

SUBJECT: H200-A/14 HEALTH CARE SHORTAGE IN RURAL AMERICA

SUBMITTED BY: Bureau of Education

REFERRED TO: Committee on Educational Affairs

1 RESOLVED, that the Bureau of Education recommend that the following policy be
2 REAFFIRMED:

3 **H200-A/14 HEALTH CARE SHORTAGE IN RURAL AMERICA**

4 The American Osteopathic Association encourages the development of teaching centers in
5 rural Federally Qualified Health Centers **AND OTHER ELIGIBLE ENTITIES**, so that
6 residents can train and stay in these areas and practice osteopathic medicine. 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H201-A/14 GRADUATE MEDICAL EDUCATION – INCREASING OPPORTUNITIES

SUBMITTED BY: Bureau of Education

REFERRED TO: Committee on Educational Affairs

1 RESOLVED, that the Bureau of Education recommend that the following policy be
2 REAFFIRMED:

3 **H201-A/14 GRADUATE MEDICAL EDUCATION – INCREASING**
4 **OPPORTUNITIES**

5 The American Osteopathic Association supports the efforts to increase the number of graduate
6 medical education training positions available to United States medical graduates. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H203-A/14 OSTEOPATHIC MEDICAL EDUCATION

SUBMITTED BY: Bureau of Education

REFERRED TO: Committee on Educational Affairs

1 RESOLVED, that the Bureau of Education recommend that the following policy be
2 REAFFIRMED:

3 **H203-A/14 OSTEOPATHIC MEDICAL EDUCATION**

4 The American Osteopathic Association will establish a mechanism by which input can be
5 contributed from interested stakeholders if a plan is formulated to pilot or implement concepts
6 identified within the blue ribbon commission report. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H205-A/14 ASSURE GME RESIDENCY POSITIONS TO
GRADUATES OF U.S. MEDICAL SCHOOLS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Educational Affairs

1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED:

3 **H205-A/14 ASSURE GME RESIDENCY POSITIONS TO GRADUATES OF U.S.**
4 **MEDICAL SCHOOLS**

5 The American Osteopathic Association will work with COCA, AACOM, AMA, ACGME,
6 AAMC and LCME to advocate for Federal Legislation that will offer GME positions first to
7 DO or MD graduates of U.S. COCA OR LCME accredited medical schools. 2014

ACTION TAKEN **APPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: H208-A/14 UNIFORMED SERVICES PHYSICIANS REQUIRING
AND ASSIGNED TO CIVILIAN RESIDENCY PROGRAMS – AOA
SUPPORT OF ALL OSTEOPATHICALLY TRAINED

SUBMITTED BY: Bureau of Education

REFERRED TO: Committee on Educational Affairs

1 RESOLVED, that the Bureau of Education recommend that the following policy be
2 REAFFIRMED:

3 **H208-A/14 UNIFORMED SERVICES PHYSICIANS REQUIRING AND**
4 **ASSIGNED TO CIVILIAN RESIDENCY PROGRAMS – AOA**
5 **SUPPORT OF ALL OSTEOPATHICALLY TRAINED**

6 The American Osteopathic Association will continue to monitor, assist and support all
7 osteopathic physicians who receive graduate medical education (GME) through the uniformed
8 services process, removing barriers to osteopathic graduate medical education approval. 1998;
9 revised 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H207-A14 GRADUATES OF LCME-ACCREDITED COLLEGES OF
MEDICINE - ADMISSION TO OSTEOPATHIC RESIDENCY
PROGRAMS

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Education

1 RESOLVED, that the Bureau of Education recommend that the following policy be SUNSET:
2 **H207-A14 GRADUATES OF LCME-ACCREDITED COLLEGES OF MEDICINE**
3 **- ADMISSION TO OSTEOPATHIC RESIDENCY PROGRAMS**
4 The American Osteopathic Association (AOA) allows each AOA Specialty College and AOA
5 Specialty Board to consider the Liaison Committee on Medical Education (LCME) graduates
6 participation in AOA residency training and become eligible to take that AOA residency's
7 corresponding certifying AOA board with corresponding AOA membership. The AOA will
8 assure that the revised residency standards allowing LCME graduates to participate in AOA
9 residency training maintain osteopathic culture and osteopathic autonomy. The AOA will
10 develop common program requirements between equivalent AOA and ACGME residency
11 programs and establish limited pilot programs allowing matriculation of a limited number of
12 LCME graduates into AOA residency programs. The AOA will develop basic Osteopathic
13 Manipulative Treatment, OMM, and OPP requirements for LCME graduates to participate in
14 AOA residency training, and that each AOA Specialty College, with input from the American
15 Academy of Osteopathy (AAO), develop any further OMT, OMM, OPP requirements it deems
16 necessary for the LCME graduates to participate in AOA residency training. 2014.

Explanatory Statement:

As of the 2020 match, no trainees will be entering AOA accredited GME programs.

ACTION TAKEN **APPROVED** *(for sunset)* _____

DATE **July 27, 2019** _____

SUBJECT: H209-A14 CLINICAL ROTATIONS FOR INTERNATIONAL
MEDICAL STUDENTS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Education

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be REAFFIRMED as AMENDED:

3 **H207-A14 ASSURE CLINICAL ROTATIONS FOR INTERNATIONAL US-**
4 **EDUCATED MEDICAL STUDENTS**

5 Policy of the American Osteopathic Association supports adequate quality rotations for
6 medical students as they pursue clinical education; and, in concert with other healthcare
7 organizations, the federal, state and local governments, will OPPOSE ~~continue to monitor,~~
8 ~~correct and work to prevent any future~~ policies that provide an unfair advantage to
9 ~~international~~ **INTERNATIONALLY-EDUCATED** medical students. 2009; reaffirmed
10 2014.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019** _____

SUBJECT: H210-A14 INHALATION OF VOLATILE SUBSTANCES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Education

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H210-A14 INHALATION OF VOLATILE SUBSTANCES**

4 The American Osteopathic Association endorses continuing medical education and medical
5 literature to enhance physician awareness of inhalation of volatile substances (huffing) and
6 endorses campaigns to enhance public awareness of this crisis. 2009; reaffirmed 2014.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H211-A14 INTEGRITY AND MISSION OF COMs UHSC GRANTING
THE DO -- MAINTAINING THE

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Education

1 RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy
2 be REAFFIRMED:

3 **H211-A14 INTEGRITY AND MISSION OF COMs UHSC GRANTING THE DO**
4 **-- MAINTAINING THE**

5 The American Osteopathic Association upholds and supports maintaining the integrity and
6 mission of Colleges of Osteopathic Medicine and University Health Science Centers granting
7 the Doctor of Osteopathic Medicine degree. 2009; reaffirmed 2014

Reference Committee Explanatory Statement:

The Reference Committee heard testimony to amend this resolution to add an emphasis on increasing the number of primary care physicians, but determined this suggestion was too limiting to other specialties.

ACTION TAKEN **APPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: H212-A14 PSYCHIATRY CURRICULUM AND STAFFING

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Education

1 RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy
2 be REAFFIRMED:

3 **H212-A14 PSYCHIATRY CURRICULUM AND STAFFING**

4 The American Osteopathic Association supports the use of members of the American College
5 of Osteopathic Neurology and Psychiatry and their commitment to serve as a resource for
6 developing core competencies and learning objectives for osteopathic psychiatry both in
7 undergraduate and graduate medical education. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H213-A14 TEENAGE ALCOHOL ABUSE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Education

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H213-A14 TEENAGE ALCOHOL ABUSE**

4 The American Osteopathic Association endorses continuing medical education for health care
5 professionals to aid them in educating lower and middle school students of the dangers of
6 alcohol and endorses outreach programs to elementary “lower” and middle schools to create
7 awareness of the dangers of alcohol. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H214-A14 MANDATORY CME COURSE REQUIREMENTS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Education

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be REAFFIRMED as AMENDED:

3 **H214-A14 MANDATORY CME COURSE REQUIREMENTS**

4 The American Osteopathic Association opposes any federal attempts to impose any specific
5 continuing medical education (CME) course requirements and will assist any ~~component~~
6 AFFILIATE societies in opposing additional ATTEMPTS BY STATES TO IMPOSE specific
7 CME course requirements. 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H217-A/14 COMMUNITY-BASED TEACHING HEALTH CENTERS
RESIDENCY SUPPORT

SUBMITTED BY: Bureau of Education

REFERRED TO: Committee on Educational Affairs

1 RESOLVED, that the Bureau of Education recommend that the following policy be
2 REAFFIRMED:

3 **H217-A/14 COMMUNITY-BASED TEACHING HEALTH CENTERS**
4 **RESIDENCY SUPPORT**

5 The American Osteopathic Association supports community-based programs as a model of
6 training for osteopathic primary care residents throughout the United States. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H219-A14 PROFESSIONAL LIABILITY INSURANCE – TRAINEE

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Education

1 RESOLVED, that the Bureau of Education recommend that the following policy be SUNSET:

2 **H219-A14 PROFESSIONAL LIABILITY INSURANCE – TRAINEE**

3 The AOA Department of Education and the appropriate councils within the AOA will work
4 with the AMA and ACGME in exploring possible mechanisms to ensure that trainees are
5 provided with sufficient professional liability insurance at all times and that potential
6 mechanisms to consider will include (2014):

- 7 1) Required full disclosure of type and amount of PLI to AOA, OPTI, and trainees;
8 2) Prohibition of claims-made policies for trainees;
9 3) Development of a superfund or backup insurance to be used in the event of hospital
10 closure or bankruptcy.

Explanatory Statement:

AOA postdoctoral training standards require that the training institution must ensure that trainees are provided with professional liability coverage for the duration of their training, and such coverage shall include protection against awards from claims reported or filed after completion of training and only applicable to actions occurring within the assigned scope of responsibilities for the approved program.

ACTION TAKEN **APPROVED** *(for sunset)*

DATE **July 27, 2019**

SUBJECT: H308-A/14 INFLUENZA VACCINATION PROGRAMS FOR
MEDICAL SCHOOLS

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Education

1 RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy
2 be REAFFIRMED:

3 **H308-A/14 INFLUENZA VACCINATION PROGRAMS FOR MEDICAL**
4 **SCHOOLS**

5 The American Osteopathic Association recommends and supports that all osteopathic medical
6 schools have an ongoing influenza vaccination program for students. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: H800-A/14 SINGLE GRADUATE MEDICAL EDUCATION
ACCREDITATION SYSTEM

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Education

1 RESOLVED, that the AOA Board of Trustees recommend that the following policy be
2 REAFFIRMED:

3 **H800-A/14 SINGLE GRADUATE MEDICAL EDUCATION ACCREDITATION**
4 **SYSTEM**

5 The American Osteopathic Association (AOA) will evaluate and report to the membership and
6 AOA House of Delegates annually, between 2015 and ~~2021~~ 2024, concerning the following
7 issues:

- 8 1) The ability of AOA-trained and certified physicians to serve as program directors in the
9 single GME accreditation system;
- 10 2) The maintenance of smaller, rural and community based training programs;
- 11 3) The number of solely AOA certified physicians serving as program directors in each
12 specialty;
- 13 4) The number of osteopathic identified GME programs and number of osteopathic
14 identified GME positions gained and lost;
- 15 5) The number of osteopathic residents taking osteopathic board certification examinations;
- 16 6) The status of recognition of osteopathic board certification being deemed equivalent by
17 the ACGME;
- 18 7) The importance of osteopathic board certification as a valid outcome benchmark of the
19 quality of osteopathic residency programs, and be it further

20 Any proposed single graduate medical education (GME) accreditation system will provide
21 for the preservation of the unique distinctiveness of osteopathic medicine, osteopathic
22 graduate medical education, osteopathic licensing examinations, osteopathic board
23 certification, osteopathic divisional societies, osteopathic specialty societies, osteopathic
24 specialty colleges, the AOA, and the osteopathic profession. The AOA will remain
25 vigilant in its oversight of the single accreditation process and utilize its ability to cease
26 negotiations as delineated in the Memorandum Of Understanding (MOU) should
27 osteopathic principles and educational opportunities be materially compromised. The
28 AOA will seek to create an exception category to allow the institution/program, on a case
29 by case basis, up to a one year extension without prejudice for an institution/program that
30 has their budget previously planned so as not to put that institution/program at a
31 competitive disadvantage. The AOA will advocate for an extension of the closure date for
32 AOA accreditation beyond July 1, 2020, where appropriate for individual programs on a
33 case by case basis. The AOA will enter into a single accreditation system that perpetuates
34 unique osteopathic graduate medical education programs. 2014

Reference Committee Explanatory Statement:

The Committee heard testimony in support of extending the reporting period to promote continued monitoring of the process to ensure a smooth transition into the single GME accreditation system. Due to the AOA's 5-year sunset policy cycle, this resolution, if passed, would be up for review in 2024.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019** _____

SUBJECT: STATEMENT OF SUPPORT FOR THE AMERICAN OSTEOPATHIC BOARD OF NEUROLOGY AND PSYCHIATRY

SUBMITTED BY: American College of Osteopathic Neurologists and Psychiatrists

REFERRED TO: Committee on Educational Affairs

1 WHEREAS, the Board of Trustees (BOT) of the American Osteopathic Association (AOA) is
2 the sole approving body conferring board certification to qualified physician candidates
3 who have completed the requirements under the jurisdiction of their respective specialty
4 certifying board⁽¹⁾; and

5 WHEREAS, the American Osteopathic Board of Neurology and Psychiatry (AOBNP) is the
6 designated specialty certifying board, empowered by the AOA Bureau of Osteopathic
7 Specialists (BOS), overseeing the evaluation of qualified physician candidates who have
8 completed the requirements of board certification of residency trained neurologists and
9 psychiatrists⁽²⁾; and

10 WHEREAS, the successful completion and designation of AOA board certification through the
11 AOBNP, a subsidiary of the BOS is recognized in all 50 states and US territories and
12 many countries around the world⁽¹⁾; and

13 WHEREAS, the members of AOBNP are active practicing physicians serving beyond their
14 standard career and personal responsibilities to research and create relevant clinical and
15 evidenced based testing formats for board candidates⁽³⁾; and

16 WHEREAS, the AOBNP continue to evaluate and review updates and create innovative and
17 verifiable testing modalities that meet the strict standards of board certification and
18 requirements of potential board applicants^(3, 4); and

19 WHEREAS, the AOBNP works diligently with AOA and the BOS to maintain the highest
20 standards to obtain and maintain board certification through innovative techniques and
21 approaches that encourage continuous professional development, enhance knowledge
22 of clinical guidelines, minimize risk in clinical practice, improve coordination of patient
23 care and evolves with the needs and expectations of the changing demographics of the
24 physician group^(4, 5); and

25 WHEREAS, the membership of the American College of Osteopathic Neurologists and
26 Psychiatrists voted to formally recognize through a resolution to be presented at the
27 AOA House of Delegates, the selfless ongoing commitment by the AOBNP to support
28 our profession through board certification; now, therefore be it^(6,7); now, therefore be it

29 RESOLVED, that the members of the American College of Osteopathic Neurologists and
30 Psychiatrists (ACONP) declare their strong support and gratitude to the American
31 Osteopathic Board of Neurology and Psychiatry (AOBNP) for their commitment

32 toward our profession and neurologists and psychiatrists eligible for board certification
33 through this board; and, be it further

34 RESOLVED, that the members of the ACONP fully support the American Osteopathic
35 Association (AOA) Board of Trustees, the AOA Bureau of Osteopathic Specialists and
36 the AOBNP for the efforts in strengthening Osteopathic Certification for the future;
37 and, be it further

38 RESOLVED, that the AOA acknowledges this statement in support of the AOBNP by the
39 members of the ACONP.

40 References:

- 41 1. “About AOA Certification”, certification.osteopathic.org
- 42 2. “FAQS”, certification.osteopathic.org
- 43 3. “Welcome to the Osteopathic Board of Neurology and Psychiatry”,
44 certification.osteopathic.org
- 45 4. “Put the Power of AOA Board Certification Behind Your Practice”,
46 certification.osteopathic.org
- 47 5. “AOA Approves Creation of Two Pathways for AOA Board Certification”, letter from
48 AOA President William S. Mayo, D.O., February 28, 2019
- 49 6. Membership of American College of Osteopathic Neurologists and Psychiatrists
- 50 7. General membership meeting vote February 27, 2019.

ACTION TAKEN **APPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: BOARD CERTIFICATION TEST RESULTS

SUBMITTED BY: American College of Osteopathic Family Physicians

REFERRED TO: Committee on Educational Affairs

- 1 WHEREAS, osteopathic board certification and recertification exams are now conducted at
2 testing centers; and
- 3 WHEREAS, results are submitted to the certifying board immediately after the test; and
- 4 WHEREAS, the American Osteopathic Association currently takes four months or longer to
5 notify the physician of his or her test results; now, therefore be it
- 6 RESOLVED, that the American Osteopathic Association ~~encourage~~ **REQUIRE** its certifying
7 boards to notify the physician **AND PROGRAM DIRECTOR, IF APPLICABLE,**
8 within eight weeks of taking the test of their ~~score~~ **RESULTS.**

Explanatory Statement:

~~The ABONMM board certification and recertification results under the auspice of the AOA completed in October 2018 took 16 weeks or longer to notify physicians of their results.~~

Reference Committee Explanatory Statement:

To assist program directors meet ACGME requirements regarding resident board pass rates, the committee recommends amending the resolution to include the receipt of test results by program directors. In light of the desire to create a more timely and efficient process, it is recommended that the time for reporting results be decreased, to the extent possible. After discussion with AOA staff, it was determined that there may be exceptional or extenuating circumstances that may delay the intended timely release of results.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: CERTIFICATION COMPONENT DEVELOPMENT

SUBMITTED BY: American College of Osteopathic Family Physicians

REFERRED TO: Committee on Educational Affairs

- 1 WHEREAS, family physicians comprise a large number of American Osteopathic Association
2 (AOA) membership; and
- 3 WHEREAS, family physicians comprise more than one half of all AOA certified physicians;
4 and
- 5 WHEREAS, decoupling from membership by the AOA has made certification the primary
6 income source for the AOA; and
- 7 WHEREAS, family physician certification has consistently provided considerable positive
8 income; and
- 9 WHEREAS, American Osteopathic Board of Family Physicians (AOBFP) certification
10 enhances and promotes membership in American College of Osteopathic Family
11 Physicians (ACOFP) and the AOA; and
- 12 WHEREAS, survival of ACOFP and survival of the AOA is likely to be heavily dependent on
13 maintaining and enhancing valid osteopathic family physician certification; and
- 14 WHEREAS, without the income provided by family physicians, most of the other specialty
15 certifying boards, as well as the AOA, would not be able to function; and
- 16 WHEREAS, a significant number of family physicians are expressing confusion, anger, and
17 disbelief that their role is being taken for granted and their interests in osteopathic
18 medicine are being shunned by the AOA and its current certifying board realignment
19 process; and
- 20 WHEREAS, many AOBFP certified physicians and many future certified family physicians
21 question the integrity of the proposed “simplified” certification which demonstrates
22 little concern for osteopathic content; now, therefore be it
- 23 RESOLVED, that the American Osteopathic Association (AOA) allows and encourages
24 interaction between the American College of Osteopathic Family Physicians (ACOFP)
25 and American Osteopathic Board of Family Physicians (AOBFP) to develop
26 components for initial and ongoing osteopathic family medicine certification.; and, be it
27 further
- 28 RESOLVED, that the resulting recommendations be submitted to the Bureau of Osteopathic
29 Specialists for consideration and discussion, without outside influence from AOA staff
30 and Board of Trustees.

Reference Committee Explanatory Statement:

The Committee recommends the resolution be referred to the ACOFP to clarify its intent. As written, the clear distinction between specialty college and specialty certifying board is blurred and sets up a potential conflict of interest.

ACTION TAKEN **REFERRED** (*to American College of Osteopathic Family Physicians*)

DATE **July 27, 2019** _____

SUBJECT: OSTEOPATHIC MANIPULATIVE TREATMENT BOOT CAMP

SUBMITTED BY: American College of Osteopathic Family Physicians

REFERRED TO: Committee on Educational Affairs

1 WHEREAS, Osteopathic Manipulative Treatment (OMT) is an essential modality of
2 osteopathic family medicine; and

3 WHEREAS, the use of OMT can reduce the need for opioid medications; and

4 WHEREAS, the use of OMT in family medicine may reduce the need for other costly
5 procedures; and

6 WHEREAS, the use of OMT can improve a patient’s health outcome; and

7 WHEREAS, osteopathic family physicians are certified in OMT by the American Osteopathic
8 Board of Family Physicians (AOBFP); and

9 WHEREAS, continuing hands-on education and review is necessary to maintain and improve
10 skills in OMT; and

11 WHEREAS, the American College of Osteopathic Family Physicians (ACOFP) has developed,
12 evaluated and implemented an Osteopathic Manipulative Medicine program (OMT
13 Boot Camp) that is practical and valuable to the practicing osteopathic family physician;
14 and

15 WHEREAS, the ACOFP believes the ACOFP OMT Boot Camp meets the requirements of
16 the current Osteopathic Continuing Certification (OCC) Component 4; now, therefore
17 be it

18 RESOLVED, that the American Osteopathic Association approve the American College of
19 Osteopathic Family Physicians’ OMT Boot Camp as partial fulfillment of the
20 requirements of the American Board of Osteopathic Family Physicians Osteopathic
21 Continuous Certification process, Component 4.

Reference Committee Explanatory Statement:

The BOS has jurisdiction over the components for OCC.

ACTION TAKEN **REFERRED** *(to Bureau of Specialists)*

DATE **July 27, 2019**

SUBJECT: AMERICAN OSTEOPATHIC ASSOCIATION SPECIALTY BOARD CERTIFICATION

SUBMITTED BY: American College of Osteopathic Family Physicians / American College of Osteopathic Internists / American College of Osteopathic Surgeons / American Osteopathic College of Dermatology / American Academy of Osteopathy / American Osteopathic Colleges of Ophthalmology and Otolaryngology – Head and Neck Surgery / American College of Osteopathic Pediatricians

REFERRED TO: Committee on Educational Affairs

1 WHEREAS, osteopathic principles and practice are a critical component of osteopathic medical
2 education; and

3 WHEREAS, osteopathic principles and practice are critical to the preservation of the
4 distinctiveness of our profession; and

5 WHEREAS, osteopathic board certification must include osteopathic principles and practice in
6 order to certify physicians who practice osteopathically; and

7 WHEREAS, the AOA Board of Trustees (BOT) adopted a resolution at its 2019 mid-year
8 meeting intending to create two pathways, one with osteopathic principles and practice
9 (specialty) and the traditional pathway including osteopathic principles and practice, as
10 well as test items on OMM/OMT; and

11 WHEREAS, confusion exists regarding the intent of the BOT; now, therefore be it

12 RESOLVED, that the AOA:

- 13 1. Reaffirms its commitment to the inclusion of osteopathic principles and practice in every
14 osteopathic board certification examination, regardless of specialty;
- 15 2. Continues the opportunity for osteopathic certifying boards to develop and administer
16 OMM/OMT practical examinations which are specific and appropriate for their specialty;
- 17 3. Allows a requirement for specialty-specific content in CME for re-certification/continuing
18 certification ~~beginning with the 2022 CME cycle~~; and
- 19 4. Continues to encourage the Accreditation Council for Graduate Medical Education to
20 include an osteopathic educational component in Osteopathic Recognized residencies.

Reference Committee Explanatory Statement:

The Committee received extensive testimony in support of the concepts encompassed within the original resolution. In its deliberation, the Committee believed that this substitute resolution most appropriately reflected the principles of those concepts. The Committee believes the substitute resolution responds to the concerns of the osteopathic profession and provides intended direction to the AOA Board of Trustees, Bureau of Osteopathic Specialists and individual certifying boards. Due to

the diversity in specialties, the Committee believes that individual certifying boards are best equipped to set the policies for their diplomates regarding the amount and category of CME.

ACTION TAKEN **AMENDED SUBSTITUTE RESOLUTION APPROVED**

DATE **July 27, 2019**

SUBJECT: AMERICAN OSTEOPATHIC ASSOCIATION SPECIALTY BOARD
CERTIFICATION TERMINOLOGY

SUBMITTED BY: American College of Osteopathic Pediatricians

REFERRED TO: Committee on Educational Affairs

- 1 WHEREAS, the mission statement of the American Osteopathic Association (AOA) is to
2 “advance the distinctive philosophy and practice of osteopathic medicine”; and
- 3 WHEREAS, the mission statement of the Bureau of Osteopathic Specialties (BOS) states that
4 “the BOS is the certifying body for the approved specialty boards of the AOA and is
5 dedicated to establishing the high standards for certification of osteopathic physicians”;
6 and
- 7 WHEREAS, the AOA advertises the DO difference on www.doctorsthatdo.org, by stating that
8 “There are more than 100,000 DOs in the US, practicing their distinct philosophy in
9 every medical specialty. We have additional training in Osteopathic Manipulative
10 Treatment (OMT) and use this tool to help diagnose, treat and prevent illness and
11 injury”; and
- 12 WHEREAS, www.doctorsthatdo.org also claims that “by combining the latest advances in
13 medical technology with OMT, Doctors of Osteopathic Medicine offer their patients
14 the most comprehensive care available in medicine today”; and
- 15 WHEREAS, osteopathic medical schools provide 4 years of distinct training in Osteopathic
16 Principles and Practice (OPP) and OMT via minimal standards established by ECOP,
17 including over 200 hours of training in OMT, with practical exams, OSCE, and
18 COMLEX exams; and
- 19 WHEREAS, the results of a survey of 214 people, 96% of whom were practicing DOs across
20 the USA, show that 88% agree that osteopathic certification terminology should clearly
21 state a holder is certified in OPP; and
- 22 WHEREAS, Appendix A of the July 2018 BOS Handbook has approved terminology for
23 certification already approved that states “General certification represents a distinct and
24 well-defined field of osteopathic medical practice”; now, therefore be it
- 25 RESOLVED, that the terminology for American Osteopathic Association issued board
26 certifications should state that a certificate holder is “Board Certified in Osteopathic
27 Principles and Practice of Pediatrics”.

Explanatory Statement:

If a person is a graduate of an osteopathic medical school including passing OSCEs, and passed all 3 COMLEX, and took the osteopathic certification exam, then their certificate should say certified in osteopathic pediatrics and OMT.

FISCAL IMPACT:

The fiscal impact will be less on osteopathic medical students and also build greater interest in our exams from osteopathic medical students because they will get credit for their years and tests taken in medical school. Also, there will be no negative fiscal impact on the AOA with our resolution, because they won't have to bear the cost of an added practical exam development and administration, when NBOME/COMLEX/OSCE already test the students.

Reference Committee Explanatory Statement:

The Committee believes this resolution is too limited in its scope and is better addressed in H-224.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: H204-A/13 UNIFIED GRADUATE MEDICAL EDUCATION (GME)
ACCREDITATION SYSTEM UNDER THE ACCREDITATION
COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME)
– PROPOSED / H209-A/13 OSTEOPATHIC-FOCUSED
TRAINING PROGRAMS

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

1 WHEREAS, at its 2018 meeting, the AOA House of Delegates REFERRED the policies noted
2 in resolutions H201-A/18 and H205-A/18 to the Bureau of Osteopathic Education
3 (BOE) to update the language in light of the single GME accreditation system; now,
4 therefore be it

5 RESOLVED, that the Bureau of Osteopathic Education recommends that the following
6 polices be SUNSET:

7 **H204 A/13 UNIFIED GRADUATE MEDICAL EDUCATION (GME)**
8 **ACCREDITATION SYSTEM UNDER THE ACCREDITATION**
9 **COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME) –**
10 **PROPOSED**

11 The American Osteopathic Association will work toward the development of fellowships in
12 osteopathic programs to create positions and/or graduate medical education (GME) slots in the
13 event of unsuccessful negotiations with the Accreditation Council for Graduate Medical
14 Education (ACGME); and any proposed unified GME accreditation system will protect and
15 preserve the unique distinctiveness of osteopathic medicine, osteopathic graduate medical
16 education, COMLEX-USA, osteopathic board certification, osteopathic divisional societies,
17 osteopathic specialty affiliates, the AOA and the osteopathic profession.

18 and

19 **H209 A/13 OSTEOPATHIC-FOCUSED TRAINING PROGRAMS**

20 The American Osteopathic Association maintains that osteopathic-focused value and programs,
21 which are defined as those programs using osteopathic principles and practice (OPP) and
22 osteopathic manipulative medicine (OMM), always remain the foundation of osteopathic
23 medical schools, COMLEX-USA, American Osteopathic Association (AOA) residency
24 programs, osteopathic board certification, osteopathic licensure, osteopathic continuing medical
25 education, and the osteopathic profession; and that all AOA residency programs, AOA
26 program directors, Directors of Medical Education, AOA training institutions, and OPTT's shall
27 maintain, measure, and enhance osteopathic-focused programs and shall continue to integrate
28 OPP, OMM, and osteopathic culture into all core competencies of all osteopathic medical
29 training programs. 2013

Explanatory Statement:

The BOE believes these policies have outlived their purpose due to the approval of the single GME accreditation system. Other AOA policies exist regarding the AOA's support of developing new graduate medical education programs and preserving and integrating osteopathic medicine into graduate medical education programs.

Reference Committee Explanatory Statement:

Other AOA policies that exist regarding the AOA's support of developing new GME programs and preserving and integrating osteopathic medicine into GME programs include H201-A/14, H800-A/14, H-300 A/16, H-329 A/16, H-212 A/17, and H-611 A/18.

ACTION TAKEN **APPROVED** *(for sunset)* _____

DATE **July 27, 2019** _____

SUBJECT: EDUCATION OF STUDENTS AND FACULTY ON OBTAINING
PERMISSION BEFORE ALL STUDENT AND PATIENT
ENCOUNTERS

SUBMITTED BY: Maine Osteopathic Association

REFERRED TO: Committee on Educational Affairs

1 WHEREAS, patient permission is the foundation for all medical practice, and gender
2 discrimination is prohibited and addressed in the American Osteopathic Association’s
3 (AOA) Code of Ethics;¹ and

4 WHEREAS, permission is defined as “the act of permitting; formal consent: authorization”²
5 which allows comfort and safety in treating patients;

6 WHEREAS, students of osteopathic medicine receive extensive training in osteopathic
7 manipulative treatment (OMT),³

8 WHEREAS, OMT is a critical procedure to treating patients and is inherently defined by the
9 AOA as a procedure,⁴

10 WHEREAS, when reflecting on curricula at various colleges of osteopathic medicine (COMs)
11 interactions requiring permission would include those with studentS patients IN
12 EDUCATIONAL ACTIVITIES, standardized patients, patients in practice, and others;

13 WHEREAS, we believe every graduate of a college of osteopathic medicine should demonstrate
14 proficiency in obtaining permission; and

15 ~~WHEREAS, obtaining permission is an Entrustable Professional Activity (EPA) as defined by~~
16 ~~the AAMC as part of several domains of competence including professionalism⁵; and~~

17 WHEREAS, time in the curricula is essential to student learning about and practicing the
18 nuances of obtaining permission and its pitfalls; now, therefore be it

19 RESOLVED, that the American Osteopathic Association (AOA) encourage all colleges of
20 osteopathic medicine to prepare their educators and graduates to learn and demonstrate
21 aptitude concerning the knowledge and practice of obtaining permission; and, be it
22 further

23 RESOLVED, that the AOA promote and encourage both educators and students in the use of
24 obtaining permission in all OMT AND/OR PHYSICAL CONTACT patient
25 interactions – whether ~~it~~ THEY be studentS patients IN EDUCATIONAL
26 ACTIVITIES, standardized patients, or others.

27

28 References
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32 2. "permission." Merriam-Webster.com. 2018. <https://www.merriam-webster.com> (11
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35 Standards. Element 6.4 and 6.6. 11 July 2017. < [https://osteopathic.org/wp-](https://osteopathic.org/wp-content/uploads/2018/02/com-continuing-accreditation-standards.pdf)
36 [content/uploads/2018/02/com-continuing-accreditation-standards.pdf](https://osteopathic.org/wp-content/uploads/2018/02/com-continuing-accreditation-standards.pdf) >.
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39 [content/uploads/policy-compendium.pdf](https://osteopathic.org/wp-content/uploads/policy-compendium.pdf) >. Accessed 03 October 2018.
40 5. ~~Association of American Medical Colleges. Core Entrustable Professional Activities for~~
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42 ~~[https://members.aame.org/cweb/upload/Core%20EPA%20Curriculum%20Dev%20Guid](https://members.aame.org/cweb/upload/Core%20EPA%20Curriculum%20Dev%20Guide.pdf)~~
43 ~~[e.pdf](https://members.aame.org/cweb/upload/Core%20EPA%20Curriculum%20Dev%20Guide.pdf) >.~~

ACTION TAKEN **APPROVED** as **AMENDED**

DATE **July 27, 2019** _____

SUBJECT: AOA BOARD CERTIFICATION TERMINOLOGY

SUBMITTED BY: Massachusetts Osteopathic Society

REFERRED TO: Committee on Educational Affairs

1 WHEREAS, the mission statement of the American Osteopathic Association (AOA) is to
2 “advance the distinctive philosophy and practice of osteopathic medicine”; and

3 WHEREAS, the mission statement of the Bureau of Osteopathic Specialties (BOS) states that
4 “the BOS is the certifying body for the approved specialty boards of the AOA and is
5 dedicated to establishing the high standards for certification of osteopathic physicians”;
6 and

7 WHEREAS, the AOA advertises the DO difference on www.doctorsthatdo.org, by stating that
8 “There are more than 100,000 DOs in the US, practicing their distinct philosophy in
9 every medical specialty. We have additional training in OMT and use this tool to help
10 diagnose, treat and prevent illness and injury”; and

11 WHEREAS, www.doctorsthatdo.org also claims that “by combining the latest advances in
12 medical technology with OMT, Doctors of Osteopathic Medicine offer their patients
13 the most comprehensive care available in medicine today”; and

14 WHEREAS, osteopathic medical schools provide 4 years of distinct training in Osteopathic
15 Principles and Practice (OPP) and OMT via minimal standards established by ECOP,
16 including over 200 hours of training in OMT, with practical exams, OSCE, and
17 COMLEX exams”; and

18 WHEREAS, the results of a survey of 214 people, 96% of whom were practicing DOs across
19 the USA, shows that 88% of respondents agree that osteopathic certification
20 terminology should clearly state a holder is certified in osteopathic principles and
21 practice; and

22 WHEREAS, Appendix A of the July 2018 BOS Handbook has approved terminology for
23 certification already approved that states, “General certification represents a distinct and
24 well defined field of osteopathic medical practice; now, therefore be it

25 RESOLVED, that the terminology for American Osteopathic Association issued board
26 certifications should state that a certificate holder is “Board certified in the Principles
27 and Practice of Osteopathic “Specialty”.

Reference Committee Explanatory Statement:

Specific terminology on certificates is determined by the BOS and the individual certifying boards. The Committee requests the BOS report back to the 2020 House of Delegates on this issue.

ACTION TAKEN **REFERRED** *(to Bureau of Specialists)*

DATE **July 27, 2019** _____

SUBJECT: OSTEOPATHIC CERTIFICATION

SUBMITTED BY: Massachusetts Osteopathic Society

REFERRED TO: Committee on Educational Affairs

1 WHEREAS, the mission statement of the American Osteopathic Association (AOA) is to
2 “advance the distinctive philosophy and practice of osteopathic medicine”; and

3 WHEREAS, the mission statement of the Bureau of Osteopathic Specialties (BOS) states that
4 “the BOS is the certifying body for the approved specialty boards of the AOA and is
5 dedicated to establishing the high standards for certification of osteopathic physicians”;
6 and

7 WHEREAS, offering a board certification exam without osteopathic content is in direct
8 conflict with the stated mission of the AOA and BOS; and

9 WHEREAS, according to www.osteopathic.org, “AOA board certification is an important
10 quality marker for patients, employers, insurers and regulators”; and

11 WHEREAS, the AOA addresses the DO difference on www.doctorsthatdo.org, by stating that
12 “There are more than 100,000 DOs in the US, practicing their distinct philosophy in
13 every medical specialty. We have additional training in OMT and use this tool to help
14 diagnose, treat and prevent illness and injury”; and

15 WHEREAS, www.doctorsthatdo.org also states that “by combining the latest advances in
16 medical technology with OMT, Doctors of Osteopathic Medicine offer their patients
17 the most comprehensive care available in medicine today”; and

18 WHEREAS, the July 2018 BOS handbook states that “the AOA, through the BOS, will
19 provide a mechanism to evaluate the validity and reliability of all certification
20 examinations conducted by AOA specialty certifying boards”; and

21 WHEREAS, the BOS has not established appropriate standards to osteopathically certify non-
22 osteopathic physicians; and

23 WHEREAS, the AOA House of Delegates (HOD) already maintains approved terminology
24 that AOA board certification is a marker of terminal academic achievement in
25 osteopathic medicine; and

26 WHEREAS, the July 2018 bylaws of the BOS include provisions for the equal application of
27 regulations and requirements or standards while conducting all or any part of an
28 examination by any specialty certifying boards; and

29 WHEREAS, the survey results supplied by The Boston Consulting Group were limited to DO
30 and MD students, residents and those newly out in practice; and

31 WHEREAS, the results of a survey of 408 people, 96% of whom were practicing DOs across
32 the USA, were presented to the AOA Board of Trustees in February 2019 showing that
33 91.8% of respondents wanted to maintain osteopathic distinctiveness in osteopathic
34 certification; and

35 WHEREAS, the results of a survey of 214 people, 97% of whom were practicing DOs across
36 the USA, shows that 85% of respondents prefer equal eligibility requirements for
37 applicants who are osteopathic and non-osteopathic; now, therefore be it

38 RESOLVED, that the American Osteopathic Association (AOA) is qualified to certify a
39 licensed physician in Osteopathic principles and practice; and

40 RESOLVED, that the Bureau of Osteopathic Specialties (BOS) should include samples of all
41 practicing osteopathic physicians in a specialty when determining its psychometric
42 parameters for osteopathic certification; and

43 RESOLVED, that the eligibility criteria for taking AOA board certification should be
44 equivalent for osteopathic and non-osteopathic licensed physicians, and should include
45 a minimum amount of learning in OPP and OMT, which would be sanctioned by the
46 AOA, AAO, or OCA, at least equivalent to the minimum amount required by ECOP
47 for osteopathic medical school graduation; and, be it further

48 RESOLVED, that the AOA should not offer an osteopathic certification option that eliminates
49 osteopathic content.

Reference Committee Explanatory Statement:

The Committee believes the intent of this resolution is addressed in Substitute H-220.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: OSTEOPATHIC CONTENT AND CERTIFICATION STANDARDS

SUBMITTED BY: Massachusetts Osteopathic Society

REFERRED TO: Committee on Educational Affairs

1 WHEREAS, the July 2018 Bureau of Osteopathic Specialties (BOS) handbook lists in Article 1.
2 Protocol for establishing specialty certifying boards, section 1, D that, “Notification of
3 the submission of a petition for establishing a new specialty certifying board and/or
4 requesting an assignment or change of jurisdiction will be sent to each AOA specialty
5 college and certifying board by the secretary of the BOS prior to consideration and
6 recommendation”; and

7 WHEREAS, the American Osteopathic Association (AOA) Board of Trustees (BOT) voted to
8 approve a resolution on February 26, 2019, which stated “to have the AOA endorse the
9 creation of two pathways to AOA board certification” one without any osteopathic
10 content; and

11 WHEREAS, the resolution voted on by the AOA BOT on February 26, 2019 that established 2
12 new osteopathic board exams, was not sent to each specialty college and certifying
13 board prior to the BOT vote; and

14 WHEREAS, no specialty board or specialty board chair was involved in the survey completed
15 by Boston Consulting Group which led to the proposed board certification changes;
16 and

17 WHEREAS, Article VIII, Section 1, G and H state that “each specialty board will establish its
18 individual requirements for years of AOA training for each primary and subspecialty
19 certification... and each specialty certifying board and CCEC will establish its individual
20 eligibility requirements for examination for certification. Practice within each field
21 under each board will be defined in the policies and procedures of each specialty
22 certifying board”; and

23 WHEREAS, the resolution approved on February 26, 2019, by the AOA BOT does not allow
24 for specialty boards to establish individual eligibility criteria for certification; and

25 WHEREAS, Article XII General Procedures of AOA Specialty Certifying Boards Section 1
26 Bureau Reviews Prior to AOA Board of Trustees states that “All recommendations
27 concerning specialty certifying boards must be presented to the Bureau before being
28 presented to the AOA Board of Trustees for approval”; and

29 WHEREAS, the AOA is a member organization of osteopathic physicians; and

30 WHEREAS, the results of a survey of 214 people, 96% of whom were practicing DOs across
31 the USA, shows that 96% of respondents feel that the decisions that shift the
32 framework of the osteopathic profession should require a public comment period

33 before implementation and 95% of respondents feel that decisions the shift the
34 framework of the osteopathic profession should require a vote by the AOA House of
35 Delegates; and

36 WHEREAS, the AOA BOT and BOS did not follow the established and published bylaws,
37 policies and procedures when it voted to change osteopathic board certification,
38 including the elimination of osteopathic content from such certification; and

39 WHEREAS, the July 2018 BOS Handbook lists in Article 1. Protocol for establishing specialty
40 certifying boards, section 1, E that, “The BOS may not waive any of the following
41 protocols”; and

42 WHEREAS, practicing osteopathic physicians who are board certified by the AOA rely on that
43 certification for hospital privileges, insurance contracts and credentialing; now, therefore
44 be it

45 RESOLVED, that the resolution voted on by the American Osteopathic Association (AOA)
46 Board of Trustees (BOT) on February 26, 2019, titled, “AOA Board Certification
47 Pathway” is VOID; and, be it further

48 RESOLVED, that any future attempts to force specialty boards to remove osteopathic content
49 from osteopathic certification exams be halted; and, be it further

50 RESOLVED, that any future attempts by the AOA to alter the standards of osteopathic
51 teaching, practice, certification or evaluation be given a sufficient comment period to
52 the AOA membership as a whole, and approved by the AOA House of Delegates via
53 2/3 majority; and, be it further

54 RESOLVED, that the AOA establish guidelines to set the general direction for minimum
55 standards for osteopathic content in osteopathic certification, but that osteopathic
56 specialty boards can maintain the ability to establish individual criteria, above and
57 beyond that, for their specific specialty exam as they are charged with writing exams and
58 evaluating candidates.

Reference Committee Explanatory Statement:

The Committee believes the intent of this resolution is addressed in Substitute H-220.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: OSTEOPATHIC SPECIALTY COLLEGES AND CERTIFICATION

SUBMITTED BY: Massachusetts Osteopathic Society

REFERRED TO: Committee on Educational Affairs

1 WHEREAS, the mission statement of the American Osteopathic Association (AOA) is to
2 “advance the distinctive philosophy and practice of osteopathic medicine”; and

3 WHEREAS, the mission statement of the Bureau of Osteopathic Specialties (BOS) states that
4 “the BOS is the certifying body for the approved specialty boards of the AOA and is
5 dedicated to establishing the high standards for certification of osteopathic physicians”;
6 and

7 WHEREAS, the July 2018 BOS handbook states that “the AOA, through the BOS, will
8 provide a mechanism to evaluate the validity and reliability of all certification
9 examinations conducted by AOA specialty certifying boards”; and

10 WHEREAS, specialty colleges are affiliated organizations with the AOA; and

11 WHEREAS, the AOA states on www.osteopathic.org, that “The AOA works with osteopathic
12 specialty colleges to advance osteopathic medicine; and

13 WHEREAS, all Osteopathic certification will lead to Osteopathic Continuous Certification; and

14 WHEREAS, the results of a survey of 214 people, 96% of whom were practicing DOs across
15 the USA, shows that 82% of respondents feel that osteopathic specialty colleges can be
16 an option to administer practical board exams; now, therefore be it

17 RESOLVED, that under the guidance of osteopathic specialty boards, and overseen by the
18 Bureau of Osteopathic Specialties, that all American Osteopathic Association affiliated
19 osteopathic specialty colleges can administer practical exams in OMT for osteopathic
20 certification, as well as provide necessary Osteopathic Continuous Certification in OMT
21 for osteopathic continuous certification.

Reference Committee Explanatory Statement:

Exams must be developed and administered by the certifying boards, not the specialty colleges.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: PARENTAL LEAVE POLICIES FOR ACCREDITATION COUNCIL
FOR GRADUATE MEDICAL EDUCATION (ACGME)
RESIDENCY PROGRAMS

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Educational Affairs

- 1 WHEREAS, the Accreditation Council for Graduate Medical Education (ACGME) requires
2 that graduate medical education institutions give written statements regarding parental
3 leave policy availability, without requiring implementation or standardization of leave
4 policies across programs¹; and
- 5 WHEREAS, length and availability of parental leave policies in place for resident physicians are
6 determined by respective specialty boards (e.g. American Board of Family Medicine,
7 etc.)¹; and
- 8 WHEREAS, there is discrepancy across specialties regarding establishment and encouragement
9 to utilize parental leave policies^{1,2,3,4}; and
- 10 WHEREAS, some specialty boards encourage minimum 8 weeks maternal leave, while female
11 surgical residents report that the American Board of Surgery leave policies are a barrier
12 to taking more than 6 weeks of leave^{1,2,3,4}; and
- 13 WHEREAS, 90% of pediatric residency programs have established maternal leave policies, as
14 compared to only 36.54% of plastic surgery residency programs^{5,6,7}; and
- 15 WHEREAS, many residency programs do not have paternal leave policies⁸; and
- 16 WHEREAS, in a survey conducted by the Association of Women Surgeons of 347 female
17 surgical residents with one or more pregnancies during residency, 72% reported that the
18 six or less weeks of leave they could obtain was inadequate and 39% seriously
19 considered leaving surgical residency due to the challenges faced regarding childbearing
20 and leave³; and
- 21 WHEREAS, residents in some specialties often face discouragement when taking parental
22 leave, and feel perceived stigma regarding pregnancy^{1,2,3}; and
- 23 WHEREAS, the Family and Medical Leave Act, covering 60% of American workers including
24 medical residents, states eligible employees are entitled to: “unpaid, job-protected leave
25 for specified family and medical reasons,” including up to twelve work weeks within a
26 12 month period for birth of a child and care for the newborn⁹; and
- 27 WHEREAS, a substantial decrease in infant mortality was found when women were given 12
28 weeks of maternity leave following the Family and Medical Leave Act¹⁰; now, therefore
29 be it

30 RESOLVED, that the American Osteopathic Association (AOA) encourages the Accreditation
31 Council for Graduate Medical Education (ACGME) to promote the standardization,
32 within the common program requirements; availability; and accessibility of requesting
33 adequate parental leave in adherence with the Family and Medical Leave Act; and, be it
34 further

35 RESOLVED, that the AOA ~~to encourageS~~ the ACGME to advocate for transparency of
36 parental leave policies ~~at the time of residency matching.~~

37 References

- 38 1. Greenfield NP. Maternity and medical leave during residency: Time to standardize?. Int J
39 Womens Dermatol. 2015;1(1):55. Published 2015 Feb 20. doi:10.1016/j.ijwd.2014.12.009
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41 Residents: A Qualitative Analysis.” The American Journal of Surgery, vol. 216, no. 4, 2018,
42 pp. 754–759., doi:10.1016/j.amjsurg.2018.07.036.
- 43 3. Rangel, Erika L., et al. “Pregnancy and Motherhood During Surgical Training.” JAMA
44 Surgery, vol. 153, no. 7, 2018, p. 644., doi:10.1001/jamasurg.2018.0153
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46 Pediatric Training Programs.” Pediatrics, vol. 131, no. 2, 2013, pp. 387–390.,
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49 First Nationwide Survey of General Surgery Residency Program Directors.” Journal of the
50 American College of Surgeons, vol. 222, no. 6, 2016, pp. 1090–1096.,
51 doi:10.1016/j.jamcollsurg.2015.12.004.
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53 Reconstructive Surgery, vol. 139, no. 1, 2017, pp. 245–252.,
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- 55 7. Humphries, Laura S., et al. “Parental Leave Policies in Graduate Medical Education: A
56 Systematic Review.” The American Journal of Surgery, vol. 214, no. 4, 2017, pp. 634–639.,
57 doi:10.1016/j.amjsurg.2017.06.023.
- 58 8. Wasser, Miriam. “Many Top Medical Training Programs Lack Paid Family Leave Policies,
59 Study Finds.” WBUR, WBUR, 13 Dec. 2018,
60 www.wbur.org/commonhealth/2018/12/12/medical-resident-paid-parental-leave.
- 61 9. Family and Medical Leave Act of 1993. Public Law 103-3, 107 Stat. 6. 1993.
- 62 10. Rossin, Maya. “The Effects of Maternity Leave on Children's Birth and Infant Health
63 Outcomes in the United States.” Journal of Health Economics, vol. 30, no. 2, 2011, pp.
64 221–239., doi:10.1016/j.jhealeco.2011.01.005.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: COMMENDATION OF AMA POLICY (AMA 955) ON EQUAL
 ACCEPTANCE OF COMLEX-USA FOR DO STUDENTS IN ALL
 US RESIDENCY PROGRAMS

SUBMITTED BY: Osteopathic Physicians and Surgeons of California

REFERRED TO: Committee on Educational Affairs

1 WHEREAS, the National Board of Osteopathic Medical Examiners (NBOME) COMLEX-
2 USA licensure examination series is an evidenced-based assessment that reflects the
3 distinctive osteopathic medical school curriculum, qualifications, competencies and
4 practice patterns of osteopathic physicians; and

5 WHEREAS, successful passage of COMLEX-USA Level 1, Level 2, Level 2 Performance
6 Evaluation are required by the AOA-Commission on Osteopathic College Accreditation
7 and all United States colleges of osteopathic medicine for graduation with the DO
8 degree; and

9 WHEREAS, many stakeholders including medical students and deans and the American
10 Medical Association have cited the unintended consequences of the USMLE (United
11 States Medical Licensing Examination) Step 1 impacting not only student well-being but
12 also detracting from students' full engagement with their educational/curricular
13 program un undergraduate medical education; and

14 WHEREAS, in this era of Single Graduate Medical Education (GME) accreditation and the
15 resulting uncertainties and anxieties, many osteopathic medical students are concerned
16 about being an effective, competitive candidate for their preferred residency specialty
17 and program; and

18 WHEREAS, some residency Accreditation Council for Graduate Medical Education (ACGME)
19 program directors require USMLE for all GME program applicants, including DOs, in
20 order to evaluate which candidates to interview and rank in the National Residency
21 Matching Program (NRMP); and

22 WHEREAS, in November 2018, the American Medical Association House of Delegates
23 adopted a new policy calling for promotion of equal acceptance of COMLEX-USA and
24 USMLE at all US residency programs; now, therefore be it

25 RESOLVED, that the American Osteopathic Association (AOA) commend the American
26 Medical Association (AMA) for its adoption of promoting equal acceptance of
27 COMLEX-USA by all US Residency Programs; and, be it further

28 RESOLVED, that the AOA dedicate resources to support initiatives to reach ACGME
29 residency and fellowship program leaders, including Program Directors and Program
30 Coordinators, about the equivalent use of COMLEX-USA and USMLE in GME
31 programs.

Reference Committee Explanatory Statement:

The Committee believes this resolution is better addressed in H-231.

ACTION TAKEN **DISAPPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: CLASSIFICATION OF OSTEOPATHIC MEDICAL GRADUATES AS UNITED STATES MEDICAL GRADUATES IN ELECTRONIC RESIDENCY APPLICATION SERVICE (ERAS)

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

1 WHEREAS, the single accreditation system between American Osteopathic Association (AOA)
2 and the American Council of Graduate Medical Education (ACGME) for graduate
3 medical education (GME) is heading to completion in 2020; and

4 WHEREAS, the final AOA match has concluded, and from this point forward both
5 osteopathic and allopathic medical school graduates will be applying to the same set of
6 GME programs; and

7 WHEREAS, osteopathic and allopathic medical students are both equally physicians under the
8 law once medical licensure is obtained; and

9 WHEREAS, program directors for GME programs utilize filters built into the Electronic
10 Residency Application Service (ERAS) to stratify applicants¹; and

11 WHEREAS, the above-mentioned ERAS filters include filtering students by medical school
12 type under the field: “Most Recent Medical School Type.” For example, there are U.S.
13 Public and U.S. Private school filters that apply only to M.D. students but there exists a
14 separate third filter category for osteopathic medical schools. As such, osteopathic
15 graduates are not considered as US medical graduates. There are also separate filters for
16 foreign medical graduates and Canadian applicants¹; and

17 WHEREAS, osteopathic medical students applying for residency programs in the new unified
18 match may have their application filtered out, without being viewed by residency
19 program directors, due students being placed in a separate “Osteopathic” category of
20 filtered applicants, in a similar manner to how foreign medical and Canadian graduates
21 are filtered out¹; and

22 WHEREAS, medical students applying for GME should be judged by programs based on
23 factors that indicate medical school performance, including class ranking, grades,
24 licensing exam scores, letters of recommendation, medical school performance
25 evaluation (MSPE), extracurricular involvement, interview performance, and research
26 conducted; and

27 WHEREAS, medical students spending money to apply to GME programs should have their
28 application given fair consideration; and

29 WHEREAS, osteopathic medical graduates are US medical graduates and should not be
30 classified as a separate subtype of medical graduate comparable to a foreign medical
31 graduate; now, therefore be it

32 RESOLVED, that the American Osteopathic Association advocates to the American
33 Association of Medical Colleges to adjust Electronic Residency Application Service
34 filters based on medical school type such that Osteopathic applicants are included and
35 recognized within the US Public or Private Medical Graduates category.

36 References

- 37 1. How Filters Work. Retrieved February 18, 2018, from
38 <https://www.aamc.org/download/446202/data/howfilterswork.pdf>

Explanatory Statement:

Each year, osteopathic medical students' applications for GME training may be discarded without being looked at in the ACGME match at various programs and in various specialties. There currently exists methods to disregard all applications by applicants who are not U.S. M.D. graduates, including U.S. D.O. applicants, without examining the applicants file. These methods consist of filters that limit applications seen by program directors based on the type of medical school from which the applicant is graduating or has graduated. Now that the GME of the ACGME will be the only programs to which applicants may apply, and in keeping the good spirit of single accreditation, there should be no filters that eliminate U.S. M.D. or U.S. D.O. students' applications from consideration based on degree type. The narrowing down of applicants should instead be based on medical school performance. This is the most fair way to ensure that all U.S. medical school graduates have an equal opportunity for their application to be seen at each program to which they apply and submit an application fee.

ACTION TAKEN **APPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: RECOGNITION OF COMLEX AND USMLE AS EQUAL LICENSING EXAMINATIONS AMONG RESIDENCY PROGRAMS

SUBMITTED BY: Maryland Association of Osteopathic Physicians

REFERRED TO: Committee on Educational Affairs

1 WHEREAS, on February 26, 2014, the Accreditation Council for Graduate Medical Education
2 (ACGME), American Osteopathic Association (AOA), and American Association of
3 Colleges of Osteopathic Medicine (AACOM) announced their agreement to a
4 Memorandum of Understanding (MOU) outlining a single graduate medical education
5 accreditation system in the United States¹; and

6 WHEREAS, the intentional benefits of the single accreditation system for osteopathic medical
7 students include preserving access to primary and subspecialty programs for osteopathic
8 medical graduates, maintaining DO students' access to opportunities in the full
9 spectrum of graduate medical education (GME), and promoting consistency across all
10 GME programs in terms of training and evaluation of residents, ensuring the
11 continuation and enhancement of world class GME²; and

12 WHEREAS, the ACGME acknowledges the Comprehensive Osteopathic Medical Licensing
13 Examination of the United States (COMLEX-USA) and United States Medical
14 Licensing Examination (USMLE) as equivalent licensing board examinations by stating
15 that the ACGME does not specify which licensing board exam(s) (i.e., COMLEX-USA,
16 USMLE) applicants must take to be eligible for appointment in ACGME-accredited
17 residency programs³; and

18 WHEREAS, according to the 2018 National Resident Matching Program (NRMP) Program
19 Director Survey, 64% of programs for all specialties utilized the USMLE with a target
20 score in mind, with 34% utilized the USMLE as a pass; while only 34% of programs
21 utilized the COMLEX-USA with a target score in mind and 27% of programs utilized
22 the COMLEX-USA as a pass⁴; and

23 WHEREAS, in 2006 Slocum and Louder published a guide on converting COMLEX-USA to
24 USMLE scores, but the information has since been outdated with further research
25 arguing against the accuracy of such conversion – illustrating a need to communicate
26 the value of the two licensing exams for program directors^{5,6}; and

27 WHEREAS, Dr. Jon Gimpel, National Board of Osteopathic Medical Education (NBOME)
28 President, commented on a potential conversion between the two exams stating,
29 “because of the different natures of the examinations, it is not possible—or even
30 desirable—to make a direct numerical comparison between the scores of the
31 COMLEX-USA examination series and those of the USMLE”⁷; and

32 WHEREAS, as stated by AACOM, “The single GME accreditation system is not expected to
33 reduce acceptance of the COMLEX-USA for residency admissions, but rather to

1 continue to grow acceptance with the goal of one day achieving universal acceptance.
2 However, it is likely – at least for a while – that some ACGME programs will continue
3 to prefer to receive a USMLE score. If a student has aspirations for such programs,
4 then that student will have to make the decision about whether to take the USMLE in
5 addition to the COMLEX-USA”⁸; and

6 WHEREAS, the American Medical Association (AMA) House of Delegates in November 2018
7 approved a resolution that advocates equality between the COMLEX-USA and USMLE
8 exams; with the policy further promoting the education and use of COMLEX-USA by
9 residency program directors for evaluation of medical students⁹; and

10 WHEREAS, in reference to the AMA 2018 House of Delegate Resolution (H-295.866), Dr.
11 Boyd Buser, Past AOA President, commented, “This important recognition indicates
12 that osteopathic medical graduates should not be compelled to take the USMLE series
13 as a condition to apply for a residency program¹⁰”; now, therefore be it

14 RESOLVED, that the American Osteopathic Association (AOA) promote equality PARITY
15 between osteopathic and allopathic medical students, residents, and physicians among
16 residency program directors; and, be it further

17 RESOLVED, that the AOA collaborate with the American Association of Colleges of
18 Osteopathic Medicine, the National Board of Osteopathic Medical Education, the
19 American Medical Association, the Accreditation Council for Graduate Medical
20 Education, and all other appropriate parties to educate residency program directors on
21 the interpretation of a Comprehensive Osteopathic Medical Licensing Examination of
22 the United States (COMLEX-USA) score with the understanding that the COMLEX-
23 USA is the most appropriate standardized exam to evaluate the competency of an
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ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019** _____

SUBJECT: ADDICTION MEDICINE CAQ

SUBMITTED BY: AOA Finance Committee

REFERRED TO: Committee on Educational Affairs

1 WHEREAS, the American Osteopathic Association (AOA) approved the Addiction Medicine
2 conjoint CAQ in 1995; and

3 WHEREAS, on April 12, 2016, the AOA passed a resolution that will provide DOs who are
4 ABAM diplomats with a process to attain an AOA subspecialty certification in
5 Addiction Medicine; and

6 WHEREAS, there are many DOs who will not benefit from the 2016 AOA resolution and still
7 seek subspecialty certification in Addiction Medicine, including those who have
8 completed an AOA approved Addiction Medicine fellowship program; and

9 WHEREAS, the Centers for Disease Control and Prevention anticipates that the number of
10 death for all drug overdoses will be 74,000 in 2017. Around 66% of the more than
11 63,600 drug overdose deaths in 2016 involved an opioid. On average, 115 Americans
12 die every day from an opioid overdose; and

13 WHEREAS, the Department of Health & Human Services, The White House Office of
14 National Drug Control Policy, and the Department of Substance Abuse and Mental
15 Health Services have acknowledged a severe shortage of Addiction Medicine specialists
16 to treat the epidemic of opioid and alcohol addictions and the AOA has committed to
17 assisting in training more physicians in substance use disorder (SUD). In October 2017
18 President Donald Trump formally declared the opioid crisis a public health emergency;
19 and

20 WHEREAS, more hospitals and insurance companies are requiring certification for the
21 treatment of addiction; those who are certified are also able to command more income
22 and opportunities; and

23 WHEREAS, there is a lack of parity among DOs and MDs now that allopathically boarded
24 physicians can become qualified to certify in addiction medicine as a subspecialty under
25 the American Board of Medical Specialties (ABMS) Preventive Medicine Certifying
26 Board, thereby making DOs who are not allopathically boarded ineligible; and

27 WHEREAS, as per policy, resolutions with a financial implication must be submitted to the
28 AOA Finance Committee for review, consideration and recommendation prior to
29 consideration by the AOA House of Delegates, therefore resolution H215 – A/2018
30 titled Addiction Medicine CAQ was referred to the AOA Finance Committee for a
31 fiscal impact analysis; now, therefore be it

- 1 RESOLVED, that Osteopathic physicians who have completed an American Osteopathic
2 Association (AOA) approved fellowships in Addiction Medicine be allowed to take the
3 primary CAQ examination in Addiction Medicine; and, be it further
- 4 RESOLVED, that A clinical practice pathway ~~previously~~ **BE DEVELOPED AND** approved
5 by the AOA **CONJOINT EXAMINATION COMMITTEE** in Addiction Medicine
6 **AND** be ~~re~~opened for three (3) years **AFTER THE INITIAL EXAM**
7 **ADMINISTRATION** for ~~all~~ **QUALIFIED** DOs who wish to become certified in
8 the subspecialty of Addiction Medicine; and, be it further
- 9 RESOLVED, that the AOA Finance Committee submits a fiscal impact of H215 – A/2018
10 titled “Addiction Medicine CAQ” to be \$151,000 while noting that the net financial
11 impact will be \$0 in year 1.

Reference Committee Explanatory Statement:

Due to the national opioid epidemic, it is the intent of the AOA that any DO with an active primary AOA board certification in any specialty would be able to seek certification through this pathway.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: ADDICTION MEDICINE CAQ

SUBMITTED BY: American Osteopathic Academy of Addiction Medicine

REFERRED TO: Committee on Educational Affairs

1 WHEREAS, the American Osteopathic Association (AOA) approved the Addiction Medicine
2 conjoint CAQ in 1995; and

3 WHEREAS, on April 12, 2016, the AOA passed a resolution that will provide DOs who are
4 ABAM diplomats with a process to attain an AOA subspecialty certification in
5 Addiction Medicine; and

6 WHEREAS, there are many DOs who will not benefit from the 2016 AOA resolution and still
7 seek subspecialty certification in Addiction Medicine, including those who have
8 completed an AOA approved Addiction Medicine fellowship program; and

9 WHEREAS, the Centers for Disease Control and Prevention (CDC) anticipates that the
10 number of death for all drug overdoses will be 74,000 in 2017. Around 66% of the
11 more than 63,600 drug overdose deaths in 2016 involved an opioid. On average, 115
12 Americans die every day from an opioid overdose; and

13 WHEREAS, the Department of Health & Human Services, The White House Office of
14 National Drug Control Policy, and the Department of Substance Abuse and Mental
15 Health Services have acknowledged a severe shortage of Addiction Medicine specialists
16 to treat the epidemic of opioid and alcohol addictions and the AOA has committed to
17 assisting in training more physicians in substance use disorder (SUD). In October 2017
18 President Donald Trump formally declared the opioid crisis a public health emergency;
19 and

20 WHEREAS, more hospitals and insurance companies are requiring certification for the
21 treatment of addiction; those who are certified are also able to command more income
22 and opportunities; and

23 WHEREAS, there is a lack of parity among DOs and MDs now that allopathically boarded
24 physicians can become qualified to certify in addiction medicine as a subspecialty under
25 the American Board of Medical Specialties (ABMS) Preventive Medicine Certifying
26 Board, thereby making DOs who are not allopathically boarded ineligible; now,
27 therefore be it

28 RESOLVED, that Osteopathic physicians who have completed an American Osteopathic
29 Association (AOA) approved fellowships in Addiction Medicine be allowed to take the
30 primary CAQ examination in Addiction Medicine; and, be it further

1 RESOLVED, that clinical practice pathway previously approved by the AOA in Addiction
2 Medicine be reopened for six (6) years for all DOs who wish to become certified in the
3 subspecialty of Addiction Medicine.

