients are either unable to afford their prescription medications or are forced to choose between buying them or other necessities like food and shelter.

There are a number of factors that distinguish the U.S. health care system and drug spending from other industrialized nations; for one, almost all countries except the U.S. have policies in place to lower drug prices, including price controls and cost-effectiveness thresholds\(^3\). By contrast, the U.S. government does not directly regulate drug prices, instead leaving it up to individual insurers to negotiate prices with drug makers. This fragmented and opaque system often results in different prices for different buyers, a power imbalance that favors corporate entities at the expense of consumers.

While numerous factors contribute to prescription drug pricing and affordability in the U.S., for purposes of this policy paper we will focus on the role of pharmacy benefit managers (PBMs)\(^4\).
PBMs are companies hired by insurers, employers, and government entities to manage prescription drug programs on behalf of health plan beneficiaries. Originating several decades ago as processors of prescription drug claims for insurers, for which they earned a flat fee, PBMs initially lowered drug prices by forming large networks of health plan customers which enabled them to negotiate discounts with drug makers. Since then, consolidation among PBMs has concentrated an 85% market share in the hands of three major players (CVS Caremark, Express Scripts and OptumRX), and drug prices have risen as a result.

PBMs affect numerous aspects of the drug supply chain, and they are adept at leveraging their power with drug makers, employers and pharmacies to extract profits that they keep for themselves rather than passing them on to patients. As a result, patients pay cost shares that do not reflect the actual lower cost of the drug, which increases out-of-pocket costs and co-pays.

The following represents a summary of PBM revenue sources:

Rebates. PBMs decide which drugs will be covered on a prescription drug plan or plan formulary, and drug makers often pay “rebates” or other fees to PBMs to have their drugs included. Drug makers then pass these costs on to consumers in the form of higher drug prices.

PBMs also determine which pharmacies will be included in a prescription drug plan's network and how much they will be paid. Sometimes, PBMs entice plan sponsors to require beneficiaries to use a mail order pharmacy – usually one with financial ties to the PBM – for certain medications.

Prior Authorization. PBMs use prior-authorization requirements to steer patients to formulary drugs regardless of their efficacy, by requiring them to obtain prior authorization if they or their providers prefer to continue the original (non-formulary) drug. This can result in harm to patients who may miss doses or experience other negative effects from adjusting to a new drug, which may not be as effective as the one they were previously stable on.

Spread pricing. “Spread pricing” refers to the difference between what a PBM charges an insurer for a drug and what it reimburses the pharmacy for it. Neither the insurer nor the pharmacy knows what the PBM charges or reimburses the other for a particular drug, and PBMs take advantage of this lack of transparency to pocket the spread.

Gag clauses (partially mooted by the federal Patient Right to Know Drug Prices and the Know the Lowest Price Acts of 2018). Prior to the passage of the aforementioned Acts in October 2018, PBMs in most states could utilize “gag clauses” to prevent pharmacists from telling customers when their copayment amount would exceed the out-of-pocket cost of a drug. PBMs then kept the customer’s overpayment, known as a “clawback,” as profit. The Acts banned gag clauses, giving pharmacists the option – but not requiring them – to tell patients when a drug would cost less out-of-pocket.

Direct and Indirect Remuneration (DIR) Fees. DIR refers to the monies that a PBM may collect from a dispensing pharmacy to offset member costs. The Centers for Medicare and Medicaid Services (CMS) originally created DIR as a way to track rebates and other price adjustments applied to Medicare Part D prescription drug plans that were not captured at the point of sale and that resulted in savings to a PBM, and ultimately to CMS (in theory).

Since its inception, DIR has transformed into a catchall term for any fees a pharmacy pays to a PBM, including fees to participate in the PBM’s network or fees paid for failing to meet certain quality measures. PBMs have also begun expanding the use of DIR from just Medicare Part D plans to commercial plans, and pocketing the savings. While some DIR fees are legitimate, many are assessed in an arbitrary and opaque manner that prevents pharmacies from fully understanding how much they will
be reimbursed for a prescription when entering into a PBM contract. In addition, many of the fees are charged retroactively which impacts the ability of independent pharmacies in particular to budget for, and ultimately implement, new patient services.

**STATE ACTION**

There is a growing desire among states to regulate PBMs, but approaches vary from state to state. Besides the gag clause ban, which Congress enacted nationally in 2018, state legislative proposals typically include one or more of the following elements: requirements that PBMs register with the state, requirements for certain mandatory disclosures by PBMs, and prohibitions on PBMs incentivizing the use of mail-order pharmacies.

As of December 2018, 23 states require PBMs to be licensed by a state agency. The agency promulgates rules for licensure, which may include state approval of compensation arrangements between PBMs and pharmacies to ensure that reimbursement rates are fair and reasonable, or requirements that PBMs disclose aggregate rebates to purchasers.

Thirteen states require substantial disclosures by PBMs, and sometimes by insurers as well, to promote transparency regarding rebates and the extent to which PBMs pass them on to insurers, and ultimately to patients, in the form of premium reductions or decreased cost-sharing requirements.

Three states currently have laws preventing PBMs from requiring or incentivizing patients to use mail-order pharmacies, which could drive some independent pharmacies out of business, thereby costing patients access to other services that their local pharmacies may provide. All major PBMs have their own mail-order pharmacies, which allow them to tightly control formularies and steer patients towards drugs for which they receive financial benefits, as well as to reap rewards from spread pricing. Large PBMs can also exclude other independent mail-order pharmacies from their networks and negotiate prices that allow them to undercut competitors, which raises antitrust questions.

PBMs were originally created to save consumers money, and increased regulation by states could theoretically drive up operating costs and reduce savings for consumers; however, extensive consolidation among PBMs has since tilted the balance of power away from consumers and obscured prices as well as the ability of outsiders to determine PBMs’ real effect on the costs of the drug supply chain. States have little power to prevent future PBM mergers, thus increased regulation and transparency requirements may be their only effective tools.

**RECOMMENDATIONS**

The AOA adopts the following statements as its official position on PBMs:

State and federal governments should work to ensure that PBMs function as originally intended; that is, to save patients money. In order to accomplish this goal, a multi-pronged approach that incorporates various elements below in order to target PBMs’ various revenue sources and address misaligned incentives should be considered.

PBMs should be required to publicly disclose any rebates or other “financial benefits” that they receive from other members of the drug supply chain and pass through a certain percentage to the plan sponsor. They should also be prevented from utilizing prior authorization requirements to steer patients to formulary drugs or mail-order pharmacies to which they have financial ties.

