American Osteopathic Association

House of Delegates

Committee on Professional Affairs

Craig Glines, DO, Chair
Gene Battistella, DO, Vice chair

July 27, 2019

CONSENT AGENDA – FOR COLLECTIVE ACTION BY THE HOUSE OF DELEGATES

Mr. Speaker, I present the following Consent Agenda, and the Committee recommends that it be APPROVED:

H-300 TRAINING – EXTENDED RELEASE-LONG ACTING (ER/LA) OPIOID RISK EVALUATION AND MITIGATION STRATEGY (REMS) (H300-A/14)

H-301 MEDICAL WEBSITES AND SMARTPHONES/TABLET COMPUTER APPS TO DIAGNOSE ILLNESS – USE OF (H301-A/14)

H-302 FLU PANDEMIC – OSTEOPATHIC TREATMENT OF (H305-A14)

H-304 NEW BORN HIV TESTING (H307-A/14)

H-305 CDC – HIV PROPOSED RULE CHANGE (H313-A/14)

H-306 INFLUENZA IMMUNIZATION FOR HEALTH CARE WORKERS AND EDUCATORS (H314-A/14)

H-307 DUE PROCESS FOR ALLEGED IMPAIRED PHYSICIANS (H316-A/14)

H-308 DRUG FORMULARIES (H317-A/14)

H-309 HOME-BASED CARE FOR FRAIL ELDERLY (H318-A/14)

H-311 IMMUNIZATION REGISTRIES (H320-A/14)

H-312 NATIONAL PRACTITIONER DATA BANK – MEMBERSHIP ACTION (H321-A/14)

H-313 IMPORTATION OF MEDICATIONS (H322-A/14)

H-314 ANY WILLING PROVIDER LEGISLATION (H323-A/14)
H-316 PHYSICALLY ACTIVE VIDEO GAMES – (EXERGAMING HEALTH) BENEFITS (H325-A/14)

H-320 HEALTHY WEIGHT FOR FAMILIES (H329-A/14)

H-321 ADMINISTRATIVE FEES (H330-A/14)

H-322 END-OF-LIFE CARE – USE OF PLACEbos IN (H331-A/14)

H-324 OSTEOpatHIC MANIpULATIVE TREATMENT (OMT) OF THE CERVICAL SpINE (H332-A/14)

H-325 RIGHT TO PRIVately CONTRACT (H334-A/14)

H-327 ABUSE OF PERFORMANCE ENHANCING SUBSTANCES AND PROCEDURES (H337-A/14)

Editorial Line 8…with the World Anti-Doping AGENCY (WADA)…

H-328 DIVERSITY IN LEADERSHIP POSITIONS (H338-A/14)

H-329 TOBACCO USE STATUS – REPORTING IN THE MEDICAL RECORD (H339-A/14)

H-330 MEDICAL COSTs INCURRED BY PATIENTs FOR SERVICES NOT COVEReD BY THEIR INSURANCE (H344-A/14)

Editorial Line 3…SURPRISEd…

H-331 ELECTRONIC MEDICAL RECORD (EMR) – STUDENT ACCESS AND USE (H345-A/14)

H-332 TESTOSTERONE THERAPY: LONG TERM EFFECT ON HEALTH (H346-A/14)


H-343 WHITE PAPERS - UPDATING

H-346 WHISTLEBLOWER POLICY – AMERICAN OSTEOpatHIC ASSOCIATION

H-349 SUPPORT FOR OMT PRIVILEGES

Editorial SUBMITTED BY…OsteopathiC and Physicians AND SURGEONS of CalifoRnia

H-358 REFERRED RESOLUTION H305-A/18 INTERFERENCE LAWS
H-360  REFERRED RESOLUTION H426-A/18 OFFICE BASED SURGERY

H-362  SAFE HAVEN NON-REPORTING PROTECTION FOR PHYSICIANS – SUPPORT FOR

And I so move.  APPROVED

H-339  PHARMACY BENEFIT MANAGERS-INCREASED REGULATION OF

Mr. Speaker, I present for consideration Resolution No. H-339, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Page 4, Line 1  THE AOA SUPPORTS HEALTH POLICY WHICH PROMOTES MAKING LIFE SAVING MEDICATIONS (I.E. EPINEPHRINE FOR ANAPHYLAXIS, NALOXONE FOR DRUG OVERDOSE, AND INSULIN/GLUCAGON FOR DIABETES) FREE FOR UNINSURED PATIENTS AND A FULLY COVERED BENEFIT FOR INSURED PATIENTS.

And I so move.  APPROVED

H-303  DIRECT-TO-CONSUMER MARKETING OF HEALTH SCREENING AND TESTING (H306-A/14)

Mr. Speaker, I present for consideration Resolution No. H-303, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Lines 5-8  The American Osteopathic Association is against DIRECT-TO-CONSUMER MARKETING OF MEDICAL TESTS AND EXAMS THAT MAY BE unnecessary, exams HEALTH SCREENING EXAMS AND TESTING marketed directly to consumers and encourages its members to educate their patients ABOUT WHICH SERVICES ARE APPROPRIATE BASED ON and follow the US Preventive Services Task Force RECOMMENDATIONS AND OTHER NATIONALLY RECOGNIZED CLINICAL PRACTICE Guidelines WHEN APPROPRIATE. 2009; reaffirmed 2014

Explanatory Statement: The Committee agrees with the Bureau of Socioeconomic Affairs’ recommendation to expand the policy and base the need for tests and exams on United States Preventive Services Task Force (USPSTF) guidelines and other nationally recognized clinical practice guidelines as outlined below:

1) USPSTF recommendations are applicable to primary care. The USPSTF is a Congressionally mandated, independent panel of medical experts in primary care and prevention composed of primary care providers-internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and other behavior specialists who are charged with making “recommendations to primary care providers about clinical preventive services.”

2) Medicare pays for preventive screening and tests assigned a grade “D” or “I” by the USPSTF. These grade assignments indicate a service is unnecessary. Someone unfamiliar with USPSTF grade
assignments may misinterpret a low grade as a non-covered service when it may not be. Prostate screening is a prime example.

3) CMS, Medicare Administrative Contractors (MACs) and private payers base their coverage determinations on nationally recognized clinical practice guidelines (which usually are developed by specialty medical societies) more so than USPSTF guidelines.

And I so move. **APPROVED**

**H-310 HEALTH CARE COSTS IN LONG TERM SERVICES AND SUPPORT (H319-A/2014)**

Mr. Speaker, I present for consideration Resolution No. H-310, and the Committee recommends that it be **APPROVED** with the following **AMENDMENTS**:

Line 3 HEALTH CARE COSTS **EFFICIENCY** IN LONG TERM SERVICES AND SUPPORT (H319-A/2014)

And I so move. **APPROVED**

**H-315 USE OF THE TERM “PHYSICIAN” DOCTOR” AND “PROVIDER” (H324-A14)**

Mr. Speaker, I present for consideration Resolution No. H-315, and the Committee recommends that it be **APPROVED** with the following **AMENDMENTS**:

Line 22 …of their **POSTGRADUATE** education, **RESIDENCY, FELLOWSHIP** training, **AND**…

**Motion from the floor of the House:** Refer to Bureau of State Government Affairs (BSGA) for consideration and comment and report back to 2020 HOD.

And I so move. **APPROVED** **(referred to Bureau of State Government Affairs)**

**H-317 MEDICARE – PRESCRIPTION ASSISTANCE FOR MEDICARE PATIENTS (H326-A/14)**

Mr. Speaker, I present for consideration Resolution No. H-317, and the Committee recommends that it be **APPROVED** with the following **AMENDMENTS**:

Lines 5-6 The American Osteopathic Association supports legislation that will allow **TO ELIMINATE THE COVERAGE GAP (DONUT HOLE) IN Medicare Part D recipients, who are in the “donut hole”, to utilize AND THE RESTRICTIONS THAT LIMIT PATIENTS FROM UTILIZING** prescription discounts…

And I so move. **APPROVED**

**H-319 CARDIOVASCULAR DISEASE AND WOMEN (H328-A/14)**
Mr. Speaker, I present for consideration Resolution No. H-319, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Lines 9-11 …Heart Truth (Red Dress) campaign; (4) will continue to recognize National Women’s Health Week and National Women’s Check-Up Day (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…

And I so move. **APPROVED**

**H-323** MINORITIES IN THE OSTEOPATHIC PROFESSION – COLLECTING DATA (H332-A/14)

Mr. Speaker, I present for consideration Resolution No. H-323, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 5 …(1) include optional questions relating to…

Line 8 … osteopathic medical colleges, osteopathic residency programs…

Lines 15-17 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 IMPLEMENT programs with multi-cultural impact.

And I so move. **APPROVED**

**H-326** PROMOTING DIVERSITY IN AOA MEMBERSHIP AND LEADERSHIP (H334-A/14)

Mr. Speaker, I present for consideration Resolution No. H-326, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Lines 5-11 The American Osteopathic Association reaffirms its commitment to promote DIVERSITY 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 Islander) into the osteopathic profession; endorses programs to encourage increased DIVERSITY IN enrollment of these groups at colleges of osteopathic medicine; and will work to identify and encourage SUCH qualified individuals from these groups for participation in those osteopathic affiliate and national activities which foster…

And I so move. **APPROVED**
Mr. Speaker, I present for consideration Resolution No. H-333, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

 Lines 5-7 The American Osteopathic Association opposes the principle that any SUPPORTS PARTICIPATION IN PATIENT satisfaction surveys WITHOUT WITH have a significant MINIMAL impact on osteopathic physician’s compensation PAYMENT.

And I so move. APPROVED

H-334 AVAILABILITY OF BIOSIMILAR PRODUCTS

Mr. Speaker, I present for consideration Resolution No. H-334, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

 Lines 14-23 RESOLVED, that the American Osteopathic Association (AOA) supports policies that strengthen the biosimilar market while preserving THE physician-PATIENT RELATIONSHIP authority over patient care and protecting patient safety, be it further

RESOLVED, THAT FDA APPROVED DRUGS SHOULD BE ACCESSIBLE TO PATIENTS, AND BE IT FURTHER

RESOLVED, THAT THE DECISION ON WHICH BIOLOGIC OR BIOSIMILAR SHOULD BE USED REST WITH THE PATIENT AND THE PHYSICIAN, AND BE IT FURTHER

RESOLVED, THAT THE AOA SUPPORTS PAYOR COVERAGE OF ALL FDA-APPROVED BIOLOGICS AND BIOSIMILARS TO ENHANCE PATIENT ACCESS AND CHOICE. 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.

And I so move. APPROVED

H-335 MATERNAL MORTALITY

Mr. Speaker, I present for consideration Resolution No. H-335, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

 Lines 11-13 …state and RELEVANT specialty medical societies…federal legislation TO establishing AND MAINTAIN maternal mortality…work with state and RELEVANT specialty medical societies…

And I so move. APPROVED
Mr. Speaker, I present for consideration Resolution No. H-336, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

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.

Explanatory Statement: See references from H-335 – A/2019 which show that a majority of pregnancy-related preventable deaths occur during the postpartum period.

And I so move. APPROVED

Mr. Speaker, I present for consideration Resolution No. H-338, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

And I so move. APPROVED

Mr. Speaker, I present for consideration Resolution No. H-342, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

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

RESOLVED, that the AOA will work to identify these misaligned incentives, and advocate for changes to the Medicare program that support physicians in delivering high-value care and discourage plans from preventing patients from seeking lower cost-effective treatment options; 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 against incentives in Federal Healthcare programs that do not promote improved health
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Craig Glines, DO, Chair EL/RR/JM
Gene Battistella, DO, Vice chair

OUTCOMES. through legislation and other regulations designed to prevent competing incentives.; AND, BE IT FURTHER

RESOLVED, THAT THE AOA WORKS TO EDUCATE THE NCQA REGARDING THE NEED TO MODIFY Hedis RULES.

And I so move. APPROVED as AMENDED

H-359 REFERRED RESOLUTION H306-A/18 - STATE GRADUATE MEDICAL EDUCATION FUNDING ALTERNATIVES

Mr. Speaker, I present for consideration Resolution No. H-359, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Page 3 Line 20 …budget shortfalls, AND ALABAMA, MICHIGAN AND TENNESSEE …
Page 9 Line 24 …efforts to provide adequate TO INCREASE GME funding.

And I so move. APPROVED

H-361 REFERRED RESOLUTION H340-A/13 – UNIFORM PATHWAY OF LICENSING OF OSTEOPATHIC PHYSICIANS

Mr. Speaker, I present for consideration Resolution No. H-361, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Lines 14-15 …mechanisms of the National Board of Osteopathic Medical Examiners, TO BE EFFECTIVE AFTER 12/31/19.

Explanatory Statement: The Committee believes that adding an effective date will allow for grandfathering in of osteopathic physicians who obtained licensure previously through the FLEX or USMLE examinations, etc.

And I so move. APPROVED

H-318 ELECTRONIC PRESCRIBING (H327-A/14)

Mr. Speaker, I present for consideration Resolution No. H-318, and the Committee recommends that it be REFERRED to the Bureau of State Government Affairs for review and comment.

Explanatory Statement: The Committee recommends that this resolution be referred to the BSGA to review current state and federal laws, and to reflect new technologies (which may include biometric screening and second factor identification) intended to make e-prescriptions more secure.

