

## CALIFORNIA DELEGATION

### 2007 AMA INTERIM MEETING – HIGHLIGHTS

As of Tuesday, November 13, 2007

#### AMA People and Elections

Gerald Murphy, MD, of Simi Valley was elected Chair of the California Delegation and

Richard Frankenstein, MD, of Santa Ana was elected Vice-Chair.

Loma Linda medical student Amber Sabbatini was elected Region I Delegate from the Medical Student Section and Stanford medical student Matthew Mori was elected Region I Alternate Delegate.

Past-President Robert Hertzka, MD, announced his candidacy for election to the AMA Council on Medical Service.

The California Delegation and Pacific RIM Caucus recognized retiring Delegation member

Judith Mates, MD.

Encinitas internist and pain management specialist, Kristin Bell, MD, was awarded the 2007 William Beaumont Award in Medicine which was established to recognize and encourage the efforts and development of younger physicians. Dr. Bell is an assistant clinical professor of medicine at UC San Diego School of Medicine. In 2005, she developed and implemented a new behavioral medicine curriculum for third-year UCSD medical students which involves interactive learning in a small-group environment.

## CALIFORNIA RESOLUTIONS

1. Health Information Technology Legislation: Reaffirmed existing policy in lieu of a California resolution which asks the AMA to support: (1) existing state and federal measures directed at promoting health information technology, with an emphasis on implementation being technology neutral; and (2) regulations that promote stronger standardized security measures such as encryption of data at rest. (Res. 818)

2. Patient Access to Off-Label Use of Avastin: Adopted as amended a California resolution which asks the AMA to: (1) oppose Genentech's efforts to prevent compounding pharmacies from directly purchasing Avastin (bevacizumab) in the interest of patient access to off-label treatments as a "practice of medicine" issue, as well as any interference by Genentech in the physician-patient relationship; (2) express its opposition by means including but not limited to

sending a letter to Genetech and issuing a press release; and (3) reaffirm Policy H-120.988 (Patient Access to Treatments Prescribed by Their Physicians) that states it is AMA's position that "a physician may lawfully use an FDA approved drug product or medical device for an unlabeled indication," and support efforts to ensure that ability. (Res. 819)

3. Insurance Company Economic Profiling of Physicians: Adopted a California resolution which asks the AMA to: (1) take all appropriate steps to actively oppose all efforts by third party payers to rank, profile or otherwise "score" physicians purely for corporate cost containment purposes; and (2) widely publicize insurance industry economic profiling practices and how they impact patient care and access. (Res. 820)

4. Residency Program At-Home Call Criteria: Referred a California resolution which asks the AMA to: (1) urge the Accreditation Council for Graduate Medical Education (ACGME) to collect additional evidence on the number of residency programs nationwide that have changed prior in-house call rotations to at-home call since July 2003; and (2) urge the ACGME to study, develop, and implement criteria under which a residency program can establish at-home call, or change a prior in-house call rotation to at-home call. (Res. 821)

Resolution 821 was referred along with Resolution 825, Monitoring of At-Home Call Implementation by Residency Programs, from the Resident and Fellow Section, which called for the AMA to: (1) oppose the use of at-home call if being used to circumvent the intent of current ACGME duty hour restrictions; (2) work with the ACGME and other interested organizations to collect additional information on how residency programs nationwide are using at-home call rotations; (3) study the impact of at-home call on resident well-being, sleep patterns, and patient safety, commenting on issues such as, but not limited to, total hours worked, number of pages and phone calls received, and hours of continuous sleep; and (4) study and develop best practices for implementing at-home call in residency and fellowship programs. (Res 825)

5. Constitutional Basis for Advocacy: Reaffirmed existing policy in lieu of a California resolution which called for the AMA to take all appropriate measures to enable and encourage open physician communications about quality of patient care and the economic conditions under which physicians practice in order to align clinical with financial interests within the health care service delivery system. (Res. 823)

6. Balance Billing for All Physicians: Adopted as amended a California resolution which asks that: (1) the AMA to devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to introduce legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interferes with patient access to care; (2) this national legislation be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician contracts; (3) the AMA develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician's right to balance bill any insured patient; and (4) the AMA Board of Trustees report back to the House of Delegates electronically by March 15, 2008, and at every House of Delegates meeting its progress toward the completion of all of these goals. (Res. 925)

