

REPORTS OF BOARD OF TRUSTEES

The following reports, 1-28, were presented by D. Ted Lewers, MD, Chair:

1. AMA PARTICIPATION IN THE WORLD MEDICAL ASSOCIATION

HOUSE ACTION: FILED

INTRODUCTION

Beginning in 1993, the Board of Trustees asked that periodic reports on World Medical Association (WMA) activities be prepared for the House of Delegates. Additionally, at the 1997 Interim Meeting, the House of Delegates adopted Resolution 622, "AMA Participation in the World Medical Association". This resolution asked that a full disclosure of all direct and indirect costs resulting from the AMA's membership in and support of the WMA be included in the Board of Trustees' annual report to the House of Delegates.

This informational report will include: a brief history of the WMA, AMA's involvement in the WMA, an overview of some current issues, and requested financial data.

BRIEF HISTORY OF THE WORLD MEDICAL ASSOCIATION

The WMA was formed in 1947 as a forum for physicians from all over the world. The WMA is often confused with the World Health Organization (WHO). These two organizations are not the same, but despite their different purposes, they are mutually supportive. The WHO is an organization of governments dealing with domestic and international public health issues. The WMA is a private organization of national medical associations; in fact, it was the first non-governmental agency which dealt with the concerns of the medical profession. It continues to be the only forum for all national medical associations.

In the aftermath of the Nuremberg Trials of the concentration camp doctors, a major objective was to form a recognized set of medical ethics which could be applied internationally. In just two years, the "International Code of Medical Ethics" was written and adopted by the WMA. Since then, several other important WMA documents have changed the face of medical practice, including "The Declaration of Helsinki," which deals with biomedical research involving human subjects. The WMA also has had a role in developing policies which affect the quality of medical care throughout the world, and has dealt with the increasingly important issue of professional freedom for physicians. Other areas of concern include medical education, (including continuing medical education), preventive health care, environmental concerns, clinical research, and the economics and delivery of health care.

The need for a non-governmental worldwide forum for physicians is substantiated by the fact that in its 50-year history, the organization has grown from 27 national medical association members to more than 70. New associations continue to apply for membership as global reorganization occurs.

AMA'S INVOLVEMENT IN THE WORLD MEDICAL ASSOCIATION

WMA member associations recognize the AMA as a leader in the promotion of standards of medical ethics. The AMA's large and well-developed policy base is the starting point for many of the WMA's ethical and socio-medical statements. As newly formed medical associations emerge from Eastern and Central Europe and the former Soviet Union, AMA policies on professional autonomy and self-regulation become increasingly important. AMA leaders have filled many leadership roles in the WMA; in fact, the current WMA President is Daniel H. Johnson, Jr., MD, an AMA Past President.

Moreover, the AMA derives numerous benefits from its membership and involvement in the WMA. These include:

- identifying emerging issues and finding solutions to common problems;
- strengthening the AMA's own policy development;
- enhancing the AMA's reputation as an activist in international health issues as our delegation forms relationships with medical leaders worldwide;

- spotlighting the AMA's involvement in human rights issues (e.g., release of wrongly imprisoned physicians), casting the AMA in a favorable light not only around the world, but in our own country;
- fulfilling the AMA's professional obligation to share knowledge;
- actively involving the Federation by consulting with specialty society colleagues for expert advice on policy matters;
- helping the AMA identify new ways to educate and assist physicians worldwide.

The Board of Trustees recognizes that AMA involvement in WMA has periodically raised concerns. Like the AMA, an organization with the breadth and depth of the WMA will occasionally stumble. On balance these issues have been resolved promptly and effectively to the general satisfaction of the AMA, and to the benefit of the world community of physicians.

Rich and poor nations are joined in the quest for scarce resources, including those needed for optimal public health. As the largest national medical association in the world, the AMA has an obligation to lead the development of health policy, and champion ethical standards in medical practice. The WMA provides the best forum in which the needs of the world's patients and physicians can be addressed.

OVERVIEW OF SELECTED CURRENT ISSUES

Cloning: The WMA is involved in an ongoing investigation into the moral, legal, ethical, social and scientific aspects of cloning. AMA Delegation members have been active participants in the workgroup established for this purpose, and AMA's CEJA Opinion and CSA Reports have been cornerstone documents for this group. The WMA expects to produce a paper for publication on this topic with substantial input from the AMA.

Pharmaceutical Issues: The Socio-Medical Affairs Committee of the WMA is examining two issues regarding pharmaceuticals and self-medication by patients. Of particular interest to the committee is the role of the physician and the patient in the self-medication process, and the concern that pharmaceutical advertising be responsible and support the physician's role.

WMA Declaration of Helsinki--Update: WMA Declaration of Helsinki--Recommendations Guiding Physicians in Biomedical Research--is considered to be the standard for ethical principles in biomedical research around the world. The complex task of updating this 1964 document has been facilitated by the AMA with substantial involvement of other national medical associations. The declaration states that the appropriate purpose of biomedical research involving human subjects is to improve diagnostic, therapeutic and prophylactic procedures, and to further the understanding of the etiology and pathology of diseases. These procedures carry potential risks of adverse consequences. This fact provides both a stimulus for trying to improve these procedures and a reason for asking research subjects to accept the risks involved, as long as the risks are balanced with the benefits. Specifically, the revision process will consider the following issues: protecting the rights of research subjects, including obtaining informed consent, giving subjects access to clinical care, and giving special consideration to pregnant women and vulnerable subjects; assuring that research involving humans is only carried out by scientifically qualified persons; balancing the risks and benefits of research; making a distinction between therapeutic and non-therapeutic research; using randomization and placebo when justified; establishing independent research ethics committees; and making sure results are reported fully and accurately. Since there is considerable worldwide interest in the Declaration among members of the research community, a working group has been formed to consider the many comments and proposed revisions while still maintaining the overall scope of the original Declaration.

Human Rights: Through the efforts of the WMA, the AMA and other national medical associations were able to secure the release from prison of Dr. Cumhuri Akpinar of Turkey. Dr. Akpinar, who works for the Ankara Forensic Medical Group, was detained in early 1999 allegedly after his name was found on a document that linked him with a terrorist group. Following a search of his home, forensic reports which documented violations of human rights were seized, and he was charged with aiding members of an illegal organization. Dr. Anders Milton, WMA Chair, attended the first day of the trial on March 4. Dr. Akpinar was released on March 5.

FINANCIAL DATA

In 1999, the AMA paid \$225,975 in annual membership dues to the WMA. This entitles the AMA to 3 of 15 seats in the Council, and 13 votes in the Assembly. The AMA's dues payment accounts for approximately 21% of the WMA's annual budget of \$1,050,000 and equates to approximately 0.13% of the AMA's 1999 annual budget.

The major expenses related to the AMA's participation in the WMA are:

DIRECT EXPENSE	\$225,975
Membership Dues	
INDIRECT EXPENSE	\$246,073
Salaries and Wages	96,621
Fringe Benefits (27%)	26,087
Travel and Meetings	122,496
Printing and Production	305
All Other Expenses	564
TOTAL 1999 EXPENSE	\$472,048*

*All figures are net.

Note: These figures are a combination of actuals and forecasts until a final accounting at the end of the year. Travel and meeting expenses are highly variable based on locations of meetings and prevailing currency exchange rates. The WMA makes partial reimbursement of travel expenses for the AMA's three Council members. This reimbursement is taken into account in "travel and meetings" shown above.

CONCLUSION

The WMA is the only international organization for national medical associations and their physician members. It seeks to form worldwide policies for the common good. The AMA's participation gives us an opportunity to exercise our professional obligation to share knowledge with our colleagues, and in turn, strengthen our organization by finding solutions to common problems. Our leadership role in the WMA solidifies our image as an organization at the forefront of healthcare issues, and allows us to form relationships with other leaders worldwide. In an increasingly global community, opportunities to interact with other nations are crucial to the AMA's future.

2. STRATEGIES FOR INCREASING ACCESS AND EXPANDING HEALTH INSURANCE COVERAGE

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

Increasing access and expanding coverage have long been a priority for the AMA, and during the past year the AMA had an unprecedented response to the troubling growth in the number of the uninsured. Two key events led to the preeminence of this issue during 1999. First was the adoption by the House of Delegates of Council on Medical Service Report 9 (A-98), which outlined a broad strategy for private sector insurance reform that would increase choice and potentially expand coverage for patients by making individually selected, purchased and owned health insurance both affordable and available as an alternative to employer-sponsored coverage. Second, during her tenure as AMA President, Nancy W. Dickey, MD, brought access and coverage to the forefront of AMA advocacy. In December 1998, Doctor Dickey spoke at the National Press Club and challenged the press, members of Congress, and other policymakers to make access and coverage priority issues.

In this report, the Board of Trustees summarizes AMA policy development and refinements, and highlights the legislative and regulatory developments, targeted outreach and coalition building activities, and communications strategies that have been undertaken during 1999 in an effort to achieve the AMA's vision for increasing access and expanding coverage.

POLICY DEVELOPMENTS AND REFINEMENTS

Extensive AMA policy favors increasing access to health care and expanding coverage for health care expenses. In the public sector, the Medicaid program serves as a “safety net” for the poor who would otherwise be uninsured, and the newly created Children’s Health Insurance Program (CHIP) provides coverage for children in families with incomes above the Medicaid eligibility limit. Recent changes in the Medicaid application process and early difficulties in CHIP enrollment are addressed in Policy H-290.982 ([AMA Policy Compendium](#)). CMS Report 5 (I-99), which is before the House of Delegates at this meeting, provides a status report on the Medicaid program, and describes Policy H-290.982 and other Medicaid and child-related policies in detail.

In addition, the Council on Medical Service has been aggressive in developing and refining AMA policy for private sector health insurance reform as presented in CMS Report 9 (A-98) and documented in Policy H-165.920. In adopting the recommendations of CMS Report 2 (A-99), which provided an update on increasing access for the uninsured, the House of Delegates established policy opposing new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations. CMS Report 2 (A-99) also described characteristics of various groups of the uninsured, and concluded that AMA policy supporting individually owned insurance (Policy H-165.920) remains relevant for addressing the coverage needs of many of the currently uninsured. Also at the 1999 Annual Meeting, CMS Report 5 discussed the voluntary choice cooperative concept necessary to implement the AMA’s private sector vision for individually owned insurance.

Policy H-165.920 contains a broad set of recommendations for reforming private sector health insurance in a manner that increases patient choice and allows for expanded coverage through individually selected, purchased and owned insurance, rather than employer-sponsored coverage. The policy calls for legislation that would allow individuals to receive tax credits for the purchase of health insurance.

Policy 165.882 includes 11 recommendations for increasing access for children including a preference for enabling children to obtain private coverage rather than being placed in Medicaid. The policy also contains four recommendations for improving access for uninsured persons of all ages, including the creation of some type of voluntary choice cooperative that would allow individuals to pool risk and receive group insurance rates outside of an employer relationship.

LEGISLATIVE AND REGULATORY DEVELOPMENTS

Several recent legislative and regulatory developments emphasize increasing access and expanding coverage, including some that would provide individuals with a tax credit to purchase health insurance. In addition, the AMA continues to be involved in assuring that public sector programs fulfill their safety net function.

Legislative Developments

A number of legislative proposals were introduced in the 106th Congress and many continue to be under development that would expand patient choice and access to health insurance by restructuring the tax code so that individuals could receive a tax credit toward the purchase of health insurance. The AMA reviewed proposals by Reps. Dick Armey (R-TX) (H.R. 2362), Charlie Norwood (R-GA) (H.R. 1136), Pete Stark (D-CA) (H.R. 2185), and John Shadegg (R-AZ) (H.R. 1687), pursuant to requests of the legislators. Although many proposals have been gaining popularity with interest groups and other members of Congress, at the time this report was written none had emerged as significant legislation in terms of leadership support or committee recognition.

All of the cited bills would amend the tax code to allow individuals without employer-sponsored coverage to receive a refundable tax credit toward the purchase of qualified health insurance coverage, excluding from eligibility those covered by Medicare, Medicaid, and other various federal health insurance programs. The amounts of the proposed credits varied from \$500 to \$1200 for each individual and from up to \$1000 to \$3600 maximum per family.

Rep. Norwood’s bill would have allowed individuals with employer sponsored coverage to receive a credit up to \$400 (and \$200 for each dependent) to use for supplementing or improving the coverage under their current policies. Rep. Stark’s bill would allow advanced payment of the credit to providers of health insurance coverage and would establish an Office of Health Insurance (OHI) under the Department of Health and Human Services to administer the program. The OHI would contract with insurance carriers in a manner similar to the Federal Employee Health Benefits Program (FEHBP) and would be required to apply premiums on a uniform, community-rated basis.

None of the bills that have been introduced is in complete accordance with AMA policy on private sector insurance reform, yet all seem to take a step in the right direction. The AMA has communicated this view to these members of Congress, while outlining its specific policy goals for long-term insurance reform and pledging to work with them and all interested parties to find some common ground before we endorse any specific legislation.

The Council on Medical Service is continuing to further refine the tax credit portion of the AMA's private sector reform proposal for individually owned insurance. CMS Report 16 (I-99), which is before the House of Delegates at this meeting, includes a preliminary examination of the economic issues related to evaluating alternative proposals for providing individuals with a tax credit for the purchase of health insurance.

Federal Regulatory Activities

Throughout 1999, the AMA has continued to promote policies to increase access for the uninsured to the Clinton Administration, including the White House, the Department of Health and Human Services (HHS), and the Health Care Financing Administration (HCFA). These communications have emphasized the need for private insurance market reforms such as tax credits and voluntary choice cooperatives as well as public sector improvements in Medicaid and CHIP. Highlights of federal regulatory activities include the following:

- In comments to HCFA on Medicaid managed care, the AMA emphasized the need to maintain Medicaid enrollees access to the public health safety net of providers that has traditionally provided their care but may be denied access to these providers due to managed care contracting decisions. In addition, the AMA has worked with HHS on the issue of maintaining access to critical safety net providers.
- In January, the Council on Medical Service met with HCFA staff to discuss Medicaid financing and CHIP implementation issues, which led to the development of CMS Reports 5 (I-99) and 2 (A-99).
- The AMA has emphasized in communications to the White House and HCFA that a need exists to improve outreach to women and children who are eligible for Medicaid coverage, but who are not enrolled in the program.

TARGETED OUTREACH AND COALITION-BUILDING

The AMA also has conducted significant targeted outreach to business organizations and employers to promote AMA policy on increasing access and expanding coverage. Specific activities include the following:

- In December 1998, Doctor Dickey's speech at the National Press Club launched a national "Physicians Work Group on Universal Coverage" (the Work Group), which included the AMA, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Emergency Physicians, the American College of Obstetricians and Gynecologists, the American College of Physicians-American Society of Internal Medicine, and the American College of Surgeons. Early in 1999, the Work Group developed a Joint Statement of Principle supporting a common goal of working toward enabling every American to have health insurance.
- The AMA hosted a national Health Sector Assembly in October 1999. Improving access to health insurance coverage was the topic of this first Health Sector Assembly, which was convened to enhance the AMA's leadership role on matters related to health. Participants represented diverse thought leaders and policy makers in key health sector organizations and fields of work.
- In February 1999, the Executive Committee of the AMA Board of Trustees met with the leadership of the U.S. Chamber of Commerce, the nation's largest association of business interests, to discuss health insurance reform, with an emphasis on the AMA's policies on individually owned and selected health insurance and increasing access for the uninsured. The discussions were productive and an AMA staff task force was created to follow-up with Chamber staff. The AMA and Chamber task forces have met several times to discuss the uninsured and increasing access through the use of mechanisms such as tax credits and voluntary choice cooperatives. In October 1999, the Chamber sponsored a Policy Forum on the Uninsured in Washington, DC, in which the AMA participated. Discussions with the Chamber will continue into the year 2000, with the goals of reaching consensus on proposals to increase access to the uninsured.

- AMA leadership and staff continue to conduct targeted outreach to individual employers and their health benefits staff to discuss AMA policies to promote patient choice and increase access for the uninsured, including outreach to corporations such as 3M, Xerox, Motorola, and Baxter International.
- AMA senior staff in Washington met with staff of the National Federation of Independent Business, which represents small employers of 50 or fewer employees, to discuss efforts to increase access to health insurance, particularly for employees of small businesses.
- AMA staff presented the AMA goal of increasing access and plan for expanding coverage to various employer health care purchasing coalitions across the country, including the Buyers Health Care Action Group in Minneapolis, the Washington Business Group on Health, and the National Business Coalition on Health.
- The AMA revised its “Expanding Access” and “Rethinking Health Insurance” advocacy booklets on expanding access and individually owned and selected health insurance and distributed them to over two hundred employers and employer purchasing coalitions throughout the country.

AMA ADVOCACY COMMUNICATIONS

Increasing access and expanding coverage were prominently communicated at the 1999 Annual Meeting with the presentation of the “Is it Good Medicine?” communications campaign, which focused on coverage as an initial key theme. To highlight the campaign, the AMA placed full-page advertisements in the Chicago Tribune and USA Today on June 21, 1999 that called for increasing access and expanding coverage.

Also during the 1999 Annual Meeting, the AMA Department of News and Information, in a cooperative effort with several state and county medical associations, produced the Hometown Radio Program with access as its sole topic. This was the second year in a row that the Hometown Radio Program had concentrated on access and coverage. This year, physician delegates participated in 46 interviews via telephone with their hometown radio stations in 10 states.

On June 14, 1999, the AMA joined other members of the Work Group in a press conference to announce the group’s joint statement and to issue a challenge to the 2000 presidential candidates to make health insurance a top priority. At the press conference the group vowed to fight for (1) health care coverage for all Americans; (2) health care coverage containing a benefits package; and (3) medical necessity under the benefits package that reflects the generally accepted standards of medical practice, supported by outcomes based-evidence.

Doctor Dickey represented the AMA during the Work Group press conference, which was just one of many speeches about access and coverage she has delivered around the country. In all, Doctor Dickey has participated in approximately 25 events during which she urged solutions to the problem of the uninsured or presented the AMA’s proposal for private sector insurance reform. Notably, she met with the Employee Benefit Research Institute in May 1999, to discuss the AMA plan for individually selected, purchased and owned insurance. Other members of the AMA Board of Trustees and senior staff have used an additional 25 speaking engagements as an opportunity to promote continued attention on the uninsured and the AMA’s proposal for private sector reform.

Doctor Dickey’s efforts to keep the nation focused on access and coverage has been noted in various media as well. AMNews featured her prominence on this topic in two separate issues during July 1999. While Doctor Dickey served as AMA President, the AMA web site’s section “From the President” included a message from Doctor Dickey on the importance of expanding coverage, as well as an excerpt from one of Abigail Trafford’s Washington Post columns, which took the form of a letter to Santa Claus telling him what she wanted for Christmas. Her request mirrors one of the primary tenets of the presidency of Doctor Dickey--universal access to health care coverage. Furthermore, one of first postings to this site by current AMA President, Thomas R. Reardon, MD, reiterated the message of the Work Group by challenging declared candidates for the year 2000 to make expanding coverage a priority.

DISCUSSION

In this report, the Board of Trustees has summarized the key AMA activities that have been undertaken during the past year in an effort to raise national awareness about the uninsured and to promote the AMA vision for reforming the private health insurance system. The Board believes that these activities are particularly timely as the nation

enters a Presidential election year. The growing number of legislative and regulatory proposals that seek to provide a tax credit for the purchase of health insurance is particularly encouraging at a time when the Council on Medical Service is refining its tax credit proposal so that the AMA will be better able to evaluate and comment on future proposals. Nonetheless, the Board believes the AMA must remain diligent in its advocacy for private sector insurance reform throughout the coming year.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

1. That the AMA continue to place the highest priority on achieving well-designed health expense coverage for all Americans.
2. That the AMA place increased emphasis on advocacy communications during the 2000 Congressional and Presidential election campaigns to promote candidate commitments to address the growing number of the uninsured.
3. That the AMA continue to develop and advocate policy in response to the needs of public sector "safety net" programs, particularly Medicaid and the Children's Health Insurance Program.

3. NATIONAL LEADERSHIP DEVELOPMENT CONFERENCE

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

At the 1999 Annual Meeting, the House of Delegates adopted Resolution 606, "Reduction of High Tuition Costs for AMA Leadership Meeting," originally introduced by the Pennsylvania delegation. The adopted version reads: "Resolved, that our AMA will study methods to increase the financial support available to members who wish to attend the leadership meeting but face a financial hardship in doing so and study ways to increase participation in the annual leadership meeting." This informational report summarizes the Board's investigation of financial support for attending the National Leadership Development Conference and describes steps being taken to meet the intent of the resolution.

DISCUSSION

The National Leadership Development Conference (NLDC) was established in 1971 to provide an educational forum for established and emerging leaders of state, county, and national medical specialty societies. Since its inception, the primary goals of the conference have been to educate the leadership of the Federation about crucial issues confronting the profession and to provide opportunities for those individuals to develop the leadership and management skills.

The NLDC has never been designed to generate revenue for the AMA. Since its founding in 1973 the National Leadership Conference and its successor, the NLDC, have been subsidized by the AMA. While a registration fee has been charged since the conferences began, the AMA has provided subsidies ranging from \$20,000 to \$300,000 per year to meet direct expenses of the conference. The variation in the amount of this subsidy is caused by factors including location, the number of and fees for nationally known speakers, and for special events tied to the NLDC, such as the AMA Sesquicentennial observation in 1996. The AMA further subsidizes the NLDC through the hundreds of hours of staff time dedicated to planning and conducting the meeting.

For the 1999 NLDC, the registration fee was \$400 for those who registered in advance and \$470 for those registering later. Reduced rates are offered for members of unified medical societies and societies with fewer than 500 members [advance registration \$290; later registration \$360], and residents and medical students [\$75]. The registration fee for the NLDC has been relatively constant with only 3 minimal increases since 1995 for a total increase of \$25, while expenses for equipment rental, food functions, hotel charges for labor, etc., have increased at a much higher rate.

In comparison with other national medical organizations that hold similar leadership meetings the AMA registration fee is low. For example, a comparable meeting by a national specialty society has a registration fee of \$599 for members who register early, then \$695 after the cutoff date. In addition, guests are charged \$250 for meal functions as compared to the function cost that AMA charges, \$25 for receptions and \$35 for lunches on average.

The Board has also looked at state medical associations that hold leadership meetings. A large state society charges \$495 for a comparable length of meeting, but does not have national speakers throughout the meeting. Other states charge \$250 to \$300 for 1-1/2 day meetings.

To address concerns about the cost of the NLDC, the AMA in 1998 began to seek unrestricted educational grants to offset some costs and to minimize the need to increase fees. Other sources of revenue currently are now being sought, including educational grants from pharmaceutical companies and allied organizations to sponsor speakers. The NLDC also has been opened up to commercial exhibitors who pay a fee to market their products or services to NLDC participants. This is only the second year in which financial sponsorship has been sought for the NLDC and a record of continued support needs to be established before registration for members facing financial hardship can be reduced.

At the 2000 NLDC, which will be held March 25-28 at the Fontainebleau Hilton, Miami, Florida, the AMA has already received a commitment from Glaxo Wellcome to support a special track within the NLDC that will be targeted specifically to attract emerging young leaders.

To increase medical student and resident participation in the NLDC, the AMA in 1999 reduced the registration fee for students/residents to \$75 from \$130. Similar discounts will apply in the future, as will reduced rates for students/residents, members of unified societies, and representatives of societies with fewer than 500 members.

CONCLUSION

The Board of Trustees supports the goal of minimizing registration fees for participants in the National Leadership Development Conference. At the same time, the Board recognizes the need for presenting a program that provides real value for the diverse group of individuals who participate.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and that the remainder of this report be filed:

1. That the Board of Trustees will monitor closely the costs of future sessions of the National Leadership Development Conference; and
2. That AMA will continue to aggressively seek outside sources of funding to reduce the cost of attendance at future conferences.

4. THE AMERICAN MEDICAL ASSOCIATION'S MEDICAL PRACTICE SURVEY RESEARCH PROGRAM (SUBSTITUTE RESOLUTION 614, A-98)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 106 AND SUBSTITUTE RESOLUTION 614 (A-98) AND REMAINDER OF REPORT FILED

At the 1998 Interim Meeting, the House of Delegates referred Board of Trustees (BOT) Report 6 (I-98). BOT Report 6 (I-98) responded to referred Substitute Resolution 614 (A-98), which asks the American Medical Association (AMA) to conduct a statistically significant survey of compensation of all physicians, nationally and regionally, over the last ten years to clearly determine the impact of current reimbursement practices and managed care on the practice of medicine; and to gather data on their impact on the number and distribution of specialists, practice structure, and practice size. The substitute resolution also calls for physician income to be reported at a per-hour rate and for the AMA to regard physician income information data as proprietary. Finally, Substitute

Resolution 614 calls for the AMA Board of Trustees to develop a report and/or presentation for the House of Delegates that delineates how physician income data are acquired and used by the AMA, what other sources of physician income data exist, the accuracy of AMA data and data from other sources on physician income, and AMA policies and procedures for releasing these data.

Previous resolutions and Board of Trustees reports have addressed this subject (Policy H-405.993, AMA Policy Compendium). BOT Report 7 (A-94) reevaluated the need for and methods of collecting, evaluating and presenting physician income data. The report, which was adopted by the House of Delegates, directed the AMA to continue to publish information on the socioeconomic characteristics of medical practice, including income, to counterbalance less accurate and comprehensive statistics released by other organizations.

This report reviews the history of data collection on physicians' practices; reviews the purpose, scope, and uses of the Socioeconomic Monitoring System (SMS) survey; discusses how the income data are collected in SMS; discusses how the accuracy of SMS income data has been verified; reviews uses of physician income data; discusses factors affecting physician earnings; reviews methodological research that has been conducted on the SMS survey; and discusses how the AMA responded to media requests for SMS income data in 1999.

HISTORY OF PHYSICIAN DATA COLLECTION

Concerns about the cost and availability of medical care and the economic status of physicians have led to a number of data collection efforts on physicians and their medical practices during the 20th Century.

The first comprehensive survey of physicians in this century was conducted in 1929 and provided much of the data analyzed by the first Committee on the Cost of Medical Care, which published its report in 1933. The data included measures of physicians' gross and net incomes, size of the communities in which they practiced, age, years in practice, areas of specialization, estimates of percent of charges collected and free care provided, and hospital privileges.

The next major physician survey was conducted jointly by the U.S. Department of Commerce and the American Medical Association in 1950. Data were provided by 55,000 of the 125,000 physicians who received the survey. The survey focused on physicians' gross and net incomes, employment status, specialty, and size of locality of practice. The 1950 data were compared to the 1929 data to determine the changes that had occurred over the period and the current economic status of physicians relative to the general population. The data were used to ascertain the validity of assertions made by many at the time that there was a nationwide shortage of physicians. It was concluded that, because physicians' incomes were not extraordinarily high, a general shortage did not exist.

Beginning in the 1950s, a major source of data on physicians' earnings has been Medical Economics Company, the publisher of Medical Economics magazine. The company surveys its subscribers about gross and net earnings, as a basis for magazine articles.

In 1966, the AMA initiated an annual mail survey of a nationally representative sample of office-based physicians to collect comprehensive information on medical practice characteristics. The survey's declining response rate led to its discontinuation in 1981. In 1981, the AMA initiated the Socioeconomic Monitoring System (SMS), which collects comprehensive information on medical practice from telephone interviews of office-based and hospital-based physicians.

In 1992, the U.S. Commerce Department discontinued reporting data from Medical Economics in The Statistical Abstract of the United States, replacing it with data from the SMS which, although based on a smaller sample of physicians, had a superior response rate (32% for the Medical Economics mail questionnaire vs. 69% for the SMS telephone interview survey). The Commerce Department evidently waited until 1992 so that a long SMS annual time series was accumulated before making the replacement.

Today, the SMS is the major source of data on physicians and their medical practices. The success of the for-sale publications based on the SMS data attests to its value to the physician community. Gross revenues from sales of the SMS data publications reached \$511,000 in 1998, which offset the direct cost of data collection.

DESCRIPTION OF SMS

The SMS is an annual telephone survey of a nationally representative sample of nonfederal patient care physicians who have completed residency training. The SMS is the AMA's project for obtaining information on physicians' practice characteristics such as hours worked, number of patient visits, professional expenses, Medicare and Medicaid participation, managed care involvement, and medical practice revenue. The scope of physicians surveyed in SMS is broader than any other physician survey; the SMS sample represents more than three-fourths of the nation's active physicians, a much higher proportion than any other source. In addition, the SMS response rate has generally been higher than that of similar physician surveys.

The SMS survey is conducted by an external survey firm with a national reputation. Currently, the survey contractor is Mathematica Policy Research.

The AMA works diligently to maintain its reputation as the leading source of medical practice information needed to represent the profession and serve physicians' needs for information about their medical practice environment. The credibility of the survey is largely due to the openness with which the survey data are made available to the public and the policy research community, as well as the survey's representativeness, high response rate, and demonstrated validity. The SMS data publications include a number of statistics (mean, median, number of respondents, standard error, and percentile distributions) so that users have complete information about the survey estimates. In addition, methodological research on the survey has been presented to the survey research community annually at meetings of the American Statistical Association.

The SMS survey is an invaluable source of data for AMA policy development and advocacy. For example, SMS survey data have been used to develop estimates of the costs of defensive medicine and the amount of charity care provided by physicians. The data have been used by AMA staff in developing congressional testimony on issues such as self-referral and revisions to the Medicare fee schedule. SMS data have been used to document the impact of Medicare payment reductions on services delivered to Medicare beneficiaries and ways physicians have reduced costs. SMS data have been cited in numerous reports of the Council on Medical Service and other AMA Councils over the years. The practice expense data from SMS have been used recently by the Health Care Financing Administration (HCFA) to revise the practice expense relative value units of the Medicare physician payment schedule. SMS data have been used in analyses conducted for medical specialty societies to provide documentation for their comments on proposed modifications to the Medicare physician payment schedule.

An independent review of the SMS survey methodology is being prepared and will be available for the December meeting of the House of Delegates.

COLLECTING PHYSICIAN INCOME DATA IN SMS

Questions about the physician's income comprise only a small part of the SMS survey (8 items out of more than 300). First the respondent is asked his or her income from medical practice in the previous calendar year, after expenses before taxes, including all income from fees, salaries, retainers, bonuses, deferred compensation, and other forms of monetary compensation, but not investment income from medical-related enterprises independent from the medical practice. Employees are instructed not to include the value of fringe benefits. Next the respondent is asked if (s)he received deferred compensation in the last year, how much, and if it was included in the net income figure just reported. (In cases where the deferred compensation was not included, the net income estimate is revised to include it). The respondent is asked if any of the net income reported was from salaries, and, if so, how much. The respondent is asked if any of the net income was received in bonuses, and, if so, how much. Attachment A provides the full text of this series of survey items.

The SMS field period typically begins in April, so that respondents will have financial information from the previous year available from tax returns.

Respondents who express concern about providing income information are assured that the information will be treated as confidential and only summary figures will be published. However, the response rate to the net income item has been lower than that of most other survey items. Recent income item response rates have been about 75%.

ACCURACY OF SMS PHYSICIAN INCOME DATA

Many physicians have questioned the “accuracy” of the income estimates derived from the SMS survey of physicians. They feel that the estimates are too high in light of their own situations and those of their colleagues.

Many physicians may be justified in their thinking that the SMS income estimates, which they learn about primarily through newspaper and magazine reports, are “too high.” This is because the news reports stress the arithmetic mean or average earnings, which do not reflect the experience of the typical physician. The distribution of physicians’ earnings is highly skewed, resulting in the arithmetic mean or average being shifted toward the high end of the distribution.

There is also a wide variation in earnings across specialties and other physician characteristics that the press does not report. Physicians in the groups whose typical earnings are not accurately characterized by the overall average would naturally think that the data reported by the press do not accurately reflect their earnings. Figure 1 illustrates the wide dispersion of physicians’ earnings across the specialty categories reported in SMS publications but typically ignored by the press. The SMS data publications provide statistics (including median, standard error, and percentile distribution) that are not presented in media reports.

A better measure of the typical physician’s earnings than the mean is the median, which is the earnings level that divides the upper and lower half of physicians in the sample. In other words, 50% of physicians in the sample earned less than the median, and 50% earned more. In 1997, the mean net income (after expenses, before taxes) of physicians in the SMS sample was \$199,600 while the median was \$164,000. In reporting the mean, the press conveys a misleading picture of the earnings of the typical physician. In 1997, 61.1% of physicians earned less than the mean of \$199,600.

In the past, HCFA periodically conducted a comprehensive survey of physicians, the Physicians’ Practice Costs and Income Survey (PPCIS). In a study done for HCFA by the Center for Health Economics Research, an independent consulting firm, comparing the 1989 PPCIS with the 1989 SMS survey, it was noted that the sampling frame, questionnaire, and data collection methods of the two surveys were quite similar. However, the field period and interview length for the PPCIS were longer, and PPCIS only surveyed physicians who were practice owners or worked in a practice owned by physicians. SMS had a higher survey response rate (61% for the PPCIS, 72% for SMS). Some of the means of survey variables compared were fairly similar, most notably net income. The 1988 mean income of PPCIS respondents was \$163,209 compared to \$153,724 for comparable SMS respondents (i.e., SMS respondents who would have been included in the PPCIS); this difference was not statistically significant at conventional confidence levels. The standard error of the mean income on SMS was considerably lower than on PPCIS (2,076 vs. 8,451).

Many surveys of physician earnings are conducted each year. Modern Healthcare magazine publishes a summary comparison of nine or more physician compensation surveys in July each year. However, the magazine’s comparisons can be misleading because they use data from different years and do not stress other differences in the surveys such as populations and definitions.

None of the physician compensation surveys yields estimates that are directly comparable to SMS estimates. However, comparison of SMS estimates of physician earnings with those from other surveys with known differences can be useful if the differences are taken into account. The following table compares SMS estimates of annual mean physician compensation for selected specialties with those from three other sources:

- The American Medical Group Association (AMGA), a trade association of large group practices that surveys only AMGA members;
- The Medical Group Management Association (MGMA), a trade association of primarily small group practices that surveys only MGMA members; and
- The Hospital and Healthcare Compensation Service (HHCS), a consulting firm that conducts a compensation survey of employed physicians.

In contrast to the three surveys described above, the SMS survey represents a broad population of physicians. It is based on a random sample of all non-federal patient-care physicians who have completed residency training. The particular specialties for comparison of the survey estimates were chosen because all of the surveys report figures for them, and the definitions of the particular specialty groups are fairly consistent across the surveys.

Estimates of Physicians' Average Annual Compensation, Various Surveys, 1997
(Thousands of Dollars)

<u>Specialty</u>	<u>AMA</u>	<u>AMGA</u>	<u>MGMA</u>	<u>HHCS</u>
Anesthesiology	236.2	244.3	269.0	187.8
Family Practice	140.9	148.1	145.2	136.7
General Surgery	225.2	249.4	252.4	229.8
Obstetrics/Gynecology	228.7	238.3	236.4	210.1
Pathology	200.9	219.6	232.4	169.1

We know that earnings of physicians in group practices typically exceed earnings of employee physicians. (Data on earnings of employee vs. other physicians are reported in Physician Socioeconomic Statistics, 1999-2000 Edition, as well as previous editions of Socioeconomic Characteristics of Medical Practice published by the AMA). Thus, estimates of mean annual earnings from the SMS would be expected to be above those of the HHCS estimates, but below the estimates from the AMGA and MGMA. The comparisons in the table above confirm that this is indeed the case. Thus, the SMS estimates can be deemed "accurate" because they fit the expected pattern in terms of comparative magnitude.

