
Washington State Medical Association

POLICY COMPENDIUM

Revised – July , 2011

ABORTION

The WSMA affirms a woman's right to an abortion as a medical decision to be made under the advice and guidance of her physician in an accredited hospital or at a licensed medical facility. The WSMA opposes any attempt to restrict the availability of all reproductive health care, including abortion, through means such as the passage of financial limitations for government funded abortions; restrictive marital or parental consent limitations; public harassment of medical facilities, personnel or patients; or intrusion into the physician-patient relationship through increasingly stringent informed consent laws. (Res 22, C-84; Res 40, C-89)

The WSMA reaffirms its support of the right of physicians to include pregnancy termination as a part of their practice. (Res A-3, A-93)

ABUSE

Children, Elderly Persons, Others at Risk

The WSMA supports and encourages physicians and other health care providers to report suspected abuse of children and "vulnerable" adults. Any person who in good faith makes a report and gives testimony in regard to suspected abuse is immune from civil or criminal liability. (RCW 26.44; CHS Rpt B, A-84; CHS Rpt D, A-83; CHS Rpt D, A-82; Res 18, B-82)

Domestic Violence

The WSMA supports and encourages the adequate education of its members and other health care providers on the identification, treatment, and referral of domestic violence victims and perpetrators. (EC Rpt A, A-96)

The WSMA supports expansion of the "Brady Bill" to include those individuals convicted of acts of domestic violence. (EC Rpt A, A-96)

ACCESS TO HEALTH CARE (HEALTH CARE REFORM)

The WSMA has adopted the following broad goals for system reform:

Access

Universal access for all Washingtonians to basic health care benefits packages available through a variety of arrangements, with the basic benefit package defined by a public/private mechanism. (Res B-8, A-96)

The WSMA believes all enrollees in state-funded comprehensive health benefit programs shall be treated equally with regard to covered services and payment to providers of those services. Excluded from this requirement are limited benefit programs for certain special populations such as Labor and Industries' workers compensation and developmental disabilities programs. (Res C-3, A-01)

The WSMA encourages due and open processes when measures related to limiting access to physician services or prescribed services are undertaken by third party payers or governmental agencies. (Res C-18, A-09)

Coverage for individuals whose incomes fall below an objective income level and who are otherwise not covered, with this coverage to be made available via state subsidized care (funded from general revenues) through a variety of alternative systems, both public and private.

The WSMA will work with County Medical Societies, where appropriate, in bringing together governmental, non-profit, and other interested organizations to improve access to care for the uninsured and the underinsured. (Res C-14, A-04)

Children

The WSMA supports the completion of universal coverage for all children in the state of Washington for a standard benefit package with reasonable payment levels, and supports the development of a system of outreach by the state and advocacy groups that assures that all children have coverage and stresses the need to access needed health services. (Res C-3, A-99; A-01)

The WSMA advocates for legislation that will provide health care benefits, including well-child, developmental and oral health care for all children to be provided at appropriate reimbursement rates. (Res C-8, A-04)

Insurance

Insurance reform to include community rating, portability of coverage and elimination of pre-existing conditions and waiting periods for the basic benefit package.

The WSMA supports legislation to enable open access to health insurance across state lines. (Res C-21, A-09)

The WSMA supports legislation to achieve portability of health insurance. (Res C-22, A-09)

The WSMA supports the stabilization of the individual insurance market so that health coverage is affordable to all people in the state. (Res C-1, A-96; BT Rpt J, A-01; EC Rpt F, A-02)

Administrative

Administrative reforms to include the use of uniform claims and forms and coding and standardized electronic processing of transactions and collection of information (to include eligibility, claims processing and payment transmission).

Costs

Health care cost predictability to include the elimination of all cost-shifting, explicit rationing (basic benefits), technology review, the use of consistent and responsible utilization review, consumer education and cost sharing, and the use of data and marketplace dynamics (i.e. contracting mechanisms, negotiated rates, payment reform) by purchasers and providers of care.

Community Clinics

The WSMA believes that maintaining community clinics is vital to medically indigent patients and their families who would not otherwise be served by the medical community. (Res A-8, A-94)

The WSMA recognizes the importance of community health clinics in providing care for some Medicaid patients and encourages that these clinics be adequately funded. (EC Rpt D, A-95)

Data Collection

Data collection and the development of a data clearinghouse function to provide standardized access to basic utilization review, eligibility standards, standard claim forms and a data repository with data available to purchasers, providers, insurers and the appropriate entities.

The capability for competing electronic claims systems to communicate with each other (a "switch" function much like automatic teller machines used by competing banks) and to provide standardized electronic processing of information (including eligibility, claims processing and payment transmission).

Liability (Tort Reform)

Tort reform to include, but not limited to, certificate of merit, alternative dispute resolution systems, several liability for non-economic damages, reform of the contingent fee system, and elimination of double recoveries while preserving subrogation rights.

Liability relief linked to conformance to practice parameters.

Personal Responsibility

Personal responsibility with individuals having an increased financial stake in their own health status and a financial involvement in the system to include meaningful out-of-pocket expenses (such as co-payment, co-insurance, deductibles, and premium sharing). A person's financial ability to pay must be factored into such policy developments so as to not implicitly shift the financial burden to the health care delivery system. (BT Rpt J, A-01; EC Rpt F, A-02)

Employers, carriers and providers helping individuals become more aware of important variables in individual health care decisions, such as indications, costs, potential outcomes and risks.

Public Health

The WSMA supports promoting financial incentives to encourage more physicians to enter primary care and/or serve in rural areas. (EC Rpt C, A-92)

The WSMA affirms that improving Population Health should be a true goal of any meaningful health reform effort and that achieving this goal requires a robust partnership between public health and medical care practitioners to carry out long-term disease prevention strategies. (Res A-3, A-09)

The WSMA support a strong public health program making available to all Washingtonians scientifically determined, cost effective preventative health services (such as immunizations and community based services such as those for communicable disease, sanitation and poison control).

Reform - General

The WSMA reaffirms its negotiating principles of proportional linkage of access and cost control in its dealings related to reform issues. (EC Rpt C, A-92)

The ability of health care organizations to work together, without fear of anti-trust actions, in the interest of economics of scale and organizational capacity, to deliver efficient care.

Not ruling out the possibility of a single payer system, either governmental or private (i.e. through a bidding process), to provide the basic health care benefits.

An adequate supply and distribution of primary care physicians. This should be accomplished by increasing funding to primary care training and assistance programs and by removing financial disincentives to primary care.

Collective bargaining by physicians within the "system" with respect to payment and working conditions if payment schedules are imposed along with defined practice patterns. (Res 1, S-91)

In addition, an individual mandate for coverage for all residents of the state if other forms of required coverage – such as those necessitating changes in federal law – are not possible; competition among managed health care systems; and, long term care protection for all Washingtonians. (BT 5/92)

The WSMA will continue to support legislation requiring all citizens of the state of Washington to have health insurance coverage for a generally accepted "basic" package of benefits with such a mandate coupled with appropriate incentives to encourage citizens to gain coverage and be "needs

tested” so that society ensures access to coverage for low income citizens.
(BT Rpt J, A-01; EC Rpt F, A-02)

Tort Reform

The WSMA supports tort reform to include, but not limited to, certificate of merit, alternative dispute resolution systems, several liability for non-economic damages, reform of the contingent fee system, and elimination of double recoveries while preserving subrogation rights.
(BT Rpt J, A-01; EC Rpt F, A-02)

The WSMA recognizes that an emergency exists in medical malpractice insurance and the tort law system, in this state and nationally. (Res C-16, A-02; EC Rpt E, A-03)

The WSMA seeks changes in the tort law system, at the state and federal levels, that: 1) moderate the rising cost of medical malpractice insurance premiums; 2) accelerate settlements to the injured party in the event of negligence; 3) reduce wasteful tort system transactional expenses so that more of the settlement goes to the injured party; 4) increase the focus of the tort law system on fairly compensating victims of negligence; and, 5) reduce the dramatic rise in awards for non-economic damages. (Res C-16, A-02; EC Rpt E, A-03)

The WSMA supports, as a part of tort reform, equitable funding of patient safety/medical error reduction programs in hospitals and other medical settings (such as an allocation of 1% of health care licensing fees and medical malpractice settlements and judgments to the Department of Health), and strengthening of physician and hospital quality assurance programs. (EC Rpt E, A-03)

The WSMA will work with other groups and organizations to seek these changes by means of legislation, regulation and/or initiative and constitutional amendments.
(Res C-16, A-02; EC Rpt E, A-03)

The WSMA will work with all specialties, particularly those most urgently affected, to advance the need for immediate reform of the tort system. (EC Rpt E, A-03)

The WSMA supports any and all legal efforts by physicians to exercise their constitutional rights to petition government for statutory changes to reform the tort system. (EC Rpt E, A-03)

Universal Coverage

The WSMA has the unqualified position that universal health care coverage is an achievable objective through a variety of mechanisms which could be private, public, or a combination thereof.
(Res C-5, A-07; Res C-1, A-09)

The WSMA supports universal health care coverage based on the following principles that largely reflect those articulated by the Institute of Medicine in its 2004 publication, *Insuring America’s Health*:

- ♦ Health care coverage should be universal so that no one is without access to health care by reason of employment status, health status, or other life circumstances.
- ♦ Health care coverage should promote timely access to high-quality care that is both therapeutically effective and economically efficient.
- ♦ Health care coverage should be continuous with no breaks in coverage that can delay or interrupt necessary medical care and expose individuals and families to the risk of severe financial hardship.

- ♦ Health care coverage should be affordable to individuals and families so that the sum of contributions to health coverage through premiums, taxes and out-of-pocket requirements do not render unaffordable the basic necessities of life.
- ♦ Health care coverage should be affordable and sustainable for society through an administrative approach that (a) maximizes efficiency through core coverage standards and operating procedures that are common to all financing entities and (b) factors into coverage decisions accurate measures of the true costs and benefits of new drugs, devices and treatment protocols

ACCIDENT PREVENTION

Head Protection

In order to prevent serious head injuries, the WSMA supports appropriate efforts to educate parents and children about protection of the head when horse riding or cycling. (Res 11, A-84)

The WSMA supports legislation mandating bicycle helmets be worn by all bicycle riders. (Res C-3, A-97)

The WSMA supports legislation mandating motorcycle helmets for all motorcycle riders. (Res 16, C-87)

Life Vests

The WSMA supports legislation requiring that persons under age 12 on boats or water craft 26 feet long and under wear life vests while riding or operating such craft. (Res. C-2, A-97)

Seat Belts

The WSMA supports revision of current seat belt use legislation to require that children not be placed in seats where they could be struck by a deploying air bag. (Res C-4, A-97)

ACCREDITATION/LICENSURE

The WSMA supports the licensing of physicians by individual states. (CPA Rpt E, A-97)

Credentials Applications

The WSMA urges all medical staffs, hospitals, health plans, health insurers and all other organizations that credential physicians to modify clauses in their credentials applications to place a time limit of not greater than 3 years on the reporting by physicians of unsuccessful claims of professional negligence against them. (Res B-7, A-03)

Criminal Background Checks

The WSMA is committed to working to ensure public safety by advocating for the use of federal criminal background checks on license applications provided that such background checks do not unduly delay the processing time. (Res B-7, A-01)

Information/Education

The WSMA encourages public educational efforts concerning scientific criteria for determination of medical necessity and efficacy, and sources of information whereby the public may determine the prevailing scientific opinion concerning various procedures and practices represented as health care. (Res 9, B-87)

JCAHO

The WSMA believes participation in the JCAHO accreditation programs should be voluntary and not tied to participation in public health insurance programs or licensing requirements. (Res B-3, A-99)

License Fees

The WSMA opposes increased license fees for physicians in training. (BT 5/90)

Medical Institutions

The WSMA urges the state of Washington to maintain appropriate accreditation for all its state medical institutions, and to expend the funds necessary to maintain standards set by accrediting authorities in order to maintain an acceptable level of psychiatric care. (Res 52, B-89)

National Practitioner Data Bank

The WSMA believes that all licensed health care providers should be subject to mandatory reporting to the National Practitioner Data Bank for: 1) adverse licensure actions; 2) adverse clinical privilege actions; 3) adverse professional society membership actions; 4) paid malpractice judgments or settlements; 5) adverse Medicare/Medicaid participation actions; and, 6) if applicable, adverse DEA licensure actions. (Res B-13, A-08)

Non-Traditional Medical Practitioners

The WSMA opposes legislatively mandated recognition, or insurance payment, for unproven services which are represented as health care, but which are not recognized by prevailing scientifically-based medical opinion as either necessary or efficacious in medical care. (Res 9, B-87)

Office Laboratory Accreditation

The WSMA endorses the accreditation program for office laboratories of the Commission on Office Laboratory Accreditation. (Res B-3, A-93)

Telemedicine

The WSMA supports legislative efforts that would require that an out-of-state provider who wishes to use telemedicine to evaluate and consult upon a patient in the state of Washington (other than on an irregular or infrequent basis) be licensed in this state. The WSMA believes that these providers should be subject to the same professional and supervisory responsibilities, quality assurance and utilization management activities consistent with the scope of practice of similar providers practicing in the state of Washington. (Res B-6, A-96)

Verification Service

The WSMA encourages the Washington State Board of Medical Examiners, hospital credentialing committees, medical societies, and professional associations to subscribe to and utilize the AMA's National Physician Credential Verification Service. (Res 1, A-91)

ADOLESCENT CARE

The WSMA is committed to Adolescent Health Care Issues through continued support of community awareness programs such as PACE and the WSMA Auxiliary's annual statewide Teen Health Forum, to address and educate teens about healthy lifestyles and the major adolescent morbidities including teen pregnancy, sexually transmitted diseases, substance abuse, and accident and injury prevention.

The WSMA supports the development of an ongoing data base on adolescent health issues in Washington State using the WSMA Adolescent Health Task Force and existing state resources for educating physicians, legislators and the public. (EC Rpt Q, A-88; EC Rpt S, A-88; Res 28, C-88; EC Rpt M, A-89; EC Rpt J, A-90)

Access

The WSMA encourages physicians to assist in the development of school-based and/or school-linked sites of care and work to assure that these activities will complement care provided by their current personal physician so that all adolescents in their communities have access to comprehensive health services. (Res A-1, A-99)

ADHD

The WSMA encourages physicians to utilize standardized diagnostic criteria in making the diagnosis of ADHD, such as the American Psychiatric Association's DSM-IV, as part of a comprehensive evaluation of children, adolescents, and adults presenting with attentional or hyperactivity complaints. (CPA Rpt D, A-97)

The WSMA encourages the University of Washington School of Medicine, all relevant residency programs within the state, and continuing medical education sponsors to expand educational efforts which will increase physician knowledge about ADHD, its treatment, and serious abuse potential of the prescribed medication. (CPA Rpt D, A-97)

The WSMA encourages the use of individualized therapeutic approaches for children diagnosed with ADHD, which may include pharmacotherapy, psycho-education, behavioral therapy, school-based and other environmental interventions, and psychotherapy as indicated by clinical circumstances and family preferences. (CPA Rpt D, A-97)

The WSMA encourages physicians to work with educators to improve their ability to recognize ADHD and appropriately recommend that parents seek medical evaluation of potentially affected children. (CPA Rpt D, A-97)

The WSMA advocates the use of state funds as grants to programs which could deliver the non-pharmacologic services for the treatment of ADHD. (CPA Rpt D, A-97)

Drivers Licenses

The WSMA supports legislation providing for graduated driving privileges for persons aged 15½ - 18 years of age. (Res C-5, A-97; Res C-12, A-98)

Foster Care Children

The WSMA believes that when placing children in foster care, all medical information should be expeditiously provided to the foster care parent. (Res 51, A-90)

The WSMA supports the development of a fee-for-service case management program for foster children within the Department of Social and Health Services. (Res A-4, A-00)

The WSMA supports the creation of a foster care health unit supervised by a physician within DSHS, devoted to ensuring access to and maintaining the quality of medical care provided to Washington State children in foster care. (Res A-5, A-05)

The WSMA encourages the state to provide preschool tuition subsidies for those 3-5 year old foster children who are not – or are unable to be –enrolled in the Head Start Program or the State's Early Childhood Education Assistance Program (ECEAP). (Res C-6, A-06)

AGING

The WSMA is committed to educating the public to better understand the cost of quality health care, nursing home costs, and to change existing attitudes regarding long term care, by encouraging such

options as home care, chore services, and the Community Options Program Entry System (COPES), to give the elderly assisted living in a less regimented, institutionalized environment.

The WSMA supports coordinated efforts with the governor's Nursing Home Advisory Council and other concerned groups, to identify problems of common interest and concern between physicians and other nursing home administrators, so the needs and interests of those residing in nursing homes can be best served. (EC Rpt K, A-89)

Injury Prevention

The WSMA promotes the use of safe and sturdy foot wear to prevent fall injuries to older adults. (Res 10, A-91)

Long Term Care

The WSMA believes private funding sources, such as private insurance, must be integrated into public funding for long-term care. The WSMA supports the collection of data on the long-term care patient in order to develop creative alternatives to nursing home care. (Res 17, 26, A-88)

Nursing Home Surveys

The WSMA urges the inclusion of physicians, preferably experienced in nursing home care, on nursing home survey teams. (Res 21, C-91)

Paperwork

The WSMA supports the development and expansion of pilot projects aimed at reducing burdensome paperwork and correspondence which does not contribute to improved patient outcomes and to continue to support improvement of nursing home care throughout the state. (Res C-3, A-93)

AIDS/HIV

Confidentiality

The WSMA believes physicians have an ethical and legal obligation to respect the rights of privacy and confidentiality of HIV-positive individuals, while allowing for appropriate transmission of information among health care providers when caring for the individual. The exchange of medical information relating to sexually transmitted diseases (HIV included) should remain confidential except when in conformation with confidentiality regulation (WAC 248-100-0016). (Res 28, B-89; Res 9, A-90; Res 35, A-90; Res 37, A-90; JC 2.18-87)

Education

As education is one of the most important means of AIDS prevention, the WSMA encourages physicians to be an educational resource to assist parents in educating their children about AIDS and AIDS prevention. The WSMA recognizes the increasing numbers of AIDS cases occurring in women and children, and emphasizes the need for stronger prevention and research efforts, as well as the provision of care and services for children born to HIV positive mothers. (EC Rpt G, A-91; Res 21, A-88)

The WSMA encourages the adequate education of its members and other appropriate health care providers on the utility of routine screening of all patients for risk behaviors for HIV/AIDS and other STDs, on the signs and symptoms of HIV disease, appropriate standards for the management of HIV disease and on appropriate messages designed to effect risk reduction among those with HIV and those not yet infected. The WSMA encourages such educational offerings to become a standard part of continuing medical education. (EC Rpt A, A-96)

Ethical Responsibility to Treat

Physicians may not ethically refuse to treat a patient whose condition is within that physician's realm of competence solely because the patient is HIV seropositive. (Res 25, A-87; JC 2.18-87)

Monitoring HIV-Infected Physicians

Any HIV-infected physician should disclose his/her serostatus to a local review committee. This committee may restrict the physician's practice, if they believe there is a significant risk to patients' welfare. One such restriction may be disclosure of physician seropositivity to patients and obtaining patient consent prior to a procedure deemed to pose a significant risk. Those who do not abide by local review committee restrictions should be reported to appropriate authorities such as the state licensure board.

