The Interim Meeting of the American Medical Association considered matters of policy, including legislative priorities, November 11-14, in Honolulu, Hawaii.

David Barbe, MD, Mountain Grove, Mo., continues to serve as the President of the American Medical Association. Dr Barbe spoke to the House of Delegates (HOD), emphasizing AMA leadership in several activities: easing requirements of MACRA-MIPS, increasing public awareness of the opioid crisis, controlling chronic diseases, fostering innovations in physician practice, and supporting changes in medical education. James Madara, MD, AMA CEO, discussed the role of the AMA in improving medical education, facilitating innovation in medical technology, and promoting a new data model to facilitate sharing of data.

Other members of the delegation had leadership roles. Edmond Cabbabe, MD, St. Louis, serves on the Council for Long Range Planning and Development. Charles Van Way, MD, Kansas City, serves on the Steering Committee of OSMAP (see below).

OSMAP, the Organization of State Medical Association Presidents, meets the day before AMA meetings, and is known for its programs presenting current and controversial topics. This year, the presentations concerned the proposed American Health Care Act, monitored injection centers, electronic participation in medical association decision-making, and the ever-unpopular maintenance of certification. Dr Barbe discussed “arcs of focus” of the AMA: improving health outcomes, facilitating physician practice, and accelerating change in medical education. He also addressed on the APRN compact, a new attempt to promote independent practice of advanced practice nurses. This issue was also discussed in the HOD. There was a presentation on Delaware’s use of blockchain technology to facilitate pre-authorization. Colorado reported on their virtual House of Delegates.

The AMA is highly concerned about the increasing number of deaths secondary to opioid overdose, which has reached 60,000 in the last year. A number of resolutions addressed this “epidemic,” which now takes more lives than motor vehicle crashes and gun violence combined. But no one has easy answers. Resolutions suggested better controls, prescribing smaller amounts, better treatment in correctional facilities, and other actions which may help. One resolution advocated the increased availability of naloxone, the opioid antagonist. Over-reliance on patient surveys may be pushing physicians to prescribe more opioids. Everyone, including the AMA, points fingers at the medical profession. But physicians cannot stop patients from wanting drugs, nor do they have any control over the companies who make the drugs. Physicians should be part of the effort to slow opioid abuse, but we cannot solve the problem by ourselves.

The current health crisis in Puerto Rico and the US Virgin Islands was addressed. The AMA has provided assistance to physician clinics on the islands. The AMA will encourage Medicare and Medicaid funding waivers to maintain access to health care. In general, the AMA continues to strongly support Medicaid by opposing work requirements, caps on Federal spending, and in general supporting Medicaid expansion.

There was continuing concern over electronic prescribing of drugs. Inadequate EHR systems, federal regulations, and state laws all set up barriers to adopting this new technology. The full promise of electronic prescribing has never been achieved. The AMA continues to lobby Congress and Federal agencies to remove such
barriers as requiring a physician’s handwritten attestation and signature for certain drugs, like opioids.

Each meeting, the Board of Trustees (BOT) and several councils report on significant matters, usually in response to resolutions from previous meetings. This year, there were significant reports on peer review, physician competence and self-assessment, and mergers of secular and religiously-affiliated hospitals. Several of these were sent back to the BOT for a re-do, including physician competence and mergers. There was a report on fees charged by open access journals. It turns out that one AMA journal may charge up to $5,000 for open access publication. Nonetheless, the AMA will work with the Federal Trade Commission to control so-called “predatory publishers.” All of these reports, and others, are available on the AMA web site.

There were two resolutions concerning freedom of speech by physicians. Resolutions in previous years addressed legislative limits on physician speech. But these centered on lawsuits against physician leaders and retaliation by health systems and hospitals. A BOT report on media relations also addressed this issue, and was returned to the BOT for revisions. Unfortunately, free speech is under serious attack from activists on both ends of the political spectrum. This issue will persist.