MOTION TO REFER – DISAPPROVED

Reaffirmed as amended:

Line 7: CMS reimbursement monetary penalty; AND WITHOUT STATE SANCTIONED CIVIL OR CRIMINAL PENALTIES.
And I so move. **REAFFIRMED as AMENDED**

**H-337 NEW PHYSICIAN IN PRACTICE DEFINITION**

Mr. Speaker, I present for consideration Resolution No. H-337, and the Committee recommends that it be REFERRED to the Committee on AOA Governance and Organizational Structure, Subcommittee on Constitution and Bylaws for review and comment.

**Explanatory Statement:** The Committee is concerned that this creates a definition that is inconsistent with how New Physician in Practice is defined for purposes of the New Physician in Practice position on the Board of Trustees.

And I so move. **APPROVED (for referral to AOA Governance and Organizational Structure, Subcommittee on Constitution and Bylaws)**

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**H-340 BACKGROUND CHECKS AND FIREARMS SAFETY TRAINING AS A CONDITION OF FIREARMS PURCHASE**

Mr. Speaker, I present for consideration Resolution No. H-340, and the Committee recommends that it be REFERRED to the Bureau on Federal Health Programs.

**Explanatory Statement:** The Committee supports firearm safety training, and recommends that this be rewritten to focus on public health policy, in accordance with the AOA’s Mission Statement.

And I so move. **APPROVED (for referral to Bureau on Federal Health Programs)**

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**H-345 CONSULTANT REPORTS ACCESSIBILITY/AVAILABILITY-AMERICAN OSTEOPATHIC ASSOCIATION**

Mr. Speaker, I present for consideration Resolution No. H-345, and the Committee recommends that it be REFERRED to the Kentucky Osteopathic Medical Association.

**Explanatory Statement:** The Committee is concerned that this resolution is too broad and requests that it be clarified and that it acknowledge legal limitations which restrict information disclosure and dissemination.

And I so move. **APPROVED (for referral to the Kentucky Osteopathic Medical Association)**

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**H-353 DECRIMINALIZATION OF SELF-INDUCED ABORTION**

Mr. Speaker, I present for consideration Resolution No. H-353, and the Committee recommends that it be REFERRED to the Student Osteopathic Medical Association.

**Explanatory Statement:** The Committee supports harm reduction strategies that encourage patients to seek needed health care without fear of legal repercussions, as in the case of a minor who may avoid seeking treatment for illness resulting from underage drinking in addition to the intent of this resolution; however, the Committee believes that the resolution should be referred back to SOMA for clarification and refinement.

And I so move. **APPROVED (for referral to the Student Osteopathic Medical Association)**
Mr. Speaker, I present the following Consent Agenda, and the Committee recommends that it be DISAPPROVED. To begin discussion, I move that it be approved.

H-344 DEVELOPMENT OF A NATIONAL IMMUNIZATION INFORMATION REGISTRY

Explanatory Statement: The Committee believes that this Resolution is duplicative of H629-A/19 CLINICAL DATA REGISTRIES AND QUALIFIED CLINICAL DATA REGISTRIES.

H-354 DE-STIGMATIZATION OF MENTAL ILLNESS IN PHYSICIANS

Explanatory Statement: The Committee recommends the approval of H-362 SAFE HAVEN NON-REPORTING PROTECTION FOR PHYSICIAN – SUPPORT FOR in lieu of this resolution, as it encompasses the Resolveds of this resolution as well as other considerations.

And I so move. APPROVED (for disapproval)

H-347 AMERICAN OSTEOPATHIC ASSOCIATION – ORGANIZATIONAL HEALTH, VIABILITY & TRANSPARENCY

Mr. Speaker, I present for consideration Resolution No. H-347, and the Committee recommends that it be APPROVED.

Explanatory Statement: The resolution calls for the AOA to provide detailed confidential business information and reports to affiliated organizations that owe no fiduciary responsibilities to the AOA, creating a risk of public release of confidential information. Moreover, the proposed disclosures are unnecessary and excessive. The AOA already makes contact information available for its Trustees (FirstInitialLastNameDO@osteopathic.org), makes tax and financial information available to members on request, its 990 tax returns are available on-line, and it provides detailed budget and expenditure information to existing appropriate oversight bodies (Finance Committee oversight of audit process, Joint Board-House Budget Review Committee).

And I so move. DISAPPROVED

H-348 EXPANSION OF MEDICAID IN ALL STATES

Mr. Speaker, I present for consideration Resolution No. H-348, and the Committee recommends that it be APPROVED.

Explanatory Statement: The Committee believes that existing policy H338-A/18 UNINSURED – ACCESS TO HEALTH CARE is more comprehensive and covers the concerns of this resolution. Further, this resolution may be overly prescriptive, veer outside of health care policy, and does not appropriately take into
account the financial constraints of states, as well as other state-based health care programs that may be in place.

And I so move. **DISAPPROVED**

**H-350** ANTI-INTIMIDATION STANDARDS AMONG PHYSICIANS

Mr. Speaker, I present for consideration Resolution No. H-350, and the Committee recommends that it be APPROVED.

**Explanatory Statement:** The Committee believes that H505-A/19 AOA RULES AND GUIDELINES ON PHYSICIANS’ PROFESSIONAL CONDUCT covers the concerns of this resolution.

And I so move. **DISAPPROVED**

**H-351** ADVOCATING FOR WOMEN’S RIGHT TO REPRODUCTIVE HEALTHCARE ACCESS AND SUPPORT OF ROE V. WADE

Mr. Speaker, I present for consideration Resolution No. H-351, and the Committee recommends that it be APPROVED.

**Explanatory Statement:** The Committee recognizes that this is a divisive topic, and wishes to respect individual physician and patient beliefs. The Committee supports comprehensive reproductive health care, as well as policies that support care for patient populations while protecting the individual physician-patient relationship as reflected in H358-A/19 INTERFERENCE LAWS; however, it feels that the content of this resolution veers overly into politics.

And I so move. **DISAPPROVED**

Mr. Speaker, I present for consideration Resolution No. H-352, and the Committee recommends that it be APPROVED.

**H-352** ADVOCATING FOR MORE DO REPRESENTATION WITHIN MEDICAL TV SHOWS AND MOVIES

**Explanatory Statement:** Due to organizational resource limitations, existing branding campaign, and high-profile osteopathic physicians on social media BOT feels that this resolution is appropriately addressed through existing channels. Further, the Committee believes that “advocating” and “lobbying for” this resolution falls outside the approved scope and resources of AOA departments.

And I so move. **DISAPPROVED**

**H-355** OPPOSING TARGETED REGULATION OF ABORTION PROVIDERS (TRAP LAWS)

Mr. Speaker, I present for consideration Resolution No. H-355, and the Committee recommends that it be APPROVED.
Explanatory Statement: The Committee believes that this Resolution is duplicative of H358-A/19.

And I so move. APPROVED

H-356 PHYSICIAN PSYCHOLOGICAL TRAUMA AND MENTAL HEALTH

Mr. Speaker, I present for consideration Resolution No. H-356, and the Committee recommends that it be APPROVED.

Explanatory Statement: The Committee recommends disapproval, as this Resolution is covered by existing policy H646-A/15 MENTAL HEALTH – OSTEOPATHIC MEDICAL STUDENT, RESIDENT, AND PHYSICIAN.

And I so move. APPROVED

H-357 NUTRITION AND LEADING BY EXAMPLE

Mr. Speaker, I present for consideration Resolution No. H-357, and the Committee recommends that it be APPROVED.

Line 16 hospitals to offer plant-based meals and eliminate AS AN ALTERNATIVE TO sugar sweetened beverages and

Explanatory Statement: The Committee recommends disapproval, as this Resolution is overly prescriptive and is more appropriately addressed by existing policy H365-A/18 NUTRITION AT AOA EVENTS.

And I so move. As per AOA policy will be referred to Finance Committee for fiscal analysis.

Mr. Speaker, this concludes the Committee’s report. I would like to thank the members of the Committee.

Committee Members:
Craig Glines, DO - Chair
Gene M. Battistella, DO - Vice chair
Julianne Sees, DO
Steven Gates, DO
Lee Ann Brown, DO
Carl Shapiro, DO
Sarah J Wolff, DO
Carol D. Bowes-Lawlor, DO
Jeff Davis, DO
Suzanne Sirota-Rozenberg, DO
Anna Hayden, DO
David Bollard, DO
Charles "Chip" Finch, DO
Henry Wehrum, DO
Ralph Naftali, DO

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Florida
AOCPMR
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Missouri
New York
Florida
New Jersey
Arizona
Ohio
Illinois
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Craig Glines, DO, Chair
Gene Battistella, DO, Vice chair

Mary Franz, DO  Kansas
David Park, DO  Utah

STAFF
Eunice Lee
Raine Richards
John-Michael Villarama
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

**ACTION TAKEN APPROVED**

**DATE July 27, 2019**
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

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**
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

ACTION TAKEN APPROVED

DATE July 27, 2019
SUBJECT: H306-A/14 DIRECT-TO-CONSUMER MARKETING OF HEALTH SCREENING AND 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 as AMENDED:

H306-A/14 DIRECT-TO-CONSUMER MARKETING OF HEALTH SCREENING AND TESTING

The American Osteopathic Association is against DIRECT-TO-CONSUMER MARKETING OF MEDICAL TESTS AND EXAMS THAT MAY BE unnecessary, exams HEALTH SCREENING EXAMS AND TESTING marketed directly to consumers and encourages its members to educate their patients ABOUT WHICH SERVICES ARE APPROPRIATE BASED ON and follow the US Preventive Services Task Force RECOMMENDATIONS AND OTHER NATIONALLY RECOGNIZED CLINICAL PRACTICE Guidelines WHEN APPROPRIATE. 2009; reaffirmed 2014

Reference Committee Explanatory Statement:
The Committee agrees with the Bureau of Socioeconomic Affairs’ recommendation to expand the policy and base the need for tests and exams on United States Preventive Services Task Force (USPSTF) guidelines and other nationally recognized clinical practice guidelines as outlined below:

1) USPSTF recommendations are applicable to primary care. The USPSTF is a Congressionally mandated, independent panel of medical experts in primary care and prevention composed of primary care providers-internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and other behavior specialists who are charged with making “recommendations to primary care providers about clinical preventive services.”

2) Medicare pays for preventive screening and tests assigned a grade “D” or “I” by the USPSTF. These grade assignments indicate a service is unnecessary. Someone unfamiliar with USPSTF grade assignments may misinterpret a low grade as a non-covered service when it may not be. Prostate screening is a prime example.

3) CMS, Medicare Administrative Contractors (MACs) and private payers base their coverage determinations on nationally recognized clinical practice guidelines (which usually are developed by specialty medical societies) more so than USPSTF guidelines.

ACTION TAKEN APPROVED as AMENDED

DATE July 27, 2019
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

ACTION TAKEN APPROVED

DATE July 27, 2019
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

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**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 screening. [https://www.cdc.gov/immigrantrefugeehealth/laws-regulations.html](https://www.cdc.gov/immigrantrefugeehealth/laws-regulations.html)

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**ACTION TAKEN** **APPROVED** *(for sunset)*

**DATE** **July 27, 2019**
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

ACTION TAKEN APPROVED

DATE July 27, 2019
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

ACTION TAKEN APPROVED

DATE July 27, 2019
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

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

ACTION TAKEN APPROVED

DATE July 27, 2019
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

ACTION TAKEN APPROVED

DATE July 27, 2019
RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED:

**H319-A/14 HEALTH CARE COSTS EFFICIENCY 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

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**
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 APPROVED (for sunset)

DATE July 27, 2019
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

ACTION TAKEN APPROVED

DATE July 27, 2019
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

ACTION TAKEN APPROVED

DATE July 27, 2019
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

ACTION TAKEN APPROVED

DATE July 27, 2019
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) providing a 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 US-trained DOs and MDs; (6) supports a policIESy 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) OPPOSE will not support legislation THAT, which would allow non-physician clinicians to be called “physicians;” (8) supports a policIESy THAT reserving the title “physician” for US-trained DOs, and MDs who have established the integrity of their education, training, examination WHICH UNIQUELY PREPARE THEM and regulations 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

Reference Committee Explanatory Statement:
Refer to Bureau of State Government Affairs (BSGA) for consideration and comment and report back to 2020 HOD.

