AMA Backs Direct Insurance

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that any catastrophic insurance cover mental illness in the same way it covers other medical conditions, he added.

When asked about the implications of the AMA's new stance for psychiatry, Dr. Rodrigo A. Muñoz said he thinks psychiatrists are divided on the insurance issue.

"A growing group [of psychiatrists] advocates direct insurance. We have submitted proposals for medical savings accounts in several places, starting 20 years ago," said Dr. Muñoz, a psychiatrist who attended the AMA meeting as a delegate for the APA. "Others believe that the poor would be left behind if federal programs do not exist."

Dr. Muñoz, a former APA president and a professor of psychiatry at the University of California, San Diego, said he plans to submit a symposium on this theme at the next annual APA meeting.

Dr. Edward L. Langston, a member of the AMA Board of Trustees, hailed the AMA's move during a press conference at the meeting. "We've taken a bold shift here, and we want to help lead this discussion because we want to have comprehensive reform," Dr. Langston said.

The recommendation would cover only a fraction of the more than 40 million uninsured Americans. About 11% of the uninsured had incomes that were more than 500% of the federal poverty level in 2004, according to an analysis by the Department of Health and Human Services. But the delegates' action gives AMA officials another tool with which to lobby for expanding the number of people with health coverage, said AMA Board of Trustees member Dr. Ardis D. Hoven.

In other issues, many physicians at the House of Delegates meeting expressed both dissatisfaction with the store-based health clinics that have sprung up in retail stores and pharmacies across the country and resignation that these clinics are here to stay.

In an effort to deal with that new reality, AMA delegates established principles for operating store-based health clinics, which include limiting their scope of practice, using standardized medical protocols from evidence-based guidelines, and informing patients in advance of the qualifications of those providing their care. In addition, the delegates called on the management of store-based health clinics to establish arrangements for their care providers to have direct access to and supervision by allopathic and osteopathic physicians, as consistent with state laws.

Clinic providers also should encourage patients to establish care with a primary care physician, the new AMA policy said.

Dr. Larry Fields, president of the American Academy of Family Physicians, said the AMA guidelines are consistent with the principles for store-based health clinics developed by his organization and are necessary to ensure patient safety and to control the scope of these clinics.

In the area of direct-to-consumer advertising, AMA delegates voted in favor of placing a moratorium on DTC advertising for newly approved prescription drugs and medical devices until physicians have become educated about the new products. Under the AMA policy, the length of the moratorium would be determined on a product-by-product basis by the FDA in consultation with the drug or device sponsor.

The guidelines are a response to the frustration that many physicians feel when patients ask for specific drugs or devices that they have seen advertised, which may not be appropriate for them, said Dr. Ronald M. Davis, an AMA Board of Trustees member, during a press conference.

The policy also recommends that product-specific DTC ads should not use actors to portray health care providers who are promoting drug or device products, because this portrayal may be misleading and deceptive. If an actor is used to portray a health care provider, a disclaimer should be prominently displayed.

The AMA also voted to discourage active and retired physicians from participating in advertising that endorses a particular drug or device product. If physicians do choose to participate in an ad, there should be a clear disclaimer that they are being paid for their endorsement, according to the new AMA policy.

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"We want to help lead this discussion," said Dr. Edward L. Langston, a member of the AMA Board of Trustees.

Last year, the Pharmaceutical Research and Manufacturers of America (PhRMA) issued voluntary "Guiding Principles" on DTC advertising that called on drug companies to spend time educating health care professionals before beginning a new DTC campaign. Under the PhRMA policy, the length of time that should be spent in this educational effort should vary from product to product.

"While there are subtle differences between our guiding principles and the AMA's report, both emphasize the critical need to educate physicians and other health care providers about a new medicine before it is advertised to the public," Dr. Paul Antony, PhRMA's Chief Medical Officer, said in a statement.