In order to improve the viability of independent pharmacies and preserve competition, PBMs should be prohibited from charging pharmacies retroactive DIR fees.

Capping patient copayments at the pharmacy reimbursement rate or the cost without insurance would help address PBM clawbacks.
The U.S. Department of Justice should enforce antitrust protections to prevent additional PBM market consolidation, which is likely to lead to further drug formulary restrictions and reductions in the number of – and PBM reimbursement for – independent pharmacies.

Lastly, governmental action to improve PBM transparency is key. The Federal Trade Commission (FTC) has the unique power to shed light on the effect of PBMs on the drug supply chain through its Section 6(b) authority and accompanying subpoena power. Section 6(b) allows the FTC to “conduct wide-ranging economic studies that do not have a specific law enforcement purpose,” and it could exercise this authority to obtain PBM rebate and fee information and to analyze PBMs’ effects on drug pricing.10

References
4. https://www.nap.edu/read/24946/chapter/5
5. https://www.ncpanet.org/advocacy/the-tools/pbm-resources

Explanatory Statement

ACTION TAKEN ____________________

DATE ____________________________
RES. NO. H-340 - A/2019 – Page 1

SUBJECT: BACKGROUND CHECKS AND FIREARMS SAFETY TRAINING AS A CONDITION OF FIREARMS PURCHASE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, firearm-related deaths in the United States have increased to a twenty year high1; and

2 WHEREAS, nearly 40,000 people died in 2017 as a result of firearm-related violence, suicides, and accidents in the United States, the highest rate among industrialized countries2,3; and

3 WHEREAS, firearms are the third-leading cause of death due to injury after poisoning and motor vehicle accidents4,5; and

4 WHEREAS, 109 firearm deaths occur each day due to firearm-related homicides, suicides, and unintentional deaths6; and

5 WHEREAS, gun violence in the United States had a total societal cost of $229 billion in 20157; and

6 Whereas, in 2017, of the 25 million individuals who submitted to a background check to purchase or transfer possession of a firearm, 103,985 were by prohibited purchasers and were blocked from making a purchase8; an estimated 6.6 million firearms are sold annually with no background checks9; now, therefore be it

15 RESOLVED, that the American Osteopathic Association (AOA) will support federal legislation requiring comprehensive criminal background checks for all firearm purchases, including sales by gun dealers, sales at gun shows, and online sales for purchase; and, be it further

19 RESOLVED, that the American Osteopathic Association (AOA) will support efforts to require firearms safety training as a condition to purchase any class of firearms in any venue; and, be it further

22 RESOLVED, that H421-A/15 is superseded by this resolution.

References
2. Id.


Explanatory Statement
The intent of this policy is to supplement the following existing policies:
H630-A/18 Comprehensive Gun Violence Reform
H318-A/16 Firearms--Commission of a Crime While Using a Firearm
H340-A/16 Physician Gag Rules--Opposition To
H450-A/15 Firearm Violence
H406-A/14 Firearm Safety

ACTION TAKEN _______________________

DATE ________________________________

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

WHEREAS, sunset resolution H-315 - A/2018, titled “HUMAN CLONING”, was referred to the Bureau on Scientific Affairs and Public Health for updated information; now, therefore be it

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends H-316 - A/2013 be SUNSET and the following white paper be adopted:

HUMAN CLONING

BACKGROUND
Somatic cell nuclear transfer (SCNT) or, to use the more common vernacular, cloning is the process of creating genetic duplication of a cell or an organism naturally or artificially. The National Institute of Health (NIH) describes “cloning” as a process “that can be used to produce genetically identical copies of a biological entity”. More specifically, the National Human Genome Research Institute (NHGRI) of NIH, identifies three categories of artificial cloning: gene, reproductive and therapeutic. The latter two types of cloning are often lumped together as “human cloning,” which is controversial and the focus of much debate.

TYPES OF CLONING
Gene Cloning
Gene cloning (also known as DNA cloning or molecular cloning) is the process wherein genes or segments of DNA are copied. DNA cloning is beneficial to medicine because the technology allows doctors to treat patients by replacing flawed genes associated with inherited diseases with healthy ones. Gene cloning is primarily seen in genetically engineered food and in animals to help them grow stronger. This type of cloning does not have the possibility of creating an adult living creature.

Reproductive Cloning
Reproductive cloning is the process of using SCNT to obtain eggs that could develop into an adult living creature. The mature somatic cell is transferred into another egg cell and allowed to develop into an embryo in a test-tube and then implanted into the womb of a living creature. The hope is that the outcome will be a birth with the same genetic makeup as the living creature from which the mature somatic cell was taken.

Reproductive cloning experimentation has been occurring for many decades but has primarily focused on animals as opposed to human beings. In 1979, mice were cloned by splitting mouse embryos. In 1996, the lamb, Dolly was successfully cloned. In 1998, several calves were cloned. Another notable cloning of a mammal was in 2003, when an endangered ox, Banteg, was cloned. While there have been a few successfully cloned mammals, there have been no verified successful attempts to clone a human embryo/being.
Therapeutic (Research) Cloning

Therapeutic cloning is the process of creating a cloned embryo in an effort to produce embryonic stem cells to help understand the epidemiology of diseases and to develop new treatments. Therapeutic cloning involves some of the same techniques used in reproductive cloning. However, the stem cells are harvested from the embryo during the test tube phase, therein destroying the embryo.

ARGUMENTS FOR OR AGAINST CLONING

In the United States and worldwide, cloning remains a moral and ethical point of consternation. There are arguments both for and against the use of cloning, but there appears to be a consensus amongst many that cloning an actual human being is not acceptable. Therapeutic cloning is often the center of most debates for many regarding balancing patient care, morals and ethics.

Arguments against therapeutic and reproductive cloning:

- Reproductive and therapeutic cloning leads to the destruction of human embryos which many see as viable human life.
- Reproductive cloning usurps the divine plan or interferes with the natural order.
- Cloning violates human dignity and treats human beings as commodities or items to be manufactured.
- Cloning causes risks to human health; the majority of implanted embryos die in gestation or result in births with significant abnormalities. In addition, the need for human embryos may cause women in poverty to compromise health due to incentives to sell embryos.

Arguments for therapeutic and reproductive cloning:

- Reproductive and therapeutic cloning presents a unique ability to research and identify treatments to address human diseases by providing insight to researchers on developmental and pathogenic events not discoverable otherwise.
- Cloning may lead to alleviation of human suffering and cures for costly and debilitating diseases by providing genetically matched tissue for transplantation.
- Cloning promotes scientific inquiry.