ACTION TAKEN REFERRED (to Bureau of State Government Affairs)

DATE July 27, 2019
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

ACTION TAKEN APPROVED

DATE July 27, 2019
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 TO ELIMINATE THE COVERAGE GAP (DONUT HOLE) IN Medicare Part D recipients, who are in the “donut hole”, to utilize AND THE RESTRICTIONS THAT LIMIT PATIENTS FROM UTILIZING prescription discounts and vouchers. 2009; reaffirmed 2014

ACTION TAKEN APPROVED as AMENDED

DATE July 27, 2019
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 AND WITHOUT STATE SANCTIONED CIVIL OR CRIMINAL PENALTIES. 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 part 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

ACTION TAKEN APPROVED as AMENDED

DATE July 27, 2019
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

ACTION TAKEN APPROVED as AMENDED

DATE July 27, 2019
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. 2004; 2009; reaffirmed as amended 2014

ACTION TAKEN APPROVED

DATE July 27, 2019
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

ACTION TAKEN APPROVED

DATE July 27, 2019
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. (1, 4, 5, 8, 9, 10, 15, 16, 23, 24) 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. (210) The placebo effect is an important adjunct in the treatment of symptoms. The alleviation of symptoms has an inherent positive psychological component; patients who perceive their symptoms to be relieved by the treatment and trust in their treating physician’s treatment plan and/or prescription for the symptom relief are more likely to obtain relief. (4, 2)

   Placebo responses are necessary for controlled clinical trials in which the patient is informed that a placebo may indeed be utilized. Physiologic responses to placebo can be pleasant or unpleasant to the patient. An unpleasant effect attributable to administration of a placebo is called a “nocebo response”. A pleasant effect is called a “positive placebo response”. It has been noted that, “a positive placebo response simply speaks
to the strength of an individual’s central control processes (i.e., mind) to recruit their
descending inhibitory system to block pain. The trained osteopathic physician knows
that pain relief occurs both in the mind and in the body.” (9  4) The basis of the placebo
effect in a therapeutic physician-patient relationship also involves good communication
skills as well as listening to the patient. (2  44, 11, 12)

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, (13) “is a primary, chronic, neurobiologic disease, with genetic, psychosocial,
and environmental factors influencing its development and manifestations. It is
classified 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. (46)

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) (1914), 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 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.

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

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

The American Bar Association (ABA) adopted a resolution concerning the promotion of pain management in all patients with chronic pain. This resolution states, “…that the American Bar Association urges federal, state and territorial governments to support fully the rights of individuals suffering from pain to be informed of, choose, and receive effective pain and symptom evaluation, management and ongoing monitoring as part of basic medical care, even if such pain and symptom management may result in analgesic tolerance, physical dependence or as an unintended consequence shorten the individual’s life.” 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.

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…”
Guidelines developed by the Agency for Healthcare Policy and Research, now the Agency for Healthcare Research and Quality (1), the American Pain Society, (2) 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. (105)

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. (223)

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. (1424) 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. (423) 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, 444, 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. (446) 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 (427) 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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Services, Public Health Service; March 1994.


6. Goldstein F. Inadequate pain management: a suicidogen (Dr. Jack Kevorkian: friend or 


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Addiction Medicine. Statement on definitions related to the use of opioids for the treatment 


15. Federation of State Medical Boards of the United States, Inc. Model Policy for the Use of 
Controlled Substances for the Control of Pain. May 2004.
20. Healthcare Facilities Accreditation Program. Accreditation Requirements for Healthcare
   Facilities. Standard 15.01.10. Chicago, Ill: Healthcare Facilities Accreditation Program,
21. National Pharmaceutical Council and Joint Commission on Accreditation of Healthcare
24. Portenoy RK. Contemporary Diagnosis and Management of Pain in Oncologic and AIDS
26 Emmanuel LL, von Gunten C, Ferris FD. Module 4-4: Pain Management. The Education
   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 APPROVED

DATE July 27, 2019
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 IMPLEMENT programs with multi-cultural impact. 2004; reaffirmed 2009; reaffirmed as amended 2014

ACTION TAKEN APPROVED as AMENDED

DATE July 27, 2019
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 pre-existing 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.
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.\textsuperscript{7,18-27}

Most of the reported cases of adverse outcomes have involved thrust or High Velocity/Low Amplitude (HVLA) types of manipulative treatment.\textsuperscript{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.\textsuperscript{28} The most common risk factors for VBAs are migraine, hypertension, oral contraceptive use and smoking.\textsuperscript{29} Elevated homocysteine levels, which have been implicated in cardiovascular disease, may be a risk factor for a VBA.\textsuperscript{30}

The risk of a VBA occurring spontaneously, is nearly twice the risk of a VBA resulting from cervical spine manipulation.\textsuperscript{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.\textsuperscript{31}

A study in 2002 conducted by Haldeman et al., reported that a VBA following cervical spine manipulation was unpredictable.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.”\textsuperscript{21} In some cases manipulation may not be the primary culprit for causing the dissection, but an aggravating factor or coincidental event.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.

In Malone et al., the authors reported 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 incidence of these types of complications could be lessened by rigorous adherence to published exclusion criteria for cervical spine manipulation.

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 paraphysiologic 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.

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. 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. 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. Other risks include cervical epidural abscess, dural puncture, spinal cord trauma, infection, hemotoma, nerve damage, vascular injury and cerebral vascular or pulmonary embolus. 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.

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


ACTION TAKEN **APPROVED**

DATE **July 27, 2019**
SUBJECT: H334-A/14 RIGHT TO PRIVATELY CONTRACT

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

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 seek SUPPORTS changes in statutes and regulations that will allow physicians individually and as defined groups to be allowed to negotiate fair contracts with private sector and public sector health plans. 2009; reaffirmed 2014

ACTION TAKEN APPROVED

DATE July 27, 2019
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 DIVERSITY, 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 DIVERSITY IN enrollment of these groups at colleges of osteopathic medicine; and will work to identify and encourage SUCH qualified individuals from these groups for participation in those osteopathic affiliate and national activities which foster leadership opportunities. reaffirmed 1979; revised 1983, 1988, 1994; reaffirmed 1999, revised 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

ACTION TAKEN APPROVED as AMENDED

DATE July 27, 2019
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 AGENCY (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

ACTION TAKEN APPROVED

DATE July 27, 2019
SUBJECT: H338-A/14 DIVERSITY IN LEADERSHIP POSITIONS

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

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

H338-A/14 DIVERSITY IN LEADERSHIP POSITIONS

The American Osteopathic Association supports increased awareness of and encourages diversity in its leadership positions and encourages its divisional and specialty societies to do the same. 1999, revised 2004; reaffirmed 2009; reaffirmed as amended 2014

ACTION TAKEN APPROVED

DATE July 27, 2019
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H39-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.


ACTION TAKEN APPROVED

DATE July 27, 2019
RESOLVED, that the Bureau on Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H344-A/14 SURPRISE 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 expenses for which they are not prepared. 2014

ACTION TAKEN APPROVED

DATE July 27, 2019
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

ACTION TAKEN APPROVED

DATE: July 27, 2019
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

ACTION TAKEN APPROVED

DATE July 27, 2019
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 SUPPORTS PARTICIPATION IN PATIENT satisfaction surveys have a significant MINIMAL impact on osteopathic physician’s compensation PAYMENT. 2014

ACTION TAKEN APPROVED as AMENDED

DATE July 27, 2019
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 THE physician-PATIENT RELATIONSHIP authority over patient care and protecting patient safety; and, be it further

RESOLVED, THAT FDA APPROVED DRUGS SHOULD BE ACCESSIBLE TO PATIENTS, AND, BE IT FURTHER

RESOLVED, THAT THE DECISION ON WHICH BIOLOGIC OR BIOSIMILAR SHOULD BE USED REST WITH THE PATIENT AND THE PHYSICIAN; AND, BE IT FURTHER

RESOLVED, THAT THE AOA SUPPORTS PAYOR COVERAGE OF ALL FDA-APPROVED BIOLOGICS AND BIOSIMILARS TO ENHANCE PATIENT ACCESS AND CHOICE. 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.


ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**
RES. NO. H-335 - A/2019 – Page 1

SUBJECT: MATERNAL MORTALITY

SUBMITTED BY: American College of Osteopathic Obstetricians and Gynecologists

REFERRED TO: Committee on Professional Affairs

WHEREAS, the United States is the only industrialized nation with a rising maternal mortality rate¹; and

WHEREAS, it is estimated that over 60% of the pregnancy related deaths are preventable²; 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.²

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 RELEVANT specialty medical societies to advocate for state and federal legislation TO establishing AND MAINTAIN Maternal Mortality Review Committees; and (3) work with state and RELEVANT 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 **APPROVED as AMENDED**

DATE **July 27, 2019**
SUBJECT: EXTENDING MEDICAID COVERAGE TO 12 MONTHS POSTPARTUM

SUBMITTED BY: American College of Osteopathic Obstetricians and Gynecologists

REFERRED TO: Committee on Professional Affairs

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
Reference Committee Explanatory Statement
See references from H-335 – A/2019 which show that a majority of pregnancy-related preventable deaths occur during the postpartum period.

ACTION TAKEN APPROVED as AMENDED

DATE July 27, 2019
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.

Reference Committee Explanatory Statement
The Committee is concerned that this creates a definition that is inconsistent with how New Physician in Practice is defined for purposes of the New Physician in Practice position on the Board of Trustees.

ACTION TAKEN REFERRED (to AOA Governance and Organizational Structure, Subcommittee on Constitution and Bylaws)

DATE July 27, 2019
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 EVIDENCE OF AND COMMITMENT 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.


ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**
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.

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. 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. 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. 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).
PHARMACY BENEFIT MANAGERS

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 AOA SUPPORTS HEALTH POLICY WHICH PROMOTES MAKING LIFE SAVING MEDICATIONS (I.E. EPINEPHRINE FOR ANAPHYLAXIS, NALOXONE FOR DRUG OVERDOSE, AND INSULIN/GLUCAGON FOR DIABETES) FREE FOR UNINSURED PATIENTS AND A FULLY COVERED BENEFIT FOR INSURED PATIENTS.

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

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

ACTION TAKEN _APPROVED as AMENDED_

DATE _July 27, 2019_
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

Whereas, firearm-related deaths in the United States have increased to a twenty year high; and

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 countries; and

Whereas, firearms are the third-leading cause of death due to injury after poisoning and motor vehicle accidents; and

Whereas, firearms are the third-leading cause of death due to injury after poisoning and motor vehicle accidents; and

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

Whereas, gun violence in the United States had a total societal cost of $229 billion in 2015; and

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 purchase; an estimated 6.6 million firearms are sold annually with no background checks; now, therefore be it

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

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

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

Reference Committee Explanatory Statement
The Committee supports firearm safety training, and recommends that this be rewritten to focus on public health policy, in accordance with the AOA’s Mission Statement.

ACTION TAKEN REFERRED (to Bureau on Federal Health Programs)

DATE July 27, 2019
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.\textsuperscript{1,2,3} The National Institute of
Health (NIH) describes “cloning” as a process “that can be used to produce genetically identical copies
of a biological entity”.\textsuperscript{4} 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.\(^4,5\) 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.\(^5,6\) Therapeutic cloning is often the center of most debates for many regarding balancing patient care, morals and ethics.

Arguments against therapeutic and reproductive cloning\(^6\):

- 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\(^6\):

- 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).\(^6,7\) 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.\(^8\) 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.\(^9\)

In an effort to address the void left by the federal government, several state legislatures have provided guidance on human cloning.\(^7\)
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.

Twenty-six (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:

1. **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. 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.

2. **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. Additionally, the AAMC recommends a ban on all forms of reproductive cloning.


4. **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.

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\textsuperscript{16}

\textbf{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.\textsuperscript{17}

\textbf{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.

\textbf{REFERENCES}

10. HB1399 (April 2019).

ACTION TAKEN APPROVED

DATE July 27, 2019
RES. NO. H-342 - A/2019 – Page 1

SUBJECT: MISALIGNED INCENTIVES IN MEDICARE PLANS

SUBMITTED BY: Florida Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

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 ADVOCATE FOR CHANGES TO THE MEDICARE PROGRAM THAT SUPPORT PHYSICIANS IN DELIVERING HIGH-VALUE CARE AND DISCOURAGE PLANS FROM PREVENTING PATIENTS FROM SEEKING LOWER COST-EFFECTIVE TREATMENT OPTIONS;; and, be it further

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

RESOLVED, that the AOA will advocate AGAINST for the prohibition of misaligned PAYMENT AND QUALITY incentives in Federal Healthcare programs THAT DO NOT PROMOTE IMPROVED HEALTH OUTCOMES through legislation and other regulations designed to prevent competing incentives.; AND, BE IT FURTHER

RESOLVED, THAT THE AOA WORKS TO EDUCATE THE NCQA REGARDING THE NEED TO MODIFY HEDIS RULES.
ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**
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.

ACTION TAKEN APPROVED

DATE July 27, 2019
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

Reference Committee Explanatory Statement
The Committee believes that this Resolution is duplicative of H629-A/19 CLINICAL DATA REGISTRIES AND QUALIFIED CLINICAL DATA REGISTRIES.

ACTION TAKEN DISAPPROVED
DATE July 27, 2019
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.
Reference Committee Explanatory Statement
The Committee is concerned that this resolution is too broad and requests that it be clarified and that it acknowledge legal limitations which restrict information disclosure and dissemination.

ACTION TAKEN REFERRED (to Kentucky Osteopathic Medical Association)

DATE July 27, 2019
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


ACTION TAKEN APPROVED

DATE July 27, 2019
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

Reference Committee Explanatory Statement
The resolution calls for the AOA to provide detailed confidential business information and reports to affiliated organizations that owe no fiduciary responsibilities to the AOA, creating a risk of public release of confidential information. Moreover, the proposed disclosures are unnecessary and excessive. The AOA already makes contact information available for its Trustees (FirstInitial.LastNameDO@osteopathic.org), makes tax and financial information available to members on request, its 990 tax returns are available on-line, and it provides detailed budget and expenditure information to existing appropriate oversight bodies (Finance Committee oversight of audit process, Joint Board-House Budget Review Committee).

ACTION TAKEN DISAPPROVED
DATE July 27, 2019
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 be it further

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


Reference Committee Explanatory Statement

The Committee believes that existing policy H338-A/18 UNINSURED – ACCESS TO HEALTH CARE is more comprehensive and covers the concerns of this resolution. Further, this resolution may be overly prescriptive, veer outside of health care policy, and does not appropriately take into account the financial constraints of states, as well as other state-based health care programs that may be in place.