Explanatory Statement:

As per policy, resolutions with financial implication must be submitted to the AOA Finance Committee for review, consideration and recommendation prior to consideration by the AOA House of Delegates.

ACTION TAKEN REFERRED (to AOA Finance Committee)

DATE July 21, 2018

SUBJECT: H300-A/14 TRAINING -- EXTENDED RELEASE-LONG ACTING
(ER/LA) OPIOID RISK EVALUATION AND MITIGATION
STRATEGY (REMS)

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H300-A/14 TRAINING -- EXTENDED RELEASE-LONG ACTING (ER/LA)**
4 **OPIOID RISK EVALUATION AND MITIGATION STRATEGY**
5 **(REMS)**

6 The AOA encourages osteopathic physicians whose practice includes the prescribing of
7 Extended Release-Long Acting (ER/LA) Opioids to complete ER/LA Opioid Risk Evaluation
8 and Mitigation Strategy (REMS) training to ensure that ER/LA opioids are prescribed, when
9 indicated, in a manner that enhances patient well-being and does not contribute to individual or
10 public harm. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H301-A/14 MEDICAL WEBSITES AND SMARTPHONES / TABLET
COMPUTER APPS TO DIAGNOSE ILLNESS – USE OF

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H301-A/14 MEDICAL WEBSITES AND SMARTPHONES / TABLET**
4 **COMPUTER APPS TO DIAGNOSE ILLNESS – USE OF**

5 The American Osteopathic Association (AOA) recognizes the values that health information
6 websites and apps provide patients and encourages their use for patients to gain information
7 about their health, and will encourage its members to recommend patients use evidence-based
8 resources so that they may continue to actively engage in their own health care. The AOA
9 should actively educate patients on the importance of seeing a physician when ill or injured and
10 in need of a medical diagnosis, and that patients not allow recommendations from these
11 medical websites or applications to be used as a basis for delaying, or as a substitute for,
12 evaluation and treatment by a physician. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H305-A/14 FLU PANDEMIC – OSTEOPATHIC TREATMENT OF

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED:

3 **H305-A/14 FLU PANDEMIC – OSTEOPATHIC TREATMENT OF**
4 The American Osteopathic Association supports the active utilization of osteopathic
5 manipulative treatment, along with other recognized and approved medical interventions, in the
6 treatment of flu pandemics and other infectious outbreaks; and will conduct programs to
7 disseminate appropriately training in osteopathic manipulative treatment. 2009; reaffirmed as
8 amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H306-A/14 DIRECT-TO-CONSUMER MARKETING OF HEALTH SCREENING AND TESTING

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED as AMENDED:

3 **H306-A/14 DIRECT-TO-CONSUMER MARKETING OF HEALTH**
4 **SCREENING AND TESTING**

5 The American Osteopathic Association is against **DIRECT-TO-CONSUMER**
6 **MARKETING OF MEDICAL TESTS AND EXAMS THAT MAY BE** unnecessary,
7 ~~exams HEALTH SCREENING EXAMS AND TESTING marketed directly to consumers~~
8 and encourages its members to educate their patients **ABOUT WHICH SERVICES ARE**
9 **APPROPRIATE BASED ON** and follow the US Preventive Services Task Force
10 **RECOMMENDATIONS AND OTHER NATIONALLY RECOGNIZED CLINICAL**
11 **PRACTICE** Guidelines ~~WHEN APPROPRIATE~~. 2009; reaffirmed 2014

Reference Committee Explanatory Statement:

The Committee agrees with the Bureau of Socioeconomic Affairs' recommendation to expand the policy and base the need for tests and exams on United States Preventive Services Task Force (USPSTF) guidelines and other nationally recognized clinical practice guidelines as outlined below:

- 1) USPSTF recommendations are applicable to primary care. The USPSTF is a Congressionally mandated, independent panel of medical experts in primary care and prevention composed of primary care providers-internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and other behavior specialists who are charged with making "recommendations to primary care providers about clinical preventive services."
- 2) Medicare pays for preventive screening and tests assigned a grade "D" or "I" by the USPSTF. These grade assignments indicate a service is unnecessary. Someone unfamiliar with USPSTF grade assignments may misinterpret a low grade as a non-covered service when it may not be. Prostate screening is a prime example.
- 3) CMS, Medicare Administrative Contractors (MACs) and private payers base their coverage determinations on nationally recognized clinical practice guidelines (which usually are developed by specialty medical societies) more so than USPSTF guidelines.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H307-A/14 NEW BORN HIV TESTING

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H307-A/14 NEW BORN HIV TESTING**

4 American Osteopathic Association policy recommends HIV testing immediately with
5 expeditious reporting of results of newborns whose mothers' HIV status is unknown and where
6 clinically indicated. 2003, reaffirmed 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H313-A/14 CDC – HIV PROPOSED RULE CHANGE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be SUNSET:

3 **H313-A/14 CDC – HIV PROPOSED RULE CHANGE**

4 The American Osteopathic Association voices its concern and opposition to the Centers for
5 Disease Control and Prevention (CDC) proposed rule-making change on 42 CFR Part 34 to
6 remove human immunodeficiency virus (HIV) testing as a requirement for immigrants and
7 refugees; and, through its resources encourages members and the public to investigate and
8 comment on the proposed rule-making. 2009; referred 2014

Explanatory Statement:

This policy is no longer needed. On November 2, 2009, the Department of Health and Human Services (HHS) and Centers for Disease Control and Prevention (CDC) published a final rule that removes HIV (Human Immunodeficiency Virus) infection from the list of communicable diseases of public health significance. As a result, HIV infection will not prevent non-U.S. citizens from entering the United States. Further, HIV testing will no longer be required for U.S. immigration medical screening. <https://www.cdc.gov/immigrantrefugeehealth/laws-regulations.html>.

ACTION TAKEN **APPROVED** *(for sunset)* _____

DATE **July 27, 2019** _____

SUBJECT: H314-A/14 INFLUENZA IMMUNIZATION FOR HEALTH CARE
WORKERS AND EDUCATORS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H314-A/14 INFLUENZA IMMUNIZATION FOR HEALTH CARE WORKERS**
4 **AND EDUCATORS**

5 The American Osteopathic Association strongly supports and recommends influenza
6 vaccinations for all health care workers and educators according to current guidelines of the
7 Centers for Disease Control and Prevention. 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H316-A/14 DUE PROCESS FOR ALLEGED IMPAIRED PHYSICIANS

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Membership recommend that the following policy be
2 REAFFIRMED:

3 **H316-A/14 DUE PROCESS FOR ALLEGED IMPAIRED PHYSICIANS**

4 It is the policy of the American Osteopathic Association that, except in the case of summary
5 suspension necessary to protect patients from imminent harm, no adverse action be taken
6 against the staff privileges of a physician by a hospital, managed care organization or insurer
7 based on a claim of physician impairment without a suitable due process hearing in accordance
8 with medical staff bylaws to determine the facts related to the allegations of impairment, and,
9 where appropriate, a careful clinical evaluation of the physician. 1999; reaffirmed 2004; 2009;
10 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H317-A/14 DRUG FORMULARIES

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED:

3 **H317-A/14 DRUG FORMULARIES**

4 The American Osteopathic Association (AOA) supports drug formularies which allow for an
5 expeditious appeal process with a further peer to peer review option. 1999; reaffirmed 2004;
6 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H318-A/14 HOME-BASED CARE FOR FRAIL ELDERLY

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED:

3 **H318-A/14 HOME-BASED CARE FOR FRAIL ELDERLY**

4 The American Osteopathic Association encourages all parties with economic and clinical
5 responsibility to develop programs and systems to assist the frail elderly patient population and
6 provide appropriate access to healthcare services. 1999; revised 2004; reaffirmed 2009;
7 reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H319A/14 HEALTH CARE COSTS IN LONG TERM SERVICES AND SUPPORT

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED:

3 **H319-A/14 HEALTH CARE ~~COSTS~~ EFFICIENCY IN LONG TERM SERVICES**
4 **AND SUPPORT**

5 The American Osteopathic Association reaffirms its commitment to the development and
6 implementation of programs that improve the efficiency of long term services and support and
7 ensure the delivery of quality care. 1984; revised 1989; reaffirmed 1994; revised 1999; reaffirmed
8 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H320-A/14 IMMUNIZATION REGISTRIES

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be SUNSET:

3 **H320-A/14 IMMUNIZATION REGISTRIES**

4 The American Osteopathic Association encourages physicians to participate in the development
5 of immunization registries in their communities and to use such registries in their practices.
6 1999; revised 2004; reaffirmed 2009; 2014

Explanatory Statement:

A new resolution was developed - CLINICAL DATA REGISTRIES AND QUALIFIED CLINICAL DATA REGISTRIES - for presentation to the HOD to encompass other public and private clinical data registries in addition to immunization registries.

ACTION TAKEN **APPROVED** *(for sunset)*

DATE **July 27, 2019**

SUBJECT: H321-A/14 NATIONAL PRACTITIONER DATA BANK –
MEMBERSHIP ACTION

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Membership recommend that the following policy be
2 REAFFIRMED:

3 **H321-A/14 NATIONAL PRACTITIONER DATA BANK – MEMBERSHIP**
4 **ACTION**

5 The American Osteopathic Association believes that adverse membership actions which do not
6 involve professional competence or conduct such as nonpayment of dues, CME deficiencies
7 and other association matters shall not be reported to the National Practitioner Data Bank
8 (NPDB) unless otherwise required by law; and that final actions of expulsion of members from
9 the American Osteopathic Association shall, when all appeal mechanisms have been exhausted
10 by the osteopathic physicians, be reported to the National Practitioner Data Bank. 1999;
11 reaffirmed 2004; 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H322-A/14 IMPORTATION OF MEDICATIONS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED:

3 **H322-A/14 IMPORTATION OF MEDICATIONS**

4 The American Osteopathic Association supports the importation of medications that may be
5 imported under the authority of the US Food and Drug Administration and encourages its
6 members to assist patients in utilizing the many programs that are available to provide patients
7 with free or reduced cost medications. 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H323-A/14 ANY WILLING PROVIDER LEGISLATION

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be REAFFIRMED:

3 **H323-A/14 ANY WILLING PROVIDER LEGISLATION**

4 The American Osteopathic Association encourages and supports the passage of legislation that
5 will ensure the freedom of patients and physicians to enter into private contracts for health care
6 services without regard to restrictions by any third party carrier; supports legislation that will
7 allow any qualified physician (DO/MD) to negotiate with any third party carrier the terms for
8 service to be provided; and supports legislation that will require any third party carrier to
9 provide prompt and complete explanation to any requesting physician (DO/MD) whom it may
10 deem unqualified. 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H324-A/14 USE OF THE TERM “PHYSICIAN” DOCTOR” AND
“PROVIDER”

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be REAFFIRMED as AMENDED:

3 **H324-A/14 USE OF THE TERM “PHYSICIAN” DOCTOR” AND “PROVIDER” -**
4 **TRUTH IN ADVERTISING**

5 The American Osteopathic Association (AOA) adopts as policy: (1) that ~~AOA members~~ DOs
6 AND MDS, are encouraged to use the terms “physician” or “doctor” to describe themselves,
7 leaving other terms such as “practitioner,” “clinician,” or “provider” to be used by non-
8 physician clinicians or to categorize health care professionals as a whole; (2) supports the
9 appropriate use of credentials and professional degrees in advertisements; (3) ~~providing a~~
10 SUPPORTS mechanisms for physicians to report advertisements related to medical care that
11 are false or deceptive; (4) opposes non-physician clinicians’ use of the title “physician” or
12 “doctor” because such communication is likely to deceive the public by implying that the non-
13 physician clinician is engaged in the unlimited practice of medicine; (5) opposes legislation that
14 would expand the use of the term “physician” OR “DOCTOR” to persons other than ~~US-~~
15 ~~trained~~ DOs; and MDs; (6) supports a ~~policies~~ THAT REQUIRE physicians and non-physician
16 clinicians TO VERBALLY DISCLOSE THEIR DEGREES WHEN IDENTIFYING themselves
17 to their patients, AND WEAR A NAMETAG WHICH CLEARLY DISPLAYS THEIR
18 DEGREE DURING ALL PATIENT ENCOUNTERS ~~noting their degree in both a verbal~~
19 ~~description as well as a visual identification by use of a nametag~~; (7) OPPOSE ~~will not support~~
20 legislation THAT, which would allow non-physician clinicians to be called “physicians;” (8)
21 supports a ~~policies~~ THAT reservEing the title “physician” for ~~US-trained~~ DOs, and MDs
22 who have established the integrity of their education, training, examination WHICH
23 UNIQUELY PREPARE THEM and regulations for the unlimited practice of medicine; and (9)
24 opposes the misuse of the title “doctor” by non-physician clinicians; in all communications and
25 clinical settings because such use deceives the public by implying THAT the non-physician
26 clinician’s education, training or credentialing is equivalent to a DO or MD. 2009; reaffirmed as
27 amended 2014

Reference Committee Explanatory Statement:

Refer to Bureau of State Government Affairs (BSGA) for consideration and comment and report back to 2020 HOD.

ACTION TAKEN **REFERRED** *(to Bureau of State Government Affairs)*

DATE **July 27, 2019**

SUBJECT: H325-A/14 PHYSICALLY ACTIVE VIDEO GAMES – (EXERGAMING HEALTH) BENEFITS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H325-A/14 PHYSICALLY ACTIVE VIDEO GAMES – (EXERGAMING HEALTH)**
4 **BENEFITS**

5 The American Osteopathic Association recommends: (1) osteopathic physicians should be
6 aware of the potential benefits of exergaming; (2) physicians should consider recommending
7 exergaming as a component of a person’s exercise program or when situational circumstances
8 prohibit other types of exercise; and (3) additional research that demonstrates the benefits of
9 exergaming. 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H326-A/14 MEDICARE – PRESCRIPTION ASSISTANCE FOR
MEDICARE PATIENTS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED:

3 **H326-A/14 MEDICARE – PRESCRIPTION ASSISTANCE FOR MEDICARE**
4 **PATIENTS**

5 The American Osteopathic Association supports legislation ~~that will allow~~ **TO ELIMINATE**
6 **THE COVERAGE GAP (DONUT HOLE) IN Medicare Part D recipients, who are in**
7 **the “donut hole”, to utilize AND THE RESTRICTIONS THAT LIMIT PATIENTS**
8 **FROM UTILIZING** prescription discounts and vouchers. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H327-A/14 ELECTRONIC PRESCRIBING

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be REAFFIRMED as AMENDED:

3 **H327-A/14 ELECTRONIC PRESCRIBING**

4 The American Osteopathic Association (AOA) supports electronic prescribing (e-prescribing)
5 for non-scheduled pharmaceuticals.

6 The AOA supports e-prescribing for all scheduled pharmaceuticals on a voluntary basis without
7 CMS reimbursement monetary penalty **AND WITHOUT STATE SANCTIONED CIVIL**
8 **OR CRIMINAL PENALTIES.**

9 The AOA encourages pharmacies to utilize e-prescribing systems that are in compliance with
10 state and federal law.

11 The AOA supports the following principles in its advocacy efforts relating to the development
12 of e-prescribing standards:

- 13 • SAFETY: Safety alerts should be prioritized and readily distinguishable from
14 commercial messages; these messages should be allowed to be suppressed for efficiency.
- 15 • E-PRESCRIBING drugs should be listed with both generic and name brands.
- 16 • PRIVACY: Information on patients' medication should be current, comprehensive,
17 accurate and maintained in compliance with HIPAA.
- 18 • TRANSPARENCY: Third part involvement must be transparent and disclosed TO
19 THE PRESCRIBING PHYSICIAN AND PATIENT.
- 20 • DESIGN: Financial interests should not dictate the design of systems (i.e., all drugs
21 should be available). Standards must require fail-safes in any system to prevent the
22 introduction of ~~new~~ health care errors.
- 23 • INTEGRATION: Systems ~~should be proven~~ and should integrate with existing
24 healthcare technology and existing workflow (i.e., download of patient data from EMR).
- 25 • SCALABILITY: Any standards should be broad-based and applicable to all healthcare
26 delivery systems.
- 27 • TIMING: These standards should be in place at the earliest possible time to allow
28 software vendors and practitioners adequate time to become compliant with said
29 standards and perform all necessary testing prior to the implementation. 2004;
30 reaffirmed as amended 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H328-A/14 CARDIOVASCULAR DISEASE AND WOMEN

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED as AMENDED:

3 **H328-A/14 CARDIOVASCULAR DISEASE AND WOMEN**

4 The American Osteopathic Association: (1) encourages its members to participate in continuing
5 medical education programs on cardiovascular disease (CVD) in women; (2) urges osteopathic
6 state and specialty associations to offer CME on CVD in women, as part of their educational
7 offerings; (3) encourages its members to participate in national initiatives on women's health,
8 especially cardiovascular health such as the National Heart, Lung, and Blood Institute's The
9 Heart Truth (Red Dress) campaign; (4) ~~will continue to recognize National Women's Health~~
10 ~~Week and National Women's Check-Up Day; and~~ (4) **WILL CONTINUE TO**
11 **RECOGNIZE NATIONAL WOMEN'S HEALTH WEEK AND NATIONAL**
12 **WOMEN'S CHECK-UP DAY; AND** (5) ~~through its website, the AOA will link to~~
13 ~~organizations whose mission is to educate patients and physicians on CVD; and~~ (6) (5)
14 encourages appropriately designed studies on contributors to CVD in women. 2004; 2009;
15 reaffirmed as amended 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H329-A/14 HEALTHY WEIGHT FOR FAMILIES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED as AMENDED:

3 **H329-A/14 HEALTHY WEIGHT FOR FAMILIES**

4 The American Osteopathic Association encourages participation of its members in personal
5 health promotion; strongly recommends osteopathic medical schools incorporate personal
6 health promotion as a part of their graded curriculum; strongly recommends participation of its
7 members in outreach efforts to engage with local school districts in order to develop and
8 improve wellness policy interventions to reduce childhood obesity; strongly recommends the
9 state and specialty associations to collaborate with local school districts and major local
10 employers to enhance wellness policy development, implementation, data assessment and
11 improvements; encourages its members to participate in national and local initiatives on obesity;
12 ~~and, through its website, the AOA will link to the most up-to-date evidence on treating obesity.~~
13 2004; 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H330-A/14 ADMINISTRATIVE FEES

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED:

3 **H330-A/14 ADMINISTRATIVE FEES**

4 The American Osteopathic Association has determined that it is ethical for an osteopathic
5 physician to charge patients fair and reasonable administrative fees as long as the patient is
6 informed of these fees in advance, and the charging of administrative fees does not violate
7 contractual or state law. 2004; 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H331-A/14 END-OF-LIFE CARE – USE OF PLACEBOS IN

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED as AMENDED:

3 **H331-A/14 END-OF-LIFE CARE – USE OF PLACEBOS IN**

4 The AOA approves the attached position paper on Use of Placebos for Pain Management in
5 End-of-Life Care and will be updated according to the current literature. 2004; 2009; reaffirmed
6 as amended 2014

7 **USE OF PLACEBOS FOR PAIN MANAGEMENT IN END-OF-LIFE CARE**

8 The placebo effect of medication can be a significant resultant action of any prescription.
9 However, the substitution of a placebo in place of effective pain medication has been widely
10 recognized as unethical, ineffective and potentially harmful. ^(4, 4, 5, 9, 10, 11, 15, 16, 23, 24 1-9) A number of
11 organizations have advised against the use of placebo substitution, including the American Pain
12 Society, Agency for Healthcare Policy and Research, World Health Organization, the
13 Healthcare Facilities Accreditation Program, Joint Commission on Accreditation of Healthcare
14 Organizations, Education on End-of-Life Care Project (co-sponsored by the American Medical
15 Association), American Nursing Association, and the American Society of Pain Management
16 Nurses.

17 This white paper describes the literature and rationale in support of the AOA’s position on the
18 controversial subject of the use of placebos for pain management in terminally ill patients.

19 I. Definition of Terms

20 A. Placebo, placebo substitution, placebo effect and nocebo response

21 A placebo is a substance presumed to be pharmacokinetically inert. Placebo substitution
22 means the substitution of a physiologically inactive substance for a comparison with the
23 physiologically active substance. Placebo effect is the positive psychosomatic response
24 of an individual to a treatment; in contrast, the nocebo response is a negative
25 psychosomatic response to a treatment.⁽²¹⁰⁾ The placebo effect is an important adjunct in
26 the treatment of symptoms. The alleviation of symptoms has an inherent positive
27 psychological component; patients who perceive their symptoms to be relieved by the
28 treatment and trust in their treating physician’s treatment plan and/or prescription for
29 the symptom relief are more likely to obtain relief. ^(4 2)

30 Placebo responses are necessary for controlled clinical trials in which the patient is
31 informed that a placebo may indeed be utilized. Physiologic responses to placebo can be
32 pleasant or unpleasant to the patient. An unpleasant effect attributable to administration
33 of a placebo is called a “nocebo response”. A pleasant effect is called a “positive
34 placebo response”. It has been noted that, “a positive placebo response simply speaks

1 to the strength of an individual’s central control processes (i.e., mind) to recruit their
 2 descending inhibitory system to block pain. The trained osteopathic physician knows
 3 that pain relief occurs both in the mind and in the body.”^(9, 4) The basis of the placebo
 4 effect in a therapeutic physician-patient relationship also involves good communication
 5 skills as well as listening to the patient.^(3, 7, 9, 11, 12)

6 To summarize, a placebo is a type of treatment, necessarily used in controlled clinical
 7 trials, that has no inherent physiological action yet is designed to mimic a therapy with a
 8 known active physiologic effect. Positive changes resulting from placebo administration
 9 would be due to expectations of success by the patient. Thus, the use of placebo effect
 10 is based on the patient’s perception of the role of the placebo agent with symptom
 11 relief. The placebo response may be enhanced with a positive patient-physician
 12 relationship.

13 B. Addiction, substance abuse and dependence, tolerance, withdrawal and pseudo-
 14 addiction.

15 Some physicians inappropriately justify using placebo in pain management to avoid
 16 “addicting” the patient. Addiction, as defined by the American Academy of Pain
 17 Medicine,⁽¹³⁾ “is a primary, chronic, neurobiologic disease, with genetic, psychosocial,
 18 and environmental factors influencing its development and manifestations. It is
 19 characterized by behaviors that include one or more of the following: impaired control
 20 over drug use, compulsive use, continued use despite harm, and craving.” ~~Actually, it is~~
 21 ~~rare for a person to develop an addiction to pain medications.~~⁽¹⁵⁾

22 Substance abuse is defined as psychological and physical dependence on substances.
 23 Some physicians are concerned that prescribing narcotics may lead to substance abuse
 24 and therefore may attempt to use a placebo to assess whether the patient truly requires
 25 narcotics for pain relief. However, there is no scientific basis for using placebo in the
 26 assessment of the patient in pain who has or may have the potential for a substance
 27 abuse. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-
 28 V)⁽¹⁴⁾, lists definitive criteria for diagnosis of psychological and physical dependence
 29 on substances. This text categorizes “Substance-Related Disorders” but does not utilize
 30 the term addiction; further, nowhere in the DSM-V is placebo administration utilized
 31 with criteria for diagnosing various forms of substance abuse. Substance dependence is
 32 defined as a cluster of cognitive, behavioral and physiological symptoms. The essential
 33 feature of a substance dependent individual is continuous use of the substance despite
 34 significant substance-related problems, such as deleterious effects on occupation,
 35 relationships, health, and others.

36 Physicians may become uncomfortable with requests for increased dosages of pain
 37 medications, fearing that a patient is manifesting a substance-related disorder. A better
 38 understanding of the concepts of tolerance, physical dependence, physiological
 39 dependence withdrawal symptoms and pseudo-addiction, may help physicians
 40 understand and more effectively treat these patients.

41 Tolerance represents a markedly diminished effect that can occur with continued use of
 42 most medications; the degree depends upon the daily dose and length of use. The need
 43 for medication titration, either due to development of tolerance or to incomplete
 44 responsiveness, is a part of routine medical care. Tolerance occurs due to compensatory
 45 changes in receptors and/or increased clearance resulting from induction of various

1 metabolic pathways. The problem of tolerance should therefore be anticipated as a
2 possible outcome in prescription pain medications.

3 Withdrawal is defined by the DSM-V ⁽¹⁴⁾ as a maladaptive behavioral change having
4 physiological and cognitive concomitants, which occurs when blood or tissue
5 concentrations of a substance decline in an individual who had maintained prolonged
6 use of the substance, frequently inappropriately. Examples of withdrawal include the
7 onset of seizures or delirium tremens in a newly abstinent alcohol chemically dependent
8 individual.

9 Pseudo-addiction is the term used to describe the behavior of a patient in pain who is
10 receiving an insufficient amount and/or an inappropriate dosing frequency of
11 administration of the prescribed pain medication. In an effort to obtain relief, the
12 patient in pain would request more frequent and/or increased medication. Such “drug
13 seeking behavior” has been deemed as “proof” of “addiction.” The reason for such
14 requests is frequently that the patient is under-dosed, receiving too little of the
15 medication and/or too long a delay between doses of the pain medication. In such
16 instances, the patient receives inappropriate pain relief, which is not an appropriate
17 criterion of a substance-abusing patient according to the DSM- V.⁽¹⁴⁾

18 II. Legal Considerations in the Use of Placebos in Pain Management

19 While there are no specific laws governing the use of placebos in any circumstance, there is
20 a considerable amount of legislation regarding a patient’s right to pain management. There
21 are several state statutes that address this issue, some of which are based on the Federation
22 of State Medical Boards’ Model Guidelines for the Use of Controlled Substances for the
23 Treatment of Pain.⁽¹⁵⁾ This document clarifies that legislative statutes accepting these
24 guidelines understand the ongoing increased scientific knowledge of pain management, and
25 thus have no need to modify legislation as the science of pain management changes. This
26 document does not mention placebo usage. ⁽¹⁶⁾

27 The American Bar Association (ABA)⁽¹⁶⁾ adopted a resolution concerning the promotion of
28 pain management in all patients with chronic pain. This resolution states, “...that the
29 American Bar Association urges federal, state and territorial governments to support fully
30 the rights of individuals suffering from pain to be informed of, choose, and receive effective
31 pain and symptom evaluation, management and ongoing monitoring as part of basic
32 medical care, even if such pain and symptom management may result in analgesic tolerance,
33 physical dependence or as an unintended consequence shorten the individual’s life.” ⁽¹⁷⁾
34 Placebo substitution for active pain medicine without informed consent on the part of the
35 patients clearly violates the nature and substance of the ABA’s position. Additionally, in two
36 Supreme Court decisions regarding the right to assisted suicide, the court promoted the
37 right of individuals to appropriate palliative care and pain management. ^(17, 18)

38 While there is little case law concerning tort or administrative findings against physicians for
39 inadequate pain management, this is likely to change in the near future. The main barrier to
40 malpractice claims for inadequate pain management is use of the customary local standard
41 to determine what constitutes ordinary care. The courts are steadily moving away from this
42 standard to a national standard which uses clinical guidelines as the determinant of ordinary
43 care. This is seen in the decision in the case of *Nowatske v. Oserloh*, where the court stated,
44 “should customary medical practice fail to keep pace with development and advances in
45 medical science, adherence to custom might constitute a failure to exercise ordinary care...”
46 ⁽¹⁹⁾

1 Guidelines developed by the Agency for Healthcare Policy and Research, now the Agency
 2 for Healthcare Research and Quality ⁽¹⁾, the American Pain Society, ⁽⁷⁾ the Healthcare
 3 Facilities Accreditation Program ⁽²⁰⁾ as well as the Joint Commission on Accreditation of
 4 Healthcare Organizations⁽²¹⁾ are good examples of sources the courts are using to determine
 5 ordinary practice.^(+13,+17) These guidelines do not support the use of placebo in any fashion
 6 except in approved research studies when the appropriate patient informed consent has
 7 been obtained. Therefore, the physician thus cannot justify the use of placebo for pain
 8 management by attempting to diagnose “addiction” or with support from any of the above
 9 regulatory agencies.⁽⁺⁶⁵⁾

10 Furthermore, under California’s elder abuse statute, ⁽²²⁾ a physician was successfully sued by
 11 the deceased’s family for inadequate pain management at the end of life. ⁽⁺²³⁾

12 III. Adverse Effects of Placebo Use

13 Pain is a universal experience and is subjective by nature. Despite the common
 14 colloquialism, “I feel your pain,” no individual can truly experience another’s pain. There
 15 are no laboratory tests or consistently reliable physical findings for assessment of pain.
 16 Patient self-report remains the gold standard for pain assessment. ⁽⁺²⁴⁾ Use of a placebo in
 17 place of an effective pain medication for attempting to determine whether the patient at
 18 end-of life is really in pain is under no circumstances appropriate.

19 There is a concern if a physician deceives the patient and substitutes a placebo treatment in
 20 the place of a known effective treatment without informing the patient. Deception has no
 21 place within the therapeutic relationship and is counter-productive. A physician may
 22 counsel a patient that “this treatment may be effective in treating your condition,” but
 23 evidence-based medicine cannot guarantee a treatment outcome.

24 In this era of informed consent, deception of the patient poses many problems, including
 25 erosion of the trust individuals and society as a whole have for physicians. There are
 26 methods of using placebos and the placebo effect that do not involve deceit, e.g., clinical
 27 trials or the use of placebo as one of the trial agents for neurolytic block. This one narrow
 28 exception uses the placebo trial as part of the treatment selection for neurolytic blockade, a
 29 highly specialized procedure performed by a few skilled pain management physicians with
 30 appropriate informed consent.

31 Substituting placebo for accepted forms of pain treatment is under-treatment of the
 32 condition. Under-treatment of pain, as detailed in the American Bar Association’s 2000
 33 report, is an ongoing problem. ⁽⁺²⁵⁾ While there have been reports of placebo efficacy in
 34 pain management, placebo control of pain occurs in fewer patients and for shorter duration
 35 than active pain treatments. ^(8-9,+64, 7, 26) It has also been argued that the prescription of an
 36 ineffective placebo in place of effective pain medication can act as a “suicidogen,” whereby
 37 an individual in pain who is given inadequate medication for relief may be prompted to
 38 hasten his/her death. ⁽⁺⁶⁾ In the clinical setting, substitution of a placebo for an active pain
 39 medication, even with the consent of the patient, is clinically suspect because better
 40 treatment alternatives exist and there are risks associated with the use of placebos. It is
 41 therefore inappropriate to substitute a placebo for a medication known to be effective in
 42 the treatment of a patient with the verified pain of a terminal illness.

43 Additionally, placebos are associated with side effects ⁽⁵³⁾ and potentially precipitate
 44 hyperalgesia ⁽⁺²⁷⁾ or withdrawal in patients previously treated with pain medications.

45 IV. Summary

1 Exquisite management of end-of-life pain is a medical imperative. Use of a placebo in place of
 2 known effective pain medication for determining whether the patient is really in pain is under
 3 no circumstances appropriate. Use of placebos does not meet the accepted criteria to diagnose
 4 substance abuse, commonly referred to by some physicians as “addiction.” There is no medical
 5 justification for the use of placebos to assess or treat pain at end of life.

6 The only appropriate use of a placebo is in approved clinical research with informed consent.

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Explanatory Statement:

Striking out statement on page 2 (lines 20-21) and corresponding reference. All remaining references have been checked and revised editorially.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H332-A/14 MINORITIES IN THE OSTEOPATHIC PROFESSION –
COLLECTING DATA

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED:

3 **H332-A/14 MINORITIES IN THE OSTEOPATHIC PROFESSION –**
4 **COLLECTING DATA**

5 The American Osteopathic Association (AOA) will: (1) include ~~optional~~ questions relating to
6 race, ethnicity, and socioeconomic status as part of the data collected from physicians in
7 membership records; (2) encourage the American Association of Colleges of Osteopathic
8 Medicine (AACOM), individual osteopathic medical colleges, osteopathic residency programs,
9 state associations and specialty colleges to submit existing data on minority representation in the
10 osteopathic profession to the AOA; (3) encourage all osteopathic organizations to work with
11 and respond to future inquiries from the AOA on this and similar matters; (4) distribute all of
12 the information gathered through this initiative only as non-identifiable or aggregate
13 demographic data; and (5) encourage all specialty colleges to establish committees to address
14 training, fellowship, cultural competency and service issues related to underrepresented
15 minorities (~~including but not limited to Hispanic/Latino Ethnicity, Black/African~~
16 ~~American, Native American, Alaska Native and Hawaiian/Pacific Islander~~) and to work
17 collaboratively with the AOA to **IMPLEMENT** programs ~~implement~~ with multi-cultural
18 impact. 2004; reaffirmed 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H333-A/14 OSTEOPATHIC MANIPULATIVE TREATMENT (OMT)
OF THE CERVICAL SPINE

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, the House of Delegates referred H-333-A/2014 OSTEOPATHIC
2 MANIPULATIVE TREATMENT (OMT) OF THE CERVICAL SPINE to the
3 Bureau of Osteopathic Clinical Education and Research (BOCER) to review and update
4 as some of the information provided in support of the position statement was out of
5 date and needed citations; and

6 WHEREAS, the BOCER reviewed referred resolution H-333 - A/2014 and developed an
7 updated position statement; now, therefore be it

8 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
9 the following policy be REAFFIRMED as AMENDED:

10 **H333-A/14 OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) OF THE**
11 **CERVICAL SPINE**

12 The American Osteopathic Association, in the hopes of advancing the science of osteopathic
13 medicine adopts the following position (2004; reaffirmed 2009 [Editor's note: This policy has
14 been referred to as some of the information is out of date and needs citations - 2014]).

15 (These recommendations are provided for osteopathic educators and physicians making
16 decisions regarding the instruction of cervical spinal manipulation and the care of patients. As
17 such, they cannot substitute for the individual judgment brought to each clinical situation by a
18 patient's physician. Like all reference resources, they reflect the best understanding of the
19 science of medicine at the time of publication, but they should be used with the understanding
20 that continued research is needed.)

21 **AMERICAN OSTEOPATHIC ASSOCIATION OSTEOPATHIC MANIPULATIVE**
22 **TREATMENT OF THE CERVICAL SPINE**

23 ~~Background and Statement of Issue~~

24 ~~There has recently been an increasing concern about the safety of cervical spine manipulation.~~
25 ~~Specifically, this concern has centered on devastating negative outcomes such as stroke. This~~
26 ~~paper will present the evidence behind the benefit of cervical spine manipulation, explore the~~
27 ~~potential harm and make a recommendation about its use.~~

28 ~~Benefit~~

29 ~~Spinal manipulation has been reviewed in meta-analysis published as early as 1992, showing a~~
30 ~~clear benefit for low back pain. There is less available information in the literature about~~
31 ~~manipulation in regards to neck pain and headache, but the evidence does show benefit. There~~
32 ~~have been at least 12 randomized controlled trials of manipulative treatment of neck pain.~~

1 Some of the benefits shown include relief of acute neck pain, reduction in neck pain as
2 measured by validated instruments in sub-acute and chronic neck pain compared with muscle
3 relaxants or usual medical care. There is also short-term relief from tension-type headaches.
4 Manipulation relieves cervicogenic headache and is comparable to commonly used first line
5 prophylactic prescription medications for tension-type headache and migraine. Meta-analysis of
6 5 randomized controlled trials showed that there was a statistically significant reduction in neck
7 pain using a visual analogue scale.

8 Harm

9 Since 1925, there have been approximately 275 cases of adverse events reported with cervical
10 spine manipulation. It has been suggested by some that there is an under-reporting of adverse
11 events. A conservative estimate of the number of cervical spine manipulations per year is
12 approximately 33 million and may be as high as 193 million in the US and Canada. The
13 estimated risk of adverse outcome following cervical spine manipulation ranges from 1 in
14 400,000 to 1 in 3.85 million manipulations. The estimated risk of major impairment following
15 cervical spine manipulation is 6.39 per 10 million manipulations.

16 Most of the reported cases of adverse outcome have involved “Thrust” or “High Velocity/Low
17 Amplitude” types of manipulative treatment. Many of the reported cases do not distinguish the
18 type of manipulative treatment provided. However, the risk of a vertebrobasilar accident (VBA)
19 occurring spontaneously, is nearly twice the risk of a VBA resulting from cervical spine
20 manipulation. This includes cases of ischemic stroke and vertebral artery dissection.

21 A concern has been raised by a recent report that VBA following cervical spine manipulation is
22 unpredictable. This report is biased because all of the cases were involved in litigation.

23 The nature of litigation can lead to inaccurate reporting by patient or provider. However, it did
24 conclude that VBA following cervical spine manipulation is “idiosyncratic and rare”. Further
25 review of this data showed that 25% of the cases presented with sudden onset of new and
26 unusual headache and neck pain often associated with other neurologic symptoms that may
27 have represented a dissection in progress.

28 In direct contrast to this concern of unpredictability, another recent report states that cervical
29 spine manipulation may worsen preexisting cervical disc herniation or even cause cervical disc
30 herniation. This report describes complications such as radiculopathy, myelopathy, and
31 vertebral artery compression by a lateral cervical disc herniation. The authors concluded that the
32 incidence of these types of complications could be lessened by rigorous adherence to published
33 exclusion criteria for cervical spine manipulation. The current literature does not clearly
34 distinguish the type of provider (i.e. MD, DO, DC or PT) or manipulative treatment
35 (manipulation vs. mobilization) provided in cases associated with VBA. This information may
36 help to understand the mechanism of injury leading to VBA, as there are differences in
37 education and practice among the various professions that utilize this type of treatment.

38 Comparison of Alternative Treatments

39 NSAIDs are the most commonly prescribed medications for neck pain. Approximately 13
40 million Americans use NSAIDs regularly. 81% of GI bleeds related to NSAID use occur
41 without prior symptoms. Research in the United Kingdom has shown NSAIDs will cause
42 12,000 emergency admissions and 2,500 deaths per year due to GI tract complications. The
43 annual cost of GI tract complications in the US is estimated at \$3.9 billion, with up to 103,000
44 hospitalizations and at least 16,500 deaths per year. This makes GI toxicity from NSAIDs the
45 15th most common cause of death in the United States.

1 Epidural steroid injection is a popular treatment for neck pain. Common risks include subdural
2 injection, intrathecal injection and intravascular injection. Subdural injection occurs in ~ 1% of
3 procedures. Intrathecal injection occurs in ~ 0.6-10.9% of procedures. Intravascular injection is
4 the most significant risk and occurs in ~ 2% of procedures and ~ 8% of procedures in pregnant
5 patients. Cervical epidural abscess is rare, but has been reported in the literature.

6 Provocative Tests

7 Provocative tests such as the DeKline test have been studied in animals and humans. This test
8 and others like it were found to be unreliable for demonstrating reproducibility of ischemia or
9 risk of injuring the vertebral artery.

10 Risk Factors

11 VBA accounts for 1.3 in 1000 cases of stroke, making this a rare event. Approximately 5% of
12 patients with VBA die as a result, while 75% have a good functional recovery. The most
13 common risk factors for VBA are migraine, hypertension, oral contraceptive use and smoking.
14 Elevated homocysteine levels, which have been implicated in cardiovascular disease, may be a
15 risk factor for VBA.

16 A study done in 1999 reviewing 367 cases of VBA reported from 1966-1993 showed 115 cases
17 related to cervical spine manipulation; 167 were spontaneous, 58 from trivial trauma and 37
18 from major trauma.

19 Complications from cervical spine manipulation most often occur in patients who have had
20 prior manipulation uneventfully and without obvious risk factors for VBA. “Most
21 vertebrobasilar artery dissections occur in the absence of cervical manipulation, either
22 spontaneously or after trivial trauma or common daily movements of the neck, such as backing
23 out of the driveway, painting the ceiling, playing tennis, sneezing, or engaging in yoga
24 exercises.” In some cases manipulation may not be the primary insult causing the dissection, but
25 an aggravating factor or coincidental event.

26 It has been proposed that thrust techniques that use a combination of hyperextension, rotation
27 and traction of the upper cervical spine will place the patient at greatest risk of injuring the
28 vertebral artery. In a retrospective review of 64 medical legal cases, information on the type of
29 manipulation was available in 39 (61%) of the cases. 51% involved rotation, with the remaining
30 49% representing a variety of positions including lateral flexion, traction and isolated cases of
31 non-force or neutral position thrusts. Only 15% reported any form of extension.

32 Conclusion

33 Osteopathic manipulative treatment of the cervical spine, including but not limited to High
34 Velocity/Low Amplitude treatment, is effective for neck pain and is safe, especially in
35 comparison to other common treatments. Because of the very small risk of adverse outcomes,
36 trainees should be provided with sufficient information so they are advised of the potential
37 risks. There is a need for research to distinguish the risk of VBA associated with manipulation
38 done by provider type and to determine the nature of the relationship between different types
39 of manipulative treatment and VBA.

40 Therefore, it is the position of the American Osteopathic Association that all modalities of
41 osteopathic manipulative treatment of the cervical spine, including High Velocity/Low
42 Amplitude, should continue to be taught at all levels of education, and that osteopathic
43 physicians should continue to offer this form of treatment to their patients.

1 Background and Statement of Issue

2 Treating chronic pain continues to be an important health issue for osteopathic physicians.
3 Chronic pain affects over 100 million Americans over the age of 18 and negatively impacts their
4 quality of life.¹ In addition, it costs \$600 billion a year in healthcare costs and loss of
5 productivity.¹ Back and neck pain are two leading causes of chronic pain and they are amongst
6 the leading causes of people living with disabilities in the United States (U.S.) as well as
7 worldwide. More specifically, back and neck pain are ranked in the top 8 diseases and injuries in
8 the U.S. regarding years lived with disability (YLDs)² and in the top 6 globally.³ Cervical spine
9 manipulation is one option for treating back and neck pain.

10 Concerns continue to arise regarding the safety of cervical spine manipulation. Specifically,
11 concerns center on the potential development of serious adverse events such as stroke and
12 cervical artery dissection after spinal manipulation. Since spinal manipulation is an option
13 available to osteopathic physicians to incorporate into the care of their patients, it is important
14 to examine these concerns and develop a position on the issue. This paper will present the
15 evidence behind the benefit of cervical spine manipulation, explore the potential harms and
16 make a recommendation about its use.

17 Benefit

18 Spinal manipulation has been reviewed in various systematic reviews and meta-analyses over the
19 past three decades. The majority of the studies conducted on spinal manipulation focus on low
20 back pain for which the evidence has shown spinal manipulation has clear benefits.⁴⁻⁷ For neck
21 pain, however, there are fewer studies and the findings vary, but there is some evidence that
22 conclude spinal manipulation benefits patients presenting with neck pain.⁸⁻¹³ This evidence
23 indicates that the benefits of spinal manipulation include relief of acute neck pain, and
24 reduction in neck pain as measured by validated instruments in sub-acute and chronic neck pain
25 compared with muscle relaxants or usual medical care.¹³⁻¹⁷ Bronfort et al.¹⁵ specifically
26 concluded that for patients with chronic neck pain, there is moderate evidence that (1)
27 manipulation and mobilization are superior to general practitioner management in the short
28 term, (2) high-technology exercise results in more pain improvement than manipulation in the
29 long term for a mix of patients with acute and chronic pain, and (3) mobilization is superior to
30 physical therapy and general medical care and similar to manipulation in both the short and
31 long term.

32 Benefits of spinal manipulation for areas beyond the low back and neck include short-term
33 relief from tension-type headaches.¹⁴ Manipulation relieves cervicogenic headache and is
34 comparable to commonly used first line prophylactic prescription medications for tension-type
35 headache and migraine.

36 Harm

37 Overall

38 The literature presents varying conclusions on the harms of spinal manipulative treatment
39 (SMT).^{6,7} In a 2017 review of risks associated with spinal manipulation, 46% percent of the
40 studies reviewed found spinal manipulation to be safe, 42% percent were neutral (did not find
41 harm/benefit); and the remaining 12% percent concluded that spinal manipulation was unsafe
42 because of the possibility of serious adverse events.⁷ Nevertheless, the existence of any adverse
43 effect should not be trivialized.

44 Studies have noted that there are two types of adverse effects as a result of SMT. The first type
45 is considered to be mild adverse events that are short-term and non-serious such as dizziness,
46 fatigue, and muscle soreness/ discomfort.^{7,18} These side effects occur in 23-83% of patients.

1 The second type of adverse events is more serious and includes cervical artery dissection,
2 stroke, spinal cord injuries, and other serious conditions outcomes related to vertebrobasilar
3 accidents (VBAs). Currently, much of the literature discusses vertebrobasilar insufficiency or
4 vertebralbasilar ischemia (VBI) which is a type of VBA and is often determined to be the link to
5 the more serious adverse events. Nonetheless, serious adverse events are seen as a rarity, and it
6 is estimated that they occur in the range of every 20,000 to 250,000,000 manipulation
7 performed.^{7,18-27}

8 Most of the reported cases of adverse outcomes have involved thrust or High Velocity/Low
9 Amplitude (HVLA) types of manipulative treatment.^{18,25} Unfortunately, many of the reported
10 cases do not distinguish the type of manipulative treatment provided.

11 VBAs

12 VBAs account for 1.3 in 1000 cases of stroke, making them a rare event. Approximately 5% of
13 patients with a VBA die as a result, while 75% have a good functional recovery.²⁸ The most
14 common risk factors for VBAs are migraine, hypertension, oral contraceptive use and
15 smoking.²⁹ Elevated homocysteine levels, which have been implicated in cardiovascular disease,
16 may be a risk factor for a VBA.³⁰

17 The risk of a VBA occurring spontaneously, is nearly twice the risk of a VBA resulting from
18 cervical spine manipulation.¹⁴ A study done in 1999 reviewing 367 cases of VBA reported from
19 1966-1993 showed 115 cases related to cervical spine manipulation; 167 were spontaneous, 58
20 from trivial trauma and 37 from major trauma.³¹

21 A study in 2002 conducted by Haldeman et al., reported that a VBA following cervical spine
22 manipulation was unpredictable.¹⁴ The authors, however, concluded that a VBA following
23 cervical spine manipulation was “idiosyncratic and rare”. Further review of the data showed
24 that 25% of the cases presented with sudden onset of new and unusual headache and neck pain
25 often associated with other neurologic symptoms that may have represented a dissection in
26 progress.³²

27 Complications from cervical spine manipulation most often occur in patients who have had
28 prior manipulation uneventfully and without obvious risk factors for a VBA.¹⁴ “Most
29 vertebrobasilar artery dissections occur in the absence of cervical manipulation, either
30 spontaneously or after trivial trauma or common daily movements of the neck, such as backing
31 out of the driveway, painting the ceiling, playing tennis, sneezing, or engaging in yoga
32 exercises.”²⁴ In some cases manipulation may not be the primary culprit for causing the
33 dissection, but an aggravating factor or coincidental event.³²

34 It has been proposed that thrust techniques that use a combination of hyperextension, rotation
35 and traction of the upper cervical spine will place the patient at greatest risk of injuring the
36 vertebral artery. In a retrospective review of 64 medical legal cases, information on the type of
37 manipulation was available in 39 (61%) of the cases. Fifty-one percent (51%) involved rotation,
38 with the remaining 49% representing a variety of positions including lateral flexion, traction and
39 isolated cases of non-force or neutral position thrusts. Only 15% reported any form of
40 extension.³²

41 Cervical Artery Dissection (CAD)

42 CAD occurs at a rate of 2.9 per 100,000 individuals every year in the general population, and a
43 large majority (89%) of the individuals diagnosed with CAD have no symptoms or no
44 significant disability that prohibits them from being productive within the following three
45 months of the event.³³ Among those with symptoms, headaches and neck pain are the

1 predominant symptoms for CAD. This creates a dilemma for physicians because cervical spine
2 manipulation is often sought to treat these medical issues. Thus, it is difficult to determine if
3 manipulation causes CAD or if CAD existed at the time of treatment.

4 Limitations of Studies and Concerns with Pre-manipulation Screening

5 Due to the design of studies (case reports or retrospective surveys), infrequent reporting of
6 adverse events, and the rare occurrence of many of the more serious complications, it is
7 difficult to determine a causal relationship between SMT and the serious adverse effect.^{7,33} Thus
8 the lingering question of whether or not pre-existing pathologies may have existed prior to the
9 patient receiving SMT remains.^{18,26,34}

10 In Malone et al., the authors reported that cervical spine manipulation may worsen preexisting
11 cervical disc herniation or even cause cervical disc herniation.²⁶ This report describes
12 complications such as radiculopathy, myelopathy, and vertebral artery compression by a lateral
13 cervical disc herniation. The incidence of these types of complications could be lessened by
14 rigorous adherence to published exclusion criteria for cervical spine manipulation.^{26,35}

15 Another noteworthy point to highlight is that the literature does not clearly distinguish the type
16 of provider (i.e. M.D., D.O., D.C. or P.T.) or manipulative treatment (manipulation vs.
17 mobilization) provided in cases associated with serious adverse effects. This information may
18 help to understand the mechanism of injury leading to serious adverse effects, as there are
19 differences in education and practice among the various professions that utilize this type of
20 treatment. It is duly noted that the osteopathic approach strictly limits the “thrust”, which is
21 more commonly referred to as “impulse” in osteopathic practicums, to the physiologic barrier
22 as opposed to the chiropractic approach may extend to the parapsysiologic space.

23 Additionally, pre-manipulation screening tools, that might be used to identify a patient’s risk for
24 VBA and cervical artery dissection have been widely criticized because they have been found to
25 be unreliable and difficult to validate.^{28,29,36-43} These studies have examined the DeKleyn’s test
26 and others like it and determined the tests are unreliable for demonstrating reproducibility of
27 ischemia or risk of injuring the vertebral artery.³⁶⁻⁴³ For this reason, researchers and groups such
28 as the Bone and Joint Decade Task Force on Neck Pain and Its Associated Disorders
29 recommend that all health care providers conduct a thorough patient history, physical
30 examination and patient self-assessment to rule out certain pre-existing conditions.^{13,44}

31 Alternative Treatments

32 Non-steroidal anti-inflammatory drugs (NSAIDs)

33 NSAIDs such as ibuprofen and aspirin are the most commonly prescribed medications for
34 neck pain. More than 30 million people worldwide use NSAIDs regularly.⁴⁵ In fact, 5% of all
35 medical visit outcomes in the U.S. include a prescription for NSAIDs.⁴⁶ NSAIDs offer
36 temporary relief, but long-term use, gender, age, strength of dose as well as consumption of
37 multiple medications simultaneously may be associated with serious risks affecting the
38 gastrointestinal (GI), renal and cardiovascular systems.^{47,48} Eighty-one percent (81%) of GI
39 bleeds related to NSAID use occur without prior symptoms.⁴⁹ Research in the United Kingdom
40 has shown NSAIDs will cause 12,000 emergency admissions and 2,500 deaths per year due to
41 GI tract complications.³⁰ The annual cost of GI tract complications in the U.S. is estimated at
42 \$3.9 billion, with up to 103,000 hospitalizations and at least 16,500 deaths per year therein
43 making GI toxicity from NSAIDs the 15th most common cause of death in the United States.⁴⁹⁻
44 ⁵¹

45 Epidural steroid injections

1 Epidural steroid injections (ESIs) are a popular treatment for neck pain.⁵⁰ Complications to
2 ESIs generally occur because of needle placement or drug administration. Common risks
3 associated with needle placement include subdural injection, intrathecal injection and
4 intravascular injection.⁵¹ Subdural injection occurs in ~ 1% of procedures, intrathecal injection
5 occurs in ~ 0.6-10.9% of procedures, and intravascular injection, the most significant risk,
6 occurs in ~ 2% of procedures.⁵¹ Other risks include cervical epidural abscess, dural puncture,
7 spinal cord trauma, infection, hematoma, nerve damage, vascular injury and cerebral vascular
8 or pulmonary embolus.^{52,53} Complications that may arise from drug administration include
9 osteoporosis, Cushing's syndrome, avascular necrosis of bone, and steroid myopathy. While
10 complications due to needle placement or administration of steroids are rare, they have been
11 reported in the literature.^{52,53}

12 Conclusion

13 Osteopathic manipulative treatment of the cervical spine, including but not limited to HVLA
14 treatment, is effective for low back and neck pain and is safe. Because of the rarity of serious
15 adverse events, trainees and practicing physicians should be provided with sufficient
16 information so they are advised of the potential risks and able to communicate the potential
17 risks to their patients. Prior to recommending cervical spine manipulations, physicians should
18 conduct a thorough patient exam and medical history review to try to identify any preexisting
19 conditions that may indicate the patient is at risk for a serious adverse event. Additionally, it is
20 recognized that there is a need for research to distinguish the risk of VBA and CAD associated
21 with manipulation done by specific provider types as well as research to determine the nature of
22 the relationship between the different types of manipulative treatment and VBA and CAD.

23 It is the position of the American Osteopathic Association that all modalities of osteopathic
24 manipulative treatment of the cervical spine, including HVLA, should continue to be taught at
25 all levels of education, and that osteopathic physicians should continue to offer this form of
26 treatment to their patients. Physicians should use a combination of medical history reviews and
27 physical exams, diagnostic studies, and best judgment to determine if a patient has any pre-
28 existing conditions that place the patient at risk of suffering a serious adverse event.

29 Special Acknowledgements

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2 Manchikanti, L. (2007). Epidural steroids in the management of chronic spinal pain: A
3 systematic review. Pain Physician, 10, 185-212.

ACTION TAKEN **APPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: H334-A/14 RIGHT TO PRIVATELY CONTRACT

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be REAFFIRMED as AMENDED:

3 **H334-A/14 RIGHT TO PRIVATELY CONTRACT**

4 The American Osteopathic Association supports the fundamental right of physicians to
5 privately contract with patients without penalties and regardless of payor, ~~within the framework~~
6 ~~of free market principles and seek~~SUPPORTS changes in statutes and regulations that will ~~TO~~
7 allow physicians individually and as defined groups ~~be allowed~~ to negotiate fair contracts with
8 private sector and public sector health plans. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H336-A/14 PROMOTING DIVERSITY IN AOA MEMBERSHIP AND LEADERSHIP

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Membership recommend that the following policy be
2 REAFFIRMED as AMENDED:

3 **H336-A/14 PROMOTING DIVERSITY IN AOA MEMBERSHIP AND**
4 **LEADERSHIP**

5 The American Osteopathic Association reaffirms its commitment to promote **DIVERSITY**
6 ~~the advancement and integration of qualified women and underrepresented minorities~~
7 ~~(including, but not limited to Hispanic/Latino Ethnicity, Black/African Americans, Native~~
8 ~~American/Alaska Natives, and Hawaiian/Pacific Islander)~~ into the osteopathic profession;
9 endorses programs to encourage increased **DIVERSITY IN** enrollment ~~of these groups~~ at
10 colleges of osteopathic medicine; and will work to identify and encourage **SUCH** qualified
11 individuals ~~from these groups~~ for participation in those osteopathic affiliate and national
12 activities which foster leadership opportunities. reaffirmed 1979; revised 1983, 1988, 1994;
13 reaffirmed 1999, revised 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H337-A/14 ABUSE OF PERFORMANCE ENHANCING SUBSTANCES
AND PROCEDURES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H337-A/14 ABUSE OF PERFORMANCE ENHANCING SUBSTANCES AND**
4 **PROCEDURES**

5 The American Osteopathic Association: (1) supports efforts to eliminate the abuse of
6 performance enhancing substances, known as doping, for the purpose of enhancing athletic
7 performance or physical appearance; (2) supports the efforts of the United States Anti-Doping
8 Agency (USADA) and its program in accordance with the World Anti-Doping **AGENCY**
9 (WADA) code and the WADA International Standards (IST) to protect clean athletes and
10 ensure their rights to compete on a fair and level playing field, free from the pressures of
11 performance enhancing drugs; and (3) encourages education of athletes, the public and
12 physicians of the dangers of these substances. 1989, revised 1994, 1999, revised 2004;
13 reaffirmed as amended 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H338-A/14 DIVERSITY IN LEADERSHIP POSITIONS

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Membership recommend that the following policy be
2 REAFFIRMED:

3 **H338-A/14 DIVERSITY IN LEADERSHIP POSITIONS**

4 The American Osteopathic Association supports increased awareness of and encourages
5 diversity in its leadership positions and encourages its divisional and specialty societies to do the
6 same. 1999, revised 2004; reaffirmed 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H339-A/14 TOBACCO USE STATUS – REPORTING IN THE
MEDICAL RECORD

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED as AMENDED:

3 **H339-A/14 TOBACCO USE STATUS – REPORTING IN THE MEDICAL**
4 **RECORD**

5 The American Osteopathic Association supports the ~~Agency for Healthcare Research and~~
6 ~~Quality's (AHRQ)~~ U.S. PREVENTIVE SERVICES TASK FORCE (USPSTF) guideline on
7 tobacco use cessation that specifically recommends ~~a method~~ of identifying tobacco use status
8 on each patient visit to increase the likelihood of physician intervention with their patients who
9 use tobacco. 1999; revised 2004; reaffirmed 2009; 2014

Explanatory Statement:

The policy is consistent with current USPSTF guidelines.

<https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1>

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H344-A/14 MEDICAL COSTS INCURRED BY PATIENTS FOR SERVICES NOT COVERED BY THEIR INSURANCE

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED as AMENDED:

3 **H344-A/14 SURPRISE MEDICAL BILL COSTS INCURRED BY PATIENTS FOR**
4 **SERVICES NOT COVERED BY THEIR INSURANCE**

5 The American Osteopathic Association (AOA) will advocate for hospitals and other sites of
6 medical services to inform patients in advance of scheduled procedures, who the service
7 providers involved in their care will be and whether or not those providers are covered IN
8 NETWORK AND COVERED by the patients' insurance. The AOA supports providing
9 patients with an estimate of all the costs of their procedure as well as the identity of all ancillary
10 providers that will be participating in their care in advance of the procedure if they are
11 personally responsible for assuring payment for these services. The AOA strongly supports
12 giving patients the opportunity to select ancillary providers who are covered IN NETWORK
13 AND COVERED by their insurance so that they are not exposed UNKNOWINGLY
14 RESPONSIBLE FOR MEDICAL EXPENSES AND to medical BILLS expenses for which
15 they are not prepared. 2014

ACTION TAKEN **APPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: H345-A/14 ELECTRONIC MEDICAL RECORD (EMR) – STUDENT
ACCESS AND USE

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy
2 be REAFFIRMED:

3 **H345-A/14 ELECTRONIC MEDICAL RECORD (EMR) – STUDENT ACCESS**
4 **AND USE**

5 The American Osteopathic Association will work with the American Association of Colleges of
6 Osteopathic Medicine and the American Osteopathic Association of Medical Informatics to
7 promote the opportunity for medical students to document and practice order entry in EMRs at
8 facilities where osteopathic medical students are trained. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H346-A/14 TESTOSTERONE THERAPY: LONG TERM EFFECT ON HEALTH

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED:

3 **H346-A/14 TESTOSTERONE THERAPY: LONG TERM EFFECT ON HEALTH**
4 The American Osteopathic Association requests that the National Institutes of Health fund
5 independent research of the long term risk/benefits of testosterone therapy. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H348-A/14 COMPENSATION TIED TO PATIENT SATISFACTION SURVEYS – OSTEOPATHIC PHYSICIAN

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED as AMENDED:

3 **H348-A/14 COMPENSATION TIED TO PATIENT SATISFACTION SURVEYS –**
4 **OSTEOPATHIC PHYSICIAN**

5 The American Osteopathic Association opposes the principle that any SUPPORTS
6 PARTICIPATION IN PATIENT satisfaction surveys **WITHOUT WITH** have a significant
7 MINIMAL impact on osteopathic physician's compensation PAYMENT. 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: AVAILABILITY OF BIOSIMILAR PRODUCTS

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, the costs of biologics are a significant factor in rising drug prices, accounting for
2 38 percent of U.S. prescription drug spending, and 70 percent of drug spending growth
3 between 2010 and 2015¹; and

4 WHEREAS, entrance of biosimilars onto drug markets have significant potential to reduce
5 drug prices and help contain spending growth, yet only 12 biosimilars have been FDA
6 approved²; and

7 WHEREAS, the development and marketing of biosimilars should be encouraged, but
8 additional consideration should be given to protecting patient; because biosimilars are
9 developed with living organisms, they vary more significantly from their reference
10 product than a chemical-based generic drug would; and

11 WHEREAS, physicians should maintain discretion over patient treatment plans and when
12 therapies may be substituted in consideration of a patient’s condition and circumstance;
13 now, therefore be it

14 RESOLVED, that the American Osteopathic Association (AOA) supports policies that
15 strengthen the biosimilar market while preserving **THE physician-PATIENT**
16 **RELATIONSHIP** ~~authority over patient care~~ and protecting patient safety; and, be it
17 further

18 **RESOLVED, THAT FDA APPROVED DRUGS SHOULD BE ACCESSIBLE TO**
19 **PATIENTS, AND, BE IT FURTHER**

20 **RESOLVED, THAT THE DECISION ON WHICH BIOLOGIC OR BIOSIMILAR**
21 **SHOULD BE USED REST WITH THE PATIENT AND THE PHYSICIAN;**
22 **AND, BE IT FURTHER**

23 **RESOLVED, THAT THE AOA SUPPORTS PAYOR COVERAGE OF ALL FDA-**
24 **APPROVED BIOLOGICS AND BIOSIMILARS TO ENHANCE PATIENT**
25 **ACCESS AND CHOICE.** ~~RESOLVED, that the AOA will advocate for policies~~
26 ~~relating to the granting of “interchangeable” status to drugs that (1) requires~~
27 ~~manufacturers to study and demonstrate to the FDA that alternating between a~~
28 ~~reference product and proposed interchangeable biosimilar has no meaningful impact~~
29 ~~on patient safety or drug efficacy; (2) that physicians maintain autonomy to designate~~
30 ~~which biologic or biosimilar product is dispensed to patients; and (3) only permit drug~~
31 ~~substitutions upon approval of the physician ordering the drug.~~

32 References

- 33
34
35
36
1. Mulcahy, Hlavka, and Case. “Biosimilar Cost Savings in the United States” Rand Health Quarterly. 2018 Mar; 7(4): 3.
 2. Cancer Treatment Centers of America. “What’s The Difference? Biosimilar and Generic Drugs” December 26, 2018.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019** _____

SUBJECT: MATERNAL MORTALITY

SUBMITTED BY: American College of Osteopathic Obstetricians and Gynecologists

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, the United States is the only industrialized nation with a rising maternal mortality
2 rate¹; and

3 WHEREAS, it is estimated that over 60% of the pregnancy related deaths are preventable²; and

4 WHEREAS, findings from state maternal mortality review committees reveal a growing
5 number of maternal deaths linked to cardiovascular disease, cardiomyopathy, and
6 overdose and suicide, with many of these deaths occurring during the postpartum
7 period.²

8 WHEREAS, African American Women are 3-4 more times likely to die of pregnancy related
9 complication; now, therefore be it

10 RESOLVED, that the American Osteopathic Association (AOA) supports (1) the important
11 work of maternal mortality review committees; (2) work with state and **RELEVANT**
12 specialty medical societies to advocate for state and federal legislation **TO** establishing
13 **AND MAINTAIN** Maternal Mortality Review Committees; and (3) work with state
14 and **RELEVANT** specialty medical societies to secure funding from state and federal
15 governments that fully supports the start-up and ongoing work of state Maternal
16 Mortality Review Committees.