Any physician who performs patient care procedures that pose a significant risk of transmission of HIV infection should voluntarily determine his/her serostatus at intervals appropriate to risk. (EC Rpt H, A-92)

Health Care Workers

Employees of the health care system who might be at risk of contacts with infected blood or other body fluids must be afforded all available and practical protection to assure a low level of personal risk of occupational infection. Universal precautions and all other applicable infection control measures must be understood and consistently used to safeguard the health of all personnel. Physicians should be aware of the legal requirement to adhere to the new OSHA regulations on bloodborne diseases. (EC Rpt H, A-92)

The WSMA believes all medical personnel should receive intensive AIDS education regarding both levels of risk and infection control precautions. If medical personnel are found seropositive, they should request medical guidance as to which activities they should/should not perform to best prevent the spread of the virus. Until there is scientific evidence to the contrary, HIV-infected health care workers should be permitted to provide care and services as long as there is no risk of patient infection and no compromise in their physical or mental ability to perform care and service. (Res 6, B-89)

Health Care Workers-Testing

The WSMA opposes mandatory testing of health care professionals, as well as mandatory disclosure of HIV seropositive health care professionals. (EC 9/91)

Mandatory Testing

WSMA opposes HIV testing as a condition of medical staff privileges. (EC Rpt H, A-92)

Needle Exchange

The WSMA supports legislation legalizing needle exchange programs as an effective means to reduce the spread of the HIV virus. (Res 57, A-89)

Partner Counseling and Referral Services

The WSMA strongly recommends that the State Board of Health modify rules around Partner Counseling and Referral Services (PCRS) so that all providers are required to routinely refer to or otherwise work with public health officials to assure that this important PCRS service is provided to all newly-identified persons with HIV infection and those who may subsequently expose other partners. (Res A-6, A-04)

Partner Notification

The WSMA believes that where there is no statute that mandates or prohibits the reporting of seropositive individuals to public health authorities and a physician knows that a seropositive

individual is endangering a third party, the physician should: 1) attempt to persuade the infected patient to cease endangering the third party; 2) if persuasion fails, notify authorities; and 3) if the authorities take no action, notify the endangered third party. (JC 2.18-87)

Patient Concern and Protection

Public education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small.

When the scientific basis for patient protection policy decision is unclear, physicians must err on the side of protecting patients. (EC Rpt H, A-92)

Reporting

The WSMA supports the development of a systematic requirement for all practitioners and laboratories identifying persons with HIV infections to report all such cases to local public health authorities in a complete, timely, and confidential fashion. (Res A-2, A-97)

Testing Patients

Explicit consent should not always be required prior to HIV testing. However, pretest counseling must always be conducted for patients receiving routine HIV testing. Post-test information in the form of a simple verbal or written report must be given for negative reports. Full pretest and post-test counseling must be conducted for patients when HIV is the focus of the medical attention, or when a history of high risk behavior is present; full post-test counseling is always required when test results are positive. Physicians must be aware that most states have enacted laws requiring informed consent before HIV testing. (EC Rpt H, A-92)

The WSMA supports informed consent and pre-test counseling requirements for testing, and the WSMA supports the simplification of pre-test counseling leading to informed consent for HIV testing. (EC Rpt G, A-91; EC Rpt G, A-90)

The WSMA supports anonymous testing to increase testing and counseling of people at risk for HIV. (EC Rpt G, A-90; Res A-2, A-97)

The WSMA supports the development of effective and efficient statewide programs of provider-referral, assisted partner-referral, partner notification, and pre- and post-test counseling to maximize acceptance of HIV testing among persons at risk. (EC Rpt G, A-90)

The WSMA strongly recommends that the State Board of Health simplify the rules around HIV counseling and testing, including the elimination of the current requirement that patients document their consent for testing separately from the general consent for care, and the highly prescriptive requirements for screening patients for risk and counseling persons in need of HIV testing. (Res A-7, A-04)

Testing Pregnant Women

The WSMA supports the USPHS/CDC guidelines urging that pregnant women undergo HIV counseling and testing and that those found to carry HIV be urged to take appropriate anti-retroviral treatment to protect their offspring. (EC Rpt A, A-96)

The WSMA supports the Center for Disease Control guidelines and strongly urges all providers seeing pregnant women to become aware of the clinical evidence and to implement the new standards for screening and treating women for HIV infection. (Res A-1, A-96)

Underground Manufacture and Sale of Drugs

Physicians should be urged to inquire of a patient with HIV infection whether the patient is taking unprescribed medications or drugs manufactured by a pharmaceutical company with an unfamiliar name. Physicians should inform the patient of the possible ineffectiveness and complications of such medications. (EC Rpt H, A-92)

ALCOHOL AND ALCOHOLISM

Advertisement

The WSMA supports regulatory or legislative action to impose standards of responsible alcohol advertising and promotion. (Res 23, A-84; Res 43, C-89)

Drinking and Driving

The WSMA supports lowering the minimum blood alcohol content which drivers are considered to be legally drunk from 0.10mg% to 0.08mg% for adults and 0.04mg% for children. (Res 41, C-89; EC 11/91)

Reporting of Blood Alcohol Content

The WSMA opposes any legislation or regulation which would require physicians who are diagnosing, treating and caring for patients involved in motor vehicle accidents to report blood alcohol levels to law enforcement agencies. (Res A-10, A-99)

Taxation

The WSMA supports legislation increasing an excise tax on alcoholic beverages with the revenue funding educational programs to prevent alcohol abuse, as well as supporting victims of alcohol abuse. (Res 44, C-89)

Treatment

The WSMA supports increased state financial resources for substance abuse treatment through the Alcohol and Drug Addiction Treatment Support Act program and/or methadone treatment programs. (Res 31, C-89)

ALTERNATIVE DISPUTE RESOLUTIONS

The WSMA supports the use of alternative dispute resolution processes in place of the existing tort law reform system in order to reduce transactional expenses, speed payment to injured parties and increase access. (EC Rpt B, '90)

Washington Dispute Resolution Alternative (WDRA)

The WSMA endorses the Washington Dispute Resolution Alternatives, (WDRA), a non-profit corporation.

The WSMA supports the development of fee schedules for administrative services of dispute resolutions that will fund WDRA financial requirements.

The WSMA encourages WDRA to seek financial support from research and grant entities committed to studying alternative dispute resolution systems. (Res 34, B-90)

AMERICAN MEDICAL ASSOCIATION

All WSMA members are strongly encouraged to become members of the AMA so that the voice of Washington State physicians can continue to be articulated to the fullest extent on the national level. (Res D-6, A-04)

ARTIFICIAL INSEMINATION

The WSMA supports the necessity of informed consent from the woman seeking artificial insemination and her husband; the parents should be informed that any child conceived by artificial insemination is entitled to the rights of a child conceived naturally. (JC 2.04-87)

Artificial Insemination by Donor

The identity of semen donors usually should not be available to recipients or resulting children; therefore, the risk of possible genetic defects should not be ignored. (JC 2.05-87)

BENEFITS PACKAGES

The WSMA will work with the government and private sector to strip away health plan benefits and provider mandates, and create a “bare bones” or catastrophic benefits package. (EC Rpt A, A-01; BT Rpt J, A-01; EC Rpt F, A-02)

Basic Health Plan

The WSMA supports implementation of the Basic Health Plan beyond its pilot project status. The plan should be expanded to be available to all working uninsured Washingtonians with income between 100% and 200% of the federal poverty level, with the necessary funding reflecting graded premiums and broadly based societal support. (Res 20, C-87; Res 2, C-88; Res 55, C-89; EC Rpt B, A-90)

Uniform Benefits Package

The WSMA encourages the development of a condition/service specific Uniform Benefits Package that is "limited," so as to create a better public recognition that resources are not available to meet all the needs of all the citizens of Washington. The WSMA actively encourages public participation in defining the "limited" package as it is the public that needs to decide between affordability and comprehensiveness. (EC Rpt K, A-94)

BIOMEDICAL RESEARCH

The WSMA supports humane animal research by qualified medical researchers, working under state and federal guidelines, as an effective, ethical and necessary method of improving the health of animals and humans. (Res 10, A-87; Res 4, A-90)

BIRTH CONTROL

The WSMA encourages reproductive privacy, including individual rights to choose or refuse the use of birth control. (EC 9/91; C-14, A-06)

Emergency Contraceptives

The WSMA supports the pilot program that allows retail pharmacists in Washington to dispense emergency contraceptives directly to patients under a prescriptive protocol, with a local physician advisor. The WSMA believes these pharmacist-physician alliances should be overseen by both the Washington State Board of Pharmacy and the Medical Quality Assurance Commission. (Res A-2, A-98)

The WSMA encourages physicians to educate patients about emergency contraception, in advance of the patient's stated need, whenever such education appears appropriate and feasible. (Res C-14, A-06)

The WSMA supports the dissemination of accurate information about emergency contraception. (Res C-14, A-06)

The WSMA supports the statewide availability of emergency contraceptives products, and associated educational services, during appropriate hours and under standards that do not pose an unreasonable burden to patients and consumers. (Res C-14, A-06)

BLOOD

Confidentiality

The WSMA supports the confidentiality of blood donors. (EC 9/89)

Selling Blood

The WSMA supports working with the Department of Social and Health Services to eliminate the requirement of welfare recipients to complete a questionnaire stating if they sell blood in order to determine whether the applicant is eligible for food stamps or other welfare benefits. (Res 14, C-85)

CANCER

The WSMA encourages local cancer surveillance units or hospital tumor registries to release information to interested radiologists, on a reason-to-know basis, the names of breast cancer patients who have had mammography performed in order to evaluate the efficiency of said radiologist testing. (Res 43, A-90)

CAPITAL PUNISHMENT

The WSMA supports the physician as a member of a profession dedicated to the preservation of life when there is a hope of doing so. Therefore, participation in a legally authorized execution is discouraged by the WSMA. (JC 2.06-87)

CASTRATION

The WSMA believes it is not appropriate for physicians to participate in the castration of sex offenders until the efficacy of such treatment is proven, or unless the physician is participating in a clinical investigation and has obtained the patient's consent and is following the guidelines for such study. (JC Rpt A, A-90)

CHIROPRACTORS

The WSMA opposes including chiropractic services under industrial insurance/workers' compensation. (EC 9/91)

Scope of Practice

The WSMA is opposed to the definition (or "like" definitions) of "chiropractic practice" as a practice providing point of entry into the health system for the treatment and referral of patients. The WSMA is opposed to all expansion of chiropractic scope, including non-spinal procedures and particularly manipulation of extremities complementary to or preparatory to a chiropractic spinal adjustment. (EC 2/90; Res 17, A-89; Res 43, B-88)

CLINICAL INVESTIGATION

In order to aid physicians in fulfilling their responsibilities when they engage in the clinical investigation of new drugs and procedures, the WSMA has established the following guidelines for clinical investigations:

- 1) A physician may participate in clinical investigation only to the extent that those activities are a part of a systematic program competently designed, under accepted standards of scientific research, to produce data which are scientifically valid and significant.
- 2) In conducting clinical investigation, the investigator should demonstrate the same concern and caution for the welfare, safety and comfort of the person involved as is required of a physician who is furnishing medical care to a patient independent of any clinical investigation.
- 3) In clinical investigation primarily for treatment –
 - a) The physician must recognize that the physician-patient relationship exists and that professional judgment and skill must be exercised in the best interest of the patient.
 - b) Voluntary written consent must be obtained from the patient, or from a legally authorized representative if the patient lacks the capacity to consent, following:
 - a) disclosure that the physician intends to use an investigational drug or experimental procedure;
 - b) a reasonable explanation of the nature of the drug or procedure to be used, risks to be expected, and possible therapeutic benefits;
 - c) an offer to answer any inquiries concerning the drug or procedure; and
 - d) a disclosure of alternative drugs or procedures that may be available.
 - i) In exceptional circumstances and to the extent that disclosure of information concerning the nature of the drug or experimental procedure or risks would be expected to materially affect the health of the patient and would be detrimental to his/her best interests, such information may be withheld from the patient. In such circumstances, such information shall be disclosed to a responsible relative or friend of the patient where possible.
 - ii) Ordinarily, consent should be in writing, except where the physician deems it necessary to rely upon consent on other than written form because of the physical or emotional state of the patient.
 - iii) Where emergency treatment is necessary, the patient is incapable of giving consent, and no one is available who has authority to act on his/her behalf, consent is assumed.

4) In clinical investigation primarily for the accumulation of scientific knowledge –

a) Adequate safeguards must be provided for the welfare, safety, and comfort of the subject. It is fundamental social policy that the advancement of scientific knowledge must always be secondary to primary concern for the individual.

b) Consent, in writing, should be obtained from the subject, or from his/her legally authorized representative if the subject lacks the capacity to consent, following: a) a disclosure of the fact that an investigational drug or procedure is to be used; b) a reasonable explanation of the nature of the procedure is to be used and risks to be expected; and c) offer to answer any inquiries concerning the drug or procedure.

c) Minors or mentally incompetent persons may be used as subjects only if:

i) The nature of the investigation is such that mentally competent adults should not be suitable subjects.

ii) Consent, in writing, is given by a legally authorized representative of the subject under circumstances in which an informed and prudent adult would reasonably be expected to volunteer him/herself or his/her child as a subject.

d) No person may be used as a subject test against his/her will.

e) The overuse of institutionalized persons in research is an unfair distribution of research risks. Participation is coercive and not voluntary if the participant is subjected to powerful incentives and persuasion. (JC 2.07-87)

CLINICAL LABORATORY IMPROVEMENT ACT

The WSMA supports the granting of a Washington State waiver from the federal CLIA licensing regulations, and opposes the Health Care Financing Administration from assessing federal fees on state physicians in addition to state laboratory fees. (EC Rpt L, A-92)

CLINICAL TRIALS

Reimbursement and Coverage Implications of

The Washington State Medical Association recommends that the Health Care Financing Administration (HCFA) and other third party payers not deny coverage and reimbursement for the costs of medical care to patients entered in qualifying clinical trials of therapeutic regimens at any phase. Covered costs should include those usually covered (hospital care and physician and other health care services), as well as the costs of all FDA-approved agents utilized in the trial, regardless of whether use is for an on-label or off-label indication. Qualifying clinical trials must satisfy all of the following inclusion criteria:

1) Treatment is being provided pursuant to a clinical trial which has been approved by the Food and Drug Administration in the form of an investigational new drug exemption, the Department of Veterans Affairs, or a qualified nongovernmental research entity;

2) The proposed therapy has been reviewed and approved by a qualified institutional review board;

3) The facility and personnel providing the treatment are capable of doing so by virtue of their experience or training;

4) There is no noninvestigational therapy that is clearly superior to the protocol treatment; and

5) The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as noninvestigational therapy. (Res C-2, A-93)

CONFIDENTIALITY

The WSMA believes the information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law.

The WSMA affirms that the physician obligation to safeguard patient confidences is subject to certain exceptions because of overriding social considerations. Where a patient threatens to inflict bodily harm to another person and there is reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities.

The WSMA encourages communicable disease and gunshot/knife wound reporting as required by statutes or ordinances. (JC 5.06-87)

Attorney-Physician Relations

The WSMA supports the discussion of a patient's history, diagnosis, treatment, and prognosis with the patient's lawyer with consent of the patient or his/her legal representative.

The WSMA affirms that it is not improper for a physician to testify in court or before a workmen's compensation board or the like in any personal injury case. (JC 5.07-87)

Computers

The WSMA believes the utmost effort must be taken to protect the confidentiality of all medical records, including all computerized medical records. (JC 5.08-87)

Insurance Company Representative

The WSMA believes the history, diagnosis, prognosis, and the like acquired during the physician-patient relationship may be disclosed to an insurance company representative only if the patient or his/her lawful representative has consented to the disclosure. (JC 5.09-87)

Hospital Commission Regulations

The WSMA supports working with the Washington State Hospital Association to repeal or modify the Washington State Hospital Commission Administrative Order 84-02 which requires hospitals to report certain patient discharge data, including information necessary for identification of discharges by diagnostic related groups. According to current Washington law, the WSMA understands that the Hospital Commission does not have the authority to collect information which is patient identifiable. (RCW 70.39.100 (5); EC Rpt I, A-84; Res 27, C-84)

Media

The WSMA believes that a physician should not discuss a patient's medical condition, disease, or illness with the press without the patient's authorization. In order to aid physicians in understanding what information is in the public domain and can be made available without the patient's consent, the

WSMA has established guidelines detailed in the 1987 Judicial Council Opinions, 5.05. (JC 5.04,.05-87)

Minors

1) When minor patients request confidential services, physicians should encourage them to involve their parents. This includes making efforts to obtain the minor's reasons for not involving their parents and correcting misconceptions that may be motivating their objections. The determination of the minor's need for confidentiality must consider the risk of parental abuse and be consistent with facilitating the timely utilization of needed health care.

2) Physicians who treat minor patients have an ethical duty to promote the autonomy of such patients by involving them in the medical decision-making process to a degree commensurate with their maturity, experience and judgment.

3) Where the law does not require otherwise:

a) Physicians should permit competent minor patients to consent to medical care and should not notify parents without the patients' consent. Depending on the seriousness of the decision, competence may be evaluated by physicians for most minors. When necessary, experts in adolescent medicine or child psychological development should be consulted. Use of the courts for competence determinations should be made only as a last resort.

b) When a minor patient requests contraceptive services, pregnancy-related care (including pregnancy testing, prenatal and postnatal care, and delivery services), or treatment for sexually transmitted disease, drug and alcohol abuse or mental illness, physicians must recognize that requiring parental involvement may be counterproductive to the health of the patient. Physicians should encourage parental involvement in these situations. However, if the minor continues to object, his or her wishes ordinarily should be respected. If the physician is uncomfortable with providing services without parental involvement, and alternative confidential services are available, the minor should be referred to those services. In cases when the physician believes that without parental involvement and guidance, the minor will face a serious health threat, and there is reason to believe that the parents will be helpful and understanding, disclosing the problem to the parents is ethically justified. When the physician does breach confidentiality to the parents, he or she must discuss the reasons for the breach with the minor prior to the disclosure.

c) For minor patients who are mature enough to be unaccompanied by their parents for their examinations, confidentiality of information disclosed during an exam, interview, or in counseling should be maintained. Such information may be disclosed to parents when the patient consents to disclosure. Confidentiality may be justifiably breached in situations for which confidentiality for adults may be breached. In addition, confidentiality for immature minors may be ethically breached, after discussing reasons for the breach with the minor, when necessary to enable the parent to make a mature and informed decision about treatment for the minor or when such a breach is necessary to avert serious harm to the minor.

d) Physicians should not feel, or be, compelled to require minors to obtain consent of their parents before deciding whether to undergo an abortion. The patient – even an adolescent – generally must decide whether, on balance, parental involvement is advisable. Accordingly, minors should ultimately be allowed to decide whether parental involvement is appropriate. Physicians should explain under what circumstances (e.g., life-threatening emergency) the minor's confidentiality will need to be abrogated.

e) Physicians should ensure that minor patients have made an informed decision after giving careful consideration to the issues involved. They should encourage their minor patients to consult alternative sources if parents are not going to be involved in the abortion decision. Minors should be helped to seek the advice and counsel of those adults in whom they have confidence, including professional counselors, relatives, friends, teachers or the clergy.

4) When laws violate these ethical standards, physicians should fulfill their legal requirements. However, such laws should be altered to conform with these guidelines. Physicians should play an active role in changing laws that are not in conformity with these standards.

5) Physicians should consider the possibility of inadvertent breach of confidentiality when a minor is receiving care under their parent's insurance, resulting in specific billing statements to the parents. (JC Rpt A, A-93)

Physicians in Industry

The WSMA believes that where a physician's services are limited to pre-employment physical examinations or examinations to determine if an employee who has been ill or injured is able to return to work, no physician-patient relationship exists between the physician and those individuals. However, the information obtained by the physician should not be communicated to a third party without the individual's prior written consent, unless it is required by law.

The WSMA believes that a physician-patient relationship does exist when a physician renders treatment to an employee, even though the physician is paid by the employer. If the employee's illness or injury is work-related, the release of medical information as to the treatment provided to the employee may be subject to the provisions of worker's compensation laws. (JC 5.10-87)

Venereal Disease and Drug Dispensing

The WSMA believes that a physician is not precluded from dispensing appropriate medication to a patient who has been diagnosed as having a venereal disease, such as gonorrhea, since forcing a patient to have such a drug dispensed in the presence of pharmacists could very well destroy the confidential nature of that particular patient-physician relationship. (JC 5.11-87)

CONTRACTUAL RELATIONSHIPS

The contractual relationships that physicians assume when they enter prepaid group practice plans are varied. Income arrangements may include hourly wages for physicians working part-time, annual salaries for those working full-time, and share of group income for physicians who are partners in groups that are somewhat autonomous and contract with plans to provide medical care.