ACTION TAKEN DISAPPROVED

DATE July 27, 2019
RES. NO. H-349 - A/2019 – Page 1

SUBJECT: SUPPORT FOR OMT PRIVILEGES

SUBMITTED BY: Osteopathic Physicians and Surgeons of California

REFERRED TO: Committee on Professional Affairs

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 APPROVED

DATE July 27, 2019
SUBJECT: ANTI-INTIMIDATION STANDARDS AMONG PHYSICIANS

SUBMITTED BY: Pennsylvania Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

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.
Reference Committee Explanatory Statement
The Committee believes that H505-A/19 AOA RULES AND GUIDELINES ON PHYSICIANS’ PROFESSIONAL CONDUCT covers the concerns of this resolution.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**
SUBJECT: ADVOCATING FOR WOMEN'S RIGHT TO REPRODUCTIVE HEALTHCARE ACCESS AND SUPPORT OF ROE V. WADE

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

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, (.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
morbidities, defined as “conditions either unique to pregnancy or potentially exacerbated by pregnancy that occurred in at least 5% of all pregnancies” is significantly higher among women who give birth than among those who have abortions.”9; and

WHEREAS, “the evidence suggests that unintended pregnancy is one of the most critical challenges facing the public health system and imposes significant financial and social costs on society. Long-term studies confirm that reducing unintended pregnancy incidences would increase labor force participation rates, improve academic achievement, have better economic efficiency, increase the level of health and reduce in crime rates among vulnerable groups.”10; and

WHEREAS, the American College of Obstetrics and Gynecology (ACOG) holds and supports the committee opinion for clinical guidelines on women’s reproductive health and rights that “safe, legal abortion is a necessary component of women’s health care… Legislative restrictions fundamentally interfere with the patient-provider relationship and decrease access to abortion for all women, and particularly for low-income women and those living long distances from health care providers.”4; and

WHEREAS, ACOG, which currently represents 58,000 OG/GYNs in the U.S. and abroad8, and the American Congress of Obstetricians and Gynecology published a position statement in 2016 emphasizing that “…Prohibitions on essential care that are based on religious or other non-scientific grounds can jeopardize women’s health and safety.”5; and

WHEREAS, physicians are trained to serve with the patient’s best interest in mind, regardless 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.

Reference Committee Explanatory Statement
The Committee recognizes that this is a divisive topic, and wishes to respect individual physician and patient beliefs. The Committee supports comprehensive reproductive health care, as well as policies that support care for patient populations while protecting the individual physician-patient relationship as reflected in H358-A/19 INTERFERENCE LAWS; however, it feels that the content of this resolution veers overly into politics.

ACTION TAKEN DISAPPROVED

DATE July 27, 2019
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 2020; 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 psychiatry; 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 television; and

WHEREAS, viewers of certain medical dramas perceive what they view on TV as credible 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”; 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.

Reference Committee Explanatory Statement
Due to organizational resource limitations, existing branding campaign, and high-profile osteopathic physicians on social media BOT feels that this resolution is appropriately addressed through existing channels. Further, the Committee believes that “advocating” and “lobbying for” this resolution falls outside the approved scope and resources of AOA departments.

ACTION TAKEN DISAPPROVED

DATE July 27, 2019
SUBJECT: DECRIMINALIZATION OF SELF-INDUCED ABORTION

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

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
Reference Committee Explanatory Statement
The Committee supports harm reduction strategies that encourage patients to seek needed health care without fear of legal repercussions, as in the case of a minor who may avoid seeking treatment for illness resulting from underage drinking in addition to the intent of this resolution; however, the Committee believes that the resolution should be referred back to SOMA for clarification and refinement.

ACTION TAKEN REFERRED (to Student Osteopathic Medical Association)

DATE July 27, 2019
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 licenses; 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.

Reference Committee Explanatory Statement
The Committee recommends the approval of H-362 SAFE HAVEN NON-REPORTING PROTECTION FOR PHYSICIAN – SUPPORT FOR in lieu of this resolution, as it encompasses the Resolveds of this resolution as well as other considerations.

ACTION TAKEN DISAPPROVED

DATE July 27, 2019
SUBJECT: OPPOSING TARGETED REGULATION OF ABORTION PROVIDERS (TRAP LAWS)

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

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 APPROVED

DATE July 27, 2019
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.\(^1\) 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.\(^2\) Recent data suggest physician burnout costs \$4.6\ billion dollars yearly.\(^3\) and the World Health Organization recently re-classified burnout as an “Occupational Phenomenon;”\(^4\) 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;\(^5\) 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\(^6\); 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 APPROVED

DATE July 27, 2019
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

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.

Reference Committee Explanatory Statement
As per AOA policy will be referred to Finance Committee for fiscal analysis.

ACTION TAKEN REFERRED (to AOA Finance Committee)

DATE July 27, 2019
WHEREAS, resolution H305-A/2018 titled H307-A/2013 INTERFERENCE LAWS was referred to the Bureau on Federal Health Programs and Bureau of State Government
Affairs for adding updated information to the policy; now therefore be it

RESOLVED, that the Bureau of Federal Health Programs and the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H307-A/13 INTERFERENCE LAWS

The American Osteopathic Association approved the following policy paper and recommendations to assist in responding to state and federal proposals and agencies that attempt to adopt interference laws (2013).

Several A NUMBER OF states have pursued legislation that dictates how physicians treat and counsel patients during a medical exam. These laws interfere with the patient-physician relationship, and undermine physician judgment AND REPRESENT a departure from evidence-based medicine. As a result, these laws are collectively referred to as “interference laws.”

There are four different classifications of interference laws. INTERFERENCE LAWS FALL INTO ONE OF FOUR DIFFERENT CLASSIFICATIONS.¹ The first prevents physicians from asking their patients about risk factors that may affect their health or the health of their families (PHYSICIAN “GAG LAWS”). An example OF A GAG LAW of this law is a 2011 Florida law which limited BARRED physicians from asking questions about a patient’s gun ownership.² The law WAS ENJOINED IN 2012 ON FIRST AMENDMENTS GROUNDS, A DECISION WHICH WAS UPHELD BY A FEDERAL APPEALS COURT IN 2017.³ Although 14 OTHER STATES HAVE CONSIDERED SIMILAR LAWS, NONE HAVE PASSED.⁴ It was no longer in effect as it was permanently enjoined in June 2012. This issue resurfaced in January 2013 when President Obama signed 23 executive orders regarding gun control. The President’s 16th executive order clarified that the Affordable Care Act “does not prohibit doctors from asking patients about guns in their homes.”²²

The second type of interference law requires physicians to discuss specific treatments that may not be APPROPRIATE OR medically necessary.⁵ Examples ONE EXAMPLE of this include IS NEW YORK’S PALLIATIVE CARE INFORMATION ACT OF 2011, WHICH REQUIRES HEALTH CARE PROVIDERS TO OFFER TO DISCUSS END-OF-LIFE OPTIONS laws which require physicians to offer patients information about end of life care. These efforts have also been pursued at the federal level, where in 2011 the Obama Administration attempted to promulgate regulations under the Affordable Care Act that would pay physicians for counseling Medicare patients on end of life options. Some argue that requiring physicians to discuss this subject with all patients is inappropriate, because physicians are AND PALLIATIVE CARE SERVICES WITH TERMINALLY ILL PATIENTS, WITHOUT DISCRETION AS TO HOW AND WHEN TO RAISE THE ISSUES.⁶
SOME ARGUE THAT REQUIRING PHYSICIANS TO DISCUSS THIS SUBJECT WITH ALL PATIENTS IS INAPPROPRIATE, BECAUSE PHYSICIANS ARE not able to use their judgment to determine which IF OR WHEN patients should receive such sensitive information. Further examples are laws which require physicians to inform women about their breast density when obtaining a mammogram, and laws which require physicians to inform patients that a negative test result for Lyme disease may not be accurate.

The third type of interference law requires physicians to provide tests or treatments which are not supported by evidence, including ones that are invasive or required without the patient’s consent. Examples of this are laws which require physicians who perform abortions to first perform a fetal ultrasound. It is argued that a fetal ultrasound is medically unnecessary and not supported by evidence-based medicine. THERE IS NO LEGITIMATE MEDICAL PURPOSE FOR REQUIRING ONE IN THIS CIRCUMSTANCE.

The fourth and final type of interference law places restrictions on the content of information that physicians can disclose to patients. Examples of this include laws which limit a physician from providing information about the dangers of chemicals used in the hydraulic fracturing process, also known as “fracking.”

Impact on the Osteopathic Medical Profession and THE Patient-Physician Relationship

Interference laws threaten the osteopathic medical profession, in particular due to the intrusion INTO THE of patient-physician relationship, which is an essential component of the osteopathic care model’s emphasis on preventive medicine and treatment of the whole patient. The patient-physician relationship is based on ethical principles of trust, confidentiality, respect, autonomy and open communication between the physician and patient.

Another critical element of osteopathic medical practice in general and the patient-physician relationship in particular is the concept of physician and patient autonomy and “patient-centered” care. The Institute of Medicine (IOM) defines patient-centered care as “providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.” Patient-centered care is an essential element in the practice of evidence-based medicine. THE American Osteopathic Association (AOA) policy supports the use of evidence-based medicine and the implementation of “all APPROPRIATE methods appropriate to optimize natural healing and to address the primary cause of disease.” The patient-physician relationship is a critical aspect of osteopathic care, due in large part to a partnership that is created between the physician and patient which relies heavily on communication. “Osteopathic physicians (DOs) consider the impact that lifestyle and community have on the health of each individual, and they work to break down barriers to good health. Osteopathic Physicians (DOs) are trained to look at the whole person, and osteopathic physicians integrate the patient into the health care delivery process as a partner.” Interference laws which prevent DOs from discussing certain health-related subjects such as the safe storage of firearms or the health implications of fracking undermine this partnership and violates the osteopathic principle of preventive medicine. If a DO is not allowed to adequately counsel a patient on the dangers of a loaded and the safe storage of firearms, they are unable to provide information which may prevent a firearm-related death in the patient’s household. IMPLICATIONS OF FRACKING UNDERMINE THIS PARTNERSHIP AND VIOLATE THE OSTEOPATHIC PRINCIPLE OF PREVENTIVE MEDICINE. DOs HELP PREVENT PEDIATRIC DEATHS BY COUNSELING CAREGIVERS ON THE IMPORTANCE
OF SEATBELT AND HELMET USE, BUT WITHOUT THE ABILITY TO ADEQUATELY
COUNSEL A PATIENT ON THE IMPORTANCE OF SAFE FIREARM STORAGE THEY MAY
BE UNABLE TO HELP PREVENT SIMILAR DEATHS FROM IMPROPERLY STORED
FIREARMS. “[T]he purpose of [a firearms] inquiry is so that the practitioner can determine what
subject matters require further follow-up in the practice of preventive medicine.”14 THE AOA policy
rejects any censorship of professional communication, supports enactment of legislation protecting the
patient-physician relationship and opposes any attempt to interfere with the patient-physician
relationship.15

Additionally, interference laws that require DOs to discuss treatments which are not medically
necessary or are not supported by evidence-based guidelines violates the osteopathic principle of
treating the whole patient and can undermine patient trust. IN KANSAS, FOR EXAMPLE,
PHYSICIANS ARE REQUIRED TO PROVIDE MISLEADING INFORMATION TO PATIENTS
REGARDING AN UNPROVEN LINK BETWEEN BREAST CANCER AND ABORTION.16 If a
DO is always required to provide information on a certain treatment, they are unable to treat the whole
patient in an objective manner, thereby preventing the DO from exercising their judgment as a
physician. TWENTY-THREE STATES CURRENTLY REQUIRE HEALTH CARE PROVIDERS
TO REFER PATIENTS TO STATE-CREATED “INFORMED CONSENT” MATERIALS, AND
ACCORDING TO A 2016 AUDIT BY RUTGERS UNIVERSITY, 31 PERCENT OF THE
INFORMATION INCLUDED IN THESE MATERIALS WAS FOUND TO BE MEDICALLY
INACCURATE.17 BLANKET REQUIREMENTS THAT DOs PROVIDE INFORMATION ON A
PARTICULAR TREATMENT, OR MEDICALLY INACCURATE INFORMATION, TO ALL
PATIENTS PREVENTS THEM FROM EXERCISING THEIR INDEPENDENT MEDICAL
JUDGMENT AND TREATING THE WHOLE PATIENT IN AN OBJECTIVE, EVIDENCE-
BASED MANNER. Similarly, interference laws which require DOs to perform certain procedures or
treatments violate the osteopathic principle of providing individualized patient-centered care. If a DO is
required to perform a certain procedure or treatment for every patient, there is no individualized
assessment as to what is in a particular patient’s best interests and there is no discussion with the patient
because the patient has no choice. Instead of individualized care, this is a “one size fits all” approach.
Ultimately, DOs are prevented from rendering individualized, evidence-based care, and patients are
prevented from being involved in patient-centered care.

