Continued from previous page

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, AAFP president, 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.

Last year, the Pharmaceutical Research and Manufacturers of America (PhRMA) issued voluntary "Guiding Principles" on DTC advertising that call 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:

► **Scaling back on salt.** In a series of actions, the AMA delegates voted to urge the FDA to revoke the "generally recognized as safe" status of salt, allowing the agency to develop limits on sodium in processed food and restaurant items.

The AMA called for at least a 50% reduction in the amount of sodium in processed foods, fast food products, and restaurant meals over the next decade. The delegates also instructed the AMA leadership to work with the FDA to improve labeling of foods and meals so consumers can better understand the amount of sodium they consume. Patients are often unaware of how much sodium is in their diet, cardiologist J. James Rohack, an AMA Board of Trustees member, said during a press conference. Patients with hypertension will often say they don't add salt to food, but they don't realize the high sodium content of processed meats, Dr. Rohack said.

► **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, according to the new policy.

► **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 brought up 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 weeks' gestation.

► **Interrogations and immigration**. The delegates also touched on the role of physicians in military interrogations and in providing care for illegal immigrants.

The House of Delegates adopted a set of ethical guidelines to limit 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 the AMA guidance.

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 during a press conference that physicians can work with the military on strategies such as rapport building.

On 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. The delegates asked AMA leaders to encourage public policy solutions on illegal immigration that take into consideration the financial impact of uncompensated care provided by hospitals, as well as by physicians, Medicare, and Medicaid. ■

Systems Issues Contribute to Malpractice Claims, Risk Management Executive Says

BY MARY ELLEN SCHNEIDER
Senior Writer

PHILADELPHIA — There are just as many systems failures at the root of malpractice cases as individual errors or negligence, Dr. Luke Sato said at the annual meeting of the American College of Physicians.

For example, the Risk Management Foundation of the Harvard Medical Institutes Inc., the insurance carrier for 18 hospitals and about 10,000 physicians in the Massachusetts area, has spent nearly the same amount of money over the years on malpractice cases involving clinical support processes as on cases resulting from a problem with the patient-clinician interaction.

Physicians are leaving themselves open to malpractice claims if they don't have proper systems for follow-up of abnormal test and lab results and other issues.

"What we see is that this is a process reengineering problem," said Dr. Sato, assistant professor of medicine at Harvard University and chief medical officer and vice president of the Risk Management Foundation.

An analysis of 2,270 malpractice cases within the insurance carrier from September 1995 to August 2005 shows that there are four high-risk categories in their system—obstetrics, surgery, medication-related problems, and diagnosis-related problems.

The diagnosis-related cases are the most prevalent and the most expensive, Dr. Sato said. Those claims usually involve some type of delayed diagnosis, failure in diagnosis, or missed diagnosis, he said.

Dr. Sato advised physicians to take a look at their office processes and set up ways within the practice to gather and document information that is critical to both the continuity of care and to avoiding malpractice claims. For example, a large portion of diagnosis-related claims in the Harvard system were traced to inadequate documentation of areas such as family history, allergy status, and medication lists.

Physicians are also leaving themselves open to malpractice claims if they don't have proper systems for follow-up of abnormal test and lab results and other issues. Referral management is another key area to focus on, Dr. Sato said.

Officials at Harvard's Risk Management Foundation have developed a best practice manual that includes examples from across the system. One best practice was developed for following up on abnormal test results: The physician schedules a telephone appointment with a patient 1 week after a potentially concerning test. This forces the provider to find and review the results prior to the call, ensures that there will be some type of patient-physician discussion, and makes it easier to add the documentation directly into the medical record, Dr. Sato said. ■

Examples of best practices from the system are available online in the "office practices" portion of the Risk Management Foundation's Web site: www.rmf.harvard.edu.

INDEX OF ADVERTISERS

3M Pharmaceuticals
Aldara 17-18

American Cancer Society
Colon Cancer Screening 8

Berlex, Inc.
YAZ 3-6

Cytyc Corporation
ThinPrep 41

Digene Corporation
DNAwithPAP 7

Duramed Pharmaceuticals, Inc. (a subsidiary of Barr Pharmaceuticals)
Mircette 14a-14b
Enjuvia 22a-22d
Seasonale 43-44

GlaxoSmithKline
Zofran 27-28

LaserScope
Gemini Laser System 24

McNeil-PPC, Inc
Monistat 25
K-Y 29

Merck & Co., Inc.
Corporate 10-11
Gardasil 30a-30b

Novo Nordisk, Inc.
Vagifem 13-14

NTD Laboratories, Inc.
Ultra-Screen 26

Organon USA Inc.
NuvaRing 21-22

P&G
Fibersure 12

Sepracor Inc.
Lunesta 36a-36b

Wyeth Consumer Healthcare
Caltrate 8a-8b
Corporate 19

Wyeth Pharmaceuticals Inc.
PREMARIN 39-40