The WSMA recognizes that under proper legal authority such plans may be established and a physician may be employed by, or otherwise serve, a medical care plan. In the operation of such plans, physicians should not be subjected to lay interference in professional medical matters, and their primary responsibility should be to the patients they serve. (JC 8.05-87)

The WSMA reaffirms its position that health insurance company contracts shall not intrude upon the essential elements of the patient-physician relationship. Physician gag clauses, Wickline clauses, and health insurance companies' claims to being "sole definers of medical necessity" are antithetical to quality patient care. (Info Rpt 9, A-98)

Physician Dismissal

The WSMA has taken a position against the institution of physician dismissal from an insurance plan contract unless a cause is identified to the party so affected. The WSMA supports legislative action

with the intent of prohibiting the insertion of such provisions in contracts for service between physicians and third party carriers. (Res B-3, A-97)

Physician-Hospital Contractual Relations

The WSMA recognizes that there are various financial or contractual arrangements that physicians and hospitals may enter. The WSMA supports the form of the contractual or financial arrangement between physicians and hospitals as dependent on the facts and circumstances of each situation. (JC 4.06-87)

Selective Contracting

1) Those health delivery or financing systems that contract with selected physicians to furnish care should utilize selection criteria based primarily on professional competence and quality care. Any economic criteria used in selective contracting should have a demonstrated relationship to the quality and appropriateness of care and to professional competency.

2) Health plans that contract with selected providers should have an established mechanism by which any provider willing to abide by terms of the plan contract could appeal a decision to deny the provider's application for participation in the plan.

3) Health plans or networks should provide public notice within their geographic service areas when applications for participation are being accepted.

4) Physicians should have the right to apply to any health care plan or network in which they desire to participate and to have that application judged on the basis of objective criteria that are available to both applicants and enrollees.

5) Selective contracting decisions made by any health care delivery or financing system should be based on an evaluation of multiple criteria related to professional competency, quality of care, and the appropriateness by which medical services are provided. In general, no single criterion should provide the sole basis for selecting, retaining, or excluding a physician from a health care delivery or financing system.

6) Prior to initiation of actions leading to termination of a physician's participation contract "for cause," the physician should be given notice specifying the grounds for termination, an opportunity for discussion, and an opportunity to initiate complete remedial activities, except in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine.

(CPA Rpt D, A-93)

CORPORAL PUNISHMENT

The WSMA opposes the use of corporal punishment in schools, and encourages all schools to adopt policies prohibiting corporal punishment. The WSMA encourages instead the use of alternative methods of discipline to produce responsible student behavior. (EC 9/91; EC Rpt I, A-91)

DATA COLLECTION

The WSMA supports the collection and objective analysis of clinical outcomes and business costs of individual health care delivery systems, and public dissemination of such information.

(Res B-5, A-93)

Release of Provider-Specific Information

WSMA policy states that the methods for collecting and analyzing provider-specific health care data must adhere to the following principles:

- 1) The methods for collecting and analyzing provider-specific health care data shall be disclosed to providers under review and to the public.
- 2) Providers under review and relevant provider organizations shall be provided with an adequate opportunity to review and respond to proposed provider-specific health care data interpretations and disclosures prior to their publication or release.
- 3) Provider-specific health care data shall be valid, accurate, objective, and used primarily for the education of consumers and providers.
- 4) Provider-specific health care data elements, including severity adjustment factors, shall be determined by a process which includes actively practicing providers knowledgeable in data definition, severity adjustment and regional variation.
- 5) Statistically valid data collection, analysis, and reporting methodologies, including establishment of a statistically significant minimum number of cases, shall be developed and appropriately implemented prior to the release of provider-specific health care data.
- 6) Reliable administrative, technical, and physical safeguards to prevent the unauthorized use or disclosure of provider-specific health care data shall be developed. Such safeguards shall treat all underlying non-public provider-specific health care data and all analyses, proceedings, records, and minutes from quality review activities on provider-specific health care data as confidential. Provisions shall be made that none of these documents be subject to discovery, or admitted into evidence in any judicial or administrative proceeding.
- 7) The quality and accuracy of the provider-specific health care data shall be routinely evaluated by a means such as conducting periodic medical records audits.
- 8) That the WSMA recognizes that the Federal Institutional Review Board (IRB) process provides an appropriate mechanism to ensure confidentiality of clinical information and controls its dissemination. (Res B-5/B-11, A-94)

DEATH/DYING

Advance Directives

The WSMA supports assurance that the specific wishes of the individual patient as specified in his/her Advance Directive be strictly honored in or out of the hospital setting. (Res A-4, A-93; Res A-5, A-06)

The WSMA reiterates its endorsements of the patient's – or the patient's designated or court appointed representative's – prerogative of formulating advance directives that ought be properly honored regardless of location. (Res C-6, A-95; Res A-5, A-06)

The WSMA encourages physicians to counsel all patients to take advantage of advance directives. (EC Rpt G, A-96)

The WSMA encourages its members to assure that they and their families, friends, and patients have all explored and discussed the options available with regard to Advance Directives and Durable

Powers of Attorney, have considered discussing same with their family members and have executed appropriately signed forms in all instances where they have concluded such would be of value to them. (Res A-1, A-02)

Cause of Death Certification

The WSMA affirms the responsibility of its members and all physicians to provide accurate, timely certification of cause of death for patients who have been under their care, and supports development of training programs and continuing medical education programs to promote the skills necessary to perform accurate cause of death certifications. (Res B-5, A-03)

Euthanasia

The WSMA strongly believes the social commitment of the physician is to prolong life and relieve suffering. For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment, including nutrition and hydration by other than normal natural methods, to let a terminally ill patient die, but he/she should not intentionally cause death.

The WSMA affirms that where a terminally ill patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis, all means of life support may be discontinued.

The WSMA encourages physicians, if arriving at decisions involving the withholding or withdrawing of invasive or extraordinary means, to have informed involvement of the patient or the patient's family or guardian. (Res 28, A-91; JC 2.14-87; Res 3, B-90; CHS Rpt H, '83)

Hospice

The WSMA encourages physicians to introduce hospice early in the course of treatment for a life threatening illness and to actively propose hospice when palliative care becomes the primary goal of treatment. (EC Rpt G, A-96)

Living Wills

The WSMA strongly supports the employment of living wills and durable power of attorney by patients to ensure their requests for life-prolonging medical treatments are met. (Res 7, B-85; Res 21, B-86)

Medical Futility in End-of-Life Care, WSMA Opinion on

When further intervention to prolong the life of a patient becomes futile, physicians have an obligation to shift the intent of care toward comfort and closure. However, there are necessary value judgments involved in coming to the assessment of futility. These judgments must give consideration to patient or proxy assessments of worthwhile outcome. They should also take into account the physician or other provider's perception of intent in treatment, which should not be to prolong the dying process without benefit to the patient or to others with legitimate interests. They may also take into account community and institutional standards, which in turn may have used physiological or functional outcome measures. Nevertheless, conflicts between the parties may persist in determining what futility means in the particular instance. This may interrupt satisfactory decision-making and adversely affect patient care, family satisfaction, and physician-clinical team functioning. To assist in fair and satisfactory decision-making about what constitutes futile intervention: (1) All health care institutions, whether large or small, should adopt a policy on medical futility; and (2) Policies on medical futility should follow a due process approach. The following seven steps should be included in such a due process approach to declaring futility in specific cases. (a) Earnest attempts should be made in advance to deliberate over and negotiate prior understandings between patient, proxy, and physician on what constitutes futile care for the patient, and what falls within acceptable limits for the physician, family, and possibly also the institution. (b) Joint decision-making should occur between patient or proxy and

physician to the maximum extent possible. (c) Attempts should be made to negotiate disagreements if they arise, and to reach resolution within all parties' acceptable limits, with the assistance of consultants as appropriate. (d) Involvement of an institutional committee such as the ethics committee should be requested if disagreements are irresolvable. Due process shall include allowing the patient or the patient's representative to have an advocate or legal counsel present at the ethics or other relevant institutional committee hearing. (e) If the institutional review supports the patient's position and the physician remains unpersuaded, transfer of care to another physician within the institution may be arranged. (f) If the process supports the physician's position and the patient/proxy remains unpersuaded, and transfer to another physician within the institution is not possible, transfer to another institution may be sought and, if done, should be supported by the transferring and receiving institution. Treatment should be continued while efforts are being made to locate and transfer to a receiving institution. (g) If transfer is not possible, the intervention need not be offered. (Res A-2, A-10)

No Codes

The WSMA believes the use of CPR in some instances can be contrary to the best interests of the patient. Therefore the WSMA believes that should the physician consider "code" harmful to the patient's best interest, it is necessary that the physician inform the charge nurse and sign the nurse's order card, or write the order as any other order. The physician's decision shall be guided by the consent of the patient, the patient's family or guardian. (JC 2.14.2-87)

The WSMA supports the enablement of basic and/or advanced life support units responding to an out-of-hospital emergency to honor a valid do-not-resuscitate directive. (Res 7, C-91)

Quality of Life

In making decisions for the treatment of seriously deformed newborns or persons who are severely deteriorated victims of injury, illness, or advanced age, the WSMA agrees that the primary consideration should be what is best for the individual patient and not the avoidance of a burden to the family or society. Life should be cherished despite disabilities and handicaps, except when the prolongation would be inhumane and unconscionable. Under these circumstances, the WSMA agrees that withholding or removing life supporting means is ethical. In situations involving newborns, the advice and judgment should be readily available, but the WSMA believes the decision whether to exert maximal efforts to sustain life should be the choice of loving parents, unless there is convincing evidence to the contrary. (JC 2.13-87)

The WSMA remains committed to professional standards that will always allow our patients to feel safe under our care without fear regarding any conflicting motives physicians may have. The WSMA remains committed to providing support for medical interventions that foster quality end of life care without participation in hastening death or providing a means for patients to hasten their own death. (Res A-7, A-07)

Withdrawal of Life Support

The WSMA agrees that for humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease to omit treatment, including nutrition and hydration by other than natural methods, to let a terminally ill patient die, but he/she should not intentionally cause death. (JC 2.14-87)

DISASTER RESPONSE

The WSMA will work to coordinate with existing national, state, and local disaster agencies a response system that will establish a plan to optimally mobilize all physicians, associated health care providers and medical students in the state to volunteer assistance appropriate to their training with

due regard to their own safety and that of their families. The WSMA will coordinate with county medical societies the role that they can play to ensure comprehensive statewide physician disaster response. (Res A-7, A-05; Res B-13, A-01)

The WSMA will participate and help coordinate disaster preparedness education programs throughout the state to enable attendees to recognize and properly respond to bio-terrorism, chemical exposures, radiation, and mass casualties. (Res A-7, A-05; Res B-13, A-01)

The WSMA supports the continued development of the Medical Reserve Corps. (Res A-7, A-05)

Education

The WSMA supports the newly-developed AMA one-day Basic Life Support and two-day Advanced Disaster Life Support education and certification program. (Res A-4, A-04)

Patient Medication Supplies

The WSMA supports state and national legislation to promote a 30-day supply of medication, upon request, to be covered by public and private insurance plans for patients with chronic conditions. (Res C-2, A-06)

DISCIPLINE AND MEDICINE

The WSMA believes a physician should expose, without fear or favor, incompetent, corrupt, dishonest, or unethical conduct on the part of members of the profession. The WSMA strongly believes that an ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws. (JC 9.04-87; Res 8, B-85)

DISCIPLINARY PROCEDURES

The WSMA approves the principle of assessing fines against citizens who conduct themselves in a manner hazardous and dangerous to the public. The WSMA supports the suspension of the license of physicians found guilty of an offense until the designated fine is paid, and such fines shall not be subject to appeal as the decision of the Medical Disciplinary Board may be appealed. (Res 28, D-83)

The WSMA affirms the need to maintain continued and improved communication among patients, physicians, hospitals, the legal profession, and the state, which will reassure the public that licensed physicians continue to meet professional, ethical and moral standards. (Res 28, B-90)

DISCRIMINATION

Gender Discrimination

WSMA policy states that all physicians should be judged solely on their medical abilities. (BT Rpt H, A-95)

Professional Discrimination

The WSMA supports legislation prohibiting health maintenance organizations, professional service corporations, health care professions, clinics, individuals, insurance companies, and hospitals from discriminating against a qualified osteopathic physician and surgeon solely on the basis of his or her designation as an osteopathic physician and surgeon, providing clinical equivalency in his or her professional training. (Res C-9, A-94)

DRUGS

Child Resistant Containers

The WSMA supports the appropriate use of child resistant containers when packaging and dispensing medications including pharmaceutical samples and veterinary drugs. (Res A-5, A-93)

Errors

The WSMA reiterates its longstanding supportive efforts to curtail the problems of drug errors. (Res A-12, A-00) As such, the WSMA encourages physicians to add a brief notation of "purpose" (i.e. symptom) on prescriptions, where appropriate, to avoid confusion on the part of either the pharmacist or the patient. The WSMA also encourages residency programs to use this technique for enhanced patient communication. In addition, the WSMA encourages all pharmacists to communicate knowledge about drug interactions, and other relevant drug information as warranted, with prescribing physicians. (Res B-1, A-95; Res B-6, A-98)

The WSMA supports clarity and legibility of all written physician communications, including prescriptions. (Res B-2, A-02)

The WSMA supports requiring that all prescriptions be hand printed, typed, or computer generated. (EC 10/04)

Governmental Group Purchase

The WSMA endorses the collaborative efforts already undertaken by many branches of state government to lower their respective pharmaceutical costs by collaborative purchasing arrangements while still permitting their respective consumers to be managed by our state's physicians with the optimum of pharmaceutical support. (Res C-9, A-04)

Imprint Coding/Labeling

The WSMA strongly supports the imprinting of solid medication forms, generic or trademark prescription, including over-the-counter preparations. The WSMA also encourages improving the labeling of vials used in medical practice. (Res 35, C-87; Res 14, C-90)

The WSMA believes symbols and logotypes should not be used on drug imprint codes. (Res A-1, A-00)

Involuntary Administration of Drugs

The WSMA believes a physician may administer certain medication to certain patients with psychological illnesses without their consent in order to protect them from harming themselves or others. The WSMA does not believe that the administration of involuntary medication for the mentally ill requires judicial review, as judicial hearings divert scarce resources from the care and treatment of the mentally ill. (Res 44, C-90)

Marijuana

The WSMA supports completion of ongoing studies legislated by RCW 69.51, regarding the clinical efficacy of marijuana. (Res C-6, A-96; EC Rpt L, A-97; Res C-9, A-98)

The WSMA supports reclassification of marijuana's status as a Schedule I controlled substance to a more appropriate schedule. (Res A-2, A-08)

The WSMA supports efforts to cease the criminal prosecution and other enforcement actions against physicians and patients acting in accordance with state medical marijuana law. (Res A-2, A-08)

Methadone

The WSMA supports the use of methadone maintenance as crucial in the treatment of opiate dependency and to decrease the spread of HIV infection. The WSMA supports legislation assuring rapid access to comprehensive methadone treatment for those who request or are referred for such treatment. The WSMA supports adequate funding for such therapy. (Res 9, C-91)

The WSMA supports changes in laws and regulations which currently prevent physicians who are deemed qualified by the medical profession from providing treatment for opiate addicted patients. (EC Rpt J, A-96)

Methaqualone

The WSMA seeks to eliminate the use of methaqualone in all patient care activities, and therefore encourages legislation to see methaqualone assigned to a Schedule One categorization of the Controlled Substances Act. Additionally, the WSMA supports voluntary activities of both community and hospital pharmacists to adopt a 48-hour delay in filling any prescription for methaqualone concomitant with a commitment not to stock such a compound on the premises. (Res 18, B-83)

Narcotics and Drug Use

The WSMA supports increased state financial resources for substance abuse treatment through the Alcohol and Drug Addiction Treatment Support Act program and/or methadone treatment programs. (Res 31, C-89)

Post Marketing Surveillance/Drug Sampling

The WSMA strongly endorses physicians' participation in post-marketing surveillance, including working with the State Department of Health to seek grant or contract funds to assure the surveillance program increases. The WSMA opposes any "novel" legislation or regulatory action that would restrict the reasonable conduct of drug sampling of licensed practitioners. (Res 37, C-87; Res 5, A-90)

Prescribing Practices

The WSMA supports the physician's legal right to diagnose illnesses and injuries, prescribe a method of treatment, and dispense prescription medication.

The WSMA endorses the use of triplicate prescription forms, as a condition for initial or re-licensure, when asked to do so by the Board of Medical Examiners Disciplinary Board, in order to facilitate investigation of allegations of misuse or over-prescriptive practices. (Res 26, D-83; PA Rpt B, '83; PA Rpt F, '83; PA Rpt F, '85; Res 38, C-87)

The WSMA believes it unethical for a physician to be influenced in the prescribing of drugs or devices by his/her direct or indirect financial interest in a pharmaceutical firm or other supplier. (JC 8.06-87)

The WSMA believes that a patient is entitled to a copy of his/her prescription for glasses, drugs, or devices and he/she has the privilege of having the prescription filled wherever he/she wishes. (JC 8.06-87)

Physician Drug Testing

The WSMA recommends that each hospital medical staff adopt a provision in the medical staff bylaws which requires physician staff members to be free from abuse of any type of substance or chemical that affects cognitive, motor or communication abilities in a manner that interferes with, or presents reasonable probability of interfering with, the physician's ability to optimally discharge his/her medical practice responsibilities.

In addition, the WSMA recommends the bylaws provide that medical staff members be required to submit to or obtain such examinations or tests as may be reasonably requested by an appropriate authority of the medical staff when reasonable suspicion suggests that a problem may exist. The WSMA recommends that each hospital medical staff establish an "impaired physician committee" to develop a testing program, establish reasonable suspicion guidelines, and methods by which positive tests, possible interventions, and rehabilitative treatment can be managed.

The WSMA believes physicians convicted of DWI should automatically be reported to the State Disciplinary Board, who may impose appropriate procedures for evaluation, treatment and on-going monitoring of substance or chemical abuse problems discovered which seems capable of affecting optimal medical care by that physician. (PA Rpt D, '87)

Single Name Identifier

The WSMA promotes policy by the Washington State Board of Pharmacy and, if needed, supports legislation which would require the use of a single name identifier for all individuals being prescribed or dispensed controlled or scheduled drugs. (Res C-11, A-95)

Thalidomide

The WSMA supports the System for Thalidomide Education and Prescribing Safety Program (STEPS) which was created to prevent fetal exposure to Thalidomide.

Treatment

The WSMA endorses court-supervised drug treatment with preservation of physician-patient confidentiality in lieu of incarceration for persons in need of such treatment arrested solely for the use of controlled substances. (Res A-1, A-01)

The WSMA endorses the three central recommendations of the Drug Addiction Treatment Task Force's drug treatment plan: 1) drug addiction treatment should be available to every Washington resident who needs it; 2) drug treatment should be complemented by other needed treatment and assistance, including mental health treatment; and, 3) special efforts should be made to assure that drug treatment, including inpatient treatment, is promptly available to children who need it. (Res A-2, A-01)

EDUCATION

CPR/AED Training

The WSMA supports CPR/AED training as part of the new mandated health requirements for high school students in Washington state. (Res A-21, A-05)

Health Education Alliance

The WSMA believes that health education is an integral part of a comprehensive health system. The WSMA supports the Health Education Alliance. (Res 7, A-86)

Public Education

The WSMA supports legislatively and through administrative action by the state, the inclusion of health education as an integral part of the legal definition of basic education. (Res 3, A-87)

School Start Times

The WSMA supports legislation which would restrict early morning school start times consistent with the findings of chronobiology and other medical studies on the performance of students. (Res C-1, A-97)

Work Hours

The WSMA reaffirms its support of legislation restricting the hours of work allowed per week and late at night for children and adolescents. (Res C-1, A-97)

EDUCATION - MEDICAL

Condom Education and Access for Teens

The WSMA urges families, schools, the media and others in positions of authority to teach the value of abstinence from premature sex through programs that teach sexual abstinence, self-discipline and responsible attitudes toward sexuality, together with refusal skills to cope with peer pressure and endorses comprehensive education which reduces the risks for unwanted pregnancy and sexually-transmitted disease, including the proper use of condoms for all who are sexually active.

(Res 9, A-92)

Continuing Medical Education

The WSMA opposes AMA policy revisions to the Physician Recognition Award which requires applicants to obtain a minimum of 20 hours of Category II credit each year, and disallows credit for independent study or reading.