LEGISLATION IN THE U.S. ON CLONING

Currently, the federal government does not explicitly prohibit cloning. However, the government does prohibit the use of federal funds for cloning, regardless of the purpose (therapeutic or reproductive cloning). The NIH primarily conducts gene cloning. NIH relies on federal funding which is prohibited from being used in therapeutic or reproductive cloning activities, and accordingly, NIH researchers have not cloned any mammals nor have any of the institutions or centers supported human cloning activities.

The Food and Drug Administration (FDA) has weighed in on human reproductive cloning. In a 1998 letter about human cloning, the FDA claimed jurisdiction over clinical research using cloning technology for reproductive purposes. The FDA equated using cloning technology to the same process as developing new drugs. In a second letter dated March 28, 2001, regarding Cloning Technology, the agency reiterated its jurisdiction over clinical research using such technology. The FDA explicitly stated that the process is subject to the Health Service Act and the Federal Food, Drug and Cosmetic Act, also indicated that all approval responsibilities for any human clinical use of any therapies derived from cloning research fell within its purview.

In an effort to address the void left by the federal government, several state legislatures have provided guidance on human cloning.
• **Eight (8) states** prohibit human cloning for any purpose – no reproductive or therapeutic cloning (cloned human embryos for embryonic stem cell research as well as to implant in a uterus for childbirth) – Arizona, Arkansas, Indiana, North Dakota, Oklahoma, South Dakota and Virginia

• **Six (6) states** prohibit state funding of human cloning for any purpose – Arizona, Arkansas, Indiana, Louisiana, Maine and Nebraska

• **Ten (10) states** have “clone and kill” laws which allow therapeutic cloning research, but prohibit cloning of embryos to be implanted for childbirth (reproductive cloning) – California, Connecticut, Illinois, Iowa, Maryland, Massachusetts, Missouri, Montana, New Jersey and Rhode Island

• **Five (5) states** allow state funding for embryonic stem cell research (therapeutic cloning or in vitro fertilization) – California, Illinois, Missouri, Maryland and New York

• **Two (2) states** have legislation that precludes health professionals from being compelled to participate in human cloning (healthcare rights of conscience laws) – Idaho and Louisiana

26 states and the District of Columbia do not have any legislation addressing therapeutic (biomedical research) and/or reproductive (to produce children) cloning.

These data were pulled from sources dated between 2015 through 2019. To the best of BSAPH’s knowledge, these policies remain in effect as of May 1, 2019.

**KEY ORGANIZATIONS SUPPORTING THERAPEUTIC/RESEARCH CLONING**

Many key organizations have made position statements regarding the benefits it views in therapeutic cloning and accordingly expressed their support. In addition, these organizations have declined to support cloning for reproductive purposes. These organizations include:

**American Association for the Advancement of Science (AAAS)** – The AAAS has a statement on Human Cloning that states it endorses a legally enforceable ban on efforts to implant a human cloned embryo for the purpose of reproduction.\(^\text{11}\) AAAS recognizes that the health risks associated with reproductive cloning make such cloning unconscionable. The AAAS, however, does encourage continued dialogue as new technology advances emerge.

Also, AAAS supports stem cell research (genetic and therapeutic cloning) which has potential health benefits. The AAAS calls for strict monitoring of the process and developments and appropriate oversight through regulation.\(^\text{11}\)

**American Association of Medical Colleges (AAMC)** – On its website under the Advocacy section, the AAMC expressly supports ongoing research into SCNT and endorses legislation that would allow therapeutic/research cloning.\(^\text{12}\) Additionally, the AAMC recommends a ban on all forms of reproductive cloning.

**American Bar Association (ABA)** - The ABA addressed this issue in 2002 and 2004. ABA supports law and policy prohibiting reproductive cloning.\(^\text{13,14}\)

**American Medical Association (AMA)** - The AMA does not endorse reproductive cloning. However, if in the future reproductive cloning is permitted, the AMA acknowledges that physicians must be educated and understand somatic cell donors must provide informed consent. Additionally, any child produced through reproductive cloning is recognized as a human-being. Code of Medical Ethics Opinion 4.2.6.\(^\text{15}\)

The AMA says physicians can determine whether they will participate in stem cell research or use its products. The AMA implores clinician researchers to be able to articulate the risks and benefits of embryonic stem cell use for research purposes. In addition, AMA encourages physicians to allow their
commitment to the welfare of patients to guide them in their professional standards. Code of Medical Ethics Opinion 7.3.\(^1\)

National Academies of Medicine, Sciences and Engineering (National Academies) - The National Academies, based on recommendations generated by 2002 joint panel, recommends a legally enforceable ban on the practice of human reproductive cloning, but does support using SCNT to produce stem cells for developing new medical therapies for life-threatening diseases and advancing knowledge.\(^2\)

AOA AND HUMAN CLONING

The osteopathic community and the AOA have discussed this issue at length since 1998. Recognizing the moral and ethical dilemmas of human cloning, AOA has continued to monitor the issue and provide updates to its constituents in order to facilitate a discussion.

After reviewing the existing literature on cloning, the American Osteopathic Association (AOA) adopts the following policies:

1. The AOA does not endorse the practice of human cloning for purposes of reproduction (efforts to implant a human cloned embryo for the purpose of reproduction).
2. The AOA recognizes the benefits and harms of human cloning for therapeutic (research) purposes with respect to embryos, donors and patients suffering from debilitating and life-threatening diseases and conditions. Physicians shall have the autonomy to determine whether or not they will participate in therapeutic cloning. They should carefully weigh all ethical and moral aspects of the process and determine what is best for the well-being of patients, society as a whole, and the advancement of medical knowledge and practice.
3. The AOA shall review its policy in light of any new evidence that will be generated by research entities as well as monitor state and federal legislation in the field and update the policy as necessary.