7. Physician Collective Bargaining: Adopted a substitute resolution in lieu of a California resolution which asks the AMA to: (1) redouble its efforts to make physician antitrust relief a top legislative priority, providing the necessary foundation for fair contract negotiations designed to preserve clinical autonomy and patient interest and to redirect medical decision-making to patients and physicians; and (2) affirm its commitment to undertake all appropriate efforts to seek legislative and regulatory reform of state and federal law, including federal antitrust law, to enable physicians to negotiate effectively with health insurers. (Res. 926)

8. Reinstatement of Economic Hardship Loan Deferment: Adopted a substitute resolution in lieu of a California resolution which asks the AMA to actively work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of post-graduate trainees with educational debt. (Res. 927)

9. Expedited Partner Therapy: Adopted a substitute resolution in lieu of a California resolution which asks the AMA to support state legislation that permits physicians to provide expedited partner therapy to patients diagnosed with gonorrhea and/or chlamydia infection. (Res. 928)

10. Limiting Charge Rule Adjustment: Adopted a substitute resolution in lieu of a California resolution which asks: (1) the AMA reaffirm Policy H-390.856 which advocates for eliminating Medicare’s limiting charge; and (2) that until such time as Medicare’s limiting charge is eliminated, the AMA advocate for increasing Medicare’s limiting charge each year until reimbursement reflects the cost of providing physician services plus a reasonable allowance for the physician’s efforts. (Res. 718)

11. Payment Cuts to Teaching Programs: Adopted a substitute resolution in lieu of a California resolution which asks the AMA to oppose payment cuts to any teaching program on the basis that the attending physician is concurrently or sequentially supervising more than one resident, fellow or student. (Res. 719)

#### OTHER KEY ACTIONS:

1. Maintaining the Physician Consortium for Performance Improvement As Physician-Led: Referred for decision a resolution which calls on the AMA to: (1) ensure that the Physician Consortium for Performance Improvement be a physician-led organization and that voting rights within this body be reserved for those participants who meet the criteria of a “physician” as defined by AMA Policy H-405.969 with continued participation by non-physicians in the development of appropriate performance measures at the workgroup level. The resolution further calls for the AMA to work to make the definition of “physician” under Medicare law consistent with H-405.969 by defining chiropractors, optometrists and podiatrists eligible for payment under their own titles. (Res. 609)

[Note: AMA Policy H-405.969, Definition of a Physician, states: The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.]

2. Antibiotic Drug Resistance: Reaffirmed existing policy in lieu of a resolution which asks the AMA to: (1) seek federal legislation to authorize a public health education campaign to promote appropriate antimicrobial use as a national health priority and to increase physicians' and patients' knowledge about the appropriate use of antibiotics; (2) notify retail pharmacy chains, and other organizations as necessary, about the dangers of inappropriate use of antibiotics, suggest ways to avoid creating excessive patient demand for antibiotics, and urge these organizations to publicize appropriate use of antibiotics in concert with this program; and (3) work in collaboration with state medical societies and medical specialty societies and other partners to develop and facilitate the implementation of educational and behavioral interventions that will assist clinicians in appropriate antimicrobial prescribing. (Res. 812)

3. Principles for Strengthening the Physician-Hospital Relationship: Adopted a resolution which asks the AMA to join with other physician groups in the Federation of Medicine to advocate for improved physician-hospital relationships in discussions with the American Hospital Association, The Joint Commission and the Centers for Medicare and Medicaid Services, and to adopt the following twelve principles as AMA policy:

#### PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes, with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.

2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.

3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.

4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.

5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.

6. The organized medical staff has inherent rights of self governance, which include but are not limited to:

a. Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the organized medical staff.

b. Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.

c. Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.

d. Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or

administration. The voting members of the organized medical staff decide any proposed changes.

e. Establishing within the medical staff bylaws: 1) the qualifications for holding office, 2) the procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee, and 3) the qualifications for election and/or appointment to committees, department and other leadership positions.

f. Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.

g. Retaining and being represented by legal counsel at the option and expense of the organized medical staff.

h. Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.

i. Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.

j. The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.

k. Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.

l. Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The

Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.

m. Enforcing the organized medical staff bylaws, regulations and policies and procedures.

n. Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.