The WSMA opposes the requirement that AMA Physician Recognition Award Category II credit only be provided by accredited sponsors. (CPA Rpt L, A-92)

The WSMA opposes legislation which would eliminate the current continuing medical education requirements. The WSMA supports mandating continuing medical education, but opposes disease specific mandatory education requirements. (EC 9/91; EC Rpt D, '91)

CME Fees for Retired Physicians

The WSMA supports reduced CME Course fees for retired physicians. (EC 10/91)

Eastern Washington Medical School

The WSMA supports expansion of a publicly-funded medical school, and a study of the feasibility of a publicly supported medical school to better serve the residents of Eastern Washington.

(Res B-4, A-03)

The WSMA endorses the development of the new Osteopathic Medical School in Eastern Washington and further supports the development of additional seats in Washington MD and DO schools.

(Res C-16, A-07)

End of Life Patient Care

The WSMA supports efforts within Washington state medical training programs to develop appropriate programs addressing the clinical and psycho-social aspects associated with patient care at the end of life. (Res A-5, A-96)

Financing Medical Education

The WSMA encourages the University of Washington Medical School to recognize prior indebtedness as legitimate financial aid need in medical school budgets. (Res 51, B-89)

Student Loan Deferments

The WSMA supports continuation of student loan deferments for resident physicians. (EC 2/92)

EMERGENCY MEDICAL SERVICES

Emergency Clinics

The WSMA urges physicians who offer acute care to the public, using the term "emergency" or "urgency" in their clinic titles, to do so only if they are fully equipped and fully staffed to handle life-threatening emergencies while arranging patient transfer to a bona fide hospital emergency facility. (PD Rpt D, '82)

First Aid/Treatment for Overdose Victims

The WSMA urges city, county, state, and federal public health, law enforcement, fire and emergency medical service agencies to develop, implement, and publicize policies that will encourage bystanders to call 911 and to provide first-aid for overdose victims. (EC Report M, A-00)

The WSMA supports public availability of naloxone as a harm reduction strategy for families of persons at risk of opioid overdose, with appropriate education. (Res A-4, A-08)

The WSMA supports legislation that would authorize basic Emergency Medical Technicians (EMTs) to administer naloxone. (Res A-4, A-08)

Poison Control

The WSMA supports the continuation and enhancement of the Washington Poison Center. (Res 19, C-84; Res A-8, A-99; Res A-11, A-00; Res A-8, A-01)

The WSMA encourages individual manufacturers of potentially toxic formulations of household and other commercial products, to consider adding non-toxic aversive products to either existent or newly introduced formulations when such formulations have been deemed as having significant toxic potentials. The WSMA supports these actions publicized as intended to augment, but in no way replace, those other proven poison prevention programs, such as child-resistant containers, appropriate packaging and labeling, parental education, etc. (Res 10, A-89)

Protocols for Health Care Practitioners

The WSMA opposes mandating protocols for health care practitioners to follow during emergency care regarding the collection of evidence for violent crime cases. (EC 9/91)

Scene of Emergency

The WSMA supports every effort to enhance cooperation between physicians and paramedical emergency personnel. The WSMA urges all local medical societies to consider a policy regarding this matter, then publish and distribute a card delineating policy for use by local paramedics or individuals who are certified in advanced life support systems. (PD Rpt B, '82; PD Rpt B, '83)

ENVIRONMENTAL HEALTH

Environmental Protection

The WSMA supports and promotes, when possible, the use of reusable, recyclable and/or biodegradable products. (Res A-1, A-04)

The WSMA encourages collaborative efforts with the medical associations in British Columbia, Alaska, Oregon, and California to the extent practical to address the clear and present danger facing our fragile environment.

The WSMA is committed working with the state's congressional delegation to support legislation encouraging appropriate behavior by individuals and companies to reduce the risks inherent in our industrialized society. (Res 47, A-89)

Hazardous Substances in the Work Place

The WSMA supports research and education on the types of hazardous substances in the work place that may cause birth defects or harm the reproductive system. (EC 9/91)

Infectious Medical Waste

The WSMA supports the development of effective infectious waste management. (Res 52, C-90)

The WSMA supports legislation placing the regulation of infectious medical waste under the direction of the Department of Health with implementation where feasible by local health departments. (Res 53, C-90)

Medical Waste

The WSMA recognizes that medical waste contributes to environmental degradation and risk to health. (Res A-1, A-04)

Mercury

The WSMA does not oppose the therapeutic use of selected beneficial mercury-containing medical products. The WSMA encourages physicians and hospitals to phase out the purchase and use of mercury-containing products where alternatives are possible. The WSMA urges medical product suppliers to continue to develop, produce, and market appropriate, cost-competitive, environmentally protective and effective mercury-free replacements. The WSMA calls upon health care professionals to encourage the institutions with which they are associated to adopt policies that will lead toward the eventual elimination of mercury containing products where effective alternatives are available. (Res A-3, A-02)

The WSMA encourages physicians to inform patients about fish consumption advisories. (Res A-3, A-02)

Nuclear

The WSMA strongly supports diplomatic negotiations between the United States and the Soviet Union leading to a mutually verifiable 50% Strategic Nuclear Weapons Reduction Treaty; further, the WSMA encourages the Washington State congressional delegation to support legislation that would lead to the successful enactment of a Comprehensive Test Ban Treaty. (Res 7, A-88)

Nuclear – Hanford

The WSMA does not support the confirmation of the Hanford reservation as a site for a high level nuclear waste repository until it is clear from both environmental and health studies that it would be safe to utilize this area. Further, the WSMA supports the concept of a thorough and immediate independent study of the safety of the N Reactor and appropriate licensure of the Nuclear Regulatory Commission. (Res 2, A-85; Res 25, C-86)

The WSMA opposes additional off-site waste being added to the overburdened Hanford Site until the current nuclear waste storage problems and environmental threat to the surrounding area are solved, and a publicly vested national plan for nuclear waste be created. (Res A-9, A-01)

The WSMA supports no further build-up of high-level nuclear waste which is not in compliance with state and federal regulations at the Hanford Nuclear Reservation. (Res C-1, A-03)

The WSMA supports working towards a solution to the Hanford Site nuclear waste problem and encourages the creation of a national plan for nuclear waste disposal to ensure optimum public health. (Res A-9, A-01)

The WSMA supports the public and environmental health requirements in the Tri-Party Agreement in all current and future clean-up plans for Hanford. (Res C-12, A-02)

The WSMA opposes any "accelerated cleanup" of Hanford tank wastes that is not scientifically demonstrated to be equivalent or superior to vitrification in providing long-term protection of human health and the environment. (Res C-1, A-03)

Toxins

The WSMA encourages legislation to assist the National Academy of Science's Institute of Medicine in undertaking pilot investigations to augment our state's poison centers' capacity to respond to today's broadened menu of "toxic" inquiries, particularly those concerning industrial, occupational and environmental hazards. (Res 4, A-90)

FEES

Charity Care

The WSMA defines charity care as a medical service provided by a physician who offers time and expertise with no requirement or expectation of monetary reimbursement from the patient or other source and does not include any expectation that physicians must subsidize the cost of providing those services. (Res B-8, A-01)

Competition

The WSMA strongly believes that competition between and among physicians and other health care practitioners on the basis of competitive factors such as quality of services, skill, experience, miscellaneous conveniences offered to patients, credit terms, fees charged, etc..., is not only ethical but is encouraged. Ethical medical practice thrives best under free market conditions when prospective patients have adequate information and opportunity to choose freely between and among competing physicians and alternate systems of medical care. (JC 6.13-87; Res C-12, A-04)

The WSMA: (1) encourages the growth and development of the physician/patient contract; (2) favors a pluralistic health care delivery system which includes fee-for-service medicine, and will lobby for the elimination of any restrictions and physician penalties for provision of fee-for-service medicine by a physician to a consenting patient; including patients covered under Medicare; and (3) defends fee-for-service payment as a reasonable, cost-effective way of reimbursing for medical services when the fee is paid by the recipient of the service with insurance reimbursement to the patient. (Res C-12, A-04)

The WSMA: (1) supports a pluralistic approach to third-party payment methodology under fee-for-service, and does not support a preference for "usual and customary or reasonable" or any other specific payment methodology; (2) affirms the following four principles: (a) Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment. (b) Physicians should continue to volunteer fee information to patients, to discuss fees in advance of service where feasible, to expand the practice of accepting any third-party allowances as payment in full in cases of financial hardship, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. (c) Physicians should have the right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service. (d) All methods of physician payment should incorporate mechanisms to foster increased cost-

awareness by both providers and recipients of service; and (3) supports modification of current legal restrictions, so as to allow meaningful involvement by physician groups in: (a) negotiations on behalf of those physicians who do not choose to accept third party allowances as full payment, so that the amount of such allowances can be more equitably determined; (b) establishing additional limits on the amount or the rate of increase in charge-related payment levels when appropriate.

Collection Agencies

The WSMA believes that in referring a delinquent account to a collection agency, the physician should first give due consideration to the patient's ability to pay the fee which is due. The physician should not utilize the services of a collection agency whose tactics and methods of collection might be unfair or abusive; nor should he/she enter into any arrangement under which he/she would lose complete control of the delinquent account or the method of its collection. (JC 6.15-87)

Fee Splitting

The WSMA believes it is ethically permissible in certain circumstances, for a surgeon to engage another physician to assist him/her in the performance of a surgical procedure and to pay a reasonable amount for such assistance, provided the nature of the financial arrangement is made known to the patient. This principle applies whether or not the assisting physician is the referring doctor. The "secret splitting of fees" is unethical.

The WSMA upholds that a physician may only receive from his/her patient payment for rendered medical services, explicitly excluding rebates of any kind.

In many cases insurance companies insist on a joint or combined bill, but the bill is being paid in most instances by two checks. This is not considered unethical by the WSMA, and all insurance plans which do not pay the individual physician in this manner should be urged to do so. (JC 6.03-87)

Fee Splitting: Clinic or Laboratory Referrals

The WSMA believes that clinics or laboratories that compensate physicians based on the amount of work referred by the physician to the clinic or laboratory are engaged in fee splitting which is unethical. (JC 6.04-87)

Fee Splitting: Drug Prescription Rebates

The WSMA believes that a physician may not accept any kind of payment or compensation from a drug company for prescribing its products. (JC 6.05-87)

Fee Splitting: Purchase of Medical Practice on a Percentage Basis

The WSMA believes a physician may pay anything he/she wants to for a medical practice as long as a set price is established, but it is unethical for a physician to pay a percentage of the income of the practice that he/she has purchased as payment for it. (JC 6.06-87)

Fee Splitting and Hospitals

The WSMA is opposed to hospitals charging physicians who utilize their facilities a percentage of the fees which they receive from their patients while being cared for in the hospital.

The WSMA feels this would amount to splitting or sharing professional fees with a lay organization which has already levied its regular bill for the services which it legitimately rendered, therefore, it is improper. (JC 6.07-87)

Fee Splitting: Rentals

The WSMA is opposed to arrangements in which physician leases office space for a percentage of gross income; the WSMA believes this to be violative of ethical principles. (JC 6.08-87)

Group Practice

The division of income among members of a group, practicing jointly or in a partnership, may be determined by the members of the group and may be based on the value of the professional medical services performed by the member and his/her other services and contributions to the group. (JC 6.02-87)

Health Care Finance Administration (HCFA)

The WSMA does not support the practice of reducing professional fees for procedures performed outside the physician's office as there could result a dangerous financial incentive to inappropriately perform office surgery on Medicare patients and a disregard by HCFA for the safety of Medicare patients. (Res 21, C-89)

The WSMA requests the AMA to demand from HCFA appropriate reimbursement for the duplication and mailing of office medical records to professional review organizations. (Res 22, C-89)

Insurance Form Completion Charges

The WSMA believes the attending physician should complete without charge the appropriate "simplified" insurance claim forms as a part of his/her service to the patient to enable the patient to receive his/her benefits. A charge for more complex forms may be made in conformity with local custom. (JC 6.09-87)

Interest Charges and Finance Charges

The WSMA believes that although harsh or commercial collection practices should be discouraged in the practice of medicine, a physician who has experienced problems with delinquent accounts may properly choose to request that payment be made at the time of treatment, or add interest or other reasonable charges to delinquent accounts. (JC 6.10-87)

Laboratory Bill

The WSMA affirms that when it is not possible for the laboratory bill to be sent directly to the patient, the referring physician's bill to the patient should indicate the actual charges for laboratory services, including the name of the laboratory, as well as any separate charges for his/her own professional services. (JC 6.11-87)

Medical Cost Containment

The WSMA supports the formation of a physicians' cooperative to provide supplies to physicians at a cost-plus-handling fee, whereby physicians can obtain quality products and maintain some control of their ever-increasing overhead expenses. (Res 46, D-88)

Medical Services

A physician should not charge or collect an illegal or excessive fee. Factors to be considered guides in determining the reasonableness of a fee include the following: a) The difficulty and/or uniqueness of the services performed at the time, skill, and experience required; b) The fee customarily charged in the locality for similar physician fees; c) The amount of the charges involved; d) The quality of performance; e) The nature and length of the professional relationship with the patient; and f) The experience, reputation, and ability of the physician in performing the kind of services involved. (JC 6.01-87)

Patient Cost Sharing

The WSMA continues to advocate the use of copays as the most favorable form of consumer cost sharing, followed in desirability by coinsurance mechanisms. Deductibles should be discouraged as a form of consumer cost sharing because of adverse impact on the community rated Uniform Benefits Package. (EC Rpt L, A-94)

Professional Courtesy

In order to aid physicians in resolving questions related to professional courtesy, the WSMA has established the following guidelines for professional courtesy issues: (JC 6.14-87)

- 1) Where professional courtesy is offered by a physician but the recipient of services insists on payment, the physician need not be embarrassed to accept a fee for his/her services.
- 2) Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his/her dependents have insurance providing benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional practice of physicians caring for the medical needs of colleagues and their dependents without charge.
- 3) In the situation where a physician is called upon to render services to another physician or his/her dependents with such frequency as to involve a significant proportion of his/her professional time, or in cases of long-term treatment, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.
- 4) Professional courtesy should always be extended without qualification to the physician in financial hardship and his/her dependents. (JC 6.14-87)

Surgical Assistant's Fee

Each physician engaged in the care of the patient is entitled to compensation commensurate with the value of the services they have personally rendered. However, the WSMA strongly believes the nature of the financial arrangement must be made known to the patient. (JC 6.12-87)

Witness Fees for Physicians

The WSMA supports the proposed amendment to Court Rule 26(b) to mandate reasonable fees for discovery from licensed health care providers. (EC 12/93)

FETAL RESEARCH

In order to aid physicians in fulfilling their ethical responsibilities when they engage in fetal research, the WSMA has established the following guidelines for fetal research:

- 1) Physicians may participate in fetal research when their activities are part of a competently designed program, under accepted standards of scientific research, to produce data which are scientifically valid and significant.
- 2) If appropriate, properly performed clinical studies on animals and nonpregnant humans should precede any particular fetal research project.
- 3) In fetal research projects, the investigator should demonstrate the same care and concern for the fetus as a physician providing fetal care or treatment in a non-research setting.
- 4) All valid federal or state legal requirements should be followed.
- 5) There should be no monetary payment to obtain any fetal material for fetal research projects.
- 6) Competent peer review committees, review boards, or advisory boards should be available, when appropriate, to protect against the possible abuses that could arise in such research.

7) Research on the so-called "dead fetus", masecrated fetal material, fetal cells, fetal tissue, fetal organs, or the placenta should be in accord with state laws on autopsy and state laws on organ transplantation or anatomical gifts. Informed and voluntary consent, in writing, should be obtained from a legally authorized representative of the fetus.

8) In fetal research primarily for treatment of the fetus:

a) Voluntary and informed consent, in writing, should be given by the gravid woman, acting in the best interest of the fetus.

b) Alternative treatment or methods of care, if any, should be carefully evaluated and fully explained. If simpler and safer treatment is available, it should be pursued.

9) In research primarily for the treatment of the gravid female:

a) Voluntary and informed consent, in writing, should be given by the patient.

b) Alternative treatment of methods of care should be carefully evaluated and fully explained to the patient. If simpler and safer treatment is available, it should be pursued.

c) If possible, the risk to the fetus should be the least possible, consistent with the gravid female's need for treatment.

10) In fetal research involving a viable fetus, primarily for the accumulation of scientific knowledge:

a) Voluntary and informed consent, in writing, should be given by the gravid woman under circumstances which a prudent and informed adult would reasonably be expected to give such consent.

b) The risk to the fetus imposed by the research should be the least possible.

c) The purpose of research is the production of data and knowledge which are scientifically significant and which cannot otherwise be obtained.

d) In this area of research, it is especially important to emphasize that care and concern for the fetus should be demonstrated. There should be no physical abuse of the fetus.

(JC 2.09-87)

FIREWORKS

The WSMA encourages the abolition, through legislation, of the sale of explosive and incendiary fireworks in Washington State. (Res 22, B-80; Res 13, D-83)

FOODS AND NUTRITION

Food Irradiation

The WSMA supports legislation classifying irradiation as a food process rather than as a food additive. (Res 1, C-84)

The WSMA supports the appropriate use of irradiation of food and encourages members to help educate their patients and their patients' relatives about this issue. (Res A-1, A-95)

Fluoridation of Municipal Water Supplies

The WSMA endorses the fluoridation of all public water supplies in Washington State, and encourages legislation and/or regulations that would require the fluoridation of public water supplies, where they are fluoride deficient. (Res 12, A-89)

Genetically Modified Foods

The WSMA recognizes that the currently available scientific evidence fails to support any contentions of hazards from genetically modified foods. (Res A-7, A-99)

Nutrition in Restaurants

The WSMA supports the reduction of the levels of saturated fat and cholesterol in prepared meals in restaurants and other food service organizations. The WSMA encourages all such establishments to offer and identify for consumers at least one menu choice compatible with the National Cholesterol Education Project Step I Diet. (Res 26, A-89)

GENETICS

Counseling

The WSMA believes that physicians engaged in genetic counseling are ethically obligated to provide prospective parents with the basis for an informed decision for childbearing.

The WSMA believes the physician should be prepared in the instance where a genetic defect is found in the fetus, prospective parents may request or refuse an abortion.

The WSMA affirms that physicians who consider the legal and ethical requirements applicable to genetic counseling to be in conflict with their moral values and conscience may choose to limit such services to preconception diagnosis and advice or not provide any genetic services. However, there are circumstances in which the physician who is so disposed is nevertheless obligated to alert prospective parents that a potential genetic problem does exist, that the physician does not offer genetic services, and that the patient should seek medical counseling from another qualified specialist. (JC 2.10-87)

Engineering

The WSMA affirms that whatever form of regulation of gene splicing, recombinant DNA research, chemical synthesis of DNA molecules, or other genetic engineering research is eventually developed, there should be independent input from the scientific community, organized medicine, industry, and others, in addition to the federal government, to prevent abuse from any sector of society, private or public.

If gene replacement with normal DNA becomes a practical reality for the treatment of human disorders, the WSMA has developed the following guidelines for treatment procedures:

- 1) If procedures are performed in a research setting, reference should be made to the Judicial Council's guidelines on clinical investigation.
- 2) If procedures are performed in a non-research setting, adherence to usual and customary standards of medical practice and professional responsibility would be required.
- 3) Full discussion of the proposed procedure with the patient would be required. The consent of the patient or his/her legal representative should be informed, voluntary and written.

- 4) There must be no hazardous or other unwanted virus on the viral DNA containing the replacement or corrective gene.
- 5) The inserted DNA must function under normal control within the recipient cell to prevent metabolic damage that could damage tissue and the patient.
- 6) The effectiveness of the gene therapy should be evaluated as best as possible. This will include determination of the natural history of the disease and follow-up examination of subsequent generations.
- 7) Such procedures should be undertaken in the future only after careful evaluation of the availability and effectiveness of other possible therapy. If simpler and safer treatment is available, it should be pursued.
- 8) These consideration should be reviewed, as appropriate, as procedures and scientific information are developed in the future. (JC 2.11-87)

Genetic Counseling Information for Physicians

The WSMA supports increased funding for existing genetic counseling centers in Washington to provide physicians and patients current information relative to genetic and environmental hazards.

The WSMA supports the use of a hotline to establish an information mechanism for physicians in the state of Washington. (Res 2, B-83; CHS Rpt D, '84)

GUNS

Gun Control

The WSMA endorses national and state legislation to ban the domestic manufacture, sale, possession and importation of any polymer plastic handguns or other firearms determined to be able to escape detection by standard airport security.