Legal Challenges
Two types of interference laws have been challenged in court. Florida’s controversial Firearm Owner’s
Privacy Act, which restricted physicians from asking patients about firearm ownership, was
permanently enjoined in June 2012 when a Florida district court found that it violated physicians’ First
Amendment rights, A DECISION WHICH WAS UPHELD BY A FEDERAL APPEALS COURT
IN 2017. In granting the injunction, the judge stated the law “chills practitioners’ speech in a way that
impairs the provision of medical care and may ultimately harm the patient.”18 The court also held that
physician questioning did not violate patients’ Second Amendment rights stating, “[t]he law does not
affect nor interfere with a patient’s right to continue to own, possess, or use firearms.

Protecting the right to keep and bear arms is irrelevant to this law.”19 IN ADDITION, A SIMILAR
2012 LAW WHICH PREVENTED PHYSICIANS IN PENNSYLVANIA FROM DISCUSSING
HOW FRACKING CHEMICALS MAY BE AFFECTING THEIR PATIENTS’ HEALTH WAS
STRUCK DOWN BY THE STATE SUPREME COURT IN 2016.20

Mandatory ultrasound laws have also been challenged on First Amendment grounds. North Carolina’s
mandatory ultrasound law was struck down as a violation of physician and patient First Amendment
rights. The court held that “[t]he Act goes well beyond requiring disclosure of those items traditionally a
part of the informed consent process. In this case, the state compels the provider to physically speak and show the state’s non-medical message to patients unwilling to hear or see [that message].

Conversely, **a nearly identical Kentucky law was upheld by a federal appeals court**, the Fifth Circuit Court of Appeals upheld a similar mandatory ultrasound law in Texas, which found that the law was reasonably related to the “informed consent” process and did not violate the First Amendment rights of physicians and patients.  

Significantly, the recent decision by circuit split between the courts the Fifth Circuit Court of Appeals sets up a possible circuit split with the Fourth Circuit Court of Appeals and sets up a probable hearing by the United States Supreme Court on the issue of mandatory ultrasound laws.

Mandatory ultrasound laws have also been challenged in court on Fourteenth Amendment Substantive Due Process grounds. A mandatory ultrasound law in Oklahoma was ruled to be unconstitutional as a violation of patients’ Fourteenth Amendment due process rights, because it placed an “undue burden” on a woman’s right to seek an abortion.

**Efforts of Medical Associations**

Several medical associations have developed policies or taken action in opposition to interference laws. In 2015, the American Medical Association (AMA) adopted reaffirmed a 2011 resolution which opposes any intrusion into patient-physician relationships and supports physician judgment. In October 2012, the American Academy of Family Physicians (AAFP), The American Academy of Pediatrics, The American College of Obstetricians and Gynecologists and the American College of Physicians issued a set of joint principles based upon their organizations’ policies which oppose governmental interference with physicians’ obligations to provide comprehensive, evidence-based information to patients.

Passed a resolution supporting the patient-physician relationship and opposing all legislative attempts to interfere with this relationship. Additionally, in July 2012, the American College of Physicians (ACP) adopted a resolution which set forth seven principles for federal and state governments to follow when attempting to interfere with the patient-physician relationship. Further, in October 2012, the heads of five medical associations (ACP, AAFP, ACOG, AAP, ACS) came together to publish an article in the New England Journal of Medicine. The article promotes physician autonomy, empowering patients to make informed decisions about their care, and preventing legislators from interfering with the patient-physician relationship. In January 2013, the Council of Medical Specialty Societies (CMSS) adopted this article as policy.

In August 2012, the American Bar Association (ABA) also adopted a resolution specifically opposing laws which prevent physicians from asking patients about firearm ownership. The ABA resolution states that these laws clearly violate the First Amendment rights of physicians and patients, and physician questioning does not in any way violate Second Amendment rights of patients.

Finally, several state medical associations have adopted resolutions on the issue of interference laws. Many of these policies are very basic and simply state the association’s opposition to any interference with the patient-physician relationship. Additionally, these policies often promote the use of evidence-based medicine, seek to preserve physician judgment and support litigation which blocks the enforcement of interference laws.

**Conclusion**
The AOA supports the protection of the patient-physician relationship as especially paramount to the osteopathic medical profession. The osteopathic care model is based upon the treatment of the whole patient and the use of preventive medicine. The patient-physician relationship is a critical FUNDAMENTAL aspect of osteopathic care, due in large part to a partnership that is created between the physician and patient which relies heavily on communication AND TRUST. Interference laws encroach on this relationship and undermine the osteopathic care model by preventing DOs from providing treatment in a manner THAT IS BASED UPON EVIDENCE they believe is best for their patients.

The AOA affirms that legislation which interferes with the patient-physician relationship impairs the autonomy of osteopathic physicians and prevents osteopathic physicians from using their best INDEPENDENT MEDICAL judgment based on years of rigorous education and training.

The AOA asserts that physicians must be able to communicate freely with patients without fear of government intrusion in order to assure safe, comprehensive and effective medical treatment. The AOA considers that legislation which THAT undermines physician judgment TO BE is a barrier to evidence-based medicine. The AOA supports the use of evidence-based medicine to ensure high quality patient care. Statutorily required medical practices interfere with evidence-based medicine by mandating a “one size fits all approach,” thereby preventing an individualized assessment of what is in a particular patient’s best interests.

The AOA affirms that legislation which interferes with the patient-physician relationship undermines patient-centered care. Patient-centered care actively involves the patient in making decisions regarding their own medical care. Statutorily required medical practices prevent patients from being involved in making medical decisions, because the patient has no choice.

The AOA affirms BELIEVES THAT the ethical principle of informed consent is undermined when patients are statutorily required to undergo certain treatments or procedures, because the patient has no choice.

The AOA opposes all legislation at the state and federal level which THAT requires physicians to discuss or perform certain treatments or procedures not supported by evidence-based guidelines, because such legislation undermines physician judgment.

The AOA opposes all legislation at the state and federal level which prevents physicians from discussing certain health-related risk factors with their patients, because such legislation violates the First Amendment rights of physicians and patients AND IS IN CONFLICT WITH EVIDENCE-BASED MEDICAL BEST PRACTICES.

The AOA believes that physicians should be free to counsel patients on end-of-life care on a case-by-case basis rather than AS A RESULT OF an across-the-board mandate.

The AOA supports court LEGAL challenges of TO interference laws that violate First Amendment and Fourteenth Amendment rights of physicians and patients under THE State and Federal Constitutions.

The AOA will monitor state and federal interference laws on an ongoing basis and update this policy as needed.

References

3. Id.

4. Id.

5. Weinberger, *supra*.


7. Weinberger, *supra*.

8. Id.


13. AACOM, *supra*.


15. AOA Policy H233-A/06, *Patient-Physician Relations*.


19. Id.


ACTION TAKEN **APPROVED**

DATE **July 27, 2019**
WHEREAS, resolution H306-A/2018 titled H308-A/2018 STATE GRADUATE MEDICAL EDUCATION (GME) FUNDING ALTERNATIVES was referred to the Bureau of State Government Affairs for updating; now, therefore be it

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

H308-A/13 STATE GRADUATE MEDICAL EDUCATION (GME) FUNDING ALTERNATIVES

The following policy paper and the recommendations provided within are approved to assist the American Osteopathic Association in responding to policy proposals aimed at funding graduate medical education (GME) at the state-level; the AOA will work with the osteopathic community to encourage and support state-level GME funding initiatives that encompass the principles outlined within this paper. (2013).

AOA POLICY PAPER:
STATE GRADUATE MEDICAL EDUCATION FUNDING

BACKGROUND
Physician training requires students to attend four years of medical school, usually paying those costs out-of-pocket or through loans. Following successful completion of medical school, their training continues as medical residents. Medical residents see and treat patients under the supervision of more experienced physicians. This training usually takes place in hospitals though residents often rotate to ambulatory sites such as clinics and physician offices. On average, this residency training takes four years to complete, although highly specialized fields may require longer training.

By and large, overall funding for graduate medical education (GME) comes from patient care revenues. However, the FEDERAL GOVERNMENT IS currently THE single largest SINGLE funder of GME, is the Department of Health and Human Services (HHS) PROVIDING APPROXIMATELY $15.9 BILLION IN FUNDING through the Centers for Medicare and Medicaid Services (CMS) IN 2018. NEARLY TWO-THIRDS OF THIS FUNDING COMES FROM MEDICARE, WITH THE MAJORITY OF THE REMAINDER FUNDED THROUGH MEDICAID. The federal government contributes approximately $159.5 billion in Medicare funds and approximately $2 billion in Medicaid dollars to help pay for GME. Additional funding is provided by the Department of Defense, the Department of Veterans Affairs and the U.S. Public Health Service. In providing Medicare funding, Congress has acknowledged that training physicians is a public good. Despite that acknowledgement, there have been periodic calls to remove GME from Medicare and Medicaid and secure other sources of funding. So far, Congress has neither acted on these recommendations nor
have other entities stepped up to assume a greater share of the financial responsibility (relative to Medicare or Medicaid) for physician training.

With calls to reduce federal spending, WITH CAPS ON THE FEDERAL BUDGET, GME FUNDING HAS BEEN AND WILL CONTINUE TO BE RELATIVELY FLAT. ADDITIONALLY, is potentially faced with a significant reduction in funding. The Obama THE TRUMP Administration and several members of Congress have HAS spoken out in favor of SUPPORTED BOTH CONSOLIDATION AND reduction OF GME funding as part of a comprehensive approach to reducing overall federal spending. ADDITIONALLY, IN DECEMBER 2018, THE CONGRESSIONAL BUDGET OFFICE ISSUED RECOMMENDATIONS TO CONSOLIDATE AND REDUCE FEDERAL PAYMENTS FOR GME AT TEACHING HOSPITALS, several bills have been introduced at the federal level that attempt to address GME funding shortages. Conversely, medical schools, hospitals and medical associations see a need to increase funding and residency slots to help train physicians and fill projected workforce shortages and are working at both the state and federal levels to achieve increased funding for GME.

There are two mechanisms in THROUGH which Medicare and Medicaid distribute GME funding: direct medical education (DME) and indirect medical education (IME) payments. DME payments are based on resident salaries, supervision and other educational costs. IME payments are based on additional operating costs of a hospital with a GME program. One of the greatest OBSTACLES TO federal GME funding is the Balanced Budget Act of 1997 (BBA), which limited the number of allopathic and osteopathic residents a hospital can count for purposes of DME and IME payment. The law also reduced the IME multiplier over a four-year period, however, the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) delayed the IME reduction. Additionally, the Budget Control Act of 2011 enacted a series of automatic budget cuts that included a 2% cut for IME payments WHICH TOOK taking effect on April 1, 2013.

MEDICARE

The formula for determining Medicare payments to hospitals for direct costs of approved GME programs is established in section 1886(h) of the Social Security Act (the Act). A DME payment is determined by multiplying a hospital-specific, base-period per resident amount by the weighted number of full-time equivalent residents working in all areas of the hospital and the hospital’s Medicare share of total inpatient days. The Affordable Care Act amended section 1886(h)(4)(E) to allow a hospital to count residents training in non-hospital settings if the residents are engaged in patient care activities and if the hospital incurs the costs of the stipends and fringe benefits of the resident during the time residents spend in that setting.

As previously mentioned, IME payments are based on additional operating costs of a GME program. The factors for IME payment generally include sicker/more complex patients, maintaining stand-by capacity for certain specialized services (e.g. burn units), residents ordering more tests and trainees being less efficient in providing care. IME payments provide for the legitimate increase in costs training hospitals incur. IME payments are calculated by adding the individual intern/resident-to-bed ratio into
a formula already established in the Medicare statute. The current IME adjustment is calculated using a multiplier set at 1.35, which means that a teaching hospital will receive an increase of approximately 5.5% in Medicare payments for every 10-resident increase per 100 beds.

MEDICAID

Despite **FEDERAL LAW NOT REQUIRING STATE MEDICAID PROGRAMS TO SUPPORT GME**, being under no obligation to do so, Medicaid is the second largest **FUNDER OF** contributor to GME programs. Several **A MAJORITY OF** states have implemented mechanisms within their Medicaid programs to supplement federal funding of GME. In most cases, Medicaid GME funding is structured similarly to Medicare, providing direct and indirect payments. The most recent data available estimates that Medicaid paid **APPROXIMATELY $43.3 billion** to GME programs in 2015, up from **$3.87 billion** in 2010. From **DESPITE THE FACT** that **MUCH OF THAT FUNDING** at least half came from matching federal payments, **THREE STATES REPORTED THAT THEY EXPLICITLY REDUCED THEIR MEDICAID SPENDING ON GME, AND ANOTHER SEVEN REPORTED AT LEAST A TEN PERCENT REDUCTION IN MEDICAID GME PAYMENTS BETWEEN 2012 AND 2015.** However, several states have reduced their funding for GME programs through their Medicaid programs.