Another test of validity implicit in the comparison regards the ability of the telephone survey technique employed by the SMS to gather "accurate" information. In contrast to the SMS technique, data for the surveys of medical practices are provided by practice administrators from administrative records, which some might regard as more objective than responses to questions by physicians over the telephone. The consistency of the pattern of SMS income estimates in relation to the medical practice survey estimates would seem to confirm physicians' ability to respond accurately to the SMS interview.

USES OF PHYSICIAN INCOME DATA

Income information from SMS fulfills many critical AMA research needs. Income data have been used to analyze the impact that managed care has had on earnings, to estimate the economic return to practice ownership relative to employment, and to determine whether year-to-year adjustments in physician payments by Medicare and other programs allow income to keep up with inflation and the cost of producing services. Income is an important variable in the AMA's Medicare physician payment microsimulation model used to assess the impact of alternative Medicare payment proposals on physicians' earnings. SMS physician income data are also used in federal policy-making; one element of the Medicare Economic Index used in updating physician payment is an SMS measure of physician income.

Many AMA members are interested in what others in their specialty, type of practice, age group, and geographic area are earning. Income data are used by medical practices to develop compensation plans for physicians and to determine annual salary adjustments. The data are used by individual physicians in negotiating compensation plans. Geographical earnings differences can indicate differences in relative supply and demand for medical services and are an important factor in many physicians' location decisions. In addition, the SMS income data have been used to adjust compensation of AMA Officers and Trustees.

FACTORS AFFECTING PHYSICIAN'S EARNINGS

The 1990s have seen numerous developments that have impacted the physician services market and earnings of physicians. In 1992, Medicare began to pay physicians under a new system that altered the relative payments for different types of services and placed a potential constraint on aggregate payments to physicians. Physicians have become more involved with managed care organizations, in which capitation and discounted fees are the norm. The physician workforce has continued to grow more than twice as fast as the general US population, creating more competition among physicians for patients. Over this period, the proportion of physicians who are female increased about 50 percent. The diffusion of new medical care technologies has resulted in changes in the service delivery

sites from inpatient to outpatient settings. These changes have had significant impacts on the way that the practice of medicine is organized and on physicians' earnings. The following relates the impacts of these significant developments on physicians and their practices.

Federal and resident physicians are excluded from the analyses because they have not been significantly affected by these developments.

Physician Involvement with Managed Care

Data from the SMS survey show that physician involvement with managed care has become nearly universal. In 1998, 94% of physicians were in practices with one or more contracts with managed care organizations. A high rate of involvement was found for physicians in all specialties, census divisions, and practice sizes. Psychiatrists and solo practice physicians, who historically had low involvement with managed care organizations, are now mostly found in practices with contracts. Among psychiatrists, 84% are in practices that have managed care contracts and 91% of solo practice physicians have such contracts.

Among physicians in practices with managed care contracts, more than half of their practice revenue, 56%, was derived from managed care revenue in 1998. In 1997, just under half of the revenue was from managed care and in 1996 the proportion was 44%. While contracts with managed care companies tend to be universally prevalent, the percentage of revenues from these contracts varies considerably by physician specialty, as shown in Figure 2.

The proportion of physicians in practices with contracts from private managed care organizations increased from 81% in 1996 to 90% in 1997 and 91% in 1998. Medicare and Medicaid contracting became more widespread between 1996 and 1998. During this period, the percentage of physicians in practices with Medicare contracts increased from 56% to 67% and the Medicaid percentage increased from 54% to 67%. In 1998, private managed care contracts accounted for 36% of practice revenue, Medicare contracts accounted for 19% and Medicaid accounted for 12%.

In 1998, 38% of physicians were in practices that had at least one capitated contract and the average capitated revenue share was 24%.

Trends in Employment and Practice Size

Two major changes in the practice of medicine are an increase in the number of physicians who are employees and an increase in the size of physician practices. The percentage of physicians who are employees increased from 22.6% in 1987 to 38.8% in 1997. In the past, physicians typically started practicing medicine as employees and became self-employed as they gained experience. Employee status continues to be prevalent among young physicians. The percentage of physicians with five years or less experience who were employees increased from just over 40% in 1987 to 65% in 1997. However, more physicians are remaining employees even as they gain experience. About one-fourth of physicians with 6-15 years experience were employees in 1987 and this percentage grew to 44% in 1997. Among physicians with over 15 years experience, the percentage of employees grew from just over 20% to 35% between 1987 and 1997.

In 1997, just over 27% of all physicians were in solo practice. Although physician practices are not as large as commonly thought, practice sizes have increased. In 1988, 50.7% of noninstitutional physicians were in practices with 2 or more physicians, 23.5% were in practices of 5 or more, 11.9% were in practices of 10 or more, 7.7% in practices of 20 or more, and 3.8% were in practices of 50 or more. By 1997, 61% of noninstitutional physicians were in practices of 2 or more, 35.2% were in practices of 5 or more, 18.6% were in practices of 10 or more, 10.3% were in practices of 20 or more and 4.8% were in practices of 50 or more. It appears that the biggest increases were in practices between 5 and 20 physicians.

Trends in Median Net Income and Hourly Earnings

Figure 3 shows the trend in median net income from 1987 to 1997. Median physician net income grew at an annual average rate of 4.3% during this period. Median physician net income increased from \$108,000 in 1987 to \$164,000 in 1997. Adjusting for inflation, median net income grew at an annual rate of 0.7% over this period.

Self-employed physicians experienced greater growth in median net income. Median net income for self-employed physicians increased at an average annual rate of 6.4%, from \$120,000 in 1987 to \$200,000 in 1997. Employees of institutions (hospitals, state and local governments, HMOs) experienced an annual growth rate of just 4.5%, from \$90,000 in 1987 to \$140,000 in 1997. Net income for employees of group practices grew at a rate of 5.6%, from \$80,000 in 1987 to \$140,000 in 1997. Although employees of group practices and employees of institutions ended up with the same median net income in 1997, they came to that level in different ways. Median net income increased steadily for employees of group practices over the ten-year period. Median net income for employees of institutions reached \$150,000 in 1993, stayed at that level in 1994 and then declined in 1995, 1996, and 1997.

The higher net income of self-employed physicians is attributable in part to a return on the investment in their practice--a premium for entrepreneurship and risk-taking--over and above compensation for providing medical services. However, self-employed physicians must also provide their own benefits that are typically provided by employers to employees. Three-fourths of employee physicians receive such benefits and these benefits represented about 5% of income for employees. Historically, self-employed physicians have had different practice and personal characteristics than employee physicians. For example, self-employed physicians work more hours and have more patient visits than employee physicians. They are more likely to be board certified and have a greater amount of practice experience. These characteristics are associated with higher income levels.

Figure 4 shows trends in net income per hour over the period 1987-97. Net income per hour for all physicians (annual net income divided by total hours worked per year) increased from \$41.00 in 1987 to \$50.40 in 1990 and \$65.90 in 1997, at an average annual rate of 4.9%. For self-employed physicians, net income per hour increased from \$44.00 in 1987 to \$54.40 in 1990 and \$72.10 in 1997, an average annual rate of increase of 5.1%.

Physician Income: An Analysis of High and Low Earners

A comparison of high earners, physicians who earn more than the 75th percentile of net income, and low earners, physicians who earn less than the 25th percentile of net income, among respondents to the SMS survey shows the following differences:

- About 90% of all high earners are board certified compared with 68% of low earners.
- More than half of low earners are employees compared with 20% of high earners.
- More than 70% of high earners are self-employed; however, 40% of low earners are also self-employed.
- Solo physicians comprise over 46% of all low earners compared with about 25% of high earners.
- Two-thirds of high earners are in practices of 2-25 physicians. Less than half of low earners are in practices of 2-25 physicians.
- The average practice size in terms of both physicians and nonphysician personnel per physician is greater among high earners.
- Female physicians make up over one-fourth of low earners and just 4% of high earners.
- Young physicians (under age 36) represent about one-fifth of low earners. Almost 80% of high earners are in their peak earning years, ages 36-55. However, half of low earners are also in this age group.
- High and low earners work about the same number of weeks per year but high earners work more hours per week, have more patient visits per week, and perform more surgeries per week.
- The percentage of practice revenue from managed care is about the same for high and low earners.
- Low earners spend almost half of their time in primary care activities. In comparison, high earners spend just 15% of their time in these activities.

Characteristics such as specialty, gender, board certification, age, and employment status differentiate high earners from low earners. However, time spent in practice and productivity levels play a major role in determining income

levels. Also, because they treat mostly nonprimary care patients, high earners are heavily involved with the small concentration of the population who account for a larger percentage of health expenditures.

Physician Actions That May Impact Earnings From Medical Practice

The SMS has tracked physician net income information since 1982. During the period 1982-1997 both average and median nominal net income declined only once, between 1993-94. Median net income declined 1.2% in 1997 but average income increased 0.3%. Lack of significant declines in physician net income has caused some puzzlement among health industry analysts. Increasing pressures from managed care companies and the Medicare program were expected to put downward pressure on income levels. Often overlooked are actions physicians can take, in response to a changing practice environment, that may have allowed them to enhance or maintain their earnings.

The 1998 SMS survey included questions on a number of these actions. Physicians were asked if, during the past two years, they had made specific changes to their practice in an effort to cut costs or increase revenues. Among responding physicians:

- 30% reduced staff costs (e.g., reduced office staff, curtailed salary increases, or reduced fringe benefits);
- 59.9% increased productivity in treating patients (e.g., reduced visit length, referred difficult cases to other physicians, substituted videos for face-to-face patient counseling, improved scheduling of surgical procedures, or did more in less time);
- 12.8% reduced amenities for patients (e.g., reduced telephone consultations or dropped commercially produced pamphlets and brochures);
- 34.3% postponed investing in new equipment;
- 18.6% joined a larger group or moved to another practice location;
- 25.6% diversified practice (e.g., dispensed pharmaceuticals, expanded in-office testing or dispensed eyeglasses).

Overall, 65.6% of physicians said that they engaged in at least one of these activities. It is not possible to directly assess whether physicians taking one or any of these actions successfully maintained or increased their income. However, the SMS sample's reinterview component provides one means of analyzing the issue. In each SMS survey, about one-third of the sample had been surveyed in the previous year. About 1300 physicians, surveyed in 1997 and 1998, provided income figures for both 1996 and 1997. Over 60% of this sample experienced an income decline between 1996 and 1997.

In the aggregate, physicians in the reinterview sample who engaged in at least one of the activities enumerated above were less likely to have experienced an income decline. Individually, only efforts to increase productivity had a statistically significant relationship with earnings. Among physicians who made specific efforts to increase productivity, 43.2% experienced an income increase between 1996 and 1997. In comparison, only 36.3% of physicians who did not take productivity enhancing measures experienced an income increase.

In general, there were not statistically significant associations between these actions and reported earnings. Still, it remains possible that physicians who experienced income declines may have prevented even greater decreases by taking these actions.

METHODOLOGICAL RESEARCH ON THE SMS SURVEY

AMA staff who manage the SMS program maintain a program of quality control and methodological research on the survey. Over the years, research has addressed survey issues such as: characteristics of nonrespondents; comparisons of data quality in mail versus telephone surveys; comparisons of data obtained from physician versus proxy respondents; an examination of an optimal telephone calling strategy for physician practices; and a comprehensive summary of the literature on physician surveys.

This research has served two major purposes. First, it has led to improvements in the SMS survey. For instance, the examination of characteristics of nonrespondents to the survey led to the weighting strategy now in use. Weights are

commonly used to adjust survey estimates so that they accurately portray the experience of the population of interest. Even when the survey response rate is fairly high, if the respondents differ from nonrespondents the survey estimates may be biased. Research has determined that SMS respondents and nonrespondents differ systematically by specialty, years of experience, AMA membership, and board certification. These characteristics are related to many of the survey variables of interest. Thus, weighting is used to adjust for survey nonresponse bias.

The second purpose of the methodological research is to enhance the visibility and credibility of AMA's survey program. Users of the data can refer to the research to better understand the properties of the data and gain assurance that crucial methodological issues have been addressed by the AMA in accepted scientific ways.

REPORTING AND RELEASE OF PHYSICIAN INCOME DATA

Although the AMA publishes income statistics in revenue-generating publications, they are not actively promoted to the press. There is no formal "release" of the income data. They have become available to the public when the books containing the data are published. Public attention seems to be drawn to the statistics only when a national newspaper or a wire service runs a story on the latest physician income estimates.

A fact sheet with survey highlights has been prepared each year for use by AMA communications staff to provide to members of the media who specifically request it. The fact sheet contains highlights from the entire survey, not just income, along with a discussion of factors (such as long work weeks, many years of education and training, and high educational debt) that help put income levels and trends into the proper perspective.

In the past, communications staff have provided copies of the income tables from the publications when requested by members of the media. Beginning in 1999, communications staff ceased providing income information other than the fact sheet. Members of the media who wanted further information were advised to purchase the publication.

In 1999, the communications strategy for handling the publication of the latest SMS income data involved proactive news management. Realizing that the media would pursue this topic, we chose to be proactive, tell our own story, and present recent physician income data against an essentially flat 10-year historic trend. In doing so, we also cited a study comparing lifetime earnings of physicians, attorneys and business leaders (physicians were lowest) and noted that most physicians, unlike many employees, have to pay for benefits out of their net income.

This communications strategy, initially undertaken to mitigate anticipated negative press, worked well and much better than past approaches. Media coverage was generally balanced and several positive stories appeared. While the press release purposely did not address the reasons for the recent decrease in physicians' median net income in 1997, various journalists connected managed care profits and practices with physicians' reduced incomes, harm to the physician-patient relationship, and compromised health care.

CONCLUSION

The AMA's SMS survey is a professionally managed, well respected source of information on medical practice. It serves many purposes within the AMA and the physician community at large.

The AMA could not prevent the press from reporting on physician income by ceasing to collect or publish income data from the SMS. There are many alternative sources of income data available to the press for reporting annual changes and levels of physician earnings.

The Board believes that ceasing to collect or publish income data would only hurt the AMA. Since other surveys are not as representative of the physician population as the SMS survey, deleting income from the SMS would leave AMA analysts without an income variable that is compatible with the other variables in the SMS survey. The absence of compatible variables would make it impossible to study questions such as those raised in Substitute Resolution 614, (A-98) regarding the factors affecting physicians' earnings, which have been addressed above. Furthermore, the income information in the AMA's publications is one of the most important reasons that consultants, analysts, and others purchase the publications. Deleting income from the publications would handicap medical practices and individual physicians who have used that information to determine fair compensation. Deleting the information from the publications would significantly lower their value to purchasers and thus lead to decreased revenues.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Substitute Resolution 614 (A-98), and that the remainder of this report be filed:

1. That the AMA continue to be the world's leader in obtaining, synthesizing and disseminating information on medical practice to physicians by continually evaluating and considering enhancements to its Socioeconomic Monitoring System data collection program.
2. That the AMA continue to monitor and study the impact of changes in the socioeconomic environment on physicians and medical practices.
3. That the AMA continue to pursue proactive news management to mitigate negative press treatment of physician income data.
4. That the AMA consider studying the impact of changes in the socioeconomic environment on women, minorities, and physicians in settings not currently covered by the Socioeconomic Monitoring System survey.
5. That the AMA survey separate family practice from general practice physician data.

Figures and attachment referenced in this report are available from the Department of Medical Practice Information.

5. TELECONSULTATIONS AND MEDICARE REIMBURSEMENT (RESOLUTION 111, A-99)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 111 (A-99) AND REMAINDER OF REPORT FILED

At the 1999 Annual Meeting of the House of Delegates, Resolution 111 was introduced by the Louisiana Delegation and referred to the Board of Trustees. Resolution 111 calls upon the AMA to: (1) study and report on any potential illegality under "fee-splitting" laws, the potential for public perception of abusive behavior by practitioners, or possible unethical financial arrangements that appear inherent in the reimbursement methodology developed by HCFA for teleconsultations; and (2) recommend that HCFA reconsider its unique methodology of reimbursing practitioners involved in teleconsultations.

BACKGROUND

On November 2, 1998, the Health Care Financing Administration (HCFA) published final rules governing the reimbursement under Medicare for teleconsultations in rural health professional shortage areas (HPSAs). Under the final rule, the consultant is responsible for billing Medicare and is to retain 75% of the fees received, remitting the other 25% to the referring practitioner. HCFA has said that the consultant may opt to share payments with the referring physician as they come in, wait until all payments are received, or share Medicare and co-insurance payments up front; however, the details of the fee-sharing arrangement are up to the practitioners to determine.

This payment arrangement is an attempt response by HCFA to comply with Section 4206 of the Balanced Budget Act of 1997 (BBA), P.L.105-33. Section 4206 directs Medicare to pay for teleconsultations in HPSAs, with the payment to be shared between the referring or presenting practitioner and the consulting practitioner.

AMA COMMENTS ON HCFA'S REIMBURSEMENT METHODOLOGY

Our AMA filed extensive comments following HCFA's July 22, 1998, Notice of Proposed Rulemaking (NPRM). AMA stated that although HCFA made a commendable effort to interpret the BBA's directive in Section 4206, the fee-sharing arrangement is troublesome due to: feasibility problems; anticipated administrative burdens on the consulting physician; the arbitrary nature of the proposed 75/25% fee split; and the apparent violation of ethical and legal prohibitions on self-referrals, fee-splitting, and anti-kickback arrangements.

In its written comments, the AMA noted HCFA's acknowledgment in the NPRM that the method of payment "could place a presenting physician in the position of violating" self-referral laws that prohibit referrals to entities which have a financial relationship with the referring physician. The AMA went on to point out that some states have similar laws, and that Principle 6.02 of the AMA's Code of Ethics states that: "a physician may not accept payment of any kind, in any form, from any source...(for) referring a patient to said source." In addition, the payment method may violate the federal anti-kickback law, which prohibits the knowing and willful offer, payment or receipt of any remuneration, directly or indirectly, in return for referrals or to induce referrals for which payment may be made under the Medicare or Medicaid programs (42 U.S.C. Section 1320a-7b(b)). In order generally to avoid violating state fee-splitting laws, any division of fees must be only among physicians (as opposed to mid-level licensed practitioners), the patient must have full knowledge of the division, and the division must be in proportion to the services actually performed. While HCFA has attempted to identify a payment division that is proportional to the services rendered, arguably this division may not represent the appropriate proportion in all cases.

In its November 8, 1998, final rule, HCFA responded to these comments by stating: "[g]iven that we require the sharing of payments and predetermine by law the payment amount allocated to the referring practitioner, we believe that our regulation does not constitute a prohibited compensation arrangement between the consulting and the referring practitioners. We do not regard the consulting practitioner as actually making a payment to the referring practitioner, but rather acting as a 'conduit' to pass a portion of the Medicare payment on."

Despite this language, as Resolution 111 reflects, concern remains that this reimbursement method places physicians at legal risk.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 111 (A-99) and that the remainder of this report be filed:

1. That our AMA request the Office of Inspector General, Department of Health and Human Services, to issue an advisory bulletin on the legality of HCFA's reimbursement methodology for teleconsultations in Health Professional Shortage Areas, and request a suspension of the application of the rule until that opinion is rendered;
2. That our AMA demand that HCFA reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various "fee splitting" or "fee sharing" reimbursement schemes; and
3. That our AMA pursue federal legislation authorizing equitable payment for clinical services delivered by physicians via telecommunications technology.

6. CREATION OF AMA DATA BASE ON INTERSTATE PRACTICE OF MEDICINE (RESOLUTION 123, A-99)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 123 (A-99) AND REMAINDER OF REPORT FILED

At the 1999 Annual Meeting, the House of Delegates referred Resolution 123, introduced by the College of American Pathologists, to the Board of Trustees. Resolution 123 called for the American Medical Association (AMA) to:

Develop and maintain a data bank containing state specific legislative, regulatory and accreditation information on the interstate practice of medicine and make the data bank available to members; and

Continue to study interstate practice of medicine issues as they relate to the quality of care available to patients.

The testimony on Resolution 123 focused on telemedicine and much of it was very positive. However, there also were many outstanding questions on the scope of the potential data bank, and the House of Delegates referred this Resolution to the Board of Trustees. The fiscal note attached to Resolution 123 was "\$260,000 per year additional operating expense."

DISCUSSION

Resolution 123 raises two issues relating to the concept of the "interstate practice of medicine." The resolution calls for the AMA to: (1) develop, maintain and disseminate information on state established legal parameters for the practice of medicine; and (2) continue studying interstate practice of medicine issues. The fiscal note related to the first of these issues. On the second, the AMA certainly is continuing to study interstate practice of medicine issues. From the growth of telemedicine in this decade through the virtual explosion of the Internet in just the last few years, these issues are continuing matters for the AMA. The Board recommends adopting the second resolve of Resolution 123.

Turning to the first resolve of Resolution 123, the Board does not question the value of maintaining information on state established parameters for the practice of medicine. Indeed, the AMA currently does this. The key issue for the Board and the House of Delegates, however, is the extent of such information collection and maintenance and, in particular, the wisdom of establishing an extensive data bank on legislative, regulatory and accreditation information on the interstate practice of medicine.

Developing and maintaining up-to-the moment information on medical licensure standards as well as other laws related to the practice of medicine is a significant task; developing additional information on all of the changing regulatory and accreditation elements imposed by the states is a far broader task. The AMA currently collects and distributes licensure information and other related information on an annual basis. However, neither the AMA nor the Federation of State Medical Boards (FSMB) presently maintain this type of information in a data bank format.

The AMA has two annual publications that provide information on state-established parameters for the practice of medicine: "State Medical Licensure Requirements and Statistics, 1999-2000" and "Licensing and Credentialing: What Physicians Need to Know."

- State Medical Licensure Requirements and Statistics, 1999-2000, sold to members for \$29.95 and to nonmembers for \$49.95, provides key state-by-state statistics on licensing requirements, fees, license renewal, continuing medical education requirements, number of physicians licensed, and exam pass/fail percentages. This publication also provides information on the regulation of the practice of telemedicine and out-of-state consulting physicians.
- Licensing and Credentialing: What Physicians Need to Know, sold to members for \$19.95 and to nonmembers for \$29.95, provides information on obtaining a first license and subsequent licenses, global medical education standards, continuing medical education, physician mobility, telemedicine and licensure, and the role of state medical boards in physician discipline.

While the AMA does catalogue medical practice act requirements and other important information relating to the practice of medicine from the different states, this information alone does not encompass all of the multiple state legal standards relating to the practice of medicine, nor does it provide a comprehensive assessment of licensure issues specific to telemedicine.

States establish numerous legislative, regulatory and accreditation standards on the practice of medicine, and it is questionable whether any comprehensive data bank could capture and maintain on a timely basis all of this information. Legal guidelines on these topics change with increasing frequency. Further, as noted by the fiscal note attached to Resolution 123, attempting to comply with the degree of specificity called for by the Resolution, especially through an up to the moment data bank mechanism, would require a significant and ongoing expense. The Board questions the necessity of undertaking such an added annual expense.

Finally, it must be noted that the AMA is not the only entity that provides information on the various state standards relating to the practice of medicine. Telemedicine, for example, is one aspect of state law that has been the subject of compilation and dissemination activity: the Center for Telemedicine Law provides this information at

<http://www.ctl.org>; the American Telemedicine Association provides this information at <http://www.atmeda.org>; and the law firm Arent Fox provides this information at <http://www.arentfox.com>.

Based on the potential expense for the AMA and the numerous questions relating to the feasibility of complying with Resolution 123, the Board recommends that the AMA continue current activities to provide information on state laws, regulations and accreditation standards relating to the practice of medicine. In recognition of member interest in telemedicine issues, the AMA will proceed to explore developing and disseminating to members and others additional information on the legal issues associated with telemedicine. This information, however, probably will not be available through a comprehensive data bank. As reliable information is collected and as further sources for this type of information is identified, the AMA will take actions to facilitate access to this information.

RECOMMENDATIONS

The Board of Trustees recommends that the House of Delegates adopt the following recommendations in lieu of Resolution 123, A-99, and for the remainder of this report to be filed:

1. That our American Medical Association continue to study interstate practice of medicine issues as they relate to the quality of care available to patients;
2. That our American Medical Association explore the provision of information on physician licensure, including telemedicine, to members and others through the World Wide Web and other media; and
3. That our American Medical Association continue making information on state legal parameters on the practice of medicine, including telemedicine, available for members and others.

7. HEALTH PLAN DRUG FORMULARIES AND LEGISLATION (RESOLUTION 524, A-99)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 524 (A-99) AND REMAINDER OF REPORT FILED

INTRODUCTION

Resolution 524, introduced at the 1999 Annual Meeting by the Pennsylvania delegation and referred to the Board of Trustees by the House of Delegates, asks:

That the American Medical Association (AMA) study the impact and advisability of federal and state legislative response to health plans limiting access to pharmaceuticals through formularies; and

That the study include: (1) coordinating, if feasible, a national cohesive policy to address the problem, including consideration of a national formulary, (2) helping state associations respond appropriately at the state legislative level, and (3) aiding patients to obtain their prescribed medications without undue delay and/or inappropriate substitutions from health plan administrators.

This is an interim Board of Trustees report that addresses some of these issues.

DISCUSSION

Current AMA Policies and Concerns About Drug Formularies

AMA Policy H-125.991 ([AMA Policy Compendium](#)) provides detailed standards for a drug formulary system that would be acceptable to the AMA, and Policy H-285.965 (also Ethical Opinion E-8.135) provides ethical guidance for physicians and managed care plans regarding drug formularies. These policies are appended to this report.

At the 1997 Interim meeting, Board of Trustees Report 9, "Pharmaceutical Benefits Management Companies (PBMs)," addressed in detail the drug use control functions of PBMs with particular emphasis on their drug formulary management practices. This report identified nine PBM drug formulary management practices that appeared to be inconsistent with AMA policy and ethical opinion in this area. These concerns were translated into nine principles, which were adopted by the House of Delegates as recommendations at the conclusion of the report:

1. Drug acquisition cost must be secondary to safety and efficacy considerations in the selection of drug products for the drug formulary. A drug formulary system must promote cost-effective prescribing.
2. There must be physician oversight of the drug formulary system.
3. Patients must have access to nonformulary drug products when medically appropriate, and the administrative burdens for physicians to obtain nonformulary drug products should be minimal.
4. Restrictive drug formularies should promote improved clinical outcomes and lowered overall health care costs. Showing only that a restrictive drug formulary lowers drug acquisition costs is insufficient evidence of success.
5. Mechanisms (e.g., consistent organization and standardized formats; on-line, real-time communication between physician office and PBM) to reduce administrative burdens on physicians who are faced with multiple drug formularies and numerous requests to switch drug products must be identified and implemented.
6. Switching of therapeutic alternates in patients with chronic diseases who are stabilized on a drug therapy regimen should be discouraged.
7. Prior authorization programs or protocols for selected drug products should be incorporated into the drug formulary system, and administrative burdens to physicians who must prescribe a drug product requiring prior authorization should be minimal.
8. Physicians, other health professionals (e.g., pharmacists), health plans, and PBMs should adhere to ethical criteria described in Ethical Opinion E-8.135 to best protect the patients who are served by drug formulary systems and to avoid conflict-of-interest problems.
9. PBMs that employ restrictive drug formularies to control drug use and cost must share in the ethical and legal responsibilities if they pressure physicians to prescribe within the drug formulary.

The AMA has been meeting with the Pharmaceutical Care Management Association (PCMA), a trade association that represents many of the PBMs (including the eight largest PBMs), in an effort to seek agreement on the above principles. While the PCMA has indicated that some of these principles are acceptable, they have expressed concerns with others. In particular, the PCMA contends that the PBMs' Pharmacy & Therapeutics (P & T) committees provide sufficient independent physician oversight of PBM drug formularies and that additional oversight of the P & T committee by those physicians affected by the formulary is impractical and inappropriate. Also, while the PCMA shares the AMA's desire to decrease the administrative burdens to physicians in adjudicating formulary decisions, the PCMA believes that PBMs have a responsibility to examine physician prescribing decisions and to contact the physician to verify medical necessity. The AMA will continue with its efforts to work with the PCMA on these issues.

State Laws and Regulations

The discussion about use of drug formularies revolves around balancing cost containment with access to drugs that are medically necessary for individual patients. Historically, restrictive drug formularies were utilized by hospitals to monitor drug regimens. However, beginning in the early 1990s, managed care organizations (MCOs) began to utilize formularies in an effort to control rising drug costs. In 1996 consumers, dissatisfied with dwindling pharmacy benefits, expressed their views to state legislators, who in turn enacted consumer protections in this area. To date, 31 states have passed laws or enacted regulations governing the use of formularies in the managed care setting; seven of these states passed such laws in 1999. Typically, the laws require MCOs to disclose their drug formularies to employers, patients and providers. Some states require MCOs to implement procedures for obtaining non-formulary drugs and to communicate those procedures to providers.

While laws governing disclosure and appeals processes continue to be enacted, legislation governing the use of restrictive drug formularies has evolved in recent years to include additional patient protections. For example, one type of legislation requires MCOs to cover a prescription drug when the prescribing physician believes the drug is medically necessary. California enacted this type of law in 1998; the law requires MCOs to establish an expedited process so that physicians may receive approval to prescribe non-formulary drugs if the physician believes such drugs are medically necessary. Likewise, a 1998 Rhode Island law allows providers to prescribe drugs that were previously covered, or were never covered, if that provider believes the prescription is medically necessary.

A second type of new legislation requires MCOs to cover drugs that have been eliminated from a drug formulary under certain circumstances. For example, a California law prohibits MCOs from limiting a patient's access to a safe and effective drug that has been eliminated from an MCO's formulary, if that drug had been on the formulary when the physician prescribed that drug to the patient. Similarly, a 1998 Tennessee law states that if an MCO amends its drug formulary and removes a drug that had been prescribed to an enrollee, the MCO must continue to pay for that drug until the enrollee completes the appeals process or until an acceptable substitute is found. Finally, a 1999 Texas law requires group health benefit plans to make covered prescription drugs for a medical condition or mental illness available to enrollees until the enrollee's plan renewal date, regardless of whether the drug has been removed from the plan's formulary.

State legislators also are recognizing the need for physician involvement in the creation and maintenance of drug formularies and are enacting legislation to ensure such involvement. This year, for example, Virginia enacted a law requiring drug formularies to be developed after consultation with and approval by a select committee. Under the Virginia law, self-insured group health insurance plans that include a prescription drug benefit may utilize a formulary only if it is developed, reviewed at least annually, and updated as necessary in consultation with and with the approval of a P & T committee. The committee must include a majority of physicians and other health care providers. A 1999 North Carolina law requires insurers who utilize closed formularies to develop their formularies in consultation with and with the approval of a P & T committee, which must include participating providers who have prescriptive authority.

National Drug Formulary

Referred Resolution 524 raises the issue of whether a national drug formulary should be considered. The Board believes this is inappropriate for various reasons. A primary reason to oppose a national drug formulary is its likely negative impact on pharmaceutical research and development. Currently, it is estimated that it costs a pharmaceutical company between \$350 million and \$500 million dollars to bring a drug from point of discovery to approval for marketing by the Food and Drug Administration (FDA). Furthermore, most investigational compounds never become marketed drug products. Drug manufacturers argue that a national formulary would impose another layer of approval beyond the current FDA approval process, creating an unacceptably high barrier to market entry in the United States. The risk of losing the considerable investment in research and development for a drug, even after it has been approved by the FDA, would strongly discourage innovation and research for new or improved drug therapies in the United States.

The Board also is concerned that a uniform national drug formulary would invite unacceptable federal regulatory intrusion into physician prescribing decisions. The better approach, we believe, is for the AMA to continue its participation in the private/public-sector coalition initiative, described below, to reach a common understanding of guiding principles in the development of formulary systems.

Formulary Principles Coalition Initiative

In September 1999, the AMA became a participant in an initiative to develop principles for drug formulary systems that hopefully would be used by those (e.g., hospitals, health plans, and PBMs) who develop and implement drug formulary systems. Other organizations who are involved in this coalition include: United States Pharmacopeia (USP); Academy of Managed Care Pharmacy (AMCP); American Society of Health-System Pharmacists (ASHP); American Association of Retired Persons (AARP); Department of Veterans Affairs (VA); and the National Business Coalition on Health.

The scope of the issues to be addressed in developing principles for drug formulary systems include:

1. The role of scientific evidence, including practice guidelines, in the development and management of formularies.
2. The role of therapeutic and economic considerations in making formulary decisions.
3. The need to establish criteria for use in evidence-based therapeutic decision-making.
4. The role of the P & T committee in developing, and continuously monitoring, updating, and administering the formulary to assure adaptability to clinical circumstances.
5. The role of medical, pharmacy, and other health care professionals in the development and management of formularies.
6. Procedures addressing the composition of the P & T committee and its freedom from conflicts of interest.
7. Linkages among formularies, utilization review, and other tools available to pharmacy benefit management to assure appropriate drug prescribing, dispensing, and use.
8. Ethical issues (e.g., disclosure and incentives) related to drug formulary systems.
9. Mechanisms to obtain a nonformulary drug for the individual patient.
10. Understanding where the accountability for the drug formulary system exists.
11. Education regarding why a formulary system is used and what it is intended to do.

The coalition members are hopeful that agreement on principles for a drug formulary system can be reached and widely disseminated.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 524 (A-99) and that the remainder of this report be filed:

1. That our AMA continue to work as part of a coalition to develop principles for drug formulary systems that are consistent with AMA policy (H-125.991 and H-285.965);
2. That our AMA continue to insist that managed care plans identify participating physicians as a “medical staff” and that they use such staff as part of properly elected pharmacy and therapeutic committees to develop and approve plan formularies; and
3. That our AMA encourage the development of innovative mechanisms, such as tiered co-pays, to allow greater choice and economic responsibility in drug selection; and
4. That our AMA defer a decision on the development of a national formulary.

8. ORGANIZATIONAL PRINCIPLES FOR PHYSICIAN INVOLVEMENT IN HEALTH PLANS AND INTEGRATED DELIVERY SYSTEMS: PROGRESS REPORT

HOUSE ACTION: FILED

At the 1998 Interim Meeting, the House of Delegates adopted amended Resolution 706 (Policy H-285.931, AMA Policy Compendium). Resolution 706 outlined organizational principles for physician involvement in health plans and integrated delivery systems (IDSs). It also directed the American Medical Association (AMA) to: (1)

aggressively advocate to private health care accreditation organizations that the organizational principles be incorporated into their standards; (2) meet with the American Association of Health Plans, Health Insurance Association of America, American Hospital Association and other appropriate entities to advocate the incorporation of these principles into the governance and management processes of health plans, networks and IDSs; (3) communicate the principles to physicians and other appropriate organizations; and (4) develop model state legislation and draft federal legislation that will mandate the organizational principles for physician involvement in health plans and IDSs.

This informational report to the House of Delegates summarizes AMA initiatives to respond to the directives outlined in Resolution 706.

AMA POLICY

Policy H-285.931, “The Critical Role of Physicians in Health Plans and Integrated Delivery Systems,” states:

Our AMA adopts the following organizational principles for physician involvement in health plans and integrated delivery systems (IDS):

Practicing physicians participating in a health plan/IDS must: (a) be involved in the selection and removal of their leaders who are involved in governance or who serve on a council of advisors to the governing body or management; (b) be involved in the development of credentialing criteria, utilization management criteria, clinical practice guidelines, medical review criteria, and continuous quality improvement, and their leaders must be involved in the approval of these processes; (c) be accountable to their peers for professional decisions based on accepted standards of care and evidence-based medicine; (d) be involved in development of criteria used by the health plan in determining medical necessity and coverage decisions; and (e) have access to a due process system.

Representatives of the practicing physicians in a health plan/IDS must be the decision-makers in the credentialing and recredentialing process.

To maximize the opportunity for clinical integration and improvement in patient care, all of the specialties including primary care participating in a clinical process must be involved in the development of clinical practice guidelines and disease management protocols.

