# AMA's Apology Is a First Step, but More Is Needed

BY MARY ELLEN SCHNEIDER
*New York Bureau*

African American physicians are looking for action to back up the words of apology recently tendered by the American Medical Association for more than a century of racial inequity and bias.

In accepting the AMA's apology, the National Medical Association (NMA), which represents minority physicians, urged the AMA leadership to work with them on three initiatives: recruiting more African American physicians, reducing health disparities among minorities, and requiring medical schools and licensing boards to make cultural competency mandatory for medical students, residents, and practicing physicians.

"We really want to use this apology as a springboard," said Dr. Nedra H. Joyner, chair of the NMA board of trustees and an otolaryngologist in Chicago. "Talk is cheap," said Dr. Carl Bell, professor of public health and psychiatry at the University of Illinois at Chicago. He said that while he is hopeful that the AMA will take some meaningful action to reduce health disparities, he is unimpressed by the apology alone. Instead, he would like the AMA take a stand on issues that would advance minority health in the United States. For example, he said that he wants to see the AMA push for single-payer national health insurance, be stronger in challenging the pharmaceutical industry, do a better job of promoting public health, and support research into minority health and mental health issues.

Dr. Warren A. Jones, the first African American president of the American Academy of Family Physicians, agreed that further action will be needed but called the AMA's apology "appropriate" and "timely." This is not an apology of convenience, he said, but a signal of a change in the mind-set of the AMA leadership.

The AMA has an opportunity to ensure that cultural competency is a tool in the medical armamentarium in the same way as the stethoscope, he said. "Now is the time for the AMA to put its resources where its mouth is," said Dr. Jones, executive director of the Mississippi Institute for Improvement of Geographic Minority Health.

**The AMA's apology is not an act of convenience but rather the signal of a change in attitude.**

**DR. JONES**

The AMA offered the apology to coincide with the release of a historic paper in its flagship journal that examined race relations in organized medicine (JAMA 2008;300:306-13). The paper, which chronicles the origins of the racial divide in AMA history, was prepared by an independent panel of experts convened by the AMA in 2005. The panel reviewed archives of the AMA, the NMA, and newspapers from the time to provide a history from the founding of the AMA through the civil rights movement.

The paper notes a number of instances where the AMA leadership fostered racial segregation and bias. For example, in 1874 the AMA began restricting delegations to the organization's national convention to state and local medical societies. This move effectively excluded most African American physicians because many medical societies, especially those in the South, openly refused membership to them. Later, in the 1960s, the AMA rejected the idea of excluding medical societies with discriminatory practices.

During the civil rights era, the AMA was seen as obstructing the civil rights agenda, the paper noted. In 1961, the AMA refused to defend eight African American physicians who were arrested after asking to be served at a medical society luncheon in Atlanta.

In its review, the independent panel applauded AMA for its willingness to explore its history. But the researchers also noted that the legacy of inequality continues to negatively affect African American physicians and patients. For example, in 2006, African Americans made up 2.2% of physicians and medical students, less than in 1910, when 2.5% were African American.

In a commentary to accompany the history, Dr. Ronald M. Davis, immediate past president of the AMA, acknowledged the "stain left by a legacy of discrimination" and outlined what AMA is doing to eliminate prejudice within the organization and improve the health of minority patients (JAMA 2008;300:323-5).

Dr. Davis said that the AMA leadership felt it was important to offer the apology because it demonstrates the "current moral orientation of the organization" and lays down a marker to compare current and future actions.

Within the organization, AMA has in place a number of policies that explicitly prohibit discrimination in membership and support funding for "pipeline" programs to engage minority individuals to enter medical school. In addition, in 2004, the AMA joined the NMA and the National Hispanic Medical Association to form the Commission to End Health Care Disparities. That group has been working to expand the "Doctors Back to School" program, which brings minority physicians into schools to encourage students to consider careers in medicine.

The ultimate goal is to have as much diversity among physicians as in the general population, where African Americans make up about 12% of the U.S. population, Dr. Davis said. "Obviously, we have a long way to go." ■

# CMS Adds to Its List of Events Medicare Won't Cover

BY MARY ELLEN SCHNEIDER
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Starting Oct. 1, Medicare won't pay for a total of 11 preventable conditions acquired during a hospital stay, up from the current 8 such conditions.