17 References

- 18 1. MacDorman MF, Declercq E, Cabral H, Morton C. Recent Increases in the U.S.
19 Maternal Mortality Rate: Disentangling Trends From Measurement Issues. *Obstet*
20 *Gynecol.* 2016;128(3):447-55.
21 2. Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from
22 nine maternal mortality review committees. Retrieved from
23 http://reviewtoaction.org/Report_from_Nine_MMRCs.

Explanatory Statement

Our nation has a rising maternal mortality rate. Mental health conditions, including suicide and overdose, are the leading cause of maternal mortality in a growing number of states. Other causes include pre-eclampsia, obstetrical hemorrhage, cardiovascular disease and cardiomyopathy. Not all states or the federal government collect data on maternal mortality. In some of states, where data is being collected and implementing best practices, they are showing a decrease in the maternal mortality rate. Maternal mortality review committees work to reduce preventable maternal deaths. Our nation has a rising maternal mortality rate. Mental health conditions, including suicide and overdose, are the leading cause of maternal mortality in a growing number of states. Other causes include pre-eclampsia, obstetrical hemorrhage, cardiovascular disease and cardiomyopathy. Not all states or the federal

government collect data on maternal mortality. In some of states, where data is being collected and implementing best practices, they are showing a decrease in the maternal mortality rate. Maternal mortality review committees work to reduce preventable maternal deaths.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: EXTENDING MEDICAID **COVERAGE** TO 12 MONTHS
POSTPARTUM

SUBMITTED BY: American College of Osteopathic Obstetricians and Gynecologists

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, Medicaid is the largest single payer of maternity care in the United States, covering
2 42.6 percent of births and playing a critical role in ensuring healthy moms and babies¹;
3 and

4 WHEREAS, Medicaid is a women’s health success story and is the pathway to jobs and
5 financial stability for women and girls. Girls enrolled in Medicaid as children are more
6 likely to attend college, and Medicaid coverage during pregnancy and a newborn’s first
7 year of life increases the likelihood that the child will experience upward mobility^{2,3}; and

8 WHEREAS, Medicaid pregnancy coverage lapses at the end of the month after 60-days
9 postpartum; and

10 WHEREAS, the postpartum period is simultaneously a time of vulnerability and maternal
11 health risk, and a transition period with often unmet maternal health needs^{4,5}; and

12 WHEREAS, findings from state maternal mortality review committees reveal a growing
13 number of maternal deaths linked to cardiovascular disease, cardiomyopathy, and
14 overdose and suicide, with many of these deaths occurring during the postpartum
15 period⁶; and

16 WHEREAS, federal legislation has been introduced in 2019 to extend Medicaid coverage to 12-
17 months postpartum; now, therefore be it

18 RESOLVED, that the American Osteopathic Association support ~~and actively work toward~~
19 ~~enactment of~~ state legislation, Section 1115 waiver applications, and federal legislation
20 to extend Medicaid coverage to 12-months postpartum.

21 References

- 22 1. Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, and Drake P. Births: Final Data
23 for 2016. National vital statistics reports; vol 67 no 1. Hyattsville, MD: National Center
24 for Health Statistics. 2018. Retrieved from
25 https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf.
26 2. National Women’s Law Center. Medicaid at 50: Celebrating Medicaid’s Contributions to
27 Women’s Economic Security (July 2015). Retrieved from [https://nwlc-](https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2015/08/final_nwlc_medicaid50th_whitepaper_3.pdf)
28 [ciw49tixgw5lbab.stackpathdns.com/wp-](https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2015/08/final_nwlc_medicaid50th_whitepaper_3.pdf)
29 [content/uploads/2015/08/final_nwlc_medicaid50th_whitepaper_3.pdf](https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2015/08/final_nwlc_medicaid50th_whitepaper_3.pdf).
30 3. Brown, DW, Kowalski, AE, and Lurie, IZ (2015). Medicaid As an Investment in
31 Children: What Is the Long-Term Impact on Tax Receipts?, National Bureau of

32 Economic Research Working Paper, 20835. Retrieved from
33 <http://www.nber.org/papers/w20835>.
34 4. Spelke B and Werner E. The Fourth Trimester of Pregnancy: Committing to Maternal
35 Health and Well-Being Postpartum. R I Med J (2013). 2018 Oct 1;101(8):30-33.
36 5. Tully KP, Stuebe AM, and Verbiest SB. The fourth trimester: a critical transition period
37 with unmet maternal health needs. Am J Obstet Gynecol. 2017 Jul;217(1):37-41.
38 6. Vestal, Christine. “For Addicted Women, the Year After Childbirth Is the Deadliest.”
39 Pew Stateline. 14 Aug 2018. Retrieved from [https://www.pewtrusts.org/en/research-](https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/08/14/for-addicted-women-the-year-after-childbirth-is-the-deadliest)
40 [and-analysis/blogs/stateline/2018/08/14/for-addicted-women-the-year-after-](https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/08/14/for-addicted-women-the-year-after-childbirth-is-the-deadliest)
41 [childbirth-is-the-deadliest](https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/08/14/for-addicted-women-the-year-after-childbirth-is-the-deadliest).

Reference Committee Explanatory Statement

See references from H-335 – A/2019 which show that a majority of pregnancy-related preventable deaths occur during the postpartum period.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019** _____

SUBJECT: NEW PHYSICIAN IN PRACTICE DEFINITION

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, a “new physician in practice” is not defined in the American Osteopathic
2 Association’s (AOA) Constitution and Bylaws; and

3 WHEREAS, there are conflicting descriptions of a “new physician in practice” referenced in
4 the AOA Constitution, Article VIII, Section C.; and

5 WHEREAS, the need for osteopathic leadership among new physicians in practice is reflected
6 by the growth of the profession and the increasing numbers of new physicians in
7 practice, while also investing in leadership development for DOs who will one day lead
8 the osteopathic medical profession; now, therefore be it

9 RESOLVED, that the American Osteopathic Association define a new physician in practice as
10 a “physician is no more than 5 years past the completion of postdoctoral training with
11 no more than 2 years gap in enrollment in an ACGME-approved postdoctoral training
12 program.”

Explanatory Statement

There is no absolute definition of a New Physician in Practice; however, there are two references to New Physician in Practice contained in the AOA Constitution. Article VIII, Section C. states, “...an osteopathic physician who has completed his/her postdoctoral training within the last five years or graduated from a college of osteopathic medicine approved by the Commission on Osteopathic College Accreditation within the last 10 years...”

It should be noted that the resolution definition is intended to be inclusive of post graduate osteopathic physicians in fellowships.

Reference Committee Explanatory Statement

The Committee is concerned that this creates a definition that is inconsistent with how New Physician in Practice is defined for purposes of the New Physician in Practice position on the Board of Trustees.

ACTION TAKEN **REFERRED** *(to AOA Governance and Organizational Structure, Subcommittee on Constitution and Bylaws)*

DATE **July 27, 2019**

SUBJECT: HOSPITAL CONSOLIDATION – OPPOSITION TO

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, 87 rural hospitals closed from January 2010 through August 2018¹; and
2 WHEREAS, on average 30 U.S. hospitals shutdown each year, with an increase expected this
3 year²; and
4 WHEREAS, a larger share of the consumer health market gives merged providers more pricing
5 power³; and
6 WHEREAS, increases in hospital market consolidation have been demonstrated as leading to
7 an increase in the price for hospital care⁴; and
8 WHEREAS, providers that merged in concentrated markets experienced price increases of 20
9 percent or more since 2006⁵; and
10 WHEREAS, an analysis of 2005-2012 Medicare fee-for-service claims and enrollment data for
11 the effect of cardiology market structure on utilization and health outcomes showed
12 that an increase in consolidation leads to statistically and economically significant
13 increases in negative health outcomes for patients⁶; and,
14 WHEREAS, that the American Osteopathic Association is concerned about the impact of
15 hospital mergers and the consolidation of health systems on patients' access to quality
16 and affordable care in rural and urban communities; now, therefore be it
17 RESOLVED, that the American Osteopathic Association opposes further consolidations of
18 hospitals and health systems that are absent of sufficient ~~legal safeguards in place~~
19 **EVIDENCE OF AND COMMITMENT** to protect patients' access to quality and
20 affordable care and physicians' ability to negotiate equitable relationships with hospitals
21 and payors.

22 References

- 23 1. 82 Rural Hospital Closures: January 2010 – Present,” UNC, Cecil G. Sheps Center for
24 Health Services Research; National Rural Health Association.
25 2. Cristin Flanagan, “U.S. Hospitals Shut at 30-a-Year Pace, With No End in Sight,”
26 Bloomberg, August 21, 2018; “Fast Facts on U.S. Hospitals, 2018,” American Hospital
27 Association, February 2018.
28 3. Fiona OM, Ben Pixels, Gregor Črešnar, N.K. Namsimhan, Marty Makary, "The
29 ObamaCare Effect: Hospital Monopolies," WSJ, April 19, 2015; Ralf Shmitzer, Alex Auda
30 Samora, Thomas Bruck, Nounproject.
31 4. Abraham JM, Gaynor M, Vogt WB. “Entry and Competition in Local Hospital Markets.”
32 Journal of Industrial Economics, vol. 55, no. 2, 2007.

- 33 5. United States of America Federal Trade Commission Office of Administrative Law Judges,
34 Docket No. 9346, In the Matter of ProMedica Health System, Inc., December 12, 2011
35 (<http://www.ftc.gov/os/adjpro/d9346/120105promedicadecision.pdf>).
36 6. Richard M. Scheffler, Daniel R. Arnold and Christopher M. Whaley, Consolidation Trends
37 In California's Health Care System: Impacts On ACA Premiums And Outpatient Visit
38 Prices, Health Affairs, 10.1377/hlthaff.2018.0472, 37, 9, (1409-1416), (2018).

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019** _____

SUBJECT: PHARMACY BENEFIT MANAGERS – INCREASED REGULATION
OF

SUBMITTED BY: Bureau of State Government Affairs / Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, multiple factors contribute to the rising cost of drugs in the United States; and
2 WHEREAS, consolidation in the pharmacy benefit manager (PBM) market has led to a power
3 imbalance that favors PBMs and other corporate members in the drug supply chain, at
4 the expense of individual consumers; and
5 WHEREAS, regulatory oversight of PBMs is currently limited at the federal level and in a
6 majority of states;
7 WHEREAS, a lack of transparency and misaligned incentives have resulted in increased drug
8 prices for consumers and large profits for PBMs; now, therefore be it
9 RESOLVED, that the resolution and following white paper be adopted as the policy of the
10 American Osteopathic Association with respect to increased governmental regulation of
11 pharmacy benefit managers.

12 PHARMACY BENEFIT MANAGERS – INCREASED REGULATION OF

13 BACKGROUND

14 The rising cost of drugs is a major concern in the U.S., where consumers pay two to six times more for
15 prescription drugs than the rest of the world¹. Between 2007 and 2017, drug spending in the U.S.
16 increased by 40%, an increase largely attributable to existing drugs rather than new drugs entering the
17 market². Increased drug prices have resulted in patient noncompliance, with sometimes fatal
18 consequences, as patients are either unable to afford their prescription medications or are forced to
19 choose between buying them or other necessities like food and shelter.

20 There are a number of factors that distinguish the U.S. health care system and drug spending from
21 other industrialized nations; for one, almost all countries except the U.S. have policies in place to lower
22 drug prices, including price controls and cost-effectiveness thresholds³. By contrast, the U.S.
23 government does not directly regulate drug prices, instead leaving it up to individual insurers to
24 negotiate prices with drug makers. This fragmented and opaque system often results in different prices
25 for different buyers, a power imbalance that favors corporate entities at the expense of consumers.

26 While numerous factors contribute to prescription drug pricing and affordability in the U.S., for
27 purposes of this policy paper we will focus on the role of pharmacy benefit managers (PBMs)⁴.

1 **PHARMACY BENEFIT MANAGERS**

2 PBMs are companies hired by insurers, employers, and government entities to manage prescription
3 drug programs on behalf of health plan beneficiaries⁵. Originating several decades ago as processors of
4 prescription drug claims for insurers, for which they earned a flat fee, PBMs initially lowered drug
5 prices by forming large networks of health plan customers which enabled them to negotiate discounts
6 with drug makers. Since then, consolidation among PBMs has concentrated an 85% market share in the
7 hands of three major players (CVS Caremark, Express Scripts and OptumRX), and drug prices have
8 risen as a result⁶.

9 PBMs affect numerous aspects of the drug supply chain, and they are adept at leveraging their power
10 with drug makers, employers and pharmacies to extract profits that they keep for themselves rather
11 than passing them on to patients. As a result, patients pay cost shares that do not reflect the actual
12 lower cost of the drug, which increases out-of-pocket costs and co-pays.

13 The following represents a summary of PBM revenue sources:

14 *Rebates.* PBMs decide which drugs will be covered on a prescription drug plan or plan formulary, and
15 drug makers often pay “rebates” or other fees to PBMs to have their drugs included. Drug makers then
16 pass these costs on to consumers in the form of higher drug prices.

17 PBMs also determine which pharmacies will be included in a prescription drug plan's network and how
18 much they will be paid. Sometimes, PBMs entice plan sponsors to require beneficiaries to use a mail
19 order pharmacy – usually one with financial ties to the PBM – for certain medications.

20 *Prior Authorization.* PBMs use prior-authorization requirements to steer patients to formulary drugs
21 regardless of their efficacy, by requiring them to obtain prior authorization if they or their providers
22 prefer to continue the original (non-formulary) drug. This can result in harm to patients who may miss
23 doses or experience other negative effects from adjusting to a new drug, which may not be as effective
24 as the one they were previously stable on.

25 *Spread pricing.* “Spread pricing” refers to the difference between what a PBM charges an insurer for a
26 drug and what it reimburses the pharmacy for it. Neither the insurer nor the pharmacy knows what the
27 PBM charges or reimburses the other for a particular drug, and PBMs take advantage of this lack of
28 transparency to pocket the spread.

29 *Gag clauses* (partially mooted by the federal Patient Right to Know Drug Prices and the Know the
30 Lowest Price Acts of 2018). Prior to the passage of the aforementioned Acts in October 2018, PBMs in
31 most states could utilize “gag clauses” to prevent pharmacists from telling customers when their
32 copayment amount would exceed the out-of-pocket cost of a drug. PBMs then kept the customer's
33 overpayment, known as a “clawback,” as profit. The Acts banned gag clauses, giving pharmacists the
34 option – but *not* requiring them – to tell patients when a drug would cost less out-of-pocket.

35 *Direct and Indirect Remuneration (DIR) Fees.* DIR refers to the monies that a PBM may collect from a
36 dispensing pharmacy to offset member costs⁷. The Centers for Medicare and Medicaid Services (CMS)
37 originally created DIR as a way to track rebates and other price adjustments applied to Medicare Part D
38 prescription drug plans that were not captured at the point of sale and that resulted in savings to a
39 PBM, and ultimately to CMS (in theory).

40 Since its inception, DIR has transformed into a catchall term for any fees a pharmacy pays to a PBM,
41 including fees to participate in the PBM's network or fees paid for failing to meet certain quality
42 measures⁸. PBMs have also begun expanding the use of DIR from just Medicare Part D plans to
43 commercial plans, and pocketing the savings. While some DIR fees are legitimate, many are assessed in
44 an arbitrary and opaque manner that prevents pharmacies from fully understanding how much they will

1 be reimbursed for a prescription when entering into a PBM contract. In addition, many of the fees are
2 charged retroactively which impacts the ability of independent pharmacies in particular to budget for,
3 and ultimately implement, new patient services.

4 **STATE ACTION**

5 There is a growing desire among states to regulate PBMs, but approaches vary from state to state.
6 Besides the gag clause ban, which Congress enacted nationally in 2018, state legislative proposals
7 typically include one or more of the following elements: requirements that PBMs register with the state,
8 requirements for certain mandatory disclosures by PBMs, and prohibitions on PBMs incentivizing the
9 use of mail-order pharmacies⁹.

10 As of December 2018, 23 states require PBMs to be licensed by a state agency. The agency promulgates
11 rules for licensure, which may include state approval of compensation arrangements between PBMs
12 and pharmacies to ensure that reimbursement rates are fair and reasonable, or requirements that PBMs
13 disclose aggregate rebates to purchasers.

14 Thirteen states require substantial disclosures by PBMs, and sometimes by insurers as well, to promote
15 transparency regarding rebates and the extent to which PBMs pass them on to insurers, and ultimately
16 to patients, in the form of premium reductions or decreased cost-sharing requirements.

17 Three states currently have laws preventing PBMs from requiring or incentivizing patients to use mail-
18 order pharmacies, which could drive some independent pharmacies out of business, thereby costing
19 patients access to other services that their local pharmacies may provide. All major PBMs have their
20 own mail-order pharmacies, which allow them to tightly control formularies and steer patients towards
21 drugs for which they receive financial benefits, as well as to reap rewards from spread pricing. Large
22 PBMs can also exclude other independent mail-order pharmacies from their networks and negotiate
23 prices that allow them to undercut competitors, which raises antitrust questions.

24 PBMs were originally created to save consumers money, and increased regulation by states could
25 theoretically drive up operating costs and reduce savings for consumers; however, extensive
26 consolidation among PBMs has since tilted the balance of power away from consumers and obscured
27 prices as well as the ability of outsiders to determine PBMs' real effect on the costs of the drug supply
28 chain. States have little power to prevent future PBM mergers, thus increased regulation and
29 transparency requirements may be their only effective tools.

30 **RECOMMENDATIONS**

31 The AOA adopts the following statements as its official position on PBMs:

32 State and federal governments should work to ensure that PBMs function as originally intended; that is,
33 to save patients money. In order to accomplish this goal, a multi-pronged approach that incorporates
34 various elements below in order to target PBMs' various revenue sources and address misaligned
35 incentives should be considered.

36 PBMs should be required to publicly disclose any rebates or other "financial benefits" that they receive
37 from other members of the drug supply chain and pass through a certain percentage to the plan
38 sponsor. They should also be prevented from utilizing prior authorization requirements to steer
39 patients to formulary drugs or mail-order pharmacies to which they have financial ties.

40 In order to improve the viability of independent pharmacies and preserve competition, PBMs should
41 be prohibited from charging pharmacies retroactive DIR fees.

42 Capping patient copayments at the pharmacy reimbursement rate or the cost without insurance would
43 help address PBM clawbacks.

1 **THE AOA SUPPORTS HEALTH POLICY WHICH PROMOTES MAKING LIFE SAVING**
2 **MEDICATIONS (I.E. EPINEPHRINE FOR ANAPHYLAXIS, NALOXONE FOR DRUG**
3 **OVERDOSE, AND INSULIN/GLUCAGON FOR DIABETES) FREE FOR UNINSURED**
4 **PATIENTS AND A FULLY COVERED BENEFIT FOR INSURED PATIENTS.**

5 The U.S. Department of Justice should enforce antitrust protections to prevent additional PBM market
6 consolidation, which is likely to lead to further drug formulary restrictions and reductions in the
7 number of – and PBM reimbursement for – independent pharmacies.

8 Lastly, governmental action to improve PBM transparency is key. The Federal Trade Commission
9 (FTC) has the unique power to shed light on the effect of PBMs on the drug supply chain through its
10 Section 6(b) authority and accompanying subpoena power. Section 6(b) allows the FTC to “conduct
11 wide-ranging economic studies that do not have a specific law enforcement purpose,” and it could
12 exercise this authority to obtain PBM rebate and fee information and to analyze PBMs’ effects on drug
13 pricing¹⁰.

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ACTION TAKEN APPROVED as AMENDED

DATE July 27, 2019

SUBJECT: BACKGROUND CHECKS AND FIREARMS SAFETY TRAINING AS
A CONDITION OF FIREARMS PURCHASE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, firearm-related deaths in the United States have increased to a twenty year high¹;
2 and

3 WHEREAS, nearly 40,000 people died in 2017 as a result of firearm-related violence, suicides,
4 and accidents in the United States, the highest rate among industrialized countries^{2,3}; and

5 WHEREAS, firearms are the third-leading cause of death due to injury after poisoning and
6 motor vehicle accidents^{4,5}; and

7 WHEREAS, 109 firearm deaths occur each day due to firearm-related homicides, suicides, and
8 unintentional deaths⁶; and

9 WHEREAS, gun violence in the United States had a total societal cost of \$229 billion in 2015⁷;
10 and

11 Whereas, in 2017, of the 25 million individuals who submitted to a background check to
12 purchase or transfer possession of a firearm, 103,985 were by prohibited purchasers and
13 were blocked from making a purchase⁸; an estimated 6.6 million firearms are sold
14 annually with no background checks⁹; now, therefore be it

15 RESOLVED, that the American Osteopathic Association (AOA) will support federal
16 legislation requiring comprehensive criminal background checks for all firearm
17 purchases, including sales by gun dealers, sales at gun shows, and online sales for
18 purchase; and, be it further

19 RESOLVED, that the American Osteopathic Association (AOA) will support efforts to require
20 firearms safety training as a condition to purchase any class of firearms in any venue;
21 and, be it further

22 RESOLVED, that H421-A/15 is superseded by this resolution.

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25 Death, 1999 – 2017.
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Explanatory Statement

The intent of this policy is to supplement the following existing policies:
H630-A/18 Comprehensive Gun Violence Reform
H318-A/16 Firearms--Commission of a Crime While Using a Firearm
H340-A/16 Physician Gag Rules--Opposition To
H450-A/15 Firearm Violence
H406-A/14 Firearm Safety

Reference Committee Explanatory Statement

The Committee supports firearm safety training, and recommends that this be rewritten to focus on public health policy, in accordance with the AOA's Mission Statement.

ACTION TAKEN **REFERRED** *(to Bureau on Federal Health Programs)*

DATE **July 27, 2019** _____

SUBJECT: REFERRED SUNSET RES. NO. H-315 - A/2018: H316-A/13 HUMAN CLONING

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, sunset resolution H-315 - A/2018, titled “HUMAN CLONING”, was referred to
2 the Bureau on Scientific Affairs and Public Health for updated information; now,
3 therefore be it

4 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends H-316 -
5 A/2013 be SUNSET and the following white paper be adopted:

6 **HUMAN CLONING**

7 **BACKGROUND**

8 Somatic cell nuclear transfer (SCNT) or, to use the more common vernacular, cloning is the process of
9 creating genetic duplication of a cell or an organism naturally or artificially.^{1,2,3} The National Institute of
10 Health (NIH) describes “cloning” as a process “that can be used to produce genetically identical copies
11 of a biological entity”.⁴ More specifically, the National Human Genome Research Institute (NHGRI)
12 of NIH, identifies three categories of artificial cloning: gene, reproductive and therapeutic. The latter
13 two types of cloning are often lumped together as “human cloning,” which is controversial and the
14 focus of much debate.

15 **TYPES OF CLONING**

16 Gene Cloning

17 Gene cloning (also known as DNA cloning or molecular cloning) is the process wherein genes or
18 segments of DNA are copied. DNA cloning is beneficial to medicine because the technology allows
19 doctors to treat patients by replacing flawed genes associated with inherited diseases with healthy ones.
20 Gene cloning is primarily seen in genetically engineered food and in animals to help them grow
21 stronger. This type of cloning does not have the possibility of creating an adult living creature.

22 Reproductive Cloning

23 Reproductive cloning is the process of using SCNT to obtain eggs that could develop into an adult
24 living creature. The mature somatic cell is transferred into another egg cell and allowed to develop into
25 an embryo in a test-tube and then implanted into the womb of a living creature. The hope is that the
26 outcome will be a birth with the same genetic makeup as the living creature from which the mature
27 somatic cell was taken.

28 Reproductive cloning experimentation has been occurring for many decades but has primarily focused
29 on animals as opposed to human beings. In 1979, mice were cloned by splitting mouse embryos. In
30 1996, the lamb, Dolly was successfully cloned. In 1998, several calves were cloned. Another notable
31 cloning of a mammal was in 2003, when an endangered ox, Banteg, was cloned. While there have been
32 a few successfully cloned mammals, there have been no verified successful attempts to clone a human
33 embryo/being.

1 Therapeutic (Research) Cloning

2 Therapeutic cloning is the process of creating a cloned embryo in an effort to produce embryonic stem
3 cells to help understand the epidemiology of diseases and to develop new treatments.^{4,5} Therapeutic
4 cloning involves some of the same techniques used in reproductive cloning. However, the stem cells are
5 harvested from the embryo during the test tube phase, therein destroying the embryo.

6 **ARGUMENTS FOR OR AGAINST CLONING**

7 In the United States and worldwide, cloning remains a moral and ethical point of consternation. There
8 are arguments both for and against the use of cloning, but there appears to be a consensus amongst
9 many that cloning an actual human being is not acceptable.^{5,6} Therapeutic cloning is often the center of
10 most debates for many regarding balancing patient care, morals and ethics.

11 Arguments against therapeutic and reproductive cloning⁶:

- 12 • Reproductive and therapeutic cloning leads to the destruction of human embryos which many
13 see as viable human life.
- 14 • Reproductive cloning usurps the divine plan or interferes with the natural order.
- 15 • Cloning violates human dignity and treats human beings as commodities or items to be
16 manufactured.
- 17 • Cloning causes risks to human health; the majority of implanted embryos die in gestation or
18 result in births with significant abnormalities. In addition, the need for human embryos may
19 cause women in poverty to compromise health due to incentives to sell embryos.

20 Arguments for therapeutic and reproductive cloning⁶:

- 21 • Reproductive and therapeutic cloning presents a unique ability to research and identify
22 treatments to address human diseases by providing insight to researchers on developmental and
23 pathogenic events not discoverable otherwise.
- 24 • Cloning may lead to alleviation of human suffering and cures for costly and debilitating diseases
25 by providing genetically matched tissue for transplantation.
- 26 • Cloning promotes scientific inquiry.

27 **LEGISLATION IN THE U.S. ON CLONING**

28 Currently, the federal government does not explicitly prohibit cloning. However, the government does
29 prohibit the use of federal funds for cloning, regardless of the purpose (therapeutic or reproductive
30 cloning).^{6,7} The NIH primarily conducts gene cloning. NIH relies on federal funding which is
31 prohibited from being used in therapeutic or reproductive cloning activities, and accordingly, NIH
32 researchers have not cloned any mammals nor have any of the institutions or centers supported human
33 cloning activities.

34 The Food and Drug Administration (FDA) has weighed in on human reproductive cloning. In a 1998
35 letter about human cloning, the FDA claimed jurisdiction over clinical research using cloning
36 technology for reproductive purposes. The FDA equated using cloning technology to the same process
37 as developing new drugs.⁸ In a second letter dated March 28, 2001, regarding Cloning Technology, the
38 agency reiterated its jurisdiction over clinical research using such technology. The FDA explicitly stated
39 that the process is subject to the Health Service Act and the Federal Food, Drug and Cosmetic Act.
40 also indicated that all approval responsibilities for any human clinical use of any therapies derived from
41 cloning research fell within its purview.⁹

42 In an effort to address the void left by the federal government, several state legislatures have provided
43 guidance on human cloning.⁷

- 1 • **Eight (8) states** prohibit human cloning for any purpose – no reproductive or therapeutic
2 cloning (cloned human embryos for embryonic stem cell research as well as to implant in a
3 uterus for childbirth) – Arizona, Arkansas, Indiana, North Dakota, Oklahoma, South Dakota
4 and Virginia
- 5 • **Six (6) states** prohibit state funding of human cloning for any purpose – Arizona, Arkansas¹⁰,
6 Indiana, Louisiana, Maine and Nebraska
- 7 • **Ten (10) states** have “clone and kill” laws which allow therapeutic cloning research, but
8 prohibit cloning of embryos to be implanted for childbirth (reproductive cloning) – California,
9 Connecticut, Illinois, Iowa, Maryland, Massachusetts, Missouri, Montana, New Jersey and
10 Rhode Island
- 11 • **Five (5) states** allow state funding for embryonic stem cell research (therapeutic cloning or in
12 vitro fertilization) – California, Illinois, Missouri, Maryland and New York
- 13 • **Two (2) states** have legislation that precludes health professionals from being compelled to
14 participate in human cloning (healthcare rights of conscience laws) – Idaho and Louisiana

15 Twenty-six (26) states and the District of Columbia do not have any legislation addressing therapeutic
16 (biomedical research) and/or reproductive (to produce children) cloning.

17 These data were pulled from sources dated between 2015 through 2019. To the best of BSAPH’s
18 knowledge, these policies remain in effect as of May 1, 2019.

19 **KEY ORGANIZATIONS SUPPORTING THERAPEUTIC/RESEARCH CLONING**

20 Many key organizations have made position statements regarding the benefits it views in therapeutic
21 cloning and accordingly expressed their support. In addition, these organizations have declined to
22 support cloning for reproductive purposes. These organizations include:

23 *American Association for the Advancement of Science (AAAS)* – The AAAS has a statement on
24 Human Cloning that states it endorses a legally enforceable ban on efforts to implant a human cloned
25 embryo for the purpose of reproduction.¹¹ AAAS recognizes that the health risks associated with
26 reproductive cloning make such cloning unconscionable. The AAAS, however, does encourage
27 continued dialogue as new technology advances emerge.

28 Also, AAAS supports stem cell research (genetic and therapeutic cloning) which has potential health
29 benefits. The AAAS calls for strict monitoring of the process and developments and appropriate
30 oversight through regulation.¹¹

31 *American Association of Medical Colleges (AAMC)* – On its website under the Advocacy section,
32 the AAMC expressly supports ongoing research into SCNT and endorses legislation that would
33 allow therapeutic/research cloning.¹² Additionally, the AAMC recommends a ban on all forms of
34 reproductive cloning.

35 *American Bar Association (ABA)* - The ABA addressed this issue in 2002 and 2004. ABA supports
36 law and policy prohibiting reproductive cloning.^{13,14}

37 *American Medical Association (AMA)* - The AMA does not endorse reproductive cloning.
38 However, if in the future reproductive cloning is permitted, the AMA acknowledges that physicians
39 must be educated and understand somatic cell donors must provide informed consent. Additionally,
40 any child produced through reproductive cloning is recognized as a human-being. Code of Medical
41 Ethics Opinion 4.2.6.¹⁵

42 The AMA says physicians can determine whether they will participate in stem cell research or use its
43 products. The AMA implores clinician researchers to be able to articulate the risks and benefits of
44 embryonic stem cell use for research purposes. In addition, AMA encourages physicians to allow their

1 commitment to the welfare of patients to guide them in their professional standards. Code of Medical
2 Ethics Opinion 7.3.¹⁶

3 *National Academies of Medicine, Sciences and Engineering (National Academies)* - The
4 National Academies, based on recommendations generated by 2002 joint panel, recommends a legally
5 enforceable ban on the practice of human reproductive cloning, but does support using SCNT to
6 produce stem cells for developing new medical therapies for life-threatening diseases and advancing
7 knowledge.¹⁷

8 **AOA AND HUMAN CLONING**

9 The osteopathic community and the AOA have discussed this issue at length since 1998. Recognizing
10 the moral and ethical dilemmas of human cloning, AOA has continued to monitor the issue and
11 provide updates to its constituents in order to facilitate a discussion.

12 After reviewing the existing literature on cloning, the American Osteopathic Association (AOA) adopts
13 the following policies:

- 14 1. The AOA does not endorse the practice of human cloning for purposes of reproduction
15 (efforts to implant a human cloned embryo for the purpose of reproduction).
- 16 2. The AOA recognizes the benefits and harms of human cloning for therapeutic (research)
17 purposes with respect to embryos, donors and patients suffering from debilitating and life-
18 threatening diseases and conditions. Physicians shall have the autonomy to determine whether
19 or not they will participate in therapeutic cloning. They should carefully weigh all ethical and
20 moral aspects of the process and determine what is best for the well-being of patients, society as
21 a whole, and the advancement of medical knowledge and practice.
- 22 3. The AOA shall review its policy in light of any new evidence that will be generated by research
23 entities as well as monitor state and federal legislation in the field and update the policy as
24 necessary.

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ACTION TAKEN **APPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: MISALIGNED INCENTIVES IN MEDICARE PLANS

SUBMITTED BY: Florida Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, third party payers and Pharmacy Benefit Managers (PBMs) incentivize patients to
2 be cost conscious by encouraging the use of lower cost medications and services
3 through deductibles, copayments, and the “donut hole”; and

4 WHEREAS, third party payers and PBMs incentivize physicians through the use of claims
5 analysis, such as HEDIS measures; and

6 WHEREAS, HEDIS measures require claims to be made through the payer or PBM directly
7 from the pharmacy; and

8 WHEREAS, purchasing medications for a “cash price” may be less expensive, but will not
9 result in the collection of claims data impacting physician quality measures; and

10 WHEREAS, these incentives create conflicting priorities, and subsequently potential ethical
11 pitfalls, for a patient to obtain medications outside of the PBM, and for the physician to
12 be penalized for this; now, therefore be it

13 RESOLVED, that the American Osteopathic Association (AOA) ~~is opposed~~ **SUPPORT to**
14 ~~incentives that do not~~ **EFFORTS TO** align patient’s behaviors with cost-effective,
15 reportable high quality care; and, be it further

16 RESOLVED, that the AOA will work to identify these misaligned incentives, **AND**
17 **ADVOCATE FOR CHANGES TO THE MEDICARE PROGRAM THAT**
18 **SUPPORT PHYSICIANS IN DELIVERING HIGH-VALUE CARE AND**
19 **DISCOURAGE PLANS FROM PREVENTING PATIENTS FROM SEEKING**
20 **LOWER COST-EFFECTIVE TREATMENT OPTIONS;** and, be it further

21 RESOLVED, that the AOA will seek to ~~influence~~ **EDUCATE** third party payers and
22 Pharmacy Benefit Managers to align patient and physician incentives, and, be it further

23 RESOLVED, that the AOA will advocate **AGAINST** ~~for the prohibition of~~ misaligned
24 **PAYMENT AND QUALITY** incentives in Federal Healthcare programs **THAT DO**
25 **NOT PROMOTE IMPROVED HEALTH OUTCOMES.** ~~through legislation~~
26 ~~and other regulations designed to prevent competing incentives;~~ **AND, BE IT**
27 **FURTHER**

28 **RESOLVED, THAT THE AOA WORKS TO EDUCATE THE NCQA REGARDING**
29 **THE NEED TO MODIFY HEDIS RULES.**

ACTION TAKEN **APPROVED** as **AMENDED**

DATE **July 27, 2019** _____

SUBJECT: WHITE PAPERS - UPDATING

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, the American Osteopathic Association (AOA) has developed many detailed, in-
2 depth policy statements also known as "white papers"; and

3 WHEREAS, these “white papers” often contain citations of relevant statistics, studies, and
4 other data; and

5 WHEREAS, the AOA attempts to use the most current data to compile these “white papers”;
6 and

7 WHEREAS, the AOA reviews all of its policies on a rolling five year basis; and

8 WHEREAS, the AOA desires to have policy statements which are up-to-date and relevant to
9 the current environment; now, therefore be it

10 RESOLVED, that when policies which are or include a “white paper” as a part of the policy are
11 reviewed as part of the regular policy review process, the reviewing entity shall review
12 and update all statistics, studies, and other data to ensure that these references are the
13 most up-to-date statistics, studies, and data that are available; and, be it further

14 RESOLVED, that the reviewing entity shall affirm in an explanatory statement that all statistics,
15 studies, and other data have been reviewed and are the most current available.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: DEVELOPMENT OF A NATIONAL IMMUNIZATION
INFORMATION REGISTRY

SUBMITTED BY: Illinois Osteopathic Medical Society

REFERRED TO: Committee on Professional Affairs

- 1 WHEREAS, immunizations currently prevent 2-3 million deaths each year worldwide; and
2 WHEREAS, an additional 1.5 million deaths could be avoided with improved vaccination rates
3 worldwide; and
4 WHEREAS, vaccines not only provide individual protection for those persons who are
5 vaccinated, they can also provide community protection by reducing the spread of
6 disease within a population; and
7 WHEREAS, physicians, patient care providers, and pharmacists have a responsibility/duty to
8 promote immunizations to all eligible people for vaccines; and
9 WHEREAS, vaccinations can be administered in many settings including physician offices,
10 community health fairs and local pharmacies providing more convenient and accessible
11 option for people to receive needed immunizations; and
12 WHEREAS, patients often change vaccination providers during the course of an individual's
13 vaccination series; and
14 WHEREAS, patient's do not always communicate receipt of vaccines to their healthcare
15 providers; and
16 WHEREAS, it is often necessary for providers to be able to access immunization records in
17 emergency situations; now, therefore be it
18 RESOLVED, that any healthcare provider delivering vaccination services must document
19 administration of all immunizations in a national immunization information registry;
20 and, be it further
21 RESOLVED, that the American Osteopathic Association (AOA) advocate for development of
22 a national immunization information registry.

Explanatory Statement

Requiring documentation of all vaccinations administered by any healthcare provider in a mandatory National Immunization Information Registry would provide healthcare providers with vital information about their patient's vaccination status, allowing for improved vaccination rates and appropriate vaccine completion, thereby reducing the number of deaths and other complications from vaccine preventable diseases, and reduction in the number of duplicate vaccinations received by patients.

References

10 facts on immunization. (2018, March). Retrieved from World Health Organization: <https://www.who.int/features/factfiles/immunization/en/>

Bach, A. a. (2015, July 1). The role of community pharmacy-based vaccination in the USA: current practice and future directions. *Integrated Pharmacy Research and Practice*, pp. 67 - 77.

Orenstein, W. a. (2017, April 10). Simply put: Vaccination saves lives. *Proceedings of the National Academy of Sciences of the United States of America*, pp. 114 - 116.

Vaccines & Immunizations: What Would Happen If We Stopped Vaccinations? (2018, June 29). Retrieved from Centers for Disease Control and Prevention: <https://www.cdc.gov/vaccines/vac-gen/whatifstop.htm>

Reference Committee Explanatory Statement

The Committee believes that this Resolution is duplicative of H629-A/19 CLINICAL DATA REGISTRIES AND QUALIFIED CLINICAL DATA REGISTRIES.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: CONSULTANT REPORTS ACCESSIBILITY/ AVAILABILITY-
AMERICAN OSTEOPATHIC ASSOCIATION

SUBMITTED BY: Kentucky Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, the mission of the American Osteopathic Association (AOA) is to advance the
2 distinctive philosophy and practice of osteopathic medicine¹; and

3 WHEREAS, as the legislative body of the AOA, the House of Delegates shall exercise the
4 delegated powers of the divisional societies in the affairs of the AOA, and shall perform
5 such other functions as set forth in the Bylaws²; and

6 WHEREAS, delegates are duly elected by AOA Divisional Societies³; and

7 WHEREAS, it is widely accepted that sound decisions are best made on factual data,
8 information, and knowledge⁴; and

9 WHEREAS, AOA consultant reports base recommendations on distillation of facts so better
10 decisions can be made⁵; and

11 WHEREAS, delegate responsibilities include serving on reference committees, participating in
12 caucuses, testifying at reference committee hearings, and ultimately voting on reference
13 committee recommendations⁶; and

14 WHEREAS, the accuracy, reliability, veracity, and validity of consultant recommendations can
15 only be assured through transparency of the entire unredacted report⁷; now, therefore
16 be it

17 RESOLVED, that in order for the members of the American Osteopathic Association (AOA)
18 House of Delegates to perform their duties as mandated in the Association Bylaws, all
19 AOA consultant reports shall be made available in their entirety, without alterations,
20 deletions, or redactions, to any AOA member, Divisional Society Executive Director,
21 and/or Health Policy Fellow.

22 References

- 23 1. <https://osteopathic.org/about/leadership/aoa-governance-documents/>
24 2. <https://osteopathic.org/wp-content/uploads/2018/02/aoa-constitution-and-bylaws.pdf>
25 3. <https://osteopathic.org/wp-content/uploads/2018/02/aoa-constitution-and-bylaws.pdf>
26 4. <http://www.tlinc.com/articl134.htm>
27 5. <https://hbr.org/1982/09/consulting-is-more-than-giving-advice>
28 6. <https://osteopathic.org/wp-content/uploads/hod-primer.pdf>
29 7. https://www.acha.org/NCHA/About/ACHA_NCHA/Generalizability_Reliability_and_Vailidity_Analysis/NCHA/About/Generalizability_Reliability_and_Vailidity_Analysis.aspx?hkey=0d3e8e2b-561a-43da-a004-b3f4901c6956
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31

Reference Committee Explanatory Statement

The Committee is concerned that this resolution is too broad and requests that it be clarified and that it acknowledge legal limitations which restrict information disclosure and dissemination.

ACTION TAKEN **REFERRED** *(to Kentucky Osteopathic Medical Association)*

DATE **July 27, 2019** _____

SUBJECT: WHISTLEBLOWER POLICY – AMERICAN OSTEOPATHIC ASSOCIATION

SUBMITTED BY: Kentucky Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, the Sarbanes-Oxley Act of 2002¹, which applies to publicly-traded companies and
2 requires them to adhere to standards in governance that increase the role board member
3 play in overseeing financial transactions and auditing procedures; and

4 WHEREAS, responsible nonprofits have been using the Sarbanes-Oxley as a standard for their
5 own financial practices, as these practices can only improve a nonprofit's internal
6 controls and provide needed transparency; and

7 WHEREAS, other provisions of Sarbanes-Oxley and the IRS 990 Form² regulate, insider
8 transactions and conflicts of interest, disclosure or transparency to the public,
9 whistleblower protection and document destruction; and

10 WHEREAS, in an era of greater scrutiny of nonprofit organizations, Sarbanes-Oxley provides
11 an excellent blueprint for nonprofits to reach a level of governance that can only help
12 their reputations and ensure the trust of their members, donors and supporters; and

13 WHEREAS, the AOA has many members and friends of the profession e.g. state & specialty
14 executive directors, PhD faculty at osteopathic institutions, etc., and many of those are
15 called on to voluntarily serve on bureaus, councils and committees or intermittently
16 advise the organization on relevant subject matter, without whose work the AOA would
17 not be able to fulfill its mission to advance the practice of osteopathic medicine; and

18 WHEREAS, the current AOA Whistleblower Policy does not clearly include these members
19 and/or volunteers as it is currently outlined, and it is prudent to have one organizational
20 policy; and

21 WHEREAS, those members and/or volunteers may be reluctant to report any concerns that
22 arise regarding the governance of the organization secondary to potential retaliatory
23 measures by the organization, leadership or staff; now, therefore be it

24 RESOLVED, that the American Osteopathic Association (AOA) adopts the following policy:

25 **Whistleblower Policy**

26 The AOA encourages its employees and members and/or volunteers to disclose and report concerns
27 regarding perceived violations of federal and state laws and regulations and perceived financial
28 irregularities.

29 Such reports may be made by any employee or member and/or volunteer openly, confidentially or
30 anonymously, and they may be made in person, by telephone or in writing, including email.

31 Employees can report such concerns without fear of reprisal to any of the following individuals:
32 department directors, the chief operations officer, the associate executive directors, the chief financial
33 officer, the general counsel, the executive director or the AOA president. Employees can also report
34 such concerns to the AOA Audit Committee.

35 Members and/or volunteers may report any concerns, charges or complaints to the AOA Committee
36 on Ethics, including violations of the AOA Constitution & Bylaws, as per Article VII, Section 1(h).

37 Employees or members and/or volunteers who prefer to raise their concerns confidentially may do so
38 by sending the appropriate executive or committee as outlined above a sealed envelope through US
39 mail or interoffice mail and marking the envelope “Personal & Confidential” or by sending an email
40 with the words “Personal & Confidential” in the subject line.

41 AOA employees or members and/or volunteers may also report their concerns about perceived
42 violations of federal and state laws and regulations and perceived financial irregularities to appropriate
43 governmental agencies without fear of adverse action.

44 The AOA complies with all applicable requirements of federal and state statutes and regulations
45 concerning employee or member and/or volunteer “whistleblower” activity, including, without
46 limitation, the Illinois Whistleblower Act [740 ILCS174/5, *et seq.*].³

47 Among its provisions, the Illinois Whistleblower Act prohibits an employer from discharging or
48 otherwise retaliating against an employee for any of the following actions:

- 49 • disclosing to a law enforcement agency or other government agency information that the
50 employer reasonably believes discloses a violation of any state or federal law, rule or regulation
- 51 • refusing to participate in any activity that would result in the violation of any state or federal
52 law, rule or regulation.

53 The Illinois Whistleblower Act also prohibits an employer from making, adopting or enforcing any rule,
54 regulation or policy that prevents its employees from disclosing information to a government or law
55 enforcement agency when employees have reasonable cause to believe that the information concerns a
56 violation of a state or federal law, rule or regulation.

57 Likewise, the AOA extends these same protections for whistleblowing activity to its members and/ or
58 volunteers. The AOA prohibits retaliation, or threat of retaliation, by or on behalf of the AOA, against
59 members and/ or volunteers for making good faith complaints, reports or inquiries under this policy or
60 for participating in a review or investigation under this policy. This protection extends to those whose
61 allegations are made in good faith, but prove to be mistaken. The AOA reserves the right to discipline
62 persons who make bad faith, knowingly false, or vexatious complaints, reports or inquiries.

63 References

- 64 1. https://pcaobus.org/About/History/Documents/PDFs/Sarbanes_Oxley_Act_of_2002.pdf
- 65 2. <https://www.irs.gov/pub/irs-pdf/i990.pdf>
- 66 3. <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2495&ChapterID=57>

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: AMERICAN OSTEOPATHIC ASSOCIATION – ORGANIZATIONAL HEALTH, VIABILITY & TRANSPARENCY

SUBMITTED BY: Kentucky Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, the American Osteopathic Association (AOA) maintains a Healthy and Viable
2 Affiliate Organizations Program to monitor and assess the status of its affiliated
3 organizations; and

4 WHEREAS, AOA state and specialty affiliates are required to report the number of classes of
5 membership annually, as well as detailed financial statements, tax returns, board
6 contacts, and annual reports; and

7 WHEREAS, AOA membership numbers cannot be assumed to remain stable given a number
8 of factors including decoupling of AOA board certification and membership, the
9 myriad of professional organizations physicians are required to join, decreased employer
10 reimbursement of professional dues; and

11 WHEREAS, transparent, healthy, and viable organizations require bidirectional communication
12 and accountability between a parent organization and its affiliates; now, therefore be it

13 RESOLVED, that the American Osteopathic Association, in order to be transparent and to
14 assure a healthy and viable organization, will annually report to the affiliate
15 organizations the following:

- 16 1. The numbers in each Class of Membership
- 17 2. Detailed financial statements, including tax returns and audits
- 18 3. A complete list of Board of Trustees' contact information
- 19 4. Clear annual reports accounting for how funds were spent and progress made,
20 including a description of how the expenditure directly helped physicians in practice
21 or contributed to the advancement of the profession

Reference Committee Explanatory Statement

The resolution calls for the AOA to provide detailed confidential business information and reports to affiliated organizations that owe no fiduciary responsibilities to the AOA, creating a risk of public release of confidential information. Moreover, the proposed disclosures are unnecessary and excessive. The AOA already makes contact information available for its Trustees (FirstInitialLastNameDO@osteopathic.org), makes tax and financial information available to members on request, its 990 tax returns are available on-line, and it provides detailed budget and expenditure information to existing appropriate oversight bodies (Finance Committee oversight of audit process, Joint Board-House Budget Review Committee).

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: EXPANSION OF MEDICAID IN ALL STATES

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, the Patient Protection and Affordable Care Act (PPACA) allows states to expand
2 Medicaid coverage to persons whose income is below 138% of the federal poverty level
3 (\$16,753 for an individual or \$34,638 for a family of four in 2019), with the federal
4 government paying 93% of the expansion cost for new enrollees in 2019 and 90% in
5 2020 and beyond; and

6 WHEREAS, the PPACA has resulted in a reduction in the healthcare uninsured rate in the
7 United States from 16% in 2010 to 8.8% in Q1 2018¹; and

8 WHEREAS, states that have enacted Medicaid expansion have experienced a reduction in
9 uninsured patients to 8.7% and states that did not expand Medicaid still have 18.4%
10 uninsured; and

11 WHEREAS, the Michigan Osteopathic Association supported the Medicaid Expansion with
12 targeted lobbying efforts in the State of Michigan; and

13 WHEREAS, Michigan’s Medicaid expansion enrollment exceeded 600,000 individuals by March
14 2015, and serves as an effective model for states that have not as yet enacted Medicaid
15 expansion²; and

16 WHEREAS, as of January 2019, 14 states (Alabama, Florida, Georgia, Kansas, Mississippi,
17 Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas,
18 Wisconsin, Wyoming) have failed to enact legislation to expand Medicaid eligibility; and

19 WHEREAS, research shows that Medicaid expansion has helped to reduce disparities in
20 coverage by income and age, has had positive economic outcomes in expansion states,
21 and infant mortality rates have declined in Medicaid expansion states and risen in states
22 that have not enacted Medicaid expansion³; and

23 WHEREAS, studies provide evidence that Medicaid expansion reduces mortality from drug
24 overdoses and increases access to treatment⁴; now, therefore be it

25 RESOLVED, that the American Osteopathic Association (AOA) incorporate Medicaid
26 expansion as a top priority to improve patient access to care and to improve health
27 outcomes; and be it further

28 RESOLVED, that the AOA support Medicaid expansion in the 14 states that have not as yet
29 enacted relevant legislation to expand Medicaid eligibility to uninsured individuals who
30 meet the definitions to qualify based on the 138% of federal poverty level as provided in
31 the Patient Protection and Affordable Care Act.

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References

1. <https://www.healthaffairs.org/d0/10.1377/hblog20180913.896261/full/>
2. <http://www.detroitnews.com/story/news/politics/2015/03/31/snyder-medicaid-expansion-reaches-residents/70731872/>
3. <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/>
4. <https://ldi.upenn.edu/healthpolicysense/medicaid-expansion-and-opioid-epidemic>

Reference Committee Explanatory Statement

The Committee believes that existing policy H338-A/18 UNINSURED – ACCESS TO HEALTH CARE is more comprehensive and covers the concerns of this resolution. Further, this resolution may be overly prescriptive, veer outside of health care policy, and does not appropriately take into account the financial constraints of states, as well as other state-based health care programs that may be in place.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: SUPPORT FOR OMT PRIVILEGES

SUBMITTED BY: Osteopathic Physicians and Surgeons of California

REFERRED TO: Committee on Professional Affairs

- 1 WHEREAS, the osteopathic profession has undergone unprecedented growth in the last 20
2 years, with DOs expected to represent 25% of all graduates in 2020; and
- 3 WHEREAS, with increased brand awareness of osteopathic medicine the use of osteopathic
4 manipulative treatment (OMT) is expected to increase; and
- 5 WHEREAS, the use of OMT has been shown to decrease use of oral pain medication (Prinsen
6 JAOA 2014) including opiates, and thus can play a role in addressing the current opioid
7 crisis; and
- 8 WHEREAS, many osteopathic physicians encounter difficulties when trying to obtain privileges
9 for the use of OMT within medical systems and hospitals; and
- 10 WHEREAS, the American Osteopathic Association does not have a standardized hospital
11 privileging document for OMT; now, therefore be it
- 12 RESOLVED, that the American Osteopathic Association (AOA) support and advocate for all
13 physicians who desire to practice osteopathic manipulative treatment (OMT) within
14 medical systems and hospitals; and, be it further
- 15 RESOLVED, that the AOA create guidelines that can be distributed upon request to hospitals,
16 medical systems, and other interested entities that standardize credentialing and
17 privileging processes, including proctoring and approval of privileges to practice OMT.

Explanatory Statement

Reference:

Prinsen JK, Hensel KL, Snow RJ. OMT associated with reduced analgesic prescribing and fewer missed work days in patients with low back pain: an observational study. J Am Osteopath Assoc. 2014;114(2): 90-98

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: ANTI-INTIMIDATION STANDARDS AMONG PHYSICIANS

SUBMITTED BY: Pennsylvania Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, the rate of suicide among physicians is greater than that of the general population
2 and more than half of surveyed medical students (58%) and residents (50.7%) screen
3 positive for depression^{1,2}; and

4 WHEREAS, according to a 2015-2016 survey of U.S. residents and fellows, 48% of the
5 respondents indicated they experienced bullying behavior from other healthcare
6 professionals including attending physicians (29%) and nurses (27%) contributing
7 negatively to the training environment and impacting physician wellness³; and

8 WHEREAS, the most common bullying behaviors described in the healthcare setting include
9 belittling, undermining work, work sabotage, unjustified criticism, and excessive
10 monitoring of one's work, followed by sarcasm, destructive innuendo, critical
11 comparisons among colleagues, and attempts to humiliate^{3,4}; and

12 WHEREAS, there is an increased awareness of the impact intimidation plays on job
13 satisfaction, toxic/difficult work environment, and the hierarchical culture pervasive in
14 medical education and graduate medical education; now, therefore be it

15 RESOLVED, that the American Osteopathic Association support the implementation of anti-
16 intimidation standards within healthcare training programs and workplaces.

17 References

- 18 1. Dyrbye L. et al. Burnout among U.S. medical student, residents, and early career physicians
19 relative to the general U.S. population. Acad Med. 2014 Mar; 89(3):443-451.
20 2. <http://afsp.org/wp-content/uploads/2016/11/ten-facts-about-physician-suicide.pdf>.
21 Accessed April 1, 2018
22 3. Article Source: Bullying in the American Graduate Medical Education System: A National
23 Cross-Sectional Survey
24 4. Chadaga AR, Villines D, Krikorian A (2016) Bullying in the American Graduate Medical
25 Education System: A National Cross-Sectional Survey. PLOS ONE 11(3): e0150246.
26 <https://doi.org/10.1371/journal.pone.0150246>. Accessed April 25, 2019
27 5. 4. [https://www2.bostonglobe.com/ideas/2019/03/15/america-becoming-doctor-can-
28 prove-fatal/u3x4xfPC9VR2zSCnKArgYM/story.html](https://www2.bostonglobe.com/ideas/2019/03/15/america-becoming-doctor-can-prove-fatal/u3x4xfPC9VR2zSCnKArgYM/story.html). Accessed April 25, 2019

Explanatory Statement

In an effort to improve physician wellness, one actionable item is to create a culture of safety and caring rather than intimidation in the traditional, toxic hierarchical teaching structure within medical education. The goal is to reduce the incidence of depression, substance abuse, and suicide among physicians and physicians in training.

Reference Committee Explanatory Statement

The Committee believes that H505-A/19 AOA RULES AND GUIDELINES ON PHYSICIANS' PROFESSIONAL CONDUCT covers the concerns of this resolution.

ACTION TAKEN **DISAPPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: ADVOCATING FOR WOMEN’S RIGHT TO REPRODUCTIVE
 HEALTHCARE ACCESS AND SUPPORT OF ROE V. WADE

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, the Supreme Court ruled in favor Jane Roe and the pursuit of safe, legal abortion
2 rights for women in the United States in 1973 in response to the unconstitutionality of
3 states’ imposition of laws and statutes that interfere with an individual’s right to
4 autonomy and privacy regarding the creation of a family¹; and

5 WHEREAS, in 1967, 17% of pregnancy-induced maternal demise was due to illegal abortion
6 complications performed without medical personnel and resources²; and

7 WHEREAS, according the CDC Abortion Surveillance Systems, “652,639 legal induced
8 abortions were reported,” which indicate 652,639 women chose abortion as their choice
9 of medical care in 2014, elucidating the enormity of need of such resources and patient
10 autonomy³; and

11 WHEREAS, according the CDC Abortion Surveillance Systems,⁴ (.0006%) women died in 2013
12 as a result of complications post legal abortion³, further elucidating the benefit of
13 women’s rights to choose as opposed to the aforementioned loss of life while abortion
14 was made illegal nationwide; and

15 WHEREAS, women of low socioeconomic status and minorities will suffer the brunt of the
16 repercussions of overturning Roe v. Wade due to the loss of funding protections for
17 Title X subsidiaries, like Planned Parenthood, that provide affordable reproductive
18 healthcare that includes annual mammograms, preventative gynecological healthcare
19 and screenings, access to birth control, sexual education, and safe abortion procedures,
20 leading to increased incidences of malignancies, unplanned and unwanted pregnancies,
21 and unsafe abortion practices⁴; and

22 WHEREAS, “abortion in the United States is an extremely safe procedure. Restrictions
23 imposed in some states are not based on medical evidence and will do nothing to
24 improve women’s health and safety. In fact, these requirements put women at risk by
25 standing in the way of safe reproductive care.”⁸; and

26 WHEREAS, “research shows that carrying an unwanted pregnancy to term is more dangerous
27 to a woman’s health than abortion.”⁸; and

28 WHEREAS, “induced abortion is among the safest outpatient procedures performed in the
29 United States.”⁹; and

30 WHEREAS, “the risk of mortality from childbirth in the United States is estimated to be 14
31 times higher than the risk from induced abortion, and the risk of all maternal

1 morbidity, defined as “conditions either unique to pregnancy or potentially
2 exacerbated by pregnancy that occurred in at least 5% of all pregnancies” is significantly
3 higher among women who give birth than among those who have abortions.”⁹; and

4 WHEREAS, “the evidence suggests that unintended pregnancy is one of the most critical
5 challenges facing the public health system and imposes significant financial and social
6 costs on society. Long-term studies confirm that reducing unintended pregnancy
7 incidences would increase labor force participation rates, improve academic
8 achievement, have better economic efficiency, increase the level of health and reduce in
9 crime rates among vulnerable groups.”¹⁰; and

10 WHEREAS, the American College of Obstetrics and Gynecology (ACOG) holds and supports
11 the committee opinion for clinical guidelines on women’s reproductive health and rights
12 that “safe, legal abortion is a necessary component of women’s health care... Legislative
13 restrictions fundamentally interfere with the patient-provider relationship and decrease
14 access to abortion for all women, and particularly for low-income women and those
15 living long distances from health care providers.”⁴; and

16 WHEREAS, ACOG, which currently represents 58,000 OG/GYNs in the U.S. and abroad⁸,
17 and the American Congress of Obstetricians and Gynecology published a position
18 statement in 2016 emphasizing that “...Prohibitions on essential care that are based on
19 religious or other non-scientific grounds can jeopardize women’s health and safety.”⁵;
20 and

21 WHEREAS, physicians are trained to serve with the patient’s best interest in mind, regardless
22 of personal moral or ethical convictions as long as the legal standard of care is practiced;
23 and

24 WHEREAS, the decision to safely terminate pregnancy should be solely at the discretion of the
25 patient and their healthcare team; and

26 WHEREAS, opposition to abortion lies on moral premise, judgement, and conviction and on
27 the idea that states should be held financially and socially accountable for the welfare of
28 women who become unexpectedly pregnant according to ACOG⁶; now, therefore be it

29 RESOLVED, that the American Osteopathic Association stand by the American College of
30 Obstetrics and Gynecology in their recommendation of increased provisions for safe
31 and legal abortion and reproductive healthcare resources and opposition of the reversal
32 of Roe v. Wade by drafting an official statement reflecting this position.

33 References

- 34 1. Parenthood, P. (n.d.). Roe v. Wade: The Constitutional Right to Access Safe, Legal
35 Abortion. Retrieved from [https://www.plannedparenthoodaction.org/issues/abortion/roe-](https://www.plannedparenthoodaction.org/issues/abortion/roe-v-wade)
36 [v-wade](https://www.plannedparenthoodaction.org/issues/abortion/roe-v-wade)
37 2. Vital Statistics of the United States 1949. Part I: Natality, Mortality, Marriage, Divorce,
38 Morbidity, and Life Table Data for the United States. General Tables by Place of
39 Occurrence with Supplemental Tables for Hawaii, Puerto Rico, Virgin Islands, and Alaska,
40 Part II: Natality and Mortality Data for the United States Tabulated by Place of Residence.

- 1 (1952). JAMA: The Journal of the American Medical Association,150(15), 1547.
2 doi:10.1001/jama.1952.03680150101037
- 3 3. Reproductive Health. (2017, November 16). Retrieved from
4 https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm
- 5 4. Women's Health Care Physicians. (n.d.). Retrieved from <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Increasing-Access-to-Abortion>
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8 5. Women's Health Care Physicians. (n.d.). Retrieved from <https://www.acog.org/About-ACOG/About-Us>
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10 6. Women's Health Care Physicians. (2016). Retrieved from <https://www.acog.org/Clinical-Guidance-and-Publications/Position-Statements/Restrictions-to-Comprehensive-Reproductive-Health-Care>
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13 7. Women's Health Care Physicians. (n.d.). Retrieved from <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Increasing-Access-to-Abortion>
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15

Explanatory Statement

The reversal of Roe v. Wade will undoubtedly increase the rate of illegal abortions performed in the United States, vastly increasing infertility and mortality risks due to patients' lack of knowledge on how and when to best perform these procedures via chemical methods. Abortions will occur regardless of its legality. At the forefront of our oath and practice is the patient's right to safety, autonomy and dignity. Therefore, depriving women of the right to safe, legal access to reproductive health, family planning, and abortion services is not only unconstitutional but directly infringes on their right to autonomy over their bodies and lives.

Moreover, women of low socioeconomic background are at highest risk due to the inevitable reduction of funding allocated to Title X programs liked Planned Parenthood. As a result, we stand in strong opposition to the reversal of Roe v. Wade, the subsequent legal repercussions for female patients who seek autonomy, and the danger to life that is illegal abortion.

Reference Committee Explanatory Statement

The Committee recognizes that this is a divisive topic, and wishes to respect individual physician and patient beliefs. The Committee supports comprehensive reproductive health care, as well as policies that support care for patient populations while protecting the individual physician-patient relationship as reflected in H358-A/19 INTERFERENCE LAWS; however, it feels that the content of this resolution veers overly into politics.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: ADVOCATING FOR MORE DO REPRESENTATION WITHIN
 MEDICAL TV SHOWS AND MOVIES

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, there are currently 114,425 practicing osteopathic physicians (DOs) in the United
2 States and DOs are projected to represent more than 20% of all practicing physicians by
3 2020¹; and

4 WHEREAS, 57% of DO physicians work in a primary care specialty and 40% work in
5 specialties such as emergency medicine, OB/GYN, anesthesiology, general surgery, and
6 psychiatry¹; and

7 WHEREAS, there have been few, if any, DO physicians represented in any of the major
8 medical dramas (e.g., Grey’s Anatomy, Chicago Med, The Good Doctor, ER, etc.) or
9 other forms of entertainment media; and

10 WHEREAS, public perception of physicians is influenced by how positively or negatively by
11 they are portrayed on television²; and

12 WHEREAS, viewers of certain medical dramas perceive what they view on TV as credible³ and
13 undoubtedly incorporate their perception into expectations as a patient; and

14 WHEREAS, it is the goal of the American Osteopathic Association to “advance the distinctive
15 philosophy and practice of osteopathic medicine”⁴; now, therefore be it

16 RESOLVED, that the American Osteopathic Association supports, advocates, and lobbies for
17 increased representation and accurate portrayal of osteopathic physicians as characters
18 in media, including, but not limited to: television shows and movies.