A health plan/IDS has the right to make coverage decisions, but practicing physicians participating in the health plan/IDS must be able to discuss treatment alternatives with their patients to enable them to make informed decisions.

Practicing physicians and patients of a health plan/IDS should have access to a timely, expeditious internal appeals process. Physicians serving on an appeals panel should be practicing participants of the health plan/IDS, and they must have experience in the care under dispute. If the internal appeal is denied, a plan member should be able to appeal the medical necessity determination or coverage decision to an independent review organization.

The quality assessment process and peer review protections must extend to all sites of care, e.g., hospital, office, long-term care and home health care.

Representatives of the practicing physicians of a health plan/IDS must be involved in the design of the data collection systems and interpretation of the data so produced, to ensure that the information will be beneficial to physicians in their daily practice. All practicing physicians should receive appropriate, periodic, and comparative performance and utilization data.

To maximize the opportunity for improvement, practicing physicians who are involved in continuous quality improvement activities must have access to skilled resource people and information management systems that provide information on clinical performance, patient satisfaction, and health status. There must be physician/manager teams to identify, improve and document cost/quality relationships that demonstrate value.

Physician representatives/leaders must communicate key policies and procedures to the practicing physicians who participate in the health plan/IDS. Participating physicians must have an identified process to access their physician representative.

Consideration should be given to compensating physician leaders/representatives involved in governance and management for their time away from practice.

ADVOCACY WITH ACCREDITING ORGANIZATIONS

The organizational principles for physician involvement were transmitted by the AMA to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), National Committee for Quality Assurance (NCQA), and the American Accreditation HealthCare Commission/URAC (AAHCC/URAC).

The JCAHO Board of Commissioners referred Policy H-285.931 to its Medical Staff Work Group. An AMA Commissioner is the chair of the Medical Staff Work Group and two members of the Organized Medical Staff Section (OMSS) Governing Council also serve on the Work Group. At its April 1999 meeting, the Medical Staff Work Group endorsed the principles outlined Policy H-285.931. JCAHO staff will work to incorporate the principles into their accreditation standards.

The NCQA prepared a crosswalk of the organizational principles to its accreditation standards. The NCQA has provided a copy of the crosswalk to AMA staff for review and comments. The NCQA Practicing Physician Advisory Committee will review the crosswalk and AMA's recommended changes to the NCQA standards at its October 1999 meeting. The 1999-2000 AMA president is the chair of the Practicing Physician Advisory Committee, and the Council on Medical Service and the OMSS are also represented on the committee.

The AAHCC/URAC recently finalized its Health Utilization Management Standards, Version 3.0. The AMA is represented on the AAHCC/URAC Board of Directors. Several of the new standards incorporate the organizational principles. Specifically, standard P-NM 15 and 15.1 require that health plans develop and implement a strategy to ensure that the perspective of participating providers is represented in health plan management processes, with an emphasis on participation by non-employee participating providers on committees that address clinical and provider payment issues. In addition, standards P-NM 17.3, 19.11, 25, and 26.2 address dispute resolution; P-NM 21.1 prohibits gag clauses; P-PC 4.1 requires that at least one participating practitioner, who has no other role in health plan management, serve on the credentialing committee; P-MP 17 requires a formal member grievance process; P-UM 26 requires a mechanism for members to access an external appeals process; and P-QM 3.8 requires that at least one participating practitioner, who has no other role in health plan management, serve on the quality management committee.

ADVOCACY WITH HEALTH PLAN AND HOSPITAL ASSOCIATIONS

In April 1999, the AMA-OMSS Governing Council, Board of Trustees liaison to the OMSS, and AMA's Division of Federal Affairs staff met with representatives of American Association of Health Plans, Health Insurance Association of America, and Blue Cross Blue Shield Association of America to explore opportunities to integrate the organizational principles in health plan policies. The primary focus of the discussion was on the process of selecting physicians to serve on health plan committees. There was mutual interest in identifying health plans that successfully integrate physicians in their medical decision-making and policy process for purposes of constructing models. The OMSS Governing Council concluded that there was sufficient interest by these organizations to warrant further dialogue on overcoming barriers to implementation. AMA staff will pursue a second meeting in the near future.

In May 1999, the American Hospital Association (AHA) and AMA leadership discussed the organizational principles for physician involvement in integrated delivery systems. Participants acknowledged growing tensions among medical staff and hospital administration stemming from competition in the marketplace and changes in health care economics. AMA and AHA leadership agreed that there is room for improvement in integrating practicing physicians into the new systems of care. They supported the initiation of staff discussions to develop a list of issues, implications of medical staff-hospital administration relationships, and pursuit of agreement on principles. The end product should be models for physicians and hospitals to develop better medical staff relations at the local level.

COMMUNICATION OF THE ORGANIZATIONAL PRINCIPLES

Through September 1999, the organizational principles have been publicized in the following manner:

- An article was placed on the AMA Web site. It is located at <http://www.ama-assn.org/advocacy/omss.htm>.
- A news item in the September 20, "AMA for You" in American Medical News that directs readers to the Web article for more information.
- A news item in the September 1, "AMA/Federation News." This e-mail newsletter is sent to approximately 400 Federation executives, communicators and editors. A feature article about the organizational principles was sent as an attachment, and editors were encouraged to include it in their newsletters and journals.
- A news item in the September 3, "AMA E-Mail News Briefs," that directs readers to the Web article for more information. This e-mail newsletter is sent to approximately 30,000 AMA members.
- Distribution to speechwriters for inclusion in various leadership speeches.

In addition, Member Communications is pursuing a feature-length article in "AMA for You" that lists the principles.

DEVELOPMENT OF MODEL STATE AND DRAFT FEDERAL LEGISLATION

The Council on Legislation reviewed Resolution 706 at its January meeting. The Council directed staff to use the principles as a benchmark for evaluating and lobbying Congress on patient rights legislation. The draft model Patient Protection Act will be modified to reflect the organizational principles.

SUMMARY

As evidenced by the foregoing information, steps are being taken with the private accrediting organizations to incorporate the organizational principles into their standards. More emphasis will be placed on continuing the dialogue with the health plan and hospital associations to pursue agreement on the principles. The AMA will also continue to pursue opportunities to communicate the organizational principles to physicians and appropriate organizations.

9. GUIDELINES FOR REVIEW OF PAP SMEARS IN THE CONTEXT OF POTENTIAL LITIGATION (RESOLUTIONS 511 AND 517, I-98)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTIONS 511 AND 517 (I-98) AND REMAINDER OF REPORT FILED

INTRODUCTION

Resolution 511, introduced at the 1998 Interim Meeting by the Ohio Delegation, and Resolution 517, introduced at the 1998 Interim Meeting by the College of American Pathologists, the American Society of Cytopathology and the Kentucky and Wisconsin Delegations, were referred to the Board of Trustees by the House of Delegates. Because the resolutions dealt with the same subject matter, they were combined for discussion. They ask:

That the American Medical Association (AMA) adopt as policy the Guidelines for Review of Pap Smears in the Context of Potential Litigation as adopted by the Ohio Society of Pathologists.

Resolution 517 also recommends:

That states adopt mechanisms by which they would exhaust non-binding arbitration prior to the filing of any civil action alleging negligence in the taking, examining or reviewing of a Pap test or the reporting of its results.

This is an interim Board of Trustees report that addresses these issues.

DISCUSSION

Current AMA Policies on Professional Liability and Pap Smears

AMA Policy H-435.973 (AMA Policy Compendium) states that courts should admit into evidence only expert medical testimony that is based on widely accepted theories of medical science or supported by a respectable minority of experts in the field at issue. Additionally, this policy states that the “Loser Pays” system of reimbursement for costs associated with litigation, where responsibility for a prevailing party’s legal expenses are borne by a losing party, should be implemented only under certain circumstances.

The AMA has longstanding policy emphasizing the importance of Papanicolaou (Pap) smears as an effective screening mechanism in women’s health care (Policy H-525.994). Specifically, AMA policy H-260.986 recognizes how the use of Pap smears has contributed greatly to the decrease in cervical cancer mortality rates, and recommends standards for performing and analyzing Pap smears.

AMA policy H-435.969 supports alternative dispute resolution (ADR) mechanisms, such as arbitration or mediation, in the context of fairly resolving issues related to medical liability claims. The AMA encourages physicians to serve as expert witnesses, and promotes the use of statutory requirements for qualification of expert witnesses, including: (1) comparable education, training, and occupational experience as the defendant-physician; (2) the occupational experience must include active medical practice or teaching experience in the same field as the defendant-physician; and (3) the active medical practice or teaching experience of the expert witness must have been gained within five years of the date of the occurrence giving rise to the claim (H-265.994).

Increased Litigation in the Context of Pap Smears

Since its inception more than 50 years ago, the Pap smear has consistently demonstrated a reduction in the number of cancer deaths among women. Increasingly, however, the Pap smear is being threatened on several fronts. One such front is an increase in the number of lawsuits filed as a result of “false negative” test results. Often, such test results serve as the basis for lawsuits alleging medical malpractice. Failing to recognize that no test is 100 percent accurate, some jurisdictions are holding that a false negative is conclusive evidence of substandard care. As a result, state pathology societies began discussing how to preserve the Pap smear, emphasizing the impossibility of a result that was 100 percent accurate. The Ohio Society of Pathologists passed such guidelines governing the review of Pap test results for the purpose of litigation or potential litigation.

Although many provisions of the Guidelines comport with existing AMA policy, section seven (7) of the Guidelines, addressing the implementation of a “Loser Pays” rule, does not provide the necessary safeguards as specified in AMA policy H-435.973. The safeguards provided by AMA policy include: (a) provisions made for retrieving fees owed to a prevailing party from a losing party’s attorney if the losing party does not have adequate assets; (b) provisions for calculating the fees owed to plaintiff’s attorney on the basis of time expended, even if a contingency fee agreement was in effect; and (c) a provision stating that a losing party will not be required to pay expenses of a prevailing party if the prevailing party’s fees exceed the losing party’s fees for such goods and services.

The AMA’s Council on Legislation (COL) discussed the efficacy of implementing the Guidelines during its meetings throughout the past year. The COL discussed the issue with the AMA’s Council on Scientific Affairs (CSA), requesting that the CSA gather scientific information about the need for the Guidelines. Members of both Councils concluded that while it is important that women continue to receive Pap testing, supporting the Guidelines would make it difficult for the AMA to oppose other procedure-specific protections for physicians faced with potential litigation. The COL recommended to the Board of Trustees that it not support the Guidelines as drafted, but that it support those provisions of the Guidelines which are consistent with existing AMA policy in the more general context of tort reform and ADR.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolutions 511 and 517 (I-98) and that the remainder of this report be filed:

1. That the AMA continue to support alternative dispute resolution (ADR) mechanisms and tort reforms consistent with AMA policy;

2. That AMA Policy H-435.973, "Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability," Section (1), *Medical Expert Witness Testimony*, be reaffirmed;
3. That the AMA Council on Scientific Affairs study the issues that are raised by the use of the Pap smear as a screening test, its inherent limitations, the implications of a single false negative test, and the appropriateness of guidelines for the review of pap smears in the context of potential litigation, and report back to the House of Delegates at the 2000 Interim Meeting; and
4. That the AMA Council on Ethical and Judicial Affairs (CEJA) examine the Guidelines for Review of Pap Smears in the Context of Potential Litigation as adopted by the Ohio Society of Pathologists to determine whether they are consistent with the ethical and judicial principles of the organization.

10. REGIONAL INPUT INTO THE ACCREDITATION PROCESS

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 809 (A-99) AND REMAINDER OF REPORT FILED

INTRODUCTION

At the 1999 Annual Meeting, the AMA House of Delegates referred Resolution 809, "Regional Input into the Accreditation Process," to the Board of Trustees.

Resolution 809 resolved that the AMA seek through appropriate means to require that regional medical professional organizations be notified by the National Committee on Quality Assurance (NCQA) of survey dates of plans in their survey area, have the opportunity to provide input during the survey process, and be provided the opportunity to submit comments.

Testimony at the reference committee indicated that NCQA currently posts site visit dates on its web site, that NCQA has arrangements for an observer, and that standards are in place for participation by appropriate individuals in the survey. However, there remained confusion about the exact survey process. Therefore, it was requested that the AMA gain clarification of the NCQA accreditation survey process and future involvement of regional organizations in the process.

This report responds to the referred Resolution 809, and seeks to provide clarifying information on the survey process, information currently available to the public, and ways to gain input to the process from the regional organizations.

DISCUSSION

Overview of Process

The NCQA survey process evaluates the core systems and processes that make up a health plan and consists of both on- and off-site evaluations conducted by teams of physicians and managed care experts. NCQA's assessment of compliance includes, but is not limited to, the following:

- Written documentation and records provided by the health plan
- On-site observations by surveyors
- Information gained by surveyors during relevant interviews with staff of the health plan
- Credentialing files
- Medical records, complaints and appeals, and utilization management cases
- Member service systems, including handling of complaints and appeals, member education and member surveys.

A national oversight committee of physicians then analyzes the survey team's findings and assigns an accreditation level based on the plan's compliance with NCQA's standards and performance relative to other plans on selected HEDIS performance measures.

Requirements

The various standards and performance measures that make up NCQA's Accreditation program fall into the following categories:

- Access and Service
- Qualified Providers
- Staying Healthy
- Getting Better
- Living with Illness

Information Available to the Public

In June of 1994, NCQA began disclosure of health plans' accreditation status to the public. The Accreditation Status List (ASL) lists all plans that have an accreditation status with NCQA, all plans with pending accreditation decisions, and all plans scheduled to be reviewed. The list, which is available by contacting NCQA at 202/955-3500, or by visiting the NCQA web site at www.ncqa.org, consists of three parts: current accreditation status (Excellent, Commendable, Accredited, Provisional, Denied, or Under Review), initial decision pending, and future reviews scheduled.

Regional Organization Input into the Process

While the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) currently allows for external input into the survey process, including public testimony, interviews, and written comments, NCQA's process currently does not.

SUMMARY

Due to the availability of survey dates on the NCQA web site, regional organizations wishing to track the review status of health plans in their respective areas can do so by accessing the Accreditation Status List. However, at this time there do not appear to be mechanisms available to provide the opportunity for input during the survey process or to submit comments.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 809 (A-99), and that the remainder of this report be filed:

1. That it is the policy of the AMA that voluntary accreditation organizations provide opportunities for interested parties to have input and to submit comments during the survey process.
2. That the AMA, through its representatives to NCQA, request that changes in the accreditation process be made to provide interested parties with the opportunity to provide input and submit comments during the survey process.

11. ALLIANCE FOR CONTINUING MEDICAL EDUCATION**HOUSE ACTION: RECOMMENDATIONS ADOPTED AND
REMAINDER OF REPORT FILED**

The Board of Trustees has received an application from the Alliance for Continuing Medical Education (The Alliance) requesting Official Observer status in the American Medical Association (AMA) House of Delegates.

The Alliance has had a long association with the AMA, especially with AMA's Division of Continuing Physician Professional Development, and with the Council on Medical Education. The Alliance is national in scope and its interests, and wishes to make official its presence at the meetings of the House of Delegates. The Alliance shares the AMA's vision and interest in improving health outcomes and the education of practicing physicians via continuing

medical education (CME) of the highest possible quality. The Alliance brings together all of those interested in CME and continuing physician professional development, including providers of CME at national and local levels, industry supporters of CME, and regulatory agencies and bodies.

The Alliance was founded in 1978 and today has more than 2300 members, of whom approximately 23%, or more than 460, are physicians. The mission of the Alliance is “to educate and support continuing medical education (CME) professionals and to promote leadership in the development of CME in order to improve the performance of health care providers and health care outcomes”. Its goals are 1) to represent and collaborate with all individuals and organizations involved in CME, regardless of their work setting, special interests, or geographical location; 2) to be the association that unites the CME community through communication, coordination, collaboration, and cooperation; and 3) to provide programs, products and services essential to the success of the CME community. The Alliance prides itself in representing persons involved in CME, from hospital secretary through academic deans for CME, but also includes industry supporters of medical education and any other players in the local or national CME scene.

The Alliance has a full-time staff. The Executive Director is Bruce J. Bellande, PhD and the headquarters offices are in Birmingham, AL. The current president is Melvin J. Freeman, MD, of Seattle, WA, a long-time member of the AMA House of Delegates, serving as a delegate from the Contact Lens Association of Ophthalmologists. A 17-member Board of Directors elected by the membership governs the Alliance. It holds an annual meeting each January that attracts more than 1500 participants. Under Dr. Freeman’s leadership the Alliance has emphasized the recruitment of community physicians, and physicians involved in CME at the state level; he currently serves as the Vice Chair of the Washington State CME Committee.

The Board of Trustees believes that the Alliance for Continuing Medical Education meets all of the criteria for Official Observer status and that the presence of an Alliance representative would be beneficial to both organizations, and ultimately beneficial to the patients that are served by our physicians.

RECOMMENDATIONS:

The Board of Trustees recommends:

1. That the Alliance for Continuing Medical Education be invited to send a Non-voting Official Observer to all meetings of the House of Delegates.
2. That the remainder of this report be filed.

12. INTERNATIONAL MEMBERSHIP CATEGORY

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

INTRODUCTION

As the largest medical organization in the world, the AMA has the capability to influence global standards of medical care, to emphasize the universality of medical ethics, and to champion the cause of the individual patient-physician relationship. New technology provides easy accessibility to quality continuing medical education (CME), and permits the sharing of ideas and new discoveries with physicians worldwide. Physicians from around the world are attracted to the education, practices, and policies embedded in American medicine, and they express this interest in an increasing number of contacts with the AMA.

This report recommends that the House of Delegates support establishment of an international membership category for the AMA.

DISCUSSION

Board of Trustees Report 26 (I-95) on the Globalization of Medicine called for the AMA to “share the results of scientific research and clinical knowledge with physician colleagues around the world and expand the opportunities for the continued growth of AMA products and services in the international marketplace.”

At the 1997 Interim Meeting, the New England Delegation introduced a resolution to the House of Delegates which was referred to the Board of Trustees for report back. The resolution called for a new international membership category, and recommended that the AMA bring its resources to the physicians of the world in order to improve access to quality health care worldwide.

The AMA now effectively has an international presence by virtue of the world wide web, substantial international publishing operations, attractiveness of CME, and availability of a wide range of clinical and socio-medical intellectual material that is valuable to physicians.

Your Board of Trustees recently considered an international strategy for the Association which would coordinate and leverage many of the AMA’s existing activities in publishing, continuing medical education, Website offerings, and advocacy within the context of the globalization of medicine. The Board believes that key international initiatives further the AMA’s vision to “promote the art and science of medicine and the betterment of the public health”. Offering AMA’s existing products, services and information through an international membership category contributes to the medical profession’s obligation to share knowledge and best practices worldwide. International membership can effectively link with our current international editions of JAMA and the Archives, with the increasing desire for internationalizing CME, with requests from national governments and healthcare providers worldwide for physician coding products, and with our international advocacy efforts at the WMA, WHO, and elsewhere.

Creation of an AMA international membership category in this context will not affect the Association’s aggressive efforts to increase our regular domestic members. Marketing of this new category will be done primarily through our international editions of the journals and through the Website. The required investment will be minimal and self-funded from other international revenue sources. The substantial net revenue from all international activities, including from this new membership, will help fund domestic programs.

Most of the major national medical specialty societies represented in this House of Delegates already have an international membership category. Requirements for membership, documentation of credentials, dues levels, and benefits vary considerably. At the 1999 President’s Forum, a special session was held on the issue of international membership, and especially the tactics for enhancing growth in membership. International members participate for a variety of reasons including preferred access to information, opportunities to attend meetings and submit research papers, and for contacts with professional colleagues. The specialty societies represented in this forum strongly supported their international membership programs.

Your Board of Trustees believes that with the appropriate verification of credentials, non-U.S. physicians should be able to affiliate with the AMA and promote the AMA Code of Ethics, obtain familiarity with standards for accreditation of medical education and take advantage of the high quality information, products, and services available through the Association.

Eligibility Criteria

An AMA membership category would be established for international medical graduates ineligible for licensure in any U.S. jurisdiction or territory who are:

- (1) practicing in countries outside of the U.S. and its territories; or
- (2) may be employed and temporarily residing in the U.S.; or
- (3) have received medical training in the U.S. but are not residing in the U.S.

The proposed eligibility criteria would require:

- (1) submission of a copy of the diploma from a medical school listed in the World Health Directory;
- (2) documentation that the individual is legally authorized to practice medicine in the country of practice shown by one of the three following options:
 - (a) verification that the individual is an international member of an AMA-recognized national medical specialty society that has a procedure for verification of international members' credentials;
 - (b) a letter from the national medical association in the country of practice attesting to the authorization of the applicant to practice medicine; or
 - (c) a letter from the registry or licensing authority of the country of practice attesting to the status of the applicant's license as one in good standing; and
- (3) an agreement to sign a pledge supporting the AMA Code of Medical Ethics.

The AMA application would make it clear that incomplete information submitted on the form would be grounds for denying the application for membership. Questions would be included to ascertain whether the applicant had a criminal record of any kind or had been disciplined by a legally sanctioned authority in the country of practice. Falsification of information provided on the application would be followed by notice of the falsification with an opportunity for a written response from the applicant.

The AMA Council on Ethical and Judicial Affairs (CEJA) will be called upon to review applications which are denied and subsequently appealed by the prospective member. CEJA would also be authorized to remove any international member from AMA rolls upon discovering violations of the Code of Medical Ethics, or an inability to continue to meet all of the membership criteria, e.g. loss of medical license. All documents and correspondence will be written in English.

Benefits and Privileges

Some preliminary conclusions have been reached on a possible benefit package and annual dues. A pilot marketing test is underway on the proposed benefit package with 4,000 non-U.S. JAMA subscribers and 4,000 non-subscribers. Four AMA membership dues levels will be tested in the international market. Test results should be available by mid-November, 1999.

The proposed benefit package would include a subscription to the U.S. edition of JAMA, member discount on other AMA publications, access to the AMA Website for members only, eligibility to qualify for the Physicians' Recognition Award (150 hours CME credits over three years), and a certificate of membership. Members in this category would have all of the privileges of membership, except that they shall not have the right to vote or to serve in any elective position.

At the conclusion of the test marketing period, benefits and /or dues amount may be adjusted to reflect preferences of potential members.

RECOMMENDATIONS

The Board of Trustees recommends:

1. That the House of Delegates approve a new non-voting category of AMA international membership for non-U.S. physicians.
2. That physicians who are eligible for this membership meet the following criteria:

An AMA membership category would be established for international medical graduates who:

- (1) practice in countries outside of the U.S. and its territories; or
- (2) may be employed and temporarily residing in the U.S.; or
- (3) have received medical training in the U.S. but are not residing in the U.S.

The proposed eligibility criteria would require:

- (1) submission of a copy of the diploma from a medical school listed in the World Health Directory;
 - (2) documentation that the individual is legally authorized to practice medicine in the country of practice shown by one of the three following options:
 - (a) verification that the individual is an international member of an AMA-recognized national medical specialty society that has a procedure for verification of international members' credentials;
 - (b) a letter from the national medical association in the country of practice attesting to the authorization of the applicant to practice medicine; or
 - (c) a letter from the registry or licensing authority of the country of practice attesting to the status of the applicant's license as one in good standing; and
 - (3) an agreement to sign a pledge supporting the AMA Code of Medical Ethics.
3. That relying upon survey and other relevant data, the AMA Board of Trustees determine the dues and benefits.
 4. That the remainder of this report be filed.

13. PHYSICIANS FOR RESPONSIBLE NEGOTIATION (PRN)

HOUSE ACTION: FILED

BACKGROUND

The AMA House of Delegates passed amended Resolution 901 at its 1999 Annual Meeting. A portion of this resolution instructs the AMA to form a national labor organization to support negotiating units for eligible employed and resident physicians in a manner consistent with the principles of medical ethics and the Current Opinions of the Council on Ethical and Judicial Affairs (CEJA). This informational report is an update on the status of that national labor organization.

STATUS OF THE NATIONAL NEGOTIATING ORGANIZATION

Since the adoption of Resolution 901 (A-99), the Board of Trustees has set in motion the necessary processes to establish the national labor organization, Physicians for Responsible Negotiations (PRN).

- In order to operate within the limits of applicable law as to both the AMA as a tax-exempt entity and PRN as a labor organization under the National Labor Relations Act and the Federal Labor Management Reporting and Disclosure Act, PRN was established on November 21, 1999, as a totally separate unincorporated association.
- The AMA Board of Trustees appointed the initial members of the PRN Governing Body; Susan Adelman, MD (Michigan), and John C. Nelson, MD (Utah); AMA Board members; Andrew Thomas (Ohio), MD, fellow physician; Ross Rubin, JD, AMA Vice President for Legislative Affairs; and Todd Vande Hey, AMA Vice President for Private Sector Advocacy. The Board of Trustees also sought nominations from various components of the federation of medicine and screened more than 90 applicants for the PRN Board. The initial appointees have selected an additional four members to fill out the Governing Body. These additional four physicians are Mark Fox, MD (New York), Michael S. Katz, MD (Delaware), Douglas Kaplan, MD (Illinois), and Jerry D. McLaughlin, II, MD (New Mexico). This Governing Body will then choose the officers of the PRN.
- PRN elected as its officers Dr. Adelman as President, Dr. Nelson as Treasurer, and Dr. Thomas as Secretary.
- PRN is being funded by an initial loan of \$1.2 million from the AMA to support operations through December 31, 2000. It is anticipated that PRN will have to seek additional loan funding from the AMA of \$1.6 million to get into mid-2002, at which point it is anticipated that PRN will achieve financial self-sufficiency.
- PRN is housed within the AMA headquarters, but as a separate organization, it rents its office space and reimburses the AMA for basic services such as copying, payroll, accounting, etc.

- The AMA provided a model draft constitution to PRN. The PRN Board of Directors has approved its Constitution and Bylaws consistent with this draft. This draft constitution stresses an overriding commitment to the promotion of quality healthcare and ties the operating philosophies of PRN to the Principles of Medical Ethics and the Current Opinions of Council on Ethical and Judicial Affairs. This means that strikes and the withholding of essential medical care are prohibited from use as negotiating strategies.
- AMA can continue to advise PRN on operating philosophies and other matters, but, as discussed below, it cannot in any manner direct the activities or operations of PRN. PRN will continue to solicit opinions and comments regarding its operations from AMA and individual physician members. This process will be facilitated through an open forum hosted by PRN during the AMA Interim Meeting.
- AMA has been and will continue to carry out its activities, as mandated by Resolution 901 (A-99), to inform physicians about their options for negotiations and about the existence of PRN. This activity has been ongoing since the 1999 Annual Meeting and is expected to continue for the foreseeable future. A group of physicians interested in organizing issues will first take part in an “education/fact finding phase” that will frequently be conducted by AMA in conjunction with the appropriate state and/or county medical society. During this phase, the physician group will explain its particular problems and concerns and will consider if organized medicine can provide assistance in answering those concerns. The physicians will also be educated on the benefits and risks associated with organizing as a labor organization. If the group’s problems still exist, and it is still interested, the physicians can then contact PRN. The physicians can then decide if the group should attempt to organize as a unit of PRN.
- The “organizing phase” involves obtaining signatures from at least 30%, but preferably 60% or more, of the eligible physicians (employed non-managers or supervisors) indicating their desire to be represented by PRN. These signature cards are then given to the National Labor Relations Board which will authorize an official campaign and election to see if a majority of the physicians vote to be represented by PRN. While this campaign and election typically takes only 4-6 weeks, it may be seriously delayed as the employer challenges the validity of PRN as a Labor Organization, the validity of the signature cards or the eligibility of the individual physicians to be represented by PRN. If a majority vote to be represented by PRN, they will then be considered a bargaining unit of PRN.
- At this point, PRN will assist these physicians in the “negotiating phase” to reach a mutually agreeable contract with their employer.
- When a contract is signed by both parties, PRN’s final duty to the physician group is to provide “contract administration” to insure the contract provisions are adhered to by the employer during the period of the contract.
- PRN is currently divided into three divisions. The Public Sector Physicians Division (PSPD) is for physicians employed in the public sector, i.e., national, state and county governmental organizations. The Employed Private Sector Physicians Division (EPSPD) will be for eligible employed physicians providing healthcare services at private institution and the Resident and Fellows Division (RFD) will be for physicians in training.
- In determining whether to organize a group that asks for PRN assistance, PRN will require a core group of physician leaders to make some financial commitment before it will commit to organize any group of physicians into a collective bargaining unit. Initiation fees and dues payments will not be paid to PRN until a group is successfully organized and a satisfactory contract is negotiated. All physicians are eligible for membership in PRN and a special membership category, with nominal dues, has been established for physicians, who are not part of a PRN collective bargaining unit.
- PRN is currently employing a staff of three, but this could increase as additional groups of physicians seek representation by PRN. The Executive Director oversees the daily business of PRN while the Representation Specialist organizes the physician groups and assists in their contract negotiations.
- During the first one to two years of operation, PRN will contract with experienced labor organizers and contract negotiators to work with the physician groups and train the Representation Specialist to conduct these activities.

Up until PRN's official launch on November 21st, the AMA received numerous inquiries regarding the decision and plans to create a national negotiating organization. AMA Board of Trustees and AMA staff made numerous presentations on negotiating options for physicians and the AMA perspective on physician labor organizations. The Organizing Committee for Physicians for Responsible Negotiation (PRN) also received inquiries from physicians, the press and other interested organizations, as well as referrals from the AMA to discuss the PRN and organizing possibilities. Now that PRN has been formally established, it will follow up on these inquiries and determine the appropriate actions to be taken.

The reception for the PRN across the country has been very positive from physicians and the public at large. As expected, concerns have been expressed similar to those presented at the A-99 meeting.

On November 29, the National Labor Relations Board released its decision in the Boston Medical Center case. This case reversed a previous NLRB decision (Cedars-Sinai) and found that resident physicians are eligible as employees to organize bargaining units under the National Labor Relations Act. The NLRB also found that the appropriate bargaining unit would include residents, fellows and other physicians who are not managers or supervisors. The Board also found that the law did not prohibit negotiations regarding academic issues, but stated that negotiation of such issues would be subject to the parties agreeing to negotiate those issues. This decision covers all private sector teaching hospitals. State laws remain in effect for public facilities.

LEGAL STATUS OF PRN AND ITS RELATIONSHIP TO THE AMA

Now that PRN has been formed, the AMA must be careful to assure that its ongoing relationship with PRN is not subject to legal challenge. This relationship must comply with various legal requirements, including those associated with the AMA's tax-exempt status and with comprehensive labor laws.

PRN is an independent legal entity. As such, the PRN governing board will adopt its own governance documents, define its scope of activities, and determine its policies, strategies and course of conduct. Under the law, the AMA cannot control, dominate or interfere with PRN. For example, the AMA cannot:

- become involved in collective bargaining activities;
- establish, amend or approve governance documents, policies or procedures for PRN;
- prohibit PRN from changing any existing governance documents, policies or procedures for PRN;
- appoint or approve PRN governing board members, after appointment of the initial board;
- require PRN or its governing board members to adopt particular positions or policies;
- "campaign" on behalf of PRN, by directing or soliciting physicians to join PRN; and
- conduct joint mailings with PRN.

This list is not to indicate, however that the AMA can not take any actions regarding PRN. The AMA can do many things to evidence its support with PRN. For example, the AMA can:

- and did establish the initial governing board to serve until PRN's first election;
- make non-binding recommendations to PRN;
- develop and share with PRN position papers and opinions on physician labor issues;
- make itself available to advise PRN on physician labor issues, at PRN request;
- publicly acknowledge and publicize that the AMA created PRN as a professional option for physician negotiations;
- publicly support PRN and its goals and objectives;

- adopt its own policies on physician labor issues (which shall not be binding on PRN);
- continue to educate physicians on their negotiating options; and
- continue its own Private Sector Advocacy activities.

While the AMA cannot dictate the policies or activities of PRN, the AMA can comment on PRN policies or activities, and is not obligated to continue its support of PRN should PRN act contrary to the AMA's policies and values.

14. TRANSMISSION OF THE FINAL REPORT OF THE FEDERATION COORDINATION TEAM

HOUSE ACTION: RECOMMENDATION ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

The House of Delegates directed that the AMA Board of Trustees commend the Federation Coordination Team for its hard work and thoughtful and frank consideration of the issues confronting the Federation and widely distribute to the Federation the Final Report of the Federation Coordination Team.

The Federation Coordination Team (FCT) began meeting in November 1996 in response to the Study of the Federation reports (Board of Trustees Report 40 I-95 and Board of Trustees Report 2 A-96). The FCT's tenure expires in December 1999, by which time the processes and mechanisms developed by the FCT are to be transferred to the AMA Board of Trustees (Policy H-545.958, AMA Policy Compendium).

This is the final FCT report to the AMA House of Delegates.

The AMA Board of Trustees transmits this final report of the Federation Coordination Team to the House of Delegates and the proposed recommendations for action.

REPORT OF THE FEDERATION COORDINATION TEAM

The Federation Coordination Team (FCT) is a cross-organizational team of originally 27 Federation leaders, supported by Federation contributions, created to improve the value of organized medicine.

This is the final report of the Federation Coordination Team. This report summarizes the team's activities during its three years of existence, presents its analysis of the current environment of the Federation of Medicine, describes projects and initiatives developed by the team, and offers recommendations to the House of Delegates and to the FCT's successor, the Federation Advisory Committee (FAC).

I. History of the Federation Coordination Team

The Federation Coordination Team (FCT) was established in 1996 with the charge of developing mechanisms and strategies to enhance the value of membership in organized medicine.

The formal charge to the FCT was:

1) Clarifying roles and achieving active coordination of efforts:

- Developing a process for helping to coordinate the responses of county, state, and specialty societies and the AMA on key issues; and
- Enhancing communication among county, state, and specialty societies and the AMA and between county, state and specialty societies and the AMA and physicians.

2) Establishing a process for pursuing collaborative efforts among Federation members:

- Identifying opportunities, including joint ventures, for county, state, and specialty societies and the AMA to work together; and
- Promoting information-sharing and compatible database development among county, state, and specialty societies and the AMA.

The establishment of the FCT was motivated by the final report of the Consortium of the Study of the Federation. Twenty-six members were selected in 1996 by a panel appointed by Joseph T. Painter, MD, who had chaired the Study of the Federation and the FCT appointed the AMA staff liaison as an official member of the team for a total of 27. The FCT members were chosen to provide a cross-section of the Federation and its physician constituencies, with representation based on age, gender, career stage, and other demographic considerations. (A complete list of FCT members is attached to this report as Appendix D.)

The FCT is a Federation-wide body, supported not only by the AMA but also by voluntary contributions from many county, state and specialty societies. (A complete list of contributors is attached as Appendix B.) When the AMA House of Delegates established the FCT in 1996, the House directed that all levels of organized medicine should participate in its funding. Subsequently, each Federation unit was encouraged to contribute. The size of the voluntary contribution was based on the size of the society. The AMA agreed to provide \$65,000 per year and staff support to the FCT.

This Federation-wide funding paid for the direct expenses of the FCT's meetings as well as printing, shipping and other expenses. The AMA subsequently provided specific funding for a major consulting project conducted for the FCT as well as financial and staff support for various other FCT projects, including the development of the standard membership application and a patient/physician advocacy project. The AMA funds the on-going maintenance of VFED, a limited access web site for Federation leaders. The FCT is grateful for the financial and other support provided by various elements of the Federation.

Recommendation 1: In the future, a pre-determined level of funding should be established (scaled accordingly to the size of the organization) for any similar work groups convened.

- Funds requested and received from state, county, and specialty organizations should be placed in a separate bank account; and
- The AMA should contribute a pre-determined amount and increase the amount according to the needs of the projects.