Added to the list of noncovered preventable conditions are surgical site infections following certain elective procedures, such as orthopedic surgeries and bariatric surgery for obesity; manifestations of poor glycemic control; deep vein thrombosis or pulmonary embolism following certain orthopedic surgeries, such as total knee replacement and hip replacement. (See box for current list of preventable conditions.)

The new conditions were included in the Acute Care Hospital Inpatient Prospective Payment final rule, which is slated to be published in the Federal Register on Aug. 19 and released earlier on the Centers for Medicare and Medicaid Services' Web site.

The expansion of the preventable conditions list was criticized by the American Medical Association for putting patient care at risk. The AMA said that Medicare officials are lumping together true "never" events such as wrong-site surgery with "often unavoidable" conditions such as surgical site infections.

"Focusing on determining whether or not medical conditions exist when the patient enters the hospital will increase Medicare spending on tests and screenings with questionable benefit to patients," Dr. J. James Rohack, AMA president-elect, said in a statement. "A more effective patient safety approach would be to encourage compliance with evidence-based guidelines by health care professionals."

Officials at CMS estimate that the nonpayment for preventable errors policy will save Medicare about $20 million a year. However, the policy is not about saving money, Kerry Weems, CMS acting administrator, said during a press conference.

"I would be perfectly happy if we never came to a point where we didn't have to pay because somebody got a hospital-acquired condition," Mr. Weems said. "This is about changing hospitals and making them safer places."

CMS had proposed adding nine new conditions to the preventable conditions nonpayment list. Agency officials pared down the list after public comments raised questioned about including the other conditions. Some conditions that were not included in the final rule are delirium, ventilator-associated pneumonia, *Staphylococcus aureus* septicemia, *Clostridium difficile*–associated disease, legionnaires' disease, and iatrogenic pneumothorax.

However, those conditions may appear in future proposals once the agency has refined them, according to Mr. Weems.

The CMS also is in talks with the National Quality Forum, the Agency for Healthcare Research and Quality, the Leapfrog Group for Patient Safety, and others about expanding the list of never events and considering how to expand the nonpayment policy to nonhospital settings such as nursing homes and home health agencies.

In addition to the expansion of the conditions on the preventable hospital-acquired conditions list, CMS is also beginning to develop three National Coverage Determinations to deny Medicare coverage for three never events—surgery on the wrong body part, surgery on the wrong patient, and wrong surgery performed on a patient. "These national coverage decisions will mandate what seems obvious—never events should never occur," Mr. Weems said. "They should not be reimbursed by the Medicare trust fund."

A proposed decision memorandum on these surgical errors is scheduled to be issued by next February and is expected to be made final by the end of next April.

Including these events in Medicare's coverage policy also would apply to Medicare Advantage plans. Medicare Advantage plans are required to follow all Medicare fee-for-service coverage policies, even when those policies differ from their commercial practices, according to the CMS.

The CMS also sent a letter to state Medicaid directors to encourage states to adopt similar policies on payment for preventable hospital-acquired conditions. The letter also provides information on how states can adopt the policies outlined in the final Medicare inpatient prospective payment system regulation. Nearly 20 states are considering methods to eliminate payment for certain never events, or already have them in place, according to the CMS.

Finally, as part of the Acute Care Inpatient Prospective Payment System final rule, the CMS is adding 13 new measures to the Reporting Hospital Quality Data for Annual Payment Update program. Under the program, hospitals are required to report quality data publicly on the Medicare Hospital Compare Web site in order to receive their full payment update. ■

## 'Never Events' Number 8 for Now

Medicare currently lists eight preventable health care–acquired conditions under its nonpayment policy and will not reimburse hospitals for secondary diagnoses associated with the following eight conditions if acquired after hospital admission:

- ► Foreign object retained after surgery.
- ► Air embolism.
- ► Blood incompatibility.
- ► Pressure ulcer at stages III and IV.
- ► Falls and trauma.
- ► Catheter-associated urinary tract infection.
- ► Vascular catheter–associated infection.
- ► Mediastinitis after coronary artery bypass graft.