AMA Delegates Lend Hand to Drug Importation

Wholesalers, pharmacies may import FDA-approved drugs, delegates say.

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

ATLANTA — Delegates to the American Medical Association's 2004 interim meeting made a bold move to support prescription drug importation by wholesalers and pharmacies, provided that certain conditions were met to ensure patient safety.

"Prescription drugs should be available at the lowest price possible, and we must ensure quality and safety," AMA Trustee Edward Langston, M.D., said at a press briefing following the vote.

The policy approved by the House of Delegates states that the drugs must be approved by the Food and Drug Administration and must be subject to reliable "track and trace" technology and a closed distribution chain. The policy was swiftly approved by the house after much discussion in committee.

The AMA also reaffirmed that it does not support personal importation of prescription drugs via the Internet until patient safety can be assured.

The policy urges the AMA to educate members regarding the risks and benefits associated with reimportation efforts.

"We're certainly gratified the AMA emphasized the need for safety" in its new policy, Jeff Trewhitt, spokesman for the Pharmaceutical Research and Manufacturers Association, told this newspaper. PhRMA, however, "remains convinced that importation is too riddled with problems to pursue."

The AMA's position on patient safety and reimportation could change once it reviews a forthcoming report from a task force of the Department of Health and Human Services, the policy said.

The issue is certain to come up in the House of Delegates again. In committee debate, Erich Garland, M.D., AMA delegate from the American Academy of Neurology, asked that the AMA look further into the cost discrepancy between Canada and other countries. Recently, "I was surprised to find that large insurance companies were reimbursing patients for medicines they got in other countries," Dr. Garland said. "We shouldn't need to reimport medicine."

Delegates backed another controversial issue—specialty hospitals—when they approved a board report encouraging competition among health facilities as a means of promoting high quality, cost-effective care. The report also opposed efforts to extend a federal 18-month moratorium on physician referrals to specialty hospitals in which they have an ownership interest.

Delegates approved several measures designed to address the influenza vaccine shortage, asking that physicians be allowed to form purchasing alliances for competitive purchasing of the vaccine comparable with large purchasers supplying pharmacy and grocery chain stores.

Language to study mechanisms to help the uninsured was also approved. Delegates in one instance broadened the scope of a board report, stipulating that federal legislation to authorize and fund state-based demonstration projects should include—but not be limited to—implementing income-related, refundable, and affordable tax credits.

In other actions, delegates voted to:

► Seek the replacement of the Medicare payment formula's sustainable growth rate with payment updates that reflect increases in the cost of medical practice.

► Pursue caps on noneconomic damages as a top priority in medical liability reform, with a request to the board of trustees to report efforts to reform the civil justice system, as part of its coalition-building activities.

► Support federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted pregnancies and sexually transmitted diseases, and that also teach about contraception and safer sex.

► Create model state legislation for physicians who testify in medical liability cases, emphasizing that they must meet statutory expert witness requirements, such as comparable education, training, and occupational experience in the same field as the defendant.

"Junk science has no place in the courtroom," said Donald Palmisano, M.D., AMA's immediate past president.

The stance on prescription drug importation and specialty hospitals provided the House of Delegates the opportunity to flex its political muscle at a time when the AMA is struggling with its identity and appeal to younger physicians.

Delegates heard the evidence for themselves in video clips of young participants in focus groups, and in new survey data, where only 11% of 800 physicians identified the AMA as a leadership body to which they could relate.

"Physicians simply aren't clear about who we are and what we do," Michael Maves, M.D., the AMA's executive vice president, said during the meeting's opening session.

In addition, "the AMA is not getting credit from physicians for the advocacy work it does," said Ajay Gupta, a principal at McKinsey & Co., a management consulting firm that conducted the survey and the focus groups.

The survey reaffirmed a longtime trend that physicians prefer their specialty or state society to a broader umbrella organization. Only 19% of the survey participants thought the AMA increased opportunities for their voices to be heard on important issues, as opposed to specialty groups (49%) and state groups (30%). In comparing current member penetration, the AMA "was fifth in the wallet behind specialty, state, and county societies," Mr. Gupta said.