Throughout its existence, the FCT has sought the involvement of all elements of the Federation, seeking their advice and input. Since its inception, the FCT has submitted a series of reports to the AMA Board of Trustees and the AMA House of Delegates detailing its efforts to strengthen the Federation by increasing the value of membership at all levels of organized medicine and by fostering collaboration among Federation entities. The House of Delegates has adopted the following reports of the FCT:

- Report of the FCT (BoT Report 32 I-96)
- FCT Roles and Responsibilities (BoT Report 17 A-97)
- Report of the FCT (BoT Report 35 A-97)
- Report of the FCT (BoT Report 17 I-97)
- Report of the FCT (BoT Report 29 I-97)
- Report of the FCT - Delivering Value to Physicians Through Improved Work Processes (BoT Report 38 A-98)
- Report of the FCT - Status Update (BoT Report 39 A-98)
- Report of the FCT - Standard Membership Application (BoT Report 40 A-98)
- Report of the FCT - Status Update (BoT Report 29 I-98)
- Report of the FCT (BoT Report 34 A-99)

In addition, the FCT has held numerous open forums in conjunction with meetings of the AMA House of Delegates and during quarterly FCT meetings. The FCT leadership has also appeared before the AMA Board of Trustees on a number of occasions to update the Board and discuss Federation issues.

The mandate from the AMA House of Delegates was for the FCT to focus on developing collaborative arrangements. It was made clear by the AMA Board of Trustees that the FCT was not charged to address governance or policy-making issues.

II. FCT Products

The FCT has developed a number of products and initiatives, which are described briefly below. A detailed status report on these products, including suggestions for the future, is contained in the attached Appendix A.

- A. VFED. The FCT created a limited-access Internet site, VFED (for "Virtual FEDeration"). VFED is available at www.vfed.org and is also available through the AMA website. VFED was designed to enable medical society leaders to share information and communicate leadership issues easily and directly. VFED also contains an archival function for messages, a "chat" room function and an upload area where files can be shared electronically.
- B. Membership. The FCT, in response to requests for ways to improve Federation membership enrollment processes, undertook three sequential activities: development of a standard membership application (BoT Report 40 A-98), improvements in the membership enrollment processes, and innovations in membership billing systems.
- C. Patient/physician advocacy. This project identifies exemplary Federation projects and shares "how-to" information with the entire Federation. VFED (www.vfed.org) is the primary mechanism for distributing this information.
- D. Integrations. A 1998 study of actual and potential medical society integration efforts identified more than 100 such situations.
- E. Work Process Improvement. This three-phase project examined potential joint ventures and partnerships. Four projects that offered the possibility of significant cost savings and interest in participation were identified. These projects were as follows: (1) Internet: Creation of a shared Internet platform for the Federation; (2) Value to Physicians: Creation of a central, shared marketing resource for the Federation; (3) Consulting Services: Creation of a Federation-wide initiative to leverage consulting services for member physicians; and (4) Outcomes Measurement: Creation of an Outcomes Measurement System for the Federation. A business plan outline was developed for each project. Ultimately, the FCT concluded that a Federation-wide structure was needed to develop and evaluate such projects, and subsequently the FCT developed a "Shared Services Organization" (SSO) proposal that is under consideration by the Federation. See Appendix A (pp. 25-27) for a detailed discussion of this important part of the FCT's work.
- F. Conflict Resolution. The FCT developed and promulgated in a report to the AMA House of Delegates (BoT Report 29 I-98) a detailed process including voluntary mediation in an attempt to achieve resolution in disputes involving Federation components. The use of the forum format to defuse potential conflicts has also been suggested.
- G. Professionalism. The FCT, in accord with the AMA and Federation support, worked on methods to coordinate continuing educational programs to focus on "best practices" and quality care "alerts" for physicians and on other professionalism issues such as public health care.
- H. Roles and Responsibilities. The FCT developed and submitted a report (BoT Report 34 A-99) at the 1999 Annual Meeting addressing the roles and responsibilities of the Federation.

III. Findings of the Federation Coordination Team

The Vision of the Federation Coordination Team (FCT)

The FCT recognizes that trust and a spirit of collaboration have not always characterized working relationships among the various components of the Federation. While there have been examples of cooperation among medical associations, particularly at the specialty society level, these activities have been carried out primarily by staff. Few

physician members are aware of any cooperative endeavors. When these endeavors are a success, each organization tends to take sole credit for that success in reporting it to its members. If the endeavor was unsuccessful, the tendency has been to assign most of the fault to the AMA.

The FCT believes that if organized medicine is to thrive, new ways of working together are critical. The FCT proceeded in its work without the impediments of tradition and entrenched methods of operation. Therefore, its agenda transcended the agendas of individual Federation components. With this in mind, it is quite clear to the FCT that significant positive changes in attitude and behavior are needed to create a new working culture. The FCT believes that its successor, the Federation Advisory Committee, is uniquely positioned to play a role in overcoming the resistance in creating a new cooperative culture within organized medicine.

The FCT believes that this new cooperative culture can be fostered in two ways:

- 1) By demonstrating the effectiveness and desirability of collaborative projects; and
- 2) By demonstrating a new way of working together that is characterized by:
 - Respect for all organizations as peers;
 - Honest and frequent communications;
 - Openness to new ideas and willingness to innovate;
 - Decision-making by true consensus – looking beyond positions and striving to address underlying issues; putting aside parochial interests to work for the greater good of medicine;
 - Ability to make tough decisions; and
 - Willingness to share credit for accomplishments when appropriate.

Toward these goals, the FCT continues to champion the "Statement of Collaborative Intent" that has been developed by the Council on Long Range Planning and Development with the assistance of the Council on Constitution and Bylaws and the Council on Ethical and Judicial Affairs. The AMA House of Delegates endorsed the Statement at its 1997 Annual Meeting and recommended that all Federation components endorse the Statement as well. The Statement seeks to promote better working relationships among medical associations, identify goals for the Federation, and set forth principles to guide these pursuits. The common link is to increase the overall level of Federation support and cooperation. (A copy of the Statement is attached to this report as Appendix C.)

Recommendation 2: The governance body of each member of the Federation should endorse the Statement of Collaborative Intent as an important first step toward strengthening the Federation.

The Environment of Organized Medicine

The FCT's examination of the environment of organized medicine presents a mixed picture. On one hand, many associations continue to achieve considerable success. For example, the AMA is a major player on the national legislative and regulatory policy scene and is the acknowledged leader in disseminating scientific information. Likewise, some specialty societies have well-earned reputations for both scientific and political activities, some state societies are influential and effective in the legislative arena, and some county societies are true leaders in their communities.

Despite such reputations, however, membership problems exist at virtually all levels of the Federation. These range from flat membership growth (and declining market share) to severe membership loss that has forced curtailment of many activities. Physicians are questioning not only the value of all medical organizations based on their dues expenditures, but also the relevance of such organizations to their lives and practices. The impact of flat or decreasing membership levels on medical societies' financial pictures has become serious in several instances.

Another trend that is affecting medical society membership is the growing popularity of two new types of alliances that attract physicians and their loyalty: demographic-based organizations and practice-based organizations. The FCT believes that organized medicine at all levels has been slow to recognize the impact of this trend on the medical profession and/or the Federation.

There are now dozens of demographic-based organizations within the profession, bringing together colleagues at the national and local levels based on gender, place of birth, education, political beliefs, and race. Many of these organizations are providing effective advocacy and representation for their members as well as special products, services, educational, and social activities.

Large group practices are also providing services to their physicians rivaling those provided in the past by geographic and specialty societies. These include representation and advocacy as well as business services such as auto leasing, insurance, etc.

Despite membership problems and financial difficulties, there appears to be little support by Federation members for significant changes in the way associations function, either individually or in collaboration. Virtually every association is strongly committed to preserving its own autonomy, and considerable resistance greets any proposal to share resources or combine initiatives.

However, some consolidation has occurred--most notably the merger of the American College of Physicians and the American Society of Internal Medicine. The FCT believes that other associations must develop various types of collaborative arrangements if organized medicine is to improve its effectiveness and efficiency in the future.

The FCT also believes that collaborative opportunities will develop due to the changes in physicians' alliances over time. The AMA/state/county society framework continues to be well positioned to address local and regional issues. The growth in numbers and influence of national medical specialty societies has positioned these organizations to significantly affect national and state affairs. This trend is dramatically altering the framework of organized medicine away from its traditional geographic basis and creating a clear challenge to the Federation's traditional framework. For future collaborative efforts to succeed, input from and participation by all segments of the Federation must be obtained.

Recommendation 3: The needs and demands of the physicians and their practices must be the prime objective of organized medicine as it seeks to improve the value of membership for its constituents.

Governance and Function

Though governance issues were not considered part of the mission of the FCT, any examination of the Federation leads to the inescapable conclusion that governance and leadership problems provide a serious impediment to coordination, collaboration, and communication among constituent associations of the Federation.

The AMA provides a strong policy-making forum that in many instances serves as the voice for all segments of the Federation. Similarly, the AMA has an effective ethical standard-setting body that has a well-respected arms-length relationship with its policy-making body. The AMA's size and influence in Washington make it the obvious choice to coordinate Federation activities in national affairs, but the functioning of the Federation in this arena exemplifies the fragility of the existing system.

At present, the AMA fulfills a dual role as the advocate for its own members and as the coordinator for the activities of all medical societies. The FCT believes that these two objectives are incompatible, and that the dual responsibility borne by the AMA is unreasonable. If the AMA is to be a proactive and often times a bold leader on behalf of its own members, it often must take aggressive and highly visible positions. The decision at the 1999 Annual Meeting to form a collective bargaining unit is an example of this. Clearly not every organization in the House was in agreement, but while all were involved in the process, the national spotlight fell on the AMA.

On the other hand, the AMA's role as coordinator for Federation-wide activities lends itself to a more deliberative and conciliatory role in which the Federation is best served if the AMA does not have a public persona.

The FCT believes that in relying on the AMA to serve both as strong advocate and as coordinator, the Federation is dooming the AMA to failure at both. When a crisis occurs within the Federation, it generally is perceived as the AMA's problem. Other organizations tend to withhold comment until the crisis blows over, leaving the AMA to confront the situation alone. While leaders at all levels of the Federation may see the challenges clearly, their organizations frequently rely on the AMA for a solution. Few Federation-wide projects will succeed without the AMA's approval and support. However, effective support (or opposition) by the majority of Federation organizations can and will influence the AMA's course.

The FCT has attempted to act as a catalyst and facilitator to assist medical societies in developing collaborative programs and services. While there have been instances--particularly at the specialty society level--where cooperative endeavors have succeeded, there remains a lack of trust and collaborative spirit among much of the Federation. Even in those instances where collaboration has succeeded, the tendency has been for each organization

to take full credit for the success in its communications to members, leaving grassroots physicians unaware that any joint effort has taken place.

The effects of inter-organizational competition are apparent and problematic. Medical organizations that compete for members, non-dues revenue, and influence, frequently are reluctant to assist other societies that may be viewed as competitors. In some instances, this non-participation also is a mechanism to minimize expenses, allowing other societies to perform--and pay for--functions that affect other components.

Recommendation 4: Because the governance and function of medical societies are intertwined, the study of each aspect should not occur separately. Members of the Federation must take the Federation-wide perspective and not focus narrowly on their own individual organizations. Components of the Federation should trust and be more willing to collaborate and coordinate with other organizations for the good of the Federation and all physicians in the country.

Form vs. Function

The Study of the Federation concluded that physicians wanted organized medicine to “get its act together” and are concerned about waste. This is apparent in the duplication of services by the various levels of organized medicine costing the associations and their physician members millions of dues dollars each year. In the FCT’s view, the concern is well placed; consequently, the FCT has attempted to identify possible ways for organized medicine to improve functionality across all organizations.

What the FCT learned, however, is that despite its size and common purposes, the Federation has surprisingly few mechanisms to facilitate coordination, collaboration, and communication among component associations. As the FCT began its work, it sought to learn from successful collaborative activities. The FCT invited presenters to come and explain the Relative Value Update Committee (RUC), Current Procedural Terminology (CPT) Editorial Panel, AMA’s Advocacy Resource Center (ARC), and the Specialty Society Coordinating Committee (S²C²). The FCT also had discussions that included the AMA’s Litigation Center and other familiar mechanisms by which medical societies collaborate on medical education, residency review, and accreditation.

In the end, however, it became apparent that none of these activities directly led to a perception among physicians that increased value was being provided. While it is true that all of these activities provide important functions, their value is not readily apparent to grassroots physicians. It is interesting to note that each of these activities began and remains as a separate functional entity, with little or no collaboration or coordination of function with Federation components. In effect, the Federation has “reinvented the wheel” each time it created a new project to deal with a specific problem.

The FCT carefully examined these activities and investigated ways that similar mechanisms could serve current areas of concern, realizing that such entities in the future must consider all elements of the Federation in order to reduce overlap and diminish competition for the same dues-paying members. The FCT encourages leaders of the Federation to place their emphasis on the functionality of activities, regardless of the form in which those activities are carried out.

Recommendation 5: Membership organizations must increasingly work together and share costs for projects and activities that enhance physicians and patients needs.

The FCT acknowledges a significant body of work that has been carried out by the Council on Long Range Planning and Development (CLRPD). The FCT is in total concurrence with the following recommendations of the CLRPD, contained in CLRPD Report 4 I-98.

1. The AMA House of Delegates recommit itself to achieving a transformation of the current Federation of Medicine into a more effective Federation that can accomplish the goals of the Statement of Collaborative Intent which are to: (a) achieve a unified voice for organized medicine; (b) work for the common good of all patients and physicians; (c) promote trust and cooperation among members of the Federation; (d) advance the image of the medical profession; and (e) increase overall efficiency of organized medicine for the benefit of our member physicians. (Policy H-530.958)

2. The AMA House reaffirms its position, as stated in policy H-545.960, that the role of the AMA includes serving as the framework for the Federation of Medicine.
3. The Speaker of the AMA House and the Chair of the AMA Board of Trustees shall jointly appoint a task force to develop a detailed plan to transform our Federation so that it can achieve the goals of the Statement of Collaborative Intent. The task force should function as a special committee of the House. The membership of the task force should reflect key dimensions of the Federation (i.e., county society, state association, specialty society, and the AMA). The task force should provide regular progress reports to the AMA House of Delegates and should submit its final report and recommendations for consideration by the AMA House and by the policy-making bodies of other Federation organizations.
4. The AMA Board of Trustees should increase its efforts to work with the medical associations in the AMA House of Delegates to provide the leadership necessary to transform the current Federation of Medicine into a more effective Federation. All of the organizations represented in the AMA House of Delegates should increase their efforts to work cooperatively with the AMA Board of Trustees to transform the current Federation of Medicine into a more effective Federation.
5. The AMA should work with other Federation elements and with the Federation Coordination Team, to identify creative ways (partnering, mergers, joint ventures, etc.) to strengthen Federation organizations.
6. Subject to the availability of resources, the AMA should support the development of an information base on strategies to strengthen Federation organizations and the AMA should develop tools and techniques to address the practical aspects of implementing such strategies.
7. All Federation organizations should analyze their strategic situations and future prospects and identify how best to serve the interests of their members and the profession. Specific consideration should be given to becoming a working partner, merger candidate, or other creative participant in a transformed Federation.
8. Subject to the availability of AMA resources or financial support from requesting Federation organizations, the AMA should provide assistance and expertise to medical societies in analyzing their strategic situations and their potential roles in a more effective Federation of Medicine.

Recommendation 6: For the Federation of Medicine to be effective, all elements of the Federation which have an interest in any given issue must be included in organized activities. The form of the entity developed to address issues must also be flexible to allow participation by all interested parties. Participation may be at the local, state, or national level, depending on the issue.

Recommendation 7: A collaborative mechanism must be developed that in times of crisis allows Federation component societies to coordinate and focus all available resources to resolve such issues on behalf of physicians.

Recommendation 8: The Federation should encourage interaction between component organizations at the county, state, and national levels, and provide an organizational structure that brings similar types of societies together in working groups to act on issues of importance.

Federation-Wide Efforts--the Governance Barrier

Any attempt to establish a coalition of medical societies faces the formidable obstacle presented by the existing governance structures of the organizations that make up the Federation. Achieving approval from the governing bodies of a group of associations contemplating a collaborative activity can be time-consuming and frustrating.

At present, few medical society leaders--elected or staff--can speak immediately, directly or authoritatively for their constituents without input from their membership and/or governing boards. As a result, the development of consensus and of collaborative initiatives involves a process that is at the mercy of the governing bodies of all the organizations limiting timely input and feedback from other Federation components. Formal and informal contact at the AMA Annual and Interim meetings remains the primary venue at which medical societies exchange information.

Other barriers exist. One is the obvious difficulty in bringing together organizations that historically have competed with each other and may be continuing to compete on other issues. Further, the one-year term of office served by most medical societies' elected officers tends to impede long-range activities and programs.

Information Overload

The large volume of information available to medical societies creates another problem. Information comes from many different sources: the AMA, government agencies, the media, other medical organizations, etc. At many Federation components a staff member performs triage of information, determines the need for immediate action, and shares information with leadership and membership. The enthusiasm and efficiency with which this triage is performed is an essential ingredient in the success of all collaborative activities.

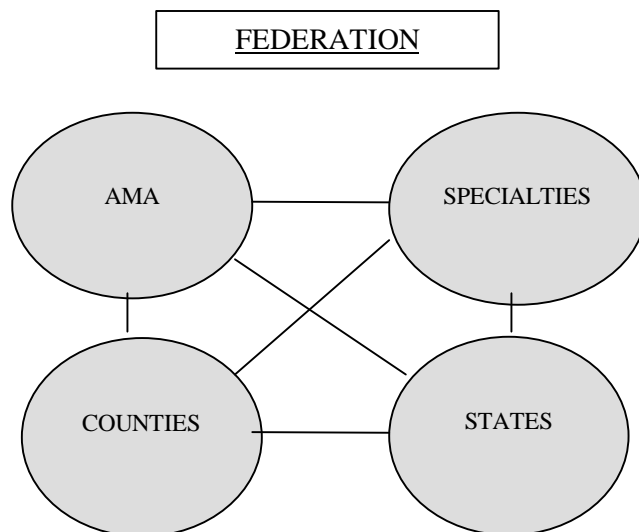
The FCT believes that the AMA is best positioned to continue the development of a coordinated electronic data network serving all components of the Federation. The AMA is widely respected as the world's leading medical publisher. In the next century, the AMA should achieve similar distinction in the field of electronic information regarding medicine.

Recommendation 9: A rapid-response mechanism should be developed by the Federation Advisory Committee (FAC) to bring items of vital interest to the attention of the designated leaders from each Federation component with expectations of timely response. This should be developed under the auspices of the FAC utilizing VFED as a communications vehicle.

Recommendation 10: The components of the Federation should indicate which person or persons within each organization qualifies as the key leader who can speak for the organization and develop a response mechanism for providing timely input to facilitate decision-making at the Federation level. VFED should serve as the primary instantaneous communications medium for this activity.

FCT's Perspective on Work

The FCT's charge to improve the function of organized medicine did not include a review of the structure of organized medicine. The FCT agrees with the Study of the Federation that a Federation of independent medical societies is the structure that will best serve the profession. The FCT's view of such a structure is shown below:



Recommendations of the FCT have proposed functional improvements consistent with such a structure. Research by the FCT and other findings indicate that physicians would like their organizations to work together more closely and effectively, but they do not wish to undermine the independence of their individual organizations. The FCT has focused on functional improvements involving new, voluntary mechanisms and processes.

More importantly, the FCT's work has addressed the needs of physicians, not the needs of physicians' organizations. It is clear to the FCT that organizational structures must be in place to support physicians and their practices. These organizations must never lose sight of the fact that the needs of their physician members--not the needs of the organizations--are the organizations' *raison d'être*.

Medical Society Staff

The role of the medical society staff member--particularly the chief executive officer (CEO)--is a pivotal one. The current role of the medical society CEO is broad, complex, and often involves highly difficult and sensitive assignments. In many organizations, the staff executive is the only source of continuity and organizational history. And the executive must deal with a succession of elected officers with diverse agendas and varying degrees of enthusiasm.

As the FCT assesses the Federation today, it is clear that many of the tasks of coordinating, collaborating, and communicating unreasonably fall--by default--to medical society executives. This arrangement will likely continue to a significant extent no matter how well Federation mechanisms are crafted. The FCT, however, emphasizes that medical society executives cannot function effectively and in the best interests of their members unless adequate support and governance systems are in place.

In many situations medical society staff members exert considerable influence over decisions made by their elected leaders and delegates. The FCT believes that in all cases the medical society's elected leaders should make policy and governance decisions with appropriate input from staff.

The FCT is encouraged by the fact that in most instances, management utilizes its influence in a manner that benefits their physician members. However, staff can also use their influence to block or significantly impede change, raising concerns that such influence might be misused to protect their job situation or to preserve the status quo.

The American Association of Medical Society Executives (AAMSE) is the professional organization for medical society executives. The FCT emphasizes the need for all medical societies to maintain a close partnership with AAMSE and to assure that their staff members continue to have available a wide range of professional management and development opportunities.

Recommendation 11: The Federation must strengthen the effectiveness of each organization's governing body to enhance the inter-workings of the Federation.

Future Directions

Recognizing the incongruity of the current system is not a criticism of the AMA or of any individual component society of the Federation. The FCT believes its findings and recommendations can be utilized to begin a constructive process toward the development of a Federation of Medicine in which all components, including the AMA, can flourish.

The AMA is in a unique position, with respect to its size, resources, and public recognition, to serve as medicine's chief spokesperson, as well as facilitating coordination, collaboration, and communication activities for all levels of the Federation. However, the AMA's ability to serve in this role is impaired by the current competition for dues dollars, non-dues revenues, and members, and by potential mistrust by other medical societies.

To assure the long-term stability and success of the Federation, the FCT believes that the Federation, including the AMA, must develop and accept a mechanism that permits the AMA to fulfill these leadership roles with the trust and support of other members of the Federation. Establishment of such a mechanism will, in the opinion of the FCT, require structural and governance changes within the Federation.

This is not a recommendation for the benefit of the AMA; however, the FCT believes that the long-term success of virtually every Federation component is linked to the success of the AMA. Success by the AMA becomes a victory for all physicians and their patients; similarly failure by the AMA weakens all levels of organized medicine.

Medical education standard setting, one of the cornerstones of the AMA since its founding in 1847, exemplifies Federation collaboration. The AMA-led efforts to build a formidable Federation presence on payment coding and nomenclature standard setting are recent examples of the power of Federation collaboration. There are, however, many more areas that merit Federation-wide response and illustrate the need for a formal extra-organizational mechanism dedicated to building partnerships that respect the contribution of the many parts of the Federation and maximize the impact for physicians and patients.

These new mechanisms would assure effective coordination, communication, and collaboration. The FCT's "Shared Services Organization" (SSO) Model is an example of a strategy that would allow Federation organizations to work cooperatively in business-type ventures. The Commission on Unity has also been assigned the task of developing a proposal for transforming organized medicine into a more effective and cohesive force that would serve physicians and their patients. The FCT encourages the Commission on Unity to be innovative, daring, and forceful in developing its recommendations.

Recommendation 12: The FCT's Shared Services Organization Model is an example of a strategy that would allow Federation organizations to work cooperatively in business-type ventures. The Federation should pursue this type of venture or a similar type, which would meet the needs of the physician members.

IV. General Observations

During the course of its deliberations, the FCT reached a number of conclusions about the Federation and about the difficulty in implementing change within it. The observations below are not offered as a criticism of any individual or group, but as a summary of the situation as it exists today. The FCT encourages the FAC, the Commission on Unity, and other entities contemplating change to keep the following observations in mind.

- **Pride.** Evaluated objectively, the levels of excellence for all medical societies will fall somewhere within a bell-shaped curve, but few medical societies will acknowledge this fact. The FCT's experience shows that medical societies' self-evaluation resembles Garrison Keillor's description of his home state's citizens' average intelligence. You should be prepared to hear that every medical society is above average.
- **Apathy.** Elected leaders of medical societies have a fixed time commitment and many are reluctant to address legacy issues on their watch. With so many medical society options, it is easier to let nature take its course than to consciously drive change.
- **Don't Tread on Us.** Medical societies are rightfully proud of their independent heritage and accomplishments. This is well suited to the nature of physicians in general. Since physician leaders see their organizations as largely political and informational--two dimensions grounded in unfettered independence--redirecting the argument for change away from these perspectives is not easy.
- **Conservatism.** Medical societies invariably trace their origins to people and not grand plans. However, few are eager to subject themselves to an overarching grand plan at this time. Medical society leaders are more inclined to let marketplace dynamics dictate their course because invariably they think "their" organizations will win.
- **Noble Causes.** Medical societies utilize operational standards regarding the business aspects of the association and are given their direction by their policy-making bodies. But these two pillars of good organizations cannot completely replace good information-gathering methods and information about what physicians want from their organization. In the FCT's view, medical societies frequently rely on highly subjective methods to demonstrate value and are woefully lacking in industry-comparative information. Without unimpeachable information, talk of efficiency will always be trumped by noble causes.
- **Pushing on a String.** Generally, no single organization or individual is empowered or willing to make decisions regarding critical and strategic direction-setting issues for medicine; so achieving closure and movement on any given issue is laborious, time-consuming, and frustrating. Despite high demands for communications, member communications are almost invariably one-way, and the leadership is unlikely to receive meaningful feedback. If you expect a populist reaction to buttress your courage to push on--forget it.
- **Contradictions.** Expect great, reputable medical societies to ignore the smaller limited medical societies and watch the great medical societies succeed due to their stature in the community.

- **Political Considerations.** Political considerations often lead medical societies and their leaders to avoid controversial issues. The risk-averse course, while it may benefit the political career of some individuals, will not serve the organization well over an extended period of time.

Based on the above observations, the FCT offers the following “suggestions” to the Federation as a whole and to individual constituent organizations as well:

1. Approach each problem from a dispassionate perspective. Take an enterprise-wide perspective and attempt to isolate the political dimension. Develop a “rule” and a proactive checklist to keep as helpful reminders of established parameters. Assign someone to regularly audit the work product.
2. Preserve and protect the policy-making and democratic underpinnings of the current Federation. This is not the problem. Democratic principles of inclusion and openness must find favor in any and all established mechanisms for improvement if they are to succeed.
3. Don’t challenge the independent and autonomous medical society concept, it will continue to be the fabric of organized medicine.
4. Don’t try to save any particular medical society or type of medical society. Consciously strive to improve the value of Federation membership and focus on helping those societies that are clearly open to change. Those that don’t want your help will only steal your energies and focus.
5. Trust your instincts, but seek out the counsel of experts too. You will need expert help and you should apply significant diligence in deciding what kind of help you want, where to get it, what your relationship will be with the consultant, and what will be the role of the consultant. Always pick highly qualified people to augment your decision-making ability when appropriate.
6. Do not recommend platitudes. The Federation won’t be bettered by artful prose. If you find yourself with a series of wish-list-like desired end results, but have not shown exactly how to do it, your work is not done. Take ideas and articulate them fully so there is no subjective interpretation of the systems, mechanisms, oversight, interactions, processes, procedures and resources described.
7. Don’t default to the body politic. Testing the waters with the AMA House of Delegates and surveying to find acceptable ideas will only guarantee middling and average solutions. Only deliver final reports with specific recommendations for approval.
8. Firmly set your aspirations for your work product and process. Spend time at inception to reach agreement on your vision, goals, objectives, and methods for accomplishing work. As your work product matures, build off your aspirations specific deliverables and track work product concerns. Adopt a rule of procedure for your team (meetings, roles of participants, etc.).
9. Establish a realistic timeframe for work and manage group dynamics. Participant focus and time commitment should be the utmost consideration. Giving members brief but significant opportunities to make an impact is best accomplished by using the meetings of the full team for final decisions and building consensus on major direction-setting activities. Let subgroups do the vast majority of the framing and analysis. Empower people who “get it” to run with the ball.
10. Take a pragmatic inventory of time, expertise, and resources. When expertise is identified and the scope and deliverables are identified, seek it out in the most efficient and expedient manner--including buying it from outside the Team. Volunteer time is not free and should be considered as a real cost. This perspective will help everyone focus on using all resources most effectively. Staff resources need to be adequate, managed, and budgeted.
11. Agree on whom you are serving and how you will interact with all other players and stick to it.
12. Be judicious about the audiences with whom you communicate, how often you do so, and what you expect to achieve from the communication. Communications resources must be realistic and carefully utilized, and their relative value weighed against other activities.

13. When appropriate, don't be reluctant to acknowledge Federation partners' shared participation in a positive outcome.
14. The AMA is an important consideration in every dimension of Federation discussions and must be strategically engaged; as it is the only realistic forum in which to push for change and its resource and other interests must be factored into every discussion.

V. Recommendations

The FCT presents the following recommendations for the Federation as it moves into the 21st Century:

1. In the future, a pre-determined level of funding should be established (scaled accordingly to the size of the organization) for any similar work groups convened.
 - Funds requested and received from state, county, and specialty organizations should be placed in a separate bank account; and
 - The AMA should contribute a pre-determined amount and increase the amount according to the needs of the projects.
2. The governance body of each member of the Federation should endorse the Statement of Collaborative Intent as an important first step toward strengthening the Federation.
3. The needs and demands of the physicians and their practices must be the prime objective of organized medicine as it seeks to improve the value of membership for its constituents.
4. Because the governance and function of medical societies are intertwined, the study of each aspect should not occur separately. Members of the Federation must take the Federation-wide perspective and not focus narrowly on their own individual organizations. Components of the Federation should trust and be more willing to collaborate and coordinate with other organizations for the good of the Federation and all physicians in the country.
5. Membership organizations must increasingly work together and share costs for projects and activities that enhance physicians and patients needs.
6. For the Federation of Medicine to be effective, all elements of the Federation which have an interest in any given issue must be included in organized activities. The form of the entity developed to address issues must also be flexible to allow participation by all interested parties. Participation may be at the local, state, or national level, depending on the issue.
7. A collaborative mechanism must be developed that in times of crisis allows Federation component societies to coordinate and focus all available resources to resolve such issues on behalf of physicians.
8. The Federation should encourage interaction between component organizations at the county, state, and national levels, and provide an organizational structure that brings similar types of societies together in working groups to act on issues of importance.
9. A rapid-response mechanism should be developed by the Federation Advisory Committee (FAC) to bring items of vital interest to the attention of the designated leaders from each Federation component with expectations of timely response. This should be developed under the auspices of the FAC utilizing VFED as a communications vehicle.
10. The components of the Federation should indicate which person or persons within each organization qualifies as the key leader who can speak for the organization and develop a response mechanism for providing timely input to facilitate decision-making at the Federation level. VFED should serve as the primary instantaneous communications medium for this activity.
11. The Federation must strengthen the effectiveness of each organization's governing body to enhance the inter-workings of the Federation.

12. The FCT's Shared Services Organization Model is an example of a strategy that would allow Federation organizations to work cooperatively in business-type ventures. The Federation should pursue this type of venture or a similar type, which would meet the needs of the physician members.
13. The Federation should acknowledge and encourage mergers of like societies to allow them a stronger voice in the AMA House of Delegates for their members.

The FCT recognizes the newly created Federation Advisory Committee (FAC), which will operate as a committee of the AMA Board of Trustees. Its charge is to complete where necessary, or in some cases maintain, the FCT's projects that are underway but will not be completed by the end of its tenure; and to encourage, facilitate, and document collaborative efforts among all levels of organized medicine. The FCT makes the following recommendations to the FAC.

14. Oversee the development and operation of a Federation conflict resolution mechanism; (Reference Appendix A, I. Conflict Resolution)

Oversee a series of Federation-wide roundtable discussions/forums on Federation issues; (Reference Appendix A, I. Conflict Resolution)

Oversee VFED--the virtual Federation leadership web site; (Reference Appendix A, II. VFED)

Oversee a membership committee to focus on all aspects of the membership process; (Reference Appendix A, III. Membership)

Oversee a committee to promote and share outstanding Federation-developed projects for patients and physicians; (Reference Appendix A, IV. Patient/Physician Advocacy)

Publish an annual "State of the Federation" report;

Develop a working mechanism to allow ideas for projects such as the Shared Services Organization to be identified, tested, and implemented on an on-going basis; (Reference Appendix A, V. Work Process Improvement)

Review carefully with the AMA Board of Trustees the work that led to the SSO proposal, monitor the development of and impediments in developing cooperative, collaborative projects in the Federation, and issue a report to the House of Delegates and the Federation in one year to summarize its findings and to make recommendations about facilitating such efforts; (Reference Appendix A, V. Work Process Improvement)

Oversee an integrations committee to highlight integration in Federation organizations and serve as a resource to those components considering mergers, develop and maintain surveys of medical societies practices to assist in understanding the medical society industry and its trends; (Reference Appendix A, VI Integrations)

Oversee the development and operation of a cross-organizational committee on professionalism; and (Reference Appendix A, VII. Professionalism)

Play a crucial role in conducting studies and further refining the roles and responsibilities of the component societies of the Federation. (Reference Appendix A, VIII Roles & Responsibilities)

This concludes the final report of the Federation Coordination Team. It is clear to the FCT that significant changes must occur within the Federation of Medicine to enhance the value of membership. Hallmarks of the change must be trust, cooperation, collaboration, and enhanced communications.

The FCT has experienced both accomplishments and frustrations during its three-year tenure while attempting to act as a catalyst for Federation activities. The FCT believes it has helped the Federation concept evolve along a continuum and wishes to encourage the Federation Advisory Committee and Committee on Unity to further develop and implement FCT programs and initiatives while devising new Federation structures and functions as appropriate.

The FCT wishes to convey a sense of urgency in these endeavors, as the window of opportunity to transform the Federation of Medicine from an aspirational concept to a reality is closing in an environment hostile to organized medicine. The FCT believes a true Federation with obvious inherent strengths is our best hope to return the practice of medicine and the health care of patients to physicians.

Members of the Federation Coordination Team wish to express their appreciation for all of the support they received over the last three years throughout the Federation especially Mr. David Cloud, Mr. Barry Eisenberg, CAE, Ms. Lila Valinoti and Ms. Cheryl Wawro. The members are also thankful for the opportunity to serve the Federation as organized medicine heads into the 21st century.

APPENDIX A

Status of completed projects and ongoing activities of the Federation Coordination Team

I. Conflict Resolution/Federation Coordination

Nature of the Product: The FCT was asked to address conflict resolution/Federation coordination concerns. The FCT's approach was targeted and limited to the issues of process and mechanisms. The FCT proposed establishing a mechanism with a defined process for medical societies to identify and resolve inter-organizational, and issue specific disputes. In order to identify areas of potential conflict, obtain expert input on the issues involved, initiate discussion, and attempt to develop consensus, the FCT also suggested holding bi-annual forums with Federation members. Three resolutions at AMA's 1998 Annual Meeting suggested the FCT study this issue and the AMA House of Delegates subsequently referred this topic to the Commission on Unity.

Current Status: The FCT has discussed this subject frequently over the 18 months. The FCT has corresponded with Council on Constitution and Bylaws and the Council on Ethical and Judicial Affairs in identifying and clarifying the nuances and parameters of the issue and the FCT has begun formulating a plan of action. The FCT articulated its thoughts on a formal mediation process for voluntary use by medical societies and reported its finding to the AMA House in December 1998. An AMA Board report on the aforementioned coordination resolutions was referred to the Commission on Unity.

The FCT has recommended that a Conflict Resolution/Federation Coordination Committee (CR/FCC) be created as a standing committee of the FAC, reporting to and directly accountable to the FAC. The sub-committee should not take actions independently of the FAC and its primary purpose would be to advise the FAC. The CR/FCC would be expected to meet quarterly and more frequently, if needed.

The CR/FCC should be a small committee composed of FAC members and other members drawn from the federation. The full FAC would elect all members.