REFERENCES

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Explanatory Statement

ACTION TAKEN _____________________

DATE _____________________________
WHEREAS, third party payers and Pharmacy Benefit Managers (PBMs) incentivize patients to be cost conscious by encouraging the use of lower cost medications and services through deductibles, copayments, and the “donut hole”; and

WHEREAS, third party payers and PBMs incentivize physicians through the use of claims analysis, such as HEDIS measures; and

WHEREAS, HEDIS measures require claims to be made through the payer or PBM directly from the pharmacy; and

WHEREAS, purchasing medications for a “cash price” may be less expensive, but will not result in the collection of claims data impacting physician quality measures; and

WHEREAS, these incentives create conflicting priorities, and subsequently potential ethical pitfalls, for a patient to obtain medications outside of the PBM, and for the physician to be penalized for this; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) is opposed to incentives that do not align patient’s behaviors with cost-effective, reportable high quality care; and, be it further

RESOLVED, that the AOA will work to identify these misaligned incentives; and, be it further

RESOLVED, that the AOA will seek to influence third party payers and Pharmacy Benefit Managers to align patient and physician incentives, and, be it further

RESOLVED, that the AOA will advocate for the prohibition of misaligned incentives in Federal Healthcare programs through legislation and other regulations designed to prevent competing incentives.

Explanatory Statement
WHEREAS, the American Osteopathic Association (AOA) has developed many detailed, in-depth policy statements also known as "white papers"; and

WHEREAS, these “white papers” often contain citations of relevant statistics, studies, and other data; and

WHEREAS, the AOA attempts to use the most current data to compile these “white papers”; and

WHEREAS, the AOA reviews all of its policies on a rolling five year basis; and

WHEREAS, the AOA desires to have policy statements which are up-to-date and relevant to the current environment; now, therefore be it

RESOLVED, that when policies which are or include a “white paper” as a part of the policy are reviewed as part of the regular policy review process, the reviewing entity shall review and update all statistics, studies, and other data to ensure that these references are the most up-to-date statistics, studies, and data that are available; and, be it further

RESOLVED, that the reviewing entity shall affirm in an explanatory statement that all statistics, studies, and other data have been reviewed and are the most current available.

Explanatory Statement
WHEREAS, immunizations currently prevent 2-3 million deaths each year worldwide; and

WHEREAS, an additional 1.5 million deaths could be avoided with improved vaccination rates worldwide; and

WHEREAS, vaccines not only provide individual protection for those persons who are vaccinated, they can also provide community protection by reducing the spread of disease within a population; and

WHEREAS, physicians, patient care providers, and pharmacists have a responsibility/duty to promote immunizations to all eligible people for vaccines; and

WHEREAS, vaccinations can be administered in many settings including physician offices, community health fairs and local pharmacies providing more convenient and accessible option for people to receive needed immunizations; and

WHEREAS, patients often change vaccination providers during the course of an individual’s vaccination series; and

WHEREAS, patient’s do not always communicate receipt of vaccines to their healthcare providers; and

WHEREAS, it is often necessary for providers to be able to access immunization records in emergency situations; now, therefore be it

RESOLVED, that any healthcare provider delivering vaccination services must document administration of all immunizations in a national immunization information registry; and, be it further

RESOLVED, that the American Osteopathic Association (AOA) advocate for development of a national immunization information registry.

Explanatory Statement

Requiring documentation of all vaccinations administered by any healthcare provider in a mandatory National Immunization Information Registry would provide healthcare providers with vital information about their patient’s vaccination status, allowing for improved vaccination rates and appropriate vaccine completion, thereby reducing the number of deaths and other complications from vaccine preventable diseases, and reduction in the number of duplicate vaccinations received by patients.
References

ACTION TAKEN _____________________

DATE _____________________________
RESOLVED, that in order for the members of the American Osteopathic Association (AOA) House of Delegates to perform their duties as mandated in the Association Bylaws, all AOA consultant reports shall be made available in their entirety, without alterations, deletions, or redactions, to any AOA member, Divisional Society Executive Director, and/or Health Policy Fellow.

References
1. https://osteopathic.org/about/leadership/aoa-governance-documents/
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Explanatory Statement

ACTION TAKEN ____________________

DATE ___________________________
SUBJECT: WHISTLEBLOWER POLICY – AMERICAN OSTEOPATHIC ASSOCIATION

SUBMITTED BY: Kentucky Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, the Sarbanes-Oxley Act of 2002, which applies to publicly-traded companies and requires them to adhere to standards in governance that increase the role board member play in overseeing financial transactions and auditing procedures; and

WHEREAS, responsible nonprofits have been using the Sarbanes-Oxley as a standard for their own financial practices, as these practices can only improve a nonprofit's internal controls and provide needed transparency; and

WHEREAS, other provisions of Sarbanes-Oxley and the IRS 990 Form regulate, insider transactions and conflicts of interest, disclosure or transparency to the public, whistleblower protection and document destruction; and

WHEREAS, in an era of greater scrutiny of nonprofit organizations, Sarbanes-Oxley provides an excellent blueprint for nonprofits to reach a level of governance that can only help their reputations and ensure the trust of their members, donors and supporters; and

WHEREAS, the AOA has many members and friends of the profession e.g. state & specialty executive directors, PhD faculty at osteopathic institutions, etc., and many of those are called on to voluntarily serve on bureaus, councils and committees or intermittently advise the organization on relevant subject matter, without whose work the AOA would not be able to fulfill its mission to advance the practice of osteopathic medicine; and

WHEREAS, the current AOA Whistleblower Policy does not clearly include these members and/or volunteers as it is currently outlined, and it is prudent to have one organizational policy; and

WHEREAS, those members and/or volunteers may be reluctant to report any concerns that arise regarding the governance of the organization secondary to potential retaliatory measures by the organization, leadership or staff; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) adopts the following policy:

**Whistleblower Policy**

The AOA encourages its employees and members and/or volunteers to disclose and report concerns regarding perceived violations of federal and state laws and regulations and perceived financial irregularities.

Such reports may be made by any employee or member and/or volunteer openly, confidentially or anonymously, and they may be made in person, by telephone or in writing, including email.
Employees can report such concerns without fear of reprisal to any of the following individuals:

department directors, the chief operations officer, the associate executive directors, the chief financial
officer, the general counsel, the executive director or the AOA president. Employees can also report
such concerns to the AOA Audit Committee.

Members and/or volunteers may report any concerns, charges or complaints to the AOA Committee
on Ethics, including violations of the AOA Constitution & Bylaws, as per Article VII, Section 1(h).

Employees or members and/or volunteers who prefer to raise their concerns confidentially may do so
by sending the appropriate executive or committee as outlined above a sealed envelope through US
mail or interoffice mail and marking the envelope “Personal & Confidential” or by sending an email
with the words “Personal & Confidential “in the subject line.

AOA employees or members and/or volunteers may also report their concerns about perceived
violations of federal and state laws and regulations and perceived financial irregularities to appropriate
governmental agencies without fear of adverse action.

The AOA complies with all applicable requirements of federal and state statutes and regulations
concerning employee or member and/or volunteer “whistleblower” activity, including, without
limitation, the Illinois Whistleblower Act [740 ILCS174/5, et seq].