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Explanatory Statement

Increasing the number of osteopathic physicians on TV and in movies has the potential to help educate the public about our profession and furthermore demonstrate the unlimited license to practice medicine that DOs hold in all 50 states. Lobbying for this exposure will be an efficient and cost-effective way to promote the DO brand. In addition, research showing that the public view of the profession is influenced by TV medical dramas suggests that viewing osteopathic physicians on television will result in viewers (the public) having an increased level of trust and familiarity with our profession..

Reference Committee Explanatory Statement

Due to organizational resource limitations, existing branding campaign, and high-profile osteopathic physicians on social media BOT feels that this resolution is appropriately addressed through existing channels. Further, the Committee believes that “advocating” and “lobbying for” this resolution falls outside the approved scope and resources of AOA departments.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: DECRIMINALIZATION OF SELF-INDUCED ABORTION

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, self-induced abortion is a deliberate termination of pregnancy performed by the
2 woman herself or with the help of non-medical assistance¹; and

3 WHEREAS, nearly half of the pregnancies in the United States are unintended²; and

4 WHEREAS, unintended pregnancies in the United States are most common among women
5 and girls of low income, especially those who are below the federal poverty level²; and

6 WHEREAS, more than 700,000 Google searches were performed looking into self-induced
7 abortions in 2015³; and

8 WHEREAS, unintended pregnancy may be the driving factor behind internet searches related
9 to self-induced abortion⁴; and

10 WHEREAS, a study with 1,235 respondents found that 73% of those individuals searching for
11 self-induced abortion indicated that they were pregnant and did not want to be, and
12 11% of those respondents reported that they had ever attempted to self-induce an
13 abortion⁴; and

14 WHEREAS, a variety of factors may serve as barriers to the utilization of abortion care
15 including, but not limited to, financial constraints, state or clinic restrictions, and travel-
16 related logistical issues⁵; and

17 WHEREAS, the World Health Organization (WHO) states that “nearly every abortion death
18 and disability could be prevented through sexuality education, use of effective
19 contraception, provision of safe and legal induced abortion, and timely care for
20 complications⁶,” and

21 WHEREAS, the American Medical Association (AMA) policy H-5.980 opposes the
22 criminalization of self-induced abortion, as does the American College of Obstetricians
23 and Gynecologists (ACOG) in the position statement on the matter^{7,8}; and

24 WHEREAS, the Massachusetts Medical Society states support of advocating against any
25 legislative efforts that criminalize self-induced abortion⁹; and

26 WHEREAS, the WHO defines an “unsafe abortion” as a “procedure for terminating an
27 unwanted pregnancy either by persons lacking the necessary skills or in an environment
28 lacking the minimal medical standards, or both,” which encompasses self-induced
29 abortion¹⁰; and

1 WHEREAS, part of the WHO’s reproductive health strategy published in 2004 outlines that
2 most maternal deaths arise from complications during childbirth, the postpartum
3 period, or after unsafe abortions¹¹; and

4 WHEREAS, as a 2014 study estimates that 2% of abortion patients had attempted a self-
5 induced abortion at some point⁸; and

6 WHEREAS, there are estimates that show in certain states as many as 100,000 women may
7 have attempted to self-induce an abortion¹²; and

8 WHEREAS, abortions managed by appropriately licensed and skilled practitioners carry risk,
9 like any medical procedure, such as infection hemorrhage, or damage to the uterus and
10 other organs¹³; and

11 WHEREAS, the criminalization of self-induced abortions may directly impact patient care by
12 leading to increased suspicion of patients presenting to healthcare providers for
13 miscarriages, potentially reducing the likelihood of patients seeking needed treatment¹⁴;
14 and

15 WHEREAS, self-induced abortions without appropriate medical supervision would be subject
16 to the same, if not greater, risk; and

17 WHEREAS, a report from the SIA legal team shows that Arizona, Delaware, Idaho, Nevada,
18 New York, Oklahoma and South Carolina have laws on record with language that
19 directly criminalizes self-induced abortion¹⁵; and

20 WHEREAS, prosecutorial overreach may be used to press criminal charges against patients
21 who have participated in self-induced abortion; and

22 WHEREAS, patients who have attempted to self-induce an abortion may be less prone to
23 access the healthcare system regarding complications due to fear of legal retribution;
24 now, therefore be it

25 RESOLVED, that the American Osteopathic Association stand in support of the
26 decriminalization of self-induced abortions along with legislative efforts to support that
27 goal, and oppose legislation that criminalizes self-induced abortion on the basis that
28 these criminalization efforts may increase our patient’s medical risk and threaten their
29 well-being.

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Reference Committee Explanatory Statement

The Committee supports harm reduction strategies that encourage patients to seek needed health care without fear of legal repercussions, as in the case of a minor who may avoid seeking treatment for illness resulting from underage drinking in addition to the intent of this resolution; however, the Committee believes that the resolution should be referred back to SOMA for clarification and refinement.

ACTION TAKEN **REFERRED** (*to Student Osteopathic Medical Association*)

DATE **July 27, 2019** _____

SUBJECT: DE-STIGMATIZATION OF MENTAL ILLNESS IN PHYSICIANS

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, a 2013 study published in *General Hospital Psychiatry* found that of about 203
2 physicians that succeeded in committing suicide, toxicology results showed a low rate of
3 pharmaceutical treatment and analysis of victim cases showed that many were mentally
4 ill or experienced problems related to job stress^{1,2}; and

5 WHEREAS, a 2016 survey of 2106 female physicians found that nearly 50% felt that they met
6 criteria for a mental illness but refused treatment³; and

7 WHEREAS, “fear of reporting the diagnosis to a medical licensing board” and “belief that a
8 diagnosis was embarrassing or shameful” are two reasons that were given by surveyed
9 female physicians behind not receiving treatment for their mental illness³; and

10 WHEREAS, for female physicians with a formal diagnosis in this survey, only 6% disclosed
11 their diagnosis on medical licensing applications³; and

12 WHEREAS, a 2017 study evaluated how many states have initial and renewal licensure
13 applications are considered “consistent” (the application did not have any questions
14 about mental health conditions or only asked about current impairment from a mental
15 health condition) and found that from 51 applications (the 50 states plus the district of
16 Columbia), only one-third of states have applications that are considered to be
17 “consistent”⁴; and

18 WHEREAS, 2,325 of 5,829 physicians surveyed (40%) in a 2016 study, cited “concerns about
19 repercussions to their medical licensure” as their reason for being reluctant to be
20 formally treated for a mental health condition⁴; and

21 WHEREAS, the above study found that physicians were more likely to be reluctant to seek care
22 for a mental health condition if they worked in a state with applications that were not
23 considered “consistent” (P = 0.002) leading to the conclusion that questions about a
24 prior mental illness or mental health conditions present a barrier to those physicians
25 that may need to seek help⁴; and

26 WHEREAS, according to the American Foundation for Suicide Prevention (AFSP), compared
27 to the general male population and general female population, the suicide rate for male
28 physicians is 1.41 times greater and the suicide rate for female physicians is 2.27 times
29 greater, respectively⁷; and

30 WHEREAS, according to the AFSP, “Among physicians, risk for suicide increases when mental
31 health conditions go unaddressed,”⁷; and

1 WHEREAS, the American Medical Association (AMA) has approved a policy on June 13th,
2 2018, that encourages state licensing boards to remove or change questions on their
3 applications that reference prior mental health conditions in favor of questions that
4 specify current physical or mental conditions using the verbiage recommended by the
5 Federation of State Medical Boards (This verbiage reads, “Are you currently suffering
6 from any condition for which you are not appropriately being treated that impairs your
7 judgement or that would otherwise adversely affect your ability to practice medicine in a
8 competent, ethical and professional manner?”)⁵; and

9 WHEREAS, the AMA cites concerns for growing rates of physician and medical student
10 depression, burnout, and suicide as being the trigger for adopting this new policy in an
11 attempt to encourage physicians to seek medical care when they need it without fear of
12 stigmatization or hindrance to their ability to obtain their medical license⁵; and

13 WHEREAS, the Florida Board of Medicine, in December 2018, in response to the new policy
14 adopted by the AMA and increasing rates of suicide among physicians, has given
15 preliminary approval to remove questions about prior mental health
16 conditions/treatment and substance abuse in favor of questions that specify if
17 applicants “currently have any condition that impairs them from safely practicing and
18 whether they currently are using drugs or intoxicating chemicals,”⁶; and

19 WHEREAS, the purpose of licensure questions asking about “any” history of mental illness is
20 to identify physicians that may present a risk to themselves or their patients. However,
21 the data presented in this resolution has shown that most physicians are not reporting
22 their conditions honestly with the current licensure questions and are avoiding seeking
23 treatment for their conditions due to fear that a diagnosis would prevent them from
24 maintaining or obtaining their licensure. This perpetuates stigmatization of mental
25 illness and puts these suffering physicians at increased risk for committing suicide; now,
26 therefore be it

27 RESOLVED, that the American Osteopathic Association (AOA) advocate in support of the
28 removal of questions on physician state licensing applications that ask about prior
29 history of mental illness in alignment with our colleagues at the American Medical
30 Association; and, be it further

31 RESOLVED, that the AOA advocate in support of questions on physician state licensing
32 applications that use the verbiage concerning current untreated or undertreated
33 conditions such as those that have been approved by the Federation of State Medical
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Explanatory Statement

Questions on the physician state licensing applications that ask about prior mental illnesses serve as a barrier to those that may need treatment due to fear of their answers affecting their licensure. An above whereas statement shows that very few physicians answer these questions honestly. The AFSP has stated that unaddressed mental illness increases rates of suicide among physicians and the barrier presented by the current state licensure questions prevents physicians from seeking care so as to avoid a diagnosis. As an organization with a holistic view of the human body as a complete unit (body, mind, and spirit), the AOA and SOMA should be active in supporting the health and wellness of their physicians, residents, and medical students.

Reference Committee Explanatory Statement

The Committee recommends the approval of H-362 SAFE HAVEN NON-REPORTING PROTECTION FOR PHYSICIAN – SUPPORT FOR in lieu of this resolution, as it encompasses the Resolveds of this resolution as well as other considerations.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: OPPOSING TARGETED REGULATION OF ABORTION PROVIDERS (TRAP LAWS)

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, Targeted Regulation of Abortion Providers (TRAP laws) are defined as legislation
2 and policy that apply ambulatory surgical center standards to family planning clinic;
3 require specific physical outlays to such clinics; require facilities or clinicians to have
4 attending rights at local hospitals; and/or require clinicians to be board-certified in
5 specific specialties in order to provide medication based and/or surgical-based
6 abortions^{1, 3, 5}; and

7 WHEREAS, TRAP laws single out medical practices of providers who provide abortions and
8 impose on them requirements that are different and more burdensome than those
9 imposed on other medical practices² which necessitates significant patient and provider
10 adaptation⁶; and

11 WHEREAS, there is no statistically significant evidence that performing an abortion at an
12 ambulatory surgical center reduces the risk of morbidities and adverse effects when
13 compared to a standard family planning clinic⁴; and

14 WHEREAS, providers of abortion reported heightened levels of stress, increased costs, and
15 lowered productivity when complying to TRAP laws without any change in outcome⁶;
16 and

17 WHEREAS, TRAP laws specifically governing abortion are more prevalent and impose more
18 stringent requirements than laws governing office-based surgeries, procedures, sedation,
19 or anesthesia^{3, 5}; and

20 WHEREAS, countries with less restrictive abortion laws have lower rates of abortions when
21 compared to countries with more restrictive laws⁸; and

22 WHEREAS, it is reported that TRAP laws directly interfere with the patient-physician
23 relationship^{3, 6} which is in violation of AOA policy H307-A/13 INTERFERENCE
24 LAWS⁷; and

25 WHEREAS, it is the recommendation of the American College of Obstetricians and
26 Gynecologists to end legislation, including TRAP laws, that impedes access to abortion
27 services and interferes with the patient-provider relationship³; now, therefore be it

28 RESOLVED, that the American Osteopathic Association oppose the Targeted Regulation of
29 Abortion Providers (TRAP laws) that impede and discriminate against a physician's
30 ability to provide appropriate care to patients seeking family planning services, including
31 abortion.

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Explanatory Statement

In light of recent bills passed in Iowa that would ban abortions on detectable heartbeat of the fetus, it is prudent that SOMA and the AOA take an official stance on laws that would prevent abortion providers from providing care to patients seeking abortions. Many TRAP laws are essentially backdoor abortion bans, especially in rural and underserved communities where there are insufficient resources to comply with these targeted regulations.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: PHYSICIAN PSYCHOLOGICAL TRAUMA AND MENTAL HEALTH

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, violence against health care workers is a demoralizing and frustrating part of
2 providing medical care for which there is little help available to the victims and is nearly
3 an epidemic.¹ Physical injury is only a small part of the overall trauma health care
4 workers face when caring for those who are not able to care for themselves; and

5 WHEREAS, physicians and medical personnel often face life and death situations for which
6 they are trained but are none-the-less psychologically traumatized and there is little if
7 any organizational assistance available.² Recent data suggests physician burnout costs
8 \$4.6 billion dollars yearly.³ and the World Health Organization recently re-classified
9 burnout as an “Occupational Phenomenon;”⁴ and

10 WHEREAS, if physicians were to seek psychological assistance for mental or emotional
11 traumas sustained within the scope of their professional duties, there are no assurances
12 that they will not be penalized by employers, insurers, or licensing and regulatory boards
13 for seeking such care. Studies have found that about 35% of physicians do not seek
14 regular health care for themselves. In one study, almost 50% of female physicians did
15 not seek treatment despite feeling that they met criteria for a mental disorder;⁵ and

16 WHEREAS, if a law enforcement officer were to experience the same type of trauma (example:
17 a death of a person within the scope of the person’s duties) they would be expected and
18 in most cases required to receive psychological assessment, treatment, and have paid
19 administrative leave to properly deal with the repercussions of the event. This treatment
20 would not adversely affect their professional standing. If a physician, resident, or
21 student were to experience the trauma of having a person die within the scope of their
22 professional duties they would be normally expected to resume their work and would
23 not receive psychological assessment, treatment, or paid time off to deal with the
24 repercussions of the event. A recent study finds that the long work hours of an intern’s
25 first year of medical residency are associated with accelerated cellular aging due to
26 prolonged stress exposure⁶; and

27 WHEREAS, if a physician were to seek professional psychological care they may be penalized
28 as evidenced by increased insurance premiums, denial of disability and life insurance
29 policies, and intrusive questions about past health care that does not likely affect
30 professional performance and may negatively impact hospital staff appointments,
31 licensure, board certification or credentialing; now, therefore, be it;

32 RESOLVED, that the American Osteopathic Association (AOA) continue to work to ensure
33 that physicians are not publicly or professionally stigmatized for seeking care and
34 treatment for injuries or psychological trauma resulting from their professional duties;
35 and, be it further

1 RESOLVED, that the AOA continue ongoing promotion of physician mental health care as a
2 necessary part of normal physician professional development requiring appropriate care
3 to avoid suicide, depression, and burnout; and, be it further

4 RESOLVED, that the AOA work with payors and other invested parties to remove any and all
5 financial penalties and stigmas associated with mental health care received ensuring the
6 continued wellness of our physician workforce.

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Explanatory Statement:

We are in a crisis for physicians in America. Burnout is an often discussed and “hot topic” epidemic. The work of the AOA & MOA has been significant on this front, but as a value to our members we believe the need for public consideration of this as a late submission to the AOA House for consideration in 2019. It is important to show our members that we care about their needs when these timely topics are discussed. Thanks for your thoughtful consideration.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: NUTRITION AND LEADING BY EXAMPLE

SUBMITTED BY: Osteopathic Physicians and Surgeons of Oregon

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, at the 2018 American Osteopathic Association (AOA) House of Delegates,
2 resolution H-365 was approved resolving that the AOA consider meal nutritional
3 content when planning events; and

4 WHEREAS, the preponderance of evidence shows negative health outcomes associated with
5 the consumption of sugar sweetened beverages and processed meats and;

6 WHEREAS, the World Health Organization, International Agency for Research on Cancer has
7 classified processed meat as carcinogenic to humans (Group 1); and

8 WHEREAS, nudges, defined as a subtle environment cues designed to make healthy food
9 choices the easy choice have been shown to increase consumption of healthy foods; and

10 WHEREAS, the AOA has the opportunity to lead by example - recognizing the impact that
11 nutrition has on human health when providing meals; and

12 RESOLVED, that sugar sweetened beverages and processed meats be excluded from all
13 American Osteopathic Association (AOA) sponsored events where a meal is served;
14 and, be it further

15 RESOLVED, that the AOA encourage osteopathic medical schools, residency programs, and
16 hospitals to offer plant-based meals and eliminate sugar sweetened beverages and
17 processed meats when meals are served.

Reference Committee Explanatory Statement

As per AOA policy will be referred to Finance Committee for fiscal analysis.

ACTION TAKEN **REFERRED** *(to AOA Finance Committee)*

DATE **July 27, 2019** _____

SUBJECT: REFERRED RESOLUTION H305 - A/2018 - INTERFERENCE LAWS

SUBMITTED BY: Bureau of Federal Health Programs / Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, resolution H305-A/2018 titled H307-A/2013 INTERFERENCE LAWS was
2 referred to the Bureau on Federal Health Programs and Bureau of State Government
3 Affairs for adding updated n information to the policy; now therefore be it

4 RESOLVED, that the Bureau of Federal Health Programs and the Bureau of State
5 Government Affairs recommend that the following policy be REAFFIRMED as
6 AMENDED:

7 **H307-A/13 INTERFERENCE LAWS**

8 The American Osteopathic Association approved the following policy paper and
9 recommendations to assist in responding to state and federal proposals and agencies that
10 attempt to adopt interference laws (2013).

11 ~~Several~~ A NUMBER OF states have pursued legislation that dictates how physicians treat and counsel
12 patients during a medical exam. These laws interfere with the patient-physician relationship, and
13 undermine physician judgment AND REPRESENT a departure from evidence-based medicine. As a
14 result, these laws are collectively referred to as “interference laws.”

15 ~~There are four different classifications of interference laws.~~ INTERFERENCE LAWS FALL INTO
16 ONE OF FOUR DIFFERENT CLASSIFICATIONS.¹ The first prevents physicians from asking their
17 patients about risk factors that may affect their health or the health of their families (PHYSICIAN
18 “GAG LAWS”). An ONE example OF A GAG LAW of this law is a 2011 Florida law which limited
19 BARRED physicians from asking questions about a patient’s gun ownership.² The law WAS
20 ENJOINED IN 2012 ON FIRST AMENDMENTS GROUNDS, A DECISION WHICH WAS
21 UPHELD BY A FEDERAL APPEALS COURT IN 2017.³ ALTHOUGH 14 OTHER STATES
22 HAVE CONSIDERED SIMILAR LAWS, NONE HAVE PASSED.⁴ ~~s no longer in effect as it was~~
23 ~~permanently enjoined in June 2012. This issue resurfaced in January 2013 when President Obama~~
24 ~~signed 23 executive orders regarding gun control. The President’s 16th executive order~~
25 ~~clarified that the Affordable Care Act “does not prohibit doctors from asking patients about guns in~~
26 ~~their homes.”²~~

27 The second type of interference law requires physicians to discuss specific treatments that may not be
28 APPROPRIATE OR medically necessary.⁵ ~~Examples~~ ONE EXAMPLE of this include IS NEW
29 YORK’S PALLIATIVE CARE INFORMATION ACT OF 2011, WHICH REQUIRES HEALTH
30 CARE PROVIDERS TO OFFER TO DISCUSS END-OF-LIFE OPTIONS laws which require
31 physicians to offer patients information about end-of-life care. These efforts have also been pursued at
32 the federal level, where in 2011 the Obama Administration attempted to promulgate regulations under
33 the Affordable Care Act that would pay physicians for counseling Medicare patients on end-of-life
34 options. Some argue that requiring physicians to discuss this subject with all patients is inappropriate,
35 because physicians are AND PALLIATIVE CARE SERVICES WITH TERMINALLY ILL
36 PATIENTS, WITHOUT DISCRETION AS TO HOW AND WHEN TO RAISE THE ISSUES.⁶

1 SOME ARGUE THAT REQUIRING PHYSICIANS TO DISCUSS THIS SUBJECT WITH ALL
 2 PATIENTS IS INAPPROPRIATE, BECAUSE PHYSICIANS ARE not able to use their judgment to
 3 determine ~~which~~ IF OR WHEN patients should receive such sensitive information. Further examples
 4 are laws which require physicians to inform women about their breast density when obtaining a
 5 mammogram, and laws which require physicians to inform patients that a negative test result for Lyme
 6 disease may not be accurate.

7 The third type of interference law requires physicians to provide tests or treatments which are not
 8 supported by evidence, including ones that are invasive or required without the patient's consent.⁷
 9 Examples of this are laws which require physicians who perform abortions to first perform a fetal
 10 ultrasound. It is argued that a fetal ultrasound is medically unnecessary and ~~not supported by evidence-~~
 11 ~~based medicine~~ THERE IS NO LEGITIMATE MEDICAL PURPOSE FOR REQUIRING ONE IN
 12 THIS CIRCUMSTANCE.

13 ~~The fourth and final type of interference law places restrictions on the content of information that~~
 14 ~~physicians can disclose to patients.~~⁵ ~~Examples of this include laws which limit a physician from~~ THE
 15 FOURTH AND FINAL TYPE OF INTERFERENCE LAW PLACES RESTRICTIONS ON THE
 16 CONTENT OF INFORMATION THAT PHYSICIANS CAN DISCLOSE TO PATIENTS.⁸
 17 EXAMPLES OF THIS INCLUDE LAWS WHICH LIMIT A PHYSICIAN FROM providing
 18 information about the dangers of chemicals used in the hydraulic fracturing process, also known as
 19 “fracking.”

20 **Impact on the Osteopathic Medical Profession and THE Patient-Physician Relationship**

21 Interference laws threaten the osteopathic medical profession, in particular due to the intrusion INTO
 22 THE ~~of~~ patient-physician relationship, which is an essential component of the osteopathic care model's
 23 emphasis on preventive medicine and treatment of the whole patient.⁹ The patient-physician
 24 relationship is based on ethical principles of trust, confidentiality, respect, autonomy and open
 25 communication between the physician and patient.¹⁰

26 Another critical element of osteopathic medical practice in general and the patient-physician
 27 relationship in particular is the concept of physician and patient autonomy and “patient-centered” care.
 28 The Institute of Medicine (IOM) defines patient-centered care as “providing care that is respectful of
 29 and responsive to individual patient preferences, needs and values, and ensuring that patient values
 30 guide all clinical decisions.”¹¹ Patient-centered care is an essential element in the practice of evidence-
 31 based medicine. **THE** American Osteopathic Association (AOA) ~~policy~~ supports the use of evidence-
 32 based medicine and the implementation of “all **APPROPRIATE** methods ~~appropriate~~ to optimize
 33 natural healing and to address the primary cause of disease.”¹²

34 The patient-physician relationship is a critical aspect of osteopathic care, due in large part to a
 35 partnership that is created between the physician and patient which relies heavily on communication.
 36 “Osteopathic physicians (**DOs**) consider the impact that lifestyle and community have on the health of
 37 each individual, and they work to break down barriers to good health. ~~Osteopathic Physicians (DOs)~~
 38 are trained to look at the whole person, and osteopathic physicians integrate the patient into the health
 39 care delivery process as a partner.”¹³ Interference laws which prevent DOs from discussing certain
 40 health-related subjects such as the safe storage of firearms or the health ~~concerns of fracking~~
 41 ~~undermines this partnership and violates the osteopathic principle of preventive medicine. If a DO is~~
 42 ~~not allowed to adequately counsel a patient on the dangers of a loaded and the safe storage of firearms,~~
 43 ~~they are unable to provide information which may prevent a firearm-related death in the patient's~~
 44 ~~household~~ IMPLICATIONS OF FRACKING UNDERMINE THIS PARTNERSHIP AND
 45 VIOLATE THE OSTEOPATHIC PRINCIPLE OF PREVENTIVE MEDICINE. DOs HELP
 46 PREVENT PEDIATRIC DEATHS BY COUNSELING CAREGIVERS ON THE IMPORTANCE

1 OF SEATBELT AND HELMET USE, BUT WITHOUT THE ABILITY TO ADEQUATELY
 2 COUNSEL A PATIENT ON THE IMPORTANCE OF SAFE FIREARM STORAGE THEY MAY
 3 BE UNABLE TO HELP PREVENT SIMILAR DEATHS FROM IMPROPERLY STORED
 4 FIREARMS. “[T]he purpose of [a firearms] inquiry is so that the practitioner can determine what
 5 subject matters require further follow-up in the practice of preventive medicine.”¹⁴ THE AOA policy
 6 rejects any censorship of professional communication, supports enactment of legislation protecting the
 7 patient-physician relationship and opposes any attempt to interfere with the patient-physician
 8 relationship.¹⁵

9 Additionally, interference laws that require DOs to discuss treatments which are not medically
 10 necessary or are not supported by evidence-based guidelines violates the osteopathic principle of
 11 treating the whole patient and can undermine patient trust. IN KANSAS, FOR EXAMPLE,
 12 PHYSICIANS ARE REQUIRED TO PROVIDE MISLEADING INFORMATION TO PATIENTS
 13 REGARDING AN UNPROVEN LINK BETWEEN BREAST CANCER AND ABORTION.¹⁶ If a
 14 DO is always required to provide information on a certain treatment, they are unable to treat the whole
 15 patient in an objective manner, thereby preventing the DO from exercising their judgment as a
 16 physician. TWENTY-THREE STATES CURRENTLY REQUIRE HEALTH CARE PROVIDERS
 17 TO REFER PATIENTS TO STATE-CREATED “INFORMED CONSENT” MATERIALS, AND
 18 ACCORDING TO A 2016 AUDIT BY RUTGERS UNIVERSITY, 31 PERCENT OF THE
 19 INFORMATION INCLUDED IN THESE MATERIALS WAS FOUND TO BE MEDICALLY
 20 INACCURATE.¹⁷ BLANKET REQUIREMENTS THAT DOs PROVIDE INFORMATION ON A
 21 PARTICULAR TREATMENT, OR MEDICALLY INACCURATE INFORMATION, TO ALL
 22 PATIENTS PREVENTS THEM FROM EXERCISING THEIR INDEPENDENT MEDICAL
 23 JUDGMENT AND TREATING THE WHOLE PATIENT IN AN OBJECTIVE, EVIDENCE-
 24 BASED MANNER. Similarly, interference laws which require DOs to perform certain procedures or
 25 treatments violate the osteopathic principle of providing individualized patient-centered care. If a DO is
 26 required to perform a certain procedure or treatment for every patient, there is no individualized
 27 assessment as to what is in a particular patient’s best interests and there is no discussion with the patient
 28 because the patient has no choice. Instead of individualized care, this is a “one size fits all” approach.
 29 Ultimately, DOs are prevented from rendering individualized, evidence-based care, and patients are
 30 prevented from being involved in patient-centered care.

31 **Legal Challenges**

32 Two types of interference laws have been challenged in court. Florida’s controversial Firearm Owner’s
 33 Privacy Act, which restricted physicians from asking patients about firearm ownership, was
 34 permanently enjoined in June 2012 when a Florida district court found that it violated physicians’ First
 35 Amendment rights, A DECISION WHICH WAS UPHELD BY A FEDERAL APPEALS COURT
 36 IN 2017. In granting the injunction, the judge stated the law “chills practitioners’ speech in a way that
 37 impairs the provision of medical care and may ultimately harm the patient.”¹⁸ The court also held that
 38 physician questioning did not violate patients’ Second Amendment rights stating, “[t]he law does not
 39 affect nor interfere with a patient’s right to continue to own, possess, or use firearms.

40 Protecting the right to keep and bear arms is irrelevant to this law.”¹⁹ IN ADDITION, A SIMILAR
 41 2012 LAW WHICH PREVENTED PHYSICIANS IN PENNSYLVANIA FROM DISCUSSING
 42 HOW FRACKING CHEMICALS MAY BE AFFECTING THEIR PATIENTS’ HEALTH WAS
 43 STRUCK DOWN BY THE STATE SUPREME COURT IN 2016.²⁰

44 Mandatory ultrasound laws have also been challenged on First Amendment grounds. North Carolina’s
 45 mandatory ultrasound law was struck down as a violation of physician and patient First Amendment
 46 rights. The court held that “[t]he Act goes well beyond requiring disclosure of those items traditionally a

1 part of the informed consent process. In this case, the state compels the provider to physically speak
2 and show the state’s non-medical message to patients unwilling to hear or see [that message].²¹

3 Conversely, A NEARLY IDENTICAL KENTUCKY LAW WAS UPHELD BY A FEDERAL
4 APPEALS COURT, ~~the Fifth Circuit Court of Appeals upheld a similar mandatory ultrasound law in~~
5 ~~Texas, WHICH FOUND~~ ~~finding~~ that the law WAS REASONABLY RELATED TO THE
6 “INFORMED CONSENT” PROCESS AND did not violate THE First Amendment rights of
7 | physicians and patients.²² Significantly, the ~~recent decision BY~~ ~~CIRCUIT SPLIT~~ ~~-BETWEEN THE~~
8 COURTS ~~the Fifth Circuit Court of Appeals sets up a possible circuit split with the Fourth Circuit~~
9 ~~Court of Appeals and~~ SETS UP a probable hearing by the United States Supreme Court on the issue of
10 mandatory ultrasound laws.

11 Mandatory ultrasound laws have also been challenged in court on Fourteenth Amendment Substantive
12 Due Process grounds. A mandatory ultrasound law in Oklahoma was ruled to be unconstitutional as a
13 violation of patients’ Fourteenth Amendment due process rights, because it placed an “undue burden”
14 on a woman’s right to seek an abortion.²³

15 **Efforts of Medical Associations**

16 Several medical associations have developed policies or taken action in opposition to interference laws.
17 | In 2015, ~~2014~~, the American Medical Association (AMA) ~~adopted~~ REAFFIRMED a 2011 resolution
18 which opposes any intrusion into patient-physician relationships and supports physician judgment. In
19 ~~October 2012~~ MAY 2018, the American Academy of Family Physicians (AAFP), THE AMERICAN
20 ACADEMY OF PEDIATRICS, THE AMERICAN COLLEGE OF OBSTETRICIANS AND
21 GYNECOLOGISTS AND THE AMERICAN COLLEGE OF PHYSICIANS ISSUED A SET OF
22 JOINT PRINCIPLES BASED UPON THEIR ORGANIZATIONS’ POLICIES WHICH OPPOSE
23 GOVERNMENTAL INTERFERENCE WITH PHYSICIANS’ OBLIGATIONS TO PROVIDE
24 COMPREHENSIVE, EVIDENCE-BASED INFORMATION TO PATIENTS.²⁵ ~~passed a resolution~~
25 ~~supporting the patient-physician relationship and opposing all legislative attempts to interfere with this~~
26 ~~relationship.~~⁴⁸ Additionally, in July 2012, the American College of Physicians (ACP) adopted a
27 resolution which set forth seven principles for federal and state governments to follow when
28 attempting to interfere with the patient-physician relationship.⁴⁹ Further, in October 2012 the heads of
29 five medical associations (ACP, AAFP, ACOG, AAP, ACS) came together to publish an article in the
30 New England Journal of Medicine.²⁰ ~~The article promotes physician autonomy, empowering patients to~~
31 ~~make informed decisions about their care, and preventing legislators from interfering with the patient-~~
32 ~~physician relationship.~~²¹ In January 2013, the Council of Medical Specialty Societies (CMSS) adopted
33 this article as policy.

34 ~~In August 2012, the American Bar Association (ABA) also adopted a resolution~~ HAS POLICY
35 specifically opposing laws which prevent physicians from asking patients about firearm ownership. The
36 ABA ~~resolution~~ POLICY states that these laws clearly violate the First Amendment rights of physicians
37 and patients, and physician questioning does not in any way violate Second Amendment rights of
38 patients.²⁶

39 Finally, several state medical associations have adopted resolutions on the issue of interference laws.
40 Many of these policies are very basic and simply state the association’s opposition to any interference
41 with the patient-physician relationship. Additionally, these policies often promote the use of evidence-
42 based medicine, seek to preserve physician judgment and support litigation which blocks the
43 | enforcement of interference laws.

44 **Conclusion**

1 The AOA supports the protection of the patient-physician relationship as especially paramount to the
2 osteopathic medical profession. The osteopathic care model is based upon the treatment of the whole
3 patient and the use of preventive medicine. The patient-physician relationship is a ~~critical~~
4 FUNDAMENTAL aspect of osteopathic care, due in large part to a partnership that is created between
5 the physician and patient which relies heavily on communication AND TRUST. Interference laws
6 encroach on this relationship and undermine the osteopathic care model by preventing DOs from
7 providing treatment in a manner THAT IS BASED UPON EVIDENCE they believe is best for their
8 patients.

9 The AOA affirms that legislation which interferes with the patient-physician relationship impairs the
10 | autonomy of osteopathic physicians and prevents osteopathic physicians from using their ~~best~~
11 INDEPENDENT MEDICAL judgment based on years of rigorous education and training.

12 The AOA asserts that physicians must be able to communicate freely with patients without fear of
13 government intrusion in order to assure safe, comprehensive and effective medical treatment.

14 | The AOA considers ~~that legislation which~~ THAT undermines physician judgment TO BE is a barrier to
15 evidence-based medicine. The AOA supports the use of evidence-based medicine to ensure high quality
16 patient care. Statutorily required medical practices interfere with evidence-based medicine by mandating
17 a “one size fits all approach,” thereby preventing an individualized assessment of what is in a particular
18 patient’s best interests.

19 The AOA affirms that legislation which interferes with the patient-physician relationship undermines
20 patient-centered care. Patient-centered care actively involves the patient in making decisions regarding
21 their own medical care. Statutorily required medical practices prevent patients from being involved in
22 making medical decisions, because the patient has no choice.

23 The AOA ~~affirms~~ BELIEVES THAT the ethical principle of informed consent is undermined when
24 patients are statutorily required to undergo certain treatments or procedures, because the patient has no
25 choice.

26 | The AOA opposes all legislation at the state and federal level ~~which~~ THAT requires physicians to
27 discuss or perform certain treatments or procedures not supported by evidence-based guidelines,
28 because such legislation undermines physician judgment.

29 The AOA opposes all legislation at the state and federal level which prevents physicians from
30 discussing certain health-related risk factors with their patients, because such legislation violates the
31 | First Amendment rights of physicians and patients AND IS IN CONFLICT WITH EVIDENCE-
32 BASED MEDICAL BEST PRACTICES.

33 The AOA believes that physicians should be free to counsel patients on end-of-life care on a case-by-
34 case basis rather than AS A RESULT OF an across-the-board mandate.

35 The AOA supports ~~court~~ LEGAL challenges ~~of~~ TO interference laws that violate First Amendment
36 and Fourteenth Amendment rights of physicians and patients under THE State and Federal
37 Constitutions.

38 The AOA will monitor state and federal interference laws on an ongoing basis and update this policy as
39 needed.

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ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: REFERRED RESOLUTION H306-A/18 - STATE GRADUATE MEDICAL EDUCATION (GME) FUNDING ALTERNATIVES

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Bureau of State Government Affairs

1 WHEREAS, resolution H306-A/2018 titled H308-A/2018 STATE GRADUATE MEDICAL
2 EDUCATION (GME) FUNDING ALTERNATIVES was referred to the Bureau of
3 State Government Affairs for updating; now, therefore be it

4 RESOLVED, that the Bureau of State Government Affairs recommend that the following
5 policy be REAFFIRMED **AS AMENDED**:

6 **H308-A/13 STATE GRADUATE MEDICAL EDUCATION (GME) FUNDING**
7 **ALTERNATIVES**

8 The following policy paper and the recommendations provided within are approved to assist
9 the American Osteopathic Association in responding to policy proposals aimed at funding
10 graduate medical education (GME) at the state-level; the AOA will work with the osteopathic
11 community to encourage and support state-level GME funding initiatives that encompass the
12 principles outlined within this paper. (2013).

13 **AOA POLICY PAPER:**
14 **STATE GRADUATE MEDICAL EDUCATION FUNDING**

15 **BACKGROUND**

16 Physician training requires students to attend four years of medical school, usually paying those costs
17 out-of-pocket or through loans. Following successful completion of medical school, their training
18 continues as medical residents. Medical residents see and treat patients under the supervision of more
19 experienced physicians. This training usually takes place in hospitals though residents often rotate to
20 ambulatory sites such as clinics and physician offices. On average, this residency training takes four
21 years to complete, although high~~LY~~ specialized fields may require longer training.

22 By and large, overall funding for graduate medical education (GME) comes from patient care revenues.¹
23 However, the **FEDERAL GOVERNMENT IS** current~~LY~~ **THE** single largest **SINGLE** funder of
24 GME, ~~is the Department of Health and Human Services (HHS)~~ **PROVIDING APPROXIMATELY**
25 **\$15.9 BILLION IN FUNDING** through the Centers for Medicare and Medicaid Services (CMS) **IN**
26 **2018.**² **NEARLY TWO-THIRDS OF THIS FUNDING COMES FROM MEDICARE, WITH**
27 **THE MAJORITY OF THE REMAINDER FUNDED THROUGH MEDICAID.**³ ~~The federal~~
28 ~~government contributes approximately \$15.5 billion in Medicare funds and approximately \$2 billion in~~
29 ~~Medicaid dollars to help pay for GME.~~ Additional funding is provided by the Department of Defense,
30 the Department of Veterans Affairs and the U.S. Public Health Service.⁴ In providing Medicare
31 funding, Congress has acknowledged that training physicians is a public good. Despite that
32 acknowledgement, there have been periodic calls to remove GME from Medicare and Medicaid and
33 secure other sources of funding. So far, Congress has neither acted on these recommendations nor

1 have other entities stepped up to assume a greater share of the financial responsibility (relative to
 2 Medicare or Medicaid) for physician training.

3 ~~With calls to reduce federal spending,~~ **WITH CAPS ON THE FEDERAL BUDGET, GME**
 4 **FUNDING HAS BEEN AND WILL CONTINUE TO BE RELATIVELY FLAT.**

5 ~~ADDITIONALLY, is potentially faced with a significant reduction in funding. The Obama-~~ **THE**
 6 **TRUMP** Administration and several members of Congress have **HAS** spoken out in favor of
 7 **SUPPORTED BOTH CONSOLIDATION AND** reducing **TION** OF GME funding as part of a
 8 comprehensive approach to reducing overall federal spending.⁵ Additionally, **IN DECEMBER 2018,**
 9 **THE CONGRESSIONAL BUDGET OFFICE ISSUED RECOMMENDATIONS TO**
 10 **CONSOLIDATE AND REDUCE FEDERAL PAYMENTS FOR GME AT TEACHING**
 11 **HOSPITALS** several bills have been introduced at the federal level that attempt to address GME
 12 funding shortages.⁶ Conversely, medical schools, hospitals and medical associations see a need to
 13 increase funding and residency slots to help train physicians and fill projected workforce shortages and
 14 are working at both the state and federal levels to achieve increased funding for GME.

15 There are two mechanisms in **THROUGH** which Medicare and Medicaid distribute GME funding:
 16 direct medical education (DME) and indirect medical education (IME) payments. DME payments are
 17 based on resident salaries, supervision and other educational costs. IME payments are based on
 18 additional operating costs of a hospital with a GME program. One of the greatest ~~hurdles in~~
 19 **OBSTACLES TO** federal GME funding is the Balanced Budget Act of 1997 (~~BBA~~), which limited the
 20 number of allopathic and osteopathic residents a hospital can count for purposes of DME and IME
 21 payment. The law also reduced the IME multiplier over a four-year period, however, the Balanced
 22 Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and
 23 Protection Act of 2000 (~~BIPA~~) delayed the IME reduction. Additionally, the Budget Control Act of
 24 2011 enacted a series of automatic budget cuts that included a 2% cut for IME payments **WHICH**
 25 **TOOK** ~~taking~~ effect on April 1, 2013.⁷

26 **MEDICARE**

27 The formula for determining Medicare payments to hospitals for direct costs of approved GME
 28 programs is established in section 1886(h) of the Social Security Act (~~the Act~~).⁹ A DME payment is
 29 determined by multiplying a hospital-specific, base-period per resident amount by the weighted number
 30 of full-time equivalent residents working in all areas of the hospital and the hospital's Medicare share of
 31 total inpatient days.¹⁰ The Affordable Care Act amended section 1886(h)(4)(E) to allow a hospital to
 32 count residents training in non-hospital settings if the residents are engaged in patient care activities and
 33 if the hospital incurs the costs of the stipends and fringe benefits of the resident during the time

Figure 1. Medicare DGME Payment Formula

$$\begin{array}{l}
 \text{DGME Payment} = \text{Total Approved DGME Amount} \times \text{Medicare Patient Load} \\
 \left(\begin{array}{l} \text{Adjusted Rolling Average FTE Count} \end{array} \right) \times \left(\begin{array}{l} \text{Per Resident Amount} \end{array} \right) \times \left(\begin{array}{l} \text{Medicare Part A Inpatient Days} \\ \text{Total Inpatient Days} \end{array} \right) + \left(\begin{array}{l} \text{Medicare Part C Inpatient Days} \\ \text{Total Inpatient Days} \end{array} \right) \times 86\%
 \end{array}$$

Source: CRS analysis of Title XVIII of the Social Security Act (SSA) and relevant regulations.
 Note: The adjusted rolling average FTE count is subject to the GME cap.

34 residents spend in that setting.¹¹

35 As previously mentioned, IME payments are based on additional operating costs of a GME program.
 36 The factors for IME payment generally include sicker/more complex patients, maintaining stand-by
 37 capacity for certain specialized services (e.g. burn units), residents ordering more tests and trainees
 38 being less efficient in providing care. IME payments provide for the legitimate increase in costs training
 39 hospitals incur.¹² IME payments are calculated by adding the individual intern/resident-to-bed ratio into

1 a formula already established in the Medicare statute. The current IME adjustment is calculated using a
 2 multiplier set at 1.35, which means that a teaching hospital will receive an increase of approximately
 3 5.5% in Medicare payments for every 10-resident increase per 100 beds.

4 **MEDICAID**

5 Despite **FEDERAL LAW NOT REQUIRING STATE MEDICAID PROGRAMS TO**
 6 **SUPPORT GME**, ~~being under no obligation to do so~~, Medicaid is the second largest **FUNDER OF**
 7 ~~contributor to~~ GME programs. Several **A MAJORITY OF** states have implemented mechanisms
 8 within their Medicaid programs to supplement federal funding of GME. In most cases, Medicaid GME
 9 funding is structured similarly to Medicare, providing direct and indirect payments. The most recent
 10 data available estimates that Medicaid paid **APPROXIMATELY \$4.33-87** billion to GME programs in
 11 2015~~2~~, up from ~~\$3.8778~~ in 2012~~09~~.^{13, 14} ~~From~~ **DESPITE THE FACT** that **MUCH OF THAT**
 12 **FUNDING**, ~~at least half~~ came from matching federal payments, **THREE STATES REPORTED**
 13 **THAT THEY EXPLICITLY REDUCED THEIR MEDICAID SPENDING ON GME, AND**
 14 **ANOTHER SEVEN REPORTED AT LEAST A TEN PERCENT REDUCTION IN**
 15 **MEDICAID GME PAYMENTS BETWEEN 2012 AND 2015**.¹⁵ However, several states have
 16 reduced their funding for GME programs through their Medicaid programs.

17 In 2005, 47 states provided \$3.18 billion through Medicaid to support GME.¹⁶ By 2015~~2~~, only 42 states
 18 and the District of Columbia (DC) supported GME through their Medicaid program.¹⁷ Arizona,
 19 Massachusetts, Montana, Rhode Island, Vermont and Wyoming have since ended GME funding, citing
 20 budget shortfalls, **AND ALABAMA, MICHIGAN AND TENNESEE REPORTED THAT**
 21 **THEY RECENTLY CONSIDERED ENDING FUNDING AS WELL**.^{18, 19} Additionally, ~~some~~
 22 ~~states like, Iowa, Michigan, Oregon and Pennsylvania, have discussed ending Medicaid support for~~
 23 ~~GME.~~¹⁹ Others, like Florida and Washington, have decreased Medicaid funding for GME in the last
 24 few years.²⁰

25 *Medicaid Fee-for-Service*

26 Forty states and the District of Columbia make DME and/or IME payments under the Medicaid fee-
 27 for-service program. A fee-for-service program is a payment model where services are unbundled and
 28 paid for separately.²⁰ ~~Twelve~~ **FOURTEEN** states and DC fund DME and/or IME programs using a
 29 calculation method similar to Medicare's GME funding formula, **SOMETIMES IN ADDITION TO**
 30 **OTHER METHODS**. ~~The remaining states calculate payments by "some other method," which~~
 31 ~~usually includes a variation~~**S** of a per-resident or lump-sum amount. The per-resident or lump-sum
 32 amount ~~S ARE~~**is** based on the "hospital's share of total Medicaid revenues, costs or patient volumes."
 33 **TWENTY-NINE STATES REPORTED CALCULATING PAYMENTS SOLELY BY**
 34 **"SOME OTHER METHOD" IN 2015**.²¹

35 *Medicaid Managed Care*

36 Capitated managed care is a state's use of risk-based capitation payments within their Medicaid
 37 program. This typically includes contracting with one or multiple managed care organizations (MCOs)
 38 to administer the Medicaid program for a defined population of Medicaid patients.²² Thirty-~~NINE~~**SIX**
 39 states and DC use capitated Medicaid managed care programs. ~~Currently, 23 states and DC included~~
 40 ~~DME and/or IME payments under their Medicaid managed care programs.~~²³

41 ~~Fourteen~~**SIXTEEN** states and DC directly pay teaching hospitals or other teaching programs under
 42 Medicaid for DME and/or IME payments.²³ This **REPRESENTS** ~~is an INCREASE~~ ~~decline~~ in the
 43 number of states who have made direct payments under managed care **SINCE 2012**.²⁴ States who make
 44 direct Medicaid payments indicate **THAT** they wish to help train future physicians who will service
 45 Medicaid beneficiaries and that using Medicaid funds to fund GME programs will help advance state

1 health policy goals. ~~Five of these states pay for both DME and IME costs and three states do not~~
 2 ~~distinguish between the two costs.~~²⁴

3 ~~Nine~~ **TWELVE** states recognize and include Medicaid DME and/or IME payments in their capitated
 4 payment rates to managed care organizations. ~~Five~~ **HALF** of these states – **IOWA**, Kansas, Kentucky,
 5 Michigan, ~~Oregon~~ **MINNESOTA** and ~~Washington~~ **MISSISSIPPI** – require MCOs to distribute the
 6 negotiated payments to teaching hospitals. The other ~~four~~ **SIX** assume MCOs will distribute the
 7 payments.²⁵

8 **ALIGNING GME FUNDING WITH HEALTH POLICY PRIORITIES**

9 States continue to look to align GME funding with other health policy goals. This can include increased
 10 funding for training in certain specialties, addressing workforce shortages in rural and underserved areas
 11 and increasing faculty positions to train new physicians. **A 2016 STUDY REVEALED THAT**
 12 **THIRTY-TWO STATES LINKED MEDICAID GME PAYMENTS TO A STATE POLICY**
 13 **GOAL OF INCREASING THE SIZE OF THE PHYSICIAN WORKFORCE, COMPARED**
 14 **TO 22 STATES IN 2012.**²⁶

15 *Kansas and Florida* **AND KANSAS**

16 In an effort to promote accountability in the use of GME funds, ~~Kansas and Florida~~ **AND KANSAS**
 17 link Medicaid GME payments to stated state policy goals. ~~Kansas~~ **IN FLORIDA, THIS** applies to
 18 both fee-for-service (**FFS**) and managed care Medicaid programs, while ~~Florida~~ **KANSAS GME**
 19 **payments focus** **ES SOLELY** on fee-for-service **FFS** payments.²⁷ Like most states, ~~Kansas and Florida~~
 20 **AND KANSAS** have focused on encouraging training in primary care specialties **AND**
 21 **INCREASING ACCESS TO CARE IN** rural and medically underserved areas.

22 Kansas also uses GME payments to promote an increased supply of physicians serving the Medicaid
 23 population, and **FUNDS TEACHING HOSPITALS AS WELL AS TEACHING SITES IN**
 24 **NON-HOSPITAL SETTINGS.** ~~increase the geographic distribution and fund teaching hospitals~~
 25 ~~that have experienced GME funding cuts through the Medicare program.~~ **IN FLORIDA, GME**
 26 **PAYMENTS HAVE BEEN EXTENDED TO INDIVIDUAL TEACHING PHYSICIANS**
 27 **UNDER FFS.** In addition to Medicare and Medicaid GME funding, Florida also **THE STATE**
 28 **ALSO** uses alternative sources to fund residency programs **IN ADDITION TO MEDICAID AND**
 29 **MEDICARE, INCLUDING THE STATEWIDE MEDICAID RESIDENCY PROGRAM**
 30 **AND THE GRADUATE MEDICAL EDUCATION STARTUP BONUS PROGRAM.** ~~servicing~~
 31 ~~Veterans Administration medical, loan repayment for residents and physicians serving underserved or~~
 32 ~~designated shortage areas after training, and offers state appropriations for additional funding to~~
 33 ~~encourage new training opportunities and cost/resource sharing between groups.~~²⁸ **THE FORMER**
 34 **WAS CREATED IN 2013 WITH \$80 MILLION IN RECURRING STATE AND**
 35 **MATCHING FEDERAL FUNDS TO SUPPORT PAYMENTS TO HOSPITALS WITH**
 36 **ACCREDITED RESIDENCY PROGRAMS, WHILE THE LATTER WAS CREATED IN**
 37 **2015 WITH \$100 MILLION ALLOCATED TO EDUCATING AND TRAINING**
 38 **PHYSICIANS IN SPECIALTIES WHICH ARE IN A STATEWIDE DEFICIT. IN 2018,**
 39 **THE FLORIDA LEGISLATURE APPROPRIATED \$242.3 MILLION TO THESE**
 40 **PROGRAMS.**²⁹

41 Florida's Community Hospital Education Act also provides funding intended for primary care
 42 specialties. This program appropriates state funds into the Medicaid program, with hospitals being paid
 43 directly from this fund to help support primary care specialty interns and residents.²⁸

44 *Texas*

45 In ~~2014, 2007,~~ the Texas legislature **ALLOCATED \$12 MILLION TO SEVERAL INITIATIVES**
 46 **WHICH TOGETHER CREATED 100 NEW RESIDENCY POSITIONS ACROSS NINE**

1 **NEW PRIMARY CARE AND TWO NON-PRIMARY CARE PROGRAMS.³⁰ IN 2015, THE**
 2 **LEGISLATURE CONSOLIDATED THESE INITIATIVES INTO A SINGLE GME**
 3 **EXPANSION PROGRAM, TO WHICH IT APPROPRIATED \$49.5 BIENNIALLY. THIS**
 4 **RESULTED IN AN INCREASE IN PER-RESIDENT FUNDING FROM \$65,000 TO**
 5 **\$75,000 PER YEAR AND THE CREATION OF 130 NEW RESIDENCY POSITIONS IN**
 6 **2016-2017.** ³¹ authorized an additional \$62.8 million in state funding for GME positions and for faculty
 7 costs. However, the additional funding was not enough to pay for the growth necessary to keep up with
 8 the physician shortage.²⁹ Texas saw a 50% cut in its GME funding in 2012-2013. Per capita formula
 9 funding cut \$25 million from its budget, now spending \$4,400 per resident from \$6,600. The Texas
 10 Higher Education Coordinating Board (THECB) family medicine residency funding saw a significant
 11 \$15.6 million cut, from \$21.2 million to \$5.6 million. THECB Primary Care Residency Program (\$5
 12 million) and THECB GME Program (\$600,000) were both cut altogether. Finally, the Physician Loan
 13 Repayment Program was cut by \$17.7 million, from \$23.3 million to \$5.6 million.

14 **SINCE 2009, THE** Texas **HEALTH AND HUMAN SERVICES COMMISSION (HHSC)**
 15 **HAS** also provideDs supplemental funding **TO FIVE STATE-OWNED TEACHING**
 16 **HOSPITALS** for approved medical residency training programs.³² In the Texas Administrative Code,
 17 the Texas Health and Human Services Commission **THE HHSC** reimburses approved state-owned or
 18 state-operated teaching hospitals, the **EACH** hospital **DIRECTLY USING A CALCULATION**
 19 **THAT IS BASED UPON THE HOSPITAL'S SELF-REPORTED MEDICAID INPATIENT**
 20 **DAYS AND RESIDENT FULL-TIME EQUIVALENTS. HHSC ALSO SEPARATELY**
 21 **PROVIDES IME PAYMENTS TO TEACHING HOSPITALS TO OFFSET THEIR**
 22 **HIGHER PATIENT CARE COSTS RELATIVE TO NON-TEACHING HOSPITALS,**
 23 **INCLUDING COSTS RELATED TO SUPERVISING AND MAINTAINING RESIDENT**
 24 **RECORDS.** ³³ s inpatient direct GME cost for hospital cost reports. The costs are calculated using a
 25 similar method as set out in Title XVIII of the Social Security Act.³⁰

26 **THESE INCREASES FOLLOW YEARS OF CUTS TO GME FUNDING, INCLUDING A**
 27 **50% CUT IN 2012-2013, WHICH LED TO THE ELIMINATION OF THE TEXAS**
 28 **HIGHER EDUCATION COORDINATING BOARD (THECB) PRIMARY CARE**
 29 **RESIDENCY PROGRAM AND THE THECB GME PROGRAM IN 2019.**

30 *Utah*

31 In 1997, Utah created the Utah Medical Education Council (UMEC) to address the state's physician
 32 shortage and coordinate GME funding that would be better aligned with the state's workforce needs.³¹
 33 UMEC is a quasi-governmental body whose responsibilities include assessing the physician workforce
 34 demands, developing and suggesting policy, finding and disbursing GME funds, addressing physician
 35 shortages in rural locations and managing the GME funds from CMS.

36 To better address the state's GME funding needs, Utah applied for, and was granted, a CMS waiver
 37 that placed GME funding into a funding pool, rather than directing money to hospitals.³² By pooling all
 38 of the state's GME funding, UMEC was able to distribute the funds directly to hospitals and programs
 39 based on specific workforce needs and objectives.³⁴ **THE WAIVER RESULTED IN A 29%**
 40 **INCREASE** The waiver has had noticeable results: the number of residents in Utah increased 29%
 41 between 1997 and 2007, from 442 residents in 25 programs to 568 residents in 30 programs.³⁵ Training
 42 hospitals and programs are now accountable to UMEC for how the GME funds are spent. UMEC also
 43 worked with training programs to encourage residents to practice in Utah. Workforce coordination
 44 efforts also identified new rural training opportunities in areas like family medicine, general surgery,
 45 internal medicine, pediatrics and psychiatry.³⁶ The, **BUT** waiver ultimately ended on June 30, 2010.³⁶
 46 **ACCORDING TO UMEC'S MOST RECENT (2016) REPORT, THE STATE HAS**

1 **AVERAGED 202 RESIDENTS PER YEAR BETWEEN 2006 – 2016, REPRESENTING AN**
 2 **APPARENT DECLINE FROM LEVELS UNDER THE WAIVER.**³⁷

3 **ADDITIONAL GME FUNDING MODELS**

4 There are several other GME funding models that have the potential to provide revenue for GME
 5 programs. These models differ based on who would receive payment, how funds would be allocated
 6 among recipients, what mechanisms would be needed to assure accountability and whether payment
 7 would be linked to the achievement of specific performance measures. These models are not mutually
 8 exclusive and could be combined to enhance stability and accommodate GME policy objectives. In
 9 some cases, a combination of several models would be necessary to pay for different kinds of costs to
 10 address specific educational or workforce objectives.

11 *All-Payor System*

12 **THE SEVERAL STATES HAVE EXPERIMENTED WITH VARIATIONS ON AN all-payor**
 13 **system, WHICH COMBINES FUNDING FROM ALL PUBLIC AND PRIVATE SOURCES**
 14 **TO PAY FOR STATE GME PROGRAMS, has proven to work in several states BUT ONLY**
 15 **MARYLAND'S IS CURRENTLY OPERATIONAL.** The AOA's Physician Education Advancing
 16 Community Health (PEACH) program is an example of a payor funded program whereby Health
 17 Maintenance Organizations would help fund GME. **ALTHOUGH PRIVATE PAYORS RARELY**
 18 **FINANCE GME DIRECTLY, THE HIGHER RATES THAT THEY PAY TO TEACHING**
 19 **INSTITUTIONS HELP TO SUBSIDIZE GME PROGRAMS.** The extents to which private
 20 insurers help fund portions of residency training and costs are nearly incalculable. The nonprofit RAND
 21 Corporation did a survey-based study in 2006 and found that private payers, like insurance companies,
 22 indirectly fund about 43% of the costs associated with training physicians. However, hospitals tend not
 23 to negotiate for physician training costs when they contract with private insurers.³⁹

24 Maryland **IMPLEMENTED THEIR** currently has an all-payor system **IN 1977.**³⁸ **PRIOR TO**
 25 **2014, THE STATE USED A PROSPECTIVE, DIAGNOSIS-BASED PAYMENT MODEL,**
 26 **WHICH KEPT THE RATE OF INCREASED SPENDING PER ADMISSION BELOW**
 27 **THE NATIONAL RATE, ALTHOUGH IT WAS LESS SUCCESSFUL AT CONTAINING**
 28 **OVERALL HOSPITAL SPENDING DUE TO INCREASED ADMISSION RATES.**³⁹
 29 **SINCE 2014, MARYLAND HAS USED A PAYMENT MODEL THAT REQUIRES EACH**
 30 **HOSPITAL TO MONITOR BOTH THE NUMBER AND COST OF ADMISSIONS,** where
 31 **the PAYMENT RATES ARE ESTABLISHED BY THE QUASI-GOVERNMENTAL** Health
 32 Services Cost Review Commission, **AND ALL PAYORS MUST PAY A GIVEN HOSPITAL**
 33 **THE SAME RATE FOR THE SAME SERVICE, BUT EACH HOSPITAL NEGOTIATES**
 34 **ITS OWN RATES** sets hospital rates for all payers.⁴⁰ Maryland has built costs associated with GME
 35 funding into its rate-setting system, **AS WELL AS SURCHARGES TO SUPPORT AN**
 36 **“UNCOMPENSATED CARE POOL” AND A PUBLIC PLAN FOR RESIDENTS WITH**
 37 **CHRONIC HEALTH CONDITIONS, INTO ITS RATE-SETTING SYSTEM.**⁴¹ The rates for
 38 graduate medical education are reviewed on an annual basis based on financial and resident count
 39 reports.⁴¹ Maryland also has a Medicare waiver **THAT ALLOWS IT TO SET MEDICARE**
 40 **PAYMENT RATES. HISTORICALLY,** in which the federal government pays more in Maryland
 41 than anywhere else. In return, Maryland has **to keep its Medicare costs below national growth FOR**
 42 **HOSPITAL PAYMENTS PER ADMISSION IN ORDER TO MAINTAIN ITS WAIVER,**
 43 **BUT THE TEST UNDER THE CURRENT WAIVER FOCUSES ON THE PER CAPITA**
 44 **GROWTH IN HOSPITAL SPENDING.**⁴² Maryland is currently in jeopardy of losing its waiver due
 45 to federal sequester concerns.

1 New York **PREVIOUSLY OPERATED AN** ~~an~~ all-payor system **THAT** ~~was created through the~~
 2 **“Professional Education Pool”** ~~which collects and distributes money for GME.~~⁴³ ~~New York requires all~~
 3 ~~payors to contribute to the fund, including Blue Cross and Blue Shield, commercial insurers, health~~
 4 ~~maintenance organizations (non-Medicaid and non-Medicare), businesses, self-insured funds and third~~
 5 ~~party administrators. There are two ways for payors to make payments: first, by voluntarily contributing~~
 6 ~~an amount based on per covered life of the individual or family; or if no direct contribution is made, a~~
 7 ~~surcharge on each payment of inpatient costs plus a 24% differential~~ **LEVIED A “COVERED**
 8 **LIVES ASSESSMENT” TAX ON PRIVATE HEALTH INSURERS BASED UPON**
 9 **MEMBER FEES BY REGION AND TYPE OF INSURANCE.** ~~The Professional Education~~
 10 ~~Pool monies are collected in a trust fund and distributed to teaching hospitals on a monthly basis in~~
 11 ~~accordance with their adjusted share of the region’s total GME spending.~~⁴³ **THE MONEIES**
 12 **COLLECTED WENT INTO TWO POOLS, ONE THAT SUBSIDIZED CARE FOR**
 13 **INDIVIDUALS WHO WERE UNABLE TO PAY AND ANOTHER THAT FUNDED GME.**
 14 **IN THE LATE 2000S, HOWEVER, THE GME FUNDING POOL WAS REALLOCATED**
 15 **TOWARD UNCOMPENSATED CARE IN TEACHING HOSPITALS, AND OTHER**
 16 **“HIGH PRIORITY” ITEMS.**⁴⁴

17 *Health Care Provider Model*

18 Medicare pays for GME through a health care provider model. This approach links payments for
 19 clinical training to patient care activities. Because the indirect payment adjustment is intended to reflect
 20 the impact of teaching activity on a hospital’s patient care costs, this model is particularly appropriate
 21 for IME payment.

22 Several variants of this model have been proposed to encourage more training in nonhospital settings.
 23 These variants include a direct pay approach whereby payment would follow the resident training in a
 24 nonhospital site; pro rata payment of hospitals and nonhospital sites based on agreements among the
 25 entities or a fixed allocation developed in accordance with national cost data; or payment to the entity
 26 that bears substantially of the costs of the nonhospital rotations. The first two variants would create
 27 substantial administrative burdens. Although less burdensome and disruptive, the third option appears
 28 less likely to achieve its stated goal. A voucher or “set-aside” system also could be established whereby
 29 a specified share of payment for direct training costs would be earmarked for nonhospital settings.

30 The principle advantage of the provider model is that regulatory, cost reporting, auditing and
 31 compliance mechanisms already are in place and well established. To this extent, these mechanisms
 32 have created persistent problems, which is also a disadvantage. This model also fails to provide financial
 33 support for training that occurs outside of patient care settings (e.g., much of the training in
 34 preventative medicine).

35 *Education Model*

36 Under this approach, payment would be made to a program sponsor, which would be held accountable
 37 for the way funds are allocated and expended. Sponsors could be universities, medical schools, colleges
 38 of osteopathic medicine, hospitals, consortia or any other entity whose primary purpose is providing
 39 education and/or health care services (e.g., a health department, public health agency, organized health
 40 care delivery system or hospital system.) Because this model treats direct GME costs as costs of
 41 education not patient care, adherents suggest that greater weight will be placed on educational needs as
 42 training decisions are made. In return for payment, the program sponsor (or its designees) would
 43 assume all (or substantially all) of the direct costs of operating the GME program. Allocation of GME
 44 costs and payments would be established through written agreements between the sponsor and clinical
 45 training sites. Because IME is a hospital cost, this model would not provide an adequate basis for IME
 46 payment.