In 2005, 47 states provided $3.18 billion through Medicaid to support GME. By 2015, only 42 states and the District of Columbia (DC) supported GME through their Medicaid program. Arizona, Massachusetts, Montana, Rhode Island, Vermont and Wyoming have since ended GME funding, citing budget shortfalls, **AND ALABAMA, MICHIGAN AND TENNESE REPORTED THAT THEY RECENTLY CONSIDERED ENDING FUNDING AS WELL.** Additionally, some states like Iowa, Michigan, Oregon and Pennsylvania, have discussed ending Medicaid support for GME. **TWELVE STATES REPORTED CALCULATING PAYMENTS SOLELY BY “SOME OTHER METHOD” IN 2015.**

Medicaid Fee-for-Service

Forty states and the District of Columbia make DME and/or IME payments under the Medicaid fee-for-service program. A fee-for-service program is a payment model where services are unbundled and paid for separately. Twelve **FOURTEEN** states and DC fund DME and/or IME programs using a calculation method similar to Medicare’s GME funding formula, **SOMETIMES IN ADDITION TO OTHER METHODS.** The remaining states calculate payments by “some other method,” which usually includes a variation of a per-resident or lump-sum amount. The per-resident or lump-sum amount **ARE** based on the “hospital’s share of total Medicaid revenues, costs or patient volumes.” **TWENTY-NINE STATES REPORTED CALCULATING PAYMENTS SOLELY BY “SOME OTHER METHOD” IN 2015.**

Medicaid Managed Care

Capitated managed care is a state’s use of risk-based capitation payments within their Medicaid program. This typically includes contracting with one or multiple managed care organizations (MCOs) to administer the Medicaid program for a defined population of Medicaid patients. Thirty **NINE** states and DC use capitated Medicaid managed care programs. Currently, **23 states and DC included DME and/or IME payments under their Medicaid managed care programs.** Fourteen **SIXTEEN states and DC directly pay teaching hospitals or other teaching programs under Medicaid for DME and/or IME payments.** This **REPRESENTS a N INCREASE** decline in the number of states who have made direct payments under managed care **SINCE 2012.** States who make direct Medicaid payments indicate **THAT** they wish to help train future physicians who will service Medicaid beneficiaries and that using Medicaid funds to fund GME programs will help advance state
health policy goals. Five of these states pay for both DME and IME costs and three states do not distinguish between the two costs.¹

Nine TWELVE states recognize and include Medicaid DME and/or IME payments in their capitated payment rates to managed care organizations. Five HALF of these states – IOWA, Kansas, Kentucky, Michigan, Oregon MINNESOTA and Washington MISSISSIPPI – require MCOs to distribute the negotiated payments to teaching hospitals. The other four SIX assume MCOs will distribute the payments.²

ALIGNING GME FUNDING WITH HEALTH POLICY PRIORITIES

States continue to look to align GME funding with other health policy goals. This can include increased funding for training in certain specialties, addressing workforce shortages in rural and underserved areas and increasing faculty positions to train new physicians. A 2016 STUDY REVEALED THAT THIRTY-TWO STATES LINKED MEDICAID GME PAYMENTS TO A STATE POLICY GOAL OF INCREASING THE SIZE OF THE PHYSICIAN WORKFORCE, COMPARED TO 22 STATES IN 2012.²

Kansas and Florida AND KANSAS In an effort to promote accountability in the use of GME funds, Kansas and Florida AND KANSAS link Medicaid GME payments to stated state policy goals. Kansas IN FLORIDA, THIS applies to both fee-for-service (FFS) and managed care Medicaid programs, while Florida KANSAS GME payments focus ES SOLELY on fee-for-service FFS payments.² Like most states, Kansas and Florida AND KANSAS have focused on encouraging training in primary care specialties AND INCREASING ACCESS TO CARE IN rural and medically underserved areas.

Kansas also uses GME payments to promote an increased supply of physicians serving the Medicaid population, and FUNDS TEACHING HOSPITALS AS WELL AS TEACHING SITES IN NON-HOSPITAL SETTINGS, increase the geographic distribution and fund teaching hospitals that have experienced GME funding cuts through the Medicare program. IN FLORIDA, GME PAYMENTS HAVE BEEN EXTENDED TO INDIVIDUAL TEACHING PHYSICIANS UNDER FFS. In addition to Medicare and Medicaid GME funding, Florida also THE STATE ALSO uses alternative sources to fund residency programs IN ADDITION TO MEDICAID AND MEDICARE, INCLUDING THE STATEWIDE MEDICAID RESIDENCY PROGRAM AND THE GRADUATE MEDICAL EDUCATION STARTUP BONUS PROGRAM, serving Veterans Administration medical, loan repayment for residents and physicians serving underserved or designated shortage areas after training, and offers state appropriations for additional funding to encourage new training opportunities and cost/resource sharing between groups.² THE FORMER WAS CREATED IN 2013 WITH $80 MILLION IN RECURRING STATE AND MATCHING FEDERAL FUNDS TO SUPPORT PAYMENTS TO HOSPITALS WITH ACCREDITED RESIDENCY PROGRAMS, WHILE THE LATTER WAS CREATED IN 2015 WITH $100 MILLION ALLOCATED TO EDUCATING AND TRAINING PHYSICIANS IN SPECIALTIES WHICH ARE IN A STATEWIDE DEFICIT. IN 2018, THE FLORIDA LEGISLATURE APPROPRIATED $242.3 MILLION TO THESE PROGRAMS.² Florida’s Community Hospital Education Act also provides funding intended for primary care specialties. This program appropriates state funds into the Medicaid program, with hospitals being paid directly from this fund to help support primary care specialty interns and residents.²

Texas

In 2014, 2007, the Texas legislature ALLOCATED $12 MILLION TO SEVERAL INITIATIVES WHICH TOGETHER CREATED 100 NEW RESIDENCY POSITIONS ACROSS NINE
NEW PRIMARY CARE AND TWO NON-PRIMARY CARE PROGRAMS.\textsuperscript{30} IN 2015, THE LEGISLATURE CONSOLIDATED THESE INITIATIVES INTO A SINGLE GME EXPANSION PROGRAM, TO WHICH IT APPROPRIATED $49.5 BILLION BIENNIALLY. THIS RESULTED IN AN INCREASE IN PER-RESIDENT FUNDING FROM $65,000 TO $75,000 PER YEAR AND THE CREATION OF 130 NEW RESIDENCY POSITIONS IN 2016-2017.\textsuperscript{31} Authorized an additional $62.8 million in state funding for GME positions and for faculty costs. However, the additional funding was not enough to pay for the growth necessary to keep up with the physician shortage.\textsuperscript{22} Texas saw a 50\% cut in its GME funding in 2012-2013. Per capita formula funding cut $25 million from its budget, now spending $4,400 per resident from $6,600. The Texas Higher Education Coordinating Board (THECB) family medicine residency funding saw a significant $15.6 million cut, from $21.2 million to $5.6 million. THECB Primary Care Residency Program ($5 million) and THECB GME Program ($600,000) were both cut altogether. Finally, the Physician Loan Repayment Program was cut by $17.7 million, from $23.3 million to $5.6 million.

SINCE 2009, THE Texas HEALTH AND HUMAN SERVICES COMMISSION (HHSC) HAS also provided\textsuperscript{32} supplemental funding TO FIVE STATE-OWNED TEACHING HOSPITALS for approved medical residency training programs. In the Texas Administrative Code, the Texas Health and Human Services Commission THE HHSC reimburses approved state-owned or state-operated teaching hospitals, the EACH hospital DIRECTLY USING A CALCULATION THAT IS BASED UPON THE HOSPITAL’S SELF-REPORTED MEDICAID INPATIENT DAYS AND RESIDENT FULL-TIME EQUIVALENTS. HHSC ALSO SEPARATELY PROVIDES IME PAYMENTS TO TEACHING HOSPITALS TO OFFSET THEIR HIGHER PATIENT CARE COSTS RELATIVE TO NON-TEACHING HOSPITALS, INCLUDING COSTS RELATED TO SUPERVISING AND MAINTAINING RESIDENT RECORDS.\textsuperscript{33} ‘s inpatient direct GME cost for hospital cost reports. The costs are calculated using a similar method as set out in Title XVIII of the Social Security Act.\textsuperscript{34}

THESE INCREASES FOLLOW YEARS OF CUTS TO GME FUNDING, INCLUDING A 50\% CUT IN 2012-2013, WHICH LED TO THE ELIMINATION OF THE TEXAS HIGHER EDUCATION COORDINATING BOARD (THECB) PRIMARY CARE RESIDENCY PROGRAM AND THE THECB GME PROGRAM IN 2019.

Utah
In 1997, Utah created the Utah Medical Education Council (UMEC) to address the state’s physician shortage and coordinate GME funding that would be better aligned with the state’s workforce needs.\textsuperscript{31} UMEC is a quasi-governmental body whose responsibilities include assessing the physician workforce demands, developing and suggesting policy, finding and disbursing GME funds, addressing physician shortages in rural locations and managing the GME funds from CMS.

To better address the state’s GME funding needs, Utah applied for, and was granted, a CMS waiver that placed GME funding into a funding pool, rather than directing money to hospitals.\textsuperscript{32} By pooling all of the state’s GME funding, UMEC was able to distribute the funds directly to hospitals and programs based on specific workforce needs and objectives.\textsuperscript{34} THE WAIVER RESULTED IN A 29% INCREASE. The waiver has had noticeable results: the number of residents in Utah increased 29\% between 1997 and 2007, from 442 residents in 25 programs to 568 residents in 30 programs.\textsuperscript{35} Training hospitals and programs are now accountable to UMEC for how the GME funds are spent. UMEC also worked with training programs to encourage residents to practice in Utah. Workforce coordination efforts also identified new rural training opportunities in areas like family medicine, general surgery, internal medicine, pediatrics and psychiatry.\textsuperscript{36} The, BUT waiver ultimately ended on June 30, 2010.\textsuperscript{36}

ACCORDING TO UMEC’S MOST RECENT (2016) REPORT, THE STATE HAS
AVERAGED 202 RESIDENTS PER YEAR BETWEEN 2006 – 2016, REPRESENTING AN APPARENT DECLINE FROM LEVELS UNDER THE WAIVER.  

ADDITIONAL GME FUNDING MODELS

There are several other GME funding models that have the potential to provide revenue for GME programs. These models differ based on who would receive payment, how funds would be allocated among recipients, what mechanisms would be needed to assure accountability and whether payment would be linked to the achievement of specific performance measures. These models are not mutually exclusive and could be combined to enhance stability and accommodate GME policy objectives. In some cases, a combination of several models would be necessary to pay for different kinds of costs to address specific educational or workforce objectives.

All-Payer System

The SEVERAL STATES HAVE EXPERIMENTED WITH VARIATIONS ON AN all-payer system, WHICH COMBINES FUNDING FROM ALL PUBLIC AND PRIVATE SOURCES TO PAY FOR STATE GME PROGRAMS, has proven to work in several states BUT ONLY MARYLAND'S IS CURRENTLY OPERATIONAL. The AOA's Physician Education Advancing Community Health (PEACH) program is an example of a payor-funded program whereby Health Maintenance Organizations would help fund GME. ALTHOUGH PRIVATE PAYORS RARELY FINANCE GME DIRECTLY, THE HIGHER RATES THAT THEY PAY TO TEACHING INSTITUTIONS HELP TO SUBSIDIZE GME PROGRAMS. The extents to which private insurers help fund portions of residency training and costs are nearly inestimable. The nonprofit RAND Corporation did a survey-based study in 2006 and found that private payers, like insurance companies, indirectly fund about 43% of the costs associated with training physicians. However, hospitals tend not to negotiate for physician training costs when they contract with private insurers.  

Maryland IMPLEMENTED THEIR currently has an all-payer system IN 1977. PRIOR TO 2014, THE STATE USED A PROSPECTIVE, DIAGNOSIS-BASED PAYMENT MODEL, WHICH KEPT THE RATE OF INCREASED SPENDING PER ADMISSION BELOW THE NATIONAL RATE, ALTHOUGH IT WAS LESS SUCCESSFUL AT CONTAINING OVERALL HOSPITAL SPENDING DUE TO INCREASED ADMISSION RATES. SINCE 2014, MARYLAND HAS USED A PAYMENT MODEL THAT REQUIRES EACH HOSPITAL TO MONITOR BOTH THE NUMBER AND COST OF ADMISSIONS, where the PAYMENT RATES ARE ESTABLISHED BY THE QUASI-GOVERNMENTAL Health Services Cost Review Commission, AND ALL PAYORS MUST PAY A GIVEN HOSPITAL THE SAME RATE FOR THE SAME SERVICE, BUT EACH HOSPITAL NÉGOTIATES ITS OWN RATES. Maryland also has a Medicare waiver THAT ALLOWS IT TO SET MEDICARE PAYMENT RATES. HISTORICALLY, in which the federal government pays more in Maryland than anywhere else. In return, Maryland has to keep its Medicare costs below national growth FOR HOSPITAL PAYMENTS PER ADMISSION IN ORDER TO MAINTAIN ITS WAIVER, BUT THE TEST UNDER THE CURRENT KAVER FOCUSES ON THE PER CAPITA GROWTH IN HOSPITAL SPENDING. Maryland is currently in jeopardy of losing its waiver due to federal sequester concerns.
New York PREVIOUSLY OPERATED AN all-payor system THAT was created through the “Professional Education Pool” which collects and distributes money for GME. New York requires all payors to contribute to the fund, including Blue Cross and Blue Shield, commercial insurers, health maintenance organizations (non-Medicaid and non-Medicare), businesses, self-insured funds and third party administrators. There are two ways for payors to make payments: first, by voluntarily contributing an amount based on per covered life of the individual or family; or if no direct contribution is made, a surcharge on each payment of inpatient costs plus a 24% differential LEVED A “COVERED LIVES ASSESSMENT” TAX ON PRIVATE HEALTH INSURERS BASED UPON MEMBER FEES BY REGION AND TYPE OF INSURANCE. The Professional Education Pool monies are collected in a trust fund and distributed to teaching hospitals on a monthly basis in accordance with their adjusted share of the region’s total GME spending. THE MONEIES COLLECTED WENT INTO TWO POOLS, ONE THAT SUBSIDIZED CARE FOR INDIVIDUALS WHO WERE UNABLE TO PAY AND ANOTHER THAT FUNDED GME. IN THE LATE 2000S, HOWEVER, THE GME FUNDING POOL WAS REALLOCATED TOWARD UNCOMPENSATED CARE IN TEACHING HOSPITALS, AND OTHER “HIGH PRIORITY” ITEMS.