Among its provisions, the Illinois Whistleblower Act prohibits an employer from discharging or
otherwise retaliating against an employee for any of the following actions:

- disclosing to a law enforcement agency or other government agency information that the
  employer reasonably believes discloses a violation of any state or federal law, rule or regulation
- refusing to participate in any activity that would result in the violation of any state or federal
  law, rule or regulation.

The Illinois Whistleblower Act also prohibits an employer from making, adopting or enforcing any rule,
regulation or policy that prevents its employees from disclosing information to a government or law
enforcement agency when employees have reasonable cause to believe that the information concerns a
violation of a state or federal law, rule or regulation.

Likewise, the AOA extends these same protections for whistleblowing activity to its members and/ or
volunteers. The AOA prohibits retaliation, or threat of retaliation, by or on behalf of the AOA, against
members and/ or volunteers for making good faith complaints, reports or inquiries under this policy or
for participating in a review or investigation under this policy. This protection extends to those whose
allegations are made in good faith, but prove to be mistaken. The AOA reserves the right to discipline
persons who make bad faith, knowingly false, or vexatious complaints, reports or inquiries.

References


Explanatory Statement

ACTION TAKEN _____________________

DATE _____________________________
WHEREAS, the American Osteopathic Association (AOA) maintains a Healthy and Viable Affiliate Organizations Program to monitor and assess the status of its affiliated organizations; and

WHEREAS, AOA state and specialty affiliates are required to report the number of classes of membership annually, as well as detailed financial statements, tax returns, board contacts, and annual reports; and

WHEREAS, AOA membership numbers cannot be assumed to remain stable given a number of factors including decoupling of AOA board certification and membership, the myriad of professional organizations physicians are required to join, decreased employer reimbursement of professional dues; and

WHEREAS, transparent, healthy, and viable organizations require bidirectional communication and accountability between a parent organization and its affiliates; now, therefore be it

RESOLVED, that the American Osteopathic Association, in order to be transparent and to assure a healthy and viable organization, will annually report to the affiliate organizations the following:

1. The numbers in each Class of Membership
2. Detailed financial statements, including tax returns and audits
3. A complete list of Board of Trustees’ contact information
4. Clear annual reports accounting for how funds were spent and progress made, including a description of how the expenditure directly helped physicians in practice or contributed to the advancement of the profession

Explanatory Statement
WHEREAS, the Patient Protection and Affordable Care Act (PPACA) allows states to expand Medicaid coverage to persons whose income is below 138% of the federal poverty level ($16,753 for an individual or $34,638 for a family of four in 2019), with the federal government paying 93% of the expansion cost for new enrollees in 2019 and 90% in 2020 and beyond; and

WHEREAS, the PPACA has resulted in a reduction in the healthcare uninsured rate in the United States from 16% in 2010 to 8.8% in Q1 2018; and

WHEREAS, states that have enacted Medicaid expansion have experienced a reduction in uninsured patients to 8.7% and states that did not expand Medicaid still have 18.4% uninsured; and

WHEREAS, the Michigan Osteopathic Association supported the Medicaid Expansion with targeted lobbying efforts in the State of Michigan; and

WHEREAS, Michigan’s Medicaid expansion enrollment exceeded 600,000 individuals by March 2015, and serves as an effective model for states that have not as yet enacted Medicaid expansion; and

WHEREAS, as of January 2019, 14 states (Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, Wyoming) have failed to enact legislation to expand Medicaid eligibility; and

WHEREAS, research shows that Medicaid expansion has helped to reduce disparities in coverage by income and age, has had positive economic outcomes in expansion states, and infant mortality rates have declined in Medicaid expansion states and risen in states that have not enacted Medicaid expansion; and

WHEREAS, studies provide evidence that Medicaid expansion reduces mortality from drug overdoses and increases access to treatment; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) incorporate Medicaid expansion as a top priority to improve patient access to care and to improve health outcomes; and

RESOLVED, that the AOA support Medicaid expansion in the 14 states that have not as yet enacted relevant legislation to expand Medicaid eligibility to uninsured individuals who meet the definitions to qualify based on the 138% of federal poverty level as provided in the Patient Protection and Affordable Care Act.
References

Explanatory Statement

ACTION TAKEN _____________________

DATE _____________________________
WHEREAS, the osteopathic profession has undergone unprecedented growth in the last 20 years, with DOs expected to represent 25% of all graduates in 2020; and

WHEREAS, with increased brand awareness of osteopathic medicine the use of osteopathic manipulative treatment (OMT) is expected to increase; and

WHEREAS, the use of OMT has been shown to decrease use of oral pain medication (Prinsen JAOA 2014) including opiates, and thus can play a role in addressing the current opioid crisis; and

WHEREAS, many osteopathic physicians encounter difficulties when trying to obtain privileges for the use of OMT within medical systems and hospitals; and

WHEREAS, the American Osteopathic Association does not have a standardized hospital privileging document for OMT; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) support and advocate for all physicians who desire to practice osteopathic manipulative treatment (OMT) within medical systems and hospitals; and, be it further

RESOLVED, that the AOA create guidelines that can be distributed upon request to hospitals, medical systems, and other interested entities that standardize credentialing and privileging processes, including proctoring and approval of privileges to practice OMT.

Explanatory Statement
Reference:

ACTION TAKEN ________________________
DATE _____________________________
WHEREAS, the rate of suicide among physicians is greater than that of the general population and more than half of surveyed medical students (58%) and residents (50.7%) screen positive for depression; and

WHEREAS, according to a 2015-2016 survey of U.S. residents and fellows, 48% of the respondents indicated they experienced bullying behavior from other healthcare professionals including attending physicians (29%) and nurses (27%) contributing negatively to the training environment and impacting physician wellness; and

WHEREAS, the most common bullying behaviors described in the healthcare setting include belittling, undermining work, work sabotage, unjustified criticism, and excessive monitoring of one’s work, followed by sarcasm, destructive innuendo, critical comparisons among colleagues, and attempts to humiliate; and

WHEREAS, there is an increased awareness of the impact intimidation plays on job satisfaction, toxic/difficult work environment, and the hierarchical culture pervasive in medical education and graduate medical education; now, therefore be it

RESOLVED, that the American Osteopathic Association support the implementation of anti-intimidation standards within healthcare training programs and workplaces.