1 The principle advantage of this approach is its focus on education. Unfortunately, it also would require
2 a major shift in program accountability and funding, particularly when training occurs in community
3 teaching hospitals rather than academic medical centers, where medical schools and hospitals are linked
4 through common ownership or other longstanding corporate or strategic ties. This approach could also
5 discourage hospitals from maintaining or starting GME programs.

6 As a variant to this model, vouchers could be given directly to residents so that they could purchase
7 their own GME. Unlike the vouchers mentioned in conjunction with the provider model, these
8 vouchers would permit residents to control funding for their graduate training, allowing monies to flow
9 to all training sites. In theory, this approach would enhance competition among GME programs. It is
10 not clear, however, how much effect it would have because programs already compete for residents and
11 rotation sites.

12 Besides the disadvantages mentioned above, this approach would require a new regulatory mechanism
13 for determining which residents qualify for funding and how many positions would be funded. It also
14 fails to address national physician workforce needs or to assure that adequate resources are available in
15 needed specialties and geographic areas. Implementing this approach could result in substantial year-to-
16 year fluctuations in program size, undermining the stability of existing programs and making faculty and
17 resource allocations difficult. Residents could also be hard pressed to hold their programs accountable
18 once training decisions are made.

19 *Planning Model*

20 Under this approach, funding would be channeled through planning or coordinating bodies such as
21 GME consortia, state GME, physician workforce commissions or task forces. The primary function of
22 these bodies would be to assess the health care needs of their communities and to allocate funds based
23 on local workforce considerations.

24 Because this approach ties training and funding decisions to local health care needs, it could provide the
25 states, payers and consumers a stronger role in allocating funds to meet workforce objectives.
26 According to the Council on Graduate Medical Education, however, existing evidence tends to suggest
27 that reliance on consortia to assume such a role may be premature. Adopting this model would also
28 require development of a new regulatory mechanism to assure accountability. Payment to state entities
29 or consortia provides little incentive to nonteaching hospitals to initiate new GME programs.

30 *Performance Model*

31 This model links payment to the achievement of specific performance measures or objectives. Funding
32 could also be used to support specific projects or demonstrations on infrastructure development or
33 particular workforce goals.

34 While this approach encourages innovation and quality enhancement, it is more suitable as a
35 supplemental funding mechanism than as a primary source of GME payment. This model is also
36 dependent on well-defined quality measures and workforce priorities. Neither may be sufficiently well
37 developed to support all GME funding decisions at this time. This approach could also result in
38 substantial year-to-year fluctuation in payments if all funding decisions are based on meeting specific
39 performance measures.

40 **CONCLUSION**

41 With federal and state budgets look to cut spending, GME programs are particularly vulnerable. AOA
42 policy, “affirms its support for maintaining and enhancing the quality of teaching programs.”⁴⁴ As states
43 address shortfalls in federal GME funding, the AOA encourages all viable models to be examined.
44 While all-payor systems have proven effective in some states, each state is different and may require its
45 own unique GME funding system. Additionally, as states and the federal government implement health

1 insurance exchanges, we encourage the exploration of using a portion of any health plan surcharge to
 2 fund GME. This will help address concerns related to workforce shortages as the covered population
 3 grows.

4 The AOA supports states creation of alternative GME funding mechanisms and the alignment of this
 5 funding with their states health care priorities. Most important, within these priorities are training those
 6 specialties with the largest workforce shortages and providing care to those residents in the greatest
 7 needs (those in rural and underserved areas).

8 The AOA believes that state GME funding must account for osteopathic programs that incorporate
 9 the holistic approach to medicine, including the promotion of osteopathic principles and tenets.

10 The AOA believes that state GME funding should focus on programs that address comprehensive
 11 health care systems that deliver care through a variety of settings. This includes training residents in
 12 hospitals, rural clinics, community-based centers and patient-centered medical homes. These programs
 13 should also provide training in advancing technologies within the delivery of care.

14 The AOA believes that state GME funding should emphasize the importance of both basic and clinical
 15 research in an effort to advance the practice of medicine and the care patients receive.

16 The AOA supports the physician-led, team-based model of care. The AOA believes that state GME
 17 funding should promote this model of care by promoting interprofessional education, so that
 18 physicians can not only learn to lead the health care team, but also better understand the skills and
 19 abilities each member brings to that team.

20 Finally, this policy is intended to complement AOA Policy, ~~H252-A/04 RESIDENCY TRAINING~~
 21 ~~SLOTS. The PEACH program~~ **H329-A/2016 GRADUATE MEDICAL EDUCATION**
 22 **FUNDING AND INCENTIVES** represents one advocacy tool developed to assist states in
 23 developing alternative GME financing, and the AOA should continue to create additional resources
 24 that support the osteopathic community in **ITS** efforts to ~~provide adequate~~ **TO INCREASE** GME
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ACTION TAKEN APPROVED as AMENDED

DATE July 27, 2019

SUBJECT: REFERRED RESOLUTION H346-A/13 - OFFICE BASED SURGERY

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Bureau of State Government Affairs

1 WHEREAS, resolution H-342-A/2018 titled H-346-A/2013 OFFICE BASED SURGERY was
2 referred to the Bureau of State Government Affairs for updating with current data;
3 now, therefore be it

4 RESOLVED, that the Bureau of State Government Affairs recommend that the following
5 policy be REAFFIRMED **AS AMENDED**:

6 **H346-A/13 OFFICE BASED SURGERY**

7 The American Osteopathic Association approves the following Policy Statement on Office-
8 Based Surgery (2008; reaffirmed as amended 2013):

9 **OFFICE-BASED SURGERY**

10 **Background**

11 A number of surgical procedures that were once only performed in hospitals or ambulatory
12 surgery facilities **CENTERS (ASCS)** can now be performed in a physician’s office. Of the 80
13 million outpatient surgeries performed in the US in 2009, **THE MOST RECENT YEAR**
14 **FOR WHICH COMPREHENSIVE DATA IS AVAILABLE**, it is estimated that over 12
15 million were performed in physicians’ offices.¹ Proponents of office-based surgery assert that
16 many procedures can be performed safely and effectively in a physician’s office due to advances
17 in technology, anesthesia, and laparoscopic techniques. In addition, many argue that office-
18 based surgery is easier to schedule and more comfortable for patients than surgery performed in
19 a hospital. Perhaps most significant, however, is the reported cost savings for office-based
20 surgery compared to surgery performed in a hospital. One study reported that the **AVERAGE**
21 cost of an **UNICOMPARTMENTAL KNEE ARTHROPLASTY** inguinal hernia repair
22 done in an office setting **WAS AN AVERAGE OF \$20,500 LESS THAN THE AVERAGE**
23 **CHARGE OF \$46,845** was \$895 compared to \$2,237 for the same procedure in the hospital.²

24 Despite these benefits, the practice of office-based surgery has been controversial due to the
25 lack of established rules and regulations. At the beginning of the 21st century, the fact that most
26 states did not regulate office-based surgery led some observers to compare it to the “Wild
27 West.”³ **AS OF** 2014, 29 states had enacted rules, regulations or guidelines that specifically
28 applied to office-based surgery.⁴ These regulations help to ensure that office-based surgery is
29 conducted with appropriate equipment, adequately trained personnel and established patient
30 safety standards. However, because this practice remains unregulated in many states, the
31 concern that surgery performed in a physician’s office may not be as safe as surgery performed
32 in a hospital or licensed **ASC** persists.

33 While the media has reported a number of stories of tragic outcomes following office-based
34 surgery, the actual ~~number~~ **RATE** of morbidity and mortality following office-based surgery
35 **THESE PROCEDURES** is hard to determine because ~~reporting~~ adverse events is only

1 required in twenty states.⁵ **REPORTING IS REQUIRED IN LESS THAN HALF OF**
 2 **ALL STATES.** ⁵ A number of reports that have been published documented adverse events.
 3 **ACCORDING TO A 2017 FLORIDA REPORT THAT COMPARED RISK-**
 4 **ADJUSTED HOSPITALIZATION RATES FOLLOWING SURGICAL**
 5 **PROCEDURES ACROSS PHYSICIAN OFFICES, FREESTANDING ASCS, AND**
 6 **HOSPITAL OUTPATIENT DEPARTMENTS IN FLORIDA, RATES WERE**
 7 **GENERALLY HIGHER FOR OFFICE-BASED PROCEDURES, ESPECIALLY**
 8 **MORE COMPLEX PROCEDURES.** ⁶

9 A 2004 survey by the American Association of Ambulatory Surgery Centers reported that only
 10 12 out of every 10,000 office-surgical center patients required emergency transfer to hospitals in
 11 2003. In another survey of 1,200 plastic surgeons, 95 deaths were reported in nearly 500,000
 12 liposuction procedures.⁶ Since 1986, at least 41 deaths and over 1,200 injuries have occurred
 13 during cosmetic surgery in Florida. Closed malpractice claims in Florida have also identified 830
 14 deaths and approximately 4,000 injuries associated with office-based surgical care occurring
 15 between 1990 and 1999.⁷ Finally, since Florida's Board of Medicine imposed mandatory
 16 reporting requirements on physicians performing office-based surgery, 20 adverse incidents and
 17 five deaths were reported in a five-month period. Although office-based surgery may be
 18 appropriate for many surgical patients, proper attention must be given to patient safety **IN**
 19 **ORDER** to avoid **MINIMIZE** adverse events.

20 **Need for Office-Based Surgery Rule Development**

21 States have taken different approaches to the regulation of office-based surgery. A variety
 22 **NUMBER** of state medical boards have adopted guidelines or rules for physicians to follow
 23 regarding **WHEN PERFORMING** office-based procedures. The North Carolina Medical
 24 Board approved a position statement on office-based procedures on Jan. 23, 2003 after
 25 surveying the physicians in the state on this necessity. **A POSITION STATEMENT**
 26 **ISSUED BY THE NORTH CAROLINA MEDICAL BOARD ON THIS ISSUE**
 27 **CONTAINS RECCOMENDATIONS ON** Guidelines address physician credentialing,
 28 emergencies, performance improvement, medical records, equipment and supplies, and
 29 personnel. Any failure to comply puts a physician at risk of disciplinary action by the board.⁷

30 **IN MANY STATES, OFFICE-BASED SURGERY CENTERS ARE EXEMPT FROM**
 31 **LICENSURE REQUIREMENTS THAT APPLY TO HOSPITALS AND ASCS**
 32 **BECAUSE THE PROCEDURES THAT THEY PERFORM ARE CONSIDERED TO**
 33 **BE RELATIVELY LOW-RISK. SOME STATES REQUIRE CENTERS TO**
 34 **REGISTER WITH A STATE AGENCY SUCH AS THE DEPARTMENT OF**
 35 **HEALTH, WHILE OTHERS DO NOT REQUIRE ANY GENERAL OVERSIGHT,**
 36 **AND SURGICAL PRACTITIONERS ARE REGULATED BY STATE MEDICAL**
 37 **LICENSING BOARDS IN THE NORMAL COURSE OF THEIR PHYSICIAN**
 38 **OVERSIGHT DUTIES.**⁸ On Feb. 25, 2005, the Washington Medical Quality Assurance
 39 Commission adopted voluntary guidelines that encourage office-based surgical facilities to be
 40 accredited. The Oklahoma Board of Medicine adopted guidelines for physicians who perform
 41 procedures that require anesthesia or sedation in an office setting. The Oregon Board of
 42 Medical Examiners developed standards for accreditation of facilities where minor procedures
 43 or those requiring conscious sedation are performed in an office setting. The South Carolina
 44 Board of Medical Examiners approved guidelines for office-based surgery that require such
 45 facilities to be accredited by an approved agency if level 2 or 3 procedures are performed.

46 **Classification of Office-Based Surgery**

1 Office-based surgical procedures are usually classified based on the level of anesthesia used.
 2 Typically the procedures are classified into three groups: Level 1, 2, and 3 or Class A, B, and
 3 C.⁹⁹ While not uniform, these classifications are often referred to by state medical boards and
 4 state legislators; therefore, understanding the different levels is an important basis for a
 5 discussion of office-based surgery. First, Level 1 surgical procedures are minor procedures
 6 performed under topical, local, or infiltration block anesthesia without preoperative sedation.
 7 Second, Level 2 surgical procedures are minor or major procedures performed in conjunction
 8 with oral, parenteral or intravenous sedation or under analgesic or dissociative drugs. Finally,
 9 Level 3 surgical procedures utilize general anesthesia or major conduction block anesthesia and
 10 require the support of bodily functions.⁹¹⁰

11 **Physicians and Staff in the Office-Based Surgical Facility**

12 One of the reasons for the large number of adverse consequences associated with office-based
 13 surgery is the fact that many individuals, both physicians and non-physicians, performing office-
 14 based surgery lack the expertise to perform the surgery and administer the anesthesia in the first
 15 place. For example, a 2010 study found that nearly 40% of physicians offering liposuction in
 16 southern California had no specific surgical training.⁴⁰¹¹ Furthermore, **FOUR DEATHS**
 17 **HAVE BEEN REPORTED SINCE 2013 AT A SINGLE SOUTH FLORIDA CLINIC** where two Florida **CLINIC**
 18 ophthalmologists and one anesthesiologist have placed advertisements for breast augmentation
 19 surgery, and several dentists have been identified as performing hair transplants and liposuction
 20 procedures. **WHERE COSMETIC SURGERY IS PERFORMED BY PHYSICIANS**
 21 **WHO ARE NOT FORMALLY TRAINED OR BOARD CERTIFIED IN PLASTIC**
 22 **SURGERY.**¹² While no single medical discipline has a monopoly on proper qualifications for
 23 performing office-based surgery, such incidents may spur state licensing boards to consider
 24 instituting licensure by specialty or board certification as opposed to an unlimited scope of
 25 practice.

26 **Equipment Required**

27 Equipment used in office-based surgery must be kept in excellent working condition and
 28 replaced as necessary. The type of monitoring equipment required in office-based settings
 29 depends on the type of anesthesia used and individual patient needs. However, every facility
 30 must have emergency supplies immediately available, including emergency drugs and equipment
 31 appropriate for cardiopulmonary resuscitation. This includes a defibrillator, difficult airway
 32 equipment, and drugs and equipment necessary for the treatment of malignant hyperthermia.

33 **Transfer Agreement**

34 Emergencies occasionally arise during surgery requiring patients to receive a level of care higher
 35 than that available in the office-based setting. Provisions must be in place to provide this care in
 36 a comprehensively outfitted and staffed facility **LOCATED NEARBY** should it be needed.

37 **Adverse Incident Reporting**

38 Adverse events that may occur in office-based surgical facilities include patient deaths, cardio-
 39 respiratory events, anaphylaxis or adverse drug reactions, infections, and bleeding episodes.
 40 Reporting of adverse incidents to an appropriate state entity is an important patient safety
 41 measure.

42 **Regulation of Office-Based Surgery**

43 Unlike hospitals and ambulatory surgery centers, not all office-based surgical facilities are
 44 subject to regulations on emergencies, fire, **SANITATION**, drugs, staff, training, and
 45 unanticipated patient transfers. Common sense dictates that states should take steps to ensure
 46 that patients who undergo surgery in physicians' offices receive the same standard of care as
 47 patients in ambulatory surgery centers or hospitals.

1 **Conclusion**

2 The practice of office-based surgery will likely continue to grow in the coming years. The
3 following statements represent the AOA’s position on **THE** appropriate use of office-based
4 surgery:

5 The AOA firmly believes that steps must be taken to ensure that office-based surgery is as safe
6 for patients as hospital- or ambulatory care center-based surgery;

7 The AOA supports state licensing boards in surveying their licensees or researching the issue of
8 office-based surgery regulation to determine if office-based surgery rule development is
9 necessary;

10 The AOA believes that Level 1 and Level 2 procedures are acceptable to be performed in an
11 office-based setting. However, Level 3 procedures should only be performed in an office setting
12 that has been accredited by an accreditation organization such as ~~the Healthcare Facilities~~
13 ~~Accreditation Program~~ The Joint Commission, the American Association for Accreditation of
14 Ambulatory Surgery Facilities (AAAASF), ~~or~~ the Accreditation Association for Ambulatory
15 Health Care (AAAHC) **OR THE AAAHC’S HEALTHCARE FACILITIES**
16 **ACCREDITATION PROGRAM;** ~~the AAAHC’s Healthcare Facilities Accreditation~~
17 ~~Program;~~

18 The AOA believes that surgery performed in a physician’s office must be done by a physician
19 or ~~health care provider~~ **NON PHYSICIAN CLINICIAN** qualified by education and training
20 to perform that specific procedure **WITH APPROPRIATE PHYSICIAN OVERSIGHT;**

21 The AOA believes that only health care providers who have completed the appropriate
22 education and training should perform office surgical procedures;

23 The AOA believes that ~~the~~ **A** physician **MUST** administering the anesthesia or **IF A NON**
24 **PHYSICIAN CLINICIAN ADMINISTERS THE ANESTHESIA, A SUPERVISING**
25 **PHYSICIAN MUST BE PHYSICALLY PRESENT IN THE OFFICE-BASED**
26 **SURGICAL FACILITY DURING THE ADMINISTRATION OF ANESTHESIA**
27 **AND REMAIN PHYSICALLY AVAILABLE UNTIL THE PATIENT HAS FULLY**
28 **RECOVERED AND** ~~supervising the administration of the anesthesia must be physically~~
29 ~~present in the office-based surgical facility during the surgery and immediately available until the~~
30 ~~patient~~ has been discharged from anesthesia care. In case of an emergency, personnel with
31 training in advanced resuscitative techniques should be immediately available until **THE** ~~all~~
32 patients **IS** ~~are~~ discharged;

33 The AOA believes office-based surgical facilities must have the appropriate medications,
34 equipment, and monitors necessary to perform the surgery and administer the anesthesia in a
35 safe manner. The equipment and monitors must be maintained, tested, and inspected according
36 to the manufacturer’s specifications;

37 The AOA believes physicians and ~~health care providers~~ **NON-PHYSICIAN CLINICIANS**
38 who perform **OFFICE-BASED** surgery ~~in an office setting~~ **SHALL BE RESPONSIBLE**
39 **FOR COORDINATING AND ENSURING APPROPRIATE CARE FOR PATIENTS**
40 **WHO REQUIRE EMERGENT, UNEXPECTED POSTOPERATIVE TRANSFER**
41 **AND/OR HOSPITALIZATION.** ~~must have a written protocol~~ **WRITTEN**
42 **PROTOCOLS MUST BE** in place for **TIMELY** transfer to an accredited hospital
43 **LOCATED** within **REASONABLE** proximity to the office. **OFFICE PERSONNEL**
44 **MUST BE APPROPRIATELY TRAINED IN EMERGENCY PROTOCOLS IN**
45 **ORDER TO BE ABLE TO RESPOND** when ~~extended or~~ emergency **OR EXTENDED**
46 services are needed to protect the health or well-being of the patients;

1 The AOA supports reporting of adverse incidents related to surgical procedures performed in
2 an office setting to a state entity, as required and appropriate, provided that these disclosures
3 will be considered confidential and protected from discovery or disclosure; and

4 The AOA supports the position that state medical licensing boards are the appropriate entity to
5 create and implement regulations regarding office-based surgery. ~~2008~~**2019**

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32 ¹² **Schorsch, Peter. *Plastic Surgery Deaths Highlight Need for Specialty Board Certification*, Florida**
33 **Politics, Dec. 19, 2017. [https://floridapolitics.com/archives/252069-plastic-surgery-deaths-highlight-](https://floridapolitics.com/archives/252069-plastic-surgery-deaths-highlight-need-specialty-board-certification)**
34 **[need-specialty-board-certification](https://floridapolitics.com/archives/252069-plastic-surgery-deaths-highlight-need-specialty-board-certification).**

ACTION TAKEN APPROVED

DATE July 27, 2019

SUBJECT: REFERRED SUNSET RES. H340-A/13 UNIFORM PATHWAY OF LICENSING OF OSTEOPATHIC PHYSICIANS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, sunset resolution H340-A/2013 titled “UNIFORM PATHWAY OF LICENSING OF
2 OSTEOPATHIC PHYSICIANS” was recommended to be REAFFIRMED AS AMENDED
3 in 2018; and

4 WHEREAS, sunset resolution H340-A/2013 titled “UNIFORM PATHWAY OF LICENSING OF
5 OSTEOPATHIC PHYSICIANS” was referred to the Bureau of State Government Affairs
6 (BSGA) for further review; now therefore be it,

7 RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be
8 REAFFIRMED as submitted.

9 **H273-A/08 UNIFORM PATHWAY OF LICENSING OF OSTEOPATHIC**
10 **PHYSICIANS**

11 The American Osteopathic Association states that the examination of the National Board of
12 Osteopathic Medical Examiners must remain as ~~an~~ **THE** avenue for the licensure of osteopathic
13 physicians and supports a uniform pathway of licensing osteopathic physicians through the
14 mechanisms of the National Board of Osteopathic Medical Examiners, **TO BE EFFECTIVE**
15 **AFTER 12/31/19**. 1991; revised 1993, 1998, 2003; 2008.

Explanatory Statement:

Osteopathic physicians (DOs) are currently required to complete Levels 1 and 2 of the National Board of Osteopathic Medical Examiners’ (NBOME) Comprehensive Osteopathic Medical Licensing Exam of the United States (COMLEX-USA) in order to graduate from osteopathic medical school, and Level 3 in order to obtain an unlimited state medical license. NBOME examinations are developed by DOs and are designed to test the competencies for osteopathic medical practice, including the unique principles and practice of osteopathic medicine, to ensure patient safety and optimize patient outcomes. COMLEX-USA includes a performance evaluation/practical component (Level 2-PE) that includes testing of osteopathic manipulative medicine and treatment. The use of COMLEX-USA for DO licensure will remain unaffected by the transition to a Single Accreditation System under the Accreditation Council for Graduate Medical Education (ACGME), and the AOA strongly supports its continuing use as the sole pathway to DO licensure as it is the only examination designed for the practice of osteopathic medicine and that has demonstrated validity for that purpose.

Further, competition for certain residency positions has led some osteopathic medical students to elect to take Steps 1 and/or 2 of the United States Medical Licensing Exam (USMLE) during medical school, in addition to COMLEX Levels 1 and 2; however, the [AMA](#) and [ACGME](#) explicitly recognize COMLEX-USA equivalently to USMLE and the AOA continues to advocate for education around COMLEX-USA for equivalent uses to USMLE by residency program directors in order to alleviate this unnecessary burden and stress on osteopathic medical students, while also assisting to preserve the integrity and distinctiveness of the profession.

Reference Committee Explanatory Statement

The Committee believes that adding an effective date will allow for grandfathering in of osteopathic physicians who obtained licensure previously through the FLEX or USMLE examinations, etc.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: SAFE HAVEN NON-REPORTING PROTECTION FOR PHYSICIANS –
SUPPORT FOR

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, the 2018 AOA House of Delegates adopted resolution H359 PREVENTING
2 PHYSICIAN BURNOUT – SAFE HAVEN NON-REPORTING PROTECTION
3 FOR PHYSICIANS which directs the Bureau of State Government Affairs to develop
4 policy in support of safe haven non-reporting protections for physicians; now, therefore
5 be it

6 RESOLVED, that the following policy paper and recommendations be adopted as the
7 American Osteopathic Association’s (AOA) position on safe haven non-reporting
8 protections for physicians and medical students; and be it further

9 RESOLVED that upon approval of safe haven non-reporting as organizational policy, the
10 AOA’s Bureau of State Government Affairs will be tasked with developing a model act
11 for consideration by the 2020 AOA House of Delegates.

12 **AOA POLICY PAPER:**
13 **SAFE HAVEN NON-REPORTING PROTECTIONS FOR PHYSICIANS**

14 **BACKGROUND**

15
16
17 Burnout among US medical students, residents and practicing physicians is a significant problem that
18 negatively impacts medical professionals as well as the patients that they serve. Physicians in the US
19 report symptoms of burnout at nearly double the rate of other US workers after controlling for work
20 hours and other factors, and between 2011 and 2014, this percentage increased by 9%.¹ Further, twenty
21 to forty percent of medical students, interns and residents report experiencing symptoms of burnout.²
22

23 Burnout is characterized by a “wide array of signs, symptoms and related conditions, including fatigue,
24 loss of empathy, detachment, depression and suicidal ideation.”³ It has also been shown to negatively
25 impact a physician’s prescribing habits, test ordering, risk of malpractice suits, and whether patients
26 adhere to their recommendations.⁴ Although the aforementioned description does not explicitly
27 reference substance use disorders, we will hereafter reference symptoms of burnout, mental health and
28 substance use issues (and their treatment) interchangeably.
29

30 Even when resources are available to help physicians and students address symptoms of burnout;
31 however, both groups report similar concerns about pursuing them. For purposes of this policy paper,
32 we will focus on concerns regarding lack of confidentiality and possible disciplinary or discriminatory
33 action by schools, employers, state medical licensing boards and other academic or professional entities.
34

REPORT OF THE FSMB WORKGROUP ON PHYSICIAN WELLNESS AND BURNOUT

The Federation of State Medical Boards (FSMB) convened a Workgroup on Physician Wellness and Burnout (Workgroup) to study the issue of physician burnout and draft recommendations to help groups in the medical community better address this issue. The Workgroup found that although numerous resources exist to help medical students and physicians experiencing symptoms of burnout or impairment through academic institutions, medical licensing boards and state physician health programs, social and professional pressures make students and physicians reluctant to seek treatment or to report seeking it.⁵ Both medical students and physicians cited fears that seeking help would result in documentation on academic or professional records which could lead to discrimination or denial of a medical license, and ultimately jeopardize their ability to practice medicine.

According to a poll conducted by the FSMB and the Medical Society of the State of New York, a state that does not currently include any questions about mental health or substance use on medical licensure applications, sixty-nine percent of physician respondents who were experiencing symptoms of burnout reported that they would be significantly less likely to seek treatment if they were required to report it on a licensing application or renewal.⁶

Further, despite evidence showing that a past history of mental health or substance use disorders does not reliably predict future risk to the public, most state licensing applications still contain questions about applicants' histories with these issues. As of 2017, 43 states asked questions about both mental and physical health conditions on their medical licensing applications, but just 23 limited all questions to disorders causing functional impairment and only six limited them to current problems.⁷¹

Although a similar number of medical licensing boards asked about both mental and physical health, questions about the latter tended to be much more lenient and vague while questions about the former were much more specific and probing.⁸ Boards were significantly more likely to ask if physicians had ever been diagnosed, treated or hospitalized for a mental health or substance use disorder than for a physical disorder, and unlike questions about physical disorders, the questions were not limited to just those conditions that might *currently* affect a physician's ability to practice.

Responses by medical licensing boards to disclosures made by physicians about their mental health were also unpredictable and varied greatly from state to state. Some boards asked for a doctor's note, others requested all medical records related to an applicant's history and treatment, others required applicants to appear before the board to defend their ability to practice medicine and still others required applicants to undergo ongoing monitoring or practice under a restricted license.

In addition to the deterrent effect that questions from medical licensing boards regarding mental health appear to have on physicians' willingness to seek help when needed or report seeking it, courts have found that many such questions run afoul of the Americans with Disabilities Act (ADA). The ADA protects individuals with disabilities, including psychiatric disabilities, from discrimination. Professional licensing bodies are not exempt from the requirements of the ADA, and courts have stated that "[public entities] may not administer a licensing or certification program in a manner that subjects qualified individuals with disability to discrimination on the basis of disability."⁸ Public entities such as a medical licensing board also may not "impose or apply eligibility criteria that screen out or tend to

¹ Gold KJ1, Shih ER, Goldman EB, Schwenk TL. "Do US Medical Licensing Applications Treat Mental and Physical Illness Equivalently?" *Journal of Family Medicine*, June 2017. 49(6):464-467. Available at: <https://www.stfm.org/FamilyMedicine/Vol49Issue6/Gold464>.

1 screen out an individual with a disability ... unless such criteria can be shown to be necessary for the
2 provision of the service, program, or activity being offered.”⁵

3
4 In order to encourage medical students and physicians to seek appropriate treatment for mental health
5 and substance use disorders, and ensure that medical licensing boards comply with the ADA, the FSMB
6 encourages medical licensing boards to adopt policies that support physician “safe haven non-
7 reporting.”

8
9 “Safe haven non-reporting” allows physicians who are receiving appropriate treatment for mental
10 health or substance use issues who are monitored and in good standing with their confidential
11 treatment program to (re)apply for licensure without having to disclose their treatment to the board.
12 Only disclosures related to issues that are not being appropriately treated and could inhibit a physician’s
13 ability to safely practice medicine would be required.

14 15 RECOMMENDATIONS

16
17 The AOA adopts the following statements as its official position on “safe haven non-reporting:”

18
19 The presence or history of a mental health or substance use disorder does not automatically render a
20 physician unfit to practice medicine, and the AOA opposes discrimination or disciplinary action against
21 a physician or medical student based solely on the presence of such a disorder, without taking into
22 consideration the individual’s behavior or treatment.

23
24 The AOA urges state medical licensing boards to regard physical and mental health disorders similarly
25 and refrain from asking about past history of mental health or substance use diagnoses or treatment on
26 licensure applications or renewals. Instead, the AOA encourages boards to focus on whether any *current*
27 physical or mental disorders are present which may impair that individual’s ability to safely practice
28 medicine. The AOA further encourages state medical licensing boards to offer a “safe haven non-
29 reporting” option for physician applicants who are undergoing appropriate treatment for current
30 mental health or substance use disorders. This alternative helps to ensure confidentiality of such
31 treatment for the individual physician while ensuring patient safety.

32
33 If medical licensing boards decide to use questions related to mental health or substance use disorders
34 on a medical licensure application or renewal, the AOA encourages boards to consider phrasing them
35 similarly to questions about physical health. For example:

36
37 ***“Are you currently suffering from any condition for which you are not being***
38 ***appropriately treated that impairs your judgment or that would otherwise adversely***
39 ***affect your ability to practice medicine in a competent, ethical and professional***
40 ***manner? (Yes/No)”***

41
42 “Appropriate treatment” includes physician participation provided through state physician health
43 programs accredited by the Federation of State Physician Health Programs, or programs following
44 similar standards and guidelines, and adherence to treatment recommendations.

45
46 Finally, the AOA encourages medical educational and professional entities, as well organizations
47 throughout the medical community, to support and educate students and physicians about confidential

1 treatment and “safe haven non-reporting” options, in order to encourage these individuals to seek
2 appropriate treatment without fear of documentation, disciplinary action or other repercussions.

3 References

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5 among health care professionals: A call to explore and address this underrecognized threat to safe, high-quality care. NAM
6 Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC. doi: 10.31478/201707b
7 2. Lapinski, et al. “
8 3. Physician Wellness and Burnout”. *Federation of State Medical Boards*. April 2016. P.5.
9 <http://www.fsmb.org/globalassets/advocacy/policies/policy-on-wellness-and-burnout.pdf>
10 4. Tait D. Shanafelt and John H. Noseworthy, “Executive Leadership and Physician Well-Being,” *Mayo Clinic Proceedings* 92, no.
11 1 (January 2017): 129–46, <https://doi.org/10.1016/j.mayocp.2016.10.004>.
12 5. *Id* at 3.
13 6. *Id* at 3.
14 7. Gold KJ1, Shih ER, Goldman EB, Schwenk TL. “Do US Medical Licensing Applications Treat Mental and Physical Illness
15 Equivalently?” *Journal of Family Medicine*, June 2017. 49(6):464-467. Available at:
16 <https://www.stfm.org/FamilyMedicine/Vol49Issue6/Gold464>.
17 8. <https://labblog.uofmhealth.org/industry-dx/state-medical-licensing-boards-practices-may-hurt-physician-mental-health>

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H400-A/14 PATIENT SAFETY AND USE OF OSTEOPATHIC
MANIPULATIVE TREATMENT (OMT) FOR PATIENTS WITH PAIN
CONDITIONS

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED:

3 **H400-A/14 PATIENT SAFETY AND USE OF OSTEOPATHIC MANIPULATIVE**
4 **TREATMENT (OMT) FOR PATIENTS WITH PAIN CONDITIONS**

5 The American Osteopathic Association affirms that OMT is a safe intervention and should be
6 considered as first-line treatment for patients with pain associated with Somatic Dysfunction
7 and other appropriate conditions. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H401-A/14 HUMAN TRAFFICKING – AWARENESS AS A GLOBAL HEALTH PROBLEM

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H401-A/14 HUMAN TRAFFICKING – AWARENESS AS A GLOBAL HEALTH**
4 **PROBLEM**

5 The American Osteopathic Association acknowledges human trafficking as a violation of
6 human rights and a global public health problem; encourages osteopathic physicians to be
7 aware of the signs of human trafficking and the resources available to aid them in identifying
8 and addressing the needs of victims of human trafficking, including appropriate medical
9 assessment and reporting to law enforcement. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H403-A/14 SAME-SEX RELATIONSHIPS AND HEALTHY FAMILIES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H403-A/14 SAME-SEX RELATIONSHIPS AND HEALTHY FAMILIES**

4 The American Osteopathic Association (AOA) recognizes the need of same-sex households to
5 have the same access to health insurance and health care as opposite-sex households and
6 supports measures to eliminate discrimination against same-sex households in health insurance
7 and health care. The AOA supports children’s access to a nurturing home environment,
8 including through adoption or foster parenting without regard to the sexual orientation or the
9 gender identity of the parent(s). The AOA recognizes and promotes healthy families by
10 lessening disparities and increasing access to healthcare for same-sex marriages and civil unions
11 and the children of those families. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H404-A/14 PUBLIC INFORMATION – CORRECTION OF, ABOUT
THE OSTEOPATHIC PROFESSION

SUBMITTED BY: Bureau of International Osteopathic Medicine

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau of International Osteopathic Medicine recommend that the
2 following policy be ~~SUNSET~~ **REAFFIRMED AS AMENDED**:

3 **H404-A/14 PUBLIC INFORMATION – CORRECTION OF, ABOUT THE**
4 **OSTEOPATHIC PROFESSION**

5 The American Osteopathic Association (AOA) will work with ~~Wikipedia and other~~ online
6 and public information sites to ~~develop~~ **ENSURE THAT** content ~~that~~ is accurate and
7 unbiased and encourage osteopathic physicians to notify the AOA Division of Media Relations
8 to address misinformation ~~on internet encyclopedias, websites, and databases~~ regarding
9 osteopathic medicine. 2014

Explanatory Statement:

~~The Wikipedia rules specifically prohibit employees of an organization from creating content about the organization's focus. The AOA is only permitted to update numbers (per the OMP report) and is not allowed to edit pages or suggest edits.~~

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019** _____

SUBJECT: H405-A/14 ALERT NETWORK – SILVER AND GOLD

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H405-A/14 ALERT NETWORK – SILVER AND GOLD**

4 The American Osteopathic Association endorses the wide-spread state adoption of emergency
5 response systems for missing mentally impaired adults throughout the United States, via “Silver
6 Alert” and “Gold Alert” networks which are also known as “Endangered Person Advisory
7 Networks.” 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H407-A/14 ALCOHOL ABUSE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H407-A/14 ALCOHOL ABUSE**

4 The American Osteopathic Association endorses local, state and federal legislation that would
5 control the consumption and purchase of alcohol by individuals under the age of twenty-one;
6 and urges that alcohol abuse prevention and treatment programs be given a high national
7 priority. 1974; reaffirmed 1978; revised 1983, 1988, 1994, 1997, 1999, 2004; reaffirmed 2009;
8 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H408-A/14 DISCRIMINATION IN HEALTHCARE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED:

3 **H408-A/14 DISCRIMINATION IN HEALTHCARE**

4 The American Osteopathic Association adopts a zero tolerance policy for all forms of patient
5 discrimination; and in concert with other healthcare organizations, and the federal, state and
6 local governments will continue to monitor, correct and prevent any future negative bias
7 towards one or more patient groups. 1999, revised 2004; reaffirmed as amended 2009;
8 reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H409-A/14 SUDDEN INFANT DEATH SYNDROME

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED as AMENDED:

3 **H409-A/14 SUDDEN INFANT DEATH SYNDROME**

4 The American Osteopathic Association urges: continued research into the causes and
5 prevention of sudden infant death syndrome (SIDS); that information based on current medical
6 literature be made available to the public on the nature of sudden infant death syndrome and
7 proper counseling be available to families who lose infants to this disease; and supports the US
8 DEPARTMENT OF HEALTH AND HUMAN SERVICES AND CENTERS FOR
9 DISEASE CONTROL AND PREVENTION ~~Public Health Service's~~ campaigns by
10 encouraging its members to educate the parents and care-givers of infants on strategies to
11 reduce the risk of SIDS. 1974; reaffirmed 1980, 1985; revised 1990, 1995, 2000; 2004 reaffirmed
12 2005; 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H410-A/14 PHARMACEUTICALS – SUPPORT EFFORTS TO
ENCOURAGE THE PROPER DISPOSAL OF UNUSED AND
EXPIRED

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED as AMENDED:

3 **H410-A/14 PHARMACEUTICALS – SUPPORT EFFORTS TO ENCOURAGE**
4 **THE PROPER DISPOSAL OF UNUSED AND EXPIRED**

5 The American Osteopathic Association ~~will work with~~ SUPPORTS the appropriate regulatory /
6 ~~environmental and public health agencies to encourage~~ the development of educational
7 materials for the public BY THE APPROPRIATE REGULATORY/ENVIRONMENTAL
8 AND PUBLIC HEALTH AGENCIES on the dangers of keeping unused and expired
9 pharmaceuticals in their possession; and will ~~insure~~ **ENSURE SUPPORTS** that such materials
10 also include education on the proper disposal of unused and expired pharmaceuticals. 2004;
11 reaffirmed 2009; 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H411-A/14 ADVERTISING - INFLAMMATORY AND UNETHICAL
BY ATTORNEYS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be REAFFIRMED as AMENDED:

3 **H411-A/14 ADVERTISING - INFLAMMATORY AND UNETHICAL BY**
4 **ATTORNEYS**

5 The American Osteopathic Association urges the American Bar Association to encourage its
6 members who advertise to employ high ethical standards in their public advertisements AND
7 AVOID INFLAMMATORY OR UNETHICAL ADVERTISING. THE AOA FURTHER
8 ENCOURAGES PHYSICIANS, AND OTHER MEMBERS OF THE PUBLIC, TO
9 REPORT INCIDENTS OF INAPPROPRIATE ADVERTISEMENTS TO STATE BAR
10 ORGANIZATIONS, ATTORNEY PROFESSIONAL ORGANIZATIONS, THE
11 FEDERAL TRADE COMMISSION AND OTHER ORGANIZATIONS WITH
12 POTENTIAL FOR INVESTIGATION. 1989; revised 1994; reaffirmed 1999; revised 2004;
13 reaffirmed 2009; 2014

Reference Committee Explanatory Statement:

The Committee believes that this resolution is not directly related to healthcare.

ACTION TAKEN **DISAPPROVED** (*will be sunset*)

DATE **July 27, 2019** _____

SUBJECT: H412-A/14 COMPARATIVE EFFECTIVENESS RESEARCH

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED:

3 **H412-A/14 COMPARATIVE EFFECTIVENESS RESEARCH**

4 The American Osteopathic Association (AOA) will continue to engage the osteopathic medical
5 profession in Comparative Effectiveness Research (CER) projects and studies across private
6 organizations and government agencies. The AOA will continue to disseminate CER findings
7 to the osteopathic medical profession, consumers of medical information, patients, family
8 members, and caregivers. The AOA adopts the following principles regarding comparative
9 effectiveness research (2009; reaffirmed as amended 2014):

10 **Physicians and Patients**

- 11 • Comparative effectiveness research should enhance the ability of osteopathic physicians
12 (DOs) to provide the highest quality care to patients utilizing the best proven and widely
13 accepted evidence based medical information at the time of treatment.
- 14 • Comparative effectiveness research should not be used to control medical decision-making
15 authority, ~~or~~ professional autonomy; **AND SHOULD NOT BE USED TO DENY**
16 **COVERAGE OR PAYMENT.**
- 17 • Comparative effectiveness research should enhance, complement, and promote quality
18 patient care, not impede it.
- 19 • Guidelines developed as a result of comparative effectiveness research studies should be
20 advisory and not mandatory.
- 21 • Comparative effectiveness research should be viewed as a positive development for patients
22 and physicians and a useful tool in the physician's armamentarium, working in concert with
23 patients.
- 24 • Physicians in practice should be included in any discussions and decisions regarding
25 comparative effectiveness research.
- 26 • Comparative effectiveness research should focus on clinical effectiveness, not cost
27 effectiveness, ~~and should not be used to deny coverage or payment.~~
- 28 • The physician/patient relationship must be protected and the needs of the patients should
29 be paramount.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H413-A/14 EPIDEMIC TERRORIST ATTACK VICTIMS,
GOVERNMENT RESPONSIBILITY OF HEALTH CARE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED as AMENDED:

3 **H413-A/14 ~~EPIDEMIC TERRORIST ATTACK VICTIMS, GOVERNMENT~~**
4 **~~RESPONSIBILITY OF HEALTH CARE~~**

5 The American Osteopathic Association ~~believes that~~ SUPPORTS victims of an epidemic
6 terrorist attackS (e.g., anthrax) ~~are victims of a new age conflict against America and as victims~~
7 ~~of an attack against America; they should~~ TO be eligible for healthcare to be covered by the
8 United States Government. 2004; reaffirmed as amended 2009; reaffirmed 2014

Reference Committee Explanatory Statement:

The Committee requires clarity on who should be included, who will benefit, definition of terrorist act, and if this is a national or international policy.

ACTION TAKEN **REFERRED** *(to Bureau on Federal Health Programs)*

DATE **July 27, 2019**

SUBJECT: H414-A/14 FLUORIDATION

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H414-A/14 FLUORIDATION**

4 The American Osteopathic Association supports the fluoridation of fluoride-deficient public
5 water supply. Reaffirmed 2004; 2009; 2014

ACTION TAKEN **APPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: H415-A/14 MATERNAL AND CHILD HEALTHCARE BLOCK GRANTS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED as AMENDED:

3 **H415-A/14 MATERNAL AND CHILD HEALTHCARE BLOCK GRANTS**
4 The American Osteopathic Association supports government expenditures for THE TITLE V
5 ~~m~~Maternal and ~~e~~Child ~~h~~Healthcare ~~b~~Block ~~g~~Grant PROGRAM and the efficient use of ITS
6 resources. THE AOA ~~and~~ supports ~~maintaining or increasing~~ ENSURING SUFFICIENT
7 funding FOR THIS PROGRAM ~~levels for the maternal and child healthcare block grants. 1988;~~
8 revised 1993, 1998, 2003, 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H416-A/14 EMPLOYEE RETIREMENT INCOME SECURITY ACT
(ERISA) OF 1974

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED as AMENDED:

3 **H416-A/14 EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) OF**
4 **1974**

5 The American Osteopathic Association supports federal legislation to reform the Employee
6 Retirement Income Security Act (ERISA) of 1974 to ensure the ability of states to guarantee
7 that clinical decisions be made by physicians and that patients have legal remedies in state court.
8 THE AMERICAN OSTEOPATHIC ASSOCIATION ALSO SUPPORTS LEGISLATION
9 THAT EXTENDS THESE PROTECTIONS TO CLINICAL DECISIONS IMPACTING
10 PATIENT ACCESS TO PRESCRIPTION DRUGS. 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: H417-A/14 BREASTFEEDING WHILE ON METHADONE
MAINTENANCE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H417-A/14 BREASTFEEDING WHILE ON METHADONE MAINTENANCE**
4 The American Osteopathic Association encourages exclusive breastfeeding by mothers in
5 methadone maintenance who are in stable recovery. 2003; reaffirmed as amended 2009;
6 reaffirmed 2014

Reference Committee Explanatory Statement:

The Committee is requesting an evaluation of breastfeeding and other forms of medical assisted treatments (MAT) for opioid addiction, not limited to methadone.

ACTION TAKEN **REFERRED** *(to AOA Bureau of Scientific Affairs and Public Health)*

DATE **July 27, 2019**

SUBJECT: H418-A/14 RAW MILK – HEALTH RISKS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED as AMENDED:

3 **H418-A/14 RAW MILK – HEALTH RISKS**

4 The American Osteopathic Association believes that all milk sold for human consumption
5 should be required to be pasteurized; ~~supports any government efforts to prohibit the sale~~
6 ~~and advertisement of raw milk to the public~~; and that ENCOURAGES osteopathic
7 physicians ~~may~~ TO educate their patients ~~of both~~ ON the safety concerns and the health risks of
8 consuming raw milk. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H419-A/14 VACCINES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H419-A/14 VACCINES**

4 The American Osteopathic Association will continue to promote evidence-based information
5 on vaccination compliance and safety. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H424-A/14 DOMESTIC AND INTIMATE PARTNER VIOLENCE –
DEVELOPMENT OF PROGRAMS TO PREVENT

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H424-A/14 DOMESTIC AND INTIMATE PARTNER VIOLENCE –**
4 **DEVELOPMENT OF PROGRAMS TO PREVENT**

5 The American Osteopathic Association will continue to support the efforts of the United States
6 Department of Health and Human Services to develop and foster programs that prevent
7 domestic and intimate partner violence. 1989; revised 1994, 1999; reaffirmed 2004; 2009;
8 reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H425-A/14 HEALTH CARE FRAUD

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED:

3 **H425-A/14 HEALTH CARE FRAUD**

4 The American Osteopathic Association urges the Center for Medicare and Medicaid Services
5 (CMS) to: (1) disclose to the public and the medical community the actual amount of "fraud" in
6 dollars, based on the reasonable definition of "fraud" omitting all denied and resubmitted
7 claims and all honest mistakes by physicians and the Medicare carriers; and (2) strongly opposes
8 the use of law enforcement agencies and auditors to enter physicians' offices without prior
9 request, warning or due process under the law for the purpose of confiscating records. 1999;
10 revised 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H426-A/14 AUTOMATED EXTERNAL DEFIBRILLATOR (AED)
AVAILABILITY

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be REAFFIRMED as AMENDED:

3 **H426-A/14 AUTOMATED EXTERNAL DEFIBRILLATOR (AED)**
4 **AVAILABILITY**

5 The American Osteopathic Association recommends an automated external defibrillator (AED)
6 be placed in as many public places as possible and supports legislation that will limit the liability
7 ~~from placement of~~ FOR INSTALLING an AED for use by the public. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: H429-A/14 MINORITIES, UNDERREPRESENTED (URM) –
INCREASING NUMBERS OF APPLICANTS, GRADUATES AND
FACULTY AT COLLEGES OF OSTEOPATHIC MEDICINE

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy
2 be REAFFIRMED:

3 **H429-A/14 MINORITIES, UNDERREPRESENTED (URM) – INCREASING**
4 **NUMBERS OF APPLICANTS, GRADUATES AND FACULTY AT**
5 **COLLEGES OF OSTEOPATHIC MEDICINE**

6 The American Osteopathic Association encourages an increase in the total number of URM
7 graduates from colleges of osteopathic medicine by the year 2020 and encourages an increase in
8 the total number of URM faculty by the year 2020. 2014

Reference Committee Explanatory Statement:

This resolution is being referred back for an update of the statistics to determine if the deadline of the goals should be extended.

ACTION TAKEN **REFERRED** *(to AOA Bureau of Scientific Affairs and Public Health and Bureau of
Osteopathic Education)*

DATE **July 27, 2019** _____

SUBJECT: H431-A/14 LEAD EXPOSURE IN CHILDREN – PREVENTION,
DETECTION, AND MANAGEMENT

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED as AMENDED:

3 **H431-A/14 LEAD EXPOSURE IN CHILDREN – PREVENTION, DETECTION,**
4 **AND MANAGEMENT**

5 The American Osteopathic Association (AOA) encourages physicians and public health
6 departments to screen children for lead based upon current recommendations and guidelines
7 established by the US Centers for Disease Control and Prevention's ~~and the Advisory~~
8 ~~Committee on~~ Childhood Lead Poisoning Prevention PROGRAM and, encourages the
9 reporting of all children with elevated blood lead levels to the appropriate health department in
10 their state or community in order to fully assess the burden of lead exposure in children and,
11 encourages public health policy initiatives that identify exposure pathways for children and
12 develop effective and innovative strategies to reduce overall childhood lead exposure. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H432-A/14 HEPATITIS C SCREENING

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED as AMENDED:

3 **H432-A/14 HEPATITIS C SCREENING**

4 The American Osteopathic Association (AOA) publicly supports universal screening of baby
5 boomers (those born 1945~~6~~-1965~~4~~) in addition to testing those at risk for hepatitis C virus
6 (HCV), and, ~~the will AOA support and~~ promote public educational programs that educate their
7 members about HCV, testing strategies, and treatment. ~~The AOA will work with Centers for~~
8 ~~Medicare and Medicaid Services to remove the restrictive language that only primary~~
9 ~~care providers can order, and be reimbursed for one-time HCV Screenings for baby~~
10 ~~boomers (1945~~6~~-1965~~4~~).~~ The AOA will work with public health entities to educate the public
11 about the need for testing and treatment. 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H435-A/14 REGULATION OF E-CIGARETTES AND NICOTINE VAPING

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be REAFFIRMED as AMENDED:

3 **H435-A/14 REGULATION OF E-CIGARETTES AND NICOTINE VAPING**

4 The American Osteopathic adopts the following policy and recommendations as provided
5 within the attached white paper. 2014

6 **~~REGULATION OF E-CIGARETTES AND NICOTINE VAPING~~**

7 **BACKGROUND**

8 In response to the negative health effects of tobacco products and cigarettes in particular, a
9 natural market for smoking cessation and reduction products has emerged over the last 30
10 years. Accordingly, the use of electronic cigarettes (e-cigarettes) has reached a rapidly
11 expanding consumer base. E-cigarettes are often used or promoted to reduce consumption of
12 tobacco products. Alternative tools to reach these goals are switching to low or light cigarettes
13 or using nicotine-infused chewing gum, lozenges, lollipops, dermal patches or hypnosis.

14 The e-cigarette name is an umbrella term that includes any battery-powered device that
15 vaporizes liquid nicotine for delivery via inhalation. These devices are most commonly referred
16 to as electronic cigarettes, e-cigarettes, e-cigs, vaping, vape pens, vape pipes, hookah pens, e-
17 hookahs, but could potentially be referred to by other terms.

18 Since its 2007 introduction in the United States, the e-cigarette market has grown to include
19 more than 250 brands. Sales are expected to reach \$1.7 billion by the end of 2013, according to
20 the Attorneys General Association. Over the next decade, it is possible that sales of e-cigarettes
21 will outstrip conventional cigarettes.

22 The attraction to e-cigarettes crosses many segments of the population, appealing to the
23 tobacco cigarette smoker trying to quit and the non-smoker who wants to try nicotine without
24 the harmful additives. Tobacco cigarette smokers can also use e-cigarettes as a source of
25 nicotine in venues where conventional cigarettes are banned, although some states and
26 municipalities have also started to ban e-cigarettes in these spaces.

27 Smoking costs the United States an estimated \$96 billion annually in direct medical expenses
28 and an additional \$97 billion in lost productivity. Overall, e-cigarettes may be less harmful for
29 heavy or moderate smokers because they may reduce exposure to carcinogens and other toxic
30 chemicals that cause serious disease and death. However, the effect of long term consumption
31 of only nicotine is unknown, and e-cigarettes have already been shown to leave behind indoor
32 air pollution that could be both hazardous to users themselves along with second hand users.
33 Additionally, many users of e-cigarettes are using them in a supplemental fashion, while
34 continuing to utilize traditional tobacco cigarettes.

1 ANALYSIS

2 The Food and Drug Administration (FDA) does not currently regulate e-cigarettes. The Family
3 Smoking Prevention and Tobacco Control Act (Tobacco Control Act), provides the FDA
4 authority to regulate the manufacture, marketing and distribution of tobacco products.
5 However, e-cigarettes are not in the purview of FDA regulation of tobacco products. Unlike
6 tobacco cigarettes, e-cigarettes enjoy the ability to advertise on television and radio. This allows
7 e-cigarette companies to market their product in a more liberal fashion in response to market
8 demands, including the use of celebrity endorsements.

9 The Composition of E-Cigarettes

10 The e-cigarette is a smokeless, battery-powered device that vaporizes liquid nicotine for delivery
11 via inhalation. The e-cigarette contains nicotine derived from tobacco plant and several
12 secondary chemical ingredients. It is primarily composed of a nicotine cartridge, atomizer, and
13 a battery. The atomizer, which converts the nicotine liquid into a fine mist, consists of a metal
14 wick and heating element. When screwed onto the cartridge, the nicotine liquid from the
15 cartridge comes into contact with the atomizer unit and is carried to the metal coil heating
16 element. A single cartridge can hold the nicotine equivalent of an entire pack of traditional
17 cigarettes.

18 While the typical e-cigarette is sold in the shape of a cigarette, many products are sold in the
19 shape of discreet objects such as pipes, pens and lipsticks. Often, they can be legally used
20 where traditional tobacco products are banned.

21 Federal Efforts to Regulate

22 The FDA can regulate e-cigarettes only if the manufacturers make a therapeutic claim, such as
23 e-cigarettes are to be used as a cessation device. The FDA jurisdictional authority covers
24 various products including food, cosmetics, animal and human drugs, medical devices and
25 radiological products. Currently, e-cigarettes do not fall within the jurisdiction of the FDA.

26 The FDA has made efforts to regulate e-cigarettes. When the FDA made a determination that
27 certain e-cigarettes were unapproved drug/device combination products, they seized e-
28 cigarettes being imported by Sottera, Inc., resulting in a lawsuit between the company and the
29 FDA. The court held that the FDA lacked authority under the drug/device provisions to
30 regulate tobacco products customarily marketed without claims of therapeutic effect.

31 This ruling offers new challenges to FDA regulation because of the novel method of nicotine
32 delivery, various mechanical and electrical parts, and nearly nonexistent safety data. Consumer
33 use, marketing, promotional claims and technological characteristics of e-cigarettes have also
34 raised decade-old questions of when the FDA can assert authority over products as drugs or
35 medical devices.

36 State Efforts to Regulate

37 Attorneys General from 40 states have urged the FDA to regulate e-cigarettes. The pressure is
38 mounting because of various reasons. For example, unlike traditional tobacco products, there
39 are no federal age restrictions that would prevent children from obtaining e-cigarettes, nor are
40 there any advertising restrictions.

41 Various jurisdictions, both states and municipalities, have enacted laws requiring licenses to sell
42 e-cigarettes and banning sales to minors. A distinctive feature of the TCA is the broad latitude
43 expressly preserved to state and local authority to regulate tobacco products. Thirty-nine states
44 and 3,671 municipalities already have laws in place restricting or prohibiting smoking in public
45 places and workplaces. ; Currently, there are 100 local laws restricting e-cigarette use in 100%

1 smoke-free venues. However, there are only 3 state laws restricting e-cigarette use in 100%
2 smoke-free venues and only 9 in other venues.

3 New Jersey became the first state to amend its public smoking laws to prohibit the use of e-
4 cigarettes in all enclosed indoor places of public access as well as in working places. ;
5 Minnesota enacted laws regulating the sale of e-cigarettes and impose criminal penalties for the
6 sale of e-cigarettes to minors. New Hampshire also enacted a law that prohibits the sale of e-
7 cigarettes and liquid nicotine to minors and distribution of free samples of such products in a
8 public place. New Hampshire also prohibits the use of such products on the grounds of any
9 public educational facility. Similarly, Utah enacted a regulation controlling the sale, gift and
10 distribution of e-cigarettes by manufacturers, wholesalers, and retailers, and King County,
11 Washington enacted an ordinance that bans the smoking of e-cigarettes in public places. Some
12 state and local restrictions on the use of e-cigarettes are driven largely by the concern that they
13 have similar damaging effects on bystanders as traditional cigarettes.

14 Arguments for E-Cigarettes

15 Smoking accounts for nearly 5.4 million cancer-related deaths worldwide each year. This
16 includes 443,000 deaths in the United States. Proponents argue that e-cigarettes do not expose
17 the user, or others close by, to harmful levels of cancer-causing agents and other dangerous
18 chemicals normally associated with traditional tobacco products.

19 Various physician groups have defended the product, based on their opinion that e-cigarettes
20 deliver nicotine without the tar and myriad of other chemicals found in regular cigarettes. At
21 this point, no one knows whether the e-cigarette alternative to tobacco cigarettes carry any
22 long-term detrimental health effects, however it is known that they contain less carcinogenic
23 elements than traditional tobacco cigarettes. According to the American Lung Association
24 there are approximately 600 ingredients in cigarettes. When burned, they create more than
25 4,000 chemicals. At least 50 of these chemicals are known to cause cancer, and many are
26 poisonous. While e-cigarettes may have less component chemicals, a study found that the usage
27 of e-cigarettes contributes to indoor air pollution. The results showed that e-cigarettes are not
28 emission free, and that their pollutants could be a danger to both users as well as secondhand
29 smokers.

30 The draw of the e-cigarette for smoking cessation is that it delivers nicotine to counter nicotine
31 withdrawal symptoms. E-cigarettes evoke the psychological response to cigarette smoking
32 because of its shape and the familiar behavior aspect of smoking. A 2011 survey of 104 e-
33 cigarette users revealed that 66% started using them with the intention to quit smoking and
34 almost all felt that the e-cigarette had helped them to succeed in quitting smoking. Another
35 survey of 3,037 users of e-cigarettes revealed that 77% of them said that they used them to quit
36 smoking or to avoid relapse. None said they used them to reduce consumption of tobacco with
37 no intent to quit smoking. However, the overall effectiveness of e-cigarettes is still in question.
38 In a randomized study, participants given e-cigarettes, nicotine patches and placebo e-cigarettes
39 that lacked nicotine were able to quit smoking at roughly the same rates, with insufficient
40 statistical power to conclude superiority of nicotine e-cigarettes.

41 Consequences of E-Cigarettes

42 Charting in unknown territory always poses the risk for consequences. Advocates contend that
43 e-cigarettes are less risky and harness the possibility to reduce smoking or even be a complete
44 smoking cessation. A major concern is that it appeals to youth by being flavorful, trendy and a
45 convenient accessory. The flavorings being used, such as candy and other sweet flavorings are

1 particularly appealing to younger populations. For this reason, these flavorings are banned in
2 traditional cigarettes.

3 Further, e-cigarette usage among children is increasing. During 2011-2012, the percentage of
4 middle school students who have tried e-cigarettes jumped from 1.4% to 2.7%. Among high
5 school students, the jump was from 4.7% to 10%, and 80.5% of high school students who use
6 e-cigarettes also smoke conventional cigarettes. These numbers could also be largely
7 underestimating the percentage of children using e-cigarettes, as many call the devices by other
8 names. Manufacturers and sellers of e-cigarettes have begun using other product names such as
9 “hookah pens,” “e-hookahs,” or “vape pens.” Even though these products differ only in name
10 and appearance from e-cigarettes, many school age children that used these devices failed to
11 identify them as such.

12 Aside from the carcinogenic and toxic effects of tobacco, smokers become addicted to the
13 nicotine. Nicotine addiction is characterized as a form of drug dependence recognized in the
14 Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Nicotine addiction is a
15 combination of positive reinforcements, including enhancement of mood and avoidance of
16 withdrawal symptoms. E-cigarette cartridges contain up to 20 times the nicotine of a single
17 cigarette, and the process of “vaping” lacks the normal cues associated with cigarette
18 completion, such as the butt of the cigarette ending a dose.

19 Conditioning has a secondary role in nicotine addiction. Smokers associate particular cues with
20 the high of smoking, often causing relapse when those seeking to quit smoking are confronted
21 with those cues. E-cigarettes allow quitting smokers to respond to those cues. This poses a risk
22 of overconsumption. The lack of finality to an e-cigarette is determined only by the battery or
23 nicotine cartridge. Distinguishable from tobacco cigarettes, smokers who have turned to the e-
24 cigarette no longer have the butt of the cigarette as a cue to stop smoking.

25 E-cigarettes are manufactured from metal and ion components that introduce concerns about
26 faulty products and malfunctions. In the United States there has been at least 2 reports of e-
27 cigarettes exploding in users’ faces and hands causing severe injuries including blown out teeth,
28 extensive burns and tissue damage to lips and tongues, burns to the hands and hearing and
29 vision loss.

30 **CONCLUSION**

31 The AOA supports FDA and state regulation of the ingredients of all electronic cigarette
32 cartridges, requiring ingredient labels and warnings, and eliminating the usage of flavors that are
33 banned in traditional cigarettes.

34 The AOA supports the FDA and state regulation prohibiting sales and advertisements of
35 electronic cigarettes to persons under the age of 18. Advertisements for electronic cigarettes
36 should be subject to the same rules and regulations that are enforced on traditional cigarettes.

37 The AOA further encourages federal, state and local government action to banning the use of
38 electronic cigarette devices in spaces where traditional cigarettes are currently barred from use.

39 The AOA promotes tobacco and nicotine cessation treatment, and the usage of any such
40 treatment that has been proven safe and effective by the FDA.

41 The AOA supports research by the FDA and other organizations into the health and safety
42 impact of e-cigarettes and liquid nicotine.

43 THE AOA SUPPORTS PHYSICIANS CONSIDERING THE RISKS OF
44 RECOMMENDING E-CIGARETTES TO PATIENTS, AS WELL AS REQUESTING

1 THAT THEIR PATIENTS SUBMIT VOLUNTARY REPORTS TO THE U.S.
2 DEPARTMENT OF HEALTH AND HUMAN SERVICES SAFETY REPORTING
3 PORTAL (WWW.SAFETYREPORTING.HHS.GOV) IF THEY SUSTAIN ADVERSE
4 REACTIONS TO E-CIGARETTES.

5 The AOA supports physicians considering the risks of recommending e-cigarettes to patients,
6 as well as requesting that their patients submit voluntary reports to the U.S. department of
7 health and human services safety reporting portal (www.safetyreporting.hhs.gov) if they sustain
8 adverse reactions to e-cigarettes.

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17 [Smoking-out-the-truth-about-e-cigarettes](http://special.app.com/article/20131027/NJLIFE04/310270144/Healthy-or-harmful-Smoking-out-the-truth-about-e-cigarettes)

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23 Schober W, Szendrei K, Matzen W, Osiander-Fuchs H, Heitmann D, Schettgen T, et al, Use of
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26 2013, available at <http://www.ncbi.nlm.nih.gov/pubmed/24373737>

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28 fte&tobacco-2012.pdf)

29 15 U.S.C. § 1335.

30 Stuart Elliotts, E-Cigarette Makers' Ads Echo Tobacco's Heyday, New York Times, August 29,
31 2013, available at [http://www.nytimes.com/2013/08/30/business/media/e-cigarette-makers-
32 ads-echo-tobaccos-heyday.html](http://www.nytimes.com/2013/08/30/business/media/e-cigarette-makers-
32 ads-echo-tobaccos-heyday.html)

33 Jordan Paradise at 353.

34 Id. at 353.

35 Tobacco fact sheet: Electronic Cigarettes (E-Cigarettes), Legacy for Longer Healthier Lives,
36 available at <http://www.legacyforhealth.org>.