**Health Care Provider Model**

Medicare pays for GME through a health care provider model. This approach links payments for clinical training to patient care activities. Because the indirect payment adjustment is intended to reflect the impact of teaching activity on a hospital’s patient care costs, this model is particularly appropriate for IME payment.

Several variants of this model have been proposed to encourage more training in nonhospital settings. These variants include a direct pay approach whereby payment would follow the resident training in a nonhospital site; pro rata payment of hospitals and nonhospital sites based on agreements among the entities or a fixed allocation developed in accordance with national cost data; or payment to the entity that bears substantially of the costs of the nonhospital rotations. The first two variants would create substantial administrative burdens. Although less burdensome and disruptive, the third option appears less likely to achieve its stated goal. A voucher or “set-aside” system also could be established whereby a specified share of payment for direct training costs would be earmarked for nonhospital settings.

The principle advantage of the provider model is that regulatory, cost reporting, auditing and compliance mechanisms already are in place and well established. To this extent, these mechanisms have created persistent problems, which is also a disadvantage. This model also fails to provide financial support for training that occurs outside of patient care settings (e.g., much of the training in preventative medicine).

**Education Model**

Under this approach, payment would be made to a program sponsor, which would be held accountable for the way funds are allocated and expended. Sponsors could be universities, medical schools, colleges of osteopathic medicine, hospitals, consortia or any other entity whose primary purpose is providing education and/or health care services (e.g., a health department, public health agency, organized health care delivery system or hospital system.) Because this model treats direct GME costs as costs of education not patient care, adherents suggest that greater weight will be placed on educational needs as training decisions are made. In return for payment, the program sponsor (or its designees) would assume all (or substantially all) of the direct costs of operating the GME program. Allocation of GME costs and payments would be established through written agreements between the sponsor and clinical training sites. Because IME is a hospital cost, this model would not provide an adequate basis for IME payment.
The principle advantage of this approach is its focus on education. Unfortunately, it also would require a major shift in program accountability and funding, particularly when training occurs in community teaching hospitals rather than academic medical centers, where medical schools and hospitals are linked through common ownership or other longstanding corporate or strategic ties. This approach could also discourage hospitals from maintaining or starting GME programs.

As a variant to this model, vouchers could be given directly to residents so that they could purchase their own GME. Unlike the vouchers mentioned in conjunction with the provider model, these vouchers would permit residents to control funding for their graduate training, allowing monies to flow to all training sites. In theory, this approach would enhance competition among GME programs. It is not clear, however, how much effect it would have because programs already compete for residents and rotation sites.

Besides the disadvantages mentioned above, this approach would require a new regulatory mechanism for determining which residents qualify for funding and how many positions would be funded. It also fails to address national physician workforce needs or to assure that adequate resources are available in needed specialties and geographic areas. Implementing this approach could result in substantial year-to-year fluctuations in program size, undermining the stability of existing programs and making faculty and resource allocations difficult. Residents could also be hard pressed to hold their programs accountable once training decisions are made.

Planning Model

Under this approach, funding would be channeled through planning or coordinating bodies such as GME consortia, state GME, physician workforce commissions or task forces. The primary function of these bodies would be to assess the health care needs of their communities and to allocate funds based on local workforce considerations.

Because this approach ties training and funding decisions to local health care needs, it could provide the states, payers and consumers a stronger role in allocating funds to meet workforce objectives. According to the Council on Graduate Medical Education, however, existing evidence tends to suggest that reliance on consortia to assume such a role may be premature. Adopting this model would also require development of a new regulatory mechanism to assure accountability. Payment to state entities or consortia provides little incentive to nonteaching hospitals to initiate new GME programs.

Performance Model

This model links payment to the achievement of specific performance measures or objectives. Funding could also be used to support specific projects or demonstrations on infrastructure development or particular workforce goals.

While this approach encourages innovation and quality enhancement, it is more suitable as a supplemental funding mechanism than as a primary source of GME payment. This model is also dependent on well-defined quality measures and workforce priorities. Neither may be sufficiently well developed to support all GME funding decisions at this time. This approach could also result in substantial year-to-year fluctuation in payments if all funding decisions are based on meeting specific performance measures.

CONCLUSION

With federal and state budgets look to cut spending, GME programs are particularly vulnerable. AOA policy, “affirms its support for maintaining and enhancing the quality of teaching programs.” As states address shortfalls in federal GME funding, the AOA encourages all viable models to be examined. While all-payor systems have proven effective in some states, each state is different and may require its own unique GME funding system. Additionally, as states and the federal government implement health
insurance exchanges, we encourage the exploration of using a portion of any health plan surcharge to
fund GME. This will help address concerns related to workforce shortages as the covered population
grows.

The AOA supports states creation of alternative GME funding mechanisms and the alignment of this
funding with their states health care priorities. Most important, within these priorities are training those
specialties with the largest workforce shortages and providing care to those residents in the greatest
needs (those in rural and underserved areas).

The AOA believes that state GME funding must account for osteopathic programs that incorporate
the holistic approach to medicine, including the promotion of osteopathic principles and tenets.

The AOA believes that state GME funding should focus on programs that address comprehensive
health care systems that deliver care through a variety of settings. This includes training residents in
hospitals, rural clinics, community-based centers and patient-centered medical homes. These programs
should also provide training in advancing technologies within the delivery of care.

The AOA believes that state GME funding should emphasize the importance of both basic and clinical
research in an effort to advance the practice of medicine and the care patients receive.

The AOA supports the physician-led, team-based model of care. The AOA believes that state GME
funding should promote this model of care by promoting interprofessional education, so that
physicians can not only learn to lead the health care team, but also better understand the skills and
abilities each member brings to that team.

Finally, this policy is intended to comply with AOA Policy, RESIDENCY TRAINING SLOTS. The PEACH program represents one advocacy tool developed to assist states in
developing alternative GME financing, and the AOA should continue to create additional resources
that support the osteopathic community in its efforts to provide adequate funding.

References
1. Fifteenth Report: Financing Graduate Medical Education in a Changing Health Care Environment, Council on Graduate Medical
3. Id.
4. Id.
10. Id.
15. Henderson, supra.
16. Id.
17. Metzler, supra.
19. Id.
20. Id.
21. Id.
23. Id.
24. Henderson 2013, supra.
25. Id.
26. Id.
27. Id.
28. Id.
30. Id.
33. Id.
34. Id.
35. Id.
36. Id.
39. Id.
40. Id.
41. Id.
44. AOA Policy H319-A/15.

ACTION TAKEN **APPROVED as AMENDED**

DATE: July 27, 2019
RES. NO. H-360 - A/2019 – Page 1

SUBJECT: REFERRED RESOLUTION H346-A/13 - OFFICE BASED SURGERY

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Bureau of State Government Affairs

1 WHEREAS, resolution H-342-A/2018 titled H-346-A/2013 OFFICE BASED SURGERY was
2 referred to the Bureau of State Government Affairs for updating with current data;
3 now, therefore be it
4
5 RESOLVED, that the Bureau of State Government Affairs recommend that the following
6 policy be REAFFIRMED AS AMENDED:

H346-A/13 OFFICE BASED SURGERY

The American Osteopathic Association approves the following Policy Statement on Office-
Based Surgery (2008; reaffirmed as amended 2013):

OFFICE-BASED SURGERY

Background

A number of surgical procedures that were once only performed in hospitals or ambulatory
surgery facilities CENTERS (ASCS) can now be performed in a physician’s office. Of the 80
million outpatient surgeries performed in the US in 2009, THE MOST RECENT YEAR
FOR WHICH COMPREHENSIVE DATA IS AVAILABLE, it is estimated that over 12
million were performed in physicians’ offices.¹ Proponents of office-based surgery assert that
many procedures can be performed safely and effectively in a physician’s office due to advances
in technology, anesthesia, and laparoscopic techniques. In addition, many argue that office-
based surgery is easier to schedule and more comfortable for patients than surgery performed in
a hospital. Perhaps most significant, however, is the reported cost savings for office-based
surgery compared to surgery performed in a hospital. One study reported that the AVERAGE
cost of an UNICOMPARTMENTAL KNEE ARTHROPLASTY inguinal hernia repair
done in an office setting WAS AN AVERAGE OF $20,500 LESS THAN THE AVERAGE
CHARGE OF $46,845 was $895 compared to $2,237 for the same procedure in the hospital.²

Despite these benefits, the practice of office-based surgery has been controversial due to the
lack of established rules and regulations. At the beginning of the 21st century, the fact that most
states did not regulate office-based surgery led some observers to compare it to the “Wild
West.”³ AS OF 2014, 29 states had enacted rules, regulations or guidelines that specifically
applied to office-based surgery.⁴ These regulations help to ensure that office-based surgery is
conducted with appropriate equipment, adequately trained personnel and established patient
safety standards. However, because this practice remains unregulated in many states, the
concern that surgery performed in a physician’s office may not be as safe as surgery performed
in a hospital or licensed ASC persists.

While the media has reported a number of stories of tragic outcomes following office-based
surgery, the actual RATE of morbidity and mortality following office-based surgery
THESE PROCEDURES is hard to determine because reporting adverse events is only
required in twenty states.\textsuperscript{5} Reporting is required in less than half of all states.\textsuperscript{5} A number of reports that have been published documented adverse events.

According to a 2017 Florida report that compared risk-adjusted hospitalization rates following surgical procedures across physician offices, freestanding ASCs, and hospital outpatient departments in Florida, rates were generally higher for office-based procedures, especially more complex procedures.\textsuperscript{6}

A 2004 survey by the American Association of Ambulatory Surgery Centers reported that only 12 out of every 10,000 office-surgical center patients required emergency transfer to hospitals in 2003. In another survey of 1,200 plastic surgeons, 95 deaths were reported in nearly 500,000 liposuction procedures.\textsuperscript{6} Since 1986, at least 41 deaths and over 1,200 injuries have occurred during cosmetic surgery in Florida. Closed malpractice claims in Florida have also identified 830 deaths and approximately 4,000 injuries associated with office-based surgical care occurring between 1990 and 1999.\textsuperscript{6} Finally, since Florida’s Board of Medicine imposed mandatory reporting requirements on physicians performing office-based surgery, 20 adverse incidents and five deaths were reported in a five-month period. Although office-based surgery may be appropriate for many surgical patients, proper attention must be given to patient safety in order to avoid adverse events.

Need for Office-Based Surgery Rule Development

States have taken different approaches to the regulation of office-based surgery. A variety of state medical boards have adopted guidelines or rules for physicians to follow when performing office-based procedures. The North Carolina Medical Board approved a position statement on office-based procedures on Jan. 23, 2003 after surveying the physicians in the state on this necessity. A position statement issued by the North Carolina Medical Board on this issue contains recommendations on guidelines address physician credentialing, emergencies, performance improvement, medical records, equipment and supplies, and personnel. Any failure to comply puts a physician at risk of disciplinary action by the board.\textsuperscript{2}

In many states, office-based surgery centers are exempt from licensure requirements that apply to hospitals and ASCs because the procedures that they perform are considered to be relatively low-risk. Some states require centers to register with a state agency such as the Department of Health, while others do not require any general oversight, and surgical practitioners are regulated by state medical licensing boards in the normal course of their physician oversight duties.\textsuperscript{8} On Feb. 25, 2005, the Washington Medical Quality Assurance Commission adopted voluntary guidelines that encourage office-based surgical facilities to be accredited. The Oklahoma Board of Medicine adopted guidelines for physicians who perform procedures that require anesthesia or sedation in an office setting. The Oregon Board of Medical Examiners developed standards for accreditation of facilities where minor procedures or those requiring conscious sedation are performed in an office setting. The South Carolina Board of Medical Examiners approved guidelines for office-based surgery that require such facilities to be accredited by an approved agency if level 2 or 3 procedures are performed.

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

Physicians and Staff in the Office-Based Surgical Facility

One of the reasons for the large number of adverse consequences associated with office-based surgery is the fact that many individuals, both physicians and non-physicians, performing office-based surgery lack the expertise to perform the surgery and administer the anesthesia in the first place. For example, a 2010 study found that nearly 40% of physicians offering liposuction in southern California had no specific surgical training. Furthermore, four deaths have been reported since 2013 at a single South Florida clinic, where ophthalmologists and one anesthesiologist have placed advertisements for breast augmentation surgery, and several dentists have been identified as performing hair transplants and liposuction procedures where cosmetic surgery is performed by physicians who are not formally trained or board certified in plastic surgery. While no single medical discipline has a monopoly on proper qualifications for performing office-based surgery, such incidents may spur state licensing boards to consider instituting licensure by specialty or board certification as opposed to an unlimited scope of practice.

Equipment Required

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

Transfer Agreement

Emergencies occasionally arise during surgery requiring patients to receive a level of care higher than that available in the office-based setting. Provisions must be in place to provide this care in a comprehensively outfitted and staffed facility located nearby should it be needed.