Immigration was discussed in two resolutions. The AMA remains supportive of immigration in general, especially of physicians, scientists, and other health workers. A resolution adopted by the HOD opposed allowing immigration enforcement (ICE) agents in hospitals. There have been some unpleasant incidents recently of patients seized while in their hospital beds.

Physician burnout, a concern at the last meeting, was only addressed superficially. One resolution suggested that hospitals and systems should institute physician wellness programs, to include emotional and psychological wellness. Another suggested changing “burnout” to “demoralization,” as if changing the name might make it easier to deal with the problem.

Resolutions supported state maternal mortality reviews, improving treatment of maternal depression, and promoting methadone treatment for opioid abuse in breastfeeding mothers. A resolution addressed concerns about the adverse effects of electronic and/or social media on mental and physical health. Another advocated limiting “screen time” for children. A resolution concerned modifications of prescriptions by pharmacists, including
generic or therapeutic substitution of medications and regulating the quantity of medicine allowed. Your AMA will continue to work with all stakeholders to improve this situation.

A great deal of attention was paid to education. The Council on Medical Education issued a report on the “crowding-out” of students in US schools by students from off-shore schools. Caribbean schools do not have teaching hospitals, but they can afford to pay hospitals large amounts to host their students. There has been legislation passed in Texas to control crowding-out. There are only so many hospitals which can host medical student education, currently about 15% of US hospitals. If they begin to sell educational slots to offshore schools, US medical education may be adversely affected. This is related to the problem of too few resident positions. Our model of medical education, both undergraduate and graduate, appears to be reaching its limits. Yet, we still project a physician shortage, and there is still great market demand for physicians. We must expand our capacity, for both undergraduate and graduate. A bill is in Congress authorizing a 15% increase in the cap on resident positions which was set 20 years ago. It’s a start.

That said, a resolution proposing a “house physician” category was not well-received. This is being considered in Florida, allowing MD and DO graduates to work as hospital physicians under supervision. Missouri has such a program already, and other states are considering such. But allowing state legislatures or Congress to manipulate medical education further than they already do has significant risks. The HOD has consistently voted against such interventions.

A resolution addressed the use of remotely scored computer-generated video interviews in order to evaluate interpersonal skills. The Association of American Medical Colleges (AAMC) presently requires this interview of all applicants to Emergency Medicine programs, and intends to expand this to all residency applicants. There is no evidence that these interviews improve resident selection. Of course, it generates income for the AAMC. Testing interpersonal skills by requiring the applicant to talk to a computer seems like an idea whose time should never come. The HOD overwhelmingly supported delaying and, if possible, stopping this practice.

The AMA remains very concerned about the cost of medications. Pricing of drugs must become more transparent. The AMA will work with the federal government and with pharmaceutical manufacturers, pharmacies, and pharmacy managers to control the cost of medications. Drug costs are only a part of total health care spending, but they are increasing more rapidly than any other component.

A Council on Science and Public Health issued reports on drug shortages, organ donation, neuropathic pain, respiratory inhalers, and cannabis use. There was general approval for retaining AMA policy on marijuana. The AMA opposes legalization both of medical uses of marijuana and of recreational use, but supports allowing research into medical uses of marijuana. A bill currently in Congress would relax some of the restrictions on cannabis research.

One resolution advocated pay for all physicians required to take call for emergency services and/or trauma. This was the subject of brisk debate, but such on-call pay has become more and more common in an increasing number of specialties.

On a delegation update, William Huffaker, MD, will be retiring from the group. Your AMA delegation continues to support your interests at the national level. Keep those e-mails coming! And be thinking of new resolutions for the MSMA Annual Convention next spring.

Missouri Physicians Health Program Executive Director Bob Bondurant (left), presented a program on physician health and well-being during the AMA Meeting. Center is Missouri physician and AMA President David Barbe, and right, co-presenter Warren Pendergast, MD, Federation of State Physician Health Programs.