37 Jordan Paradise at 354.

38 Id.

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41 Sophie Novaek, E-Cigarette Ads spark Lawmakers' Concern for Youth, The National Journal
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2 ~~Id. at 331.~~
3 ~~Dan Radel supra.~~
4 ~~Id., The National Association of Attorneys General letter to the FDA.~~
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6 ~~21 U.S.C. § 387g(a)(1)(A).~~
7 ~~Jordan Paradise at 373.~~
8 ~~American Nonsmokers' Foundation., U.S. State and Local Laws Regulating Use of Electronic~~
9 ~~Cigarettes. www.no-smoke.org.~~
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1 ~~Matt Richtel, E-Cigarettes, By Other Names, Lure Young and Worry Experts, New York~~
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Explanatory Statement:

The conclusions in the white paper are still relevant, with one additional edit. The analysis in the body of the white paper is outdated and therefore should be deleted.

Reference Committee Explanatory Statement:

The Committee requests an updated policy paper.

ACTION TAKEN **REFERRED** *(to Bureau of State Government Affairs)*

DATE **July 27, 2019** _____

SUBJECT: H406-A/14 FIREARM SAFETY

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED as AMENDED:

3 **H406-A/14 FIREARM SAFETY**

4 THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) RECOMMENDS THAT
5 ~~DURING ROUTINE PATIENT CARE, WHEN APPROPRIATE,~~ PHYSICIANS ASK
6 PATIENTS AND/ OR CAREGIVERS ABOUT THE PRESENCE OF FIREARMS IN
7 THE HOME AND COUNSEL PATIENTS WHO OWN FIREARMS ABOUT THE
8 POTENTIAL DANGERS INHERENT IN GUN OWNERSHIP, ESPECIALLY IF
9 **VULNERABLE INDIVIDUALS** CHILDREN AND ADOLESCENTS ARE PRESENT.
10 The AOA RECOMMENDS ~~supports and encourages~~ strategies such as secure storage and the
11 use of safety locks TO ELIMINATE ~~for eliminating~~ the inappropriate access to firearms by
12 **VULNERABLE INDIVIDUALS** children and adolescents and RECOMMENDS ~~supports~~
13 ~~and encourages~~ all physicians to educate families in the safe use and storage of firearms. 1994;
14 revised 1999, 2004; reaffirmed 2009; 2014

Explanatory Statement:

This policy was amended to strengthen the recommendation that physicians routinely counsel and provide education on safe use and storage for patients who own firearms and have children in the home.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: PROTECTING PATIENTS WITH PRIVATE INSURANCE FROM
BALANCE BILLING **FOR EMERGENCY MEDICAL CARE**

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

1 WHEREAS, varying state laws to address balance billing have garnered the interest of federal
2 law makers to mandate a federal standard to address the practice of balance billing; and

3 WHEREAS, 14 percent of emergency department visits are likely to include balance billing^{1, 2};
4 and

5 WHEREAS, 20 percent of patients admitted to the hospital via the emergency department are
6 likely to receive balance billing^{1, 2}; and

7 WHEREAS, we believe that it is important that patients be protected from egregious balance
8 billing practices; and

9 WHEREAS, we recognize that physicians practice under a variety of compensation
10 arrangements, e.g., independent contractor, salary, hourly compensation, percentage of
11 gross or net billing, or a combination of these; now, therefore, be it

12 RESOLVED, that the American Osteopathic Association (AOA) ~~will~~ supportS patients’ right
13 to access emergency medical ~~procedures~~ CARE at a REASONALBE cost ~~that is~~
14 ~~based on competitive private market rates~~; and, be it further

15 RESOLVED, that the AOA, in ~~an~~ emergency medical ~~procedure~~ CARE, supports a system in
16 which patients are removed from the process of resolving outstanding medical expenses
17 that is beyond their cost sharing responsibilities **FOR IN-NETWORK CARE; AND,**
18 **BE IT FURTHER**

19 **RESOLVED, THAT DISPUTES OVER THE REASONABLE COST FOR OUT OF**
20 **NETWORK EMERGENCY CARE BE DETERMINED BY AN**
21 **INDEPENDENT, THIRD PARTY OR ARBITRATION.**

22 References

- 23 1. C. Garmon and B. Chartock, “One in Five Inpatient Emergency Department Cases May
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Reference Committee Explanatory Statement:

“Surprise billing” results from insurance companies passing out-of-network payment responsibilities to patients. The best practice for resolving payment disputes between insurance companies and care providers is the use of independent third party databases or an Independent Dispute Resolution

process using a third party arbiter. This resolution advocates for the inclusion of these best practices in any legislation.'

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019** _____

SUBJECT: REFERRED SUNSET RES. NO. H-403 - A/2018: H403-A/13 ~~AIRBAGS IN AUTOMOBILES OCCUPANT PROTECTION IN PASSENGER VEHICLES~~

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 WHEREAS, sunset resolution H-403 - A/2018 titled “AIRBAGS IN AUTOMOBILES” was
2 referred to the Bureau on Scientific Affairs and Public Health (BSAPH) to develop a
3 white paper on all automotive safety, including airbags; now therefore be it,

4 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that H-403 -
5 A/2018 be reaffirmed as amended and the following white paper, titled “OCCUPANT
6 PROTECTION IN PASSENGER VEHICLES”, be adopted:

7 **Occupant Protection In Passenger Vehicles**

8 **INTRODUCTION**

9 Today, almost every vehicle on the road has safety features that help drivers to be safer, either through
10 protecting drivers and passengers involved in a crash or to preventing passenger vehicle crashes. This paper will
11 provide information on all vehicle safety features and whether or not the feature is federally mandated, as well as
12 recommend associated policy for adoption by the AOA.

13 **OCCUPANT PROTECTION IN PASSENGER VEHICLES**

14 Occupant protection includes safety belts, lower anchor and tethers for children (LATCH), airbags, and active
15 head restraints. These features were designed to protect both drivers and passengers.

16 In 2016, National Highway Traffic Safety Administration (NHTSA) developed a fact sheet with information on
17 passenger vehicle occupant protection, which included the use of restraints and benefits of safety belts, frontal
18 airbags, and child restraints. According to the fact sheet, safety belts saved an estimated 14,668 lives of
19 passenger vehicle occupants 5 years old and older in 2016, frontal air bags saved an estimated 2,756 lives, and car
20 seats saved an estimated 328 lives of children under the age of 5 years.¹ NHTSA estimated that lap/shoulder
21 safety belts, when used, reduce the risk of fatal injury among front-seat passenger vehicle occupants by 45%;
22 moderate to critical injury to front-seat passenger vehicle occupants by 50%; fatal injury in front-seat light truck
23 occupants by 60%, and moderate to critical injury to front-seat light truck occupants by 65%.¹

24 Frontal airbags, combined with lap/shoulder bags offer effective safety protection for passenger vehicle
25 occupants. NHTSA estimated that the use of frontal airbags without safety belts reduced the fatality risk by
26 11%, and when using safety belts, fatality drops further by 14%. In 2016, frontal airbags saved an estimated
27 2,756 lives. From 1987, when airbags first began to be installed in passenger vehicles, through 2016, 47,648 lives
28 were saved.¹

29 NHTSA estimated that car seat use in passenger vehicles reduce the risk of fatal injury by 71 % for infants
30 younger than 1 year of age and 54 % for toddlers age 1 to 4 years. For infants and toddlers, the risk of fatal
31 injury in light trucks is 58 % for infants younger than 1 year, and 59 % for toddlers ages 1 to 4 years. In 2016,
32 car seat restraints saved an estimated 328 lives of children age 4 years and younger (313 associated with the use
33 of car seats and 15 with the use of adult safety belts). NHTSA estimated that an additional 42 lives could have
34 been saved (a total of 370 children age 4 and younger). Since 1975, the lives of 11,274 children 4 years old and
35 younger involved in automobile accidents were saved because of child restraint use.¹

1 There is an abundance of technology available to protect occupants of passenger vehicles. Most of the
2 advancements have been in place for many years. As technology progressed, many of the features improved,
3 resulting in more saved lives.

4 ***Safety-Belt Features***

5 While the seat belt is the most important piece of automotive safety equipment, enhanced features have helped
6 the seat belt do its job more efficiently.²

7 On March 1, 1967, the first Federal Motor Vehicle Safety Standard (FMVSS) mandate required that all passenger
8 vehicles have safety belts. FMVSSs are United States federal regulations specifying the design, construction,
9 performance, and durability requirements for passenger vehicles safety-related components, systems, and design
10 features. FMVSSs are developed and enforced by the National Highway Traffic Safety Administration
11 (NHTSA), pursuant to the National Traffic and Motor Vehicle Safety Act of 1966.

12 Safety belts now have belt tensioners; a device designed to pull a seat belt tight in an accident. This feature helps
13 position passengers properly to take full advantage of a deploying airbag.²

14 Force limiters, companions to belt tensioners, reduce the force of the seat belt above a certain threshold and, in
15 conjunction with belt tensioners and airbags, lessen the risk of upper body injuries to front seat passengers.²

16 Other seatbelt enhancements include inflatable seatbelts and adjustable shoulder anchors. Some car models have
17 inflatable safety belts in the rear seat that reduces the force of the seat belt on passengers involved in an accident.
18 Inflatable safety belts help protect the elderly and children who are the primary rear seat occupants.²

19 Safety belts also have adjustable shoulder anchors that help position the belt across the chest instead of the neck,
20 which helps prevent neck injuries.²

21 ***Latch (Lower Anchors and Tethers for Children)***

22 All passenger vehicles are now required to have the LATCH system. This system not only encourages the use of
23 child safety seats but also integrates lower anchors and top tether attachment points. These anchors and
24 attachment points allow the installation of the car safety seat to be effortless and eliminate the challenges and
25 incompatibilities of installing a car safety seat. However, in some cars and trucks, the LATCH system is
26 challenging to use correctly.²

27 NHTSA developed a traffic fact sheet that contains information on the fatal motor vehicle crashes and facilities,
28 based on the Fatality Analysis Reporting System (FARS). Assuming that all passenger vehicle crashes have the
29 LATCH system, in 2017, there were 23,351 passenger vehicle occupants killed in fatal crashes, 794 (3.3%) were
30 infants (less than 1 year) to age 14. Of the 794 children killed, 244 (31%) were in a child restraint seat, 202 (25%)
31 were in a lap belt only or shoulder, and lap belt and 103 (13%) were unknown. Of the 39,822 passenger vehicle
32 occupants who survived in fatal crashes, 4,700 (11.8%) were infants (less than 1 year) to age 14 and 509 (11%)
33 was unrestrained. Of the 63,373 passenger vehicle occupants involved in fatal crashes, 5,494 (8.7%) were infants
34 (less than 1 year) to age 14, and 776 (15%) was unrestrained.³

35 ***Airbags***

36 Since 1998, front airbags have been standard on all new cars, and since 1999, airbags have been standard on light
37 trucks. The on-board computer-connected crash sensors detect a frontal collision and trigger the bags. In a few
38 milliseconds, the bag inflates, then immediately deflates.²

39 Airbags have saved thousands of lives, but they also have the potential to cause children or occupants who do
40 not use a seat belt to suffer injury or even death.² “From 1987 to 2015, frontal air bags saved 44,869 lives. That
41 is enough people to fill a major league ballpark.”⁴ In 2016, the estimated number of lives saved by frontal airbags
42 were 2,756.⁴

43 According to a Special Crash Investigations Report released in January 2009, from 1990 through January 1, 2009,
44 there have been 296 airbag-related fatalities, (191 children, 92 adult drivers, and 13 adult passengers).⁵ Also, the
45 Takata airbag defection has caused 16 deaths in the U.S.; and 24 deaths and 300 injuries worldwide.⁴

46 Adaptive or dual-stage front airbags were introduced in 2003 and became the standard by 2007. Most airbag
47 systems now have sensors that detect weight and the seat position of the driver and front passenger. The airbag

1 system will deactivate if it senses that the driver is positioned too close to the wheel or the front passenger or
2 child is out of position. This system minimizes injury from an accident.²

3 **Side Airbags.** Side-impact airbags protect the torso of front seat passengers. (Consumer Reports 2016)
4 Depending on the passenger vehicle model, side airbags are offered as standard or optional equipment
5 on many new passenger vehicles.⁴

6 **Side Curtain Airbags.** Side curtain airbags are designed to prevent occupants from hitting their heads
7 and shielding them from flying debris. They remain inflated longer than other airbags to keep people
8 from being ejected during a rollover or a high-speed side crash.²

9 A standard enacted late in 2007 and effective September 1, 2009, NHTSA mandated that all automakers
10 phase in additional side-impact protection as a standard feature for their cars, trucks, and SUVs by
11 2013.⁷

12 ***Active Head Restraints***

13 In a rear crash, active head restraints move up and forward to cradle the head and absorb energy to diminish
14 whiplash injury.²

15 **ACCIDENT AVOIDANCE SYSTEMS**

16 The automotive industry is continually developing traffic safety technologies that will help drivers avoid crashes.
17 Some of these technologies have a warning system and rely on the driver to take corrective action, while others
18 are designed to automatically brake or steer, thus taking an active action approach to accident prevention. These
19 features are expected to contribute to an overall improvement in traffic safety.

20 AAA Foundation for Traffic Safety developed a research brief that presented the probable safety benefits of
21 various advanced driver assistance systems and provided estimates regarding the numbers of crashes, injuries,
22 and deaths that such systems could have potentially helped to prevent based on the characteristics of the crashes
23 that occurred on U.S. roads in 2016.⁸

24 According to the brief, the Forward Collision Warning (FCW) could theoretically have prevented an estimated
25 69-81% of all rear-end crashes, 76-81% of angle crashes, and 23-24% of single-vehicle crashes, totaling
26 approximately 2.3 million crashes and 7,166 fatal crashes per year between 2002 and 2006. In 2016, there were
27 an estimated 1,994,000 crashes, 884,000 injuries and 4,738 deaths that could have been prevented or mitigated by
28 the FCW system if it were a standard feature in all vehicles.⁸

29 The brief estimated that Lane Departure Warning (LDW) and Lane Keeping Assistance (LKA) technology
30 equipped in passenger vehicles could have theoretically addressed 179,000 crashes and 7,529 fatal crashes
31 annually between 2004 and 2008. In 2016, there were an estimated 519,000 crashes, 187,000 injuries, and 4,654
32 deaths that could have been prevented or mitigated by LDW or LKA systems.⁸

33 The brief estimated that blind spot warning systems (BSW) could have prevented approximately 24% of all lane-
34 changing crashes between 2004 and 2008. In 2016, there were an estimated 318,000 crashes, 89,000 injuries, and
35 274 deaths that could have been prevented by the BSW system.⁸

36 There is also an abundance of advanced driver assistance technology available. This technology is designed to
37 prevent crashes. The features are relatively new; thus, they will have varying levels of NHTSA recognition.

38 ***Forward Collision Prevention/Warning (FCW)***

39 **Adaptive Headlights.** Adaptive headlights are primarily intended to move side-to-side to help illuminate curves
40 and corners. “These headlights use electronic sensors that can detect your steering angle to swivel based on the
41 direction your car is heading.”⁹

42 **Bicycle Detection.** The bicycle detection feature alerts the driver to a potential collision with a bicyclist ahead.
43 NHTSA has not set any performance specifications for this feature.¹⁰

44 **Forward-Collision Warning (FCW).** Forward-collision warning utilizes cameras, radar or laser to scan for
45 autos ahead and alert the driver that they are moving toward a vehicle in their path excessively quick and an
46 accident is inescapable. Most Forward-Collision warning systems alert the driver with a visual and or audible

1 signal to a potential accident, allowing time for a reaction.²

2 This system meets NHTSA performance specifications but is an option on many new cars, SUVs, and trucks.¹¹

3 **Left Turn Crash Avoidance.** Left turn car avoidance feature monitors traffic when the driver turns left at low
4 speeds. The sensor automatically activates warning sounds, dash lights, and brakes when a driver turns left into
5 another car's path. NHTSA has not set any performance specifications for this feature.¹²

6 **Obstacle Detection.** Obstacle detection uses sensors mounted on the front and/or rear bumpers to determine
7 the distance between the car and a nearby object. If an object is detected, the sensor automatically slows down
8 the passenger vehicle. NHTSA has not set any performance specifications for this feature.¹³

9 **Pedestrian Detection.** This system utilizes the features of the Forward-Collision Warning system and
10 automatically initiates the car's braking system to protect pedestrians from being hit. The car's camera or radar
11 looks for a pedestrian in the path of the vehicle. Some systems will alert the driver with an audible or visual alert,
12 and some systems will automatically initialize the emergency braking system if the collision is deemed high.²

13 NHTSA has not set any performance specifications for this feature but recognized that this is a promising
14 technology. This system is currently an option on many new cars, SUVs, and trucks.²

15 ***Braking, Tire Pressure, and Anti-Rollover***

16 **Brake Assist.** Brake Assist helps detect when a driver is braking to maximum strength. In conjunction with
17 anti-lock brakes, the system allows braking without locking the wheels. Studies have shown that most drivers are
18 not braking as hard as they can, so Brake Assist intervenes to reach the shortest stop distance possible.²

19 **Traction Control.** Traction control electronically controls the wheels spinning motion during acceleration to
20 obtain the maximum traction. This system is useful in wet, icy, or snowy conditions.²

21 **Electronic Stability Control (ESC).** Electronic stability control (ESC) is a step beyond traction control. In
22 order to avoid sliding or skidding, this system helps keep the vehicle on its intended path during a turn. ESC
23 uses a series of sensors connected to a computer to detect wheel speed, steering angle, side movement, and yaw
24 (rotation). If the car drifts outside the intended path, the stability control system momentarily brakes one or
25 more wheels and reduces the power of the engine to pull the car back on track depending on the system.²

26 ESC is particularly useful for tall, heavy-duty vehicles such as sports equipment pickups; helping to keep the
27 vehicle from rollover.²

28 The federal government required stability control on all vehicles by the 2012 model.²

29 **Anti-Lock Braking System (ABS).** Before the invention of the anti-lock braking system (ABS), car wheels
30 easily locked during hard braking which caused the front tires to slide and made steering impossible; which is
31 dangerous on slippery surfaces. ABS prevents this from occurring. ABS uses sensors that are controlled by a
32 computer on each wheel. The system maximizes the braking action on each wheel to avoid locking the wheel
33 which results in the driver maintaining control of the car to avoid hitting obstacles.²

34 “Over the past 10 years, most car manufacturers have made ABS standard in their vehicles. The federal
35 government required all new cars to have ABS by September 1, 2011.”¹⁴

36 **Automatic Emergency Braking (AEB).** AEB adds to the advantages of forward-crash cautioning. AEB will
37 detect a potential crash, and if the response time is moderate, the vehicle will start braking.² This system engages
38 Dynamic Brake Support and Crash Imminent Braking technology.

39 **Dynamic Brake Support (DBS) and Crash Imminent Braking (CIB).** If the driver does not brake
40 hard enough to evade a crash, the DBS system will automatically supplement the driver's braking to
41 avoid the collision. If the driver does not take any action to prevent the accident, the CIB system will
42 automatically apply the car's brakes to slow or stop the vehicle. (National Highway Traffic Safety
43 Administration n.d.) This system has been available on some car models since 2006 but is typically an
44 optional feature on many new cars, SUVs, and trucks.¹⁵ NHTSA does recommend the CIB and DBS
45 system if it meets NHTSA's performance specifications.

1 **Temperature Warning.** Temperature warning alerts the driver when the outside temperature is detected to be
 2 at or below freezing, which can affect road conditions. NHTSA has not set any performance specifications for
 3 this feature.¹⁶

4 **Hill Descent Assist.** Hill descent assist works with the passenger vehicle's existing braking systems to block the
 5 driver from going past a certain speed while traveling downhill or on treacherous terrain. If the vehicle begins
 6 accelerating past a safe downhill speed, this feature further applies the brakes. NHTSA has not set any
 7 performance specifications for this feature.¹⁷

8 **Hill Start Assist.** Hill start assist uses sensors in the vehicle to detect when a vehicle is on an incline. For a set
 9 time, the system maintains the brake pressure as the driver switches from the brakes to the gas pedal. Once the
 10 driver presses the accelerator, it releases the brake. In cars with a manual transmission, the Hill Start Assist also
 11 maintains brake pressure until the driver lets up on the clutch. NHTSA has not set any performance
 12 specifications for this feature.¹⁸

13 *Driver State Monitoring*

14 **Tire-Pressure Monitor System.** Tire pressure monitoring systems (TPMS) warn drivers of under or
 15 overinflated tires. The system helps to increase the car's fuel economy and potentially prevent a tire blowout
 16 which can be dangerous at high speeds and lead to a car accident. The federal government required all new
 17 vehicles to include this system starting in late 2007.¹⁹

18 **Curve Speed Warning.** Curve speed warning uses Global Positioning System (GPS) to alert the driver of
 19 upcoming sharp turns. This feature tracks the passenger vehicle speed and location and warns the driver to slow
 20 down when approaching curves and exits. NHTSA has not set any performance specifications for this feature.²⁰

21 **High-Speed Alert.** High-speed Alert uses a built-in speed sensor and GPS to compare a database of known
 22 road speed limit against the driver's actual speed and alerts the driver if they are speeding. Some versions may
 23 track school and work zones. Future versions may be able to read limits through a camera. NHTSA has not set
 24 any performance specifications for this feature.²¹

25 **Adaptive Cruise Control (ACC).** ACC utilizes lasers, radar, cameras, or a blend of these to keep a steady
 26 distance between the driver and the vehicle ahead. If the traffic slows, some systems automatically stop the car
 27 and automatically accelerate to full speed when the traffic returns to normal. The system allows the driver to lose
 28 their focus on driving, which is a hazard.²

29 **Push Button Start.** Push Button Start simplifies turning the passenger vehicle on and off using a key fob
 30 unique to the vehicle. NHTSA has not set any performance specifications for this feature.²²

31 **Drowsiness Alert.** Drowsiness alert borrows some of the sensors from lane departure warning systems to track
 32 lane markings and the automobile's lane position. Many versions of this feature will track how often the driver
 33 departs from the lane over a short period to determine if the driver may be drowsy. This feature may alert the
 34 driver using a coffee cup or other symbol on the dash suggesting that the driver take a break and when it will be
 35 safe to pull over. NHTSA has not set any performance specifications for this feature.²³

36 **Automatic High Beams.** Automatic high beam lights switch from high to low and back again to improve
 37 nighttime visibility and as conditions warrant.²

38 *Parking and Backing Assistance*

39 **Backup Camera.** The backup camera assistance system is activated when the driver of a passenger places the
 40 gear in reverse. The monitor is in the center console of the passenger vehicle and displays items behind the car.
 41 This system is primarily used as a parking aid or spotting a child or pedestrian concealed in the blind zone.²

42 NHTSA required this life-saving technology on all new vehicles in May 2018.¹¹

43 **Back-up Warning.** Back-up warning uses sensors mounted to the rear bumper. These sensors detect objects
 44 in the path of the vehicle. The system may beep or vibrate if an object is in the way.²⁴

45 At this time, this is not a new car standard. As stated above, NHTSA required this life-saving technology on all
 46 new vehicles in May 2018.¹⁵ In the future, manufacturers are expected to pair the back-up warning and the back-

1 up camera systems in new cars.

2 **Parking Assist System.** Parking assist incorporates sensors in the car's front, rear, or both bumpers. The
3 system alerts the driver that light poles, walls, shrubbery, and other obstacles are close when the passenger
4 vehicle is moving at a slow speed (parking speed).²

5 **Automatic Parallel Parking.** Automatic parallel parking can detect objects in front and back of a car while
6 parking. It provides audible warnings when detecting one or more objects. Advanced sensors read the gaps
7 between vehicles in the area where the driver chooses to park. The feature will not activate if there is insufficient
8 room to parallel park, which helps ensure that the car does not bump into any nearby vehicles. When initiated,
9 this feature takes over some of the vehicle's steering and acceleration functions needed to park.²⁵

10 **Rear Cross-Traffic Alert.** Rear cross-traffic alerts sense traffic crossing the path of a passenger vehicle as the
11 driver backs out of a parking space or driveway. Some systems automatically brake to prevent an accident.²

12 The Rear cross-traffic alert system is not a standard feature for passenger vehicles, but the federal government
13 does mandate the feature for such vehicles as buses and trucks. However, manufacturers often pair rear cross
14 traffic alert with back-up cameras; so the mandate may increase the popularity of rear cross traffic alert features
15 soon.²⁶

16 *Lane and Side Assistance*

17 **Lane-Departure Warning (LDW).** Lane-departure warning alerts the driver when the car drifts out of its lane
18 without activating the turn signal. The system uses a camera or lasers to monitor lane markers. The system will
19 chime, the dashboard will blink, or the steering wheel or seat will vibrate to warn the driver that they are drifting
20 into another lane.² This system meets NHTSA's performance specifications and is an option on many new cars,
21 SUVs, and trucks.¹⁵

22 **Lane-Keeping Assist (LKA).** Lane-keeping assist will generate mild steering to put the driver back in their
23 lane. This system also senses when the driver leaves their lane.²

24 NHTSA has not set performance specifications for this technology, but this technology may be available on new
25 cars, SUVs, and trucks.¹⁵

26 **Blind-Spot Warning (BSW) or Blind Spot Detection (BSD).** BSW utilizes radars or cameras and shines a
27 light or symbol in or adjacent to the outside mirrors to warn the driver that another vehicle is driving in the
28 parallel lane in an area that the drivers outside mirrors cannot detect. This system will sound an audible warning
29 if the driver attempts to change lanes or uses their turn signal to indicate that they plan to change lanes. There
30 are additional advanced systems that can initiate the braking system or the steering system in order to move the
31 vehicle back towards the center of the lane.²

32 NHTSA has not set performance specifications for BSW, but NHTSA recognizes this as a promising
33 technology. On many new cars, SUVs, and trucks, this system is an option and can help avoid a crash.¹⁴

34 **Side View Camera.** Side view cameras improve visibility on the passenger side, and in some cases provide the
35 driver with a circuit view of the surrounding area of the car. The driver can use this feature to protect bumpers,
36 side mirrors, trim, and wheel rims from damage at low speeds. This camera also provides an expanded view of a
37 lane beside the driver when the driver uses their turn signal or when the driver manually activates this feature.
38 This feature is similar to the blind spot monitor.²⁷

39 *Communication*

40 **911 Notification - Automatic Crash Notification (ACN).** ACN is technology designed to notify emergency
41 responders that an accident has occurred and provide the location. This system uses sensors to detect a
42 deployed airbag or detect a dramatic and sudden deceleration. Once this is detected, the system will
43 automatically connect to an operator who will be able to talk with the accident victims.¹⁵

44 This system has the potential to reduce death and disability by reducing the time it takes for emergency medical
45 services to reach an accident scene and transport victims to a hospital.¹⁵

46 NHTSA has not set performance specifications for this technology. This system is available as an option on

1 many new cars, SUVs, and trucks.¹⁵

2 **Telematics.** Telematics is the use of cellular, Global Positioning Satellite (GPS), and other technology (e.g., GM
3 OnStar, BMW Assist, Hyundai Bluelink, Kia UVO, Lexus Safety Connect, Mercedes-Benz’s mBrace, and Toyota
4 Safety Connect) to gather and transmit data. “This system allows the driver to communicate with a central
5 dispatch center at the touch of a button. This center knows the location of the vehicle and can provide route
6 directions”²⁸ of emergency aid on request.²

7 **CONCLUSION**

8 There are many safety features to prevent automobile accidents and protect drivers. Because some do carry the
9 potential risk of harm, these features continue to evolve. Research is regularly conducted to ensure that
10 passenger vehicles are able to lessen the impact of crashes, reduce injuries and help drivers prevent crashes.
11 However, consumer education is needed on the proper use of existing safety features. NHTSA, for example, not
12 only conducts research and establish standards, but insurance companies and not-for-profit agencies such as
13 AAA Foundation for Traffic Safety conduct research.

14 Although some crashes are unavoidable, the probability that passenger vehicle crashes, **INJURIES, AND**
15 **DEATH** will continue to decrease is high because of the ongoing research, available educational opportunities,
16 and existing and future advanced technologies.

17 After review of the existing literature on automotive safety, including airbags, the American Osteopathic
18 Association (AOA) adopts the following policies: The American Osteopathic Association:

- 19 (1) supports the ongoing efforts of the National Safety Council (NSC), the National Highway Traffic and Safety
20 Administration (NHTSA), the National Transportation Safety Board (NTSB) and other responsible safety
21 organizations to educate the public regarding the proper use of all occupant protection devices in passenger
22 vehicles, including safety belts, child safety seats, and airbags;
- 23 (2) urges continued corporate development and research into safer airbags and monitoring of adult and child
24 fatalities resulting from airbag deployment; and
- 25 (3) encourages the National Safety Council, the National Highway Traffic and Safety Administration, the
26 National Transportation Safety Board, and other responsible safety organizations to educate the public
27 regarding the benefits and potential dangers of all occupant protection equipment and accident avoidance
28 systems.

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ACTION TAKEN **APPROVED** as **AMENDED**DATE **July 27, 2019**

SUBJECT: REFERRED SUNSET RES. NO. H-421 - A/2018: H427-A/13 PHYSICIAN-PATIENT RELATIONSHIP AS RELATED TO PROPOSED GUN CONTROL LAWS, PROTECTION OF THE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 WHEREAS, sunset resolution H-421-A/2018 titled “H427-A/13 PHYSICIAN-PATIENT
2 RELATIONSHIP AS RELATED TO PROPOSED GUN CONTROL LAWS,
3 PROTECTION OF THE” was referred to the Bureau on Scientific Affairs and Public
4 Health (BSAPH); now, therefore be it

5 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
6 following policy be REAFFIRMED.

7 **H427-A/13 PHYSICIAN-PATIENT RELATIONSHIP AS RELATED TO**
8 **PROPOSED GUN CONTROL LAWS, PROTECTION OF THE**

9 While the American Osteopathic Association supports measures that save the
10 community at large from gun violence, the AOA opposes public policy that mandates
11 reporting of information regarding patients and gun ownership or use of guns except in
12 those cases where there is duty to protect, as established by the Tarasoff ruling, for fear
13 of degrading the valuable trust established in the physician-patient relationship. ~~THE~~
14 ~~AOA RECOMMENDS THAT DURING ROUTINE PATIENT CARE,~~
15 ~~PHYSICIANS ASK PATIENTS AND/ OR CAREGIVERS ABOUT THE~~
16 ~~PRESENCE OF FIREARMS IN THE HOME AND COUNSEL PATIENTS WHO~~
17 ~~OWN FIREARMS ABOUT THE POTENTIAL DANGERS INHERENT IN GUN~~
18 ~~OWNERSHIP, ESPECIALLY IF CHILDREN ARE PRESENT.~~ 2013

Explanatory Statement:

The HOD Reference Committee referred this sunset policy to BSAPH in July 2018, stating that the amendment, as written, is a separate resolution (unrelated to the Tarasoff ruling) and should be resubmitted as such. BSAPH added an edited version of this statement to H406-A/14 FIREARM SAFETY which is submitted as a sunset policy for the 2019 HOD meeting.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: CMS RULES ON PSYCHOTROPIC MEDICATIONS IN NURSING FACILITIES

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

1 WHEREAS, The Centers for Medicare and Medicaid Services (CMS) has initiated several
2 regulatory initiatives to decrease the use of antipsychotic and other psychotropic
3 medications in Nursing Facilities (NFs); and

4 WHEREAS, in November of 2017, CMS announced several regulatory changes for nursing
5 facilities including an expanded definition of psychotropic medication and new
6 limitations on the use of as needed (PRN) psychotropic medications⁽¹⁾; and

7 WHEREAS: the definition psychotropic medications now includes “any drug that affects brain
8 activities associated with mental processes and behavior”. These drugs include, but are
9 not limited to, the following drug categories: antipsychotic, antidepressant, antianxiety,
10 hypnotic, as well as medication classes that may affect brain activity. This expanded list
11 of psychotropic medications includes central nervous system agents, mood stabilizers,
12 anticonvulsants, muscle relaxants, anticholinergic medications, antihistamines, N-
13 methyl-D- aspartate receptor modulators, and over-the-counter natural or herbal
14 products⁽¹⁾; and

15 WHEREAS: CMS has placed a 14-day limit on the duration of use of “psychotropic
16 medications” when prescribed for PRN. For antipsychotics, a 14-day limitation is
17 applied to all PRN orders; as a result, these orders may not be extended beyond the 14-
18 day limit. To continue their use, a new order for the PRN antipsychotic may be written
19 if the prescribing practitioner directly examines and assesses the resident and documents
20 clinical rationale. This clinical rationale must include the benefit of the medication for
21 that resident. This documentation is required every 14 days for a resident receiving a
22 PRN antipsychotic without exception, including hospice patients.⁽¹⁾; and

23 WHEREAS: hospice patients are often residents in a NFs, and psychotropic medications are
24 often employed for symptom relief and comfort measures; and

25 WHEREAS: CMS rules requiring repeated direct examination, re-documentation of clinical
26 rationale, and re-ordering of medication which can result in delayed treatment or care;
27 and

28 WHEREAS, osteopathic physicians desire to ensure our patients receive the care they need in a
29 timely manner; now, therefore be it

30 RESOLVED, that the American Osteopathic Association (AOA) petition The Centers For
31 Medicare And Medicaid Services (CMS) to exclude hospice patients from the CMS rules
32 for use of psychotropic and antipsychotic medication in NFs; and, be it further

1 RESOLVED, that the AOA work with CMS to refine the rules governing the PRN use of
2 antipsychotic and **OTHER** psychotropic medications **FOR ANY NURSING**
3 **FACILITY PATIENT** to improve the continuity of patient care, decrease costs, and
4 ease physician burden, based on scientific evidence and valid clinical studies.

5 References:

6 1. Centers for Medicare & Medicaid Services (CMS). Revision to State Operations Manual (SOM)
7 appendix PP for phase 2, F-tag revisions, and related issues, Section F757. CMS website.
8 [https://www.cms.gov/Medicare/Provider-Enrollment-and-](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf)
9 [Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf)
10 [.pdf](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf). Accessed November 10, 2017.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019** _____

SUBJECT: OPPOSITION TO PATIENT DISCRIMINATION OF OSTEOPATHIC PHYSICIANS BECAUSE OF RACE, COLOR, RELIGION, GENDER, SEXUAL ORIENTATION, GENDER IDENTITY OR NATIONAL ORIGIN

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

1 WHEREAS, the American Osteopathic Association (AOA) has historically taken a strong
2 position against osteopathic physicians discriminating against patients because of, but
3 not limited to their race, color, religion, gender, sexual orientation, gender identity or
4 national origin; and

5 WHEREAS, the AOA Code of Ethics assures that patients have autonomy and freedom of
6 choice when selecting an osteopathic physician; and

7 WHEREAS, some patients have refused to allow a physician treat them based solely on the
8 physician's race, color, religion, gender, sexual orientation, gender identity or national
9 origin; and

10 WHEREAS, physicians have no similar protections against patients refusing to receive care
11 from a physician due to the physician's race, color, creed, religion, gender, sexual
12 orientation, gender identity or national origin; and

13 WHEREAS, this discrimination is an abuse and misinterpretation by the patient of their
14 protected autonomy; and

15 WHEREAS, physicians, especially those in areas with limited physician availability may be
16 called upon to treat a patient who has previously declined to be treated by a particular
17 physician are compelled by medical ethics to provide emergency treatment to these
18 patients; and

19 WHEREAS, without the intervention of these physicians, the patient would be at great risk of
20 loss of life or limb; and

21 WHEREAS, physicians acting in these situations place themselves at significant risk of being
22 accused of acting unethically; and

23 WHEREAS, the AOA has no statement supporting these physicians in providing life or limb
24 saving treatment despite the patient expressing a desire not to be treated by the
25 physician due solely to the physician's race, color, religion, gender, sexual orientation,
26 gender identity or national origin; now, therefore be it

27 RESOLVED, that the American Osteopathic Association (AOA) deems it ethical for
28 osteopathic physicians to provide care to a patient in LIFE THREATENING

1 EMERGENCIES even when the patient has refused treatment from the physician
2 because of the physician's race, color, religion, gender, sexual orientation, gender
3 identity or national origin; and, be it further

4 RESOLVED, that the American Osteopathic Association (AOA) supports the education of the
5 public that osteopathic physicians should be evaluated by their skill and knowledge
6 rather than by race, color, religion, gender sexual orientation, gender identity or national
7 origin.

Reference Committee Explanatory Statement:

The Committee believes that the content in this resolution violates the Patient’s Bill of Rights and state laws that address this issue vary.

ACTION TAKEN **REFERRED** *(to the Iowa Osteopathic Medical Association)*

DATE **July 27, 2019** _____

SUBJECT: RECOGNITION OF HEALTH CARE AS A HUMAN RIGHT

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Public Affairs

1 WHEREAS, the World Health Organization recognizes “the highest attainable standard of
2 health as a fundamental right of every human being,” and states “the right to health
3 includes access to timely, acceptable, and affordable health care of appropriate quality”¹;
4 and

5 WHEREAS, the United States ranks 33rd out of 34 countries in the Organization for
6 Economic Co-operation and Development (OECD) in percentage of insured
7 population (with 88.5%), with nearly every other country at > 98%²; and

8 WHEREAS, 25-30 million Americans are still uninsured after implementation of the
9 Affordable Care Act (ACA), and the non-partisan Congressional Budget Office
10 estimates that this number would increase to 48 million, and continue to increase
11 annually, with an ACA repeal³; now, therefore, be it

12 RESOLVED, that the American Osteopathic Association recognizes that health care is a
13 human right for every person⁴, not a privilege.

14 References:

- 15 1. World Health Organization Media Center. “Health and Human Rights.” Fact Sheet N°232, Dec
16 2015. Accessed Feb 2017. <http://www.who.int/mediacentre/factsheets/fs323/en/>
17 2. OECD (2015), Health at a Glance 2015: OECD Indicators, OECD Publishing, Paris.
18 http://dx.doi.org/10.1787/health_glance-2015-en
19 3. Congressional Budget Office. “How Repealing Portions of the Affordable Care Act Would Affect
20 Health Insurance Coverage and Premiums.” Jan 2017. <https://www.cbo.gov/publication/52371>
21 4. Bauchner, H. “Health Care in the United States: A Right or a Privilege.” JAMA. 2017; 317(1):29.
22 <http://jamanetwork.com/journals/jama/fullarticle/2595503> - Journal of the American Medical
23 Association (JAMA), the editor-in-chief of JAMA voiced a hope that all physicians and professional
24 societies will “speak with a single voice and say that health care is a basic right for every person, and
25 not a privilege to be available and affordable only for a majority.”

Reference Committee Explanatory Statement:

The committee believes that the resolution, as written, lacks clarity and direction.

ACTION TAKEN **REFERRED** *(to the Michigan Osteopathic Medical Association)*

DATE **July 27, 2019**

SUBJECT: OSTEOPATHIC PHYSICIANS AND THE AVAILABILITY OF
NALOXONE

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Public Affairs

1 WHEREAS, opioid deaths are at epidemic proportion. In 2017, the number of overdose deaths
2 involving opioids was six times higher than in 1999; and

3 WHEREAS, on average 130 Americans die every day from an opioid overdose; and

4 WHEREAS, rapid administration of naloxone can potentially reverse the effects of opioid
5 overdose; and

6 WHEREAS, studies have shown naloxone administration by bystanders significantly improves
7 the odds of recovery compared to no naloxone administration; now, therefore be it

8 RESOLVED, that physicians discuss naloxone and how to obtain it with their patients and
9 patients' families, struggling with opioid addiction, and encourage them to have these
10 kits available at all times.

Explanatory Statement:

References:

(ref. Wide-ranging online data for epidemiological research (WONDER). Atlantic, Ga.: CDC, National Center for Health Statistics; 2017.

(ref. Effectiveness of bystander naloxone administration and overdose education programs: a meta-analysis, Rebecca Giglio, et al. Injury Epidemiology. 2015 Dec; 2(1): 10.

Reference Committee Explanatory Statement

The Committee believes this resolution is covered under H632 A/18.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: PHYSICIAN AWARENESS OF FIREARM SAFETY IN OLDER PERSONS

SUBMITTED BY: Pennsylvania Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

- 1 WHEREAS, in 2016, gun violence in America was declared a public health crisis; and
- 2 WHEREAS, there have been 4.2 deaths every day due to gun violence in the Commonwealth
3 of Pennsylvania; and
- 4 WHEREAS, 27% of adults older than 65 years of age own one or more firearms and more than
5 37% reside in a home where a firearm is present; and
- 6 WHEREAS, it is estimated that older individuals are those most likely to develop vision and
7 hearing loss, dementia, physical disability and other conditions incompatible with safe
8 firearm us; and
- 9 WHEREAS, males over age 65 are the group most likely to successfully complete suicide using
10 a firearm; and
- 11 WHEREAS, under federal law a person suffering from mental illness is not prohibited from
12 purchasing a firearm unless they have been committed to a mental institution; and
- 13 WHEREAS, there are numerous reports of innocent individuals, including loved ones and
14 caregivers, who have been unintentionally or mistakenly injured or killed at the hands of
15 an older person; now, therefore be it
- 16 RESOLVED, that the American Osteopathic Association (AOA) develop materials to ensure
17 physicians are made fully aware of the staggering statistics of the gun crisis in American
18 as related to the population of older individuals; and be it further
- 19 RESOLVED, that AOA develop educational programs to ensure that physicians are taught
20 about the importance of asking questions about firearm safety as part of clinical
21 responsibility; and, be it further
- 22 RESOLVED, that AOA develop or partner with appropriate groups to provide appropriate
23 screening tools regarding firearm safety; and, be it further
- 24 RESOLVED, that the AOA encourage discussion regarding gun safety so that it is viewed by
25 physicians as a routine part of health care for older adults and vulnerable persons.

Explanatory Statement:

For more than 20 years, the American College of Physicians (ACP) has advocated for the need to address firearm-related injuries and deaths in the United States. Yet, firearm violence continues to be a public health crisis that requires the nation's immediate attention. The policy recommendations in this

paper *Reducing Firearm Injuries and Deaths in the United States: A Position Paper from the American College of Physicians* build on, strengthen, and expand current ACP policies approved by the Board of Regents in April 2014, based on analysis of approaches that the evidence suggests will be effective in reducing deaths and injuries from firearm-related violence

The following physician associations - American College of Surgeons, American College of Obstetricians and Gynecologists, American Public Health Association, American Psychiatric Association, American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, and American Bar Association supported a call to action to address gun violence as a public health threat, which was subsequently endorsed by 52 additional organizations that included clinician organizations, consumer organizations, organizations representing families of gun violence victims, research organizations, public health organizations, and other health advocacy organizations.

The position paper is attached for your consideration.

Reference Committee Explanatory Statement

This subject is addressed in H-425. Additionally, the white paper only addresses individuals with dementia; it does not specifically address older persons.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: OPPOSING ZERO-TOLERANCE IMMIGRATION POLICIES AND THE SEPARATION OF FAMILIES AT THE BORDER

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

1 WHEREAS, a zero-tolerance immigration policy is defined as the immediate prosecution and
2 detention of adults entering the country illegally, without exception for those seeking
3 asylum or accompanied by minors;¹ and

4 WHEREAS, zero-tolerance immigration policies have the added effect of separating children
5 from their families at the time of detention;¹ and

6 WHEREAS, according to the American Academy of Pediatrics in 2017, the basic standards of
7 care for immigrant children in detention in the US were not met; specifically there were
8 “egregious conditions in processing centers included inadequate bathing and toilet
9 facilities, constant light exposure, children sleeping on concrete floors, confiscation of
10 belongings, insufficient food, denial of access to thorough medical care, lack of mental
11 health support plus physical and emotional maltreatment;”² and

12 WHEREAS, children accumulating Adverse Childhood Experiences (ACEs), such as the
13 trauma of being separated from their families and being placed in separate detention
14 centers that do not adequately meet their basic needs, experience increased risks of
15 cancer, heart disease, mental health disorders, other diseases, and early death^{1,4,5}; and

16 WHEREAS, separation of families fleeing persecution in their home countries led to an
17 increase in depression/anxiety and posttraumatic stress disorder⁶; and

18 WHEREAS, there is evidence that this separation from their families can damage the children’s
19 attachment relationships, cause toxic stress, and even led to greater health disparities¹;
20 and

21 WHEREAS, alternative approaches to detention centers exist and are more humane and less
22 expensive³; and

23 WHEREAS, there is no empirical evidence to demonstrate that threats of detainment deter
24 individuals from seeking asylum⁷; and

25 WHEREAS, statements condemning the separation of immigrant families have already been
26 issued by the Royal College of Pediatrics and Child Health, the American Academy of
27 Pediatrics, the Canadian Pediatric Society, the American Medical Association, the
28 Canadian Medical Association, and the International Society for Social Pediatrics &
29 Child Health⁶; and

1 WHEREAS, according to the American Osteopathic Association’s code of ethics, section 13,
2 “A physician shall respect the law. When necessary a physician shall attempt to help to
3 formulate the law by all proper means in order to improve patient care and public
4 health”⁸; now, therefore be it,

5 RESOLVED, that the American Osteopathic Association (AOA) oppose zero-tolerance
6 immigration policies, especially policies where children are separated from their families;
7 and, be it further

8 RESOLVED, that the AOA act to discourage existing and future efforts to create, enforce, or
9 legislate similar zero-tolerance immigration policies.

10 **References**

- 11 1. Wood, L.C.N. (2018). Impact of punitive immigration policies, parent-child separation and child
12 detention on the mental health and development of children. *BMJ Paediatrics Open*, 2 (1). Retrieved
13 from: doi:10.1136/bmjpo-2018-000338
- 14 2. Linton, J., Griffin, M., Shapiro, A. (2017) Detention of Immigrant Children. Retrieved from:
15 <http://pediatrics.aappublications.org/content/139/5/e20170483.long>.
- 16 3. A Guide to Children Arriving at the Border: Laws, Policies and Responses. In (June 2015 ed.).
17 American Immigration Council.
- 18 4. Felitti, V.J., Anda, R.F., Nordenberg, D., et al (1998). Relationship of Childhood Abuse and
19 Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse
20 Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine*, 14(4), 245-258.
- 21 5. About Adverse Childhood Experiences.
22 https://www.cdc.gov/violenceprevention/acestudy/about_ace.html. Accessed January 31, 2019.
- 23 6. Miller, A., Hess, J.M., Bybee, D., et al (2019). Understanding the mental health consequences of
24 family separation for refugees: Implications for policy and practice. *American Journal of*
25 *Orthopsychiatry*, 88(1), 26-37.
- 26 7. There are alternatives: A handbook for preventing unnecessary immigration detention. (2015).
27 International Detention Coalition.
- 28 8. American Osteopathic Association Code of Ethics. (July 24, 2016). Retrieved from
29 <https://osteopathic.org/about/leadership/aoa-governance-documents/code-of-ethics/>

Reference Committee Explanatory Statement

The Committee believes the resolution does not focus actionable healthcare issues.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: RECOGNIZING FOOD INSECURITY AS A PUBLIC HEALTH ISSUE

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

1 WHEREAS, food insecurity is defined as “the disruption of food intake or eating patterns
2 because of lack of money and other resources”¹; and

3 WHEREAS, the United States Department of Agriculture (USDA) has reported that 11.8
4 percent (15 million) of U.S. households experienced food insecurity during 2017²; and

5 WHEREAS, in 2017² food insecurity was inequitably experienced at high rates in households
6 with children headed by single women (30.3 percent), Black (non-Hispanic) households
7 (21.8 percent), Hispanic households (18 percent), and households with children headed
8 by a single man (19.7 percent); and

9 WHEREAS, scientific literature has “consistently found food insecurity to be negatively
10 associated with health outcomes” including increased likelihood of childhood asthma
11 and earlier onset of limitations in activities of daily living for seniors³; and

12 WHEREAS, a constitutional objective of the American Osteopathic Association is to “to
13 promote the public health”; now, therefore be it,

14 RESOLVED, that the American Osteopathic Association recognizes food insecurity as a public
15 health issue.

16 **References**

- 17 1. U.S. Department of Human and Health Services: Office of Disease Prevention and Health Promotion.
18 (2019, February 11). Food Insecurity. Retrieved February 11, 2019, from
19 [https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-](https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/food-insecurity)
20 [health/interventions-resources/food-insecurity](https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/food-insecurity)
- 21 2. Alisha Coleman-Jensen, Matthew P. Rabbitt, Christian A. Gregory, and Anita Singh. 2018. Household
22 Food Security in the United States in 2017, ERR-256, U.S. Department of Agriculture, Economic
23 Research Service.
- 24 3. Gundersen, C., & Ziliak, J. P. (2015). Food Insecurity And Health Outcomes. Health Affairs, 34(11),
25 1830–1839. <https://doi.org/10.1377/hlthaff.2015.0645>

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: COMMUNITY PHARMACIES; REQUIRED NOTIFICATION OF
PRIMARY CARE PROVIDERS REGARDING VACCINATION
ADMINISTRATION

SUBMITTED BY: Illinois Osteopathic Medical Society

REFERRED TO: Committee on Public Affairs

- 1 WHEREAS, immunizations currently prevent between 2 – 3 million deaths each year
2 worldwide; and
- 3 WHEREAS, an additional 1.5 million deaths could be avoided with improved vaccination rates
4 worldwide; and
- 5 WHEREAS, vaccines not only provide individual protection for those persons who are
6 vaccinated, they also provide community protection by reducing the spread of disease
7 within a population; and
- 8 WHEREAS, physicians and patient care providers have a responsibility/duty to promote
9 immunizations to all eligible people for vaccine preventable illnesses; and
- 10 WHEREAS, **IN SOME STATES** vaccinations can be administered by pharmacists educated
11 in the practice of immunization delivery; and
- 12 WHEREAS, community pharmacies provide a convenient and accessible option for people to
13 receive needed immunizations; now, therefore be it
- 14 RESOLVED, that the American Osteopathic Association support measures that would require
15 pharmacists to provide documentation of immunizations, administered in the
16 community-based pharmacy setting, to the patient’s primary care physician **IN**
17 **APPROPRIATE REGISTRIES.**

Explanatory Statement:

Requiring pharmacists and/or delegated pharmacy technicians at community based pharmacies to provide documentation of immunizations administered to patients directly to their primary care provider would reduce the number of duplicate vaccinations received by patients, enhance provider awareness and readiness to assist patients experiencing vaccine-related adverse events, and increase appropriate reporting of vaccine-related events in the Vaccine Adverse Event Reporting System (VAERS) by primary care providers.

References

1. 10 facts on immunization. (2018, March). Retrieved from World Health Organization: <https://www.who.int/features/factfiles/immunization/en/>
2. Bach, A. a. (2015, July 1). The role of community pharmacy-based vaccination in the USA: current practice and future directions. Integrated Pharmacy Research and Practice, pp. 67 - 77.

3. Orenstein, W. a. (2017, April 10). Simply put: Vaccination saves lives. Proceedings of the National Academy of Sciences of the United States of America, pp. 114 - 116.
4. Vaccines & Immunizations: What Would Happen If We Stopped Vaccinations? (2018, June 29). Retrieved from Centers for Disease Control and Prevention: <https://www.cdc.gov/vaccines/gen/gen/whatifstop.htm>

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019** _____

SUBJECT: FIREARM VIOLENCE

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

1 ~~WHEREAS, nearly two-thirds of deaths by firearm are related to suicide; and~~
2 ~~WHEREAS, of the remaining one-third of firearm deaths 83% are related to gangs or~~
3 ~~the drug trade; and~~
4 ~~WHEREAS, the right to keep and bear arms is a constitutionally protected right; and~~
5 ~~WHEREAS, legally owned firearms are used for self-defense 2.4 million times per year,~~
6 ~~much more than they are used for suicide or to commit crimes; and~~
7 WHEREAS, current American Osteopathic Association (AOA) firearm violence policy is
8 represented by ~~9~~ **separate MULTIPLE** policies, several of which are due for sunset
9 review in 2020; now, therefore be it
10 RESOLVED, that the American Osteopathic Association (AOA) develop a comprehensive
11 policy which consolidates all current firearm violence policies into a single unified policy
12 ~~that addresses the core causes of violence and the criminality associated, as well~~
13 ~~as the mental health issues associated with suicide while upholding the civil~~
14 ~~rights of law abiding citizens; and, be it further~~
15 RESOLVED, that the American Osteopathic Association (AOA) present it for consideration
16 by the 2020 AOA House of Delegates.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: AMENDMENT TO THE AMERICAN OSTEOPATHIC ASSOCIATION
CONSTITUTION & BYLAWS – BUREAU OF EMERGING LEADERS
AND NEW PHYSICIAN IN PRACTICE

SUBMITTED BY: AOA Bureau of Emerging Leaders

REFERRED TO: Committee on Constitution & Bylaws

1 WHEREAS, the proposed amendments were presented to the July 2018 House of Delegates
2 for its first reading; now, therefore be it

3 RESOLVED, that the AOA House of Delegates approve the following amendments to the
4 American Osteopathic Association Constitution & Bylaws:

5 Old material crossed out (~~crossed out~~) | New material in CAPS

6 **AOA Constitution**

7 Article VIII – Board of Trustees and Executive Committee - Section 1 D

8 **Pages 2-3 - Lines 41-8**

9 D. ONE POSTDOCTORAL TRAINEE, TO INCLUDE INTERN, RESIDENT, OR A
10 FELLOW, member elected by the ~~h~~House of ~~d~~DelegateS to serve for one year. Candidates
11 for the ~~intern/resident~~POSTDOCTORAL TRAINEE position shall be enrolled in an
12 ACGME OR AOA-approved internship, residency or, ~~if enrolled in an ACGME-approved~~
13 ~~residency shall have applied for an AOA approval of the ACGME-Approved residency~~
14 FELLOWSHIP. Candidates for the ~~intern/resident~~POSTDOCTORAL TRAINEE position
15 shall be nominated by the ~~council of interns and residents~~**BUREAU OF EMERGING**
16 **LEADERS. CANDIDATES SHOULD BE MEMBERS IN GOOD STANDING OF**
17 **THE AOA.**

18 Article VIII – Board of Trustees and Executive Committee - Section 3

19 **Page 3 – Line 25-26**

20 For all trustees, with the exception of the President, President-Elect and the Past Presidents
21 for the preceding two years, the aggregate terms of Office of Trustees shall be limited to
22 twelve (12) years, with the exception that a trustee may complete the term in which twelve
23 (12) years or more of service is completed. Time served as a student member,
24 ~~intern/resident~~POSTDOCTORAL TRAINEE member, or as new physician in practice
25 member shall not be included in calculating the twelve years of service.

26 **AOA Bylaws**

27 Article V – House of Delegates – Section 1 – Certification of Delegates and Alternates – Part B
28 – Specialty Colleges

29 **Page 9 - Lines 41-42**

30 Each AOA recognized specialty college shall elect one delegate and at least one alternate to the
31 AOA House of Delegates in a manner prescribed in its constitution and Bylaws. No specialty
32 college delegate or alternate shall ~~also be a member of the divisional society's delegation to~~
33 **CONCURRENTLY SERVE AS A DELEGATE FOR A DIVISIONAL SOCIETY AT the**
34 **AOA's House of Delegates. The Secretary of each specialty college shall certify the name of its**

1 delegate and alternate to the Chief Executive Officer of the AOA at least 30 days prior to the
2 first day of the annual meeting of the AOA House of Delegates. Each delegate and alternate
3 must be a member in good standing of this association and his specialty college.

4 Article V - House of Delegates - Section 11 - Representation of Osteopathic Physicians In
5 Postdoctoral Training TRAINEES AND/OR NEW PHYSICIANS IN PRACTICE

6 **Page 11 - Lines 20-36**

7 Section 11-Representation of Osteopathic Physicians In Postdoctoral Training TRAINEES
8 AND/OR NEW PHYSICIANS IN PRACTICE

9 Osteopathic ~~physicians in~~ postdoctoral ~~training~~ TRAINEES AND/OR NEW PHYSICIANS
10 IN PRACTICE may be represented in the House of Delegates by two individuals who, at the
11 time of the annual meeting, shall be enrolled in postdoctoral training programs OR
12 CURRENTLY A NEW PHYSICIAN IN PRACTICE AS DEFINED BY THE
13 ASSOCIATION. The two individuals and their alternates shall be selected by vote of the
14 AOA's ~~Council of Interns and Residents~~ BUREAU OF EMERGING LEADERS (BEL). The
15 delegates (and alternate delegates) selected by the ~~Council of Interns and Residents~~ BEL shall
16 serve as the representatives of osteopathic ~~physicians in~~ postdoctoral ~~training~~ TRAINEES AND
17 NEW PHYSICIANS IN PRACTICE. ~~and THESE DELEGATES shall not also be members~~
18 ~~of a divisional society or specialty college delegation to the AOA's~~ INDIVIDUALS SERVING
19 AS A BEL DELEGATE SHALL NOT CONCURRENTLY SERVE AS A DELEGATE
20 FOR ANY OTHER GROUP AT THE AOA House of Delegates. The ~~chair of the Council of~~
21 ~~Interns and Residents~~ CHAIR OF THE BEL shall certify the nameS of its delegates and
22 alternate delegates to the Chief Executive Officer of the AOA in writing or by electronic
23 communication at least 30 days prior to the first day of the annual meeting of the AOA House
24 of Delegates. Each delegate and alternate must be a member in good standing of this
25 Association.

ACTION TAKEN **APPROVED** _____

DATE **July 27, 2019** _____

1 accredited by this Association and located in the state represented by that divisional society, such
2 student delegate to be elected according to the Bylaws of the American Osteopathic Association.

3 C. Specialty Affiliates Each AOA recognized Specialty College shall be represented by one delegate to
4 be selected as provided in the bylaws of the American Osteopathic Association.

5 Section 2-Presiding Officer

6 The presiding officer of the House of Delegates shall be the Speaker and, in his absence or at his
7 request, the Vice Speaker shall preside.

8 **Article VII – Officers**

9 Section 1-Elected Officers

10 The elected officers of this Association shall be the President, President-Elect, First Vice-President,
11 Second Vice-President and Third Vice-President. The First Vice-President shall be a person who has
12 had previous experience as a member of the Board of Trustees. The officers shall be elected annually
13 by the House of Delegates for a term of one year, or until their successors are elected and installed. The
14 President-Elect shall automatically succeed to the presidency upon his installation, during the annual
15 meeting of the House of Delegates following his election to the office of President-Elect. In the case of
16 the inability upon the part of the president to serve during the term of office for which he/she has been
17 elected, and therefore the office becomes vacant, the President-Elect shall become president for the
18 unexpired portion of the term and continue in that office for the term in which the President-Elect was
19 originally elected. In such case, if the President-Elect is unable to serve for the full unexpired term of
20 the president's office, then the responsibility of filling the office of President shall devolve upon the
21 Board of Trustees.

22 Section 2-Administrative Officers

23 The administrative officers shall be Chief Executive Officer, a Controller, a General Counsel, and an
24 Editor who shall be appointed by the Board of Trustees and employed to serve for such term as the
25 Board shall define. The duties of these officers shall be those usual to such officers in their respective
26 offices and such others as are set forth in the Bylaws. The Chief Executive Officer shall be the
27 Secretary of the Association.

28 **Article VIII - Board of Trustees and Executive Committee**

29 Section 1-Board of Trustees

30 The Board of Trustees shall be the administrative and executive body of the association and perform
31 such other duties as are provided by the bylaws. The Board of Trustees of this association shall
32 consist of twenty-nine members.

33 A. Seven elected officers: The President, President-Elect, The Past Presidents for the preceding
34 two years, First Vice-President, Second Vice-President, and Third Vice-President;

35 B. Eighteen at-large trustees, six of whom shall be elected annually by the house of delegates to
36 serve for three years;

37 C. One new physician in practice member elected by the House of Delegates to serve for one
38 year. Candidates for the new physician in practice position shall be osteopathic physicians
39 who have completed their postdoctoral training within the past five years or received the
40 DO degree within the previous ten years shall be nominated by the council of new
41 physicians in practice;

1 D. ONE POSTDOCTORAL TRAINEE, TO INCLUDE INTERN, RESIDENT, OR A
2 FELLOW, member elected by the ~~h~~House of ~~d~~Delegates to serve for one year. Candidates
3 for the ~~intern/resident~~POSTDOCTORAL TRAINEE position shall be enrolled in an
4 ACGME OR AOA-approved internship, residency or, ~~if enrolled in an ACGME-approved~~
5 ~~residency shall have applied for an AOA approval of the ACGME-Approved~~
6 ~~residency~~FELLOWSHIP. Candidates for the ~~intern/resident~~POSTDOCTORAL
7 TRAINEE position shall be nominated by the ~~council of interns and residents~~BUREAU OF
8 EMERGING LEADERS. CANDIDATES SHOULD BE MEMBERS IN GOOD
9 STANDING OF THE AOA.

10 E. One student member elected by the House of Delegates to serve for one year. Candidates
11 for the student position shall be nominated, in altering years, by the Council of Osteopathic
12 Student Government Presidents (COSGP) and the Student Osteopathic Medical Association
13 (SOMA); and

14 F. One public member elected by the House of Delegates to serve for a three-year term, with a
15 one-term limit. Candidates for the public member position shall not be physicians and shall
16 be nominated by the committee on administrative personnel.

17 Section 2-Executive Committee

18 The Executive Committee of this Association shall consist of the President, President-elect, Past
19 Presidents for the preceding two years, the chairs of the Departments of Affiliate Affairs, Business
20 Affairs, Governmental Affairs, Professional Affairs, Research, Quality and Public Health, and the
21 Chair and Vice-Chair of the Department of Educational Affairs.

22 Section 3-Term Limit

23 For all trustees, with the exception of the President, President-Elect and the Past Presidents for the
24 preceding two years, the aggregate terms of Office of Trustees shall be limited to twelve (12) years,
25 with the exception that a trustee may complete the term in which twelve (12) years or more of
26 service is completed. Time served as a student member, ~~intern/resident~~POSTDOCTORAL
27 TRAINEE member, or as new physician in practice member shall not be included in calculating the
28 twelve years of service.

29 **Article IX - Amendments**

30 This Constitution may be amended by the House of Delegates at any annual meeting by a two-thirds
31 vote of the total number of delegates accredited for voting, provided that such amendments shall have
32 been presented to the House and filed with the Chief Executive Officer at a previous annual meeting,
33 who shall cause them to be distributed by first class mail, postage prepaid, to each divisional and
34 specialty society entitled to and voting representatives to the house of delegates, posted on the AOA's
35 website, and published in *the Journal of the American Osteopathic Association* not less than two months or
36 more than four months prior to the meeting at which they are to be acted upon.

37 **Article X - Gender Disclaimer**

38 The American Osteopathic Association is open to persons of both sexes and does not discriminate
39 against any persons because of sex; therefore, the wording herein importing the masculine or feminine
40 gender includes the other gender and imports no such discrimination.

1 **BYLAWS**

2 **Article I - Divisional, District and Affiliated Societies**

3 **Section 1-Divisional Societies**

4 Any state, territorial, provincial or foreign osteopathic organization, or an organization of
5 osteopathic physicians serving in the uniformed services of the United States, which may desire to
6 become a divisional society of the American Osteopathic Association and be chartered as a
7 divisional society of this Association, shall apply on a prescribed form, submit evidence that its
8 constitution, Bylaws, and Code of Ethics generally conform to those of this Association, and
9 maintain an organizational structure which shall generally conform to that of this Association.

10 Upon such application, the Chief Executive Officer and the Board of Trustees shall investigate and,
11 finding satisfactory proof, shall recommend to the House of Delegates that a charter be issued. The
12 Association shall not issue such a charter to more than one divisional society in a given area.

13 **Section 2-District Societies**

14 Divisional societies may, within their own areas, organize district societies whose relationship to the
15 divisional society shall in all respects conform to that existing between the division and this
16 Association.