The principal activities of the CR/FCC would be to oversee the development and operation of a Federation conflict resolution mechanism and oversee the promotion and organization of a regular series of Federation roundtable discussions/forums on Federation issues. It would be bound by the AMA's Ethical and Corporate Practices.

A sub-mechanism of the CR/FCC would be a standing committee that would help medical societies resolve disputes. The process for resolving disputes was developed by the FCT and subsequently has been referred to the Commission on Unity. In the event a mechanism (perhaps the FCT-developed mechanism) is recommended by the Commission on Unity, the FCT envisions the oversight and custodian responsibility being placed with a subcommittee of CR/FCC.

The nature of the Conflict Resolution subcommittee, for parties to a dispute, requires special attention in the design and oversight function that should be coordinated with input from AMA legal staff.

II. VFED

Nature of the Product: The FCT created a limited-access Internet site, www.vfed.org, separate from the AMA web site, called VFED (for “Virtual FEDeration”) to allow medical society leaders (member and non-members of the AMA) to share information and communicate leadership issues. VFED was structured to allow users to submit information easily and directly without an editorial approval process. VFED can continue to serve as a principal electronic communication medium for all Federation leaders with the long-term objective of replacing paper communications. VFED also contains an archival function for messages, a “chat” room function and an upload area where files can be shared electronically. Certain legal and oversight issues require continued attention.

Current Status: VFED was launched at the June 1998 AMA Annual Meeting. Currently, 1,400 leaders are registered to use the site. A Request for Proposal process was used to assess the ongoing cost of maintaining site functionality and leadership service. In the next year, the VFED project will require concentrated efforts to educate the intended audience through available marketing and communication channels. Staff efforts to coordinate marketing, work with AMA field staff to promote the site, and to respond to questions will be required. An aggressive marketing campaign including the development, production, and distribution of brochures and related promotional pieces also is suggested. The VFED promotion should continue to highlight the FCT projects, including any new initiatives under the FAC.

An oversight process is contained in the VFED Charter. Due to VFED’s design and emphasis on simplicity, it is not envisioned that VFED oversight requires a formal mechanism, but a process and expectations for the site are contained in the description of the VFED Operational Process.

The FCT recommends that VFED be the direct responsibility of the FAC, and that one FAC member is given primary responsibility for working with VFED's operational staff.

III. Membership

Nature of the Product: The FCT was asked to study and make recommendations on ways to improve the Federation membership enrollment process to reduce entry barriers to membership and reduce duplication and inefficiency. The FCT divided the work into three sequential products: 1) a standard membership application, 2) membership enrollment processes, and 3) membership system innovations.

Current Status: The FCT developed a standard membership application and is distributing it to state and county medical societies as well as actively promoting its implementation. Additional work may be needed to accommodate national specialty societies. The second work product--enrollment process improvement--involves articulating process improvement strategies and descriptions of process barriers and establishing protocols to speed electronic data transfer. The FCT’s objective is to promote Federation information exchange using the basic data elements established in the standard application. The AMA data and information technology are essential to Federation enrollment process improvement. The processing product will also assess best practices in medical society enrollment. Through discussions with AAMSE and the Federation, the FCT has sought to build consensus on enrollment process improvements. The FCT and AAMSE have formed a joint committee to study these issues. The final product--Federation membership system innovation--is highly dependent on successful completion of the first two phases and will most likely be approached as an extension of the combined efforts in achieving progress on both the application and the enrollment process.

The FCT recommends that the FAC direct its efforts in the membership arena to address interaction with AMA, AAMSE, and with all of the components in the Federation. Ideally, the FAC would focus on all aspects of the membership process within the Federation. The FAC should, in some capacity, solicit input from physician leaders directly engaged in membership activities at various types of medical societies.

IV. Patient/Physician Advocacy

Nature of the Product: The Patient/Physician Advocacy (PPA) project identifies exemplary Federation projects and shares “how to” information with the Federation. This project tested the Federation

coordination objective. Also, this project has helped build substantive features on VFED, the FCT's electronic communication source for Federation leaders.

Current Status: Two programs have been developed and are available on VFED. "Conflict Resolution in Managed Care" describes the experience of Federation members in dealing with difficult managed care issues through three modules: Negotiation, Legislation, and Litigation. This project also is responsible for building the Federation "Issues Center," also located on VFED, that entails collecting existing Federation presentations, i.e. speeches and PowerPoint presentations, for sharing among Federation leaders. Sharing Federation projects and actively cultivating cross-Federation learning is an essential Federation activity for the future.

The FCT recommends that a Patient/Physician Advocacy Committee (PPAC) be created as a standing committee of the FAC. The committee would report to the FAC and would be accountable to it. The PPAC would be a small committee composed of FAC members and other members that may be drawn from the Federation.

The PPAC objective would be to identify, promote, and share outstanding Federation developed projects for patients and physicians. It would have broad authority to carry out activities within its predefined charge. The PPAC should work closely with the VFED Operational Process and in coordination with staff to promote the exchange of exemplary Federation projects.

In addition to sharing and promoting Federation activities, the PPAC also would be directly responsible for reporting on Federation projects for inclusion in the FAC's "State of the Federation" annual report.

V. Work Process Improvement

Nature of the Product: The Work Process Improvement (WPI) project has been a major focus of the FCT's charge to demonstrate increased membership value through development and promotion of projects of collaboration and cooperation among Federation organizations

Current Status: There have been three phases in this project. The first was identifying potential joint ventures and partnerships. A national consulting firm was utilized and six diagnostic partners were selected (American Academy of Otolaryngology and Head & Neck Surgery, American Medical Association, California Medical Association, Medical Society of the State of New York, Ohio State Medical Association, and the Texas Medical Association) to complete this phase. A multitude of potential projects was identified by working with the diagnostic partners. The second phase involved narrowing the list of prospective projects and constructing an outline for a business plan for the projects. Four projects that offered the possibility of significant cost savings and at the same time, would elicit a good level of interest and participation were identified. The FCT concluded, however, that what was needed was a federation-wide structure to analyze potential projects, come to agreement on projects, implement the projects, and measure the results to determine whether a particular project should be continued. This represented the third phase of work. After receiving input from the Federation on the issues that would need to be addressed in setting up such a structure, the FCT, in conjunction with its consultants, developed the "Shared Services Organization"(SSO) proposal.

FCT's Deliverable and Plan of Action: A 2-pronged plan of action was initially undertaken. One potential project that received nearly universal endorsement (a uniform Internet initiative for the Federation) was selected to attempt implementation. At the same time, the process of educating the Federation and seeking support for the SSO proposal began. After several months of discussions and meetings, the FCT found itself unable to make any substantial progress towards implementing the Internet initiative. Several lessons were learned in this process, including the extent of the "lack of trust" issue in the Federation, the risk-adverse nature of medical associations, and the inability of the Federation to work expeditiously in creating cooperative business ventures. These findings reinforced the FCT's conclusion that for the Federation to seize and implement collaborative, cooperative projects in a timely manner, a new structure needed to be developed. The FCT has developed the SSO Model as the possible answer to fill this need.

The SSO would be a limited-focus joint venture company that would be owned and directed by the participating medical societies, providing a more effective Federation as envisioned by the Study of the

Federation. Its purpose would be to find efficiencies through joint efforts among medical societies, but it also facilitates necessary investment and administrative focus for organized medicine. It would enable medical societies to add value to their organizations through collaborative work, but would not be apparent to the individual members of the medical society. The SSO proposal calls for a joint venture that facilitates collaborative action to improve how medical societies provide products and services to physician members. It would be designed to address business operational matters and would have no intended impact on organized medicine's political, governance, or policymaking systems. The four initiatives identified in the "Diagnostic Phase" of the WPI (Internet, Value to Physicians, Consulting Services, and Outcomes Measurement) could serve as initial projects of the SSO. The SSO would serve as a transition mechanism to catalyze pilot projects.

The FCT has met with the AMA Board of Trustees (BoT) to lay out the SSO proposal and to seek AMA support. Similarly, the FCT presented an overview of the proposal at the 1999 National Leadership Development Conference, and met with several state medical associations and national medical specialty societies in June, 1999, and again in July, 1999, to describe the proposal in detail and to seek additional input and support. A booklet outlining the SSO proposal in detail was produced and distributed.

The SSO proposal would involve creation of an entity that gives operational oversight, control, and responsibility to the investor-owners, not to any one single entity. The AMA has responded to the FCT's proposal by rejecting it. In a letter dated August 16, 1999, the AMA stated that "we can find little value to either the AMA or the Federation that cannot be achieved in other ways." The letter goes on to state "We feel that there is a simple answer to shared services among the Federation members and that is simply to make them known and available to other Federation members and then share them on good economic terms for each party. Clearly, all of us at the AMA are prepared to work closely with innovative ways of sharing the programs, products and systems that we have developed in order to help reduce the overhead costs of all of us in organized medicine."

The FCT recognizes that without AMA support and participation, it will be difficult for the SSO to become operational. While the FCT agrees the SSO does represent a new organizational entity for the Federation, the FCT has concluded that some sort of formalized structure is needed to have an effective mechanism for evaluating and initiating joint collaborative "business-type" functions. The decentralized governance of the SSO would allow identification of projects deemed of value from throughout the Federation and not just those that "we [the AMA] have developed." Furthermore, the FCT is concerned that without an ongoing structure that can develop expertise in evaluating, testing, and implementing ideas for collaborative projects, there will be repetitive "recreation of the wheel" each time a potential project is proposed, with a new organizational structure required in each situation to evaluate and implement the project.

The FCT is aware that there is currently an initiative underway involving the AMA and several national medical specialty societies to further the concept of the Internet project and to seek to bring it to fruition. This will be a major undertaking, but the FCT applauds this particular effort, since the FCT's analysis suggests it will provide significant benefits, both in reducing overall expenditures and increasing the quality of the product, if it is successful. Similarly, the FCT has been made aware of interest in each of the other three projects developed in the "diagnostics" phase of the FCT's work on Work Process Improvement. The FCT would observe that the relative difficulty in achieving consensus, as well as the duplicative efforts required to evaluate and develop strategies for implementation of each of these projects, affirms the need for an SSO-type approach to foster collaborative projects. The need to act rapidly to seize opportunities in the rapidly changing business environment in which medical associations must work also suggests the need for a mechanism to rapidly assess and implement programs to avoid the "too little, too late" phenomenon.

The FCT believes that the FAC will have a significant responsibility to identify and foster cooperative, collaborative projects for Federation organizations. There are significant obstacles for making a project come to fruition, and the FCT recommends that the FAC strive to develop a working mechanism to allow ideas for such projects to be identified, tested, and implemented on an on-going basis. The FCT further recommends that the FAC and the AMA Board of Trustees, review carefully, the work that led to the SSO proposal, monitor the development of and impediments in developing cooperative, collaborative projects in the Federation. FCT also recommends a report to be issued to the House of Delegates and the Federation in one year to summarize its findings and to make recommendations about facilitating such efforts.

VI. Integrations

Nature of the Product: The Integrations project was suggested by the FCT as a means to catalogue and analyze medical society integration efforts in the Federation (e.g., ACP-ASIM merger) and to develop a better information base. Products would produce a series of reports (e.g., white papers) reflecting the case study of Federation integration by type (i.e., horizontal, vertical) and variety (i.e., county-state, county-county, specialty-specialty).

Current Status: A survey conducted in 1998 identified more than 100 Federation cooperative efforts for study. Resource limitations have precluded additional work on the project, but the FCT has requested assistance from CLRPD in developing a report-writing format.

The FCT recommends that an Integration Committee (IC) be created as a standing committee, reporting to, and accountable to the FAC. The committee would be a small committee composed of FAC members and other members who might be drawn from the Federation.

The IC objective would be to oversee the development and operation of a medical society industry scanning committee highlighting integration activity.

The FCT suggests that the committee have broad authority to carry out activities within its defined charge. The FCT has asked the CLRPD to provide assistance in developing a standard reporting format for Federation case studies/evaluation of integration activities. In addition to promoting and distributing reports on medical society integration, the IC would be responsible for developing and maintaining surveys on medical society practices. The IC would maintain a repository of integration industry patterns. The IC's primary communication vehicle would be written reports.

VII. Professionalism

Nature of the Product: The FCT worked closely with the AMA Professional Standards Groups to develop a Federation mechanism for professionalism issues (e.g., a RUC-like entity for professionalism issues).

Current Status: Resource priorities did not allow the FCT to continue this effort. The FCT did, however, present the concept in several forums including the Specialty Society Presidents' Forum, where it received a strong positive response. The FCT has been encouraged to develop a process that would bring the Federation together with the AMA in this area.

The FCT recommends that a Professionalism Coordination Committee (PCC) be created as a subcommittee of the FAC and be accountable to it. The PCC would be broadly representative of the Federation and would include a larger panel of Federation leaders appointed by medical societies.

The PCC would function as a steering committee and accomplish most of its work by utilizing ad hoc committees comprised of members of the panel. The PCC would have broad authority to carry out its activities within its predetermined charge and would seek resources from the FAC.

The PCC would have no legal status separate from FAC and AMA, and would be bound by AMA's Ethical and Corporate Practices. The steering committee would be expected to meet regularly and maintain considerable flexibility about its mission. The PCC would be charged with the active planning, development, and operation of a cross-organizational professionalism committee.

The FCT suggests that the PCC conduct its work in the most appropriate venue including face-to-face meetings, conference calls and on-line conferences. PCC activities would include coordination, brainstorming sessions, educational sessions (leadership), leveraged communications, active listening, and report writing. The PCC would conduct all communications and outreach through the FAC.

VIII. Roles and Responsibilities

Nature of the Product: The Roles and Responsibilities project analyzed an ideal division of responsibilities and provided a report summarizing the baseline understanding of the existing work relationships among Federation medical societies. AAMSE and the Study of the Federation both failed to complete such a task.

Current Status: The Roles and Responsibilities report has been adopted by the House of Delegates at A-99 and has been distributed to the Federation for use as a self-assessment tool within each organization.

The FCT believes this report and self-assessment tool will lead to a better understanding of how organizations function in relation to themselves, their members, and other entities within the Federation. The Commission on Unity during the next 18 months will study the report, and the FCT is optimistic that the Commission's activities will advance the objectives of this report.

APPENDIX B

Listing of Contributors 1997-1999

Academy of Medicine of Cincinnati	American Society of Anesthesiologists, Inc.
Academy of Medicine of Toledo and Lucas County	American Society of Clinical Oncology
Alameda-Contra Costa Medical Association	American Society of Colon & Rectal Surgeons
American Academy of Allergy, Asthma & Immunology	American Society of General Surgeons
American Academy of Child and Adolescent Psychiatry	American Society of Internal Medicine
American Academy of Facial Plastic & Reconstructive Surgery	American Society of Plastic & Reconstructive Surgeons, Inc.
American Academy of Family Physicians	American Urological Association, Inc.
American Academy of Insurance Medicine	Arizona Medical Association, Inc.
American Academy of Neurology	Arkansas Medical Society
American Academy of Ophthalmology	Association of Military Surgeons of the U.S.
American Academy of Pain Medicine	Aurora-Adams County Medical Society
American Academy of Pediatrics	Bexar County Medical Society
American Association of Clinical Urologists, Inc.	Broome County Medical Society
American Association of Neurological Surgeons	Bucks County Medical Society
American College of Allergy, Asthma and Immunology	California Medical Association
American College of Cardiology	Capital Medical Society
American College of Chest Physicians	Charlotte County Medical Society
American College of Emergency Physicians	Chemung County Medical Society
American College of Gastroenterology	Clear Creek Valley Medical Society
American College of Nuclear Medicine	College of American Pathologists
American College of Obstetricians and Gynecologists	Colorado Medical Society
American College of Physician Executives	Connecticut State Medical Society
American College of Physicians	Dallas County Medical Society
American College of Preventive Medicine	Delaware County Medical Society
American College of Radiology	Denver Medical Society
American College of Rheumatology	El Paso County Medical Society
American Gastroenterological Association	Endocrine Society
American Institute of Ultrasound in Medicine	Fairfax County Medical Society
American Medical Group Association	Fairfield County Medical Association
American Psychiatric Association	Florida Medical Association, Inc.
American Sleep Disorders Association	Forsyth-Stokes-Davie County Medical Society
American Society for Dermatological Surgery, Inc.	Harris County Medical Society
American Society for Gastrointestinal Endoscopy	Hawaii Medical Association
American Society for Reproductive Medicine	Indianapolis Medical Society
American Society of Addiction Medicine	Iowa Medical Society
	Jefferson County Medical Society
	Jefferson County Medical Society
	Jefferson Parish Medical Society

Kalamazoo Academy of Medicine
 Kansas Medical Society
 Kentucky Medical Association
 Lake Superior Medical Society
 Larimer County Medical Society
 Lee County Medical Society, Inc.
 Lehigh County Medical Society of PA., Inc.
 Los Angeles County Medical Association
 Mahoning County Medical Society
 Maine Medical Association
 Massachusetts Medical Society
 Mecklenburg County Medical Society
 Medical Association of Atlanta
 Medical Association of Georgia
 Medical Association of the State of Alabama
 Medical Society County of Erie Inc
 Medical Society of Delaware
 Medical Society of Milwaukee County
 Medical Society of New Jersey
 Medical Society of Sedgwick County
 Medical Society of the County of Westchester
 Medical Society of the District of Columbia
 Medical Society of the State of New York
 Medical Society of Virginia
 Memphis and Shelby County Medical Society, Inc.
 Mesa County Medical Society
 Metropolitan Medical Society of Greater Kansas City
 Metropolitan Omaha Medical Society
 Michigan State Medical Society
 Minnesota Medical Association
 Mississippi State Medical Association
 Missouri State Medical Association
 Monroe County Medical Society
 Montgomery County Medical Society
 Nebraska Medical Association
 New Hampshire Medical Society
 New Mexico Medical Society
 New York County Medical Society
 North Carolina Medical Society

Ohio State Medical Association
 Oklahoma State Medical Association
 Orange County Medical Association
 Oregon Medical Association
 Orleans Parish Medical Society
 Palm Beach County Medical Society, Inc.
 Pennsylvania Medical Society
 Philadelphia County Medical Society
 Pierce County Medical Society
 Pima County Medical Society
 Polk County Medical Society
 Pueblo County Medical Society
 Radiological Society of North America
 Renal Physicians Association
 Rhode Island Medical Society
 Riverside County Medical Association
 San Bernardino County Medical Society
 San Francisco Medical Society
 Shawnee County Medical Society
 Snohomish County Medical Society
 Society for Investigative Dermatology
 Society for Vascular Surgery
 Sonoma County Medical Association
 South Carolina Medical Association
 South Dakota State Medical Association
 Spokane County Medical Society
 Tarrant County Medical Society
 Tennessee Medical Association
 Texas Medical Association
 Thurston Mason County Medical Society
 Travis County Medical Society
 Tulsa County Medical Society, Inc.
 Utah Medical Association
 Vermont Medical Society
 Volusia County Medical Society
 Washington State Medical Association
 Wayne County Medical Society
 West Virginia State Medical Association
 Yolo County Medical Society

APPENDIX C

Statement of Collaborative Intent

At its 1997 Annual Meeting, the AMA House of Delegates endorsed the following Statement of Collaborative Intent and asked that it be distributed to members of the Federation of Medicine for endorsement by their policy-making bodies.

Preamble

The Federation of Medicine is a collaborative partnership in medicine. This partnership is comprised of the independent and autonomous medical associations in the AMA House of Delegates and their component and related societies. As the assemblage of the Federation of Medicine, the AMA House of Delegates is the framework for this partnership.

Goals

The goals of the Federation of Medicine are to:

- achieve a unified voice for organized medicine;
- work for the common good of all patients and physicians;
- promote trust and cooperation among members of the Federation;
- advance the image of the medical profession; and
- increase overall efficiency of organized medicine for the benefit of our member physicians.

Principles

1. Organizations in the Federation should collaborate in the development of joint programs and services that benefit patients and member physicians.
2. Organizations in the Federation should be supportive of membership at all levels of the Federation.
3. Organizations in the Federation should seek ways to enhance communications among physicians, between physicians and medical associations, and among organizations in the Federation.
4. Each organization in the Federation of Medicine should actively participate in the policy development process of the AMA House of Delegates.
5. Organizations in the Federation have a right to express their policy positions.
6. Organizations in the Federation should support, whenever possible, the policies, advocacy positions, and strategies established by the Federation of Medicine.
7. Organizations in the Federation should support an environment of mutual trust and respect.
8. Organizations in the Federation should inform other organizations in the Federation in a timely manner whenever their major policies, positions, strategies, or public statements may be in conflict.
9. Organizations in the Federation should support the development and use of a mechanism to resolve disputes among member organizations.
10. Organizations in the Federation should actively work toward identification of ways in which participation in the Federation could benefit them.

APPENDIX D

Federation Coordination Team

Jay A. Gregory, MD, Chair
Muskogee, Oklahoma

Oakland, California

George E. McGee, MD, Vice Chair
Hattiesburg, Mississippi

Joel M. Karlin, MD
Lakewood, Colorado

Charles S. Amorosino
Tallahassee, Florida (resigned 97)

H. Clifton Knight, MD
Indianapolis, Indiana

Joseph P. Annis, MD
Austin, Texas

Marie G. Kuffner, MD
Los Angeles, California

Cathy O. Blight, MD
Flint, Michigan

D. Ted Lewers, MD
Easton, Maryland

Mary S. Carpenter, MD
Winner, South Dakota

Timothy B. Norbeck
New Haven, Connecticut

Ann C. Cea, MD
Rye Brook, New York

Colin C. Rorrie, Jr., PhD, CAE
Irving, Texas

Hunter C. Champion
New Orleans, Louisiana

Krishna K. Sawhney, MD
Taylor, Michigan

Ronald J. Clearfield, MD
New Kensington, Pennsylvania

Robert W. Seligson, MBA, CAE
Raleigh, North Carolina

David M. Cloud
Chicago, Illinois (resigned 4/99)

David M. Shapiro, MD
Alva, Florida

Martin G. Dillard, MD
Bethesda, Maryland

Roy W. Skoglund, MD
Roseburg, Oregon (resigned 5/98)

Stephen C. Duffy
Alexandria, Virginia

John W. Spurlock, MD
Bethlehem, Pennsylvania

Lewis E. Foxhall, MD
Houston, Texas

Jennifer E. Trottman, MD
Philadelphia, Pennsylvania

Paul E. Galanti
Richmond, Virginia (resigned 97)

Robert M. Wah, MD
San Diego, California

William N. Guertin

Rowen K. Zetterman, MD
Omaha, Nebraska

15. UPDATE ON CORPORATE RELATIONSHIPS**HOUSE ACTION: FILED****PURPOSE**

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the 1999 Corporate Review process through November 1, 1999, as outlined in Board of Trustees Report 20 (A-99).

BACKGROUND

At the June 1999 Annual Meeting, the American Medical Association House of Delegates approved revised principles to govern the AMA's corporate relationships. The new "Guidelines for American Medical Association Corporate Relationships" have been incorporated into the corporate review process. AMA managers are responsible for reviewing all projects to make sure that they are in keeping with these guidelines. Corporate activities that involve the association of the AMA name or logo with a company, non-federation association, or foundation, or include commercial support must undergo review by the internal staff Corporate Review Team.

The Corporate Review Team evaluates each project in relationship to the following:

- Type, purpose and duration of the activity;
- AMA objective the activity serves;
- Audience;
- Company, association, foundation, or academic institution involved;
- Source of external funding
- Use of the AMA logo;
- Editorial control/copyright
- Exclusive or non-exclusive nature of the arrangement;
- Financial analysis inclusive of revenues, direct expenses, contribution margin, support expenses, general and administrative expenses and net margin; and
- Status of single and multiple supporters.

The Corporate Review Team is comprised of vice presidents from the following areas: Ethics Standards; Legal; Science; Finance; Foundation, International and Corporate Relations; Communications; Membership and Publishing. It meets the first Monday of every month.

Corporate Review Process Overview

The AMA Board of Trustees is informed of all corporate arrangements. The Board of Trustees conducts an in-depth random audit of approximately 1% of CRT reviewed projects on an annual basis.

The following types of activities are reviewed by the Corporate Review Team:

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to ACCME Standards and Essentials.
- Independent and company-sponsored foundation supported projects.
- AMA licensing and publishing programs. These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks, examples are, health and education licensing programs such as consumer books, and physician information licensing such as Guides To Permanent Impairment.
- Member service provider programs such as new AMA subsidiary programs or other member benefits.
- Non-profit association collaborations outside of the Federation. The CRT reviews all Non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.
- Collaboration with academic institutions only if there is corporate sponsorship.
- AMA product provider programs where the AMA sells third parties' products for the AMA physician catalog.

- Physician certification programs that establish standards for certification, commendation or recognition of physicians, products or services available to physicians such as AMAP when external funding or association with corporate entities are indicated.
- Vendor request for usage of AMA name beyond a client listing.

The Board of Trustees reviews the following:

- Any activity directed to the public with external funding.
- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Upon request of a dissenting member of the Corporate Review Team.
- Any other activity upon request of the Corporate Review Team.

RESULTS OF THE CORPORATE REVIEW PROCESS

As of November 1, 1999, 72 activities had been reviewed; 61 were approved, eight were not approved and three were held for further development. Of the 61 approved projects, 26 were educational grants, 14 were member service programs, five were licensing agreements and 16 were considered “other”. “Other” included three information products, five conference/co-sponsorships, one physician credentialing project, two professional books and related media projects and five Internet projects. (See Appendix A – AMA’s approved Corporate Relationships for a more detailed listing.) Of these 61 projects, the majority are new programs. Contracts from previously approved projects up for renewal did not go through the CRT again as long as there were no significant changes made to the contracts.

CONCLUSION

The Board of Trustees believes that the corporate review process continues to be successfully integrated into the AMA’s organizational culture. The AMA staff, Corporate Review Team, and Board of Trustees have demonstrated a high level of commitment, assuring that corporate review processes are in place. The guidelines are appropriately applied to all new ventures, while maintaining an environment where creative programs that meet physician member and patient needs can continue to be developed.

UNRESTRICTED EDUCATIONAL GRANTS

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations/Foundations</u>	<u>Approval Date</u>
Conferences/Media Briefings			
1100-0299	Robert Wood Johnson Youth & Violence Project	Robert Wood Johnson	09/27/99
1101-0226	Physician Awareness Program to collect data to increase physician/public awareness of need for organ donors	Partnership for Organ Donation supported by Burroughs-Wellcome Co., Sandoz Pharmaceutical Co., & Wyeth Ayerst Labs.	01/18/99
1101-0245	Robert Wood Johnson AMOD – research, planning for media campaign to address student binge drinking	Robert Johnson Foundations	11/15/99
1101-0246	Plan and host Y2000 11 th World Conference Tobacco	Glaxo-Wellcome	01/15/99
1101-0277	Public Attitudes Survey on Organ Donation	The William G. McGowan Foundation, American Society of Transplant Physicians, Partnership for Organ Donation, American Liver Foundation, Burroughs Wellcome Co., Sandoz Pharmaceutical Corp., Wyeth Ayerst Laboratories	08/02/99
1101-0287	United Airlines as official sponsor – 11 th World Conference	United Airlines	09/13/99
1103-0242	CME Research Summit – planning conference	Pharmacia & UpJohn	12/15/98
1103-0251	Emerging Physicians Leaders Conference	The Josiah Macy, Jr. Foundation	03/01/99
1104-0258	Project on Quality at End of Life – multicentered examination of patient/caregiver experiences and outcomes	Nathan Cummings Foundation	03/01/99
2201-0237	AMA Science News media Briefings	Bristol – Myers Squibb, Other Funding sought	11/20/98
2201-0260	Auto Safety Brochure – distributed through Primary Care Physicians	General Motors	06/22/99
3303-0275	Health Sector Assembly – invitational conference to stimulate national agenda on critical health issues	Pfizer, AMGEN, Purdue Pharma, Johnson & Johnson	08/02/99
Educational/Informational Material			
1100-0272	Quality Care Alerts – 2 pg. educational piece developed on healthcare topic, co-sponsored with specialty societies	Funding not finalized*	07/12/99
1101-0269	California Wellness Project – A subcontract with USF to AMA to write retrospective on GAPS model; entitled “Lessons Learned”	University of California – San Francisco	06/07/99

1104-0263	EPEC Continuation Grant – continue curriculum to address skills and knowledge to train physicians for end-of-life care	Robert Wood Johnson Foundation	04/19/99
5502-0167	Breast Cancer/Genetic Testing CME Aetna Distribution	Aetna/U.S. Healthcare – Distributor, Myriad Laboratories funder	12/03/98
5502-0234	Health Management Bulletins – OTC’s – a patient education component addressing pediatric dosing safety issues	McNeil, Consumer Healthcare	12/02/98
5502-0240	Migraine: A Patient Guide To Treatment	Glaxo-Wellcome	11/20/98
5502-0270	AMA Diabetes Education – physician directed CME and patient booklets	Eli Lilly	06/07/99
5502-0271	AMA CME – Genital Herpes – meeting, interactive case studies, patient materials	Glaxo-Wellcome	07/12/99

Website/Internet

5502-0236	JAMA Women’s Health Web site - birth control and menopause	J & J Corporate (Ortho-McNeil)	11/23/98
5503-0220	AMA Health Insight – on-line patient oriented health information	Emory Healthcare	06/03/99

* Project concept approved only. Each issue of Quality Care Alert will be re-submitted to CRT for approval of topic/funding relationship.

5503-0239	Health Insight Web Site – patient education – Benign Prostatic Hyperplasia	Abbott Laboratories	02/15/99
5503-0278	AMA Health Insight – on-line patient education – Pertussis/Whooping Cough	Abbott Laboratories	09/09/99

Awards

3302-0264	Glaxo Welcome Grant for C. Everett Koop Award – “Best Professional Entry” educational video on health/medicine targeted to physicians	Glaxo-Wellcome	04/19/99
6602-0293	Nathan Davis International Awards recognize physicians/programs contribution to better public health worldwide	Funding not finalized*	10/08/99

MEMBER SERVICE PROVIDERS

3301-0241	Multi-Year Student Benefit Stedmans Concise Medical Dictionary	Lippincott, Williams & Wilkins	11/20/99
3301-0266	AMA Membership ID Card featuring Hertz logo	Hertz	05/03/99

5503-0284	WRQ Y2K project provides physicians and other visitors to the AMA site with means to test software and hardware for Y-2K compliance	Rainier Technology Group, Sarcom, WRQ	09/13/99
5505-0126	TechnologyLink/Computerware for physicians	IBM	11/01/99
5505-0129	CapitaLink/Credit Card for physicians and their families	First USA	03/01/99
5505-0252	AMA Sponsored Employee/Employer group insurance – life, disability income, health, long term care, and ancillary benefits-prescription drug card, vision care and dental	Companies TBD*	03/01/99
	* Approval of concept only. Project returns to CRT for final approval when funding/companies confirmed.		
5505-0261	AMA Solutions, Inc. - Internet on-line services for physicians and immediate family at discounted rates	CompuServe, EarthLink Network	05/03/99
5505-0262	AMA Solutions, Inc. - Discounted express mail for physician practices	FedEx Corp.	04/19/99
5505-0273	AMA Solutions, Inc. - Office furnishings at discounted prices	Haworth	07/12/99
5505-0281	AMA Solutions, Inc. – Office Supplies at discounted prices	Penny Wise, Division of Jacobs Gardner	09/13/99
5505-0296	Medical savings accounts for group practice physicians, their employees and dependents	MSavers, L.L.C, Merrill Lynch, Pierce, Fenner & Smith Inc.	10/08/99
5505-0301	Home and Auto Warranty Insurance Program	American International Group	11/01/99
5505-0302	AMA-Sponsored Home Equity Line of Credit Program	US Bank	11/01/99
5505-0303	AMA-Sponsored Unsecured Line of Credit Program	US Bank	11/01/99

LICENSING AGREEMENTS

Data and Content Licensing

1101-0247	Guides to the Evaluation of Permanent Impairment – software applications	Jtech, Inc.	02/01/99
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JAMA Licensing

5502-0205	International Licensing – Turkish Editions	Turgut Yayincilik ve Ticaret, AS	06/22/99
5502-0206	International Licensing – Argentina	AP Americana de Publicaciones	06/22/99

Internet/Related Media

5502-0297	International Licensing Web sites - under strict guidelines feature AMA Scientific publications on international licensee web sites	Completed: Elea Ciencia, Editorial Ltda., Brazil. Pending: Praha Communication, Czech Republic; Edilys, Greece; Praha Communication, Hungary; ESI Stampa Medica, Italy; Mainichi Newspapers, Japan; MediMedia Pacific, Korea; Publicaciones Americana de Mexico, Mexico; JAMA Middle East Agency, Middle East; Science Press Pakistan, Pakistan; Praha Communications, Poland; HCP Network, Ltd., Russia; Perun, d.o.o., Slovenia; MediMedia Pacific, SE Asia; Ediciones Doyma, Spain; Publicaciones Profesionales Internacionales, Spain; Turgut Yayincilik ve Ticaret, AS, Turkey.	10/08/99
5503-0268	AMA/Intel Internet Roadshow - to encourage physician usage of effective internet tools to improve health care delivery	Intel	05/03/99

OTHER**Conference/Co-Sponsorship**

1100-0290	Co-sponsorship of Bioterrorism Conference	University of California, San Diego School of Medicine, John Hopkins Center for Civilian Biodefense Studies, Scientific Application International Corporation (SAIC), Public Health Foundation	09/16/99
1101-0298	National Donor Day to increase awareness for organ donation	Saturn/UAW	10/08/99
2207-0238	Co-sponsor "National Race For the Cure" 10 th Anniversary	Breast Cancer Foundation	11/20/98
3301-0286	CPT 2000 Coding Symposium	American Academy of Professional Coders	09/13/99
5503-0285	Joint San Diego County/AMA YPS Reception	TBD (Project concept approved. Final approval given when funders confirmed.)	09/13/99

Education/Information/Content Development

1101-0300	AMA/ABA Pamphlet - Doctors and Lawyers Working Together	ABA	11/01/99
2201-0280	Moyers' Production request for AMA to be outreach association	Last Acts	09/30/99

2207-0243	Development of educational materials to enable physicians to implement a compliance program for fraud & abuse enforcement	Price Waterhouse Coopers LLP	12/15/98
Professional Books and Related Media			
2207-0249	Journal of Health Care Compliance	Aspen Publications (no logo usage)	02/01/99
5504-0256	Psychopharmacology for Primary Care Physicians' reference book regarding diagnostic aspects of mental disorders and any treatments	Scientific Therapeutics Inc, Smith Kline Beecham, American Psychiatric Press, Inc.	05/03/99
Professional Credentialing			
1102-0282	AMAP® - Compatible Physician Systems nationwide call for physician performance systems identified as AMAP compatible	TBD (Project concept approved. Final approval given when companies confirmed.)	09/13/99
Internet Services			
4403-0250	Distribution of Y2K Guidelines Manual on specialty society member only web sites	American Academy of Ophthalmology, American Academy of Dermatology, American College of Radiology	02/17/99
5503-0257	Emory MiniMedical School at the AMA – web site	Emory Medical School	06/22/99
5503-0283	Intel Digital Certificates – state of the art internet security for information transfer	Intel	09/13/99
5503-0291	MyHealthSource – cooperative effort between medical societies to offer patient high quality health information via the internet	Founding Societies – American Academy of Ophthalmology, American Academy of Orthopaedic Surgeons, American Academy of Pediatrics, American College Allergy, Asthma & Immunology, American College of Obstetricians & Gynecologists, American Psychiatric Association, American Society of Plastic and Reconstructive Surgeons	10/08/99
5505-0270	Internet Shopping Mall for AMA Members – access to internet retailers	BATNET	06/07/99

**16. FINAL REPORT OF THE INTER-COUNCIL TASK FORCE
ON PRIVACY AND CONFIDENTIALITY
(RESOLUTIONS 860, A-98; 430, I-98; AND 801, A-99 AND
RECOMMENDATION 12 OF BOARD OF TRUSTEES REPORT 9-A-98)**

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTIONS 860 (A-98), 430 (I-98), AND 801 (A-99), AND
RECOMMENDATION 12 OF BOARD OF TRUSTEES REPORT 9-A-98, AND
REMAINDER OF REPORT FILED**

At the 1998 Interim meeting of the American Medical Association (AMA) House of Delegates (HOD), the Board of Trustees (BOT) empanelled an Inter-Council Task Force On Privacy and Confidentiality. The Task Force was composed of the following individuals: Donald J. Palmisano, MD, JD, Task Force Co-Chair, AMA BOT; James L. Borland, Jr., MD, Task Force Co-chair, Council on Medical Education; William G. Plested III, MD, AMA BOT; Frank A. Riddick, Jr., MD, Council on Ethical and Judicial Affairs; Barbara Rockett, MD, Council on Legislation; Joseph M. Heyman, MD, Council on Medical Service; Myron Genel, MD, Council on Scientific Affairs; and Paul R. Barach, MD, Council on Long Range Planning and Development.