The WSMA supports appropriate legislation that would restrict the sale and private ownership of large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon. (Res 29, C-87; Res 22, C-90)

Trauma Prevention

The WSMA supports working with the Washington Chapter of the American College of Surgeons to enact safe and sane legislation relating to the purchase of firearms to include:

- 1) Firearm education and safety certification prior to purchase;
- 2) Licensure appropriate to the class of firearm desired for purchase; and
- 3) Establishment of an appropriate waiting period between application for purchase and/or licensure and purchase of the firearm. (Res C-1, A-93)

Waiting Period

The WSMA urges the Washington State legislature to enact legislation mandating a waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer in this state. (Res 22, C-90)

HEALTH CARE

Allocation of Limited Resources

The WSMA supports the establishment of health care priorities that are based on the needs of the citizens of Washington State. The WSMA actively encourages public dialogue to form a consensus as to what constitutes basic health care services. (EC Rpt P, A-89)

Basic Health Plan

The WSMA supports the adequate funding of the Health Services Account to meet the health needs of the people of the state. (Res C-2, A-96)

The WSMA supports through legislation and the state budget an expansion of funding for the BHP so that a minimum of 200,000 low income adults and children are provided insurance coverage through this program. (Res C-12, A-97; Res C-4, A-98)

The WSMA supports full funding of the Washington Basic Health Plan as a vehicle to provide health insurance coverage for all individuals and families up to 250% of the Federal Poverty Level. (BT Rpt J, A-01; EC Rpt F, A-02)

Cost Disclosure

The WSMA supports disclosure of inpatient/outpatient, nursing home, home health services and pharmacy charges to the prescribing physician on a regular basis and that physicians be actively encouraged to review charges for their prescribed care. (Res B-7, A-93)

Financing, Health Care

The WSMA supports innovative consumer-driven and controlled health care financing programs such as MSAs linked to high-deductible, unmanaged insurance and defined-contribution employer programs. (Res C-3, A-03)

Health Care Policy Principles

The WSMA supports the following policy principles on health care:

1. There should be universal access to affordable health insurance and a government sponsored safety net.
2. The health care system should allow and encourage the availability of different levels of coverage beyond a basic level of protection for those who want it. There must be choice of types of insurance, of physicians and other caregivers – to reflect our pluralistic culture.
3. The health care system should be based on fairness and equity, reflecting personal responsibility and accountability by all stakeholders – patients, physicians and providers of services, public and private payers and insurers. The federal tax code should treat those covered by employer-based insurance or individual-based insurance equally.
4. The delivery and financing of the system must include administrative simplification and standardization, with clear accountability and responsibility by all participants.
5. The financing of the system should include incentives to improve quality, control cost, enhanced efficiency and eliminate the use of ineffective health services and inappropriate variations in care. The system must include improved patient safety and a reformed system for compensating patients injured within the healthcare delivery system. (BT Rpt H, A-07; Res C-8; A-08)

Mandated Benefits

The WSMA reaffirms its long-standing policy of opposition to legislative or regulatory mandates of benefits (CPA Rpt F, A-97), except that the Board of Trustees, or the Executive Committee acting between meetings of the board, has the authority to determine when a proposed mandate represents such a clearly overriding social or economic benefit as to warrant an exception to this policy. (EC Rpt M, A-99)

Medical Home

The WSMA supports the implementation of strategies that promote primary care as described in the following “Core Principles of a Patient-Centered Medical Home” adopted in March 2007 by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA). (Res A-13, A-08)

Core Principles of a Patient-Centered Medical Home

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex healthcare system including subspecialty care, hospitals, home health agencies, nursing homes as well as the patient’s community (e.g., family, public and private community-based services).

Quality and safety are hallmarks of the medical home in which practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient’s family.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home.

Medical Savings Accounts

The WSMA affirms its support for the goal of universal access to health insurance for all Washington citizens and recognizes and supports that Medical Savings Accounts (MSAs) should be given an opportunity to be further investigated, developed and implemented as one methodology to achieve this goal. (BT 1/95)

Preventive Health Care

The WSMA encourages physicians to offer evidence-based cost-effective preventive care and early detection tests and encourages all third party payers to cover the cost of evidence-based cost-effective preventive care and early detection tests. (Res A-8, A-00; A-01)

Quality, Cost Effectiveness

The WSMA encourages insurers and the payer to explore new and innovative options for health care coverage such as prepaying "wellness" and insuring "sickness".

The WSMA encourages the gathering of essential health care data for research in both the public and private sectors to promote quality, cost-effective health care services. The WSMA supports research and pilot studies for the development of practice parameters and outcomes research, specifically supporting pilot projects with the Health Quality Foundation to test in this state the efficacy of practice parameters established by national specialty societies.

The WSMA supports the Health Quality Foundation and urges specialty society participation in Foundation research programs. The WSMA also supports the Foundation through financial assistance.

The WSMA encourages investigating the feasibility of supporting state legislation to provide standards of efficacious utilization review and certification of companies providing UR services in order to maintain high standards.

The WSMA supports development of state-wide, acceptable technology assessment criteria that promote services that meet standards of efficacy and improved outcome but do not stifle innovation. (EC Rpt P, A-89)

Quality, Definition

The WSMA supports the following definition of quality in health care:

Defining, continually assessing and improving quality is a proper role of the medical profession.

Quality in health care is defined as the extent to which there is continual improvement in meeting or exceeding professionally established, measurable criteria of health care while balancing the patients' goals and values with established ethical guidelines.

Quality of care may be assessed by:

- *Clinical Outcomes*

Acceptable outcomes should be derived from "evidence-based" processes (ie confirmed by the peer review literature) where possible and based on peer consensus as an alternative.

- *Health Status*

The health status of both patients and populations should be compared using concise, validated instruments to measure peer practices.

- *Patient Satisfaction*

Satisfaction with process of care including access should be measured using concise, validated instruments to assess peer practices.

- *Value*

Value varies directly with the degree of quality, and inversely to the cost of care (value = Q/C). Value is important to patients and payers, and its determination is an expression of professionalism.

Continuous Quality Improvement is the preferred method for improving quality. There are no absolute values for quality; rather, practitioners should strive continuously to improve outcomes within the resources available. This process requires the institutional and administrative commitment of the organization with which the practitioner is affiliated.

All available sources of expertise for parameters or guidelines for care should be utilized, and should be accessible to all practitioners in multiple, optimally usable forms. Practitioners, payers (including federal and state governments), and health care organizations share the responsibility for dissemination of validated practice parameters, so that all patients may benefit.

The organizational and practitioner specificity of performance data should be disseminated on the basis of "need to know," and should be risk/severity adjusted. This information should be used to improve the quality of medical care and not for the purpose of regulation or marketing.

The WSMA promotes this definition as a national model for defining quality in health care. (CPA Rpt D, A-96)

Quality Improvement Programs

The WSMA endorses statewide, physician-led quality improvement programs like COAP (Clinical Outcomes Assessment Program) and supports adequate funding through, but not limited to, collaborative public/private sources. (Res B-4, A-00)

Reform

The WSMA believes that any health care reform must include an effective public health system. (Res C-8, A-08)

The WSMA considers restoration and improvement of our primary care system one of its highest priorities legislatively, with insurance companies, and in support of the system changes needed toward this end. (Res A-13, A-08)

Reform, Washington State - 1994 Legislative Session

The WSMA works to support successful implementation of the Washington Health Services Act of 1993 and opposes efforts that would undermine its key components such as universality of coverage, "willing provider", negotiations, etc.

The WSMA also assists physicians in meeting the challenges of the Act in terms of supporting their ability to participate in Certified Health Plans.

The WSMA works through its PACE Program and other means to educate the public regarding the Act, reinforcing our support of their concerns regarding physician choice, cost effectiveness and quality of care. (EC Rpt C, A-93)

Reform, Washington State - 1995 Legislative Session

The WSMA reaffirms its position to the Washington Health Services Commission that it not "micro-manage" the health care system in the state through the regulatory process.

The WSMA will continue to encourage the Washington Health Services Commission to not preclude the development of an RVS option.

The WSMA will work to protect and strengthen the collective negotiations provisions of the Health Services Act.

The WSMA will work to protect and strengthen the "Any Willing Contractor ("Provider") provisions of the Health Services Act and continue to educate members and the public regarding its intent and consumer choice benefit.

The WSMA promotes data use policies that reflect confidentiality standards, case mix, and quality and not just resource consumption.

The WSMA supports legislation or regulation that requires uniform public disclosure of each CHP's administrative costs as a percentage of premium, services covered and provided by whom, utilization review processes, and consumer participation requirements.

The WSMA supports the Health Services Act's mandate that there be a uniform process for Certified Health Plans to determine the enrollees' satisfaction with the CHP.

The WSMA supports legislation that requires CHPs to use uniform provider credentialing and recredentialing forms.

The WSMA supports legislation or regulation that would require CHPs to disclose to physicians the individual within the CHP who is reviewing their work, including the individual's name and credentials, and that CHPs be held proportionately responsible for their utilization review decisions.

The WSMA supports legislation or regulation that would mandate that any reviews, accreditation or licensing surveys conducted within the state of Washington be accomplished at the same time and that uniform standards should be applied.

The WSMA will introduce legislation to eliminate the Health Personnel Resources Plan and to turn all personnel planning activities over to the Health Services Commission and that the estimated resultant savings of \$500,000 be reallocated to immunizations for children.

The WSMA will urge the commission to recommend to the legislature that the state of Washington not take on new roles as a CHP or health insuring entity, other than a Registered Employer Health Plan (as defined by the Washington Health Services Act of 1993) between now and 1999.

The WSMA will urge the commission to recommend to the legislature that the state of Washington not be permitted to remain as a Registered Employer Health Plan after 1999.

The WSMA will urge the commission to recommend to the legislature that the plans offered by the state of Washington, through the Health Care Authority, not be treated as ERISA exempt for the purposes of premium tax, data and other state requirements until such time as the state no longer serves as a health insuring entity, CHP or Registered Employer Health Plan.

The WSMA adopts the position, and urges its adoption by the state, that the members of the legislature and all employees of the state of Washington participate under all provisions of the Health Services Reform Act of 1993 as equals with other state citizens. (EC Rpt C, A-94)

Role of the Consumer/Provider

The WSMA supports the establishment of a Health Education Commission with representatives to include the Office of the Superintendent of Public Instruction, Department of Health, higher education, health care professionals and the medical auxiliary, adult education experts, purchasers and consumers in order to establish and implement strategies for educating the general adult population on health care economics, decision making and healthy life practices.

The WSMA supports legislation for either redirecting existing resources or securing additional resources for a comprehensive health education curriculum in our state schools (K-12).

The WSMA supports greater consumer accountability in health care purchases, such as the broader use of co-payments and deductibles, and for healthy lifestyles. (EC Rpt P, '89)

Universal Coverage

The WSMA has the unqualified position that universal health care coverage is an achievable objective through a variety of mechanisms which could be private, public, or a combination thereof. (Res C-5, A-07)

HEALTH MANPOWER

The WSMA supports strategies that will link the issues of economic development with early education career counseling and curriculum selection so as to attract necessary qualified applicants into medicine and associated health care careers. (EC Rpt P, '89; EC Rpt B, '90)

The WSMA supports an adequate database for knowing present manpower capabilities and future needs. (EC 11/94)

Bedside Care

The WSMA is supportive of the Bedside Care Giver concept in order to aid in solving the shortage of bedside care givers. (Res 46, B-90)

Rural Deficiencies

The WSMA encourages initiatives to develop rural tracks in the health care professional schools in order to improve access in rural areas. (EC Rpt P, '89; EC Rpt B, '90)

University of Washington

The WSMA is committed to assisting the University of Washington School of Medicine and the state legislature in developing strategies for attracting and retaining candidates in primary care specialties. (EC Rpt P, '89; EC Rpt B, '90)

HEALTH PLAN ACTIVITIES/POLICIES

The WSMA believes health plans should: 1) Provide adequate, comparable and understandable information to their beneficiaries about the content and cost containment policies of their plans, prior to and during enrollment; 2) Ensure that patients have a broad choice of physicians and protection from loss of continuity for at least six months, if their employer changes health plans; 3) Have dispute resolution processes that are timely, independent, and fair, such as the right of patients to use court action or other alternative external dispute resolution processes against health plans if necessary to uphold the terms of the patient's contract; and, 4) Provide access to covered services and specialty care which are medically needed and appropriate. (Res C-2, A-99)

The WSMA believes that the health plans should have a network of primary care and specialty care physicians in place prior to marketing to employers and patients. (Res C-2, A-99)

“All Products” Clauses

The WSMA opposes “all products” clauses by health plans with substantial market power in Washington state. (Res C-2, A-00)

Compensation Schedules

The WSMA believes health plans should include an attachment in physician and non-physician provider contracts entitled, “Compensation Schedule” that provides a comprehensive compensation schedule for each plan or company product which clearly delineates the services covered, reimbursement for each service, and penalty charges for failure to provide a compensation schedule, so that they can be negotiated, renewed, or terminated individually.

Conversion to For-profit Status

The WSMA supports a policy that any public assets derived through the not-for-profit status of health insurers, health service contractors and HMOs that become available through the conversion from a not-for-profit to a for-profit status be retained in similar not-for-profit organizations or in foundations supporting the health of the community. (Res C-6, A-00)

Dispute Resolution

The WSMA believes health plan contracts should include provisions that would: 1) permit physicians to mandate mediation and binding arbitration to resolve disputes with carriers, but would also ensure that physicians and non-physician providers have access to the court system in cases where the transactions costs of mediation and arbitration are not suitable, where substantial issues of law reform are present or in other appropriate cases; and, 2) define issues subject to arbitration in such cases as all disputes, including termination without cause by carriers, for reasons that are inappropriate. (Res C-7, A-99)

Electronic Data Interchange

The WSMA supports solutions that would require all health plans (and HMOs) to offer real-time standardized non-proprietary electronic data interchange to all physicians at no additional cost. (Res C-3, A-00)

Fee Schedules in Capitation Provider Contracts

The WSMA believes health plans should include an attachment in capitation-based physician or non-physician provider contracts entitled, “Compensation Schedule for Capitation Contracts” that includes the following: A) the amount to be paid per enrollee, per month; B) the manner in which the insurer will determine who is an enrollee at the beginning of any particular month; C) the precise terms of the stop loss arrangement; D) the boundaries of the service area; E) the fee-for-service schedule to which this compensation arrangement will revert in the event the number of enrollees assigned to physicians or non-physician providers falls below a designated actuarial minimum and what that minimum is; F) the number of covered lives and the fee-for-service schedule upon which physicians or non-physician providers will be paid for those covered services provided to enrollees not specifically made a part of the capitation arrangement. Physicians shall have the right to audit the books and records of the company or a payer solely for purposes of determining the accuracy of any capitation payment; and, G) the complete list of services expected in return for compensation. (Res C-8, A-99)

Medical Necessity

The WSMA believes health plans should define medical necessity by a reasonably prudent physician standard, rather than the opinion of the medical director of a health insurance company. (Res C-9, A-99)

Premium Payment Cycles

The WSMA supports changes in health plan premium payment cycles to require employers to pay premiums by the 15th of the month preceding the month for which coverage is to be provided so that current month eligibility can be determined. (Res B-3, A-01)

Term and Termination in Provider Contracts

The WSMA believes health plan provider agreements should provide that: 1) the non-compensation terms of any agreement should be binding throughout the relationship of the parties; 2) a provider be given a reason in writing when a plan exercises the “without cause” clause in a contract; 3) the compensation terms for each plan or product should be re-negotiated annually and reviewed or rejected individually; and, 4) whenever a contract is terminated, a reason for such termination must be stated in writing. (Res C-14, A-99)

The WSMA believes the reasons for termination of health plan provider agreements should be given, whether at the end of the agreement’s term or otherwise. (Res C-14, A-99)

HOME HEALTH CARE

The WSMA supports the revision of Medicare reimbursement to provide adequate reimbursement for physician management services offered to beneficiaries in the home care setting capitation reimbursement. (Res 19, D-91)

Planned Home Births

The WSMA recommends the following safeguards for planned home births: 1) only low risk patients should be approved for planned home births; and, 2) any practitioner who wishes to provide this service must agree to submit data to the department for each birth (possibly as a condition of reimbursement) to allow the performance of appropriate peer review of procedures and outcomes, similar to those practices which occur in a hospital or birth center environment. (EC Rpt D, A-98)

HOSPITALS

Admission Fee

The WSMA affirms that charging a separate and distinct fee for the incidental, administrative, non-medical service the physician performs in securing the admission of a patient to a hospital is unethical. (JC 4.01-87)

Assessments, Compulsory

The WSMA believes the hospital management does not have the privilege to make compulsory assessments of members of the medical staff for building funds or to demand an audit of staff members' personal financial records as a requisite for staff appointment. Compulsory assessments are not in the best traditions of ethical practice. (JC 4.02-87)

Billing for Housestaff Services

The WSMA affirms that when a physician assumes responsibility for the services rendered to a patient by a physician housestaff, the physician may ethically bill the patient for services which were performed under the physician's personal direction and supervision. (JC 4.03-87)

"Corporate Practice of Medicine" Doctrine

The WSMA supports the clarification of the "Corporate Practice of Medicine" Doctrine in such a way as to:

- 1) Preserve independent clinical decision-making;
- 2) Provide protection to physicians who bring to light quality of care concerns arising out of an employment situation;
- 3) Prohibit non-compete clauses in physician-hospital employment contracts;
- 4) Require that hospitals and employed physicians be insured for professional negligence separately and that physicians be allowed to select their own carrier;
- 5) Require that medical staff and clinical privileges be considered separately from employment considerations;
- 6) That physicians be allowed to own hospitals and ambulatory care centers; and,
- 7) That closed medical staff policies be prohibited within any hospital facility in Washington State; assuming the provider meets that hospital's medical staff requirements.
(EC Rpt I, A-94)

Emergency Coverage

The WSMA endorses elective rather than mandatory emergency coverage through Medical Staff Bylaws, Rules and Regulations. (EC Rpt F, A-08)

The WSMA endorses that hospitals no longer require mandatory emergency coverage for non-assigned patients as a prerequisite to hospital privileges. (EC Rpt F, A-08)

The WSMA endorses the principle of reasonable payment of physicians by hospitals for on-call coverage whether or not they are required to be physically present in the facility. (Res C-4B, A-09)

Health Facility Ownership by Physician

The WSMA believes a physician may own or have a financial interest in a for-profit health facility, nursing home, or other health facility, such as a free-standing surgical center or emergency clinic. However, the physician has an affirmative ethical obligation to disclose his/her ownership of a health facility to his/her patient, prior to admission or utilization. (JC 4.04-87)

Hospital Utilization Review

The WSMA does not support the Health Care Financing Administration (HCFA) utilization review regulations that attempt to take the review process out of the hands of physicians and to focus it on financial criteria and will work to modify any regulations with the above intent. (Res 29, C-84)

Medical Staff

The WSMA believes the organized medical staff is an integral part of the hospital structure. The organized medical staff performs essential hospital functions even though it may often consist primarily of independent practicing physicians who are not hospital employees. The WSMA endorses that members of the organized medical staff may choose to act as a group for the purpose of communicating and dealing with the governing board and others with respect to matters that concern the interest of the organized medical staff and its members. This is ethical so long as there is no adverse interference with patient care or violation of applicable laws. (JC 4.05-87)

The WSMA is opposed to the establishment of closed medical staff policies by any hospital in Washington State. (Res 4, B-86)

Medical Staff Self Governance

The WSMA believes the organizational and structural mechanism best suited to action protecting the patients' best interest is the self-governing medical staff. (HMS Rpt A, '90)

Physician Relations

The WSMA supports the organizing of hospital medical staffs into physician corporations which access the expertise necessary to fully cooperate on a business-like basis with their hospitals on the DRG prospective payment system, and on a number of other cooperative arrangements and joint ventures in the interest of quality patient care and the preservation of their hospitals' economic viability necessary to their continuation as a valuable community resource. (EC Rpt D,C-83; Res 9, C-83; Res 12, C-83)

Record Authentication

The WSMA supports working with the Washington State Hospital Association and other groups to seek appropriate statutory or regulatory relief which would permit alternative forms of authentication of medical records. (Res B-10, A-93)