In other news from the AMA House of Delegates:

▶ **Interrogations and immigration.** The delegates touched on the role of mental health professionals and other physicians in military interrogations and in providing care for illegal immigrants.

The House of Delegates adopted a set of ethical guidelines aimed at limiting physician participation in interrogation of prisoners and detainees. Under the new guidelines, physicians must not conduct or directly participate in interrogations because it undermines the role of the physician as a healer. The prohibition on direct participation includes monitoring with the intention of intervening, under guidance from the AMA. However, the guidelines spell out a role for physicians to help develop interrogation strategies that are not coercive. Dr. Priscilla Ray, chair of the AMA Council on Ethical and Judicial Affairs, which developed the proposal, said at a press conference that physicians can work with the military on strategies such as rapport building.

On the issue of caring for illegal immigrants, delegates voted to have AMA leadership ask that when federal agencies such as the U.S. Department of Homeland Security or U.S. Customs and Border Protection have custody of an undocumented foreign national, that they assume the cost of that person's health care instead of passing it on to the physician or hospital.

▶ **Obtaining organs.** The delegates approved a policy that allows for public solicitation of organs from living donors as long as it adds to the overall number of available organs and does not disadvantage others who are waiting for a transplant. This type of directed donation is acceptable as long as donors do not receive payment beyond reimbursement for travel, lodging, lost wages, and medical care associated with the donation, the new policy says.

▶ **Emphasizing electronic records.** Delegates voted for the AMA to support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records and instructed AMA officials to get involved in efforts to define and promote standards for the interoperability of health information technology systems. But the delegates also established as AMA policy that physicians should not be required to adopt electronic medical records by either public or private payers.

▶ **Meddling in medicine.** AMA delegates voiced their opposition to the "interference of government in the practice of medicine" through the use of government-mandated recitations to patients.

The issue was raised in response to pending federal legislation, the Unborn Child Pain Awareness Act of 2005 (S. 51), which proposes that physicians read a mandatory script to all women who seek abortions at more than 20-week gestation. ■

Defensive Medicine Consumes 10% of Premium Dollars

BY JOYCE FRIEDEN
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WASHINGTON — The costs of malpractice insurance and defensive medicine account for about 10 cents of every dollar spent on health care premiums, several speakers said at a press briefing sponsored by America's Health Insurance Plans.

Medical liability and defensive medicine represented the "lion's share" of cost increases in the physician and outpatient areas, Michael Thompson, principal at the New York office of PricewaterhouseCoopers, said at the briefing.

Litigation and defensive medicine also accounted for about a third of the costs associated with poor-quality health care, said Mr. Thompson, noting that the cost of poor-quality care was spread throughout the health care system.

According to AHIP President Karen Ignagni, efforts must be made to reduce the amount of poor-quality care being given. "We have a system where 45% of what's being done is not best practice," she said. "No public or private entity could operate at that rate."

Overall, the rate of increase in health care premiums was 8.8% in 2004-2005, down significantly from 13.7% in 2001-2002, noted Jack Rodgers, managing director at PricewaterhouseCoopers. One factor contributing to the slowdown was a decrease in the rate of cost increases for prescription drugs, according to Mr. Thompson. "It's now trending in line with overall premiums," he said.

Part of the reason for that decrease is employers' increasing use of three-tiered or four-tiered drug programs, in which patients pay a larger share for brand-name drugs, especially if there are generic equivalents. In 2000, only 27% of patients were in drug plans with three or more tiers; in 2004, the figure was 68%, he said. In addition, cost trends were helped by a drop in the number of state mandates that are being added each year, from 80 in 2000 to less than 40 in 2004, Mr. Thompson said.

Despite these problems, Mr. Thompson said in an interview that he did not expect premium increases to go higher next year. "We're looking at the same number or maybe a little lower," he predicted.

Part of the stabilization will likely be tied to consumers having to pay more for their health care costs and becoming more aware of prices as a result, Mr. Thompson added. ■