7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.

8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.

9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.

10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.

11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.

12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body. (Res. 828)

4. Educating the American People About Health System Reform: Adopted as amended a resolution which asked the AMA to: (1) reaffirm AMA policy in support of pluralism, freedom of enterprise and its strong opposition to a single payer system; (2) distribute its policy positions on health system reform to all declared candidates for the presidency of the United States of America and formally request their public support of those positions; and (3) undertake a media campaign designed to educate the American people about AMA policy on health system reform, emphasizing pluralism, individual ownership of health insurance and the insurance market reforms necessary to allow free market principles to function. (Res. 717)

5. Support for Appropriate Billing and Payment Procedures by Physicians: Referred a resolution which asks the AMA to: (1) oppose any federal or state legislation that dictates how a physician bills for medical services, that inhibits fair market contracting between physicians, and that inhibits physicians from freely practicing medicine within acceptable professional standards; and (2) oppose any federal or state legislation that limits billing and payment for a defined medical service or group of services to a single medical specialty. (Res. 921)

6. AMA's National Health Care Policy Agenda: In response to Resolution 607 adopted by the House of Delegates at I-06, the AMA Board of Trustees developed the AMA's National Health Care Policy Agenda which outlines the priority health issues that candidates for Congress and President should address in the 2008 elections. The AMA will share this health care policy agenda with every incumbent Member of Congress and the candidates for President, and will widely distribute it to the media. The AMA's National Health Care Policy Agenda will also be used to develop questionnaires for congressional candidates seeking support from organized medicine.

#### AMA NATIONAL HEALTH CARE POLICY AGENDA

The American Medical Association (AMA) believes that all Americans are worthy of a fair and affordable health system.

Today, Americans are faced with a fragmented health system. Millions don't visit a doctor until their illness reaches a serious stage. As a nation, we can and should do better.

At the center of the AMA's vision is the concept that every American, regardless of means, has health insurance. And every patient maintains the freedom to choose his or her own doctors and health plans, and maintains control over his or her own care. For a senior, this includes having ready access to doctors in the Medicare program. For a pregnant woman, it means finding a physician who hasn't been forced out of business by high liability insurance rates. And for everyone, it means receiving the best care possible. Specifically:

- The AMA urges lawmakers to implement a system of tax credits to enable individuals to buy health insurance. We have a detailed proposal for this system.
- Under current law, Medicare will make deep cuts in payments to doctors every year until 2015. This policy erodes patient access to care and is a barrier to practice

innovations. Congress and the next Administration need to permanently replace the flawed payment formula.

- Medical lawsuits are driving up health costs for everyone and making it hard for many to find a doctor. The AMA seeks reasonable limits on the noneconomic damages juries can award so that doctors aren't forced to move, cut services or go out of business.

Physicians and other health providers must work with government and private payers on strategies to restrain rising health care costs while maintaining quality of care. Medical science and technology have moved forward at a lightning pace. Patients are ready for the American health system to follow suit. The AMA is committed to:

- Finding new ways to enable doctors to use promising new technology
- Pioneering new methods to measure and improve the quality of care
- Preventing errors by studying ones that have happened, without the threat of lawsuits
- Directing more resources and effort toward disease prevention
- Helping Americans lead more healthful lifestyles
- Eliminating gaps in care, particularly for racial and ethnic minority patients, the elderly, and low-income families
- Preparing better for large-scale health care emergencies

Today, patients are forced to endure miles of insurance company red tape and piecemeal policy attempts to solve one problem or another. America's patients will be best served when our country eliminates the disproportionate influence of insurers and government into medical decision-making. These important decisions must be placed in the hands of the patient and the physician.

Our nation needs a well-trained medical work force, and more doctors in primary care. We must make sure our medical education stay the best in the world, and make paying for it less burdensome. So too must we address the barriers that threaten the viability of many physician practices, such as:

- Payments that fail to reflect the true cost of providing care
- Health insurers' deceptive business practices
- Antitrust rules that restrict doctors from negotiating with health insurance companies

As physicians and medical students, we see firsthand every day how urgently our patients need a better health system. Together, we can shape one America truly deserves