References
3. Article Source: Bullying in the American Graduate Medical Education System: A National Cross-Sectional Survey

Explanatory Statement
In an effort to improve physician wellness, one actionable item is to create a culture of safety and caring rather than intimidation in the traditional, toxic hierarchical teaching structure within medical education. The goal is to reduce the incidence of depression, substance abuse, and suicide among physicians and physicians in training.
ACTION TAKEN _____________________

DATE ___________________________
WHEREAS, the Supreme Court ruled in favor Jane Roe and the pursuit of safe, legal abortion rights for women in the United States in 1973 in response to the unconstitutionality of states’ imposition of laws and statutes that interfere with an individual’s right to autonomy and privacy regarding the creation of a family; and

WHEREAS, in 1967, 17% of pregnancy-induced maternal demise was due to illegal abortion complications performed without medical personnel and resources; and

WHEREAS, according the CDC Abortion Surveillance Systems, “652,639 legal induced abortions were reported,” which indicate 652,639 women chose abortion as their choice of medical care in 2014, elucidating the enormity of need of such resources and patient autonomy; and

WHEREAS, according the CDC Abortion Surveillance Systems,4 (.0006%) women died in 2013 as a result of complications post legal abortion, further elucidating the benefit of women’s rights to choose as opposed to the aforementioned loss of life while abortion was made illegal nationwide; and

WHEREAS, women of low socioeconomic status and minorities will suffer the brunt of the repercussions of overturning Roe v. Wade due to the loss of funding protections for Title X subsidiaries, like Planned Parenthood, that provide affordable reproductive healthcare that includes annual mammograms, preventative gynecological healthcare and screenings, access to birth control, sexual education, and safe abortion procedures, leading to increased incidences of malignancies, unplanned and unwanted pregnancies, and unsafe abortion practices; and

WHEREAS, “abortion in the United States is an extremely safe procedure. Restrictions imposed in some states are not based on medical evidence and will do nothing to improve women’s health and safety. In fact, these requirements put women at risk by standing in the way of safe reproductive care.”; and

WHEREAS, “research shows that carrying an unwanted pregnancy to term is more dangerous to a woman’s health than abortion.”; and

WHEREAS, “induced abortion is among the safest outpatient procedures performed in the United States.”; and

WHEREAS, “the risk of mortality from childbirth in the United States is estimated to be 14 times higher than the risk from induced abortion, and the risk of all maternal
of personal moral or ethical convictions as long as the legal standard of care is practiced; and

WHEREAS, the decision to safely terminate pregnancy should be solely at the discretion of the patient and their healthcare team; and

WHEREAS, opposition to abortion lies on moral premise, judgement, and conviction and on the idea that states should be held financially and socially accountable for the welfare of women who become unexpectedly pregnant according to ACOG6; now, therefore be it

RESOLVED, that the American Osteopathic Association stand by the American College of Obstetrics and Gynecology in their recommendation of increased provisions for safe and legal abortion and reproductive healthcare resources and opposition of the reversal of Roe v. Wade by drafting an official statement reflecting this position.

References
Explanatory Statement

The reversal of Roe v. Wade will undoubtedly increase the rate of illegal abortions performed in the United States, vastly increasing infertility and mortality risks due to patients’ lack of knowledge on how and when to best perform these procedures via chemical methods. Abortions will occur regardless of its legality. At the forefront of our oath and practice is the patient’s right to safety, autonomy and dignity. Therefore, depriving women of the right to safe, legal access to reproductive health, family planning, and abortion services is not only unconstitutional but directly infringes on their right to autonomy over their bodies and lives.

Moreover, women of low socioeconomic background are at highest risk due to the inevitable reduction of funding allocated to Title X programs liked Planned Parenthood. As a result, we stand in strong opposition to the reversal of Roe v. Wade, the subsequent legal repercussions for female patients who seek autonomy, and the danger to life that is illegal abortion.

ACTION TAKEN _____________________

DATE _____________________________
RES. NO. H-352 - A/2019 – Page 1

SUBJECT: ADVOCATING FOR MORE DO REPRESENTATION WITHIN MEDICAL TV SHOWS AND MOVIES

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, there are currently 114,425 practicing osteopathic physicians (DOs) in the United States and DOs are projected to represent more than 20% of all practicing physicians by 2020¹; and

WHEREAS, 57% of DO physicians work in a primary care specialty and 40% work in specialties such as emergency medicine, OB/GYN, anesthesiology, general surgery, and psychiatry¹; and

WHEREAS, there have been few, if any, DO physicians represented in any of the major medical dramas (e.g., Grey’s Anatomy, Chicago Med, The Good Doctor, ER, etc.) or other forms of entertainment media; and

WHEREAS, public perception of physicians is influenced by how positively or negatively by they are portrayed on television²; and

WHEREAS, viewers of certain medical dramas perceive what they view on TV as credible³ and undoubtedly incorporate their perception into expectations as a patient; and

WHEREAS, it is the goal of the American Osteopathic Association to “advance the distinctive philosophy and practice of osteopathic medicine”⁴; now, therefore be it

RESOLVED, that the American Osteopathic Association supports, advocates, and lobbies for increased representation and accurate portrayal of osteopathic physicians as characters in media, including, but not limited to: television shows and movies.

References
Explanatory Statement
Increasing the number of osteopathic physicians on TV and in movies has the potential to help educate the public about our profession and furthermore demonstrate the unlimited license to practice medicine that DOs hold in all 50 states. Lobbying for this exposure will be an efficient and cost-effective way to promote the DO brand. In addition, research showing that the public view of the profession is influenced by TV medical dramas suggests that viewing osteopathic physicians on television will result in viewers (the public) having an increased level of trust and familiarity with our profession.