In June 1999, the HOD adopted BOT Report 36 (A-99), Interim Report of the Inter-Council Task Force on Privacy and Confidentiality, which summarized the work of the Task Force to that date and set forth proposed AMA policy on privacy and confidentiality. The current report represents the subsequent work of that Task Force, whose charge has now been completed.

Resolution 430 (I-98), introduced by the American Association of Public Health Physicians, was referred. It calls for the AMA to encourage the use of patient-specific clinical data for public health surveillance and prevention policies; support public health officials in their constant vigil to assure patient records remain private and confidential with policies that guard against the risk of intentional or unintentional release of patient-specific data in any form; and inform physicians of their legal and ethical duty to report to public health authorities those illnesses, injuries, and other conditions of public health significance as required by law, and the reasons why such report is necessary.

Resolution 860 (A-98), introduced by the Section on Medical Schools and referred to the BOT, calls for the AMA to reaffirm Policy H-315.984 and to endorse the principles developed by the American College of Epidemiology on "Health Data Control, Access, and Confidentiality" and to use those principles as the basis of AMA policy.

Resolution 801 (A-99) was introduced by the Wisconsin Delegation and was referred to the BOT. It calls for the AMA to study the issue of the breach of confidentiality of the doctor-patient relationship by self-insuring employers, especially the use of confidential medical records and claims information in employment decisions by the employer and, should such study reveal instances where there is possible breach of confidentiality or a possible breach of doctor-patient relationship by self-insuring employers, the AMA should work with appropriate business and regulatory authorities, agencies, and associations to stop such practices.

Recommendation 12 of BOT Report 9 (A-98) was referred to the BOT. Remaining issues in that recommendation to be addressed by the Task Force include further study of patient privacy and confidentiality in the following areas: access to genetic testing information by blood relatives to whom this information holds significance; adequate safeguards in the context of sale or discontinuation of a medical practice; and appropriate channels through which compliance with respect to confidentiality of medical records can be assessed, enforcement achieved, and patient grievances addressed.

AMA POLICY

A series of reports have been adopted by the HOD in the past few years that outline and clarify AMA policy on patient privacy and confidentiality issues (Appendix 1 contains the adopted policy from these reports):

BOT Report 9 (A-98), Privacy and Confidentiality

BOT Report 36 (A-99), Interim Report of the Inter-Council Task Force on Privacy and Confidentiality

CEJA Report 6 (A-99), Access to Medical Records by Non-Treating Medical Staff

PRIVACY AND PUBLIC HEALTH

The Task Force met with leaders of the American Association of Public Health Physicians, reviewed existing AMA policy with regard to public health reporting, and discussed the interface between physicians and their public health colleagues.

The Task Force agreed that public health physicians need access to patient information for one of three broad purposes:

- Intervention in an identified or potential public health emergency
- Conduct of public health surveillance
- Conduct of epidemiologic research

In the case of real or potential public health threats (e.g., outbreaks of communicable disease), practicing physicians must consult with their public health colleagues to treat diagnosed disease and engage in medically appropriate disease prevention. In such cases, the same provisions for patient privacy and confidentiality must be observed as would be in place for any other physician to physician consultation. Policy H-140.956 (AMA Policy Compendium) states: "Physicians in administrative and other nonclinical roles must put the needs of patients first. At least since the time of Hippocrates, physicians have cultivated the trust of their patients by placing patient welfare before all other concerns. The ethical obligations of physicians are not suspended when a physician assumes a position that does not directly involve patient care."

AMA also has a long history of supporting appropriate public health reporting by physicians in support of public health surveillance (Policies H-10.982, H-10.984, H-20.941, H-20.963, H-30.967, H-60.956, H-85.970, H-440.938, H-440.968, H-515.969, H-440.995, H-515.971, E-5.057). Physicians have an obligation to be aware of and comply with all state and federal laws that apply to them, including those pertaining to participation in public health surveillance programs. Physicians can be reassured by the level of vigilance to patient confidentiality that is characteristic of the vast majority of public health departments.

Finally, epidemiologic research on public health diseases and problems should be guided by the same principles for and safeguards on privacy and confidentiality that apply to all other medical research. Hence, research conducted by public health physicians and departments should be held to the procedures and standards delineated in BOT Report 36 (A-99): "where possible, informed consent should be obtained before personally identifiable health information is used for any purpose. However, in those situations where specific informed consent is not practical or possible, either (a) the information should have identifying information stripped from it or (b) an objective, publicly accountable entity must determine that patient consent is not required after weighing the risks and benefits of the proposed use. Re-identification of personal health information should only occur with patient consent or with the approval of an objective, publicly accountable entity."

PRIVACY AND PUBLIC HEALTH REPORTING

The Task Force considered the principles developed by the American College of Epidemiology (ACE) on Health Data Control, Access, and Confidentiality and met with a representative from ACE. The Task Force understands the intent of the ACE principles but believes patients' best interests are served by its own carefully deliberated language on research and patient privacy and confidentiality, as adopted by the HOD in Report 36 (A-99).

PHYSICIANS' PERSONAL MEDICAL RECORDS

Resolution 4 (A-99), introduced by the American Society of Addiction Medicine and referred to the BOT, calls for the AMA to affirm that physicians who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients; that physicians should not be required to reveal their personal medical histories to patients or to the public at large; that when patients, including physicians who are patients, exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment; and that physicians who treat other physicians should not be required to report any aspects of their physician-patients' medical history to governmental agencies or other entities, beyond that which would be required for patients who are not physicians.

The Task Force agreed that the medical records of physicians should be subject to the same privacy and confidentiality safeguards as those of any other patient. Nevertheless, the issues raised by this resolution were of sufficient complexity and uniqueness that they are being considered in a separate report (BOT Report 17, I-99).

CONFIDENTIALITY AND SELF-INSURING EMPLOYERS

The Task Force recognized that employers frequently use or have access to data in their roles as providers of employee health benefit plans, direct medical care, and wellness programs. In an attempt to regulate costs, for example, self-insured employers monitor employee treatment and prescription claims approved by their benefit plan administrators. Employees are understandably concerned that employers would use this data for discriminatory purposes, despite laws--such as the Americans with Disabilities Act--that may provide a legal remedy if the employer did discriminate based on an employee's health status.

The Task Force believes that employers can effectively use health information in a manner that protects employees' privacy. For example, payments made by contract benefits administrators can be monitored using aggregated claims data, which do not link individual employees with particular medical conditions. However, the Task Force is concerned that not all employers recognize such confidentiality practices and believes that the AMA should work to prevent potential confidentiality breaches by self-insured employers.

Toward that end, the Task Force reviewed existing AMA policy, and believes it adequately provides a platform for AMA advocacy to prevent confidentiality breaches by self-insured employers. However, because self-insured employers' use of confidential medical information raises a plethora of issues surrounding inappropriate access to confidential employee medical information, further study by relevant AMA Councils may be warranted.

ACCESS TO GENETIC TESTING BY RELATIVES

The Task Force considered the issue of access to genetic testing information by blood relatives to whom this information holds significance. In doing so, the Task Force reviewed relevant Opinions of the Council on Ethical and Judicial Affairs (Opinions 2.137, 2.138, 2.12, 2.132, 2.135, 2.139, 5.05, 2.23, and 5.057), a policy statement currently under consideration by the Massachusetts Medical Society, and a 1998 statement of the American Society of Human Genetics Subcommittee on Family Disclosure.

The Task Force recognized the sensitive nature of genetic information and believes that its confidentiality requires protection at least equal to the protection offered other sensitive health information. Therefore, results of genetic tests should not be disclosed to third parties without the explicit informed consent of the screened individual.

At the same time, the Task Force also recognized that the information obtained from genetic testing may be valuable to blood relatives of the screened individual. Therefore, the Task Force agreed that, before testing, physicians should counsel patients carefully about the familial implications of genetic test results. In particular, physicians should emphasize the importance of sharing the information with a relative in instances where there is a high likelihood that the relative is at risk of serious harm, and where the relative could benefit from early monitoring or from treatment. If the patient does not consent to the information being disclosed, physicians should weigh carefully the harm that may result from failing to disclose the information to the relative against the harm that may result to the patient from the disclosure, subject to relevant law.

The Task Force took particular note of Ethical Opinion 2.138, Genetic Testing of Children, which addresses the special issues involved when considering genetic testing for children and in safeguarding the privacy and confidentiality of children with regard to genetic information.

SALE OR DISCONTINUATION OF A MEDICAL PRACTICE

Recommendation 12(f) of BOT Rep. 9 (A-98) calls upon the AMA to study whether adequate safeguards are in place to protect patient confidentiality in the context of sale or discontinuation of a medical practice.

Typically, in the context of a sale or discontinuation of a medical practice, the medical record does not necessarily go with the physician. Some state laws and regulations outline what to do in the event of a sale or transfer of a medical practice. In some jurisdictions, patient records can be transferred with other assets as part of a practice sale; other jurisdictions only permit a change in physical custody of the record and no transfer of ownership. In all cases,

in order to comply with licensing requirements and to avoid civil liability, it is crucial that patients are given adequate notice and an opportunity to authorize or object to the transfer of their medical records.

The Task Force believes that patient notice and required authorization provides a significant safeguard to protect patient confidentiality. Additionally, the Task Force notes that only de-identified and/or aggregate data should be used for “business decisions,” including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

PATIENT GRIEVANCES

Recommendation 12 of BOT Report 9 (A-98) calls for AMA study of appropriate channels through which compliance with respect to confidentiality of medical records can be assessed, enforcement achieved, and patient grievances addressed.

Patient confidence can be breached under a number of circumstances, ranging from inadvertent error to egregious disclosures under false pretenses, for monetary gain, or for malicious harm.

The medical practice acts in each state provide a vehicle for addressing physician lapses and/or breaches. The Task Force concluded that pursuit of patient grievances through the vehicle of these acts and their licensure status is the appropriate mechanism for misconduct by physicians. Parallel mechanisms do not exist for breaches by institutions or corporations. An appropriate channel for addressing patient grievances with regard to breaches of privacy and confidentiality by institutions and organizations should be developed.

RECOMMENDATIONS

In light of the discussions over the past year by the Inter-Council Task Force on Privacy and Confidentiality, the Board of Trustees recommends that the following policy statements be adopted and that the remainder of this report be filed:

1. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.
2. Before genetic testing, physicians should counsel patients on the familial implications of genetic test results and emphasize the importance of sharing results in instances where there is a high likelihood that a relative is at risk of serious harm, and where the relative could benefit from early monitoring or from treatment.
3. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for “business decisions,” including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.
4. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.
5. That this report be adopted in lieu of Resolutions 430 (I-98), 860 (A-98), and 801 (A-99), as well as Recommendation 12 of BOT Report 9 (A-98).

APPENDIX

Previously Adopted AMA Policy on Privacy and Confidentiality

BOT Report 9 (A-98)--Patient Privacy and Confidentiality

1. The American Medical Association (AMA) affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:
 - a. That there exists a basic right of patients to privacy of their medical information and records and that this right should be explicitly acknowledged;
 - b. That patients' privacy should be honored unless waived by the patient in a meaningful way; or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability;
 - c. That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled;
 - d. That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure.
2. The AMA reaffirms Policies H-60.695 and CEJA Opinion E-5.055 regarding confidentiality in the care of minors as well as individuals under guardianship or conservatorship. In summary:
 - a. Confidential care is critical for minors as well as individuals under guardianship or conservatorship, particularly when they request contraceptive services, pregnancy-related care, or treatment for other sensitive conditions such as substance abuse.
 - b. Physicians should allow emancipated and mature minors to give informed consent for medical care without parental consent or notification, in conformance with state and federal law.
 - c. Physicians should encourage the involvement of parents, guardians and conservators when it would be in the best interest of the patient.
 - d. Physicians should discuss their policies about confidentiality with such patients and their parents or guardians, explaining the conditions under which confidentiality would be abrogated.
3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals.
 - a. Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible.
 - b. Patients and physicians should be educated about the consequences of signing overly broad consent forms.
 - c. Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information.
 - d. A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.
4. Whenever possible, medical records should be de-identified for purpose of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
6. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
7. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

8. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.
9. The AMA must guard against the imposition of unduly restrictive barriers to patient records that would impeded or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, the AMA endorses the oversight and accountability provided by an IRB.
10. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must give their uncoerced permission after being fully informed about the purpose of such disclosures.

BOT Report 36 (A-99)--Interim Report of the Inter-Council Task Force on Privacy and Confidentiality

1. Where possible, informed consent should be obtained before personally identifiable health information is used for any purpose. However, in those situations where specific informed consent is not practical or possible, either (a) the information should have identifying information stripped from it or (b) an objective, publicly accountable entity must determine that patient consent is not required after weighing the risks and benefits of the proposed use. Re-identification of personal health information should only occur with patient consent or with the approval of an objective, publicly accountable entity.
2. The AMA strongly support the voluntary adherence of all Institutional Review Boards (IRBs) to the standards of the Common Rule (45 CFS 46), regardless of whether or not the institution receives federal funding.
3. The AMA urges the Federal Government to consider augmenting the standards of the Common Rule to state that IRBs may waive or modify the requirement of a researcher to obtain the specific informed consent of a research subject for use of his or her personally identifiable health information only when it can be documented that:
 - a. There is no practicable alternative to the use of such personally identifiable health information and that, in any case, such information is de-identified at the earliest practicable opportunity;
 - b. The health researcher has fully disclosed which of the personally identifiable health information to be collected or created will be linked to other personally identifiable health information;
 - c. If, in the course of the proposed research, such health researcher intends to link personally identifiable health information to other health information or if there is a risk that such information may be linked, appropriate safeguards are employed to protect such information against re-identification or subsequent unauthorized linkage;
 - d. The institutional review board shall have the opportunity to review any publication of information based upon the personally identifiable health information collected or created under the provisions of this section to ensure that no disclosures are made which might identify an individual;
 - e. At the conclusion of the proposed health research or at some specific date, the health researcher shall destroy all of the data containing personally identifiable health information as well as all copies of such data, but that the institutional review board may extend the date of destruction if the researcher demonstrates a continuing or new need for protected health information for which such researcher would be qualified for a waiver of informed consent in accordance with this section; and
 - f. The health researcher has presented adequate assurances that none of the data containing protected health information will be given, loaned, sold, disseminated or otherwise disclosed to other parties.

4. Research projects that fall outside the purview of an IRB process, as well as operational uses of personally identifiable health information, should be subject to review by local Confidentiality Assurance Boards (CABs) and should be held to the same standards that apply to Institutional Review Boards.
5. AMA encourages medical schools, teaching institutions, and other entities that conduct medical research to assure that their IRBs are afforded adequate personnel and other resources to accomplish their mission "to safeguard the rights and welfare of human research subjects."
6. That Policy H-315.983 (AMA Policy Compendium) be reaffirmed, which states that the AMA "will not support the use of national Unique Patient Identifiers unless and until their necessity and safety are more convincingly demonstrated.

CEJA Report 6 (A-99)--Access to Medical Records by Non-Treating Medical Staff

1. Physicians who use or receive information from medical records share in the responsibility for preserving patient confidentiality and should plan an integral role in the designing of confidentiality safeguards in health care institutions. Physicians have a responsibility to be aware of the appropriate guidelines in their health care institution, as well as the applicable federal and state laws.
2. Informal case consultations that involve the disclosure of detailed medial information are appropriate in the absence of consent only if the patient cannot be identified from the information.
3. Physicians or other health care professionals not directly involved in a patient's care who wish to gain access to confidential medical information must obtain explicit patient consent before doing so.
4. Monitoring user access to electronic or written medical information is an appropriate and desirable means for detecting breaches of confidentiality. Physicians should encourage the development and use of such monitoring systems.

**17. PHYSICIANS AS PATIENTS:
THEIR RIGHT TO CONFIDENTIALITY
(RESOLUTION 4, A-99)**

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 4 (A-99) AND
REMAINDER OF REPORT FILED**

INTRODUCTION

At the Annual Meeting of the House of Delegates, the American Society of Addiction Medicine introduced Resolution 4, "Physicians as Patients: Their Right to Confidentiality," which was referred to the Board of Trustees. Resolution 4 calls upon the AMA to: (1) affirm that physicians who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients; and (2) adopt the following policy:

- Physicians should not be required to reveal their personal medical histories to their patients or the public at large;
- When physicians who are patients, exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment; and
- Physicians who treat other physicians should not be required to report any aspects of their physician-patients' medical history to governmental agencies or other entities, beyond that which would be required for patients who are not physicians.

DISCUSSION

Physicians, as other individuals, do have a right to keep their medical information confidential, and physicians generally have been deemed under no legal obligation to disclose their health status to patients. However, courts have made notable exceptions to this general rule.

For example, a number of courts have held that there is a duty to disclose HIV infection. In Faya v. Almarez, 620 A. 2d 327 (Md. 1992), for example, patients brought an action against the surgeon's estate and employer, Johns Hopkins, for compensatory and punitive damages for lack of informed consent. The court agreed with patients--who learned of the surgeon's infection through death notices in the local newspaper--that the surgeon should have disclosed his seropositivity.

A few courts also have held that there is a duty to disclose substance abuse. In Hidding v. Williams, 578 So. 2d 1192 (La. Ct. App. 1991), the patient sued on an informed consent theory, alleging in part that the physician had failed to disclose that he was a chronic alcoholic. The court held that such a failure to disclose violated Louisiana's informed consent requirements. A more recent Georgia Court of Appeals decision, Cleveland v. Albany Urology Clinic, PC, 235 Ga. App. 838; 509 S.E.2d 664, *cert. granted*, No.S99G0600, 1999 Ga. LEXIS 554 (May 28, 1999), similarly held that a urologist's failure to disclose his cocaine use was a material concealment.

In the more recent Cleveland case, the AMA sent a strong letter to the Georgia Supreme Court to consider as it reviews the Georgia Court of Appeals holding. The letter, dated September 13, 1999, emphasized that though the AMA opposes the misuse of cocaine and other addictive substances by any persons, including physicians,

“subjecting physicians to civil liability merely for failing to disclose to patients a substance abuse problem would inhibit physicians from securing needed treatment. Such a chilling effect on substance abuse treatment would run counter to public policy....Moreover...any act of professional negligence, regardless of cause, would still give rise to a cause of action for any patient injured by the negligent act....Encouraging impaired physicians to seek treatment while recompensing patients injured by their negligent acts is consistent with this [public] policy.”

The AMA believes that court decisions requiring physicians to disclose substance abuse problems do not serve the public well. In fact, such disclosure seemingly is counterintuitive to the overall goal of patient safety. If a physician's practice would pose an unacceptable level of risk to patients, then the medical profession should act together to either prevent the individual from practicing or modify the physician's practice to reduce the risk posed to patients. The AMA believes that a better means to accomplish the goal of patient safety is reflected in current AMA policy on this issue, which is highlighted below.

First, it is unethical for a physician to practice medicine while under the influence of a controlled substance, alcohol, or other chemical agents that impair the ability to practice medicine. (Policy E-8.15, AMA Policy Compendium)

Second, though physicians are no more likely than other members of the population to use alcohol and other drugs, or to require treatment for problems associated with such use, our AMA clearly supports physician-specific programs to prevent, detect, and treat physicians impaired due to substance abuse problems.

For example, Policy H-295.979 encourages the education and prevention of substance abuse among medical students, residents, and fellows. Policy H-95.984 encourages testing physicians for drug use under appropriate circumstances for purposes of treatment. Policies H-275.964 and H-95.955 encourage state medical societies to maintain effective physician health programs, which address substance abuse problems. And, Policy H-235.977 encourages medical staff bylaws to provide a mechanism for addressing physician impairment, which includes substance abuse.

Third, physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues in accordance with the legal requirements in each state and assisted by the following guidelines:

Impairment should be reported to the hospital's in-house impairment program, if available. Otherwise, either the chief of an appropriate clinical service or the chief of the hospital staff should be alerted. Reports may also be made directly to an external impaired physician program. Practicing physicians who do not

have hospital privileges should be reported directly to an impaired physician program, such as those run by medical societies, when appropriate. If none of these steps would facilitate the entrance of the impaired physician into an impairment program, then the impaired physician should be reported directly to the state licensing board. (Policy E-9.031 and Policy H-275.952)

However, disclosure of a physician's impairment to patients would not be appropriate. It risks destroying physicians' right to confidential medical treatment. Disclosure also places the onus on patients to determine which physicians are "safe," reducing the responsibility that is appropriately placed on state licensing boards, employers, and health care peer review committees to monitor physicians and set appropriate standards.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 4 (A-99) and that the remainder of this report be filed:

1. That the AMA reaffirm policies relating to the prevention, detection, and treatment of substance abuse among physicians, Policies H-95.955; H-95.984; H-235.977; H-275.952; H-275.964; H-295.979; E-8:15; and E-9.031;
2. That the AMA continue to work with the American Society of Addiction Medicine, the American Psychiatric Association, and other interested organizations to address concerns regarding substance abuse among physicians; and
3. That the AMA consider for possible intervention pending and future court cases in which the principles of informed consent are inappropriately expanded to require disclosure of a physician's impairment, including substance abuse problems, or information otherwise protected by laws governing patient privacy and confidentiality.

18. OUR AMA REPRESENTATION PROGRAM

HOUSE ACTION: FILED

Recommendation 20 of the Final Report of the Ad Hoc Committee on Structure, Governance, and Operations, adopted at the 1998 Interim Meeting, called for the Board of Trustees to obtain external independent expertise to determine the value of the Representation Program and to make specific recommendations to the House of Delegates in establishing the criteria for assessing the value of an appearance relative to achievement of objectives identified in our AMA strategic plan, with a report to the House at the 1999 Interim Meeting.

The Standing Rules Relating to Travel and Expenses of General Officers states "The mission of the AMA Board Representation Program is to represent the American Medical Association before other organizations, government, media, and the public in order to:

- Increase membership and gain a better understanding of the needs of the membership;
- Maintain and enhance relationships within the profession, throughout the Federation, and with external groups and organizations;
- Provide and obtain information;
- Present the AMA's position or views on issues that may arise;
- Advance the aims, purposes, and policies of the Association; and
- Demonstrate the AMA's leadership in the health arena.

Our AMA Representation Program is guided by the Spokesperson guidelines, which note that "the Board, Officers, Speakers, EVP and staff all have a representation responsibility (i.e., speaking for the profession and advocating for the profession in the broad sense of meeting, discussing, and advocating our views with others . . .) Trustees should be active spokespersons for the Association on any issues involving Association policy, particularly in areas of specialty expertise or where particular local, geographic, or organizational connection makes them uniquely authoritative."

In developing an Action Plan for this evaluation, your Board determined that the amount of information readily available on the Representation Program was not sufficient to begin the process of analysis and recommendation. A comprehensive retrospective review of the activities of the Representation Program was therefore undertaken, spanning the Board years between A-97 and A-99. The additional codes required to generate this report annually are being incorporated into the tracking system. This report summarizes the information gleaned from that retrospective review. Also present in this report is a review of the policies of Federation medical societies with regard to deployment of Board members on behalf of their associations.

This information will form the basis for a process of external review and assessment by interested stakeholders and independent consultants. The following two steps are planned for early 2000:

- Organizations hosting AMA Board members at some point during the past two years will be selected randomly. This representative sample will be asked to participate in structured interviews on their expectations for, experience of, satisfaction with, and suggestions for our AMA Representation Program.
- A panel will be convened by your Board to review the results of this descriptive analysis, relevant policies of other organizations, and structured interviews. This panel will be composed of representatives from the Board, House, Councils, Sections, geographic medical societies, specialty societies, and independent consultants with expertise in governance, associations, communications, and advocacy. Together, this panel will be asked to consider the current Representation Program and to generate specific recommendations for modifications in the program, if appropriate, and a methodology for on-going evaluation of the program.
- The findings of the panel will be transmitted to the 2000 Annual meeting.

DATA DESCRIPTION

The statistics presented in this report were derived from retrospective review and analysis of the data contained in the Officer Scheduling System of the AMA. This database is used to track the scheduled activities of your Board throughout their tenure as AMA Board members. Because the database was not designed to support this level of statistical analysis, the level of detail that can be achieved is limited.

Data are presented in units of Trustees Days, which correspond to one trustee, for one day. In other words, one trustee going on a two-day assignment would constitute two Trustees Days. Two trustees fulfilling a one-day assignment would also constitute two Trustee Days.

Data are broken down into one of four categories of Trustee Days:

- Fixed Annual Compensation (FAC) Days: Trustee Days performed by those Officers who receive a fixed annual stipend for their service, of which there are four--the Immediate Past President, President, President-Elect, and Board Chair.
- Per Diem (PD) Days: Trustee Days performed by those trustees who are compensated for their service on a per diem basis, of which there are 14.
- Resident/Fellow (RF) Days: Trustee Days performed by the Resident/Fellow member of your Board.
- Medical Student (MS) Days: Trustee Days performed by the Medical Student member of your Board.

Each year, trustees convene for a fixed number of days to participate in regularly scheduled meetings of the full Board, the Annual and Interim Meetings, and the National Leadership Development Conference. **These days are not included in the data presented here and are not considered to be part of the Representation Program.** In 1999, these commitments involved a total of 780 Trustee Days (average of 39 days per Board member). In the past compensation for these days have been referred to as Honorarium payments.

At times, an assignment for the Representation Program will require an additional day or two of Board member travel. **These data do not include travel days served by Board members.**

The presented data also relate to primary assignments only. That is, assignments are categorized by the major reason for the representation visit. In many cases, secondary activities are arranged in association with the primary assignment. For example, while visiting a medical school, a trustee may meet with local media, visit the nearby county medical society, or address a regional specialty society chapter. In some cases, these secondary activities may occur on the day before or following a primary assignment day. **These data do not include days associated with secondary activities.**

Readers are therefore cautioned that the Trustee Days reflected in the current report are an underestimate of the number of days that trustees may be on the road in service of our AMA. Any variations between these tallies and time commitments reflected in other reports are attributable to the non-Representation Program responsibilities of Board members, travel days, or days associated with secondary activities. Readers are further cautioned that the statistics presented in this report are only as good as judgment will allow, based on retrospective review of the meeting descriptions and information available. The database on which these analyses are based is being revised to allow for prospective collection of this information, beginning in January 2000.

TYPES OF TRUSTEE ACTIVITIES

AMA Meetings: The largest number of Trustee Days were devoted to meetings hosted or coordinated by our AMA. Examples include the President's Forum, the Tobacco Task Force, the US Chamber of Commerce, the Task Force on Comprehensive School Health Education, the Family Violence Task Force, the Practice Parameters Forum, meetings with Councils, etc. This category does not include meetings associated with the AMAP program, the AMA Foundation, the National Patient Safety Foundation, or AMA Sections.

AMAP Meetings: This category includes meetings related to the governance of AMAP. Examples include the Performance Measures Advisory Committee, Specialty Advisory Committee, AMAP Governing Body, etc.

Alliance Meetings: This category includes participation by trustees in meetings of the AMA Alliance or one of its member chapters.

Civic Meetings: This category includes meetings with civic organizations around the country, such as Voter's Leagues, Rotary Clubs, etc.

County Medical Society Meetings: This category includes attendance at and speeches sponsored by county medical societies.

COLA Meetings: The AMA participates formally in meetings of the COLA Board.

Corporate Meetings: Trustees were occasionally involved in meetings with or sponsored by for-profit corporate entities. In some cases these were associated with AMA priority issues and programs. In other cases, the assignment involved delivery of a speech by a Board member at a corporate-sponsored health policy meeting.

AMA Foundation Meetings: These assignments involved trustee participation in free-standing meetings of the AMA Foundation or its immediate predecessor, the AMA-ERF.

Foundation Meetings: These involved meetings by trustees with or sponsored by Foundations other than the AMA Foundation.

Government Meetings: AMA trustees were involved in a series of meetings and assignments with various governmental bodies and entities, including the White House, Senate, Congress, regulatory bodies, and special committees. This category does not include delivery of formal AMA testimony by Board members, which is summarized below.

House Planning Meetings: Two ex-officio members of your Board--the Speaker and Vice Speaker--are involved in planning meetings preparatory to each House meeting.

Hospital Meetings: Board members occasionally go to hospitals or medical centers. These meetings are usually related to CME or health policy activities of the medical center.

International Travel: Board members represent our AMA at such international meetings as the World Medical Association and World Health Association. In BY97-98, there was also a cooperative project between our AMA and the Japanese Medical Association. Occasionally a trustee is invited to participate as a speaker in an international meeting. All international travel is approved by your Board as a whole.

JCAHO Meetings: As one of the parent organizations, AMA is formally represented in the JCAHO governance structure. Of our AMA delegates to the JCAHO, four are members of your Board.

Media: For some Trustee Days, contacts with the media was the primary purpose of the assignment. These assignments might be organized media tours, editorial board meetings, press briefings, or requested appearances on broadcast media programming.

Medical School Meetings: Board members participate in CME and policy meetings at medical schools around the country. They also are invited to give commencement and welcoming addresses to medical school classes. This category does not include the formal medical school visitation program, which is summarized below.

Medical School Visitation Program: Each medical school visit is done by a team of AMA representatives, including a trustee and either the Medical Student trustee or Resident/Fellow trustee.

NCQA Meetings: An AMA Board member participates in the governance of NCQA.

National Patient Safety Foundation: Several Board members serve on your Board of the National Patient Safety Foundation (NPSF), including the NPSF Executive Committee.

Meetings of AMA Sections: Board members attend meetings with the leadership of or hosted by the various Sections of the AMA House. Some trustees are assigned as formal liaisons between your Board and the relevant Section.

State Medical Society Meetings: Board members are authorized to attend one meeting per year of their state medical society. In addition, they attend meetings of state medical societies when invited to participate in some formal way with the leadership or in a significant speaking role.

National Medical Specialty Society Meetings: Board members are authorized to attend one meeting per year of their specialty medical society. In addition, they attend meetings of specialty medical societies when invited to participate in some formal way with the leadership or in a significant speaking role.

Testimony: Board members are sometimes assigned to deliver formal testimony on behalf of our AMA on important policy issues, most frequently to elements of the federal government but occasionally to entities such as the IOM.

Other Meetings: As in all such analyses, a portion of formal trustee assignments were devoted to meetings and activities not readily classified into one of the foregoing categories. Most often, these meetings were other national, non-medical organizations. Others were participation in coalitions not convened by our AMA, meetings with patient or issue advocacy groups, and similar activities.

DATA SUMMARY

Data were analyzed for two Board years, spanning the period between A-97 and A-99. Little significant variation was noted between the two 12 month periods. Consequently this report provides statistics on the Board Year spanning A-98 to A-99, for clarity of presentation.

During that period of time, the Representation Program was comprised of 1113 Trustee Days. Of these, 457 were Fixed Annual Compensation (FAC) Days, representing an average of 114 days per Officer. Non-officer Trustee (NT) Days resulted in 589 days, representing an average of 42 days per trustee. During the year, the Medical Student trustee contributed 18 days to the Representation program, and the Resident/Fellow contributed 49 days.

Of all of the assignments that year, 21% involved activities in which there was formal participation by members of the Federation.

In some cases, hosting organizations reimbursed our AMA for all or a portion of the expenses associated with trustee participation in the Representation Program assignment. Typically such reimbursement was provided by non-Federation organizations requesting that a trustee deliver an address or make formal remarks about AMA policy or programs. Examples include medical school addresses, corporate roundtables, government meetings, or hospital-based continuing medical education programs. Of the assignments that year, the AMA received full or partial reimbursement for expenses associated with 21% of them.

Detailed information is provided about the activities of your Board in Table 1.

POLICY STATEMENT REVIEW

Medical societies sitting in the House were solicited for policies pertaining to the deployment of Officers and Board members on society business. Responses were received from more than 60 organizations.

Careful review of these responses revealed that the vast majority of the information submitted pertained to the compensation and/or reimbursement of trustees, officers, and directors for their activities on behalf of their association.

Little information was available about the organizations' guidelines for decisions about what trustees and officers were asked to do, relative to senior staff or to general members of the organization. There does appear to be significant variation among societies relative to the amount of voluntary time requested from and contributed by the elected leadership of medical societies. Not surprisingly, a major factor in this variation appears to be the size of the organization.

To elicit more relevant information about deployment of and representation by trustees and officers, targeted questions about these policies will be included in the random interviews to be conducted with Federation members in Part 3 of the overall evaluation of the Representation Program.

SUMMARY AND CONCLUSION

Significantly more information has been gathered about the nature and targeted audiences of activities of AMA trustees as part of our AMA Representation Program. It is worthwhile to note that the largest investments appear to be related to meetings hosted by our AMA or formal participation by our AMA in related accreditation organizations.

Of the Trustee Days filled by Representation Program assignments, 41% were fulfilled by one of the four Officers receiving Fixed Annual Compensation--the Board Chair or one of the three AMA Presidents (average 114 days per trustee). The 14 Non-officer Trustees completed an additional 53% of the Trustee Days (average 42 days per trustee), the remaining 6% being served by the Medical Student and Resident/Fellow trustees. Clearly the FAC trustees served considerably more days than their Per Diem colleagues.

Meetings hosted or organized by our AMA--including meetings with AMA Sections, House planning meetings, the Medical School Visitation Program, and AMAP meetings--were responsible for 341 (30.6%) Trustee Days in Board Year 1998-1999.

An additional 164 Trustee Days (14.7%) of Trustee Days were occupied with filling AMA slotted seats in related organizations, including JCAHO, the National Patient Safety Foundation, COLA, the AMA Foundation, and NCQA. AMA trustees also fill AMA slotted seats at the World Health Organization and World Medical Association, but these are not included in the 14.7% figure because they are intermingled with other international assignments.

Trustee Days spent on assignments to Federation organizations--state medical societies, county medical societies, and medical specialty societies--accounted for 159 Trustee Days (14.3%).

Our AMA invests a significant amount of human and financial resources in the Representation Program. Your Board will report back to the House at A-2000 about the results of and recommendations stemming from the structured interviews and panel analysis of these activities.