Smoking

The WSMA supports the prohibition of smoking in all hospitals in Washington State. (Res 14, A-89; Res 5, A-86; Res A-3, A-00)

Staff Privileges

The WSMA believes that physicians who are involved in the granting, denying, or termination of hospital privileges should be guided by concern for the welfare and best interests of patients in discharging this responsibility. The WSMA feels obtaining medical staff privileges is a privilege and not necessarily a right. The granting of medical staff privileges should be based on one's knowledge, training and other relevant factors. (JC 4.07-87)

State Hospital Commission

The WSMA supports working with the hospital association, medical service bureaus and others in support of a new policy for the hospital commission – a policy aimed at data collection and monitored marketplace. The WSMA does not support the rate-setting functions of the hospital commission. (Res 42, C-88; Res 27, C-84)

IMMUNIZATIONS

The WSMA supports development of a national adult immunization policy to assure: ongoing, stable funding to support vaccine purchase and public programs for age-appropriate delivery of vaccines in the public and private sectors; incentives and policies to encourage vaccine development for a stable vaccine supply; research into the safety of vaccines, to evaluate the effectiveness of vaccine delivery strategies, and to better understand the transmission of disease; national guidance to outline and encourage effective vaccine delivery; and, state flexibility to tailor the implementation of evidence-based strategies to meet the needs of local and regional populations. (Res C-4, A-05)

The WSMA endorses the continuation of a Universal Vaccine Purchase and Distribution Program structure for purchase, storage, and distribution of vaccines, with the intent of maximizing access to vaccines while minimizing cost, complexity, and workload for vaccine providers. (Res A-5, A-09)

The WSMA supports the use of the current immunization schedule published by the Centers for Disease Control Advisory Committee for Immunization Practices. (Res A-12, A-08)

The WSMA supports full funding for all childhood immunizations, including Hepatitis B.
(Res 23, A-92)

The WSMA supports the State Board of Health Task Force on Immunization Policy recommendations to identify more comprehensive funding sources for universal distribution of childhood vaccines.
(Res C-9, A-01)

The WSMA encourages physicians to offer evidence-based cost-effective vaccines and encourages all third party payers to cover evidence-based cost-effective vaccines in a timely manner.
(Res A-7, A-00)

Availability

The WSMA supports appropriation of funds by the state legislature to enable the State Health Department 1) to purchase sufficient doses of the routinely recommended childhood vaccines to allow immunization of all children in Washington State according to the recommendations of the Committee on Immunization Practices Advisory Committee of the Public Health Service, and 2) to enable the State Health Department to distribute such vaccines to physicians' offices and to local health departments for administration to children. (Res 45, A-89; Res 12, C-86)

The WSMA supports coordinated efforts with the Department of Health in developing means of assuring a closer approach to universal up-to-date immunization of all children attending day care facilities in this state. (Res 49, A-90)

CHILD Profile System

The WSMA encourages all member physicians providing childhood immunization services to fully utilize the CHILD Profile system by enrolling all of their pediatric patients in this electronic immunizations registry and maintaining accurate, up-to-date immunization profiles on these patients.
(Res A-10, A-08)

Flu

The WSMA supports the Washington State Hospital Association's commitment to decrease morbidity from flu by encouraging immunization in their workforce and implementing infection prevention activities. (Res A-3, A-10)

The WSMA encourages all Washington physicians to receive appropriate and timely influenza vaccination and to encourage their office staff and patients likewise to receive such immunization.
(Res A-3, A-10)

Hemophilus Influenza Type B Immunization

The WSMA supports the adoption of legislation to require that children under age 5 be immunized against Hemophilus Influenza Type B in order to attend public and private day care facilities and preschools. (Res 13, A-85)

Hepatitis A

The WSMA supports routine vaccination of children ages 2 to 18 against hepatitis A, and supports efforts to provide information about the safety, effectiveness and importance of the hepatitis A vaccination. (Res A-4, A-99)

Hepatitis B - Adolescent

The WSMA supports school-based Hepatitis B vaccination programs and state and federal funding of such projects. (Res C-4, A-95)

HPV

The WSMA urges physicians to follow the Advisory Committee on Immunization Practices (ACIP) recommendation for routine administration of human papilloma virus (HPV) vaccine to 11- to 12-year-old girls. (Res A-1, A-06)

The WSMA supports state funding for the addition of HPV vaccine to the state childhood immunization program, with state support for an adequate supply of vaccine. (Res A-1, A-06)

Liability

The WSMA endorses/supports research on the issue of liability of the drug companies for bad results of vaccines and design legislation to limit liability which would result in lower vaccine costs. (Res 45, A-89; Res 12, C-86)

Mandatory Health Care Worker Vaccination

The WSMA supports a statewide mandate by the state Board of Health requiring all health care workers with direct patient care responsibilities to show proof of annual influenza vaccination or appropriate documentation of a medical contraindication, religious exemption, or signed declination listing their reason for refusing immunization vaccination. (Res A-2, A-06)

New Vaccines

The WSMA urges all physicians caring for children and adolescents to promote the new vaccines (tetanus, diphtheria and acellular pertussis [Tdap]; conjugated meningococcal; and HPV for girls) for children and adolescents and also use the immunization visits as opportunities to provide other important services, such as well child check-ups, risk assessment, and counseling, to this age group. (Res A-1, A-06)

IMPAIRED PHYSICIANS

The WSMA supports the Washington Physicians Health Program and continues to provide input and assistance to the program as appropriate. (PA Rpt D, '88)

The WSMA supports the litigation stress-support program established by the WSPIA to help physicians and their families cope with and manage the stress related to malpractice litigation. (PA Rpt D, '88; Res 60, A-89; PA Rpt A, '90)

Reporting of

The WSMA believes that physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues. (JC Rpt E, A-93)

INFORMED CONSENT

The WSMA believes the patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. Informed consent is a basic social policy for which exceptions are permitted: 1) where the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent; or 2) when risk-disclosure poses such a serious psychological threat of detriment to the patient as to be medically contraindicated. Social policy does not accept the paternalistic view that the physician may remain silent because divulgence might prompt the patient to forego needed therapy. (JC 8.07-87)

The WSMA upholds that to have another physician operate on one's patient without the patient's knowledge and consent is a deceit. The patient is entitled to choose his/her own physician, and he/she should be permitted to acquiesce in or refuse to accept the substitution. (JC 8.12-87)

INSURANCE

Equal Pay for Equal Work

The WSMA supports public policy that allows for the recognition of qualitative distinctions in skill, training and expertise between physicians and other providers of health care. In particular, clarification is needed where public policy mandates third party coverage for the services of various providers of health care or requires that non-physicians be reimbursed at physician rates. (Res 16, A-89)

The WSMA is opposed to differential specialty-based fee reimbursement for the same work or differential geographic-based fee reimbursement. (Res 45, B-88; EC 9/91)

Hospital Staff Requirement

The WSMA opposes a requirement that office-based physicians must be a member of a hospital staff in order to participate in a health plan or insurance product. (Res B-11, A-99; EC Rpt L, A-00)

Reimbursement

The WSMA encourages insurance companies and businesses in the state of Washington to provide reimbursement for medical services designed to prevent morbidity and mortality. (Res 15, C-88)

The WSMA advocates for reimbursement for all professional services, including communication services, provided through physicians' practices. (Res B-2, A-00)

The WSMA supports efforts to persuade the legislature to pass a statute requiring insurance companies to reimburse outpatient diabetes self-management education and care which could be delivered safely and less expensively than an inpatient setting. (Res A-89)

Standardized Remittance Advice

WSMA policy encourages that all third party payers utilize a standardized remittance advice (payment voucher). (Res B-14, A-94)

Third Party Carriers

The WSMA is committed to working with the medical directors of the various third party insurance carriers to provide more effective continuity of care. (Res 20, B-90; EC 11/90)

The WSMA opposes insurance cancellation or non-renewal of policy based on the insured submitting claims on the policy for the insured's choice of health care provider. (EC 9/91)

The WSMA opposes legislation or regulation requiring physicians to withhold patient billing until receipt of reimbursement of third party carriers. (EC 7/88)

LABOR AND INDUSTRIES

Independent Medical Examinations

The WSMA supports the implementation of competency standards for physicians who perform Independent Medical Examinations (IMEs). (Res B-5, A-00)

Injured Workers

The WSMA supports changes to the applicable laws and regulations in Washington state relating to the treatment of injured workers to replace the concept of “fixed” and “stable” with the more appropriate concept of “maximum medical improvement”. (Res B-5, A-97; EC Rpt E, A-98)

Labor and Industries Payment

The WSMA supports the Department of Labor and Industries' adoption of a resource-based relative value schedule basis of payment for services provided L&I beneficiaries. (BT 1/91)

LEGISLATION

Children’s Access Prevention (CAP)

The WSMA endorses and supports passage of Children’s Access Prevention (CAP) legislation in the state of Washington to prevent children’s access to firearms. Passage of this legislation by the state legislature is a high priority of the WSMA in the interest of the public health and of the children in this state. (EC Rpt A, A-96)

Evaluation of Legislation

The WSMA adopted the following guidelines regarding evaluation of legislation:

Does the proposed legislation:

- 1) Provide for, or move toward, universal health insurance coverage for all Washington residents?
- 2) Provide for adequate and appropriate funding, including for Medicaid and other public programs?
- 3) Move away from micromanagement of the health care system?
- 4) Provide administrative relief for physicians and their practices?
- 5) Provide for clinical sovereignty and/or physician leadership in the health care marketplace?
- 6) Provide for reasonable consumer choice of health (insurance) plans and providers as the private marketplace drives for greater cost controls and more managed care?
- 7) Have any effect on licensure and use of other provider groups?
- 8) Lead to improvements in the health of Washington citizens?
- 9) Provide a broad definition of managed care with adequate protection for consumers and providers?
- 10) Support WSMA liability reform goals?
- 11) Support WSMA goals regarding health care data – its collection, use and confidentiality?
- 12) Advance insurance reforms that preserve portability and affordability of coverage for those who need it most?
- 13) Use language and concepts that are understandable to consumers and providers?
(BT 11/94)

Legislative Priorities

The WSMA always includes among its highest legislative priorities an issue which improves the health and welfare of our patients, benefits their care, provides for better access to care, reduces injuries or promotes healthy lifestyles. (Res C-6, A-97)

Washington Physicians Health Program

The WSMA supports full funding for the Washington Physicians Health Program that is unencumbered by the legislative budget and appropriation process. (EC Rpt H, A-96; Res D-4, A-01)

The WSMA supports increasing the surcharge to \$35 per physician license, and by annual adjustments to reflect increases in the Consumer Price Index thereafter. (Res C-18, A-99)

LIABILITY

The WSMA supports continued study of the relationship between compliance with professional "practice parameters" or "practice guidelines" with relief from professional liability, but that direct support for this concept should be withheld until such time as the relationship has been proven, through study and research, to be efficacious and that conclusive evidence as to their effectiveness is available. (EC Rpt M, A-94)

Insurance

The WSMA endorses the Washington State Physicians Insurance Exchange and the Washington State Physicians Insurance Association (dba Physicians Insurance) as the physician-owned and directed professional liability company in Washington State created by the WSMA for the benefit of physicians, which is truly responsive to the needs of physicians, offers excellent claims service, physician defense, and competitively priced coverage. (Res 54, B-90)

The WSMA encourages the state to fund liability insurance to allow more retired volunteer physicians to participate in treating the medically uninsured. (Res 11, C-90; Res C-10, A-02)

Liability Induced Stress

The WSMA, working with other appropriate groups, is committed to identifying the types of resources and/or programs that are available to assist physicians and their families in coping with liability-induced stress. (Res 37, B-88)

Liability Reform

The WSMA, through its legislative and governmental affairs program, will work with the Liability Reform Coalition to defend continued WSTLA legislative attacks on the Liability Reform Act of 1986.

In strategizing its legislative efforts, the WSMA will seek opportunities to link liability reform issues with other various issues, including access to care, (i.e. liability reform and prenatal care).

The WSMA supports continued aggressive physician and public education and communications campaigns on tort reform, working with the Liability Reform Coalition to the extent possible, and working independently as necessary to mobilize grassroots public opinion on the benefits derived from reform efforts and the need for additional reform. (EC Rpt B, A-89)

The WSMA resolved that the Liability Reform Committee continue to work with the Washington section of ACOG and the Washington State Obstetrical Association and the WAFP to improve the access to prenatal care for the state's Medicaid populations. (EC Rpt B, A-88)

Volunteer Physicians

The WSMA supports legislation providing immunity from civil liability for retired physicians providing free services to low income people. (EC 9/91)

LIABILITY REFORM POSITIONS

The following legislative proposals form the framework for the WSMA's liability reform efforts:

Joint and Several Liability

There should be no joint liability among multiple defendants, except for instances of collusion among defendants, or hazardous or toxic waste causes.

Collateral Source Rule

Legislation should be enacted to prevent multiple recoveries in personal injury cases by eliminating the collateral source rule. A court should be directed to reduce any jury award by the amount a plaintiff receives from government programs such as disability plans, employee wage continuation plans, and health insurance programs.

Government Standards Defense

Government pre-marketing approval or compliance with government specifications should be a defense in a tort case involving such products where all required government regulations are followed and no material information is withheld.

Expert Testimony

Experts should have recognized expertise in the specialty area at issue and should have been engaged in the practice of medicine at the time of the incident about which they are testifying. They must have had a valid license to practice medicine in the State of Washington at the time of the incident complained of, and no opinion can be admitted in evidence unless it is corroborated by other objective evidence.

Offers of Settlement

An offer of settlement procedure should be implemented to permit a party to make a formal offer to another party to settle the lawsuit for a stated amount. If the party to whom the offer is made does not accept the offer and does not better its position at trial, then the party that refused the offer should be required to pay the offering party's reasonable attorneys' fees.

Contingent Attorneys' Fees

Attorneys should be prohibited from receiving by way of a contingent fee more than one-third of the first \$300,000 of any award of settlement, one-quarter of the next \$200,000 of any award or settlement, and ten percent of the amount of any award or settlement in excess of \$500,000.

Certificate of Merit

As a means of discouraging frivolous lawsuits, before filing a lawsuit the plaintiff's attorney should be required to certify to the court that he/she has consulted with another professional in the same discipline who has concluded there are meritorious grounds to the suit.

Tax Consequences of Damage Awards

Juries should be advised at the time of trial of the tax consequences for federal income tax purposed of any award they make to the plaintiff.

MANAGED CARE

The WSMA supports physicians in recognizing and dealing with both the positive and negative aspects of managed care in order to promote the best possible balance of interests between patients, physicians, and delivery systems. In adopting the following guidelines, the WSMA:

- 1) Supports a medical marketplace that allows for experimentation and innovation, and choice for the consumer.
- 2) Supports a consensus model of managed care that includes the following elements:
 - a) Medical decision-making focused at the physician/patient level.
 - b) The widespread sharing of clinical and utilization information among physicians to assure efficiency, effectiveness and continuous quality improvement.
 - c) Practice guidelines incorporated to foster a uniformly high standard of care.
 - d) The management of effective delivery of health care services through maintaining the primacy of the physician/patient relationship in the entire process.
 - e) Control health care costs by reducing or eliminating unneeded and/or ineffective services.
 - f) Simple and straightforward administrative procedures for patients and physicians to improve patient relations, reduce costs, and free physicians from burdensome paperwork.
 - g) Integration of computer technology to support individual clinical practice and administration.
 - h) Local arrangements to minimize unnecessary care, fairly compensate physicians, and share risk and reward.
 - i) Continuing patient education concentrated on those health care areas that promise the greatest health gain.
 - j) Increased communication among providers and purchasers to resolve quickly those issues that add indirect costs.
 - k) Disclosure to all health care plan participants regarding limits of plan, financial incentives which may limit care, and means to appeal.

(EC Rpt H, A-95)

Ethical Issues

The WSMA has adopted the following guidelines regarding ethical issues in managed care:

- 1) The duty of patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice. Physicians must continue to place the interests of their patients first.
- 2) When managed care plans place restrictions on the care that physicians in the plan may provide to their patients, the following principles should be followed:

a) Any broad allocation guidelines that restrict care and choices – which go beyond the cost/benefit judgments made by physicians as a part of their normal professional responsibilities – should be established at a policy making level so that individual physicians are not asked to engage in ad hoc bedside rationing.

b) Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for any care they believe will materially benefit their patients.

c) Physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Managed care plans should create structures similar to hospital medical staffs that allow physicians to have meaningful input into the plan's development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis and updated to reflect advances in medical knowledge and changes in relative costs.

d) Adequate appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in unfair denials of care, i.e., denial of care that, in the physician's judgment, would materially benefit the patient. In such cases, the physician's duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise when a health plan has an allocation guideline that is generally unfair in its operation. In such cases, the physician's duty as patient advocate requires not only a challenge to any denials of treatment from the guideline but also advocacy at the health plan's policy-making level to seek an elimination or modification of the guideline. Physicians should assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient's best interests.

e) Managed care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information. Full disclosure requires that managed care plans inform potential subscribers of limitations or restrictions on the benefits package when they are considering entering the plan.

f) Physicians also should continue to promote full disclosure to patients enrolled in managed care organizations. The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan. Full disclosure includes informing patients of all of their treatment options, even those that may not be covered under the terms of the managed care plan. Patients may then determine whether an appeal is appropriate, or whether they wish to seek care outside the plan for treatment alternatives that are not covered.

g) Physicians should not participate in any plan that encourages or requires care at below minimum professional standards.

3) When physicians are employed or reimbursed by managed care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians' personal financial interests and the needs of their patients. Efforts to contain health care costs should not place patient welfare at risk. Thus, financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care.

a) Any incentives to limit care must be disclosed fully to patients by plan administrators upon enrollment and at least annually thereafter.

b) Limits should be placed on the magnitude of fee withholds, bonuses and other financial incentives to limit care. Calculating incentive payments according to the performance of a sizable group of physicians rather than on an individual basis should be encouraged.

c) Health plans or other groups should develop financial incentives based on quality of care. Such incentives should complement financial incentives based on the quantity of services used.

4) Patients have an individual responsibility to be aware of the benefits and limitations of their health care coverage. Patients should exercise their autonomy by public participation in the formulation of benefits packages and by prudent selection of health care coverage that best suits their needs.

5) All plans should be required to annually disclose to all insureds the percent of premium used to pay for health care services and the percent of premium used for administrative overhead and profit. (JC Rpt A, A-95)

MATERNAL AND INFANT HEALTH CARE

Access

The WSMA supports "First Steps", and encourages all obstetrical providers to actively provide maternity access to Medicaid beneficiaries, and assume a reasonable share of Medicaid patients in order to more equally distribute the workload. (EC Rpt H, A-90)

Breast Milk

The WSMA affirms its commitment to the promotion of breast milk as the "healthiest choice" for babies while supporting a reduction of toxicants to human breast milk.