ACTION TAKEN _____________________

DATE ______________________________
WHEREAS, self-induced abortion is a deliberate termination of pregnancy performed by the 
woman herself or with the help of non-medical assistance; and

WHEREAS, nearly half of the pregnancies in the United States are unintended; and

WHEREAS, unintended pregnancies in the United States are most common among women 
and girls of low income, especially those who are below the federal poverty level; and

WHEREAS, more than 700,000 Google searches were performed looking into self-induced 
abortions in 2015; and

WHEREAS, unintended pregnancy may be the driving factor behind internet searches related 
to self-induced abortion; and

WHEREAS, a study with 1,235 respondents found that 73% of those individuals searching for 
self-induced abortion indicated that they were pregnant and did not want to be, and 11% of 
those respondents reported that they had ever attempted to self-induce an abortion; and

WHEREAS, a variety of factors may serve as barriers to the utilization of abortion care 
including, but not limited to, financial constraints, state or clinic restrictions, and travel-
related logistical issues; and

WHEREAS, the World Health Organization (WHO) states that “nearly every abortion death 
and disability could be prevented through sexuality education, use of effective 
contraception, provision of safe and legal induced abortion, and timely care for complications”; and

WHEREAS, the American Medical Association (AMA) policy H-5.980 opposes the 
criminalization of self-induced abortion, as does the American College of Obstetricians 
and Gynecologists (ACOG) in the position statement on the matter; and

WHEREAS, the Massachusetts Medical Society states support of advocating against any 
legislative efforts that criminalize self-induced abortion; and

WHEREAS, the WHO defines an “unsafe abortion” as a “procedure for terminating an 
unwanted pregnancy either by persons lacking the necessary skills or in an environment 
lacking the minimal medical standards, or both,” which encompasses self-induced 
abortion; and
WHEREAS, part of the WHO’s reproductive health strategy published in 2004 outlines that most maternal deaths arise from complications during childbirth, the postpartum period, or after unsafe abortions; and

WHEREAS, as a 2014 study estimates that 2% of abortion patients had attempted a self-induced abortion at some point; and

WHEREAS, there are estimates that show in certain states as many as 100,000 women may have attempted to self-induce an abortion; and

WHEREAS, abortions managed by appropriately licensed and skilled practitioners carry risk, like any medical procedure, such as infection hemorrhage, or damage to the uterus and other organs; and

WHEREAS, the criminalization of self-induced abortions may directly impact patient care by leading to increased suspicion of patients presenting to healthcare providers for miscarriages, potentially reducing the likelihood of patients seeking needed treatment; and

WHEREAS, self-induced abortions without appropriate medical supervision would be subject to the same, if not greater, risk; and

WHEREAS, a report from the SIA legal team shows that Arizona, Delaware, Idaho, Nevada, New York, Oklahoma and South Carolina have laws on record with language that directly criminalizes self-induced abortion; and

WHEREAS, prosecutorial overreach may be used to press criminal charges against patients who have participated in self-induced abortion; and

WHEREAS, patients who have attempted to self-induce an abortion may be less prone to access the healthcare system regarding complications due to fear of legal retribution; now, therefore be it

RESOLVED, that the American Osteopathic Association stand in support of the decriminalization of self-induced abortions along with legislative efforts to support that goal, and oppose legislation that criminalizes self-induced abortion on the basis that these criminalization efforts may increase our patient’s medical risk and threaten their well-being.

References


Explanatory Statement

ACTION TAKEN _____________________

DATE _____________________________
WHEREAS, a 2013 study published in General Hospital Psychiatry found that of about 203 physicians that succeeded in committing suicide, toxicity results showed a low rate of pharmaceutical treatment and analysis of victim cases showed that many were mentally ill or experienced problems related to job stress; and

WHEREAS, a 2016 survey of 2106 female physicians found that nearly 50% felt that they met criteria for a mental illness but refused treatment; and

WHEREAS, “fear of reporting the diagnosis to a medical licensing board” and “belief that a diagnosis was embarrassing or shameful” are two reasons that were given by surveyed female physicians behind not receiving treatment for their mental illness; and

WHEREAS, for female physicians with a formal diagnosis in this survey, only 6% disclosed their diagnosis on medical licensing applications; and

WHEREAS, a 2017 study evaluated how many states have initial and renewal licensure applications are considered “consistent” (the application did not have any questions about mental health conditions or only asked about current impairment from a mental health condition) and found that from 51 applications (the 50 states plus the district of Columbia), only one-third of states have applications that are considered to be “consistent”; and

WHEREAS, 2,325 of 5,829 physicians surveyed (40%) in a 2016 study, cited “concerns about repercussions to their medical licensure” as their reason for being reluctant to be formally treated for a mental health condition; and

WHEREAS, the above study found that physicians were more likely to be reluctant to seek care for a mental health condition if they worked in a state with applications that were not considered “consistent” (P = 0.002) leading to the conclusion that questions about a prior mental illness or mental health conditions present a barrier to those physicians that may need to seek help; and

WHEREAS, according to the American Foundation for Suicide Prevention (AFSP), compared to the general male population and general female population, the suicide rate for male physicians is 1.41 times greater and the suicide rate for female physicians is 2.27 times greater, respectively; and

WHEREAS, according to the AFSP, “Among physicians, risk for suicide increases when mental health conditions go unaddressed,”; and
WHEREAS, the American Medical Association (AMA) has approved a policy on June 13th, 2018, that encourages state licensing boards to remove or change questions on their applications that reference prior mental health conditions in favor of questions that specify current physical or mental conditions using the verbiage recommended by the Federation of State Medical Boards (This verbiage reads, “Are you currently suffering from any condition for which you are not appropriately being treated that impairs your judgement or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?”); and

WHEREAS, the AMA cites concerns for growing rates of physician and medical student depression, burnout, and suicide as being the trigger for adopting this new policy in an attempt to encourage physicians to seek medical care when they need it without fear of stigmatization or hindrance to their ability to obtain their medical license; and

WHEREAS, the Florida Board of Medicine, in December 2018, in response to the new policy adopted by the AMA and increasing rates of suicide among physicians, has given preliminary approval to remove questions about prior mental health conditions/treatment and substance abuse in favor of questions that specify if applicants “currently have any condition that impairs them from safely practicing and whether they currently are using drugs or intoxicating chemicals,”; and

WHEREAS, the purpose of licensure questions asking about “any” history of mental illness is to identify physicians that may present a risk to themselves or their patients. However, the data presented in this resolution has shown that most physicians are not reporting their conditions honestly with the current licensure questions and are avoiding seeking treatment for their conditions due to fear that a diagnosis would prevent them from maintaining or obtaining their licensure. This perpetuates stigmatization of mental illness and puts these suffering physicians at increased risk for committing suicide; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) advocate in support of the removal of questions on physician state licensing applications that ask about prior history of mental illness in alignment with our colleagues at the American Medical Association; and, be it further

RESOLVED, that the AOA advocate in support of questions on physician state licensing applications that use the verbiage concerning current untreated or undertreated conditions such as those that have been approved by the Federation of State Medical Boards.

References


Explanatory Statement

Questions on the physician state licensing applications that ask about prior mental illnesses serve as a barrier to those that may need treatment due to fear of their answers affecting their licensure. An above whereas statement shows that very few physicians answer these questions honestly. The AFSP has stated that unaddressed mental illness increases rates of suicide among physicians and the barrier presented by the current state licensure questions prevents physicians from seeking care so as to avoid a diagnosis. As an organization with a holistic view of the human body as a complete unit (body, mind, and spirit), the AOA and SOMA should be active in supporting the health and wellness of their physicians, residents, and medical students.