TABLE 1: AMA REPRESENTATION PROGRAM, BOARD YEAR 1998-1999

<u>Meeting Type</u>	FAC¹ Days	PD² Days	MS³ Days	RF⁴ Days	Total Days
AMA Meetings	95	128	1	3	227
Government Meetings	23	58			81
JCAHO Meetings	7	73			80
State Medical Society Meetings	24	35	1	5	65
International Meetings	60	4			64
County Medical Society Meetings	25	27		4	56
Medical School Meetings	22	17	2	10	51
AMAP Meetings	21	24			45
Med School Visitation Program	4	12	8	18	42
Civic Society Meetings	23	16			39
Specialty Society Meetings	16	22			38
National Patient Safety Foundation	11	24			35
Meetings with Media	17	17			34
Meetings with Corporations	19	10			29
AMA Foundation Meetings		23	1	2	26
AMA Testimony	4	19			23
AMA Sections	3	8	5	5	21
COLA		17			17
Hospital Meetings	7	4		2	13
HOD Planning Meetings		6			6
NCQA	6				6
Meetings with Other Foundations	2	3			5
Alliance Meetings		1			1
Other/Miscellaneous	58	51			109
TOTAL MEETINGS (days per Trustee average)	457 (114)	589 (42)	18 (18)	49 (49)	1113

¹Fixed Annual Compensation Days--President(s) and BOT Chair²Per Diem Days³Medical Student Trustee Days⁴Resident/Fellow Trustee

NOTE: Data does not include trustee time associated with regularly scheduled meetings of the BOT, the Annual or Interim Meeting, the National Leadership Development Conference, fulfillment of secondary assignments, or travel associated with assignments.

**19. EXCELLENCE IN GOVERNANCE: IMPLEMENTATION OF
THE FINAL REPORT OF THE AD HOC COMMITTEE ON
STRUCTURE, GOVERNANCE AND OPERATIONS**

HOUSE ACTION: POSTPONED UNTIL THE 2000 ANNUAL MEETING

**20. AMERICAN ASSOCIATION OF ORAL
AND MAXILLOFACIAL SURGEONS**

**HOUSE ACTION: RECOMMENDATIONS NOT ADOPTED AND
REMAINDER OF REPORT FILED**

The Board of Trustees has received an application from the American Association of Oral and Maxillofacial Surgeons (AAOMS) requesting Official Observer status in the American Medical Association (AMA) House of Delegates (HOD).

The AAOMS has had a long association with the AMA and is eager to make its presence at the HOD meetings official. Similar to the AMA, the AAOMS is national in scope. Both the AMA and AAOMS share similar goals and concerns regarding patient care, the health of the public, and excellence in training and education. Additionally, AAOMS actively participates as the AMA Relative Value Update Committee and Practice Expense Advisory Committee, as well as on the AMA's National Advisory Council of Physicians Against Family Violence. The AAOMS has a close working relationship with the American Society of Anesthesiologists and sits on the Surgical Specialty Group of the American College of Surgeons.

AAOMS was founded in 1918 and now has approximately 7000 members. The mission of the AAOMS is to support its members' ability to practice their specialty through education, research and advocacy. It is interested in competency and advancing clinical skills of its members. Ten percent of the membership of AAOMS is trained as physicians as well as oral surgeons in dual-degree programs. Most of these individuals are members of the American Medical Association. Oral and maxillofacial surgeons have worked side by side with general surgeons, otolaryngologists and emergency physicians on trauma teams and in emergency rooms for many years. By virtue of the residency training, clinical practice and continuing education of oral and maxillofacial surgeons, this organization brings a unique perspective and expertise that can be both cogent and valuable to organized medicine.

Robert Rinaldi, PhD, is the AAOMS executive director. The headquarters are in Rosemont, IL. The organization has a House of Delegates style of governance and with representation from all sectors. Its sessions are conducted in a democratic manner.

As the pace of technological and scientific development accelerates, one of the greatest challenges to health care professionals is to exchange new information and create alliances with colleagues who promote high quality care for all of our patients and their families. Just as the public expects safe and competent medical care from physicians, it expects the same from other health professionals. Close associations such as the one proposed build new relationships and achieve common goals.

The Board of Trustees believes that the AAOMS meets all of the criteria for Official Observer status and that the presence of an AAOMS representative would be beneficial to both organizations and to the patients that we serve.

RECOMMENDATION:

The Board of Trustees recommends:

1. That the American Association of Oral and Maxillofacial Surgeons be invited to send a non-voting Official Observer to all meetings of the House of Delegates.
2. That the remainder of this report be filed.

**21. STATUS REPORT: ALLOCATION OF TOBACCO SETTLEMENT
FUNDS BY STATE GOVERNMENTS FOR INTERVENTIONS IN
TOBACCO USE PREVENTION AND CONTROL**

HOUSE ACTION: FILED

At the 1999 Annual Meeting, the House of Delegates adopted Resolution 428, which asked our American Medical Association (AMA) to:

“Emphatically reaffirm its commitment to long-standing House of Delegates tobacco control policies, most especially Substitute Resolution 413 (I-98) requiring states to use tobacco settlement monies for legitimate public health purposes, education and prevention of nicotine addiction, treatment of diseases related to nicotine addiction and tobacco use, and improved access to medical services; and

“Encourage and work with state and specialty societies to vigorously lobby state legislatures to:

- a) assure that a significant percentage (depending on the objectively determined needs of the state) of the tobacco settlement monies be set aside first for tobacco control, nicotine addiction prevention, cessation and disease treatment for tobacco control and related public health purposes and medical services, and
- b) assemble an appointed state level task force including experts in public health and program evaluation and consumer advocacy, to determine the best utilization of those set aside monies through review of local needs and nationally established tobacco control guidelines and programs; and

“Report back to the House of Delegates at I-99 on the progress of these actions as well as the status of actions from Substitute Resolution 431 (I-98) as previously requested.”

INTRODUCTION

On November 23, 1998, attorneys general representing 46 states entered into an agreement with the tobacco industry to settle state-based lawsuits against the industry brought because of expenses to state governments from treatment of tobacco-related illnesses. This Master Settlement Agreement (MSA) calls for a combined total payment to the states of more than \$206 billion in the first 25 years, although the MSA specifies that the payments could extend indefinitely beyond that time. Four states had previously entered into individual settlement agreements with the tobacco companies (Florida, Texas, Mississippi, and Minnesota).

The MSA also calls for a variety of changes in tobacco industry advertising practices and a limited number of “public health” measures that are beyond the scope of this report. The best publicized of these has been the end of large billboard advertising by the tobacco companies. The most useful of these provisions may prove to be the creation of the American Legacy Foundation, an independent organization that was created to mount extensive national education, counter-advertising, and grantmaking for tobacco use prevention and control. Former AMA President Lonnie R. Bristow, MD has been named to the Foundation’s board.

The Centers for Disease Control and Prevention (CDC), through the Office on Smoking and Health, has issued a report called “Best Practices for Comprehensive Tobacco Control Programs.” This excellent document details the elements of statewide, comprehensive tobacco control programs, with a state-by-state recommendation of funding levels for such programs. The document recommends the following target areas for spending by states, and considers them essential to comprehensive programs:

- Community programs to reduce tobacco use
- Chronic disease programs to reduce the burden of tobacco-related illness
- School programs
- Enforcement
- Statewide tobacco use prevention programs
- Counter-marketing
- Cessation programs
- Surveillance and evaluation
- Administration and management

STATE ACTIONS RELATED TO THE MSA FUNDS

While the state attorneys general settled the lawsuits, state legislatures must decide how to spend the funds. When the settlements were reached, state officials were quick to proclaim their interest in tobacco use prevention activities. The states, lobbying through the National Conference of State Legislatures, the National Governors Association, and key individual members of those groups, also obtained the federal share of the MSA monies without directives from Congress on how that portion of the funds should be spent.

Over the past few months, about 25 of the 46 states (as of this writing) have dealt with the tobacco settlement money. Of those, only 6 states have provided sufficient funding for truly comprehensive tobacco control programs. About 10 states have directed some funding to tobacco control, but at levels well below the CDC recommendations. The other 11 states that have dealt with the settlement have not appropriated any funds whatever for tobacco-related issues. At this time, only about 4% of the initial year's payments from the tobacco industry to states have been allocated to tobacco control.

Another problem arises when lawmakers make unrealistic assumptions about the fundamental nature of prevention efforts. A case in point is Montana. After months of debate, state lawmakers agreed to allocate only about \$7 million of its \$922 million tobacco settlement for health issues over the next two years (CDC minimum recommended spending--\$9 million/year). But legislators demand to see the money well spent, and that means the state Department of Public Health and Human Services must return to the 2001 Legislature with a glowing report card. "We have to show that the money produced results or we can kiss that cash goodbye," said Nancy Ellery, of the state Health Policy and Services Division. The message is that Montana will invest an inadequate sum on its anti-smoking campaign, and will cut that investment if returns aren't seen immediately. The industry is investing hundreds of millions in Montana alone on its pro-smoking campaign, and will keep spending indefinitely. The Board believes that a terribly shortsighted approach to tobacco control is evident, a tactic that could doom the tobacco control program in states that take this approach--and Big Tobacco wins again.

While some of the initial results of the legislative battles were disappointing and others were fruitful, the size of the awards to the states and the long-term availability of the money present both opportunity and challenge. In at least some of the states that did not appropriate adequate funds for tobacco control and health measures, the issue can be revisited in future legislative sessions. Where there has been success, the role of the health community must become an evaluation/watchdog function. The California experience has shown state administrations may be quite bold in raiding the tobacco control funds, diverting them for other purposes. This will be a long-term struggle in most states.

A summary of each state's actions to date on the MSA funds is available from the Department of Science and Public Health Advocacy. While it is as current as possible, state legislatures may have acted on these issues after this report was written. An excellent on-line source for information is www.tobacco.org, with daily news updates on settlement and other tobacco control issues.

AMA ACTIVITIES TO SUPPORT APPROPRIATE USE OF SETTLEMENT FUNDS

Our AMA has been quite active in advocating for using MSA funds as recommended by the House of Delegates.

- At the AMA State Legislative Conference in January 1999, Neil Weisfeld, deputy executive director of the Medical Society of New Jersey and Tom Houston, MD, AMA director of Science and Public Health Advocacy Programs made plenary presentations on settlement issues.
- On March 3, 1999, the AMA Advocacy Resource Center, Science and Public Health Advocacy Programs, the SmokeLess States National Program Office, the Center for Tobacco Free Kids, and the CDC collaborated on a "fly-in" meeting in Chicago specifically for state and specialty society representatives to discuss strategies around the allocation of funds. Fourteen state societies, the AMA Alliance, and several medical specialty groups participated.
- Following the "fly-in," a packet of materials distributed at that conference was mailed to the state legislative directors of all the state medical societies.
- The settlement was on the agenda at the AMA State Legislative Roundtable in August 1999.

- In October 1999, the AMA sent to state and medical specialty society executive directors the final version of the CDC “Best Practices” monograph described above, along with other materials on the settlement from the Center for Tobacco Free Kids. State medical society presidents were sent a separate letter about the settlement and the information that had been distributed, urging action on the issue.
- The AMA SmokeLess States National Program Office and the Center for Tobacco Free Kids, along with the American Cancer Society, the American Heart Association, and the American Lung Association sponsored a conference in Chicago October 21-23, 1999 called “Show Me the Money.” This conference was an in-depth review of the MSA funds issue, and included sessions on getting medical societies involved with the settlement, participating in legislative hearings, using media for advocacy on the issue, and other relevant topics. About 100 persons from nearly every state attended. Four state medical societies sent representatives, and AMA federation relations and state legislation staff attended the conference.
- During 1999, the AMA SmokeLess States National Program Office (with funds from the AMA Foundation dedicated to tobacco control “special opportunities”) awarded grants of about \$60,000 each to 5 of our grantee state coalitions, and to nine non-SmokeLess States groups to develop a state tobacco control plan and to generate recommendations for settlement spending. Their respective state medical societies were notified of these grants, and were encouraged to join the effort. An article appeared in AMNews discussing this activity.

CONCLUSION

The Board of Trustees believes that the MSA promise of billions of dollars flowing to the states from the tobacco companies will be a hollow victory if appropriate funding is not secured in the state legislatures. To date, only a small minority of state legislatures has acted to spend the funds on truly comprehensive tobacco use prevention and control programs.

While state medical society involvement in this process is not a guarantee of success, it is clear that without medical society effort, the health community in the states will be much less likely to achieve adequate funding for tobacco control and health measures through MSA monies. In all the states, it is clear that strong public-private partnerships among the state health departments, the federal government’s tobacco control initiatives, and the non-governmental organizations involved in tobacco control are essential.

Our AMA will continue to monitor the situation in the states, provide technical assistance and encouragement to the health community for settlement-related effort, and work closely with our national partners in this process.

22. AMA BUDGET FISCAL 2000

HOUSE ACTION: FILED

The Board of Trustees is pleased to present a fiscal 2000 budget based on the AMA’s Statement of Strategic Direction for 2000. The budget reflects some shifts in resource allocation based on the AMA’s commitment to meeting member needs. The 2000 budget includes consolidated operating revenues of \$278.6 million, consolidated operating expenses of \$272.3 million and income taxes of \$6.9 million, resulting in revenues less than expense of \$600,000.

Membership dues and AMA’s business operations will contribute almost \$115 million net margin in 2000 to support the AMA’s professional association activities, leadership, management and policy development and overhead. The 2000 budget reflects increased spending on Health Policy Advocacy and a comprehensive integrated communication strategy. Additional expenditures are budgeted in Information Resources as well, reflecting our continued commitment to investments in technology. The Subsidiaries are projected to continue to contribute significantly to the AMA’s bottom line, with 2000 budgeted operating results after taxes of more than \$6.5 million. Reserves are projected to grow to \$175 million, and should remain comfortably ahead of target reserve levels. Supplement budget information has been included with the Interim Meeting handbook mailing to Members of the House of Delegates and will be discussed at the Reference Committee F hearing.

23. MEDEM, INC. - STATUS REPORT

HOUSE ACTION: FILED

The American Medical Association's (AMA) Board of Trustees (BOT) reviewed a concept paper in early 1999 on a joint venture between the AMA and specialty societies. The concept paper reviewed reasons why organized medicine should develop a consumer health site on the Internet, and proposed a joint venture by organized medicine. The Board approved continued discussions with specialty societies and has reviewed this project on an ongoing basis. In October 1999, the BOT approved AMA entering into a partnership with six specialty societies for implementation of a consumer web initiative termed Medem.com. The following informational report provides the background on the impetus for the venture and an update on its current status.

BACKGROUND

The Internet is the fastest-growing vehicle for communications in history. Internet users in the US alone number in excess of 100 million. The influence of the Internet is becoming ubiquitous and is being seen throughout the healthcare environment. Consumers will continue to obtain an ever-increasing portion of their health information from the Internet. Patients in particular are using the Internet to access information that was previously difficult or inconvenient for them to find due to the complexity of the healthcare system or the increasing bureaucracy of managed care.

While the potential of the Internet to educate, influence, inform, entertain, and empower the user offers immense promise for healthcare, there is also the very real threat of misinformation and misuse. Many physicians for example, report having been "negatively impacted" by poor, out-of-context, incomplete or inaccurate information downloaded by their patients via the Internet. Consumers consistently identify reliable and credentialed healthcare information to be of principal interest and they increasingly seek out physician-focused professional and specialty society sites. Unfortunately, few such reputable services are available via the Internet and fewer still are widely known and adequately promoted. Given the massive patient demands for information and the time pressures now being placed upon clinicians, such a reference would be of great value for physicians. Few physicians, however, report having such an Internet resource currently available to their patients.

Acting independently in an effort to create a patient-physician information service, individual medical societies would likely provide some value to their physician members but would have a difficult time making any substantial consumer impact at a national level. At the same time the AMA has been and should continue in the consumer Internet health business. Working together however, the Board believes the federation of medicine can create a "critical mass" of content and consumer-physicians mind-share that will act as the foundation upon which to construct a healthsource website as a national brand name, thereby delivering real and tangible impact to consumers and physicians.

DISCUSSION

In early 1999, the AMA and some specialty societies agreed that a window of opportunity existed for physicians, their societies and their representatives to combine their content and resources and deliver to consumers the finest in credentialed healthcare information via the Internet. Therefore, the AMA entered into a collaborative arrangement with the following specialty societies to determine the viability of an organized medicine health Web site:

- American Academy of Ophthalmology
- American Academy of Pediatrics
- American College of Obstetricians and Gynecologists
- American Psychiatric Association
- American Society of Allergy, Asthma and Immunology
- American Society of Plastic Surgeons.

In addition to the above societies, six other specialties were approached and decided against partnering at that time.

All societies believed that development of a consumer health web site must be accomplished in a fashion that supports, promotes, enhances, and empowers the patient-physician relationship, is financially sound in a highly competitive environment, successfully and positively impacts consumers, patients, and physicians, and creates a

sustainable long term model. To achieve these goals, the combined information would be delivered to consumers directly via an Internet site/service and also within the context of their own physicians' Web site and online service. Success here would mean that the public would be educated and influenced in their healthcare decisions and perspectives in large part via this online site/service controlled by those most capable of providing medical care, planning, education and perspective: their physicians.

The AMA and the above-mentioned specialty societies committed to the development of a business plan to assess the viability of and the financial arrangements for medicines' super healthcare web site. A draft business plan was developed and the Executive Summary was provided to each society in April for review as to its soundness in terms of the financials, business opportunity, structure and management of such a site. The primary focus of this initiative was the development and delivery of quality, credentialed information by physicians for consumers via the Internet. The preliminary business plan was approved in June and activity commenced on development of the corporation and finalizing partnership documents.

KEY DEADLINES

The timing for finalizing the business plan and development of Medem.com and the associated creation of a not-for-profit editorial and content organization as well as a for-profit service company (Medem, Inc) was as follows:

- | | |
|---|------------------|
| • Initial Round of Financing Complete | May 15, 1999 |
| • Medem and Medem, Inc established | June 15, 1999 |
| • Specialty Society Pilots Identified | August 15, 1999 |
| • Second Round Financing Package Complete | October 30, 1999 |
| • Second Round Financing Complete | January 1, 2000 |
| • Consumer Site Launch | March 31, 2000 |

CURRENT STATUS

In late October the AMA signed an agreement with the six above-mentioned specialty societies to proceed with development and incorporation of the company.

The announcement of development of the consumer oriented web initiative, Medem.com, was made in a national news conference in New York City on October 28, 1999. The news conference was well attended and the venture received extensive, positive national press coverage. The AMA also has received numerous phone calls from physician members, primarily in support of this endeavor as well as supporting calls from specialty societies applauding the venture. Currently, a temporary informational website has been developed at www.Medem.com. The purpose of this website is to provide viewers with background information on Medem, its founding partners and to provide viewers with a status report on Medem's development.

At the same time, the issue of the exclusivity of the arrangement, i.e., only seven medical societies involved, has been questioned. From a business perspective it was difficult to negotiate a business deal with too many partners. Initially, 13 medical specialty societies were asked to participate. Only 10 responded and only the 7 mentioned decided to commit the resources to proceed. At this time, Medem has opened participation to other interested specialty and state societies. Medem has sent a notice to these societies to ascertain their interest in joining Medem, Inc. A meeting will be held in conjunction with the 1999 Interim Meeting for all those interested.

Medem staff is working to develop the consumer site home page and develop a layout for the site. As stated the anticipated rollout of the site is March 31, 2000. AMA's Health Insight is envisioned as key component of the new web site. In addition, Medem.com will provide physicians an opportunity to develop a home page with a link to the site. While this provides a new member benefit for the other partners in Medem, Inc., the AMA already has a viable program, Physician Select. We are currently working out the details on how AMA's Physician Select will interface with Medem's Practice On Line.

CONCLUSION

The Board has been kept apprised of the AMA's involvement in the consumer web site since its inception. The Board has received updates at each Board meeting in 1999 as well as several special communiqués when key dates or decisions arose. The Board will continue to monitor AMA's involvement in Medem, Inc. and will assure that the ethical and corporate guidelines of the AMA are followed as we proceed with this venture.

The Board will keep the House apprised of this activity.

24. PUBLIC HEALTH ACTIVITIES OF THE AMERICAN MEDICAL ASSOCIATION

HOUSE ACTION: FILED

At the American Medical Association (AMA) 1999 Annual Meeting, the House of Delegates adopted, as amended, Resolution 409 (A-99), entitled "Support for Public Health." This resolution from the Nebraska delegation requests "...the Board of Trustees to include in their long range plans, goals and strategic objectives to support the future of public health in order to fulfill society's interest in assuring the conditions in which people can be healthy. This shall be accomplished by AMA representation of the needs of its members' patients in public health-related areas, the promotion of necessary funding and promulgation of appropriate legislation which will bring this to pass," and "That the Board of Trustees report at each Interim Meeting the results of our AMA efforts to promote and improve public health."

INTRODUCTION

Medicine and public health were strongly united throughout the history of medicine until the turn of the century. Past unity can be seen in the founding purpose of our AMA (...betterment of public health), professional actions of Nathan Davis, MD, (e.g., Chicago's sewage system), and unacted- upon prevention and population aspects of the Flexner report. The relationship that weakened over the last 100 years is now again growing strong. The requested public health accountability report is another sign of the vitality of the medicine-public health movement and an opportunity to assure physicians with a public health and prevention interest that the AMA is acting in support of their concerns. Our AMA already co-chairs the Medicine/Public Health Initiative with the American Public Health Association (APHA) and has developed a public health staffing structure in Professional Standards.

AMA - Public Health Policy

A review of the AMA Policy Compendium indicates that approximately 12% of our AMA policy is in whole or part related to public health. The most significant of these policies are included on the AMA's Public Health Web site page. These policies include support for the Medicine/Public Health Initiative in Policy H-440.911: Medicine/Public Health Initiative and H-440.910: Medicine-Public Health Congress: Follow-Up Action.

AMA - Public Health History

Randolph Smoak, MD, briefly summarized our AMA's involvement in public health in his closing speech to the 127th Annual Meeting of the APHA – thus becoming the first AMA president to address the APHA in its 127-year history. Nathan Davis, MD, founder of our AMA, crusaded for sanitation and public health all his life. When Dr. Davis moved to Chicago in 1849 one of his first actions was to write to a colleague identifying public health issues that needed to be addressed including the lack of a hospital and no sewage system or water supply. Dr. Davis was instrumental in having Chicago's sewage system built and its first hospital opened. Henry Bowditch, MD, was president of our AMA in 1877 after founding the APHA in 1872.

"Public Health" Definition

In this report "public health" is construed in its widest sense, encompassing efforts to promote prevention in general (e.g., prevention curriculum in medical schools) and specific prevention activities (e.g., tobacco control), as well as traditional public health activities (e.g., surveillance).

AMA Staffing Changes To Support Public Health

Until January 1999, there was no central structure or staff specifically responsible for public health at our AMA. Because of the wide scope of public health, activities at our AMA are the responsibility of many organizational units each with its own appropriate expertise. For example, integration of public health approaches into medical education is the responsibility of the Medical Education Group.

Increasingly, association-wide awareness of public health priorities and methods, as well as strategies and coordination for public health efforts, have become the responsibility of two newly organized AMA Units: Clinical and Public Health Practice and Outcomes; and Science and Public Health Advocacy Programs. Both of these Units are under the Senior Vice President for Professional Standards, Reed V. Tuckson, MD. Dr. Tuckson has presented AMA senior administration and the Board of Trustees with a process for a shared vision, prioritized agenda, and coordinated infrastructure on health promotion and disease prevention at our AMA.

Other AMA Support

The Section Council on Preventive Medicine is also a resource for support and counsel. Additionally, a group of Federation Public Health Advisors has been formed to ensure that the state medical societies and medical specialty societies with an interest in public health have a voice that is heard in our AMA.

Federation

In addition to AMA Units and their staff now dedicated to public health, our AMA has two Federation societies with particular commitment to public health: the American Association of Public Health Physicians and the American College of Preventive Medicine.

Activities Tracking System

An e-mail survey of all AMA staff in Chicago, Washington, DC, and New York offices was initiated to identify programs and activities that relate to public health, including health promotion and disease prevention. A summary table of activities reported in this manner is included in the appendix. (Note: The appendix is available from the Department of Clinical and Public Health Practice and Outcomes.) This e-mail survey will be repeated at regular intervals to identify new programs and activities. Staff will maintain the status of each reported activity through the activity's assigned contact. Early next year, activity specifics will be available to AMA members as a searchable database. The first staff survey makes it clear that AMA staff do not always recognize public health aspects and implications of their efforts, especially when such efforts have not been labeled as public health. Staff are being sensitized to public health issues that are, or could be, incorporated into their programs. Future staff surveys will increase the number of public health activities recognized and reported in the ongoing database.

AMA Strategic Planning

Our AMA 1999 Strategic Plan includes some public health activities. The Core Purpose of our AMA remains "to promote the art and science of medicine and the betterment of the public health." Indeed the Plan declares that "improving medicine and the health of the public will always be the focus of what we do." The Envisioned Future is that "the AMA is the medical profession's leading force in solutions, knowledge and tools that promote health." Of the 14 specific initiatives noted in the plan one is "Public Health Focus – The AMA's public health presence will be focused on tobacco, substance abuse, and violence as major public health issues on which the AMA has a special opportunity to have a real impact." Strategy 1.1E is "the translation of knowledge into integrated medicine and public health practice." Strategy 1.2A is the "development and dissemination of information to physicians and patients related to counseling patients and communities on appropriate care, health promotion and disease prevention, and medical care." Strategy 1.2B is the "development and dissemination of health information on appropriate care, health promotion and disease prevention, and medical science to patients and communities." Strategy 3.1 is to "provide a comprehensive, relevant, responsive policy base focused on promoting professionalism through the enhancement of scientific expertise, application of that expertise to achieve quality care, and promotion of the health of the public." Subsection B of 3.1 is to accomplish this strategy as it relates to public health.

The AMA 2000 Strategic Plan was created before the resolution that prompted this report. The Strategic Plan will be distributed at the Interim 1999 meeting of the House of Delegates.

The AMA 2001 Strategic planning process will begin at a February 2000 Board of Trustees retreat. These deliberations will be guided in part by a report on the Environment of Medicine that includes public health concerns.

Legislation and Special Program Support

Our AMA has been a staunch supporter of categorical prevention efforts such as the successful tobacco legislation at the federal and state level. Our AMA has also supported other categorical initiatives at the federal and state level, such as substance abuse, alcohol abuse, violence, gun injuries, and AIDS. Our AMA has also aggressively pressed for general prevention and public health issues such as improved payment for prevention in medical programs and for increased funding for public health.

Web Site for Public Health

A year ago, the AMA established a Public Health home page on AMA's Web site. The page was developed under the Cooperative Actions for Health Program, a project of the Medicine/Public Health Initiative. The content of this page is being expanded to include all AMA public health activities, relevant AMA policy, news, Federation public health activities, and other items of interest on public health and prevention.

Medicine/Public Health Initiative

There is an ongoing alliance between our AMA and the APHA, with support from a coalition of more than 40 organizations and individuals in medicine and public health dedicated to joint efforts. Formed in 1994, the Medicine/Public Health Initiative promotes joint strategic planning and stimulates national, state, and local collaborative efforts. The seven primary goals of the Initiative are to engage the community; change education of those in medicine and public health; create joint research; devise a shared view of health and illness; work together in health care provision; jointly develop health care assessment measures; and create networks to translate ideas into actions.

Cooperative Actions for Health Program

Cooperative Actions for Health Program (CAHP) is an AMA-APHA effort under the Medicine/Public Health Initiative that builds collaboration between medicine and public health. CAHP provided 19 mini-grants for collaborative projects that linked medicine and public health. It also developed a communications network to share information and exchange ideas. CAHP ensured AMA-APHA coordinated efforts on tobacco.

Buckle-Up America

Buckle-Up America is an AMA-APHA effort under the Medicine/Public Health Initiative funded through the National Highway Traffic and Safety Administration to provide grants to promote community coalitions that develop strategies to reduce traffic accidents.

JAMA Coverage of Public Health

In addition to editorials, original articles, and research on public health issues, the Journal of the American Medical Association (JAMA) has a section for public health. Articles of special relevance to the readership are repeated from the Morbidity and Mortality Weekly Report of the Centers for Disease Control and Prevention. Approximately 6% of the January-September 1999 articles in JAMA were public health in whole or in part.

American Medical News Coverage of Public Health

In addition to extensive coverage of public health news, American Medical News has a weekly section entitled Public Health/Clinical Issues/Patients.

Proposed Communications Plan for Public Health

There is a proposed Communications Plan for AMA health of the public programs. The proposal suggests internal structural changes that can improve staff awareness and participation in AMA public health activities and better communication of these efforts to the Federation, members, other physicians, public health groups, and others.

Public Health Survey

A survey is under way of a sample of physicians with a public health orientation to determine activities and programs that our AMA might engage in that incorporate public health with medicine to benefit the health of patients. Survey results will be available early next year before the Board of Trustee strategic planning retreat.

A survey of Federation societies has been initiated to identify their public health priorities. The Alliance and non-Federation public health groups are also being asked to express their public health priorities. Results of these efforts will be reported on our AMA's Web site.

Identifying Public Health Physicians

Through the cooperation of several parts of our AMA, physicians with an interest in public health are being identified so that their concerns can be determined and appropriate supportive actions taken. Some physicians with an interest in public health can be identified through their medical specialty and through membership in specific medical societies. However, the majority of these physicians will be identified through statistical modeling applied against the full AMA masterfile of all physicians in the country. As our AMA reaches out to physicians with a public health interest it is hoped that public health physicians will see our AMA as a champion of their causes.

Student Medicine-Public Health Initiative

Our AMA is exploring the creation of a student medicine-public program. A few such joint efforts between medical schools and public health schools, and public health associations, have recently been formed.

International Medicine-Public Health

Our AMA is exploring the possibilities of participating in the World Health Organization "Towards Unity For Health" effort to promote closer cooperation internationally of medicine and public health. The AMA is a founder and active partner in the World Medical Association, which may be an appropriate vehicle for global cooperation with world-wide public health efforts.

Interim Meeting Public Health Report

At each Interim Meeting there will be a concise report of AMA public health activities from the Board of Trustees.

Distribution of AMA Public Health Activities Report

This report will be distributed to the Federation, public health organizations, and other interested groups and persons. The report will be available for comment on the Public Health page of AMA's Web site.

CONCLUSION

This report identifies AMA public health activities. The report also serves as a structure for a yearly report on AMA public health activities at the Interim Meeting.

25. UPDATE ON AMA ACTIVITIES WITH OTHER ACCREDITATION ORGANIZATIONS

HOUSE ACTION: FILED

INTRODUCTION

In response to Policy H.450.959(4) (AMA Policy Compendium), at each annual and interim meeting the AMA Board of Trustees reports to the House of Delegates on the AMA's activities with other accreditation organizations. These reports usually include information on the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); the American Accreditation HealthCare Commission (AAHCC/URAC) which continues to use the acronym URAC in reference to its original name as the Utilization Review Accreditation Commission; the National Committee for Quality Assurance (NCQA); and COLA.

This report provides information on activities of the AAHCC/URAC, COLA, NCQA, and JCAHO. In addition, JCAHO and NCQA joint activities with the American Medical Accreditation Program® (AMAP®) are included in a separate report on AMAP activities. Information also is included regarding Resolution 419, I-98, "Potential Accreditation Process for Public Health Departments." Resolution 419 asks the AMA to work with relevant agencies and organizations to develop a process to establish criteria for the voluntary accreditation of state and local health departments.

DISCUSSION

American Accreditation HealthCare Commission (AAHCC/URAC)

The American Medical Association (AMA) continues to be successful in advocating policy by participating in the standards development of the American Accreditation HealthCare Commission/URAC. AAHCC/URAC continues to be a leader in defining quality benchmarks for managed care and in developing accreditation programs. Currently, AAHCC/URAC offers nine different accreditation programs and has issued more than 1,200 accreditation certificates to 300 managed care organizations doing business in all 50 states. The accreditation programs offered include Group Health Utilization Management Organizations; Group Health Networks; Workers' Compensation Utilization Management Organizations; Workers' Compensation Networks; Credentials Verification Organizations; Health Call Center Standards; and Case Management Organizations.

The AMA has been a corporate member of AAHCC/URAC since 1991. Throughout our membership, advocacy of AMA policy has been very successful. Much of this success has involved the key areas of protecting the patient/physician relationship and assuring clinical expertise of review staff. AAHCC/URAC has always taken an aggressive approach to developing standards for the accreditation of new industries in the emerging practice of health care.

With the addition in 1999 of Illinois and Washington State, AAHCC/URAC now counts 26 states and the District of Columbia as jurisdictions that recognize one or more AAHCC/URAC healthcare accreditation programs as a quality benchmark for managed care companies. Illinois recognized AAHCC/URAC accreditation on August 19, 1999, when Gov. George Ryan signed SB 251, a major patient protection bill, into law. Section 80 of the law establishes a quality assessment program for health care plans and authorizes acceptance of accreditation by AAHCC/URAC as fulfilling this requirement. Section 85 of the law states that no person may conduct a utilization review program in Illinois without showing, at least once every two years, compliance with or accreditation under AAHCC/URAC Health Utilization Management Standards. The law further states that if a utilization review program receives accreditation from a national organization other than AAHCC/URAC, that organization's standards must meet or exceed AAHCC/URAC standards. In addition, the Washington State Office of the Insurance Commissioner recognizes AAHCC/URAC accreditation in its publication "Navigating Managed Care." The publication also lists the two managed care companies in Washington that have received AAHCC/URAC accreditation. "Navigating Managed Care" points out that an accredited health care plan meets a set of quality standards.

Among other recent AAHCC/URAC developments this year:

- The release of the second generation of accreditation standards for health call centers. These centers respond to requests from health plan members for guidance about their health care. The revised Health Call Center Standards accommodate the full range of telephone health information programs. They are broader in scope than the prior version, titled 24-Hour Telephone Triage and Health Information Standards, which applied only to call centers that provided around-the-clock coverage. The new standards will enable AAHCC/URAC to accredit health call centers that operate less than 24 hours a day. The standards provide a number of important consumer protections in accordance with AMA policy, including protecting the confidentiality of consumer information and ensuring that only qualified health professionals provide clinical information and opinions. The standards also establish minimum requirements for how long the call center may keep a patient on hold before connecting the patient with its representative.
- Development of AAHCC/URAC standards for organizations that conduct external reviews of medical necessity decisions. More than 20 states have enacted external review laws and external review is a prominent feature of most managed care legislation in Congress. Also, AAHCC/URAC's revised Health Plan Standards require accredited health plans to offer an external review process to their members. AAHCC/URAC's new External Review Organization Standards will address the scope of external reviews, qualifications of reviewers, and the external review process, including documentation, time frames, expedited reviews, and notification of external review decisions. AAHCC/URAC's Standards Committee, on which the AMA is represented, has crafted the current draft of the External Review Organization Standards and has released the standards for a 60-day period of public comment.
- Accreditation of seven case management organizations under its Case Management Organization Standards. AAHCC/URAC developed its case management organization standards through input from major constituencies affected by managed care, including the AMA. The standards cover the areas of staff structure and qualifications, quality improvement, information management, oversight of delegated functions, ethics, complaints, and the case management process. Due to AMA advocacy efforts, the standards address approaches to ensure the establishment of appropriate patient protections, such as policies for confidentiality of patient information, informed consent, dispute resolution, and other issues.

The AMA has enjoyed a successful relationship with AAHCC/URAC and is well represented on the Commission's Board of Directors. After consultation with the Council on Medical Service, the AMA Board of Trustees earlier this year appointed Ardis D. Hoven, MD, to serve as the AMA's representative on the Commission's Board for a three-year term expiring in April 2002. Doctor Hoven has been extensively involved in dialogue with third-party payors and utilization review organizations having served as the first female president of the Kentucky Medical Association in 1993-94, and as a member of the Practicing Physicians Advisory Council (PPAC) to the Health Care Financing Administration from 1995 to 1999. Currently, Doctor Hoven serves on the AMA's Council on Medical Service.

COLA

Herman I. Abromowitz, MD, Timothy T. Flaherty, MD, and J. Edward Hill, MD represent the AMA on the COLA Board of Directors.