Lack of confidence in the AMA has manifested in declining membership rolls. The percentage of nonrenewals in AMA membership has doubled from 10% to 20% over the last decade, with young, active physicians accounting for most of the decline. "That amounts to 430,000 physicians who are no longer members," Mr. Gupta said.

AMA could conceivably boost its membership by focusing on medical society activists and "positive" society supporters, two groups of physicians that embrace the idea of society medicine, Mr. Gupta suggested. About 290,000 physicians represent these "joiner" segments, though most are mature physicians, not young ones, he said.

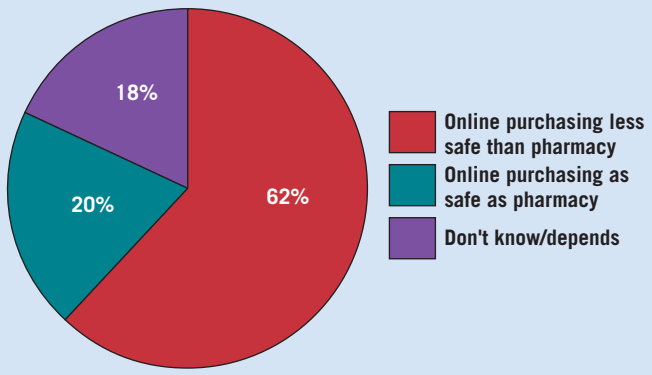
"Joiners" have "a remarkably uniform view of what they want us to deliver: focused advocacy on priority issues, opportunities for involvement, and communications about progress and results," Dr. Maves said.

Targeting residents should be a key strategy, said Brooke Bible, the medical student representative to the AMA's political action committee. While the AMA enjoys an excellent student constituency, "the residency period—where people get tired, jaded, or busy—is where we lose members."

The campaign begins in 2005, using surveys, town meetings, and other grassroots activities to connect with physicians, Gary Epstein, the AMA's new chief marketing officer, said in an interview. Patients in particular have always supported the AMA's charge, "and we need to leverage that" as a resource, he said. ■

VITAL SIGNS

Most Americans Do Not Trust Online Prescription Drug Market



Note: Based on a survey of 2,200 adults conducted May 14 to June 17, 2004.
Sources: Pew Internet & American Life Project, Princeton Survey Research Associates

KEVIN FOLEY, RESEARCH

Experts Advocate Tort Reforms That Go Beyond Damage Caps

BY MARY ELLEN SCHNEIDER
Senior Writer

ALEXANDRIA, VA. — Traditional tort reform measures like damage caps won't address some of the fundamental problems with the medical liability system, experts said at a meeting on patient safety and medical liability sponsored by the Joint Commission on Accreditation of Healthcare Organizations.

To deal with the current malpractice situation, the medical community needs to address the reasons why people sue—injuries, unmet expenses, and anger, said Lucian L. Leape, M.D., of the department of health policy and management at the Harvard School of Public Health, Boston.

"The main reason most people sue is because they are angry at the physician," Dr. Leape said. But the current system and the most commonly proposed reforms, such as damage caps, don't address the need to increase disclosure of errors to patients or incentivize physicians to offer apologies.

In the current tort system, filing a lawsuit is often the only way that patients feel they can get information about what happened to them or impose a penalty on the physician, said Michelle Mello, Ph.D., also of the department of health policy and management at the Harvard School of Public Health. But this process often fails to secure an admission of responsibility or an apology, she said.

Traditional reforms such as caps would undercompensate seriously injured patients and increase administrative costs, Dr. Mello said. But they would not help deter medical malpractice, she said.

Damage caps also fail to address the poor correlation between medical injury and malpractice claims, she said. Instead of focusing on caps, the medical community needs to consider an administrative compensation system to replace torts.

The malpractice system is "blocking efforts at patient safety," said Troyen A. Brennan, M.D., professor of medicine at Harvard Medical School, Boston, and professor of law and public health at the Harvard School of Public Health.

A new system should separate compensation for injuries from deterrence, he said. To do that, liability for negligence has to be eliminated, and reporting has to be made based on patient injury.

Physicians have to realize that reporting patient injury is part of their professional responsibility. Currently, some physicians do not disclose errors or injuries. It's a rational economic response to their rising premiums and fear of being sued, he said, but it's not an ethical response. ■