Adverse Incident Reporting

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

Regulation of Office-Based Surgery

Unlike hospitals and ambulatory surgery centers, not all office-based surgical facilities are subject to regulations on emergencies, fire, sanitation, drugs, staff, training, and unanticipated patient transfers. Common sense dictates that states should take steps to ensure that patients who undergo surgery in physicians’ offices receive the same standard of care as patients in ambulatory surgery centers or hospitals.
Conclusion

The practice of office-based surgery will likely continue to grow in the coming years. The following statements represent the AOA’s position on the appropriate use of office-based surgery:

The AOA firmly believes that steps must be taken to ensure that office-based surgery is as safe for patients as hospital- or ambulatory care center-based surgery;

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

The AOA believes that Level 1 and Level 2 procedures are acceptable to be performed in an office-based setting. However, Level 3 procedures should only be performed in an office setting that has been accredited by an accreditation organization such as the Healthcare Facilities Accreditation Program, the Joint Commission, the American Association for Accreditation of Ambulatory Surgery Facilities (AAASF), or the Accreditation Association for Ambulatory Health Care (AAAHC) OR THE AAAHC’S HEALTHCARE FACILITIES ACCREDITATION PROGRAM; the AAAHC’s Healthcare Facilities Accreditation Program;

The AOA believes that surgery performed in a physician’s office must be done by a physician or health care provider qualified by education and training to perform that specific procedure WITH APPROPRIATE PHYSICIAN OVERSIGHT;

The AOA believes that only health care providers who have completed the appropriate education and training should perform office surgical procedures;

The AOA believes that the physician MUST administering the anesthesia or IF A NON PHYSICIAN CLINICIAN ADMINISTERS THE ANESTHESIA, A SUPERVISING PHYSICIAN MUST BE PHYSICALLY PRESENT IN THE OFFICE-BASED SURGICAL FACILITY DURING THE ADMINISTRATION OF ANESTHESIA AND REMAIN PHYSICALLY AVAILABLE UNTIL THE PATIENT HAS FULLY RECOVERED AND supervising the administration of the anesthesia must be physically present in the office-based surgical facility during the surgery and immediately available until the patient has been discharged from anesthesia care. In case of an emergency, personnel with training in advanced resuscitative techniques should be immediately available until THE all patients IS are discharged;

The AOA believes office-based surgical facilities must have the appropriate medications, equipment, and monitors necessary to perform the surgery and administer the anesthesia in a safe manner. The equipment and monitors must be maintained, tested, and inspected according to the manufacturer’s specifications;

The AOA believes physicians and health care providers NON-PHYSICIAN CLINICIANS who perform OFFICE-BASED surgery in an office setting SHALL BE RESPONSIBLE FOR COORDINATING AND ENSURING APPROPRIATE CARE FOR PATIENTS WHO REQUIRE EMERGENT, UNEXPECTED POSTOPERATIVE TRANSFER AND/OR HOSPITALIZATION, must have a written protocol WRITTEN PROTOCOLS MUST BE in place for TIMELY transfer to an accredited hospital LOCATED within REASONABLE proximity to the office. OFFICE PERSONNEL MUST BE APPROPRIATELY TRAINED IN EMERGENCY PROTOCOLS IN ORDER TO BE ABLE TO RESPOND when extended or emergency OR EXTENDED services are needed to protect the health or well-being of the patients;
The AOA supports reporting of adverse incidents related to surgical procedures performed in an office setting to a state entity, as required and appropriate, provided that these disclosures will be considered confidential and protected from discovery or disclosure; and

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

5 Id.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**
WHEREAS, sunset resolution H340-A/2013 titled “UNIFORM PATHWAY OF LICENSING OF OSTEOPATHIC PHYSICIANS” was recommended to be REAFFIRMED AS AMENDED in 2018; and

WHEREAS, sunset resolution H340-A/2013 titled “UNIFORM PATHWAY OF LICENSING OF OSTEOPATHIC PHYSICIANS” was referred to the Bureau of State Government Affairs (BSGA) for further review; now therefore be it,

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRMED as submitted.

H273-A/08 UNIFORM PATHWAY OF LICENSING OF OSTEOPATHIC PHYSICIANS

The American Osteopathic Association states that the examination of the National Board of Osteopathic Medical Examiners must remain as THE avenue for the licensure of osteopathic physicians and supports a uniform pathway of licensing osteopathic physicians through the mechanisms of the National Board of Osteopathic Medical Examiners, TO BE EFFECTIVE AFTER 12/31/19. 1991; revised 1993, 1998, 2003; 2008.

Explanatory Statement:
Osteopathic physicians (DOs) are currently required to complete Levels 1 and 2 of the National Board of Osteopathic Medical Examiners’ (NBOME) Comprehensive Osteopathic Medical Licensing Exam of the United States (COMLEX-USA) in order to graduate from osteopathic medical school, and Level 3 in order to obtain an unlimited state medical license. NBOME examinations are developed by DOs and are designed to test the competencies for osteopathic medical practice, including the unique principles and practice of osteopathic medicine, to ensure patient safety and optimize patient outcomes. COMLEX-USA includes a performance evaluation/practical component (Level 2-PE) that includes testing of osteopathic manipulative medicine and treatment. The use of COMLEX-USA for DO licensure will remain unaffected by the transition to a Single Accreditation System under the Accreditation Council for Graduate Medical Education (ACGME), and the AOA strongly supports its continuing use as the sole pathway to DO licensure as it is the only examination designed for the practice of osteopathic medicine and that has demonstrated validity for that purpose.

Further, competition for certain residency positions has led some osteopathic medical students to elect to take Steps 1 and/or 2 of the United States Medical Licensing Exam (USMLE) during medical school, in addition to COMLEX Levels 1 and 2; however, the AMA and ACGME explicitly recognize COMLEX-USA equivalently to USMLE and the AOA continues to advocate for education around COMLEX-USA for equivalent uses to USMLE by residency program directors in order to alleviate this unnecessary burden and stress on osteopathic medical students, while also assisting to preserve the integrity and distinctiveness of the profession.
Reference Committee Explanatory Statement
The Committee believes that adding an effective date will allow for grandfathering in of osteopathic physicians who obtained licensure previously through the FLEX or USMLE examinations, etc.

ACTION TAKEN APPROVED as AMENDED

DATE July 27, 2019
RES. NO. H-362 - A/2019 – Page 1

SUBJECT: SAFE HAVEN NON-REPORTING PROTECTION FOR PHYSICIANS – SUPPORT FOR

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, the 2018 AOA House of Delegates adopted resolution H359 PREVENTING PHYSICIAN BURNOUT – SAFE HAVEN NON-REPORTING PROTECTION FOR PHYSICIANS which directs the Bureau of State Government Affairs to develop policy in support of safe haven non-reporting protections for physicians; now, therefore

be it

RESOLVED, that the following policy paper and recommendations be adopted as the American Osteopathic Association’s (AOA) position on safe haven non-reporting protections for physicians and medical students; and be it further

RESOLVED that upon approval of safe haven non-reporting as organizational policy, the AOA’s Bureau of State Government Affairs will be tasked with developing a model act for consideration by the 2020 AOA House of Delegates.

AOA POLICY PAPER:
SAFE HAVEN NON-REPORTING PROTECTIONS FOR PHYSICIANS

BACKGROUND

Burnout among US medical students, residents and practicing physicians is a significant problem that negatively impacts medical professionals as well as the patients that they serve. Physicians in the US report symptoms of burnout at nearly double the rate of other US workers after controlling for work hours and other factors, and between 2011 and 2014, this percentage increased by 9%.1 Further, twenty to forty percent of medical students, interns and residents report experiencing symptoms of burnout.2

Burnout is characterized by a “wide array of signs, symptoms and related conditions, including fatigue, loss of empathy, detachment, depression and suicidal ideation.”3 It has also been shown to negatively impact a physician’s prescribing habits, test ordering, risk of malpractice suits, and whether patients adhere to their recommendations.4 Although the aforementioned description does not explicitly reference substance use disorders, we will hereafter reference symptoms of burnout, mental health and substance use issues (and their treatment) interchangeably.

Even when resources are available to help physicians and students address symptoms of burnout; however, both groups report similar concerns about pursuing them. For purposes of this policy paper, we will focus on concerns regarding lack of confidentiality and possible disciplinary or discriminatory action by schools, employers, state medical licensing boards and other academic or professional entities.
The Federation of State Medical Boards (FSMB) convened a Workgroup on Physician Wellness and Burnout (Workgroup) to study the issue of physician burnout and draft recommendations to help groups in the medical community better address this issue. The Workgroup found that although numerous resources exist to help medical students and physicians experiencing symptoms of burnout or impairment through academic institutions, medical licensing boards and state physician health programs, social and professional pressures make students and physicians reluctant to seek treatment or to report seeking it. Both medical students and physicians cited fears that seeking help would result in documentation on academic or professional records which could lead to discrimination or denial of a medical license, and ultimately jeopardize their ability to practice medicine.

According to a poll conducted by the FSMB and the Medical Society of the State of New York, a state that does not currently include any questions about mental health or substance use on medical licensure applications, sixty-nine percent of physician respondents who were experiencing symptoms of burnout reported that they would be significantly less likely to seek treatment if they were required to report it on a licensing application or renewal.

Further, despite evidence showing that a past history of mental health or substance use disorders does not reliably predict future risk to the public, most state licensing applications still contain questions about applicants' histories with these issues. As of 2017, 43 states asked questions about both mental and physical health conditions on their medical licensing applications, but just 23 limited all questions to disorders causing functional impairment and only six limited them to current problems.

Although a similar number of medical licensing boards asked about both mental and physical health, questions about the latter tended to be much more lenient and vague while questions about the former were much more specific and probing. Boards were significantly more likely to ask if physicians had ever been diagnosed, treated or hospitalized for a mental health or substance use disorder than for a physical disorder, and unlike questions about physical disorders, the questions were not limited to just those conditions that might currently affect a physician's ability to practice.

Responses by medical licensing boards to disclosures made by physicians about their mental health were also unpredictable and varied greatly from state to state. Some boards asked for a doctor's note, others requested all medical records related to an applicant's history and treatment, others required applicants to appear before the board to defend their ability to practice medicine and still others required applicants to undergo ongoing monitoring or practice under a restricted license.

In addition to the deterrent effect that questions from medical licensing boards regarding mental health appear to have on physicians' willingness to seek help when needed or report seeking it, courts have found that many such questions run afoul of the Americans with Disabilities Act (ADA). The ADA protects individuals with disabilities, including psychiatric disabilities, from discrimination. Professional licensing bodies are not exempt from the requirements of the ADA, and courts have stated that “[public entities] may not administer a licensing or certification program in a manner that subjects qualified individuals with disability to discrimination on the basis of disability.”

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screen out an individual with a disability … unless such criteria can be shown to be necessary for the 
provision of the service, program, or activity being offered.5

In order to encourage medical students and physicians to seek appropriate treatment for mental health 
and substance use disorders, and ensure that medical licensing boards comply with the ADA, the FSMB 
encourages medical licensing boards to adopt policies that support physician “safe haven non- 
reporting.”

“Safe haven non-reporting” allows physicians who are receiving appropriate treatment for mental 
health or substance use issues who are monitored and in good standing with their confidential 
treatment program to (re)apply for licensure without having to disclose their treatment to the board. 
Only disclosures related to issues that are not being appropriately treated and could inhibit a physician’s 
ability to safely practice medicine would be required.

RECOMMENDATIONS

The AOA adopts the following statements as its official position on “safe haven non-reporting:”

The presence or history of a mental health or substance use disorder does not automatically render a 
physician unfit to practice medicine, and the AOA opposes discrimination or disciplinary action against 
a physician or medical student based solely on the presence of such a disorder, without taking into 
consideration the individual’s behavior or treatment.

The AOA urges state medical licensing boards to regard physical and mental health disorders similarly 
and refrain from asking about past history of mental health or substance use diagnoses or treatment on 
licensure applications or renewals. Instead, the AOA encourages boards to focus on whether any current 
physical or mental disorders are present which may impair that individual’s ability to safely practice 
medicine. The AOA further encourages state medical licensing boards to offer a “safe haven non- 
reporting” option for physician applicants who are undergoing appropriate treatment for current 
mental health or substance use disorders. This alternative helps to ensure confidentiality of such 
treatment for the individual physician while ensuring patient safety.

If medical licensing boards decide to use questions related to mental health or substance use disorders 
on a medical licensure application or renewal, the AOA encourages boards to consider phrasing them 
similarly to questions about physical health. For example:

“Are you currently suffering from any condition for which you are not being 
appropriately treated that impairs your judgment or that would otherwise adversely 
affect your ability to practice medicine in a competent, ethical and professional 
manner? (Yes/No)”

“Appropriate treatment” includes physician participation provided through state physician health 
programs accredited by the Federation of State Physician Health Programs, or programs following 
similar standards and guidelines, and adherence to treatment recommendations.

Finally, the AOA encourages medical educational and professional entities, as well organizations 
throughout the medical community, to support and educate students and physicians about confidential
treatment and “safe haven non-reporting” options, in order to encourage these individuals to seek appropriate treatment without fear of documentation, disciplinary action or other repercussions.

References


ACTION TAKEN APPROVED

DATE: July 27, 2019