COLA has met twice since the Annual Meeting. COLA continues to focus on its strategic business plan and internal operations. Issues currently being addressed by COLA are:

- Its deeming renewal by HCFA.
- States such as Oregon dropping their CLIA exemption because of HCFA's increase in the fees it charges to states exempt from CLIA regulations to cover overhead costs that benefit all laboratories. COLA believes that this issue should be tracked since fees paid by accrediting organizations to HCFA will also be passed along to laboratories.
- Assisting, through educational mechanisms, laboratories that have been identified as sharing proficiency testing data among each other.

As of August 31, 1999, COLA has accredited 6,441 laboratories. Under its Medical Practice Achievement (MPA) Program, accreditation has been granted as follows: 35 facilities; 112 physicians within facilities; 5 managed care organizations; 1,307 MCO sites and 2,029 MCO physicians. During its October 1999 meeting, the COLA Board approved accreditation of 986 laboratories and 252 MPA participants.

COLA and the Ohio Academy of Family Physicians (OAFP) have signed an agreement to: a) reduce the number of on-site surveys Ohio physicians must have to meet the requirements of MCOs and the NCQA and b) to assist physicians in improving the quality of health care by keeping proper patient records and by maintaining a safe and convenient site for delivery of care.

NCQA

The AMA and the NCQA continue to work cooperatively on several fronts. Last summer, the NCQA determined that the AMA uses required sources to verify DEA certificates and Medicare/Medicaid sanctions and maintains this information in the Masterfile under the same requirements as for NCQA's credentials verification organizations. The AMA Physician Profile is now an NCQA-accepted source of verification of medical school, residency-training history, American medical specialty board certification, DEA status, and Medicare/Medicaid sanctions.

This latest recognition of elements of the Masterfile paved the way for an AMA/NCQA agreement related to the American Medical Accreditation Program® (AMAP®). Under the agreement, managed care organizations (MCOs) that utilize data obtained through AMAP may rely upon the data as being in full compliance with the relevant NCQA MCO credentialing standards. In addition, AMAP is recognized as a qualified supplier of office site review services.

The AMA was provided an opportunity to respond to an NCQA crosswalk comparing its standards and the AMA Organization Principles for Physician Involvement in Health Plans and Integrated Delivery Systems (AMA Policy H-285.931). The AMA noted that many of the principles are already part of the NCQA accreditation standards, and that several standards require participation in quality management and improvement, utilization management, and credentialing. However, the AMA recommended the addition of a standard to require that the health plan develop and implement a representative process for the selection and removal of practitioner leaders serving on the governing body, or advisory committees to the governing body or management by the plan's participating providers.

Major changes in the NCQA 2000 standards included: acceptance of the National Practitioner Data Bank as a source for information on sanctions or limitations on licensure; continuation of a two-month grace period when determining whether a recredentialing decision was made within the required two-year time frame; modified scoring for timeliness of recredentialing decisions; and elimination of "non-critical" elements from the medical record review, limiting the review to six critical elements-problem list, allergies, history, diagnoses, treatment plans and appropriate treatment. Also, the requirement for initial credentialing as it relates to on-site review of health professionals' gynecologists, and high volume behavioral health practitioners. At recredentialing, site reviews are required for all primary care practitioner sites with 50 or more members and all high volume behavioral health practitioners.

Gary F. Krieger, MD and Arthur Traugott, MD, represent the AMA on the NCQA Practicing Physician Advisory Council.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

The AMA is well represented on the JCAHO Board by AMA Commissioners Yank D. Coble, MD; Timothy T. Flaherty, MD; Richard S. Frankenstein, MD; William E. Jacott, MD; William H. Mahood, MD; Donald J. Palmisano, MD, and Richard B. Tompkins, MD. Doctor Jacott serves as Chairman of the JCAHO Board of Commissioners.

Some JCAHO activities that have occurred beginning July 1999 through November 1999 follow.

AMA Resolution 419 (I-98), Accreditation of State and Local Public Health Departments

This resolution was forwarded to the JCAHO for consideration. After exploring the issues, the American Public Health Association (APHA) was contacted. It was determined that since APHA does not have a position on the accreditation of public health departments, JCAHO would not pursue this matter further at this time.

New Accreditation Program--Assisted Living

The JCAHO Board of Commissioners authorized the development of a new accreditation program for assisted living. Draft standards for the program have been developed and are currently undergoing field evaluation. The standards are based on a set of principles developed by an expert panel consisting of individuals experienced in providing assisted living services, which included providers, physicians, and representatives of national professional and consumer organizations. The program was developed in response to substantial interest in such a program. Studies showed that providers have a need for objective validation of their competency to care for residents having complex needs, and that a growing number of states are establishing licensure or other regulatory requirements.

Pain Assessment and Management Standards

The JCAHO Board of Commissioners approved new standards for the assessment and management of pain for all of its accreditation programs, except the laboratory program. Implementation of the standards will be deliberate and will not be judged for compliance until at least 2001. Through mid-year 2000, a comprehensive effort will be undertaken to engage the field in a discussion of the subject matter and to assess the readiness of accredited organizations to comply with the standards.

Restraint and Seclusion Standards

Draft standards on restraint and seclusion for inclusion in the JCAHO comprehensive accreditation manuals for behavioral health care and for hospitals are undergoing field review. The standards would be applicable to patients receiving behavioral health care. Concurrent with their development, the Health Care Financing Administration (HCFA) released new conditions of participation related to patients' rights, which focus on the use of restraint and seclusion. In part, the new standards relate to the new HCFA conditions of participation. The AMA has expressed concern regarding the conditions, particularly the provision requiring an evaluation by a licensed independent practitioner within one hour of the initiation of the use of restraints.

The JCAHO field review contains questions related to several controversial issues: initial face-to-face evaluation of the individual in restraint or seclusion by a licensed independent practitioner; continuous monitoring of the individual in restraint or seclusion; use of medications; applicability of the standards; and unique characteristics of residential treatment centers, group homes, and day programs. The field review will conclude in late November, when proposed changes will be reviewed by a task force, appropriate advisory committees, and the Standards and Survey Procedures Committee. Contemplated implementation is slated for July 1, 2000.

Random Unannounced Survey Policy

The JCAHO Board of Commissioners modified its random unannounced survey policy. Beginning in January 2000, organizations will receive no advance notice of the random survey. In addition, the window for scheduling the surveys will be increased to between nine and thirty months following the organization's triennial survey.

Accreditation with Commendation

Effective December 31, 1999, the JCAHO will discontinue Accreditation with Commendation as an official accreditation category for health care organizations. Accreditation with Commendation was introduced in 1991 as a new accreditation decision category to recognize organizations that demonstrated exemplary performance. As it was implemented, concerns were expressed that their decision category was leading organizations to place undue pressure both within their organizations and on JCAHO surveyors.

Performance Measurement Activities

Progress continues toward the goal of integrating performance measurement data into the accreditation process of the JCAHO. The Joint Commission has received data transmissions from the listed performance measurement systems for the third and fourth quarters of 1998 and the first quarter of 1999. In addition, there is ongoing progress toward the identification and implementation of core measures for the hospital and long term care programs. Four advisory panels have been established to identify core measures for the five initial priority focus areas for hospitals (acute myocardial infarction, heart failure, pneumonia, pregnancy and related conditions, and surgical procedures

and complications). Each panel has met twice and during November and December, field and stakeholder comment will be sought on the identified core measure sets.

AMA Seat on Behavioral Health Care PTAC

In addition to seats on the JCAHO Professional and Technical Advisory Committees (PTACs) on hospitals, ambulatory care, home care, long term care, and networks, the AMA has been invited to nominate a representative and alternate representative to the JCAHO Behavioral Health Care PTAC. Nominations have been solicited for this and other vacant PTAC seats from the federation. The AMA Board of Trustees will consider the nominations at its December 1999 meeting.

SUMMARY

AMA representatives serving on boards and committees of other accreditation organizations, as well as staff, will continue to monitor activities and standards of these organizations to assure that AMA policy and positions are considered.

The Board of Trustees will provide an update on the activities of these accreditation organizations at the 2000 Annual Meeting.

26. AMERICAN MEDICAL ACCREDITATION PROGRAM (AMAP)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

INTRODUCTION

At the 1999 Annual Meeting, the House of Delegates filed for information Board of Trustees Report 40, "American Medical Accreditation Program." Report 40 provided an update on the following AMAP activities: actions of the AMAP Governing Body; AMAP as an independent organization; AMAP implementation activities; Parts 4 and 5 of AMAP - Clinical Process and Patient Outcomes; clinical performance measurement directory; and the Performance Measurement Coordinating Council (PMCC).

This report discusses the House of Delegates AMAP policy and recent Board of Trustees' actions regarding AMAP. An update on AMAP activities since the 1999 Annual Meeting is provided in Appendix A.

BACKGROUND

Board of Trustees Report 40, American Medical Accreditation Program (AMAP), A-99, included the following regarding an "independent AMAP Organization:"

For several months, at the request of the primary care specialty societies and associated specialty Boards, AMA and AMAP leadership have been engaged in discussions about physician accreditation and the structure of an organization that accredits individual physicians. The American Board of Medical Specialties (ABMS) and the Council of Medical Specialty Societies (CMSS) have also been observers of these discussions. The societies and Boards have collectively referred to themselves as the "Quadri-Specialty Leadership Consortium." The members of the Consortium are the: American Academy of Family Physicians, American Academy of Pediatrics, American Board of Family Practice, American Board of Internal Medicine, American Board of Obstetrics and Gynecology, American Board of Pediatrics, American College of Obstetricians and Gynecologists and the American College of Physicians--American Society of Internal Medicine.

The AMAP Specialty Advisory Committee (SAC) met in late May 1999. During this meeting, representatives of the specialty societies on the SAC, as well as interested representatives of the AMAP Specialty Forum were briefed on the discussions with the Quadri-Specialty Consortium. The attendees were also asked about their interest in participation in future discussions about these issues. A formal request for participation by the SAC organizations is being solicited.

Accordingly, as we prepare for the next phase in AMAP's evolution, future discussions will focus on how AMAP can most effectively work with specialty societies and state medical societies to coordinate activities, minimize duplication, strengthen the physician accreditation process, and determine if this is the time for the creation of an independent entity to operate AMAP, with support and sponsorship from AMA and other components of organized medicine.

Board of Trustees' Actions

Over the past several months, the Board of Trustees conducted a thorough assessment of AMAP that resulted in the following actions.

- Reaffirmed its commitment to develop an individual physician quality assessment and measurement program.
- Directed staff to explore many other opportunities for the program and potential changes in structure and partnerships, both business and construct, in order to achieve this objective.
- Approved in principle extension of the terms of the current members of the AGB for a period not to exceed 12 months, beginning January 1, 2000, and requested staff to make individual recommendations to the Board at its December 1999 meeting.
- Requested the AGB to consider appointing members to its 2000 advisory committees from among current members, for a period not to exceed 12 months and concurrent with AGB member's terms, beginning January 1, 2000.

(The Board of Trustees will consider recommendations for appointees to the 2000 AGB at its December 1999 meeting. The appointed governing body will make AMAP advisory committee appointments at its January 2000 meeting.)

After a thorough search for potential operating partners, the Board of Trustees approved staff recommendations to enter into an agreement with The MEDSTAT Group.[®] Additional partnerships continue to be explored.

In keeping with the AMA's continued commitment to demand the highest professional standards for medicine and physician accreditation, The MEDSTAT Group has been retained to enhance the effectiveness and value of our AMAP program. Under AMA direction, MEDSTAT will work with the AMA to lower AMAP operating costs, evaluate emerging market needs and opportunities, and provide improved service to existing and future AMAP customers.

MEDSTAT is an Ann Arbor, Michigan-based company that was chosen for its expertise in the collection and management of health care information and databases across all sectors of the health care industry. It has worked extensively with employers, health plans, and accreditation organizations, including National Committee for Quality Assurance (NCQA) and Joint Commission on Accreditation of Healthcare Organizations (JCAHO). During its 20-year existence, MEDSTAT has earned a reputation for high quality service and has enjoyed a successful track record of marketing products to the health care industry. MEDSTAT's shared vision with the AMA for realizing the potential of AMAP makes it the clear choice for this assignment.

AMAP remains committed to developing and maintaining standards for physician performance and quality measurement, consistent with the AMA's mission and strategic direction. The Board of Trustees looks forward to working with MEDSTAT and to the added expertise and guidance it will provide in strengthening the AMAP program for all stakeholders.

At its August 1999 meeting, the Board of Trustees voted:

- To authorize staff to develop a governance mechanism that allows for AMAP to set standards and make accreditation decisions independently as defined in the Joint Statement of the AMA and the Quadri-Specialty Leadership Consortium.

- To authorize staff to enter into negotiations with state medical associations, medical specialty societies, specialty boards, and others to explore the creation of an independent entity and determine the level of their financial and political commitment to such an entity.

DISCUSSION

Discussions regarding AMAP's governance structure indicated that in addition to specialty societies, other stakeholders, as well as employers and purchasers, perceive that AMAP standard-setting and accreditation activities may be inordinately influenced by House of Delegates policies.

The House of Delegates is the policy making body of the AMA. The House establishes policy on professional standards for physician performance and quality measurement and this must be maintained. In reviewing previous House of Delegates policy related to activities of the ACGME, JCAHO, and other accreditation organizations, it was determined that the House of Delegates sets AMA policy and directs our representatives to seek incorporation of it into the standards and processes of these organizations. The Board believes that consideration should be given to handling policy related to AMAP's accreditation and standard setting activities in a similar manner.

The Board of Trustees recognizes and acknowledges that every effort should be made to remove the perception that the standard-setting and accreditation actions of AMAP are directed by the House of Delegates. This perception must be removed if AMAP products are to be accepted by the above entities for use in making decisions regarding physician performance and if AMA and the profession are to maintain the leadership role and commitment to the highest professional standards for medicine and physician accreditation. In fact, the AMAP standards and development and accreditation decision processes are broad-based, consensus driven, and overseen by the AMAP Governing Body, in conjunction with its advisory committees. AMAP is the mechanism through which the AMA is currently developing standards for physician performance and quality measurement.

Over the next few months, the Board of Trustees strategic plan for AMAP will be refined. This will include discussions regarding:

- The organizational and governance structures of AMAP;
- AMAP's relationship and interaction with the Federation, other health care entities, and government agencies; and
- Further review of current House of Delegates policy related to AMAP activities and operations.

SUMMARY

The Board of Trustees believes that adoption of the following recommendations will assist in its deliberations, as well as provide for flexibility in interaction and discussions with other parties wishing to participate in AMAP. Moreover, the adoption of these recommendations will assist in negating the perception that AMAP activities are and could be inordinately influenced by the House of Delegates. At the same time, the recommendations will permit the House of Delegates to continue establishing Association policy on professional standards for physician performance and quality measurement, just as it does with accreditation standards and policies for JCAHO, ACGME and other accreditation organizations. The AMAP Governing Body will continue to fulfill its purpose, as stated in its operating principles, "to establish and maintain standards and operating procedures for physician accreditation."

RECOMMENDATIONS:

The Board of Trustees recommends approval of the following:

1. Beginning with the 1999 Interim Meeting, the House of Delegates may establish policy on professional standards for physician performance and quality measurement, consistent with current House of Delegates roles with other accreditation organizations, such as JCAHO and ACGME. The AMA will request that its representatives seek incorporation of those policies into the standards and processes of AMAP.
2. The Board of Trustees develop principles regarding the ways in which the House of Delegates may have ongoing input on issues related to AMAP structure and operations, for consideration by the House of Delegates.

3. Policies 450.954, 450.956, 450.957 and 450.959 (Appendix B) be suspended pending development of these principles.
4. The Board of Trustees report back to the House of Delegates at the 2000 Annual Meeting.
5. That AMAP continue aggressively to develop performance and outcomes measurement instruments.
6. That the Board of Trustees present a clear and detailed business strategy and make available for perusal the business plan for AMAP at the 2000 Annual Meeting.
7. That the AMA/AMAP continue its present business endeavors, expend budgeted money judiciously to develop both its strategic and business plans, and pursue other ventures to better position AMAP for evaluation by the House of Delegates at the 2000 Annual Meeting.
8. That AMA Policies 450.954, 450.956, 450.957, and 450.959 be suspended if necessary, until the 2000 Annual Meeting to allow the Board of Trustees/AMAP flexibility to investigate reasonable and financially prudent business solutions to AMAP's financial viability. (These same policies would not be suspended with respect to the performance and outcomes development activities.)
9. That the Board of Trustees continue to exercise its fiduciary oversight of AMAP activities.

APPENDIX A

AMAP IMPLEMENTATION ACTIVITIES/ ACCREDITED PHYSICIANS

As of November 1999, AMAP is operational in seven states and the District of Columbia--Connecticut, Hawaii, Idaho, Massachusetts, Montana, New Jersey, and Utah. In addition, the Iowa Medical Society has signed a sponsorship agreement.

During the period of August 1998 through the 3rd Quarter 1999, the AMAP Governing Body (AGB) Accreditation Review Committee acted on the accreditation status of 2,366 physicians. Of those, 1,683 (71%) were accredited having met all required standards and attaining at least the minimum number of the points for the supplemental standards. An additional 683 physicians (29%) were not accredited because one or more required standards were not met, the minimum number of supplemental points was not attained, or both.

PARTS 4 & 5 OF AMAP - CLINICAL PROCESS AND PATIENT OUTCOMES AND RELATED ACTIVITIES

Based on a recent AMA survey, clinical performance measurement activities, both within and outside the profession appear to continue unabated. The 2000 Clinical Performance Measurement Directory reports more than 200 existing performance measurement activities, approximately one-third of which are conducted by national medical specialty and state medical societies and another one-third by the private sector; the Quality Improvement Organizations/Peer Review Organizations account for an additional 20 percent of activities. Of interest, the data report a shift in sponsorship of activities within the private sector during the past year. The number of not-for-profit organizations sponsoring performance measurement activities decreased from 45 to 15 organizations, while the number of for-profit organizations increased from 20 to 55 within the same time frame. The implications of these findings are being examined. In addition, the degree to which any of these programs comply with AMAP criteria for systems and/or attributes of good measures—both of which were developed to enhance the credibility of physician performance measurement activities—has yet to be determined.

The AMAP Performance Measures Advisory Committee (PMAC), Specialty Advisory Committee (SAC), and Specialty Forum (SF) continue to provide methodological and clinical expertise toward the development and implementation of Parts 4 and 5 of AMAP, and includes: 1) identifying AMAP-compatible physician performance measurement *systems* and 2) identifying AMAP core physician performance measurement *sets*. Accordingly,

- criteria for AMAP-compatible physician performance measurement systems have been finalized and; a “call for systems” is currently planned for early 2000;
- an *AMAP Adult Diabetes Measurement Set* has been developed;

- two additional work groups to develop measurement sets have been established, prenatal care testing and chronic stable angina;
- a framework for integrating specialty society-developed physician performance measurement sets into AMAP has been proposed; and
- a plan to expedite the development of physician performance measurement sets is under development.

In addition, the nomenclature for Parts 4 and 5 has been reviewed and updated to more accurately reflect the current vernacular. Although initially Parts 4 and 5 of AMAP were described as “clinical performance” and “patient care results” respectively, it soon became apparent that, while logical, these terms did not correspond to common usage. Consequently, Parts 4 and 5 have been renamed “clinical process” and “patient outcomes” to be consistent with comparable activities external to AMAP. Furthermore, because development efforts to date have demonstrated that condition-specific distinctions between process and outcome measures may often be minimal, Parts 4 and 5 are being merged as appropriate. For example, the diabetes measurement set includes both process and intermediate outcome measures—eye exams and HgbA1c test values respectively. Therefore, it is not appropriate to think of Parts 4 and 5 as separate entities.

AMAP STANDARDS REVISIONS

At its 1999 meetings, the AGB approved clarifying changes to the AMAP Accreditation Standards and footnotes to become, effective January 1, 2000.

- “Special consideration” may now be provided to physicians who have had actions or a history of revocation of DEA registration “due to substance abuse that have not involved patient care or resulted in felony conviction.”
- In response to concerns regarding the opportunity for physicians who have not completed U.S. residencies to achieve AMAP accreditation, the AGB approved the following footnote to Standard 6S, which provides four supplemental points for the completion of U.S. residencies:

Special consideration may be given to a physician who has not completed a residency training program approved by the ACGME, AOA, Royal College of Physicians and Surgeons of Canada, or College of Family Physicians of Canada, provided that such physician: 1) is licensed by the licensing board in the state of application and has maintained such license, without disciplinary action, continuously for at least ten (10) years; 2) has been an active member, with clinical privileges, of the organized medical staff of the same organization for at least five years and that such organization has demonstrated performance measurement practices; and 3) submits a written request for special consideration, accompanied by a recommendation and performance profile form confirming the physician's satisfactory participation in such performance measurement activities from the chief medical officer (or equivalent) and the chair of the physician's department or section of the organization identified in #2.

Applicants who meet the above criteria for special consideration shall be eligible to receive three of the four supplemental points for Standard 6S. Availability of this special consideration shall expire on or before January 1, 2005.

- The date for which Standard 19R, participation in an AMAP-approved self-assessment program, becomes a requirement was changed from January 1, 2000, to January 1, 2001.
- In addition, clarifying changes were made to the standards related to current ABMS board recertification, professional liability claims experience, continuing medical education, and peer review.

The revised AMAP standards for 2000 will be available on the AMAP web site.

AMAP PUBLICATIONS/COMMUNICATIONS

The following printed pieces were developed to meet the needs of AMAP applicants:

- *Guide to Written Policies and Procedures*
This booklet was developed to help AMAP applicants with the environment of care site review, the most problematic area of the AMAP accreditation process. The booklet provides samples of written policies and procedures that can be adapted for the applicant physician's office. The guide is also available on the AMAP Web site.
- *10 Steps to a Successful Office Site Review*
 - Chart
 - Detailed ExplanationThese aids were developed to assist an applicant physician's office staff to prepare for the EOC site review. They are available in hard copy and also on the AMAP Web site.
- *AMAP Information Resources Sheet*
This sheet was designed to be included with an AMAP application and describes the resources available to the applicant to prepare for the accreditation process: *The Reference Manual* and *The Guide to Required Written Office Policies and Procedures*. The sheet also describes how to access the resources either by mail or through the AMAP Web site.
- *Self-assessment for AMAP Accredited Physicians Who Move*
This office self-assessment was developed for accredited physicians who move their primary office site. Completion and submission of the self-assessment assures compliance with the EOC site review requirements and maintains the physician's accreditation status, until the next full accreditation cycle.
- *Communication Kit for Accredited Physicians*
A kit of materials, including sample press releases, letters to patients, hospitals and health plans, and statements for individual physician Web sites and correspondence were developed to assist accredited physicians in communicating their status to their patients, the community and health plans.
- *Advertising*
Advertisements were run in the following publications to enhance market awareness for AMAP, to introduce AMAP as an employer healthcare quality initiative, and in support of AMAP trade show and meeting activities: *Healthplan*; *Utah Business*; *Hartford Business Journal*; *Modern Healthcare*; *Managed Healthcare*; and *MGMA Update*.
- *AMAP Web Site*
The AMAP Web site has undergone regular maintenance and has also expanded. The 1999 Standards, Reference Manual, and A Guide to Required Written Policies and Procedures are currently present on the AMAP Web site and are able to be downloaded. A new feature, AMAP Educational Messages, has been established and currently features tips on how to prepare for the EOC site review and patient record review. AMAP press releases, AMAP's mission statement, recent *AMAP FAX UPDATES*, and information on the call for comments on the AMAP Adult Diabetes Physician Performance Measurement Set are also part of AMAP's Web site.
- *Approved AMAP Self-Assessment Programs*
The AMAP Self-Assessment Program Review Committee has approved thirty-three (33) programs. Medical specialty or content area of these programs are: cardiology; emergency medicine; endocrinology; family medicine; gastroenterology; internal medicine; medical practice management; nuclear medicine; obstetrics and gynecology; ophthalmology; orthopaedic surgery; pathology; physical medicine and rehabilitation; plastic surgery; radiation oncology; radiology; and ultrasound medicine.

PERFORMANCE MEASUREMENT COORDINATING COUNCIL (PMCC)

Consistent with Board of Trustees Report 40-A-99, the PMCC has formed a Diabetes Clinical Logic Work Group, the objectives of which are to:

- Consider a clinical logic framework to serve as the basis for development of future condition-specific measurement sets by accrediting bodies;
- Reach consensus on the clinical recommendations for the management of adult diabetes from which performance measures with different purposes are derived;
- Determine if single data collection for diabetes measures with different purposes is feasible and, if so, to specify revisions necessary to respective organization's data collection specifications to achieve this goal; and
- Consider a vehicle for operationalizing single data collection.

At the suggestion of PMCC members, AMAP, JCAHO, and NCQA have adopted a uniform set of attributes of performance measures. The PMCC also plans to establish two additional condition-specific Work Groups in early year 2000.

NATIONAL FORUM FOR HEALTH CARE QUALITY MEASUREMENT AND REPORTING (NATIONAL FORUM)

The National Forum is a not-for-profit membership organization created to develop and implement a national strategy for measuring and reporting health care quality. The Forum, originally proposed in 1998 by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, officially launched its efforts at a public roundtable discussion on September 23, 1999. At that time, the National Forum announced that Kenneth W. Kizer, MD will serve as the President and Chief Executive Office of the Forum. Doctor Kizer previously served for five years as the Under Secretary for Health in the U.S. Department of Veterans Affairs.

AMAP (Randolph Smoak, Jr., MD), NCQA (Margaret O'Kane), and JCAHO (Dennis O'Leary, MD) hold non-voting, liaison seats on the Board. In addition, AMAP will participate on the Research and Quality Improvement Council. The AMA, represented by Thomas R. Reardon, MD, AMA President, also is a member of the National Forum's Convener Panel.

At the October 1999 National Forum Board meeting, voting members approved individuals to serve on the National Forum Framework Board; the Framework Board will advise the National Forum Board. A public announcement of Framework Board members is expected shortly.

The National Forum Board expects to meet again in December 1999, at which time a work plan for the Forum will be presented.

APPENDIX B

H-450.954 AMAP

The AMA policy is that: "All reasonable efforts will be made to implement AMAP with the active involvement of the relevant state medical societies. In a state where the AMA and the state medical society have not yet developed an agreement to implement AMAP:

- (1) AMAP will not actively solicit individual physicians to apply for accreditation without written or electronic agreement from the state medical society;
- (2) AMAP will not actively solicit potential local customers for AMAP-generated information without written or electronic agreement from the state medical society;
- (3) AMAP may respond to physician requests for AMAP accreditation and shall communicate in writing or electronically that information to the relevant state medical society within 30 days of the request; and
- (4) AMAP may service contracts with multi-state clients for AMAP-generated information when contracted physicians are located in that state, and shall communicate in writing or electronically that information to the relevant state medical society." (Res 817, A-98)

H-450.956 AMAP "No Involvement" Policy

Our AMA (1) reaffirm the intent of the AMAP to be a collaborative effort among Federation partners; and (2) will always give preference to qualified federation components as contractors for implementation of AMAP in any state. (Sub. Res. 825, I-97)

H-450.957 Activities of the American Medical Accreditation Program (AMAP)

The AMA Board of Trustees directs the AMAP Governing Body, appropriate Advisory Committees, and staff to fully and completely review all current efforts with the goal of improved communications and collaboration between AMAP and the Federation.

Our AMA urges medical staffs to use AMAP as source for information in their appointment, reappointment, and credentialing of medical staff members, and to encourage their members to become AMAP accredited.

The AMAP, working with the AMA OMSS will advise medical staffs of the benefits of AMAP accreditation to them and their medical staff members. (BOT Rep. 22, I-97)

H-450.959 American Medical Accreditation Program (AMAP)

(1) The AMA will continue implementation of the American Medical Accreditation Program (AMAP) with retention of the name and the five components of the program (credentials, personal qualifications, environment of care, clinical performance, and patient care results). (2) Through AMAP, the AMA will develop its own national physician credentialing criteria. (3) As AMAP development and implementation proceed, the AMA will continue to include Federation (county, state, and specialty medical societies) and related organizations in every phase, including: appointment to the Governing Body; defining roles for each Federation component on the Advisory Committees; and the formation of partnerships with appropriate Federation organizations in each of the five components of AMAP. (4) AMAP will maintain ongoing liaison, and where appropriate, will explore joint activities with other accreditation organizations such as the JCAHO, NCQA, Accreditation Association of Ambulatory Health Care, American Accreditation HealthCare Commission, COLA, et.al. (5) AMA policy will continue to be used in the development and implementation of AMAP standards and criteria, such as requirements for credentialing of physicians, continuing education, board certification, etc. (6) Participation by AMAP partnering organizations and by physicians will continue to be voluntary. (7) The AMA will continue to explore and clarify the role of medical staffs in AMAP. (BOT Rep. 20, I-96; BOT Rep. 39, A-97; Res. 710, A-97; Reaffirmed: BOT Rep. 2, I-97)

**27. BOARD OF TRUSTEES COMMENTS ON CLRPD REPORT 3-I-99:
"ADDING A PUBLIC MEMBER (NON-PHYSICIAN)
TO THE AMA BOARD OF TRUSTEES"**

HOUSE ACTION: FILED

Report 3-I-99 of the Council on Long Range Planning and Development was prepared in response to a request of the House of Delegates for an analysis of whether adding a public member to the Board of Trustees would be beneficial to the governance of the AMA. At its October meeting, the Board reviewed the Council's analysis and shared with the Council some aspects of this topic that the Board felt were not addressed in the Council's report. At that time, the Board indicated that it would share its comments with the House of Delegates to the extent that they are not reflected in the Council's report. This report is submitted to the House of Delegates for that purpose.

The Council's report recommends that the House of Delegates express the view that the concept of a public member on the Board has enough merit to warrant the development of an implementation plan for how this might be done, and ask the Council to develop such a plan. The concept and accompanying implementation plan would then be reviewed together by the House of Delegates at the 2000 Annual Meeting.

The Board recommends that the House of Delegates consider the following points as it considers CLRPD Report 3-I-99:

1. The comparison to corporate boards of directors, which constitutes a substantial part of the Council's analysis, is valid only up to a point, and even comparisons to other non-profit boards is somewhat limited. The AMA Board of Trustees has a number of unique characteristics, one of which is the very substantial time commitment that is required. Most corporate Boards meet quarterly (at the most) and only for a day or day and a half each time. The AMA Board's average meeting schedule of 36 days per year (exclusive of special assignments) would severely limit the number and kind of candidates who would consider service as a public member of the AMA Board.
2. The level of involvement by the AMA Board in the overall activity level of the AMA through management oversight is greater than for corporate boards. A substantial amount of involvement-based background on the AMA is necessary to participate in this oversight responsibility of the Board. It would be hard to find among "public member" candidates.
3. A considerable amount of the work of the Board requires a medical background, and more specifically clinical experience, for appropriate understanding and participation.
4. It is the Board's view that most individuals who serve on Boards do so based on some vested interest. While this is not bad per se, a "public member" may have vested interests or biases that are not grounded in medicine, and could be in conflict with the AMA's mission. This could present a considerable challenge in the selection process of a "public member."
5. The Board of Trustees is already quite diverse. The only common characteristic shared by all Board members is that they are physicians and AMA members.
6. The Council's report has a fiscal note of "no significant impact." This is clearly inaccurate. The travel and meeting costs alone would be substantial.

The Board is aware of the general popularity of the concept of "external" or "public" members on boards. However, the Board believes that a public member should not be considered simply as an abstract concept. What specific contribution can the AMA expect such a member to make to the work of the Board or the governance process of the AMA? The Board has considered this question, and does not find a compelling answer to it in the CLRPD report. In fact, a number of Board members serve on other Boards, either as part of their AMA responsibilities or as part of other professional activities, and the overall experience has been that public members generally have not added materially to the work of those bodies, and sometimes have constituted a diversion or negative factor. The Board does not believe that a sufficient conceptual or practical case has been made in support of the idea of a public member to warrant the substantial additional work of developing an implementation plan or the additional expense that such expansion of the Board would inevitably involve.

28. BOARD OF TRUSTEES COMMENTS ON "REPORT ON AMA BOARD OF TRUSTEES COMPENSATION," A REPORT OF THE HOD COMMITTEE ON TRUSTEE COMPENSATION

HOUSE ACTION: FILED

The AMA Board of Trustees appreciates the hard work of the HOD Committee on Trustee Compensation in the preparation of its report in response to Recommendation 13 of the Report of the Ad Hoc Committee on Structure, Governance, and Operation of the AMA. However, a fundamental misunderstanding exists regarding the HOD Committee's authority to "...determine the structure of compensation and to establish the amount of compensation for the Board of Trustees annually."

The Board has been advised by the AMA General Counsel as follows:

As an Illinois not-for-profit corporation, the AMA is subject to the Illinois General Not For Profit Corporation Act of 1986, as amended from time to time (the "Act"). Section 108.05(c) of the Act reads:

"Unless otherwise provided in the articles of incorporation or bylaws, the board of directors, by the affirmative vote of a majority of the directors then in office, shall have authority to establish reasonable compensation of all directors for services to the corporation as directors, officers or otherwise, notwithstanding the provisions of Section 108.60 of this Act."

Section 108.05(c) clearly indicates that a board of directors has the exclusive authority to set director compensation, unless this power is explicitly reserved to another body of the corporation in the corporation's articles of incorporation or bylaws. The cross-reference in Section 108.05 to Section 108.60 simply clarifies that a board of directors has the authority to set director compensation, notwithstanding the normal restriction on voting as to matters in which directors may have a conflict of interest.

Therefore, the law currently reserves authority to the AMA Board to establish appropriate compensation for AMA Officers and Trustees. Under these circumstances, the Board would be obliged to regard the report of the HOD Committee on Trustees Compensation as an advisory report rather than as a directive to the AMA Board.

Should the House of Delegates choose to amend the bylaws to alter the Board's authority in this area, the Board of Trustees would still have substantial concerns if two provisions of the HOD Committee's report would be carried forward as directives to the Board. The following provisions would limit the authority of the Chair to manage the representation responsibilities of the Board, and thus adversely affect Board performance on behalf of the AMA:

- the apparent limitation of Trustees to an average of 50 days in addition to the regularly scheduled meeting days for conducting AMA business and representation responsibilities; and
- the weekend compensation rate set at half the rate for weekday work.

It should be recognized that the Board Chair is responsible for delegating representation assignments to individual Board members. In doing so, the Board Chair considers the 1) functions required for a specific assignment, 2) special qualifications of the individual Trustee, 3) needs and expectations of the organization making the request, and 4) availability of the individual Trustee. In carrying out these responsibilities, the Board Chair needs flexibility in making assignments. It should be noted that the vast majority of assignments are in response to requests for a specific Officer or Trustee. Some assignments, such as JCAHO, would essentially prevent an Officer/Trustee from serving on any other representation functions, if a fifty day limit were imposed. The AMA Board strongly believes that if such an average is imposed, this should be a target rather than an absolute limit. Otherwise, the Board Chair will be substantially hampered in assigning the "right Trustee" to the "right assignment" at the "right time."

In most compensation formulas, weekends are recompensed at equal if not higher rates. Indeed, Board members who are in active practice often can incur higher costs to cover practice arrangements over weekends than they incur for weekdays. Trustees must pay a premium for weekend work arrangements--either in time when they cover the practice for partners or associates, or in money to reimburse a colleague to substitute for them while they are away on AMA business. Therefore, imposing an arbitrary half rate for weekends is unreasonable.

Having stated the above, the Board believes that the HOD Committee report is a good report in addressing other key issues of Board compensation and representation. The Board agrees with many of the findings and conclusions in the report and has addressed a number of the same issues in recent years. The Board already has taken steps to redistribute its workload and has made special provisions, including expanded training, to enhance the effectiveness and efficiency of Board members in carrying out their responsibilities. Furthermore, in keeping with the "Governance Report" recommendations, the Board recognizes that the President, President-Elect, Immediate Past President, and the Board Chair are the primary spokespersons for the AMA, and they already receive the majority of assignments consistent with that role.