Chemical Abuse

The WSMA is committed to actively participating in addressing the increasing incidence of cocaine-addicted newborns by interacting with substance abuse contractors, the DSHS Prenatal Care Program, and other state agencies and community groups to identify: 1) the needs of cocaine-addicted parents and babies; 2) the means by which to meet those needs; and 3) ways of educating the community about available resources. (EC Rpt N, A-88)

The WSMA is committed to working with state agencies, community groups and the legislature to address the chemical abuse of infants by developing non-punitive treatment for mothers and babies through innovative pilot programs of prevention, treatment, counseling, and care both during pregnancy and following birth. (EC Rpt H, A-90)

Infant Mortality

The WSMA disseminates information to physicians, hospitals and the public about the high incidence and socio-economic causes of infant mortality and encourages the utilization of available resources for the reduction of infant mortality. (Res 18, A-87)

The WSMA is financially and otherwise committed to working with research groups, including the University of Washington, in an attempt to identify and correlate infant and maternal deaths based upon age, economic status, race – as well as health and environmental issues. (Res 9, A-84; Res 1, A-86)

Prenatal Care

The WSMA is committed to working with communities and organizations to encourage education prior to pregnancy and early prenatal care. (Res 27, A-88)

The WSMA supports the concept of ante-partum care for low-income mothers, including increasing its communication, liaison, and cooperation with the Department of Social and Health Services and private organizations to promote high-quality prenatal care for low-income mothers. (Res 22, A-85)

The WSMA continues to support and monitor statewide pilot projects of the Unicorn Perinatal Program, as long as such pilot projects are in common agreement with the WSMA and state chapters of the American College of Obstetrics/Gynecology and the Washington Academy of Family Physicians. (EC Rpt H, A-90)

Sickle Cell Anemia

The WSMA endorses mandated universal screening for sickle cell disease as part of the existing newborn screen with the assurance that appropriate funding for expansion of genetic counseling centers be provided. (EC 9/90; Res 53, A-89; Res 22, A-87)

Sudden Infant Death Syndrome (SIDS)

The WSMA encourages physicians and parents to place infants on their backs for sleeping and supports efforts by the SIDS Foundation of Washington to educate the public about SIDS risk factors. (Res A-1, A-97)

Testing of Neonates

The WSMA supports working with the Department of Health to adopt a policy encouraging anonymous testing of either all or random samples of blood, urine or other body fluids of neonates to identify frequency rates of the presence of addictive drugs and/or the HIV virus. The WSMA supports the initiation of such pilot projects. (Res 8, A-91; Res 2, A-90)

MEDICAID

Access

In order to provide more adequate access to health care for Washington state's needy, the WSMA strongly supports increased funding for the state Medicaid program. (EC Rpt P, '88)

The WSMA supports reimbursement policies that promote access to the Medicaid program in accordance with its intent and enabling legislation. (Res 48, C-88)

The WSMA supports the expansion of the Medicaid eligibility for pregnant mothers and infants up to 185% of the federal poverty level, and to children below age 5 to families below 100% of the federal poverty level. (Res 6, C-88)

Co-payment, Repeal

The WSMA opposes the recently implemented co-payment for certain classes of Medicaid patients announced by the Department of Social and Health Services, Medical Assistance Division; the WSMA also supports repeal of the state's 1993-95 biennial budget provision, enacted during the 1993 legislative session, requiring the department to impose the co-payment. (Res C-9, A-93)

Hospice Care

The WSMA supports inclusion of hospice care as a permanent part of the MAA program. (EC Rpt F, A-92)

Reform

The WSMA is committed to working with the Department of Social and Health Services, and other concerned groups, such as the advocates of Medicaid beneficiaries, to support reform of the Medicaid

program – including reform of the benefit, payment and delivery structures of the Medicaid program, as well as the relocation of the Division of Medical Assistance within a separate Department of Health – to increase its responsiveness to the health care needs of those the program is intended to serve. (Res 3, C-91; EC Rpt P, A-88)

The WSMA advocates changes in the tax structure so that society as a whole bears the burden of cost of care for the economically disadvantaged. (EC Rpt P, A-88)

The WSMA supports the privatization of the Medicaid program by means of a voucher system for Medicaid beneficiaries which would allow them to select the health care delivery plan of their choice. (EC 1/95)

Reimbursement

The WSMA supports the concept of deferred compensation for Medicaid service. (EC Rpt F, A-92)

The WSMA requests the state legislature to fund the Medicaid program at a level that will reimburse physicians the reasonable costs associated with providing cost effective, quality, medical care. (Res 32, C-86)

The WSMA believes Medicaid should be reimbursed at today's Medicare rates, and Medicare should be reimbursed at today's commercial insurance rates. (EC Rpt A, A-01)

The WSMA discourages reimbursement practices based on medical specialty. (Res 6, A-74; Res 45, A-88)

The WSMA supports the establishment of a resource-based relative value schedule basis of payment by the state of Washington for service provided Medicaid beneficiaries. (Res 2, C-87)

The WSMA opposes payment for the delivery of obstetrical services in the home (home deliveries). (EC 4/92)

MEDICAL BOARDS

The WSMA supports the continued actions of the WSMA Medical Boards Task Force in working with the Board of Medical Examiners, Medical Disciplinary Board and the Department of Health to identify and implement methods by which the licensing and disciplining of physicians occurs as efficiently as possible while at the same time assuring that the activities of the boards are sufficient to satisfy their legislative mandate and to protect the public. (EC Rpt D, A-90)

Authority

The WSMA opposes any effort to dilute or eliminate the medical boards' rule making authority and/or to reduce the boards to an advisory committee. (EC Rpt D, A-91)

Governor Appointments

The WSMA supports governor appointments of physicians to the Medical Disciplinary Board and encourages allowing the WSMA to nominate candidates to the governor from which appointments would be made. (BT 11/90)

Osteopathic Boards

The WSMA believes that the actions and procedures of the Washington State Medical Board and the Washington State Osteopathic Board should be similar, while remaining separate, and that the

WSMA, together with the Washington Osteopathic Association should encourage and work with the Boards and Department of Licensing for a closer relationship. (Res 30, B-88)

Physician Assistant on Board of Medical Examiners

The WSMA supports the concept of a physician assistant on the Board of Medical Examiners, with all the rights and privileges of a board member, but with a vote on physician assistant matters only. (Res 16, C-86)

MEDICAL DIRECTORS

The WSMA supports requiring medical directors of health plans to have a valid license to practice medicine in the state of Washington. The WSMA also believes that decisions regarding clinical medicine made by medical directors of health plans should be considered the practice of medicine and therefore subject to the surveillance and constraints of the Medical Quality Assurance Commission. (Res C-10, A-98)

Accountability

The WSMA believes that the Medical Quality Assurance Commission should be recognized by both the public and by the profession, and by related industries, as having authority and the responsibility to pass judgments about medical decisions made or implemented by medical directors or analogous physicians throughout the state of Washington. (Res C-6, A-98)

MEDICAL ETHICS

The WSMA upholds the American Medical Association's principles of medical ethics. (JC Rpt B, A-05; Res 19, B-86)

Additionally, the WSMA supports a professional education program for its members regarding medical ethics, and the WSMA will make available copies of the WSMA Judicial Council Report and Opinions updates as they are issued. (Res 19, B-86)

MEDICAL QUALITY ASSURANCE COMMISSION

Complaints

The WSMA supports legislation, rulemaking or administrative action that would enable informal discussion and disposition of a complaint at a level below a reportable threshold. (EC Rpt B, A-01)

The WSMA believes that complaints filed against a physician should not be disclosed to the public until the Medical Quality Assurance Commission (MQAC) files formal charges and that any such information disclosed to the public or to organizations must be accurate. (EC Rpt H, A-96)

The WSMA supports appropriate legislative or administrative action which would require the state to provide access to all of the substantive information except the identity of a complainant contained in the investigative file. (EC Rpt H, A-97)

The WSMA supports appropriate legislative or administrative action which would provide penalties against those who file malicious complaints against physicians. (EC Rpt H, A-97)

The WSMA supports appropriate legislative or administrative action which would require that complaints which could not be substantiated be dismissed and not be allowed to be re-opened and added on to subsequent allegations. (EC Rpt H, A-97)

Organizational Structure

The WSMA supports legislation, rulemaking or administrative action that would result in a significant organizational change in the current MQAC-DOH relationship: that administrative law judges be used to conduct hearings; that MQAC have responsibility over investigators and attorneys working for it; and, that MQAC retain all rule-making and policy-setting authority affecting the practice of medicine and MQAC operations. (EC Rpt B, A-01)

Per Diem

The WSMA believes that the \$50 per diem currently provided to MQAC members should be substantially increased. (EC Rpt H, A-96)

MEDICARE

Anti-Emetic Reimbursement in Conjunction with Chemotherapy

The WSMA supports the concept of anti-emetics and chemotherapy being considered as a single covered service and should continue to be covered as an integral part of chemotherapy. (Late Res 2, A-92)

Assignment

The WSMA encourages and supports the further development of voluntary Medicare assignment programs at the county medical society level. (EC Rpt O, '90; EC Rpt L, '89)

Doctorcare Programs (Voluntary Medicare Assignment Program)

The WSMA is committed to the implementation of voluntary Medicare assignment programs, or Doctorcare Programs, through staff support to county medical societies. (EC Rpt O, '90)

Fees

The WSMA supports the elimination of differential fees based on physician specialty, and supports differential fees that respect differences in the cost of providing services between rural and urban physicians. (BT 11/88)

Nursing Home Services

The WSMA supports Medicare reimbursement revisions to provide adequate reimbursement to cover on-site and off-site management services for beneficiaries in the nursing home setting. (Res 20, D-91)

Payment Reform

The WSMA supports the formation of a single statewide Medicare physician payment region for the state of Washington. (Res 10, A-92; Res B-2, A-94)

The WSMA supports restoration of payment of EKG interpretations. (EC 2/92, Res 1, A-92)

The WSMA supports the elimination of discriminatory payment policies imposed on new physicians. (EC 2/92)

The WSMA supports altering the definition of new patient visit classification. (EC 2/92)

The WSMA supports change in payment restrictions for surgical assistants. (EC 2/92)

The WSMA supports changes in rules regarding billing for medical supplies to allow adequate reimbursement for costs. (EC 2/92)

Reform

The WSMA supports Medicare reform that includes needs testing for Medicare beneficiaries. (EC Rpt A, A-01)

Regulation

The WSMA is resolved to work with the AMA and local Medicare carriers to implement Medicare rules and regulations in a fair and objective manner, not jeopardizing good patient care, or compromising the due process rights of physicians. (PA Rpt C, '89)

The WSMA supports working through the AMA and state congressional delegations to amend the Medicare laws and regulations so that Medicare would be required to use the same standards and apply the same penalties to all physicians, regardless of participation or non-participation status. (PA Rpt C, '89)

Supplemental Insurance

The WSMA applauds the efforts underway to standardize the description of Medicare Supplemental Insurance policies, and urges continued efforts so that senior citizens can easily compare policies and understand the coverage. (Res 31, A-88)

MEN'S HEALTH

The WSMA supports and encourages national, state and local efforts to secure access and remove barriers to healthcare for men. (Res C-9, A-05)

The WSMA supports the creation of a state Commission on Men's Health. (Res C-9; A-05)

MENTAL HEALTH CARE

The WSMA encourages legislation to revise Washington's Involuntary Treatment Act to lessen the barriers to providing appropriate medical and psychiatric treatment to mentally ill patients whose illness renders them incapable of making rational treatment decisions on their own behalf, while at the same time respecting the mentally ill individual's right to self-determination when this would not result in negative consequences to the individual or to others or to property.

Benefits

The WSMA believes that all governmental and private health insurance programs should provide benefits for emotional and mental illness that are equivalent in scope and duration to those benefits provided for other illnesses. (Res 9, B-86; Res C-10, A-00)

Involuntary Administration of Drugs

The WSMA believes a physician may administer certain medication to certain patients with psychological illnesses without their consent in order to protect them from harming themselves or others. The WSMA does not believe that the administration of involuntary medication for the mentally ill requires judicial review, as judicial hearings divert scarce resources from the care and treatment of the mentally ill. (Res 44, C-90)

MIGRANT WORKERS

The WSMA believes that the issue involving exclusion of seasonal workers from the full access provisions of the 1993 Health Services Act must be corrected in order to satisfy the WSMA's position on universal access. (EC 12/93)

MINORITY HEALTH CARE

The WSMA supports coordination of efforts between the WSMA and the Washington State Association of Black Professionals in Health Care and other similar organizations. (Res 27, D-90; S Res 22, A-86)

NON-SCIENTIFIC PRACTITIONERS

The WSMA believes it is wrong to engage in or to aid and abet in treatment which has no scientific basis and is dangerous, is calculated to deceive the patient by giving him/her false hope, or which may cause the patient to delay in seeking proper care until his/her condition becomes irreversible. (JC 3.01-87)

NURSING

The primary bond between medical practice and nursing is mutual ethical concern for patients. One of the duties in providing reasonable care is fulfilled by a nurse who carries out the orders of the attending physician. Where orders appear to the nurse to be in error or contrary to customary medical and nursing practice, the physician has an ethical obligation to explain those orders to the nurse involved. Whenever a nurse recognizes or suspects error or discrepancy in a physician's orders, the nurse has an obligation to call this to the attention of the physician. The ethical physician should neither expect nor insist that nurses follow orders contrary to standards of good medical and nursing practice. In emergencies when prompt action is necessary and the physician is not immediately available, in the performance of reasonable care a nurse may be justified in acting contrary to the physician's standing orders for the safety of the patient. Such occurrences should not be considered to be a breakdown in professional relations. (JC 3.02-87)

The WSMA supports the representation of the nursing profession to full membership on the Board of Governors of the Joint Commission on Accreditation of Healthcare Organizations. (Res 8, D-89)

Education/Training

The WSMA encourages and supports the training of more nursing personnel, with appropriate remuneration. The WSMA endorses state rather than federal licensing of all health care practitioners. The WSMA believes that the education and training of nursing personnel be under the supervision of nurses, in consultation with other health care professionals where appropriate. (Res 14, D-88)

Nursing in Public Schools

The WSMA supports the appropriate numbers and professional qualifications of school nursing staff to provide needed health services in our various public school districts. (Res 50, A-90)

Scope of Practice

The WSMA is opposed to expanding the prescriptive authority for nurse practitioners without clear physician oversight and credentialing by the Board of Medical Examiners. (EC 2/90).

OPTOMETRY

The WSMA believes an ophthalmologist may employ an optometrist as ancillary personnel to assist him/her provided the optometrist is identified to patients as an optometrist. (JC 3.03-87)

ORGANS

Allocation of Organs and Other Scarce Medical Resources

The WSMA has established the following guidelines regarding ethical considerations in the allocation of organs and other scarce medical resources among patients:

1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need.

a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria become. In making quality of life judgments, patients should first be prioritized so that extremely poor outcomes are avoided; then patients should be prioritized to change in quality of life, but only when there are very substantial differences among patients.

b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria.

c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.

2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible.

a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need.

b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first come, first served" approach or some other equal-opportunity mechanism should be employed to make final allocation decisions.

c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tier system, a minimal threshold approach, and a weighted formula.

3) Decision-making mechanisms should be objective, flexible and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.

4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.

5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.

6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them. (JC Rpt E, A-94)

Donation

The WSMA supports legislation mandating the inclusion of organ donation consent forms on drivers licenses. (Res 6, A-84)

The WSMA supports the exploration of methods to greatly increase organ donation, including the “presumed consent” modality or organ donation for the state of Washington (Res C-5, A-98), and will work to educate its members and the public on the benefits of a presumed consent policy of organ donation. (Res A-6, A-99)

Organ Transplantation

The WSMA has established the following guidelines for organ transplantations to aid physicians in fulfilling their ethical responsibilities when they engage in transplantations.

1) Care must be taken to protect the rights of both the donor and the recipient, and no physician may assume a responsibility in organ transplantation unless the rights of both donor and recipient are equally protected.

2) The physician should provide his patient, who may be a prospective organ donor, with that care usually given other being treated for a similar injury or disease.

3) When a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician. Death shall be determined by the clinical judgment of the physician. In making this determination, the ethical physician will use currently accepted available scientific tests.

4) Full discussion of the proposed procedure with the donor and recipient or their responsible relatives or representatives is mandatory. The physician should be objective in discussing the procedure, in disclosing known risks and possible hazards, and in advising of the alternative procedures available. The physician should not encourage expectations beyond those which the circumstances justify. The physician's interest in advancing scientific knowledge must always be secondary to his primary concern for the patient.

5) Transplant procedures of body organs should be undertaken:

a) only by physicians who possess special medical knowledge and technical competence developed through special training, study, and laboratory experience and practice; and b) in medical institutions with facilities adequate to protect the health and well-being of the parties to the procedure.

6) Transplantation of body organs should be undertaken only after careful evaluation of the availability and effectiveness of other possible therapy. (JC 2.12-87)

The WSMA holds the position that if a liver transplantation program is developed in the state of Washington, it should be implemented as a collaborative effort between the University of Washington and private institutions. (Res 47, B-88)

PATIENT

Choice

The WSMA reaffirms its commitment to patient choice. (EC Rpt L, A-94)

Patient Informed Consent

The WSMA believes that physicians must properly inform the patient of the diagnosis and of the nature and purpose of the treatment undertaken or prescribed. The physician may not refuse to so inform the patient. (JC 8.11-87)

Principles of Patient Care

- 1) All patients deserve quality medical care from their physicians;
- 2) All patients merit respect, courtesy and dignity in the delivery of health care services;
- 3) All patients deserve information about their diagnosis, treatment options and risks, prognosis, and costs in order to participate in decisions about their health care;
- 4) All patients should be free to choose the health care delivery system that best suits their needs and provides them with a choice of physicians;
- 5) All patients may seek an additional professional opinion, if they so desire;
- 6) All patients deserve to have their health care managed in a confidential manner.
(EC Rpt A, A-93)

PEER REVIEW

The WSMA supports peer review in the forms of medical society ethics committees, hospital credentials and utilization committees, and other forms of peer review that have been long established by organized medicine to scrutinize physicians' conduct. The WSMA supports peer review as a balance between the physician's right to exercise his/her medical judgment freely with his/her obligation to do so wisely and temperately. (JC 9.09-87)

The WSMA strongly believes that peer review is best accomplished by a physician-sponsored and managed organization with review being performed by local practicing physicians in the same specialty as the physicians being reviewed. (PA Rpt B, '91; PA Rpt B, '90)

Confidentiality

The WSMA supports enactment of laws to protect physician peer review activities outside the hospital setting from discovery. (Res 27, C-86; EC Rpt C, A-98)

Included in Practice of Medicine Definition

The WSMA believes peer review should be included in the Washington statutory definition of the practice of medicine, and that peer review participation should be justly compensated. The WSMA believes insurance carriers that provide professional liability insurance to physicians should expand the scope of coverage to include participation in peer review. (Res 2, B-89)

PHYSICIAN ASSISTANTS

The WSMA supports issuing a single license renewable every two years to physician assistants practicing only under the supervision/sponsorship of a MD or DO. (Res 7, A-92)

The WSMA supports the concept of administrative simplification of the physician assistant licensing process. (Res 7, A-92)

The WSMA supports the position that the state participate in the funding of the MEDEX Northwest Physician Assistant Training Program, which would increase the supply of physician assistants for the state of Washington. (Res 8, A-92)

The WSMA supports legislative changes in RCW 18.71A that would clarify the ability of the supervising physician to delegate tasks to the physician assistant that involve the care of the foot and ankle. (Res 13, A-92)

PHYSICIANS

Referral of Patients

The WSMA believes that a physician may refer a patient for diagnostic or therapeutic services to another provider whenever he/she believes that this may benefit the patient. As in the case of referrals to physician-specialists, referrals to limited practitioners should be based on their individual competence and ability to perform the services needed by the patient. (JC 3.04-87)

Sale of Health Related Goods from Physicians' Offices

The WSMA has established the following guidelines regarding the sale of health related goods from a physicians' office: "Health-related products" are any products that, according to the manufacturer or distributor, benefit health. "Selling" refers to the activity of dispensing items that are provided from the physician's office in exchange for money and also includes the activity of endorsing a product that the patient may order or purchase elsewhere that results in direct remuneration for the physician.

The primary obligation of physicians is to serve the interests of their patients. In-office sale of health-related products by physicians may present a conflict of interest, could risk placing undue pressure on the patient, and could erode patient trust. When these items offer some health-related benefits, the physician's influence over the sale is amplified and makes it even more necessary for physicians to be cognizant of their special relationship with their patients.

Physicians who do sell health-related products from their offices should not sell any health-related goods whose claims lack scientific validity. Physicians should rely on peer-reviewed literature and other unbiased sources that review evidence in a sound, systematic fashion when judging the efficacy of the product.

Physicians who sell health-related products from their offices should follow these guidelines to limit their conflicts of interest, minimize the risk of brand endorsement, and ensure a focus on benefits to patients.

a) Physicians may distribute health-related products to their patients in order to make useful products readily available to those patients who may benefit from the use of such products. Recommendations to use a product must be made in the patient's best interest, not solely to supplement the physician's income.

b) Physicians must disclose fully the nature of their financial arrangement with a manufacturer or supplier to sell health-related products. Disclosure includes informing patients of financial interests as well as about the availability of the product or other equivalent products elsewhere. Disclosure can be accomplished through face-to-face communication or by posting an easily understood written notification in a prominent location that is accessible by all patients in the office. In addition, physicians should, upon request, provide patients with understandable literature that relies on scientific standards in addressing the validity of the health-related goods. (JC Rpt B, A-99)

Sale of Non-Health Related Goods from Physicians' Offices

The WSMA has established the following guidelines regarding the sale of non-health related goods from a physicians' office:

- a) Physicians should not sell non-health-related goods from their offices or other treatment settings, with the exception noted below.
- b) Physicians may sell low-cost non-prescription goods from their offices for the profit of community organizations, provided that a) the goods in question are low-cost, b) the physician takes no share in profit from their sale, c) such sales are not a regular part of the physician's business, d) sales are conducted in a dignified manner, and e) sales are conducted in such a way as to assure that patients are not pressured into making purchases.