ACTION TAKEN _____________________

DATE _____________________________
WHEREAS, Targeted Regulation of Abortion Providers (TRAP laws) are defined as legislation and policy that apply ambulatory surgical center standards to family planning clinics; require specific physical outlays to such clinics; require facilities or clinicians to have attending rights at local hospitals; and/or require clinicians to be board-certified in specific specialties in order to provide medication based and/or surgical-based abortions; and

WHEREAS, TRAP laws single out medical practices of providers who provide abortions and impose on them requirements that are different and more burdensome than those imposed on other medical practices which necessitates significant patient and provider adaptation; and

WHEREAS, there is no statistically significant evidence that performing an abortion at an ambulatory surgical center reduces the risk of morbidities and adverse effects when compared to a standard family planning clinic; and

WHEREAS, providers of abortion reported heightened levels of stress, increased costs, and lowered productivity when complying to TRAP laws without any change in outcome; and

WHEREAS, TRAP laws specifically governing abortion are more prevalent and impose more stringent requirements than laws governing office-based surgeries, procedures, sedation, or anesthesia; and

WHEREAS, countries with less restrictive abortion laws have lower rates of abortions when compared to countries with more restrictive laws; and

WHEREAS, it is reported that TRAP laws directly interfere with the patient-physician relationship which is in violation of AOA policy H307-A/13 INTERFERENCE LAWS; and

WHEREAS, it is the recommendation of the American College of Obstetricians and Gynecologists to end legislation, including TRAP laws, that impedes access to abortion services and interferes with the patient-provider relationship; and

RESOLVED, that the American Osteopathic Association oppose the Targeted Regulation of Abortion Providers (TRAP laws) that impede and discriminate against a physician’s ability to provide appropriate care to patients seeking family planning services, including abortion.
References


7. AOA Policy H307-A/13 INTERFERENCE LAWS.


Explanatory Statement

In light of recent bills passed in Iowa that would ban abortions on detectable heartbeat of the fetus, it is prudent that SOMA and the AOA take an official stance on laws that would prevent abortion providers from providing care to patients seeking abortions. Many TRAP laws are essentially backdoor abortion bans, especially in rural and underserved communities where there are insufficient resources to comply with these targeted regulations.

ACTION TAKEN _____________________

DATE ______________________________
WHEREAS, violence against health care workers is a demoralizing and frustrating part of providing medical care for which there is little help available to the victims and is nearly an epidemic. Physical injury is only a small part of the overall trauma health care workers face when caring for those who are not able to care for themselves; and

WHEREAS, physicians and medical personnel often face life and death situations for which they are trained but are none-the-less psychologically traumatized and there is little if any organizational assistance available. Recent data suggests physician burnout costs $4.6 billion dollars yearly. and the World Health Organization recently re-classified burnout as an “Occupational Phenomenon;” and

WHEREAS, if physicians were to seek psychological assistance for mental or emotional traumas sustained within the scope of their professional duties, there are no assurances that they will not be penalized by employers, insurers, or licensing and regulatory boards for seeking such care. Studies have found that about 35% of physicians do not seek regular health care for themselves. In one study, almost 50% of female physicians did not seek treatment despite feeling that they met criteria for a mental disorder; and

WHEREAS, if a law enforcement officer were to experience the same type of trauma (example: a death of a person within the scope of the person’s duties) they would be expected and in most cases required to receive psychological assessment, treatment, and have paid administrative leave to properly deal with the repercussions of the event. This treatment would not adversely affect their professional standing. If a physician, resident, or student were to experience the trauma of having a person die within the scope of their professional duties they would be normally expected to resume their work and would not receive psychological assessment, treatment, or paid time off to deal with the repercussions of the event. A recent study finds that the long work hours of an intern’s first year of medical residency are associated with accelerated cellular aging due to prolonged stress exposure; and

WHEREAS, if a physician were to seek professional psychological care they may be penalized as evidenced by increased insurance premiums, denial of disability and life insurance policies, and intrusive questions about past health care that does not likely affect professional performance and may negatively impact hospital staff appointments, licensure, board certification or credentialing; now, therefore, be it;

RESOLVED, that the American Osteopathic Association (AOA) continue to work to ensure that physicians are not publicly or professionally stigmatized for seeking care and treatment for injuries or psychological trauma resulting from their professional duties; and, be it further
RESOLVED, that the AOA continue ongoing promotion of physician mental health care as a necessary part of normal physician professional development requiring appropriate care to avoid suicide, depression, and burnout; and, be it further

RESOLVED, that the AOA work with payors and other invested parties to remove any and all financial penalties and stigmas associated with mental health care received ensuring the continued wellness of our physician workforce.

References
2. Steussy, Lauren “Doctors share how burnout nearly led them to suicide” https://nypost.com/2019/02/19/a-burnout-epidemic-is-hurting-doctors-and-their-patients/ Published 19 February 2019.

Explanatory Statement:
We are in a crisis for physicians in America. Burnout is an often discussed and “hot topic” epidemic. The work of the AOA & MOA has been significant on this front, but as a value to our members we believe the need for public consideration of this as a late submission to the AOA House for consideration in 2019. It is important to show our members that we care about their needs when these timely topics are discussed. Thanks for your thoughtful consideration.

ACTION TAKEN _______________________
DATE ____________________________
WHEREAS, at the 2018 American Osteopathic Association (AOA) House of Delegates, resolution H-365 was approved resolving that the AOA consider meal nutritional content when planning events; and

WHEREAS, the preponderance of evidence shows negative health outcomes associated with the consumption of sugar sweetened beverages and processed meats and;

WHEREAS, the World Health Organization, International Agency for Research on Cancer has classified processed meat as carcinogenic to humans (Group 1); and

WHEREAS, nudges, defined as a subtle environment cues designed to make healthy food choices the easy choice have been shown to increase consumption of healthy foods; and

WHEREAS, the AOA has the opportunity to lead by example - recognizing the impact that nutrition has on human health when providing meals; and

RESOLVED, that sugar sweetened beverages and processed meats be excluded from all American Osteopathic Association (AOA) sponsored events where a meal is served; and, be it further

RESOLVED, that the AOA encourage osteopathic medical schools, residency programs, and hospitals to offer plant-based meals and eliminate sugar sweetened beverages and processed meats when meals are served.

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________