17 **Section 3-Affiliated Organizations**

18 Upon application from any organization for a charter as an affiliated organization, the Board of
19 Trustees and the Chief Executive Officer shall investigate such organization and, upon satisfactory
20 proof of a general agreement in policy and governing rules with those of this Association, shall
21 recommend to the House of Delegates the issuance of such a charter. The Association shall not issue a
22 charter to any organization, which duplicates the function or prerogatives of any presently affiliated
23 organization. All organizations which have as their membership osteopathic physicians in good
24 standing with the AOA, whether holding a current charter of affiliation or not, shall have as a medium
25 of communication all publications of the AOA.

26 **Section 4-Amendments to Governing Documents**

27 Any amendments to the Constitution, Bylaws, Code of Ethics, and other governing documents, by
28 whatever name called, of such a divisional society or affiliated organization shall be submitted to the
29 Board of Trustees of the American Osteopathic Association, who shall review such amendments to
30 determine whether, with the proposed amendments, the Constitution, Bylaws, Code of Ethics, or
31 other governing documents would continue to conform generally to those of this Association and,
32 with respect to the divisional society only, whether the organizational structure would continue to
33 conform generally to those of this Association. Until such proposed amendments are given written
34 approval of the Board of Trustees of the American Osteopathic Association, the divisional society or
35 affiliated organization shall continue to operate under its previously approved Constitution, Bylaws, or
36 other governing documents.

37 **Article II – Membership**

38 **Section 1-Classification**

39 The members of this Association shall be classified as follows:

- 40 a. Regular Members
- 41 b. Honorary Life Members
- 42 c. Life Members
- 43 d. Associate Members
- 44 e. Student Members

- 1 f. Honorary Members
- 2 g. International Physician Members
- 3 h. Allied Members

4 Section 2-Membership Requirements

5 *a. Applicants for Regular Membership*

6 An applicant for regular membership in this Association shall be a graduate of a college of
7 osteopathic medicine approved by the American Osteopathic Association and shall be eligible for
8 licensure as an osteopathic physician and/or surgeon or shall be in a training program, which is a
9 prerequisite for his licensure.

10 Application shall be made on the prescribed form and shall be accompanied by payment of the
11 appropriate dues amount.

12 Unless specifically noted, an applicant whose completed application and payment of appropriate dues
13 has been received and processed shall be enrolled as a regular member. An applicant whose
14 membership in this Association has previously been withdrawn for reasons other than failure to meet
15 CME requirements or non-payment of dues, or who has previously been convicted of a felony offense
16 or whose license to practice has at any time been revoked, shall be further required to obtain the
17 endorsement of the secretary of the divisional society in the state, province, or foreign country in which
18 the applicant resides (or the endorsement of the secretary of the uniformed services divisional society in
19 the case of applicants currently serving in the uniformed services of the United States), or, lacking this
20 endorsement, an applicant who is in good standing in his community shall provide letters of
21 recommendation from three members of the Association and provide a personal written statement as
22 to why membership in the Association should be extended or restored. Such information and
23 application shall be carefully reviewed by the Committee on Membership, which shall make an
24 appropriate recommendation for reinstatement to the Board of Trustees.

25 An applicant whose license to practice is revoked or suspended, or who is currently serving a sentence
26 for conviction of a felony offense, shall not be considered eligible for membership in this Association.

27 *b. Honorary Life Member*

28 Honorary life membership shall be conferred on each president upon conclusion of his term of
29 office.

30 Such honorary life membership shall not exempt the holder thereof from the maintenance of regular
31 membership in his divisional society or from assessments levied by this Association.

32 Honorary life membership may also be conferred by the Board of Trustees on a regular member who
33 has been in good standing for 25 consecutive years immediately preceding, and who has rendered
34 outstanding service to the profession at either the state or national level, or who is recommended for
35 such a membership by official action of his divisional society and the Committee on Membership.
36 Such honorary life members shall have the privileges and duties of regular members including the
37 payment of assessments levied by the Association, but shall not be required to pay dues.

38 *c. Life Member*

39 Life membership may be granted to any regular member who has reached the age of 70 years, or who
40 has completed 50 years of osteopathic practice, whichever comes first, and who has been in good
41 standing for 25 consecutive years immediately preceding. The Committee on Membership may waive
42 this requirement on individual consideration. Such members shall have the privileges and duties of
43 regular members, but shall not be required to pay dues or assessments beginning the year in which the
44 age of 70 is attained.

1 Life membership may also be granted by the Board of Trustees or its Executive Committee on
2 recommendation of his divisional society, to any regular member who has become permanently totally
3 disabled. Such members shall have the privileges and duties of regular members, but shall not be
4 required to pay dues or assessments.

5 *d. Associate Member*

6 By specific action of the Board of Trustees, or its Executive Committee, associate memberships may be
7 granted to the following:

8 Graduates of accredited schools of medicine, dentistry or podiatry holding teaching, research or
9 administrative positions in AOA accredited healthcare facilities and colleges or who practice jointly
10 with regular members of this Association;

11 Doctors of philosophy or education and other nondoctoral personnel holding teaching, research or
12 administrative positions in AOA accredited healthcare facilities or colleges; administrative employees of
13 this Association, affiliated organizations and divisional societies; and any other professionals as
14 determined by the Board of Trustees, excepting osteopathic physicians and students in colleges of
15 osteopathic medicine.

16 Such associate members shall be required to pay dues and assessments as determined by these Bylaws.
17 They shall receive a complimentary online subscription to the Association's publications and shall be
18 eligible for such benefits as are periodically established by the Board of Trustees.

19 Associate members shall not be eligible for membership in the House of Delegates or the Board of
20 Trustees, or to hold any elective offices of this Association. Special listing in the *AOA Yearbook and*
21 *Directory of the Osteopathic Profession* shall be provided.

22 *e. Student Member*

23 Student membership status shall be granted to each undergraduate student in an approved college of
24 osteopathic medicine.

25 At such time as a student member graduates from his osteopathic college, he shall automatically
26 become enrolled as a regular member of the Association. Each student member shall receive such
27 publications and other literature, except the *AOA Yearbook and Directory*, as may be directed by the
28 Board of Trustees or the House of Delegates.

29 *f. Honorary Member*

30 By specific action of the Board of Trustees, honorary membership may be granted to individuals, not
31 eligible for any other category of membership, who support the goals and objectives of this
32 Association. Such honorary members shall not be required to pay dues or assessments. They shall
33 receive complimentary copies of the Association's publications and such other services as authorized by
34 the Board of Trustees. Honorary members shall not be eligible for membership in the House of
35 Delegates or the Board of Trustees, or hold any elective offices of this Association. Special listing in the
36 *AOA Yearbook and Directory* shall be provided.

37 Such membership, when conferred, shall remain in full force and effect unless revoked by action of the
38 Board of Trustees of the American Osteopathic Association.

39 *g. International Physician Members*

40 By specific action of the Board of Trustees, or its Executive Committee, international membership
41 may be granted to the following allopathic physicians who are:

42 Graduates of schools of medicine located outside of the United States on an official list of schools
43 recognized by the AOA, and holding a license for unlimited scope of medical practice including the

1 authority to prescribe without limitation in their country of practice, and these allopathic physicians
2 reside and practice outside of the United States and who support the goals and objectives of the AOA
3 and the AOA Code of Ethics

4 Such International Physician Members will be required to pay dues and assessments as determined by
5 these Bylaws. They shall receive a complimentary subscription to the Association's publications and
6 shall be eligible for such benefits as are periodically established by the Board of Trustees.

7 International Physician Members shall not be eligible for membership in the House of Delegates or
8 the Board of Trustees, or to hold any elective offices of this Association. Special listing in the *AOA*
9 *Yearbook and Directory* shall be provided.

10 *b. Allied Member*

11 By specific action of the Committee on Membership, allied membership may be granted to those
12 licensed allied healthcare providers who are currently employed, with an active member of the AOA,
13 contribute to the practice of that member, are not eligible for any other category of membership and
14 who support the goals and objectives of this Association.

15 Such allied members shall be required to pay dues and assessments as determined by these Bylaws.
16 They shall be eligible for such benefits as may periodically be determined by the Board of Trustees.

17 Allied members shall not be eligible for membership in the House of Delegates or the Board of
18 Trustees, or to hold any elective offices of this Association. Special listing in the *AOA Yearbook and*
19 *Directory* will be provided.

20 By specific action of the Committee on Membership, allied membership may be granted to
21 allopathic physicians holding an MD degree and licensed to practice in the United States who
22 support the AOA mission and subscribe to its Code of Ethics.

23 Individuals who have received their training and/or degree in osteopathic medicine from a school that
24 is not accredited by the AOA Bureau of Professional Education are not eligible for membership in the
25 AOA.

26 Section 3-Disciplinary Action

27 The membership of any member of the Association who, in the opinion of the Executive Committee
28 of the Association, purposely and persistently violates the established policy of the Association or who
29 seeks to undermine the unity of the osteopathic profession or of any of its divisional societies or
30 affiliated organizations may be revoked, suspended, or placed on probation by action of the Executive
31 Committee of the Association upon the recommendation of the Committee on Membership, after the
32 member has been given notice and an opportunity to be heard before such action is taken. Any
33 individual whose membership has been so revoked, suspended, or placed on probation shall have the
34 right of appeal to the Board of Trustees of the AOA at its next regular meeting, requesting a review of
35 the action of the Executive Committee, and the Board of Trustees, on review, may in its discretion
36 take such action in regard thereto as it deems appropriate.

37 Section 4-Continuing Medical Education

38 Regular members shall be required to satisfy Continuing Medical Education (CME) requirements. The
39 CME requirements shall be determined and administered by the Board of Trustees. Members who do
40 not meet the CME requirement are subject to such disciplinary action as is determined to be
41 appropriate by the Board of Trustees, including revocation of membership, suspension, censure or
42 probation.

43 **Article III - Dues and Assessments**

1 Section 1-Payment of Dues

2 The annual dues of regular members of the Association shall be payable in advance on or before 1
3 June, the beginning of the fiscal year.

4 A member whose dues shall remain unpaid for three months shall become suspended. He may be
5 reinstated upon payment of dues and assessments provided such payments are received prior to the
6 end of the current fiscal year, or, if later, by applying as a new member.

7 Section 2-Dues Rates

8 *a. Members*

9 The annual dues of all members of the Association (except for allied members discussed in section 2c
10 and student members discussed in section 2d, below) shall be determined by the House of Delegates
11 and administered by the Board of Trustees.

12 *b. Hardship Cases*

13 Upon recommendation of the Committee on Membership, the Board of Trustees, or its Executive
14 Committee, may remit a part or all of the annual dues of a member in good standing who, because of
15 physical disability, maintain a limited practice or no practice. For just cause, properly authenticated,
16 similar action may be taken by the Board of Trustees, or its Executive Committee, in regard to regular
17 members not otherwise specifically covered by other provisions of this Article.

18 *c. Allied Members*

19 The annual dues rates for allied members shall be determined and administered by the Board of
20 Trustees.

21 *d. Student Rate*

22 Student members shall not be liable for dues or any assessment.

23 *e. International Physician Members*

24 The annual dues rates for International Physician Members shall be determined and administered by
25 the Board of Trustees.

26 Section 3-Assessments

27 To meet emergencies the Board of Trustees may levy such assessments as may be necessary,
28 provided that the total of such assessments in any one-year shall not exceed the amount of the
29 annual dues. Failure to pay such assessments shall incur the same penalty as failure to pay dues.
30 Those dropped from membership for nonpayment of dues during the fiscal year in which an
31 assessment is levied shall be required to pay the assessment prior to reapplying for membership.

32 Section 4-Refunding Dues

33 No dues will be refunded if a membership is terminated for cause or because of resignation.

34 **Article IV - Code of Ethics**

35 Section 1

36 The House of Delegates shall establish a Code of Ethics for the information and guidance of the
37 members. Members of the Association, in their daily conduct, shall comply with the provisions of the
38 Code of Ethics. The Code shall cover duties of physicians to patients, duties of physicians to other
39 physicians and to the profession at large, and responsibilities of physicians to the public. The House
40 of Delegates shall not adopt any provisions of the Code of Ethics, which may be in conflict with the
41 Constitution or Bylaws of the Association.

1 Section 2

2 The Code of Ethics may be amended by the House of Delegates at any annual meeting by two-thirds
3 vote of the total number of delegates accredited for voting, provided a copy of the proposed
4 amendment is deposited with the Chief Executive Officer at least 90 days before the annual meeting
5 at which it is to be voted upon.

6 It shall be the duty of the Chief Executive Officer to have the proposed amendment distributed by
7 first class mail, postage prepaid, to each divisional and specialty society entitled to send voting
8 representatives to the House of Delegates, posted on the AOA's website, and published in *The Journal*
9 *of the American Osteopathic Association* not later than one month before the annual meeting at which the
10 amendment is scheduled for consideration.

11 The American Osteopathic Association has formulated this Code to guide its member physicians in
12 their professional lives. The standards presented are designed to address the osteopathic physician's
13 ethical and professional responsibilities to patients, to society, to the AOA, to others involved in
14 healthcare and to self.

15 Further, the American Osteopathic Association has adopted the position that physicians should play a
16 major role in the development and instruction of medical ethics.

17 **Article V - House of Delegates**

18 Section 1-Certification of Delegates and Alternates

19 *a. Divisional Societies*

20 The Chief Executive Officer of this Association shall furnish to the secretary of each divisional
21 society, 75 days before the first day of the annual meeting of the House of Delegates, a statement of
22 the number of regular members of this Association located in the area represented by that divisional
23 society or, in the case of the uniformed services divisional society, the number of regular members
24 of this Association currently serving in the uniformed services of the United States.

25 Based on that statement, each divisional society shall select, in a manner prescribed by its
26 Constitution and Bylaws, the number of delegates (and their alternates) to the House of Delegates of
27 this Association to which it is entitled under the provisions of the Constitution of the American
28 Osteopathic Association. Delegates and alternates must be regular or student members in good
29 standing of this Association and of the divisional societies, which they represent. Delegates (and
30 their alternates) shall serve during the annual meeting of the House of Delegates and during the
31 interim between annual meetings or until their successors are elected. The secretary of each
32 divisional society shall certify its delegates and alternates to the Chief Executive Officer of this
33 Association in writing at least 30 days prior to the first day of the annual meeting of the House of
34 Delegates.

35 In the event that any state, provincial or foreign osteopathic association does not become a
36 chartered divisional society, the regular members of this Association in that jurisdiction, at a
37 regularly called meeting, may elect or appoint one delegate (and alternate) as their representative in
38 the House, and such delegate (and alternate) shall be accredited in the same manner and have the
39 same privileges as those of a divisional society.

40 *b. Specialty Colleges*

41 Each AOA recognized specialty college shall select one delegate and at least one alternate to the AOA
42 House of Delegates in a manner prescribed in its constitution and Bylaws. No specialty college delegate
43 or alternate shall also be a member of the divisional society's delegation to CONCURRENTLY
44 SERVE AS A DELEGATE FOR A DIVISIONAL SOCIETY AT the AOA's House of Delegates.

1 The Secretary of each specialty college shall certify the name of its delegate and alternate to the Chief
2 Executive Officer of the AOA at least 30 days prior to the first day of the annual meeting of the AOA
3 House of Delegates. Each delegate and alternate must be a member in good standing of this association
4 and his specialty college.

5 Section 2-Voting

6 Each delegate shall have one vote in the House, except when one-fourth of the members present shall
7 call for the yeas and nays on any question; the Chief Executive Officer shall, before any other motion
8 can be made, call the roll by divisional societies and enter the yeas and nays in the record. In recording
9 such vote each divisional society shall be given one vote for each 20 regular members of the American
10 Osteopathic Association located in the area represented by that divisional society (or in the case of the
11 uniformed services divisional society, one vote for each 20 regular members of the American
12 Osteopathic Association currently serving in the uniformed services of the United States), as certified
13 to 75 days before the annual meeting of the House of Delegates under the requirements of Section 1
14 of this Article, and such votes may be cast by any one of the delegation then seated or divided among
15 the various members of the delegation as the delegation in caucus shall decide.

16 Section 3-Committee on Credentials

17 The Committee on Credentials shall consist of three or more members appointed by the President and
18 it shall be the duty of the Committee to receive and validate the credentials of the delegates to the
19 House and to report all delegates entitled to be seated in the House. The Chief Executive Officer shall
20 furnish the Credentials Committee a list showing the number of delegates to which each divisional
21 society is entitled. In case any organization has selected more than its legal representation, the Chief
22 Executive Officer shall drop surplus names from the list, beginning at the bottom, and shall notify the
23 divisional society of his action.

24 Section 4-Seating of Delegates

25 A delegate having been seated shall remain the accredited delegate throughout the meeting. In the
26 event that an accredited delegate has failed to qualify and assume his seat when the House convenes on
27 the second day of the meeting, his accredited alternate may be seated. If a delegate, having been seated,
28 finds himself unable to be present on account of physical disability or other cause acceptable to the
29 House, his alternate may be seated for that roll call period and shall continue as delegate until the
30 previously seated delegate shall return for duty at a subsequent roll call. In that case the alternate
31 delegate who has been seated may, by direction of the House, be dropped from the roll and the
32 previously seated delegate shall return to his seat in the House.

33 Section 5-Annual Meeting

34 The annual meeting of the House of Delegates shall be held during June, July or August, and separate
35 from the annual convention or clinical assembly of the Association, upon call of the President.
36 Special sessions of the House of Delegates may be called by the President. The delegates shall be
37 given at least two weeks notice and the object or objects shall be stated in the call of such special
38 meeting.

39 Section 6-Presiding Officer

40 The Speaker of the House of Delegates shall be its presiding officer. The Vice Speaker shall preside
41 over the House of Delegates in the absence of or at the request of the Speaker and assume all duties of
42 the Speaker.

43 Section 7-New Business

44 No new business shall be introduced on the last day of the meeting of the House of Delegates
45 except by a two-thirds consent of those members present, provided two-thirds of the seated

1 delegates are in attendance.

2 Section 8-Quorum

3 One-half of the accredited delegates of the House shall constitute a quorum.

4 Section 9-Governing Rules

5 The meetings of the House of Delegates and of all other bodies of this Association shall be governed
6 by Robert's Rules of Order Newly Revised, except in such instances as are specifically provided for in
7 the Constitution and Bylaws of the Association or in the order of business which may be adopted from
8 time to time. The order of business and any special rules adopted at the beginning of the meeting shall
9 govern the procedure unless unanimously suspended.

10 Section 10-Representation of Student Councils

11 The student council of each accredited college of osteopathic medicine and each branch campus may
12 be represented in the House of Delegates by its president (and such president's alternate elected by
13 such student council) as a member of the delegation of the divisional society representing the state in
14 which such college of osteopathic medicine and branch campus is located. Each such student delegate
15 shall be accredited in the same manner and have the same privileges as the other members of the
16 divisional society delegation; however, the chief administrative officer of each accredited college of
17 osteopathic medicine and each branch campus shall certify the student council president and alternate
18 to the Chief Executive Officer of this Association in writing or by electronic communication at least
19 30 days prior to the first day of the annual meeting of the House of Delegates and such Chief
20 Executive Officer shall forthwith similarly certify each student council president and alternate to the
21 secretary of the appropriate divisional society.

22 Section 11-Representation of Osteopathic Physicians In Postdoctoral Training TRAINEES AND/OR
23 NEW PHYSICIANS IN PRACTICE

24 Osteopathic ~~physicians in postdoctoral training~~ TRAINEES AND/OR NEW PHYSICIANS IN
25 PRACTICE may be represented in the House of Delegates by two individuals who, at the time of the
26 annual meeting, shall be enrolled in postdoctoral training programs OR CURRENTLY A NEW
27 PHYSICIAN IN PRACTICE AS DEFINED BY THE ASSOCIATION. The two individuals and
28 their alternates shall be selected by vote of the AOA's ~~Council of Interns and Residents~~ BUREAU OF
29 EMERGING LEADERS (BEL). The delegates (and alternate delegates) selected by the ~~Council of~~
30 ~~Interns and Residents~~ BEL shall serve as the representatives of osteopathic ~~physicians in postdoctoral~~
31 ~~training~~ TRAINEES AND NEW PHYSICIANS IN PRACTICE. ~~and THESE DELEGATES shall not~~
32 ~~also be members of a divisional society or specialty college delegation to the AOA's~~ INDIVIDUALS
33 SERVING AS A BEL DELEGATE SHALL NOT CONCURRENTLY SERVE AS A DELEGATE
34 FOR ANY OTHER GROUP AT THE AOA House of Delegates. The ~~chair of the Council of Interns~~
35 ~~and Residents~~ CHAIR OF THE BEL shall certify the names of its delegates and alternate delegates to
36 the Chief Executive Officer of the AOA in writing or by electronic communication at least 30 days
37 prior to the first day of the annual meeting of the AOA House of Delegates. Each delegate and
38 alternate must be a member in good standing of this Association.

39 Section 12-Representation of Student Osteopathic Medical Association

40 The Student Osteopathic Medical Association (SOMA) may be represented in the House of Delegates
41 by one member of the SOMA Board selected by vote of the SOMA Board (or such SOMA member's
42 alternate, who shall also be a member of the SOMA Board selected by the SOMA Board). No SOMA
43 delegate or alternate shall also be a member of a divisional society's delegation representing the state in
44 which such SOMA Board member's osteopathic college is located. The SOMA delegate shall be
45 accredited in the same manner and have the same privileges as the other members of the divisional

1 society delegation; however, the Chief Administrative Officer of SOMA shall certify the SOMA
2 delegate and alternate to the Chief Executive Officer of this Association in writing or by electronic
3 communication at least 30 days prior to the first day of the annual meeting of the House of Delegates.

4 **Article VI—Elections**

5 Section 1--Qualifications

6 Except where positions are designated as public members, membership in both the AOA and a
7 divisional society shall be a requisite for qualification for any officer or for any member of any
8 department, division, bureau or committee of the Association, however selected, if the incumbent
9 shall be an osteopathic physician.

10 Section 2--Nominations

11 Nomination of all officers and trustees of this Association, and nomination of the Speaker and Vice
12 Speaker of the House of Delegates, excepting nomination of those otherwise provided for in the
13 Constitution, shall be a regular order of business in the House of Delegates at the annual meeting of
14 the House. Nominations may be made from the floor immediately preceding the balloting.
15 Nominating speeches shall not exceed two minutes.

16 Section 3--Method of Election

17 Election of such officers and trustees as are elected by the House of Delegates shall take place during
18 the last day of the annual meeting. All elections shall be by ballot except as hereinafter provided in this
19 section and a majority of all votes cast shall be necessary to elect. In recording such vote, each
20 divisional society shall be given one vote for each 20 regular members of the American Osteopathic
21 Association located in the area or serving in the uniformed services of the United States represented by
22 that division, and such votes may be cast by any one of the delegation then seated or divided among
23 the various members of the delegation as the delegation in caucus shall decide. If there shall be but one
24 nominee for a given office or trusteeship it shall be the duty of the secretary to cast the elective ballot
25 for that nominee. The Speaker and Vice Speaker of the House shall be elected to serve for one year or
26 until their successors are elected and installed.

27 Section 4--Installation

28 The officers who have served throughout that meeting shall complete all business of the annual
29 meeting so far as is practicable. The officers-elect shall be installed as the final order of business and
30 shall assume the authority of their respective offices upon adjournment of the meeting.

31 **Article VII--Board of Trustees**

32 Section 1--Duties

33 The Board of Trustees shall:

- 34 a. Direct the management of the affairs of the Association between annual meetings. It shall
35 meet coincident with the annual meeting of the House of Delegates and at other times on call
36 of the President, shall make all arrangements for the annual meetings, shall appoint all
37 standing and special committees not otherwise provided for in these Bylaws, and may fill by
38 appointment any vacancy occurring in its own membership or any other elective office until
39 the time of the next meeting of the House of Delegates. A quorum of the Board shall be a
40 majority of the members thereof.
- 41 b. Appoint a Chief Executive Officer, a Controller, a General Counsel, and an Editor, and shall
42 fix the amount of their salaries and the length of their terms of office. It shall fix the duties of
43 the Chief Executive Officer, Controller, General Counsel, Editor and all other officials,
44 committees, departments and bureaus necessary to the proper execution of the policies of the

1 Association and not fixed by these Bylaws.

- 2 c. Have the responsibility of management of the finances of the Association and shall authorize
3 and supervise, the House of Delegates concurring, all expenditures thereof. It shall appoint a
4 certified public accountant to audit the financial records of the Association and certify to the
5 accuracy of the statement of financial condition of the Association to be reported at the
6 annual meetings.

7 No appropriation shall be made by the House of Delegates except upon recommendation of
8 the Bureau of Finance approved by the Board of Trustees, and all resolutions, motions or
9 otherwise, having for their purpose the appropriation of funds, shall first be referred without
10 discussion to the Bureau of Finance of the Board of Trustees. An adverse ruling on such
11 motions may be overruled by a three-fourths vote of the House of Delegates.

- 12 d. Provide for the publication of an official journal of the Association and such other
13 publications as are deemed necessary or shall be directed by the House of Delegates

- 14 e. Maintain and revise the Administrative Guide annually. The general purpose of this manual
15 shall be to provide a handy reference book of concise statements of the duties of all officials,
16 committees, departments, bureaus and employees of the Association, to the end that there
17 shall be no conflict of jurisdiction or duplication of effort. Copies of such Guide shall be
18 furnished to each divisional society and affiliated organization as well as officers of the
19 American Osteopathic Association and other groups or individuals as directed by the Board
20 of Trustees of the Association.

- 21 f. Establish such departments, committees, bureaus, councils, and commissions, and authorize
22 the president's creation of such task forces, as shall be necessary to further the policies of the
23 Association and determined by the House of Delegates and shall determine the duties and
24 powers of such departments, committees, bureaus, councils, commissions and task forces.

- 25 g. Approve from its own membership, based on the President's appointment, the chairs of the
26 departments. The department chairs shall direct the activities of their respective
27 departments. However, the public member of the board shall not be eligible to serve as a
28 department chair. The Board shall also approve, based on the President's appointment, the
29 members of the various committees, bureaus, councils, commissions and task forces under
30 the departments

- 31 h. Decide finally all questions of an ethical or judicial character. It shall have investigated by the
32 Committee on Ethics all charges or complaints of violation of the Constitution, Bylaws, or of
33 grossly unprofessional conduct of any member. The Board shall have the power to censure,
34 place on probation for not exceeding a three-year period, suspend for not exceeding a three-
35 year period or expel a member, as the findings warrant. A member may be cited to appear
36 before it by the Board of Trustees or the Committee on Ethics to answer charges or
37 complaints of unethical or unprofessional conduct. Upon the final conviction of any member
38 of an offense amounting to a felony under the law applicable thereto, or the final revocation
39 of, or suspension of, his license to practice in a state on the grounds of having committed a
40 violation of a disciplinary provision of the licensing law by a duly constituted state licensing
41 agency, or the voluntary surrender of his license while under charges of having committed
42 said violation, such member shall automatically be deemed expelled from membership in this
43 Association; a conviction shall be deemed final for the purposes hereof when affirmed by an
44 appellate tribunal of final jurisdiction or upon expiration of the period allowed for appeal.
45 The Committee on Membership shall be granted the authority to restore to membership a

1 doctor whose license was revoked, and later retroactively reinstated by his licensing board.

2 If, because of a breach of the Code of Ethics, a member shall have been suspended, or
3 expelled from a divisional society or affiliated organization by proper action of such
4 divisional society or affiliated organization, the Board of Trustees of this Association shall
5 review the record of such decision. The decision may first be referred to the Committee on
6 Ethics for recommendations. If the Board shall concur in the action of the divisional society
7 or affiliated organization, such member shall be suspended for the same period of time or
8 expelled from this Association upon the same basis as in the decision of the divisional society
9 or affiliated organization. The Board is authorized to adopt and amend from time to time, in
10 the manner directed by the Board, a Guide for Administrative Procedure regulating the
11 procedure applicable to matters involving violations of the Code of Ethics.

12 Section 2--Appeal

13 A minority of one-third or more members of the Board of Trustees present at any session may
14 appeal to the House of Delegates from the decision of the majority on any question at the current
15 meeting.

16 Section 3--Executive Committee

17 The Executive Committee shall transact the business of the Board of Trustees between meetings.

18 Section 4--By-Mail Vote

19 Between meetings of the Board of Trustees and of the Executive Committee, a by-mail vote, or vote
20 by other means of electronic communications, on any urgent matter may be taken of the members of
21 the Board of Trustees, or Executive Committee, if a consent in writing setting forth the action so
22 taken shall be signed by all of the trustees or members of the Executive Committee entitled to vote
23 with respect to the subject matter thereof, any such vote to be entered into the records at the next
24 meeting of the Board.

25 Section 5--Indemnification

26 Each trustee, officer, and employee of this Association now or hereafter in office and his heirs,
27 executors, and administrators, and each trustee, officer, and employee of this Association and his heirs,
28 executors, and administrators who now acts, or shall hereafter act at the request of this Association as
29 employee, trustee, director, or officer of another corporate entity controlled by this Association, shall
30 be indemnified by this Association against all costs, expenses, judgments, fines, and amounts or
31 liability therefore, including counsel fees, reasonably incurred by or imposed upon him in connection
32 with or resulting from any action, suit, proceeding, or claim to which he may be made a party, or in
33 which he may be or become involved by reason of his acts of omission or commission, or alleged acts
34 of omission or commission as such trustee, officer, or employee, or, subject to the subsequent
35 provisions of the section, any settlement thereof, whether or not he continues to be such trustee,
36 officer, or employee at the time of incurring such costs, expenses, judgments, fines or amounts,
37 provided that such indemnification shall not apply with respect to any matters as to which such
38 trustee, officer, or employee shall be finally adjudged in such action, suit, or proceeding to have been
39 individually guilty of misconduct, misfeasance, or malfeasance in the performance of his duty as such
40 trustee, officer, or employee. The indemnification herein provided shall, with respect to any settlement
41 of any such suit, action, proceeding, or claim, include reimbursement of any amounts paid and
42 expenses reasonably incurred in settling any such suit, action, proceeding, or claim, when the Board of
43 Trustees has determined that such settlement and reimbursement appear to be for the best interests of
44 this Association. Such determination shall be made (1) by the Board of Trustees or by a majority vote
45 of a quorum consisting of trustees who were not parties to such action, suit, or proceeding, or (2) if
46 such a quorum is not obtainable (or, even if obtainable, a quorum of disinterested trustees so directs)

1 by independent legal counsel in a written opinion. The foregoing right of indemnification shall be in
2 addition to and not exclusive of any and all other rights as to which any such trustee, officer, or
3 employee may be entitled under any bylaw, agreement, or otherwise.

4 Expenses incurred in defending a civil or criminal action, suit, or proceeding may be paid by the
5 Association in advance of the final disposition of such action, suit, or proceeding as authorized by
6 the Board of Trustees or Executive Committee in the manner heretofore provided, upon receipt of a
7 written undertaking by or on behalf of the trustee, officer, or employee to repay such amount unless
8 it shall ultimately be determined that he is entitled to be indemnified by the Association as authorized
9 in this section.

10 The Board of Trustees may authorize the Association to purchase and maintain insurance on behalf of
11 any person who is or was a trustee or employee of the Association or is or was serving at the request
12 of the Association as a trustee, director, officer, employee, or agent of another corporate entity
13 controlled by the Association against any liability asserted against him and incurred by him in any such
14 capacity, or arising out of his status as such, whether or not the Association would have the authority
15 or power to indemnify him against such liability under the provisions of this section.

16 **Article VIII--Duties of Officers**

17 Section 1--President

18 The President shall be the chairman of the Board of Trustees and of the Executive Committee and
19 shall perform the duties usually pertaining to his office. He shall nominate, subject to approval by the
20 Board of Trustees, all appointive officers, unless otherwise specified in the Bylaws and in accordance
21 with the directives contained in the Administrative Guide or as established by the Board of Trustees
22 or the House of Delegates.

23 Section 2--President-elect

24 The President-elect shall perform the duties of the office of the President in the absence of or at the
25 request of the President.

26 Section 3--Vice-Presidents

27 The Vice-Presidents, in the order of their designation and in the absence or at the request of the
28 President and President-elect, shall perform the duties of the office of the President.

29 Section 4--Speaker/Vice-Speaker of the House of Delegates

30 The Speaker or the Vice-Speaker of the House of Delegates shall perform such duties as custom and
31 parliamentary usage require. The Speaker shall appoint reference committees of the House to perform
32 functions for which they are created subject to the approval of the House. He shall have such other
33 privileges and duties as may be assigned to him by the House of Delegates, which privileges and duties
34 shall not be in conflict with the privileges and duties assigned by the Constitution and Bylaws to other
35 officers of the Association. The Vice-Speaker of the House of Delegates shall assume the duties of the
36 Speaker in his absence or at his request.

37 Section 5--Chief Executive Officer

38 The Chief Executive Officer shall:

- 39 a. Be the chief administrative officer of the Association and of the central office. He shall be
40 the executive and recording secretary of the Association. He shall counsel with the other
41 administrative officers and with the heads of departments in the central office to produce
42 the greatest possible cooperation and efficiency in the conduct of the affairs of the
43 Association under the President and the Board of Trustees. He shall cooperate with the
44 chairmen of various agencies of the Association in the execution of the policies of the

1 Association as outlined by the House of Delegates. It shall be his duty to coordinate the
2 work performed by the various departments, bureaus, and committees of the Association.

- 3 b. Direct the joint activities of the Association and the divisional societies as provided by the
4 Bylaws, and may select one or more of the trustees or like officers of the divisional societies,
5 to assist him in this work in their respective areas.
- 6 c. Be responsible for the correspondence of the Association and shall keep accurate record of the
7 proceedings of the House of Delegates and the Board of Trustees. d. Be responsible for the
8 supervision of assistance to the divisional societies in all matters according to the policies laid
9 down by the Association and for the supervision of the execution of plans of the Association
10 with regard to colleges, affiliated organizations and campaigns.
- 11 d. Keep on file an accurate record of all transactions of his office, which shall at any time be
12 subject to examination by the President or the Board of Trustees, shall make an annual report
13 to the House of Delegates and Board, and shall perform such other duties as are prescribed by
14 the Board not in conflict with the Constitution and Bylaws of this Association.
- 15 e. Be the statistical officer of the Association, and shall have charge of the archives, including
16 legal, historical and scientific records of value to the Association.
- 17 f. Be authorized to provide such assistance as is necessary for the proper conduct of the
18 central office, subject to the directives of the Board of Trustees, and at the expiration of his
19 term shall deliver to his successor all property and papers pertaining to his office. He shall
20 file bond with such surety company and in such amount as the Board of Trustees shall
21 determine.

22 Section 6--Controller

23 The Controller shall:

- 24 a. Have charge of the funds and assets of the Association, cooperate with the Chief Executive
25 Officer and Editor under the direction of the Board of Trustees, and disburse such funds
26 only in the manner prescribed by the Board of Trustees.
- 27 b. Be responsible for the collection of dues and assessments as provided in these Bylaws; shall
28 cooperate with like officers of the divisional societies and may delegate them to assist him in
29 their respective societies.
- 30 c. Keep on file accurate records of the transactions of his office, which shall at all times be
31 subject to examination by the Board of Trustees. He shall prepare reports quarterly for the
32 Board of Trustees and annually for the House of Delegates and the Board, and at the
33 expiration of his employment; he shall deliver to his successors or to the Board, or their
34 assigned agent, all monies, records and other property of the Association subject to his
35 jurisdiction. He shall perform such other duties as may be prescribed by the Board
36 consistent with the Constitution and Bylaws of the Association.
- 37 d. Be provided with such assistance as is necessary to the proper conduct of his office, subject to
38 the directives of the Board of Trustees through the Chief Executive Officer. He shall file
39 bond with such surety company and in such sum as the Board of Trustees may determine.

40 Section 7--General Counsel

41 The General Counsel shall:

- 42 a. Be the chief legal officer of the Association, responsible for oversight and management of all
43 legal services provided to the Association, its trustees, officers and staff to ensure protection

1 of the Association’s legal rights and maintenance of its operations consistent with the limits
2 established by law.

- 3 b. Provide legal advice and guidance to the trustees, officers, and staff, bureaus, councils, task
4 forces, commissions and committees of the Association on the legal implications of matters
5 relevant to the Association, including compliance with federal, state, and local laws and
6 regulations applicable to a tax-exempt, not-for-profit membership organization and adherence
7 to internal organizational policies and procedures.
- 8 c. Draft and review contracts and other legal documents, policies and procedures; research
9 pertinent to legal issues; prepare written and oral opinions and position statements on issues
10 identified by the Association’s trustees, officers, staff, bureaus, councils, task forces,
11 commissions and committees;
- 12 d. Represent or coordinate the representation of the Association in judicial and administrative
13 proceedings; and
- 14 e. Select and retain outside counsel, as required, to obtain legal opinions or to handle claims
15 and litigation. Supervises legal work of other Association attorneys and outside counsel.

16 Section 8--Editor

17 The Editor shall:

- 18 a. Have the editorial direction, in accordance with the established policies of the Board of
19 Trustees and House of Delegates, of *The Journal of the American Osteopathic Association*, other
20 periodical publications of the Association and of the *AOA Yearbook and Directory*, under the
21 general supervision of the Chief Executive Officer, and shall cooperate with all departments
22 of the central office.
- 23 b. Be provided with such assistance as is necessary to the proper conduct of his office, subject
24 to the directives of the Board of Trustees through the Chief Executive Officer.

25 **Article IX--Departments, Bureaus, and Committees**

26 The Board of Trustees and House of Delegates, consistent with the powers given to it by these
27 Bylaws, shall establish and determine the duties of departments, bureaus, councils, commissions,
28 committees, and task forces necessary to further the policies of the Association. The Association’s
29 departments shall include the Departments of Affiliated Affairs, Business Affairs, Educational Affairs,
30 Governmental Affairs, Professional Affairs, and Research, Quality & Public Health. The activities of
31 all departments, bureaus and committees shall, so far as possible, be executed in close cooperation
32 with the Chief Executive Officer. Upon the expiration of the terms of office of chairs and members of
33 the departments, bureaus, or committees, all records of the same shall be delivered by the chairs to the
34 Chief Executive Officer. All employed staff of departments, bureaus, and committees in the offices
35 shall be under the jurisdiction of the Chief Executive Officer.

36 **Article X--Conventions and Meetings**

37 Whenever referred to in this Constitution and Bylaws, the words annual meeting shall refer to the
38 annual meetings of the Board of Trustees or of the House of Delegates, respectively, and the words
39 annual convention or clinical assembly shall refer to the annual clinical assembly of the Association.

40 Section 1--Annual Clinical Assembly

41 The annual clinical assembly shall be held at such time and place as may be determined by the Board
42 of Trustees, provided, however, such action may be changed by the House of Delegates by a two-

1 thirds vote of the total number of delegates accredited for voting.

2 Section 2--Annual Meetings

3 The annual meetings of the Board of Trustees shall be held at such time and place as may be
4 determined by the Board of Trustees, provided, however, such action may be changed by the House of
5 Delegates by a two-thirds vote of the total number of delegates accredited for voting.

6 **Article XI—Amendments**

7 Section 1--Bylaws

8 These Bylaws may be amended at any annual or special meeting of the House of Delegates by a two-
9 thirds vote of the total number of delegates accredited for voting, provided that the amendment shall
10 have been filed with the Chief Executive Officer at least two months before the meeting at which the
11 amendment is to be voted upon. Upon receiving a copy of the amendment, it shall be the duty of the
12 Chief Executive Officer to cause it to be distributed by first class mail, postage paid, to each divisional
13 and specialty society entitled to send voting representatives to the House of Delegates, posted on the
14 AOA’s website, and published in *The Journal of the American Osteopathic Association* at least one month
15 before the meeting. The Board of Trustees may revise the proposed amendment if necessary to secure
16 conformity to this Constitution and Bylaws and shall then refer it to the House for final action not
17 later than the day prior to the end of the meeting.

18 Section 2--Articles of Incorporation

19 The Articles of Incorporation of this Association may be amended by the adoption of a resolution by
20 the Board of Trustees setting forth the proposed amendment and directing that the amendment be
21 submitted to a vote at a meeting of the House of Delegates, which may be either an annual or a special
22 meeting. Written or printed notice setting forth the proposed amendment or a summary of the changes
23 to be effected thereby shall be posted on the AOA’s website and delivered not less than five nor more than
24 40 days before the date of the meeting, either personally or by mail, by or at the direction of the
25 President, or the Chief Executive Officer, or the officers or persons calling the meeting, to each
26 delegate entitled to vote at such meeting.

27 Written or printed notice shall include the printing of the amendment in the electronic and/or printed
28 issue of *The Journal of the American Osteopathic Association* published not less than five days or more than
29 40 days before the date of the meeting. The proposed amendment shall be adopted upon receiving at
30 least two-thirds of the votes entitled to be cast by the total number of delegates accredited for voting.

31 **Article XII--Gender Disclaimer**

32 The American Osteopathic Association is open to persons of both sexes and does not discriminate
33 against any person because of sex; therefore, the wording herein importing the masculine or feminine
34 gender includes the other gender and imports no such discrimination.

SUBJECT: AMENDMENT TO THE AOA CONSTITUTION – CHANGE TO TERM LIMIT FOR MEMBERS OF THE BOARD OF TRUSTEES

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS) / CAGOS Constitution & Bylaws Subcommittee

REFERRED TO: Committee on Constitution & Bylaws

1 WHEREAS, the AOA Board of Trustees in July 2017 approved a resolution calling for a
2 reduction of the term limit for service on the Board of Trustees from 12 years to 9
3 years; and

4 WHEREAS, changing the term limit requires an amendment to the AOA Constitution; and

5 WHEREAS, the proposed amendment were presented to the July 2018 House of Delegates for
6 its first reading; now, therefore be it

7 RESOLVED, that the following amendment to the AOA Constitution be approved:

8 Old material crossed out (~~crossed-out~~) | New material in CAPS

9 **Article VIII—Board of Trustees and Executive Committee**

10 Section 3—Term Limit

11 For all trustees ELECTED PRIOR TO JULY 2019, with the exception of the President, President-Elect
12 and the Past Presidents for the preceding two years, the aggregate terms of the Office of Trustees shall be
13 limited to twelve (12) years, with the exception that a trustee may complete the term in which twelve (12)
14 years or more of service is completed. FOR ALL TRUSTEES ELECTED IN OR AFTER JULY 2019,
15 WITH THE EXCEPTION OF THE PRESIDENT, PRESIDENT-ELECT, AND THE PAST
16 PRESIDENTS FOR THE PRECEDING TWO YEARS, THE AGGREGATE TERMS OF OFFICE OF
17 TRUSTEES SHALL BE LIMITED TO NINE (9) YEARS, WITH THE EXCEPTION THAT A
18 TRUSTEE MAY COMPLETE THE TERM IN WHICH NINE (9) YEARS OR MORE OF SERVICE IS
19 COMPLETED. Time served as a student member, intern/resident member, or as new physician in
20 practice member shall not be included in calculating the ~~twelve~~ years of service ON THE BOARD OF
21 TRUSTEES.

HOD Reference Committee Explanatory Statement:

The Committee believes that the proposed nine-year term limit would not provide sufficient time to ensure proper maturation of Trustees before ascending to the position of President-elect and President. The additional three years under the current term limit allows for time needed to develop the breadth of expertise and leadership competence.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: EXECUTIVE COMMITTEE OF THE AOA BOARD OF TRUSTEES,
COMPOSITION OF

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Constitution & Bylaws

1 WHEREAS, the AOA Board of Trustees in July 2017 approved a resolution calling for the
2 elimination of the position of Vice Chair of the Department of Educational Affairs, to
3 be effective in July 2020, following significant completion of the transition to a single
4 accreditation system; and

5 WHEREAS, the defined composition of the Executive Committee of the American
6 Osteopathic Board of Trustees includes the Vice Chair of the Department of
7 Educational Affairs; and

8 WHEREAS, there will no longer be a Vice Chair of the Department of Educational Affairs in
9 July 2020; and

10 WHEREAS, the Board of Trustees has approved the following amendment to the AOA
11 Constitution for consideration of the AOA's House of Delegates in July 2019; and

12 WHEREAS, the proposed amendment were presented to the July 2018 House of Delegates for
13 its first reading; now, therefore be it

14 RESOLVED, that the following amendment to the AOA Constitution be approved:

15 Old material crossed out (~~crossed-out~~) | New material in CAPS

16 **AOA Constitution**

17 **Article VIII—Board of Trustees and Executive Committee**

18 Section 2—Executive Committee

19 The Executive Committee of this Association shall consist of the President, President-elect,
20 Past Presidents for the preceding two years, the chairs of the Departments of Affiliate Affairs
21 RELATIONS, Business Affairs, EDUCATIONAL AFFAIRS, Governmental Affairs,
22 Professional Affairs, AND Research, Quality, and Public Health, ~~and the Chair and Vice Chair~~
23 ~~of the Department of Educational Affairs.~~

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: AOA BOARD OF TRUSTEES – PUBLIC MEMBER POSITION

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Constitution & Bylaws

- 1 WHEREAS, the American Osteopathic Association (AOA) has not filled the public member
2 position on the Board of Trustees since the position was first authorized by the Board
3 of Trustees; and
- 4 WHEREAS, the AOA recognizes the value of a public member on those bureaus, councils and
5 committees that are directly involved in public functions, such as accreditation and
6 certification; and
- 7 WHEREAS, there are public members on the Commission on Osteopathic College
8 Accreditation and the Bureau of Osteopathic Specialists; and
- 9 WHEREAS, the AOA’s Board of Trustees engages in certain private organizational decisions
10 regarding the future of the osteopathic profession; and
- 11 WHEREAS, the AOA Board of Trustees will retain the ability to invite appropriate experts and
12 other resources to join its discussions when such input is desired, without formally
13 designating such individuals as a public member; and
- 14 WHEREAS, the proposed amendment were presented to the July 2018 House of Delegates for
15 its first reading; now, therefore be it
- 16 RESOLVED, that the AOA eliminate the public member position from the Board of Trustees;
17 and be it further
- 18 RESOLVED, that the following amendment to the AOA Constitution and the AOA Bylaws be
19 approved:

20 Old material crossed out (~~crossed-out~~) | New material in CAPS

21 **AOA Constitution**

22 Article VIII - Board of Trustees and Executive Committee

23 Section 1-Board of Trustees

24 The Board of Trustees shall be the administrative and executive body of the association and
25 perform such other duties as are provided by the bylaws. The Board of Trustees of this
26 association shall consist of TWENTY-EIGHT ~~twenty-nine~~ members.

27 A. Seven elected officers: The President, President-Elect, The Past Presidents for the preceding
28 two years, First Vice-President, Second Vice-President, and Third Vice-President;

29 B. Eighteen at-large trustees, six of whom shall be elected annually by the House of Delegates
30 to serve for three years;

1 C. One new physician in practice member elected by the House of Delegates to serve for one
2 year. Candidates for the new physician in practice position shall be osteopathic physicians who
3 have completed their postdoctoral training within the past five years or received the DO degree
4 within the previous ten years shall be nominated by the council of new physicians in practice;

5 D. One intern/resident member elected by the house of delegate to serve for one year.
6 Candidates for the intern/resident position shall be enrolled in an AOA-approved internship or
7 residency or, if enrolled in an ACGME-approved residency shall have applied for an AOA
8 approval of the ACGME-Approved residency. Candidates for the intern/resident position shall
9 be nominated by the council of interns and residents; AND

10 E. One student member elected by the House of Delegates to serve for one year. Candidates
11 for the student position shall be nominated, in altering years, by the Council of Osteopathic
12 Student Government Presidents (COSGP) and the Student Osteopathic Medical Association
13 (SOMA); ~~and~~

14 ~~F. One public member elected by the House of Delegates to serve for a three-year term, with a~~
15 ~~one-term limit. Candidates for the public member position shall not be physicians and shall be~~
16 ~~nominated by the committee on administrative personnel~~

17 **AOA Bylaws**

18 Article VII - Board of Trustees

19 Section 1-Duties

20 The Board of Trustees shall:

21 g. Approve from its own membership, based on the President's appointment, the chairs of the
22 departments. The department chairs shall direct the activities of their respective departments.

23 ~~However, the public member of the board shall not be eligible to serve as a department chair.~~

24 The Board shall also approve, based on the President's appointment, the members of the
25 various committees, bureaus, councils, commissions and task forces under the departments.

ACTION TAKEN APPROVED

DATE July 27, 2019

SUBJECT: AOA HOUSE OF DELEGATES VOTING RULES

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Constitution & Bylaws

1 RESOLVED, that the following proposed amendments to the American Osteopathic
2 Association (AOA) Bylaws will provide for all voting of the AOA House of Delegates
3 to be one vote per delegate system; and be it further

4 RESOLVED, that the following amendment to the AOA Bylaws be approved:

5 Old material crossed out (~~crossed out~~) | New material in CAPS

6 **AOA Bylaws**

7 Article V – House of Delegates

8 Section 2-Voting

9 Each delegate shall have one vote in the House., ~~except when one-fourth of the members~~
10 ~~present shall call for the yeas and nays on any question; the Chief Executive Officer shall,~~
11 ~~before any other motion can be made, call the roll by divisional societies and enter the yeas and~~
12 ~~nays in the record. In recording such vote each divisional society shall be given one vote for~~
13 ~~each 20 regular members of the American Osteopathic Association located in the area~~
14 ~~represented by that divisional society (or in the case of the uniformed services divisional society,~~
15 ~~one vote for each 20 regular members of the American Osteopathic Association currently~~
16 ~~serving in the uniformed services of the United States), as certified to 75 days before the annual~~
17 ~~meeting of the House of Delegates under the requirements of Section 1 of this Article, and such~~
18 ~~votes may be cast by any one of the delegation then seated or divided among the various~~
19 ~~members of the delegation as the delegation in caucus shall decide.~~

20 Article VI - Elections

21 Section 3-Method of Election

22 Election of such officers and trustees as are elected by the House of Delegates shall take place
23 during the last day of the annual meeting. All elections shall be by ballot except as hereinafter
24 provided in this section and a majority of all votes cast shall be necessary to elect. ~~In recording~~
25 ~~such vote, each divisional society shall be given one vote for each 20 regular members of the~~
26 ~~American Osteopathic Association located in the area or serving in the uniformed services of~~
27 ~~the United States represented by that division, and such votes may be cast by any one of the~~
28 ~~delegation then seated or divided among the various members of the delegation as the~~
29 ~~delegation in caucus shall decide.~~ If there shall be but one nominee for a given office or
30 trusteeship it shall be the duty of the secretary to cast the elective ballot for that nominee. The
31 Speaker and Vice Speaker of the House shall be elected to serve for one year or until their
32 successors are elected and installed.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H506-A/14 AOA RULES AND GUIDELINES ON PHYSICIANS' PROFESSIONAL CONDUCT

SUBMITTED BY: Bureau of Membership / Ethics Subcommittee

REFERRED TO: Committee on Constitution & Bylaws

1 RESOLVED, that the Bureau of Membership and Ethics Subcommittee recommend that the
2 following policy be REAFFIRMED:

3 **H506-A/14 AOA RULES AND GUIDELINES ON PHYSICIANS'**
4 **PROFESSIONAL CONDUCT**

5 The American Osteopathic Association (AOA) supports the AOA Rules and Guidelines on
6 Physicians' Professional Conduct and recognizes that it is a separate and distinct document
7 from the AOA's Code of Ethics. 2014

8 **American Osteopathic Association:**
9 **Rules and Guidelines on Physicians' Professional Conduct**

10 Professionalism and Physician Responsibilities

11 Professionalism is a core competency expected of all physicians. Physicians are among the
12 most highly educated and trained professionals in our society and should enjoy the respect of
13 their peers and the community. Society expects them to perform various roles. As healthcare
14 providers, they diagnose and treat patients; as advisors, they provide patients with an
15 understanding of their health status and the potential consequences of decisions regarding
16 treatment and lifestyles; as advocates, physicians communicate with patients, their caregivers,
17 and their health insurers the needs of the patient; and as counselors, they listen to their patients
18 and discuss their condition with family members and others involved in health-care decision-
19 making. Physicians are entrusted by their patients and their patients' families with private and
20 confidential information, much of which is related to healthcare, but frequently includes other
21 personal details.

22 Osteopathic physicians, in order to enjoy the continued respect and trust of society, recognize
23 the responsibilities and obligations they bear and in order to maintain their status as
24 professionals, must act accordingly. Medical ethics includes many tenets that should guide
25 osteopathic physicians in their professional and personal activities. Although ethics and
26 professionalism encompass broad concepts, some of the recognized elements are:

- 27 • Non-maleficence – first, do no harm
- 28 • Acting as a positive role-model
- 29 • Displaying respect in interactions with others
- 30 • Legal and ethical behavior
- 31 • Appropriate management of potential conflicts of interest
- 32 • Beneficence – a physician should act in the best interest of the patient/altruism/placing
33 the needs of the patient first
- 34 • Autonomy – the patient has the right to refuse or choose their treatment

- 1 • Dignity – the patient (and the medical professional involved with their care) has the
- 2 right to dignity, truthfulness and honesty
- 3 • Participation in self-evaluation programs and acceptance of constructive criticism from
- 4 others.

5 The AOA’s Code of Ethics offers rules to guide physicians in their interactions as physicians with their
6 patients, with society, and with the AOA. This document is intended to supplement the Code of
7 Ethics by providing rules and guidance for physicians’ conduct as professionals in the broader context
8 beyond the traditional role in the delivery of care. Some of the Rules and Guidelines are mandatory
9 (i.e., "shall" or "shall not"), while others are permissive (i.e., "may," "should," "should not" or "may
10 not") and recognize a physician’s discretion to assess the specific context and situation and exercise
11 professional judgment.

12 Finally, the Rules and Guidelines are designed by the AOA to provide guidance to physicians in
13 appropriate professional behavior and to provide a structure for regulating conduct. Any assessment of
14 a physician's conduct must be made with due consideration to the facts and circumstances that existed
15 at the time of the conduct in question and recognize that a physician may have had to act based upon
16 uncertain or incomplete information. The Rules and Guidelines are not intended to be a basis for civil
17 liability. Rather, perceived failure of a physician to comply with an obligation or prohibition imposed
18 by the Code of Ethics or these Rules and Guidelines is a basis for invoking the AOA’s disciplinary
19 process through the Bureau of Membership’s Subcommittee on Ethics.

- 20 1. A physician's conduct shall be consistent with the requirements of the law, whether providing
- 21 medical/professional service to patients or in conducting business and personal affairs.
- 22 2. Physicians should use their status as professionals only for legitimate purposes and not to take
- 23 advantage of economic or social opportunities or to harass or intimidate others.
- 24 3. A physician has an obligation to pursue a patient's best interests and to be an advocate for the
- 25 patient. In so doing, physicians shall conduct themselves in a civil manner. When appropriate,
- 26 physicians should disclose and resolve any conflict of interest that might influence decisions
- 27 regarding care.
- 28 4. Patients may come from any of a broad spectrum of cultures and beliefs. Physicians should
- 29 conduct themselves with appropriate respect for their patients’ social and cultural needs and
- 30 provide necessary care without regard to gender, race, color, religion, creed, age, marital status,
- 31 national origin, mental or physical disability, political belief or affiliation, veteran status, gender
- 32 identity or sexual orientation.
- 33 5. Physicians are allowed limited autonomy to govern conduct within their own profession
- 34 through participation on state licensing boards, hospital credentialing committees and in peer
- 35 review processes. Physicians should fully participate in self-regulation by setting, maintaining,
- 36 and enforcing appropriate practice standards. Regulations and rules with respect to healthcare
- 37 delivery shall be developed with the best interests of patient care in mind rather than advancing
- 38 private interests or protecting friends or colleagues from adverse action.
- 39 6. Physicians are responsible for observance of the Code of Ethics and these Rules and Guidelines
- 40 on Professional Conduct. While compliance depends primarily upon understanding of and
- 41 voluntary compliance with these obligations, physicians should also make efforts to secure their
- 42 observance by other physicians through expression of formal or informal peer opinion or, when
- 43 necessary, invocation of disciplinary proceedings. Where a protected peer review process is
- 44 available, adverse events and medical errors should be fully disclosed.
- 45 7. Physicians should be aware of disparities in medical care within the United States and
- 46 internationally. Where possible, physicians should assist those less fortunate in securing access
- 47 to appropriate medical care.

ACTION TAKEN **APPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: H600-A/14 HOSPICE – FEDERAL REIMBURSEMENT FOR
REQUIRED FACE-TO-FACE VISITS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED as AMENDED:

3 **H600-A/14 HOSPICE – FEDERAL REIMBURSEMENT PAYMENT FOR**
4 **REQUIRED FACE-TO-FACE VISITS**

5 The American Osteopathic Association supports reasonable federal reimbursement
6 PAYMENT to hospice organizations for federally required face-to-face visits for patients
7 enrolled in hospice ~~prior to the start of their third hospice benefit period.~~ 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H601-A/14 PALLIATIVE CARE – FEDERAL FUNDING FOR
SUPPORT SERVICES

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED:

3 **H601-A/14 PALLIATIVE CARE – FEDERAL FUNDING FOR SUPPORT**
4 **SERVICES**

5 The American Osteopathic Association supports federal funding for chaplain, social work and,
6 home health aide provider services for palliative care patients. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H602-A/14 MEDICARE TRANSITION CARE CODES

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be SUNSET:

3 **H602-A/14 MEDICARE TRANSITION CARE CODES**

4 The American Osteopathic Association encourages the Centers for Medicare & Medicaid
5 Services to simplify and clarify the rules for submission of Transition Care Codes. 2014

Explanatory Statement:

The BSA recommends to sunset H602-A/14. On March 17, 2016, CMS published a document titled “Frequently Asked Questions about Billing the Medicare Physician Fee Schedule for Transitional Care Management Services” that clarify rules for submission of these codes. The Transitional Care Management services were resurveyed in 2018. According to Medicare claims data, there has been increased use of these services, which indicates an understanding of the codes.

<https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-tcms.pdf>

ACTION TAKEN **APPROVED (for sunset)** _____

DATE **July 27, 2019** _____

SUBJECT: H605-A/14 REGULATION OF HEALTH INFORMATION TECHNOLOGY SOFTWARE

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED as AMENDED:

3 **H605-A/14 REGULATION OF HEALTH INFORMATION TECHNOLOGY**
4 **SOFTWARE**

5 The American Osteopathic Association (AOA) supports a new risk-based oversight framework
6 for clinical software, developed through a multi-stakeholder consensus-based process. The
7 framework should take into account risk relative to intended use, cost/benefit of proposed
8 oversight, and the principle of shared responsibility. Patient safety and appropriate
9 improvements in quality, effectiveness, and efficiency of care delivery should be paramount.
10 This framework should not conflict with or duplicate the medical device regulation framework.
11 The AOA does not support ~~federal regulation of health software because it poses the lowest~~
12 ~~risk of potential harm and data should not be treated as a medical device regardless of the~~
13 ~~category of health information technology associated with the data. The AOA supports a~~
14 ~~national network for reporting patient safety events, WHERE DATA CAN BE ACCESSED,~~
15 ~~ANALYZED, AND COMMUNICATED IN A TIMELY MANNER. which should be able to~~
16 ~~analyze data that can be communicated quickly.~~ Existing programs should be leveraged and
17 utilized. The AOA supports a common data structure that will enable interoperability; setting a
18 clear course of action, supporting an exchange infrastructure, and adopting standards that will
19 make it easier to share information so that physicians and patients can make informed
20 decisions. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H606-A/14 EMERGING STATES – ASSISTANCE BY OTHER STATES
AND THE AOA

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be REAFFIRMED as AMENDED:

3 **H606-A/14 ~~EMERGING STATES AFFILIATES IN NEED~~ – ASSISTANCE BY**
4 **OTHER STATES AFFILIATES AND THE AOA**

5 The American Osteopathic Association encourages liaison between state AFFILIATE
6 organizations whether formal or informal and supports assistance to ~~emerging~~ state
7 AFFILIATE organizations IN NEED. 1979; revised 1984, 1989; reaffirmed 1994; revised 1999;
8 reaffirmed 2004; 2009; 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H607-A/12 OSTEOPATHIC TERMINOLOGY - GLOSSARY OF

SUBMITTED BY: Bureau of Membership

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Membership recommend that the following policy be
2 REAFFIRMED:

3 **H607-A/12 OSTEOPATHIC TERMINOLOGY, GLOSSARY OF**

4 The American Osteopathic Association designates the entries in the Glossary of Osteopathic
5 Terminology as the AOA’s official terms and definitions; whenever terms or definitions in the
6 Glossary of Osteopathic Terminology conflict substantively with AOA policy, AOA branding
7 guidelines or AOA publications’ style guidelines, the AOA will seek to resolve the conflict
8 through the Glossary of Osteopathic Terminology’s standard process for revision and external
9 input; and the JAOA-The Journal of the American Osteopathic Association’s “Instructions for
10 Authors” will advise authors to use the terms and definitions in the Glossary of Osteopathic
11 Terminology. 2012

ACTION TAKEN **APPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: H607-A/14 GOVERNMENT INTERVENTION IN PRIVATE PRACTICE

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED as AMENDED:

3 **H607-A/14 GOVERNMENT INTERVENTION IN PRIVATE PRACTICE**

4 The American Osteopathic Association strongly recommends that any intervention by
5 FEDERAL, **STATE** OR PRIVATE third party payers (~~Medicare, Medicaid and other third-~~
6 ~~party insurers~~), shall not IMPOSE A FINANCIAL PENALTY ON penalize any physician
7 without proper peer review and opportunity for appeal, ~~without prejudice or penalty~~; and
8 encourages the continued availability of judicial review of claims of ~~Part B Medicare and other~~
9 ~~third-party payers~~. 1985; revised 1990, 1994; reaffirmed 1999; revised 2004; reaffirmed 2009;
10 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H608-A/14 DRUG THERAPY SURVEYOR GUIDELINES FOR NURSING HOMES

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED:

3 **H608-A/14 DRUG THERAPY SURVEYOR GUIDELINES FOR NURSING**
4 **HOMES**

5 The American Osteopathic Association supports drug therapy surveyor guidelines regarding
6 inappropriate drug use in nursing facilities be developed in collaboration with professional
7 organizations possessing clinical expertise in geriatrics and long-term care medicine. 1999;
8 revised and reaffirmed 2004; reaffirmed 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H609-A/14 CENTERS FOR MEDICARE AND MEDICAID (CMS)
COMMUNICATIONS WITH PHYSICIANS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED as AMENDED:

3 **H609-A/14 CENTERS FOR MEDICARE AND MEDICAID (CMS)**
4 **COMMUNICATIONS WITH PHYSICIANS**

5 The American Osteopathic Association supports the distribution of thorough and current
6 written information by all Medicare administrative contractors on the correct preparation and
7 coding of Medicare claims to all physicians and supports communication to the physician of the
8 complete reasons JUSTIFICATION for the ~~rejection~~ DENIAL of any Medicare claims. ~~be~~
9 ~~communicated to the physician.~~ 1999; revised 2004; reaffirmed as amended 2009; reaffirmed
10 2014

ACTION TAKEN **APPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: H610-A/14 MANDATED PATIENT CARE – ASSIGNMENT OF

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED:

3 **H610-A/14 MANDATED PATIENT CARE – ASSIGNMENT OF**

4 The American Osteopathic Association strongly opposes any attempt by a third-party payer,
5 business, institution or government to mandate a patient be seen and managed by any
6 individual, including a hospitalist, or anyone other than the patient's **AND THEIR** physician
7 in any setting without the concurrence of the patient's physician. 1999; revised 2004; reaffirmed
8 2009; 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H611-A/14 INVESTMENT TAX

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED as AMENDED:

3 **H611-A/14 INVESTMENT TAX**

4 ~~Policy of~~ The American Osteopathic Association notes that it is the responsibility of all
5 osteopathic associations with 501 {c}(6) tax status to urge their state legislators, U.S. senators
6 and ~~congressmen~~ REPRESENTATIVES, to defeat any proposed expansion of the tax on
7 unrelated business income to include dividends, capital gains and/or interest income on
8 reserves and current operational funds, under the 501 {c}(6) tax status. 1999; revised 2004;
9 reaffirmed as amended 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H613-A/14 OMT – OSTEOPATHIC MANIPULATIVE TREATMENT

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED:

3 **H613-A/14 OMT – OSTEOPATHIC MANIPULATIVE TREATMENT**

4 The American Osteopathic Association urges that in all forms of communication the term
5 OMT shall always be “Osteopathic Manipulative Treatment.” 1999; revised 2004; reaffirmed
6 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H614-A/14 THIRD-PARTY PAYERS AND UTILIZATION REVIEW
FIRMS – ACCOUNTABILITY

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED:

3 **H614-A/14 THIRD-PARTY PAYERS AND UTILIZATION REVIEW FIRMS –**
4 **ACCOUNTABILITY**

5 The American Osteopathic Association supports the disclosure of the origin of utilization
6 review criteria used by third-party payers. 1994; revised 1999, 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H615-A/14 MAIL ORDER PHARMACY

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be REAFFIRMED as AMENDED:

3 **H615-A/14 MAIL ORDER PHARMACY**

4 The American Osteopathic Association opposes pharmaceutical programs that require all
5 medications be delivered to the patient's residence as failing to act in the best interests of the
6 patient; and that maintenance medication prescriptions ~~may~~ SHOULD be obtainable **BY**
7 **THE MEANS PREFERRED BY THE PATIENT** at a pharmacy at the patient's discretion.
8 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H617-A/14 MEDICARE PHYSICIAN PAYMENT

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be SUNSET:

3 **H617-A/14 MEDICARE PHYSICIAN PAYMENT**

4 The American Osteopathic Association will work with the Centers for Medicare and Medicaid
5 Services (CMS), Congressional Committees of jurisdiction and the Medicare Payment Advisory
6 Commission (MedPAC) to reform the Medicare physician reimbursement formula to protect
7 and enhance the ability of osteopathic physicians to provide quality care and protect Medicare
8 beneficiaries access to physician services; and will identify and aggressively pursue the
9 enactment of long-term remedies to the sustainable growth rate (SGR) formula that protect and
10 maintains quality patient care. 2004; reaffirmed as amended 2009; reaffirmed 2014

Explanatory Statement:

The BSA recommends to sunset. In April 2015, the Medicare Sustainable Growth Rate (SGR) formula for physician payment was permanently repealed and replaced by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

ACTION TAKEN **APPROVED (for sunset)**

DATE **July 27, 2019**

SUBJECT: H618-A/14 MERGERS AND BUY-OUTS OF THIRD PARTY PAYERS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED:

3 **H618-A/14 MERGERS AND BUY-OUTS OF THIRD PARTY PAYERS**

4 The American Osteopathic Association advocates that all third party payers automatically
5 enrolling physicians in all products of an acquiring company should notify the physician of the
6 products offered and permit physicians to reject one or all of the products of the acquiring
7 company. 2004; 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H619-A/14 FEDERAL HEALTH INFORMATION TECHNOLOGY
INCENTIVES – AOA SUPPORT

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED:

3 **H619-A/14 FEDERAL HEALTH INFORMATION TECHNOLOGY**
4 **INCENTIVES – AOA SUPPORT**

5 The American Osteopathic Association supports the federal Health Information Technology
6 (HIT) initiatives by assisting its members through education and other services necessary for
7 them to adopt the appropriate technology which would be cost effective for their practices.
8 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H622-A/14 LOCAL COVERAGE DETERMINATION

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED:

3 **H622-A/14 LOCAL COVERAGE DETERMINATION**

4 The American Osteopathic Association encourages public and private insurance carriers, as well
5 as the Centers for Medicare and Medicaid Services to utilize the local coverage determination
6 (LCD) adopted in the State of Florida as a guide when determining coverage requirements for
7 osteopathic manipulative treatment. [Editor's note: All Medicare Local Coverage Determination
8 (LCD) policies are accessible via the Internet at
9 http://www.cms.hhs.gov/DeterminationProcess/04_LCDs.asp. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H623-A/14 LATEX ALLERGY

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H623-A/14 LATEX ALLERGY**

4 The American Osteopathic Association strongly encourages hospitals and other healthcare
5 facilities to provide non-latex alternatives. 1999; revised 2004; reaffirmed 2009; reaffirmed as
6 amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H624-A/14 MANAGED CARE PLANS – SERVICE, ACCESS AND COSTS IN

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED:
3 **H624-A/14 MANAGED CARE PLANS – SERVICE, ACCESS AND COSTS IN**
4 The American Osteopathic Association supports efforts to combine tiered formulary and open
5 access models with expanded use of variable co-pays that reflect the total costs of these
6 programs and supports efforts to design benefits that align consumer needs and accountability
7 and individual physician incentives. 1999; revised 2004; reaffirmed as amended 2009; reaffirmed
8 as amended 2014

Reference Committee Explanatory Statement:

The policy should be referred to the BSA for clarification on intent of the resolution, definition of “open access models”, and relevance of the resolution.

ACTION TAKEN **REFERRED** *(to Bureau of Socioeconomic Affairs)*

DATE **July 27, 2019**

SUBJECT: H625-A/14 FAMILY MEDICAL LEAVE ACT (FMLA) EMPLOYEE
RELATIONSHIP MODIFICATION

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED:

3 **H625-A/14 FAMILY MEDICAL LEAVE ACT (FMLA) EMPLOYEE**
4 **RELATIONSHIP MODIFICATION**

5 The American Osteopathic Association supports legislation amending the Family Medical
6 Leave Act (FMLA) Basic Leave Entitlement ‘To care for the employee’s spouse, son or
7 daughter, or parent, who has a serious health condition’ to include responsible designee; and
8 requests the Department of Labor to include these changes at the federal level. 2009; reaffirmed
9 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H626-A/14 PHARMACEUTICAL PACKAGING/ ENVIRONMENTAL
RESPONSIBILITY

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED as AMENDED:

3 **H626-A/14 PHARMACEUTICAL PACKAGING/ ENVIRONMENTAL**
4 **RESPONSIBILITY**

5 The American Osteopathic Association supports environmentally responsible packaging of
6 PHARMACEUTICAL samples. 1991, reaffirmed 1994, 1999; revised 2004; reaffirmed 2009;
7 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H627-A/14 INDUSTRY TRANSPARENCY STANDARDS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED as AMENDED:

3 **H627-A/14 INDUSTRY TRANSPARENCY STANDARDS**

4 The American Osteopathic Association AOA: (1) acknowledges the contributions made by
5 pharmaceuticals, biologics, and medical devices to the improved health, management of disease,
6 and enhanced life function for millions of patients cared for by ~~osteopathic~~ physicians **AS**
7 **DISTINGUISHED IN H-346-A/16 AND AS OUTLINED IN H-623-A/18**; (2)
8 acknowledges concerns regarding the perception that pharmaceutical and device companies
9 have undue influence over physicians; (3) affirms its commitment to providing all osteopathic
10 physicians, their patients, and the public timely, accurate, and relevant information on advances
11 in medical science, treatment of disease, prevention, wellness, and other information that
12 advances mental and physical health; (4) continues its commitment to life-long learning for all
13 osteopathic physicians; (5) supports transparency in its industry partnerships by ~~creating a~~
14 ~~public web site that discloses~~ DISCLOSING all industry partnerships entered into to advance
15 life-long learning; (6) will further advance transparency by encouraging all partners to disclose
16 fully their relationship with the AOA and other organizations; (7) directs the Council on
17 Continuing Medical Education to adopt and implement transparency standards; (8) discourages
18 business practices that interfere with the patient-physician relationship, attempt to unduly
19 influence the practice of medicine, or attempt to inappropriately persuade patients to seek
20 services or products; and (10) stands resolute that our commitment to advancing medical
21 science, quality health care, the treatment of disease, and transparency in our actions, along with
22 the ethical code by which our members serve, are the principles by which we engage industry
23 partners. 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H630-A/14 ELECTRONIC HEALTH RECORDS SOFTWARE –
REPORTING ERRORS TO PHYSICIANS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED as AMENDED:

3 **H630-A/14 ELECTRONIC HEALTH RECORDS SOFTWARE – REPORTING**
4 **ERRORS TO PHYSICIANS**

5 The American Osteopathic Association ~~will request that~~ SUPPORTS **PROMPT**
6 NOTIFICATION **BY** ELECTRONIC HEALTH RECORD (EHR) vendors ~~of electronic~~
7 ~~health records notify~~ TO physician clients of reported software errors and PROVISIONS OF
8 ~~provide~~ software updates **THAT CORRECT THESE ERRORS**, in a systematic, COST-
9 EFFECTIVE and timely fashion **AT NO COST TO THE EHR USER** ~~as is standard in~~
10 ~~other industries that correct these errors to enhance patient safety.~~ 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019** _____

SUBJECT: H631-A/14 ELECTRONIC MEDICAL RECORD/PROFESSIONAL CREDENTIALS – SIGNATURE FOR

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be SUNSET:

3 **H631-A/14 ELECTRONIC MEDICAL RECORD/PROFESSIONAL**
4 **CREDENTIALS – SIGNATURE FOR**

5 The American Osteopathic Association (AOA) will work with Electronic Health Record (EHR)
6 vendors and the Healthcare Information and Management Systems Society to change the
7 commonly used designation on EHR signature lines from “ordering MD” to “ordering
8 physician/provider”. The AOA encourages all certified EHR vendors to provide a mechanism
9 so documenting professionals can appropriately designate their degree or other professional
10 credential. 2014

Explanatory Statement:

The BSA recommends to sunset H631-A/14. The ONC has confirmed that requirements in the certification criteria for the 2014 and 2015 edition of certified electronic health record technology (CEHRT) are agnostic to any specific professional credential.

ACTION TAKEN **APPROVED** *(for sunset)* _____

DATE **July 27, 2019** _____

SUBJECT: H635-A/14 BEER'S CRITERIA FOR POTENTIALLY
INAPPROPRIATE MEDICATION USE IN OLDER ADULTS-USE OF

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED:

3 **H635-A/14 BEER'S CRITERIA FOR POTENTIALLY INAPPROPRIATE**
4 **MEDICATION USE IN OLDER ADULTS-USE OF**

5 The American Osteopathic Association recognizes the limitations of the Beer's Criteria as
6 published by the American Geriatrics Society, ~~due to the limitations and intent of the criteria as~~
7 ~~a measure of physician quality of care~~ **AS GUIDELINES AND NOT MANDATES TO**
8 **LIMIT OR PROHIBIT ACCESS TO MEDICATIONS DEEMED APPROPRIATE**
9 **BY THE PATIENT'S PHYSICIAN. 2014**

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019** _____

SUBJECT: H637-A/14 PHYSICIAN TESTING PROCESS FOR UNLIMITED
LICENSURE – COLLABORATION TO PROTECT THE INTEGRITY
OF THE

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be ~~REAFFIRMED~~**SUNSET**:

3 **H637-A/14 PHYSICIAN TESTING PROCESS FOR UNLIMITED LICENSURE –**
4 **COLLABORATION TO PROTECT THE INTEGRITY OF THE**
5 The American Osteopathic Association will collaborate with the American Medical Association,
6 the Scope of Practice Partnership and the Federation of State Medical Boards to ensure that the
7 National Board of Medical Examiners maintains and preserves the integrity of the testing
8 process used to license only physicians (DO / MD) for the unlimited practice of medicine.
9 2009; reaffirmed 2014

ACTION TAKEN **APPROVED** (*for sunset*)

DATE **July 27, 2019** _____

SUBJECT: H638-A/14 MAINTENANCE OF LICENSURE

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be REAFFIRMED as AMENDED; and, be it further;

3 RESOLVED, that policy number H227-A/17 be deleted:

4 **H638-A/14 MAINTENANCE OF LICENSURE**

5 The American Osteopathic Association (AOA) (1) supports the development of state level
6 maintenance of licensure (MOL) programs to demonstrate that ~~osteopathic~~ **ALL** physicians are
7 competent TO ~~and~~ provide quality care **THAT INCORPORATES RELEVANT**
8 **TECHNOLOGICAL AND SCIENTIFIC ADVANCEMENTS** over the course of their
9 career. Flexible pathways for achieving MOL should be maintained. The requirements for MOL
10 should balance transparency with privacy protection and not be overly burdensome or costly to
11 physicians or state licensing boards. (2) ~~The AOA will~~ **e**ContinueS to address and promote
12 physician competency through the teaching of core competencies at the predoctoral and
13 postdoctoral levels as well as ongoing physician assessment through Osteopathic Continuous
14 Certification (OCC) ~~and the AOA Clinical Assessment Program (CAP) or its equivalent.~~
15 (3) ~~The AOA will~~ **e**ContinueS to work with State Osteopathic Affiliates, the American
16 Association of Osteopathic Examiners and other stakeholders to establish; AND implement
17 MOL policies that promote patient safety and the delivery of high quality of care. (4) ~~THE~~
18 **AOA, THROUGH ITS BUREAUS, COUNCILS AND COMMITTEES, WILL**
19 **CONTINUE TO ENSURE THAT OCC IS COMPARABLE TO OTHER**
20 **MAINTENANCE OF CERTIFICATION PROGRAMS SO IN TERMS OF**
21 **QUALITY AND CONTENT THAT OCC CAN BE** RECOGNIZED BY THE
22 FEDERAL GOVERNMENT, STATE GOVERNMENTS AND OTHER REGULATORY
23 AGENCIES AND CREDENTIALING BODIES AS EQUIVALENT TO OTHER
24 NATIONAL CERTIFYING BODIES' "MAINTENANCE" OR "CONTINUOUS"
25 CERTIFICATION PROGRAMS. (5) ~~WHILE THE AOA SUPPORTINGS~~ THE USE OF
26 BOARD CERTIFICATION AS A **MARK RECOGNITION** OF QUALITY AND
27 EXCELLENCE, SIGNIFYING THE HIGHEST PHYSICIAN ACHIEVEMENT IN A
28 PARTICULAR SPECIALTY; ~~THE AOA~~ OPPOSES ANY EFFORTS TO REQUIRE OCC
29 AS A CONDITION **OF** MEDICAL LICENSURE; (6) ~~THE AOA DEFERS TO~~
30 **COLLABORATES WITH** ENTITIES PROPERLY QUALIFIED FOR AND TASKED
31 WITH DECISION-MAKING REGARDING
32 INSURANCE ~~REIMBURSEMENT~~ **PAYMENT**, HOSPITAL PRIVILEGES, NETWORK
33 PARTICIPATION, MALPRACTICE INSURANCE COVERAGE, PHYSICIAN
34 EMPLOYMENT, TO DETERMINE THE ROLE OF PHYSICIAN BOARD
35 CERTIFICATION AND OCC OR OTHER "MAINTENANCE OF CERTIFICATION"
36 PROGRAMS IN SUCH DECISIONS; (7) ~~THE AOA THROUGH THE BUREAU OF~~
37 **OSTEOPATHIC SPECIALISTS WILL** CONTINUES TO INNOVATE AND

1 **IMPROVE THE OCC PROCESS**~~REVIEW THE OCC PROCESS SO AS TO MAKE~~
2 ~~IT MORE MANAGEABLE AND ECONOMICALLY FEASIBLE.~~ 2010; REVISED
3 2015; REVISED 2017. 2010 [~~See also H258-A/08~~]; approved as amended 2014

Explanatory Statement:

Combined with H227-A/17 EQUIVALENCY POLICY FOR OSTEOPATHIC CONTINUOUS CERTIFICATION. Recommend deletion of H227-A/17.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019** _____

SUBJECT: REFERRED RES. NO. H-636 - A/2018 STANDING AGAINST
RESTRICTIVE HOUSING AND SOLITARY CONFINEMENT FOR
JUVENILE INMATES OF PRISON SYSTEMS IN THE US

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

1 WHEREAS, sunset resolution H-636 - A/2018, titled “STANDING AGAINST
2 RESTRICTIVE HOUSING AND SOLITARY CONFINEMENT FOR JUVENILE
3 INMATES OF PRISON SYSTEMS IN THE US”, was referred to the Bureau on
4 Scientific Affairs and Public Health (BSAPH) to study the frequency and impact of
5 solitary confinement and isolation on juvenile well-being; now, therefore be it,
6 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
7 attached white paper, titled, “OPPOSING RESTRICTIVE HOUSING AND
8 SOLITARY CONFINEMENT FOR JUVENILE INMATES OF PRISON SYSTEMS
9 IN THE U.S.”, be adopted:

10 **Opposing Restrictive Housing and Solitary Confinement for Juvenile Inmates of Prison**
11 **Systems in the U.S.**

12 **Introduction**

13 Every day approximately 53,000 youth under the age of 18 are sent to correctional facilities as a result
14 of juvenile or criminal justice involvement.¹ Correctional facilities generally offer limited medical and
15 mental health care, resulting in harmful health outcomes, such as increased violence, mental illness,
16 cognitive impairment, and increased risk of disease. It is not uncommon for incarcerated youth to be
17 housed in solitary confinement or restrictive housing while in these facilities. The use of solitary
18 confinement further compromises the quality of the health care detainees receive, and results in long-
19 lasting, adverse physical, psychological, and social effects. Thus, the use of such housing has become a
20 major public health concern in the U.S.

21 For many individuals who are committed to improving health outcomes for juvenile youth, there has
22 been an urgent need for interventions and reformation programs that encourage humane alternatives
23 and movement towards the abolishment of juvenile solitary confinement in the U.S. In fact, several
24 professional and human rights organizations have taken positions in favor of limiting or eliminating
25 solitary confinement.

26 The purpose of this paper is to discuss the frequency and impact of solitary confinement (isolation) on
27 juvenile well-being and to present the AOA’s position opposing restrictive housing and solitary
28 confinement for juvenile inmates in the U.S.

29 **Solitary Confinement**

30 The term, solitary confinement, is often used interchangeably with the terms segregation, isolation, and
31 restrictive housing. The National Commission on Correctional Health Care refers to solitary
32 confinement, or isolation, as the housing of an adult or juvenile with minimal to rare meaningful

1 contact with other individuals. Additionally, the United States Department of Justice defines restrictive
2 housing as any type of detention that involves one of the following:²

- 3 1. Removal from the general inmate population, whether voluntary or involuntary.
- 4 2. Placement in a locked room or cell, whether alone or with another inmate.
- 5 3. Inability to leave the room or cell for the vast majority of the day, typically 22 hours or more.

6 There are several forms of restrictive housing. High security facilities that contain solitary confinement
7 units are called supermaximum (“supermax”) facilities.³ These facilities house inmates who have
8 engaged in violent behavior aimed at other inmates or staff in another institution or those who were
9 not compliant at lower-security prisons. Some supermax facilities also house inmates in protective
10 custody or those considered to be a “special population”, such as prisoners on death row. In addition
11 to these facilities, there are facilities that contain solitary confinement cells, known as segregated
12 housing or secured housing units, in institutions that are not considered supermax facilities.³

13 By design, solitary confinement restricts human contact and environmental stimulation. The facilities
14 commonly have minimal natural light, leaving detainees exposed to constant artificial light, and inmates
15 experience punitively distasteful meals, have limited personal items, and are denied opportunities to
16 communicate with others.³

17 **Public Health Implications**

18 Though data on the frequency and duration of solitary confinement is scant, the Office of Juvenile
19 Justice and Delinquency Prevention reports that half of the individuals in the juvenile penal system
20 were isolated for more than four hours at a time.⁴ Exact statistics are not readily available, since the
21 federal government does not require prisons to report the number of juveniles in solitary confinement,
22 the frequency, or the amount of time they are isolated.³

23 In some jurisdictions, youth may be detained in solitary confinement for several weeks or months. In
24 addition to the harms associated with adults in solitary confinement, youth may also lack educational
25 options or interaction with their families, and they may experience the beginning of mental illnesses
26 that commonly occur during late adolescence.⁵

27 Many studies have underscored the troubling realities of physical and mental health outcomes directly
28 related to the increase of solitary confinement. While incarceration alone yields unintentional but
29 inevitable consequences on wellness, especially mental health issues, solitary confinement amplifies the
30 risk of anxiety, depression, psychosis and self-harm, as supported by both the American Psychological
31 Association and American Academy of Child and Adolescent Psychiatry.⁶

32 The practice of placing youth in solitary confinement is especially troubling since children and young
33 adults are still developing physically, mentally, and socially and are more vulnerable to the noted long-
34 lasting negative effects of solitary confinement. Accordingly, mental health problems are more
35 prevalent among youth inmates compared to adult inmates, with 95% of youth in the juvenile penal
36 system having at least one mental health problem, and 80% of youth developing more than one mental
37 health illness.⁷

38 Furthermore, the Centers for Disease Control and Prevention reports that suicide is the 3rd leading
39 cause of death for youth, resulting in approximately 4,600 deaths per year.⁸ However, young people in
40 prisons are 18 times more likely to commit suicide than their counterparts in the community.⁷ Thus,
41 isolation of juveniles increases the risk of both mental illness and suicide for adolescents and young
42 adults. Thus, concerns about the use of solitary confinement have mounted.

43 In a July 14, 2015, speech at the NAACP National Convention, President Barack Obama announced
44 that he had asked Attorney General Loretta Lynch to conduct a review of “the overuse of solitary

1 confinement across American prisons.” The President directed that the focus not only on
2 understanding how, when, and why correctional facilities isolate certain prisoners from the general
3 inmate population, but also that it includes strategies for reducing the use of this practice throughout
4 our nation’s criminal justice system.

5 Among other findings, the study report summary noted that implementation of solitary confinement
6 and the length of time an inmate is isolated is the discretion of correctional officers, not decided by a
7 court or jury. The report also recommended that the Bureau end the practice of placing juveniles in
8 restrictive housing, pursuant to the standards proposed in the Sentencing Reform and Corrections Act
9 of 2015.²

10 The United Nations has also taken a stance against solitary confinement and considers isolation within
11 juvenile facilities a form of torture. The U.N. has encouraged the U.S. to create federal and state
12 legislature ratifying the Convention on the Rights of the Child , an international agreement set forth by
13 the U.N. to protect children from abuse. To date, only seven U.S. states have placed any prohibition
14 on juvenile solitary confinement.³

15 The American Academy of Child and Adolescent Psychiatry highlights the code of ethics surrounding
16 the psychiatrist's responsibility to not only reduce the harmful impacts of the behavior of others but the
17 community and social effects as well.⁷ Often, correctional facilities have a culture of their own that
18 produce a different code of ethics for the survival and safety of juvenile inmates; this can create a
19 dilemma for clinicians as it relates to providing quality care to inmates.

20 **Racial and Gender Disparities**

21 Within the issue of solitary confinement in juvenile detention facilities, there is a concern that certain
22 races/ethnicities are disproportionately exposed to these practices than youth from other
23 races/ethnicities. Across the nation, the youth rate of incarceration is 152 per 100,000. However, the
24 Black youth placement rate is nearly three times higher than the national rate at 433 per 100,000.
25 Comparatively, the White youth placement rate is 86 per 100,000, nationally. According to the
26 Department of Justice, Black youth are five times more likely to be detained compared to Whites.
27 When examining the system further, Black males and Native American females are an over-represented
28 population in the U.S. juvenile prison system. Currently, in the U.S., Black males under the age of 18
29 make up 14% of the total population; however, 43% of Black males under 18 years of age are in
30 juvenile facilities. Nationally, Native Americans make up less than 1% of all youth, but 3% of Indian
31 females are in juvenile facilities.⁷

32 Over the last decade, the racial disparity in youth placed in the juvenile penal system has increased by
33 nearly 22%.⁹ As a result of disparities in the number of justice-involved juveniles, minority youth
34 detainees are more likely to suffer severe psychological/mental health issues and live in restrictive
35 facilities away from home. Black juveniles, specifically, are experiencing worse health outcomes,
36 especially mental health outcomes, due to disparities in the juvenile penal system.⁹

37 **Social and Societal Impact**

38 Family support and love are essential for the development of juveniles social identity.⁹ However, visits,
39 phone calls, and sometimes even letters are prohibited during solitary confinement, creating additional
40 separation between inmates, their families, and the outside world in general.

41 Isolation due to incarceration creates separation from society that makes it very difficult to form a
42 social identity. Solitary confinement exacerbates the social complexities and behaviors of re-entering
43 into society by aggravating preexisting depression or anxiety due to separation from home or the
44 community. Consequently, isolation hinders the development of juveniles making it extremely difficult
45 for them to reintegrate into the community easily or productively.³

1 Additionally, author, Jessica Lee, highlights that solitary confinement also negatively impacts the
2 physical growth of juveniles by restricting much needed exercise and nutrition.³

3 **Reformation Efforts**

4 The impact of juvenile solitary confinement has led to a call for reform by legislators and scientific
5 scholars.³ Although some states have been successful in abolishing or reducing solitary confinement, it
6 is still practiced within the juvenile penal system.⁴ This call for reform regarding solitary confinement
7 has the potential to shift the juvenile justice system toward a more ethical and just model.

8 • **Federal Reformation Efforts**

9 U.S. Representative Cedric Richmond presented a bill calling for a study across the nation on the
10 impacts that solitary confinement has on mental health. The intent of this bill, known as the Solitary
11 Confinement Study and Reform Act of 2014, was to reduce the use of solitary confinement.³ The bill
12 died and was reintroduced to the House in 2015.

13 In 2015 Senator Cory Booker introduced, Maintaining Dignity and Eliminating Unnecessary Restrictive
14 Confinement of Youth, commonly known as the Mercy Act. The Mercy Act entails the following:

- 15 1. Prohibits the use of solitary confinement of juveniles in federal custody, except for a maximum of three
16 hours, if the juvenile harms any individual.
- 17 2. Requires that facilities first use less restrictive measures to control behavior before placing the juvenile
18 into solitary.
- 19 3. If, after the maximum three hours of solitary have ended, the juvenile still poses a risk of physical harm
20 to themselves or anyone else, then the juvenile can be transferred to a different juvenile facility or
21 “internal location” where he or she can be treated without the use of solitary.

22 The Mercy Act was introduced to the Senate in 2017, but no further action has been taken.³

23 • **State & Local Reformation Efforts**

24 In the state of New York, legislators agreed to ban solitary confinement for inmates younger than 21 at
25 Riker’s Island and implement a practice where inmates between the ages of 18-21 undergo counseling
26 and classes in a different facility as an alternative.³ The reason for this reform was to combat the
27 psychological effects that solitary confinement has on young adults and youth. Other states have joined
28 in on State and Local reformation with varying approaches to the public health issue. For instance, in
29 Pennsylvania mentally ill inmates will no longer be placed in solitary confinement; instead, they will be
30 placed in special treatment units.

31 Although these laws are progressive, they do not address all of the concerns about solitary confinement
32 among youth. There has been a huge push by activists and researchers for Congress and the U.S.
33 Department of Justice to bring forth uniformity across the nation’s legislation to provide a standard and
34 just approach to juvenile inmates regarding solitary confinement in the U.S. prison system.¹⁰

35 • **Educational Efforts**

36 Many medical and research organizations, such as the National Alliance for Suicide Prevention, have
37 developed recommendations and interventions for “improving the level and quality of collaboration
38 between the juvenile and mental health systems, primarily for suicide prevention.”¹¹ These collaborative
39 efforts are tailored to promoting education, awareness, and prevention support and services for youth
40 in the juvenile prison system. In these educational programs, organizations and researchers identify
41 protective factors to decrease mental illness and suicide. In so doing, many organizations also are
42 promoting data collection and inmate screening/assessment tools to increase information on solitary
43 confinement in an effort to better understand and combat the psychological and social impacts of
44 solitary confinement. More information and knowledge will allow health care professionals and public

1 health practitioners to monitor the social development and health outcomes for inmates in juvenile
2 facilities.¹³

3 **Opposition To Reformation Efforts**

4 Despite evidence of deleterious effects of solitary confinement in the juvenile penal system, there is still
5 some opposition to reformation efforts. Opponents suggest that solitary confinement serves pragmatic
6 purposes. For example, when prisons are overloaded with inmates, there is no physical space for them,
7 or enough staff to run the prison. In this instance, solitary confinement provides additional housing
8 space for inmates.¹² Others contend that solitary confinement aids in the rehabilitation of character as it
9 becomes a means of reflection for inmates. Another viewpoint is that solitary confinement offers
10 prison safety for inmates who are a threat to staff, other inmates, or the public.¹³ Finally, some believe
11 that solitary confinement provides guards/officers with the means to discipline and maintain order
12 within the prison walls.¹⁵

13 **Conclusion**

14 Nearly half of juveniles placed in the U.S. Prison system experience solitary confinement. As a result,
15 the majority of these juveniles also have detrimental, long-lasting, physical and psychological health
16 outcomes. Education, counseling, and rehab programs are all positive alternatives to solitary
17 confinement that raises health outcomes for youth. Increased State and Federal legislation that actively
18 opposes juvenile solitary confinement will not only positively impact youth outcomes, but society as
19 well when inmates reintegrate into their communities. Opposing solitary confinement and restrictive
20 housing would be a significant step forward in saving lives and improving health and well-being
21 outcomes.

22 **American Osteopathic Association Policy**

23 Given the research surrounding the negative impacts of restrictive housing and solitary confinement,
24 the American Osteopathic Association adopts the following policy statements as its official position on
25 opposing restrictive housing and solitary confinement for juvenile inmates of the prison system in the
26 U.S.:

- 27 1. The official position of the American Osteopathic Association (AOA) is that youth incarceration is
28 meant to be rehabilitation and that the use of juvenile solitary confinement and/or restrictive housing
29 imparts serious psychological and physical harms.
- 30 2. The American Osteopathic Association encourages increased research and data collection surrounding
31 the prevalence of the use of solitary confinement /restrictive housing among juveniles.
- 32 3. The American Osteopathic Association opposes the use of solitary confinement and/or restrictive
33 housing among juveniles in the penal system and supports the abolishment of the use of solitary
34 confinement and isolation for incarcerated youth set forth at the United Nations Convention on the
35 Rights of the Child.

36 **References**

- 37 1. Sawyer, Wendy. *Youth Confinement: The Whole Pie*. (2018). Retrieved From
38 <https://www.prisonpolicy.org/reports/youth2018.html>
- 39 2. United States Department of Justice. *Report and Recommendations Concerning the Use of Restrictive Housing*. (2017).
40 Retrieved From [https://www.justice.gov/archives/dag/report-and-recommendations-concerning-use-](https://www.justice.gov/archives/dag/report-and-recommendations-concerning-use-restrictive-housing)
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6 Housing Adolescents with Adults Behind Bars*. Retrieved from
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18 Force. *Preventing Suicide Working with Youth Who are Justice Involved: Executive Summary*. (2013). Retrieved From
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ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: CLINICAL DATA REGISTRIES AND QUALIFIED CLINICAL DATA REGISTRIES

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 WHEREAS, clinical data registries and qualified clinical data registries (QCDRs) are used to
2 collect patient information on various diseases, conditions, exposures, or procedures;
3 and data can be used for various purposes including quality improvement, clinical
4 research, disease surveillance, and value-based reimbursement; and

5 WHEREAS, clinical data registries and QCDRs not only play an important role in improving
6 population health, while also playing an increasingly important role in physician
7 reimbursement through quality payment reporting programs; ~~and~~

8 ~~WHEREAS, approximately 53% of clinical data registries report using their data for~~
9 ~~quality measure development, 61% report using data for clinical decision support~~
10 ~~development, 39% report being qualified clinical data registries for MIPS~~
11 ~~reporting, and 17% of registries report that their data is used to help determine~~
12 ~~payment for health services;⁴ now, therefore be it~~

13 RESOLVED, that the American Osteopathic Association (AOA) supports the development of
14 clinical data registries to improve the quality of patient care, improve population health,
15 and promote high-value care and, be it further

16 RESOLVED, that the AOA will support efforts to make reporting more simplified and
17 efficient and expand participation in clinical data registries and Qualified Clinical Data
18 Registries (QCDRs) for the benefit of population health; **AND, BE IT FURTHER**

19 **RESOLVED**, the AOA will advocate to ensure that (1) participation in clinical data registries
20 and QCDRs does not place a substantial cost burden on physicians; (2) data is used to
21 improve quality of care for patients; (3) registry data is not used to penalize physicians;
22 (4) that measures developed for reporting through clinical data registries and QCDRs
23 are developed in collaboration with physicians and specialty groups; and (5) that
24 physicians play an integral role in the oversight of clinical data registries and QCDRs.

25 **References**

- 26 1. ~~Blumenthal S. The Use of Clinical Registries in the United States: A Landscape~~
27 ~~Survey. eGEMs (Generating Evidence & Methods to improve patient outcomes).~~
28 ~~2017;5(1):26.~~

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: COMMUNICATION TECHNOLOGY-BASED AND REMOTE
EVALUATION SERVICES

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 WHEREAS, Centers for Medicare and Medicaid Services finalized policy for new
2 communication technology-based and remote evaluation services in the 2019 Physician
3 Fee Schedule that will pay physicians, rural health clinics (RHCs) and federally qualified
4 health centers (FQHCs) for virtual check-in appointments, remote evaluation of pre-
5 recorded (store and forward) patient information, and telephone or internet
6 consultations services furnished using communication technology; and

7 WHEREAS, the new policy will allow payment to physicians, RHCs and FQHCs for use of
8 telecommunication technology and are not meant to substitute for in-person services;

9 WHEREAS, the new communication technology-based and remote evaluation services are
10 distinct from Medicare telehealth services as set forth in section 1834(m) of the Social
11 Security Act and are not subject to the same statutory requirements; now, therefore be it

12 RESOLVED, that the American Osteopathic Association (AOA) will work to ensure that the
13 use of new communication technology-based and remote evaluation services, which
14 resemble other Medicare telehealth and remote monitoring services are paid at a rate
15 consistent with the time and work involved for the physician.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: INCIDENT TO BILLING BY PHYSICIAN ASSISTANTS AND
ADVANCE PRACTICE REGISTERED NURSES

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 WHEREAS, the American Osteopathic Association advocates to preserve the physician-led,
2 team-based model of care as the most effective approach to delivering high-quality care;
3 and

4 WHEREAS, decreasing physician oversight of patient care can result in overutilization of
5 diagnostic services¹, overprescribing of medications², unnecessary or inappropriate
6 referrals³, and ultimately poorer outcomes; and

7 WHEREAS, the Medicare Payment Advisory Commission has recently advised the Centers for
8 Medicare & Medicaid Services to eliminate from federal regulation the provision
9 allowing APRNs and PAs to bill “incident to” physician services has the potential to
10 drive further scope of practice expansions; and

11 WHEREAS eliminating the “incident to” billing provision for APRNs and PAs may financially
12 harm independent practices, as services billed by non-physicians practitioners under
13 their own provider identification number are reimbursed at 85 percent of the Medicare
14 physician fee schedule rate; now, therefore be it

15 RESOLVED, that the American Osteopathic Association (AOA) supports maintaining the
16 “incident to” billing provision for APRNs and PAs in order to preserve the physician-
17 led, team-based model of care; and, be it further

18 RESOLVED, that the AOA will advocate to ensure that physicians who collaborate with
19 advance practice registered nurses and physician assistants in their practices will
20 continue to be able to earn full reimbursement for their collaborative efforts through
21 “incident to” billing; and, be it further

22 RESOLVED, that the AOA will advocate to ensure that reimbursement for any APRN and PA
23 services billed under the non-physician practitioner’s provider identification number will
24 be reimbursed at an appropriate rate based on the provider’s background and training.

25 **References**

- 26 1. <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1939374>
27 2. [https://www.journalofnursingregulation.com/article/S2155-8256\(17\)30071-6/fulltext](https://www.journalofnursingregulation.com/article/S2155-8256(17)30071-6/fulltext)
28 3. [https://www.mayoclinicproceedings.org/article/S0025-6196\(13\)00732-5/abstract](https://www.mayoclinicproceedings.org/article/S0025-6196(13)00732-5/abstract)

Explanatory Statement:

The AOA does not have clear policy on the “incident to” billing provision or appropriate levels of reimbursement for APRNs and PAs by CMS.

ACTION TAKEN **APPROVED** _____

DATE **July 27, 2019** _____

SUBJECT: PATIENT MATCHING OF ELECTRONIC HEALTH RECORD DATA

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 WHEREAS, identification and duplication of patient records is a growing problem within the
2 US electronic health record (EHR) ecosystem; and

3 WHEREAS, the mismatching of patient records can result in inadequate or inappropriate care
4 that harms patient outcomes; and

5 WHEREAS, no national standards currently exist for patient matching; now, therefore be it

6 RESOLVED, that the American Osteopathic Association adopt the following policy paper on
7 patient matching of EHRs:

8 **Policy Brief on Patient Matching**

9 **Overview:**

10 As patient electronic health information can be more easily shared between physicians, health information
11 exchanges, and payers, patient identification (patient matching) remains a persistent problem in ensuring that
12 electronic health record (EHR) data is complete and accurate. Errors and missing information remain common
13 in the electronic health record ecosystem, with approximately 8% of all records being split or duplicate. This
14 error rate is higher (14% to 16%) within large health systems that store vast amounts of data for a large number
15 of patients.¹ When excluding matching within organizations to analyze patient matching rates between
16 organizations, the match rate can drop to 50%.² These high duplication and mismatch rates often translate into
17 unnecessary resource use and poor outcomes when patient records are not up-to-date or contain inaccurate
18 information. A 2016 report indicated that 4% of duplicate records result in negative clinical care and outcomes.

19 Robust and accurate information exchange is central to delivering high quality, cost effective care. Although it
20 requires significant investment, improving patient matching rates will provide benefits to the greater healthcare
21 system that extend far beyond individual encounters. Being able to effectively capture, track, and share data
22 relating to patients' social determinants of health is crucial to delivering high-value care management and
23 promoting well-being outside of a hospital. Not only would accurate capture and sharing of patient data promote
24 better care coordination once a patient is back in their community, but it also supports better population level
25 analytics.³ Despite the need to improve patient matching, no clear standards for patient matching exist, and there
26 are numerous legal and operational barriers to driving standardization across the healthcare landscape.

27 **Past and Current Proposals**

28 Policy efforts to improve the matching of patient records in an increasingly digital health care system date back
29 to the mid-1990s. As part of the Health Information Portability and Accountability Act (HIPAA) in 1996,
30 Congress directed the Department of Health and Human Services (HHS) to develop a unique identifier for each
31 individual, employer, provider, and plan within the US healthcare system. However, following the passage of
32 HIPAA, there was significant pushback against this provision due to privacy and security concerns. As a result,

1 Congress walked back the proposal by inserting language into appropriations bills that prohibited HHS from
2 using federal funds to develop unique patient identifiers (UPIs) for individuals.

3 As the number of digital patient records across the US health care system proliferates, it is becoming increasingly
4 important that providers can de-duplicate records and effectively match them to the proper patient. As of March
5 of 2019, as part of the HHS Centers for Medicare & Medicaid Services (CMS) and the Office of the National
6 Coordinator's (ONC) Proposed Rule on Interoperability and Information Blocking, HHS is proposing to
7 improve patient matching by establishing standards for EHR developers regarding demographic data elements
8 necessary within EHRs for patient matching. The rule also includes a request for information on what data
9 elements would be useful in ensuring accurate patient matching and whether national standards for patient
10 identification would be useful. Without a UPI, the most effective way to ensure accuracy of matched patient
11 records is through the use of social security numbers. A study published in Perspectives in Health Information
12 Management asserts that creating a field for at least the last 4 digits of a patient's social security number, and
13 capturing a patient's full middle name, would increase match accuracy substantially.⁴

14 **Challenges of Each Approach**

15 While there is a great amount of discussion around national standards for patient demographic data and the need
16 for additional identifying information, there is disagreement on whether it would be more appropriate to
17 encourage the use of social security numbers or to seek legislative action to create unique patient identifiers.

18 Inclusion of social security numbers in patient records would improve patient matching, and standards that
19 require fields for social security numbers in EHRs would not require legislative action. However, various
20 challenges exist to achieving widespread adoption of this practice. First, individuals are often reluctant to provide
21 SSNs out of concern for identity theft. Under this approach, patients would likely have various records with
22 different providers containing their SSNs, increasing their exposure to identity theft risk. Although this perceived
23 risk may be marginal, the fear is likely to be a deterrent to patients offering this information. Second, many states
24 outlaw the collection of social security numbers for health care purposes, and a federal standard that included
25 SSN collection would not apply in these states. Third, as a result of federal legislation, Medicare now provides
26 patients with Medicare cards and is actively shifting away from having patients provide social security numbers.
27 Alternatively, the use of Medicare cards can improve patient matching for this particular population.⁵

28 As an alternative to social security numbers, various groups have proposed using different unique patient
29 identifiers, including numbers that would be issued by CMS, encouraging the use of biometrics as an additional
30 authenticator, or incorporating additional personal authenticators within patient records that patients would then
31 confirm (personal questions or text message authentication). However, these changes would be costly to
32 implement and there is no consensus on what approach would be best.

33 **Position of the AOA**

34 In light of the current debate regarding the most effective way to match patient data that does not present
35 privacy and security risks, the AOA supports efforts to develop national standards with appropriate safe guards
36 for authentication, and collection of patient demographic data. In order to make the sharing of patient data more
37 efficient and accurate, all health care organizations must collect the same information and enter it in a
38 standardized format. The AOA will support policies that will achieve standardization of identifying data in
39 patient records.

40 Additionally, because patient health data is particularly sensitive information and patient records contain large
41 amounts of identifying information, the AOA will support the strengthening of privacy and security standards
42 for the certification of EHRs and application programming interfaces.

1 **References**

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3 Susan Ridgely, Jeff Rothenberg, and Roger Taylor, Identity Crisis: An Examination of the Costs and Benefits
4 of a Unique Patient Identifier for the U.S. Health Care System. Santa Monica, CA: RAND Corporation,
5 2008. <https://www.rand.org/pubs/monographs/MG753.html>.
6 2. [http://perspectives.ahima.org/why-patient-matching-is-a-challenge-research-on-master-patient-index-mpi-](http://perspectives.ahima.org/why-patient-matching-is-a-challenge-research-on-master-patient-index-mpi-data-discrepancies-in-key-identifying-fields/)
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9 [critical-to-achieving-full-promise-of-digital-health-records](https://www.pewtrusts.org/en/research-and-analysis/reports/2018/10/02/enhanced-patient-matching-critical-to-achieving-full-promise-of-digital-health-records)
10 4. [https://www.pewtrusts.org/en/research-and-analysis/reports/2018/10/02/enhanced-patient-matching-](https://www.pewtrusts.org/en/research-and-analysis/reports/2018/10/02/enhanced-patient-matching-critical-to-achieving-full-promise-of-digital-health-records)
11 [critical-to-achieving-full-promise-of-digital-health-records](https://www.pewtrusts.org/en/research-and-analysis/reports/2018/10/02/enhanced-patient-matching-critical-to-achieving-full-promise-of-digital-health-records)
12 5. [https://www.managedhealthcareexecutive.com/health-management/why-addressing-sdoh-starts-patient-](https://www.managedhealthcareexecutive.com/health-management/why-addressing-sdoh-starts-patient-matching/page/0/1)
13 [matching/page/0/1](https://www.managedhealthcareexecutive.com/health-management/why-addressing-sdoh-starts-patient-matching/page/0/1)

ACTION TAKEN **APPROVED**_____

DATE **July 27, 2019**_____

SUBJECT: POST-PARTUM DEPRESSION (Response to RES. NO. H-612 - A/18
referencing H-615-A/13)

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

1 WHEREAS, the Ad Hoc Committee on July 21, 2018 referred H615-A/13 POSTPARTUM
2 DEPRESSION to the Bureau on Scientific Affairs and Public Health to produce a
3 report on outcomes; and

4 WHEREAS, the policy encourages American Osteopathic Association members to participate
5 in continuing medical education programs on postpartum depression (PPD); urges
6 colleges of osteopathic medicine (COMs) and osteopathic state and specialty
7 associations to offer CME on PPD as part of their educational offerings; and endorses
8 the use of screening tools and encourage the measurement of outcomes in their use;
9 now, therefore, be it

10 RESOLVED, that Bureau on Scientific Affairs and Public Health (BSAPH) receive additional
11 time to collect the requested data from American Osteopathic Association’s internal
12 sources as well external key stakeholders (e.g., COMS, osteopathic state and specialty
13 associates); and, be it further

14 RESOLVED, that BSAPH develop and administer a survey to its external stakeholders to
15 collect the requested information and provide a final report to the House of Delegates
16 in July 2020.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: COOPERATION OF THE VETERANS ADMINISTRATION AND NON-VA CLINICIANS

SUBMITTED BY: Florida Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

1 WHEREAS, there is always a need to improve the quality of healthcare worldwide; and
2 WHEREAS, this goal can be in part accomplished by sharing medical records between all
3 Providers involved in patient care; and
4 WHEREAS, there is difficulty in sharing of Healthcare records between VA clinicians and
5 Non-VA clinicians; and
6 WHEREAS, this failure to share records may cause unnecessary duplication of services in both
7 systems which affects patient care; and
8 WHEREAS, in the Non-VA system there is an impact on the reporting of quality measures
9 because of missing information or disinformation; and
10 WHEREAS, this missing information impacts the accuracy of HEDIS reporting as well as the
11 overall status of complete healthcare received now; therefore be it
12 ~~RESOLVED, that the leadership of the American Osteopathic Association coordinate with~~
13 ~~the leadership of the VA to SUPPORTS expedite~~ the development and
14 implementation of methodology for the ~~easy~~ **EFFICIENT AND SECURE** sharing
15 of the data in patient records between all VA and Non-VA clinicians; ~~and, be it further~~
16 ~~RESOLVED, that both organizations work to ensure that the data be available to ALL~~
17 ~~interested third parties (CMS, ACOs, Insurance Companies, etc.) in an~~
18 ~~acceptable fashion for accurate data reporting regarding individual patients.~~

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: PRIOR AUTHORIZATION – PATIENT AUTHORIZATION

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

1 WHEREAS, insurers, pharmacy benefit managers (PBMs), and third party administrators
2 (TPAs), collectively Payors, continue to use the prior authorization (PA) to deny
3 patients medically necessary medications; and

4 WHEREAS, one of the ways Payors accomplish this is to make the PA process more
5 complicated and cumbersome than needed so as to discourage use of the PA process;
6 and

7 WHEREAS, one of the techniques used by Payors to complicate the PA process is to require
8 prescribers to obtain the patient’s written permission to act as their agent in the PA
9 process; and

10 WHEREAS, completing the PA process requires a significant knowledge of medicine and
11 medication, a level of knowledge not usually possessed by the patient; and

12 WHEREAS, requiring a signed patient authorization to allow the physician to complete the PA
13 process serves no purpose other than to delay or complicate the PA process; and

14 WHEREAS, one of the roles of a physician is to be an advocate for the patient within a
15 complex healthcare system; now, therefore be it

16 RESOLVED, that the American Osteopathic Association advocate with insurers, pharmacy
17 benefit managers (PBMs), third party administrators (TPAs), legislators and
18 administrative agencies to allow the physician to complete the entire prior authorization
19 process on behalf of the patient without the patient’s written authorization.

Reference Committee Explanatory Statement:

The committee believes that this resolution adds detail not encompassed by existing AOA policy on prior authorization, H-640-A/16, regarding advocating on behalf of the patient. Per H-637-A/18, policies on prior authorization will be consolidated in 2020.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: OBESITY TREATMENT REIMBURSEMENT IN PRIMARY CARE

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Ad Hoc Committee

1 WHEREAS, obesity is a public health crisis which costs the US over \$147 billion annually as of
2 2008 in lost productivity, medical care, morbidity and disability; and

3 WHEREAS, the prevalence of obesity was 39.8% and affected about 93.3 million of US adults
4 in 2015~2016¹; and

5 WHEREAS, Obesity-related conditions include heart disease, stroke, type 2 diabetes and
6 certain types of cancer that are some of the leading causes of preventable, premature
7 death; and

8 WHEREAS, ensuring physician reimbursement for obesity treatment should be a priority to
9 reduce morbidity and mortality of the population; and

10 WHEREAS, it is well within the scope of practice of ALL primary care physicians to treat this
11 condition and obesity is not currently a payable diagnosis for primary care; now,
12 therefore, be it

13 RESOLVED, that the American Osteopathic Association (AOA) publicly affirms and
14 advocates that all diagnosis codes for obesity and morbid obesity be a billable and
15 reimbursable diagnostic code for any and all practicing primary care physicians; and, be
16 it further

17 RESOLVED, that the AOA work with insurers, payors, legislators, and other stakeholders to
18 ensure access to treatment for obesity to address this public health epidemic.

19 References

- 20 1. Centers for Disease Control Overweight and Obesity,
21 <https://www.cdc.gov/obesity/data/adult.html>; Accessed March 15, 2019.

Reference Committee Explanatory Statement:

The Bureau of Socioeconomic Affairs should review the feasibility of obtaining payment for the treatment of obesity as a primary diagnosis and whether new CPT and diagnosis codes need to be created for payment purposes.

ACTION TAKEN **REFERRED** *(to Bureau of Socioeconomic Affairs)*

DATE **July 27, 2019**

SUBJECT: PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT REFORM

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Ad Hoc Committee

1 WHEREAS, according to an American Medical Association (AMA) survey, more than 90% of
2 physicians said prior authorizations including, but not limited to, prescriptions,
3 procedures and durable medical equipment, had a significant negative clinical impact,
4 with 28 percent reporting that prior authorizations had led to a serious adverse event
5 such as a death, hospitalization, disability, permanent bodily damage, or another life-
6 threatening event for a patient in their care;¹ and

7 WHEREAS, the vast majority of physicians (86 percent) described the administrative burden
8 associated with prior authorization as “high or extremely high,” and 88 percent said the
9 burden has gone up in the last five years; and

10 WHEREAS, 66% of prescriptions that get rejected at the pharmacy require a prior
11 authorization, only 29% of patients end up with the original prescribed medication and
12 40% of patients end up abandoning the treatment altogether; and

13 WHEREAS, formulary changes are made indiscriminately and capriciously without notification
14 to prescribers or patients and insurance enrollment periods are limited but policy and
15 formulary changes by insurers can be made at any time; and

16 WHEREAS, nonmedical switching, when patients are switched to an alternative drug because
17 the drug was removed from the formulary, worsened outcomes for 95% of chronic
18 disease patients; now, therefore be it,

19 RESOLVED, that the American Osteopathic Association (AOA) adopt the following policy
20 statement and affirm its tenets as a priority for advocacy:

21 The American Osteopathic Association (AOA) asserts that physicians using appropriate
22 clinical knowledge, training, and experience should be able to prescribe and/or order
23 without being subjected to the need to obtain prior authorizations. The AOA further
24 maintains that a physician's attestation of clinical diagnosis or order should be sufficient
25 documentation of medical necessity for durable medical equipment. In rare
26 circumstances when prior authorizations are clinically relevant, the AOA upholds they
27 should be evidenced-based, transparent, and efficient to ensure timely access and ideal
28 patient outcomes. Additionally, physicians that contract with health plans to participate
29 in a financial risk-sharing agreement should be exempt from prior authorizations.

30 The AOA affirms that prior authorizations should be standardized and universally
31 electronic throughout the industry to promote uniformity and reduce administrative
32 burdens. Prior authorizations create significant barriers for physicians to deliver timely

1 and evidenced-based care to patients by delaying the start or continuation of necessary
2 treatment. The manual, time-consuming and varied processes used in prior
3 authorization programs burden physicians, divert valuable resources away from direct
4 patient care, and lead to negative patient outcomes.

5 The AOA believes that generic medications should not require prior authorization. The
6 AOA further affirms that step therapy protocols used in prior authorization programs
7 delay access to treatments and hinder adherence. Therefore, the AOA maintains that
8 step therapy should not be mandatory for patients already on a course of treatment.
9 Ongoing care should continue while prior authorization approvals or step therapy
10 overrides are obtained. Patients should not be required to repeat or retry step therapy
11 protocols failed under previous benefit plans. Additionally, the AOA asserts that health
12 plans should restrict utilization management programs to “outlier” physicians whose
13 prescribing or ordering patterns differ significantly from their peers after adjusting for
14 patient mix and other relevant factors; and, be it further

15 RESOLVED, that the AOA assert and advocate to legislators, insurance companies, and
16 insurance regulatory bodies that formulary changes should not occur more than 1 time
17 per year and that any change require a 90 day written notice to the patient and
18 prescribing physician that includes rationale for the change, and where the prescribed
19 device or medication can be obtained; and, be it further

20 RESOLVED, that the AOA formally join other stakeholders in publicly supporting & affirming
21 the “Prior Authorization and Utilization Management Reform Principles”
22 ([https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-](https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-with-signatory-page-for-slsc.pdf)
23 [with-signatory-page-for-slsc.pdf](https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-with-signatory-page-for-slsc.pdf)) in addition to the aforementioned policy statement;
24 and, be it further

25 RESOLVED, that the AOA consider adoption of the above policy statement in addition to the
26 AOA’s existing policy on prior authorization (H640-A/16 PRIOR
27 AUTHORIZATION, etc.).

28 References

- 29 1. “1 in 4 doctors say prior authorization has led to a serious adverse event” in AMA News,
30 [https://www.ama-assn.org/practice-management/sustainability/1-4-doctors-say-prior-](https://www.ama-assn.org/practice-management/sustainability/1-4-doctors-say-prior-authorization-has-led-serious-adverse)
31 [authorization-has-led-serious-adverse](https://www.ama-assn.org/practice-management/sustainability/1-4-doctors-say-prior-authorization-has-led-serious-adverse) February 5, 2019. Accessed March 15, 2019.

Reference Committee Explanatory Statement:

The AOA policy compendium contains multiple policies relating to prior authorization, including H640-A/17 and H632-A/17 which overlap significantly, but not entirely, with the proposed policy. The BSA should report to the House on how existing policy could be enhanced by incorporating elements of the proposed policy not already covered.

ACTION TAKEN **REFERRED** (to *Bureau of Socioeconomic Affairs*)

DATE **July 27, 2019**

SUBJECT: ADDRESSING THE GENDER PAY GAP IN THE MEDICAL PROFESSION

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

1 WHEREAS, the average female practicing physician can expect to earn as much as 37% less
2 than her average male colleague¹⁻⁵; and

3 WHEREAS, a recent study reports that female physicians working with an academic
4 appointment at public medical schools in the US can expect to earn, on average, 19.8%
5 less than their male colleagues³; and

6 WHEREAS, in a recent survey it was reported that female resident physicians can expect to
7 earn, on average, as much as \$900 less than their male colleagues and where other
8 studies have shown that newly practicing female physicians can earn as much as 17%
9 less than their male colleagues^{4,6}; and

10 WHEREAS, these disparities in income persist despite current United States federal law
11 mandating the equal compensation of men and women for equal work in the same
12 establishment and with due respect to permissible ‘affirmative defenses’ under the Equal
13 Pay Act of 1963⁹; and

14 WHEREAS, literature supports that these disparities in income persist even when factors that
15 may contribute to them, including but not limited to, choice of specialty, family
16 dynamics, working environment, and individual earning characteristics are controlled for
17 ^{1-3,6-7}; and

18 WHEREAS, these disparities in income are likely to appear early in a woman’s career, persist
19 throughout it, and even widen as women continue to practice throughout their career^{6,8};
20 and

21 WHEREAS, these disparities in income between women and men, referred to as the “gender
22 pay gap”, may result from a system of inequality at the detriment of women in the
23 medical profession; and

24 WHEREAS, AOA Policy H207-A/17 NON-GENDER DISCRIMINATION, reads, “The
25 American Osteopathic Association requires all of its recognized training institutions,
26 both osteopathic and allopathic, to provide equally for their physicians and students”;
27 now, therefore be it,

28 RESOLVED, that the American Osteopathic Association (AOA) acknowledge the existence of
29 the “gender pay gap” between male and female physicians in the United States; and, be
30 it further

1 RESOLVED, that AOA shall support the adoption of policies and practices that ensure the
2 equitable compensation of physicians **WHO WORK THE SAME JOB** regardless of
3 gender ~~who work with the same job title and job description, and with equivalent~~
4 ~~or comparable credentials and qualifications, requiring the same responsibility,~~
5 ~~effort, and skill, and under similar working circumstances in the academic,~~
6 ~~clinical, and support programs that are promoted by, accredited by, endorsed by,~~
7 ~~or otherwise funded by the AOA.~~

8 References

- 9 1. American College of Physicians. (2017). “Research on Compensation Equity and
10 Transparency in the Field of Medicine”.
- 11 2. Butkus, R. et al. (2018). “Achieving Gender Equity in Physician Compensation and Career
12 Advancement: A Position Paper of the American College of Physicians”. Annals of Internal
13 Medicine. 168: 721-723.
- 14 3. Jena, A. , Olenski, A., Blumenthal, D. (2016). “Sex Differences in Physician Salary in US
15 Public Medical Schools”. JAMA Internal Medicine. 176(9):1294-1304.
- 16 4. Doximity. (2018). “2018 Physician Compensation Report” American Medical Association
17 House of Delegates Resolution 10(A-18). (2018) “Gender Equity in Compensation and
18 Professional Advancement”
- 19 5. Lo, A., Richards, M., Chou, C., Gerber, S. (2011). “The \$16,819 Pay Gap For Newly
20 Trained Physicians: The Unexplained Trend Of Men Earning More Than Women”. Health
21 Affairs. 30,2:193-201.
- 22 6. Freund, K. et al. (2016). “Research Report - Inequities in Academic Compensation by
23 Gender: A Follow-up to the National Faculty Survey Cohort Study”. Academic Medicine.
24 91,8:1-6.
- 25 7. Bowles, HR. et al. (2005). “Constraints and triggers: Situational mechanics of gender in
26 negotiation.” J Pers Soc Psychol. 89:951–965.
- 27 8. United States. Department of Labor. Office of the Solicitor. (1963). Equal Pay Act of 1963
28 EPA. Pub. L. 88-38. 29 U.S. Code Chapter 8 § 206(d). Washington..

Explanatory Statement:

Please note that the use of the phrase “evidence-based” throughout this resolution is intended to specify that any policies or actions that arise from the adoption of this resolution ought to be based on available evidence and analysis rather than anecdote or conjecture. Further, note that the phrase “affirmative defenses” used in line 12 is a legal term used to describe those permissible discrepancies in compensation which are based on factors other than sex that include seniority, merit, quantity or quality of production by which employees may be compensated differently as established in the Equal Pay Act of 1963.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: BUDGET ADJUSTMENT PARAMETERS

SUBMITTED BY: Joint Board House Budget Review Committee

REFERRED TO: AOA House of Delegates

1 WHEREAS, the House of Delegates met in July, 2016 and approved the following Budget
2 Adjustment Parameters Policy:

3 “RESOLVED, that without explicit approval of the Joint Board/House Budget
4 Review Committee the AOA Board of Trustees may take no financial actions between
5 meetings of the AOA House of Delegates which when taken together either decrease
6 AOA's cash or increase its long term or recurring short term debt (to include operating
7 leases and other contractual obligations) to an aggregated amount greater than 10% of
8 the AOA's total equity as audited in the prior year; and, be it further

9 RESOLVED, that this policy will be reviewed by the Joint Board/House Budget
10 Review Committee every three years.”, and

11 WHEREAS, the Finance Committee reviewed the Budget Adjustment Parameters Policy
12 and believes it remains relevant and appropriate; now, therefore, be it

13 RESOLVED, that the Finance Committee re-affirms its support of the Budget Adjustment
14 Parameters Policy; and be it further

15 RESOLVED, that this resolution be forwarded to the Joint Board/House Budget Review
16 Committee for consideration.

Explanatory Statement:

The above budget adjustment parameters were initially approved by the Joint Board/House Budget Review Committee in July 1995. These parameters were re-affirmed by the Joint Board/House Budget Review Committee in July 1998, July 2001, July 2004, July 2007, July 2010, July 2013, July 2016 and July 2019. These budget adjustment parameters were reviewed and approved by the Joint Board/House Budget Review Committee in July, 2019 as part of the three-year review process as required by the initial resolution.

Continuation of this policy is in accord with the specific subset of the budget adjustment provision contained in the Reserve Requirement Policy.

ACTION TAKEN APPROVED

DATE July 28, 2019

****EDITORIAL NOTE:** Per the HOD Speaker, due to the nature and timing of this resolution it will not need to be addressed by the Rules & Order of Business Reference Committee as a late entry.**

SUBJECT: FY 2020 WAIVER FROM RESERVE REQUIREMENT POLICY

SUBMITTED BY: Joint Board House Budget Review Committee

REFERRED TO: House of Delegates

1 WHEREAS, the AOA Reserve Requirement Policy RES. NO. H-701 – A/2013 requires that
2 the AOA’s operating budget be balanced on an annual basis; and

3 WHEREAS, the AOA anticipates a significant decline in FY2020 dues revenue from FY2019
4 and prior years because of the decrease in annual membership dues (regular
5 membership dues category reduced by \$90 beginning in FY 2020) and the elimination
6 of the \$90 annual certification maintenance fee; and

7 WHEREAS, the extent to which membership – and therefore membership dues revenue - will
8 decline in FY2020 because of the decoupling of membership from certification is
9 uncertain and unpredictable; and

10 WHEREAS, the AOA’s revenues from accreditation of postdoctoral training programs will
11 continue to decline as the transition to the single postdoctoral accreditation system
12 continues; and

13 WHEREAS, the AOA budget contained an operating deficit of \$6.4 million when the Finance
14 Committee met on June 24, 2019 to review the budget; and

15 WHEREAS, the reserve balance at May 31, 2020 is projected to be 78.4 percent of total
16 operating expenses two years earlier as compared to a reserve requirement of 75
17 percent; and

18 WHEREAS, the AOA Finance Committee will continue to attempt to balance the operating
19 budget in FY 2020 and FY 2021; now, therefore, be it

20 RESOLVED, that the AOA House of Delegates waives the requirements contained in the
21 Reserve Requirement Policy for Fiscal Year 2020 (June 1, 2019 – May 31, 2020) to fund
22 the budgeted net operating deficit of \$4.5 million from reserves; and, be it further

23 RESOLVED, that the Joint Board/House Budget Review Committee will report back to the
24 House of Delegates at its annual business meeting in 2020.

ACTION TAKEN APPROVED

DATE July 28, 2019

****EDITORIAL NOTE:** Per the HOD Speaker, due to the nature and timing of this resolution it will not need to be addressed by the Rules & Order of Business Reference Committee as a late entry.**

SUBJECT: APPROVAL OF THE AOA BUDGET, FISCAL YEAR 2020

SUBMITTED BY: Finance Committee

REFERRED TO: Joint Board House Budget Review Committee

1 RESOLVED, that the Fiscal Year 2020 Proposed Budget of the American Osteopathic
2 Association be approved as submitted.

ACTION TAKEN **APPROVED**

DATE **July 28, 2019**