Secret Remedies

The WSMA believes that it is unethical for a physician to prescribe, dispense, administer, or promote the use of any drug whose content or effect are unknown to him/her or to refuse to inform the patient (or his/her legal representative) about the identity and purpose of any drug which he/she has prescribed, dispensed, or administered to the public. (JC 2.17-87)

Unnecessary Services

The WSMA believes it is unethical for a physician to provide or prescribe unnecessary services or unnecessary ancillary facilities. (JC 2.15-87)

Worthless Services

The WSMA believes that a physician should not seek compensation for providing services which he/she knows or should know are generally regarded among reputable physicians as worthless. (JC 2.16-87)

Young Physicians

The WSMA definition of "young physician" will be in accordance with the AMA definition (currently "physicians under 40 years of age or in their first eight years of practice"). (Res A-1, A-09)

Recognizing the need to promote increased participation of young physicians in association activities and programs, the WSMA established the Young Physicians Committee, and the Young Physicians "Reach Out" Program. (Res 11, D-87; EC Rpt K, '88)

PHYSICIAN ADVERTISING AND PUBLICITY

The WSMA has established the following guidelines regarding physician advertising and publicity: There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize himself as a physician through any commercial publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television, or other advertising) provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain

any false or misleading statement, or shall not otherwise operate to deceive.

The form of communication should be designed to communicate the information contained therein to the public in a direct, dignified, and readily comprehensible manner. Aggressive, high-pressure advertising and publicity may create unjustified medical expectations. Any advertisement or publicity, regardless of format or content, should be true and not misleading.

The communication may include: a) the educational background of the physician; b) the basis on which fees are determined (including charges for specific services); c) available credit or other methods of payment; and d) other information about the physician which a reasonable person might regard as relevant in determining whether to seek the physician's services. Any advertising or other public representation where the physician claims to be board certified shall name the certifying board.

Patient testimonials, like other methods of advertising, are permitted to the extent they are not false or misleading. However, a physician using a testimonial must be able to substantiate that the experience related in the testimonial is representative of what the patients generally experience.

Statements relating to the quality of medical services are extremely difficult, if not impossible, to verify or measure by objective standards. Claims regarding experience, competence, and the quality of the physician's services may be made if they can be factually supported and if they do not imply that he has an exclusive and unique skill or remedy. A statement that a physician has cured or successfully treated a large number of cases involving a particular serious ailment may imply a certainty of result and create unjustified and misleading expectations in prospective patients.

Consistent with federal regulatory standards which apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, radio, or television, should determine in advance that his communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those which a reasonable, prudent advertiser should have discovered. (Res 12, B-87; Res 20, A-89; Res 42, A-90; JC Rpt A, A-99)

The WSMA has adopted the following guidelines regarding physician competition: Some competitive practices accepted in ordinary commercial and industrial enterprise, where profit-making is the primary objective, are inappropriate among physicians. Commercial enterprises, for example, are free to solicit business by paying commissions. They have no duty to lower prices to the poor. Commercial enterprises are generally free to engage in advertising "puffery", to be boldly self-laudatory in making claims of superiority, and to emphasize favorable features without disclosing unfavorable information.

Physicians, by contrast, have an ethical duty to subordinate financial reward to social responsibility. A physician should not engage in practices for pecuniary gain that interfere with his medical judgment and skill or cause a deterioration of the quality of medical care. Ability to pay should be considered in reducing fees, and excessive fees are unethical.

Physicians should not pay or receive commissions or rebates or give kickbacks for the referral of patients to other health care providers. Likewise, they should not make extravagant claims or proclaim extraordinary skills. Such practices, however common they may be in the commercial world, are unethical in the practice of medicine because they are injurious to the public.

Freedom of choice of physician and free competition among physicians are prerequisites of optimal medical care. The Principles of Medical Ethics are intended to curtail abusive practices that impinge on these freedoms and exploit patients and the public. (JC Rpt A, A-94; JC Rpt A, A-99)

PHYSICIAN HEALTH PLAN PARTICIPATION

The WSMA has established policy on physician access to the marketplace, consumer choice, and physician-health plan relations including disclosure and due process issues associated with selective contracting as follows:

- Health plans that contract with selected physicians to furnish care should utilize selection criteria based primarily on professional competence and quality care.
- Any economic criteria used in selective contracting should have a demonstrated relationship to the quality and appropriateness of care and to professional competency.
- Consumers in Washington state should not be offered or enrolled in any health care insurance plan before a health insurance carrier can guarantee the consumer that it has the ability to deliver the product it is marketing, including having the appropriate physicians already under contract who can provide the services covered in the benefits package.
- Health plans that contract with selected providers should have an established mechanism by which any provider willing to abide by terms of the plan contract could appeal a decision to deny the provider's application for participation in the plan.
- Health plans or networks should provide public notice within their geographic service areas when applications for participation are being accepted.
- Physicians should have the right to apply to any health plan or network in which they desire to participate and to have that application judged on the basis of objective criteria that are available to both applicants and enrollees.
- Selective contracting decisions made by any health care delivery or financing system should be based on an evaluation of multiple criteria related to professional competency, quality of care and the appropriateness by which medical services are provided. In general no single criterion should provide the sole basis for selecting, retaining, or excluding a physician from a health care delivery or financing system
- Prior to initiation of actions leading to termination of a physician's participation in a contract "for cause", the physician should be given notice specifying the grounds for termination, an opportunity for discussion, and an opportunity to initiate complete remedial activities, except in cases where harm to patients is eminent or an action by a state medical board or government agency effectively limits the physician's ability to practice medicine.
- The WSMA supports physician-directed health plans which are intended to provide willing physicians access to the market.
- The WSMA supports the ability of physicians to effectively aggregate and participate in the market (i.e., repeal of Certificate of Need laws and creation of antitrust relief).
- The WSMA endorses the concept of Medical Savings Accounts (MSAs) and promotes evaluation of their acceptance and efficacy in the market.
- The WSMA opposes legislation, ballot initiatives or regulations that would mandate inclusion of "any willing provider" or all classes of providers in health plans or networks.

(BT Rpt H, A-96)

PHYSICIAN PRACTICE

Addiction Medicine

The WSMA recommends that medical treatment of psychoactive substance use disorders should be provided by physicians with training, experience, and competence in addiction medicine. Recognition of those who practice addiction medicine should not be limited to any particular one of the 24 specialties recognized by the American Board of Medical Specialties or the specialties recognized by the American Osteopathic Association. (Res B-4, A-93)

The WSMA recognizes that addiction medicine specialists are the authority in the diagnosis and treatment of addictive disorders, and supports changes in state statutes to reflect this in patient referral, management, and compensation. (Res A-2, A-09)

The WSMA supports changes in state and federal laws and regulations to reduce restrictions placed on office-based physicians which currently prevent them from providing treatment for opiate addicted patients. (Res C-7, A-95)

The WSMA encourages its members to take more active roles in providing drug addiction treatment to afflicted individuals and to work with the State Department of Health and the Medical Quality Assurance Commission as well as other state and federal agencies to further curtail the ever-increasing morbidity and mortality associated with the detrimental effects of the wide variety of addictive drugs (including alcohol) available to our citizens in 2004. (Res B-5, A-04)

Appointment Charges

The WSMA believes that a physician may charge a patient for a missed appointment or for one not canceled within 24 hours in advance if the patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration for the patient and their circumstances. (JC 8.01-87)

Billing

The WSMA opposes legislation or regulation requiring physicians to withhold patient billing until receipt of reimbursement of third party payers. (EC 7/88)

Case Management

The WSMA recognizes patient-physician and patient-care related telephone consultation and related physician case management ministrations as legitimate medical services requiring physician time and expertise and affirms the physicians' right to charge and receive payment for such consultation, as identified in the 1990 CPT codes for these services (AMA). (Res 6, B-91)

Clinical Practice Parameters

The WSMA believes physicians should take an active leadership role in the development of clinical practice parameters. (BT 11/94)

Clinics

The WSMA upholds that physicians practicing in a group or clinic are, both individually and as a group, subject to the Principles of Medical Ethics. (JC 8.02-87)

Consultation

The WSMA believes that physicians should obtain consultation whenever they believe that it would be helpful in the care of the patient or when requested by the patient or the patient's representative. When a patient is referred to a consultant, the referring physician should provide a history of the case and such other information as the consultant may need, and the consultant should advise the referring

physician of the results of the consultant's examination and recommendations relating to the management of the case as soon as possible. A physician selected by a patient for the purpose of obtaining a second opinion on an elective procedure is not obligated to advise the patient's regular physician of the findings or recommendations unless requested by the patient. (JC 8.03-87; JC Rpt C, A-93)

Contingent Physician Fees

The WSMA believes a physician's fee for services should be based on the value of the service provided by the physician and should not be contingent on the outcome. (JC 8.04-87)

Definition of "Primary Care":

Primary care is the appropriate point at which patients may access medical care, regardless of the nature of the medical problem, or the organ system involved, AND

It is the reference point for the ongoing supervision and coordination of the patient's health maintenance and therapy of illness, and for the appropriate use of consultants and community resources.

Definition of "Primary Care Physician":

A primary care physician holds a Doctor of Medicine or Doctor of Osteopathy degree, and is most often trained in family practice, general internal medicine, general pediatrics, or obstetrics and gynecology.

Physicians of other specialties (MDs or DOs) may also choose to provide primary care under those circumstances in which they assume the responsibility for all aspects of the patient's care, including continuing care, treatment and referral of the patient.

A primary care physician has maintained a general clinical practice and appropriate continuing medical education.

Definition of "Non-physician Primary Care Provider":

A team approach to primary care may include physician assistants and advanced registered nurse practitioners who have training in primary care. Such individuals should provide primary care only under the supervision of a primary care physician.

Definition of "Managed Care":

The term "managed care" refers to a variety of techniques and/or organizational structures used by health care delivery systems to control health care costs and to promote continuous quality improvement in the delivery of health care. Managed care may be achieved by: prospective assessment of care; general rules governing medical decision-making; benefit design; or, by provider selection. "Managed care" does not necessarily require individual patient care management by a physician ("gatekeeper") or health maintenance organization systems of health care delivery.

Definition of Relationship of Primary Care to Managed Care Delivery Systems:

Some managed care systems (i.e. health maintenance organizations) emphasize primary care physician coordination of patient care as a means of achieving quality, cost effective health care while utilizing appropriate resources. Other systems (i.e. preferred provider organizations) may not rely on primary care physician coordination of care, but instead use concepts such as restricted physician panels, reimbursement discounts, utilization review and prior approval. Overall care is "managed" by the plan. (EC Rpt I, A-93)

Doctor/Physician, Use of the Term

The WSMA believes any practitioner who refers to him/herself as “doctor” or “physician” should be required to include their professional degree immediately after their name for the purpose of advertising, written correspondence, business cards, or any other printed professional representation. (Res C-8, A-03)

Imaging, Reimbursement of

The WSMA opposes any attempts by federal and state legislators, regulatory bodies, hospitals, private and government payers, and others to restrict reimbursement for imaging procedures based on physician specialty, and supports the reimbursement of imaging procedures being performed and interpreted by physicians based on the proper indications for the procedure and the qualifications and training of the imaging specialists in that specific imaging technique regardless of their medical specialty. (Res C-14, A-05)

Laboratory Services

The WSMA believes that a physician should not misrepresent the laboratory services performed and supervised by a non-physician as the physician's professional services. The professional relationship between the laboratory and the physician should be clear and not misleading.

The WSMA believes it is unethical for two or more physicians to secretly split or share the fees that have been given by a patient supposedly as reimbursement for the service of one man alone. When it is more practical for the physician to include the laboratory charge in his/her own statement, the physician's bill to the patient should indicate the charges apart from the charges for his/her own professional services. (JC 8.08-87)

Lien Laws

The WSMA believes it is not improper for a physician to use a physicians' lien law as a means of assuring payment of his/her fee, provided his/her fee is fixed in amount and not contingent on the amount of settlement of the patient's claim against a third party. (JC 8.09-87)

Practice Parameters

The WSMA strongly opposes the adoption of any public policy by the Washington State Legislature or any regulatory agency which would encourage the delivery of health care services which are substantially outside of the recognized and accepted standards prevailing in the medical community. (Res 17, A-89)

Providers, Use of the Term

The WSMA condemns the use of the term “provider” to describe its members and urges any organization which employs the term to describe physicians by their proper, professional titles of either “physician” or “doctor”. (Res B-9, A-99; Res B-1, A-06)

Psychiatric Services

The WSMA recognizes the unique and essential role of psychiatric services in the delivery of appropriate medical care. (Res C-9, A-95)

Second Opinions

The WSMA believes that physicians should recommend that a patient obtain a second opinion whenever they believe it would be helpful in the care of the patient. When recommending a second opinion, physicians should explain the reasons for the recommendation and inform their patients that patients are free to choose a second-opinion physician on their own or with the assistance of the first physician. Patients are also free to obtain second opinions on their own initiative, with or without their physician's knowledge.

With the patient's consent, the first physician should provide a history of the case and such other information as the second-opinion physician may need. The second-opinion physician should maintain confidentiality of the evaluation and should report to the first physician if the consent of the patient has been obtained.

After evaluating the patient, a second-opinion physician should provide the patient with a clear understanding of the opinion, whether or not it agrees with the recommendations of the first physician.

When a patient initiates a second opinion, it is inappropriate for the primary physician to terminate the patient-physician relationship solely because of the patient's decision to obtain a second opinion.

In some cases, patients may ask the second-opinion physician to provide the needed medical care. In general, second-opinion physicians are free to assume responsibility for the care of the patient. It is not unethical to enter into a patient-physician relationship with a patient who has been receiving care from another physician. By accepting second-opinion patients for treatment, physicians affirm the right of patients to have free choice in the selection of their physicians.

There are situations in which physicians may choose not to treat patients for whom they provide second opinions. Physicians may decide not to treat the patient in order to avoid any perceived conflict of interest or loss of objectivity in rendering the requested second opinion. However, the concern about conflicts of interest does not require physicians to decline to treat second-opinion patients. This inherent conflict in the practice of medicine is resolved by the responsible exercise of professional judgment.

Physicians may agree not to treat second-opinion patients as part of their arrangements with insurers or other third-party payers. Physicians who enter into such contractual agreements must honor their commitments.

Physicians must decide independently of their colleagues whether to treat second-opinion patients. Physicians may not establish an agreement or understanding among themselves that they will refuse to treat each others' patients when asked to provide a second opinion. Such agreements compromise the ability of patients to receive care from the physicians of their choice and are therefore not only unethical but also unlawful. (JC Rpt C, A-93)

Testing

The WSMA believes that it is ethical for physicians to perform all appropriate testing deemed necessary according to sound medical judgment on all patients in order to define appropriate treatment. (Res 1, B-90)

PHYSICIAN PROFILING

The WSMA has adopted the following principles on physician profiling and the public release of physician-specific data:

- 1) Physician organizations and practicing physicians who are representative of the profile group shall be meaningfully involved in the development of all aspects of the profile methodology, including collection methods, formatting, and methods, means and appropriate audience for release and dissemination.

- 2) The entire methodology for collecting and analyzing the data shall be disclosed to all relevant physician organizations and to all physicians under review.

- 3) Data collection and analytical methodologies shall be used that meet accepted standards of validity and reliability.
- 4) The limitations of the data sources and analytic methodologies used to develop physician profiles, as well as appropriate and inappropriate uses of the data, shall be clearly identified and acknowledged.
- 5) Physician profiling initiatives shall use standard-based norms derived from widely accepted, physician-developed practice guidelines to be used primarily to educate physicians.
- 6) Physician profiles and any other information regarding physician performance shall be shared with those physicians under review prior to dissemination. Opportunity for corrections or the addition of helpful explanatory comments shall be provided prior to publication. The profiles shall either include only data that reflect care under the control of physician for whom the profile is prepared or shall state to what extent the data are not under the control of the physician.
- 7) Comparisons of physician profiles shall adjust for patient case mix and other relevant risk factors, control for physician peer group when appropriate, and distinguish between the ordering or referring physician and the physician providing the service or procedure.
- 8) Effective safeguards to protect against the unauthorized use or disclosure of physician profiles shall be developed and implemented.
- 9) Effective safeguards to protect against the dissemination of inconsistent, incomplete, invalid, inaccurate, or subjective profile data shall be developed and implemented.
- 10) The quality and accuracy of physician profiles, data sources, and methodologies shall be evaluated regularly.
- 11) Physicians should be reimbursed for the reasonable costs that are required for assembling, formatting, and transmitting data and information to organizations that develop and/or disseminate physician profiles.
- 12) The benefits of physician profiling should outweigh the costs of developing and disseminating the profiles. (CPA Rpt D, A-95)
- 13) Physician-specific information released to the public must be relevant, meaningful, helpful, and reliable.
- 14) Information released to the public should be conclusive; that is, information should not be released until a final determination is made.
- 15) Information released to the public should be verifiable.

(CPA Rpt A, A-98)

PHYSICIAN RECORDS

Availability to Other Physicians

The WSMA believes the interest of the patient is paramount in the practice of medicine, and everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who have served or are serving the patient. A physician who formerly has treated a patient should not refuse for any reason to make his/her records of that patient promptly available on request to another physicians presently treating the patient. Proper authorization for the use of records must

be granted by the patient. Medical reports should not be withheld because of an unpaid bill for medical services. (JC 7.01-87)

Body Mass Index (BMI), Inclusion of

The WSMA recognizes that the Body Mass Index (BMI) and waist circumference in adults and the BMI from the “Body Mass Index for Age Growth Charts in Children” are essential pieces of data for the patient medical record. (Res A-22, A-05)

Discoverability

The WSMA supports non-discoverability and exemption from freedom of information acts any data evaluating or measuring physician performance that is generated by a regularly constituted Quality Assurance Committee of a health care organization, regardless of whether the organization is a public or private entity. (BT 1/95)

Health Services Information System

The WSMA believes that significant physician involvement is crucial to the development of any state sanctioned HSIS regardless of when it is established. (EC 12/94)

Information and Patients

The WSMA upholds that notes made in treating a patient are primarily for the physician's own use and constitute his/her own property. However, on request of the patient, a physician should provide a copy of a summary of the record to the patient or to another physician, an attorney, or other person designated by the patient.

The WSMA believes that the patient record is a confidential document involving the physician-patient relationship and should not be communicated to a third party without the patient's prior written consent, unless required by law or to protect the welfare of the individual or the community. (JC 7.02-87)

Records of Physicians on Retirement

A patient's records may be necessary to the patient in the future not only for medical care but also for employment, insurance, litigation, or other reasons. Therefore, the WSMA believes that when a physician retires or dies, patients should be notified and urged to find a new physician and should be informed that upon authorization, records will be sent to the new physician. Records which may be of value to a patient and which are not forwarded to a new physician should be retained, either by the physician him/herself, another physician, or such other person lawfully permitted to act as a custodian of the records. (JC 7.03-87)

Sale of a Medical Practice

The WSMA believes that a physician or the estate of a deceased physician may sell to another physician the elements which comprise his/her practice, such as furniture, fixture, equipment, office leasehold and goodwill. In the sale of a medical practice, the purchaser is buying not only furniture and fixtures, but also good will, i.e., the opportunity to take over the patients of the seller. The WSMA understand the transfer of records of patients to be subject to the following: 1) all active patients should be notified that the physician (or his/her estate) is transferring the practice to another physician who will retain custody of their records and that at their written request, within a reasonable time as specified in the notice, the records or copies will be sent to any other physician of their choice; 2) a reasonable charge may be made for the cost of duplicating records; 3) a physician or his/her estate who is selling his/her practice may not ethically sell his/her patients' records to another physician. (JC 7.04087)

Records on Termination of a Partnership

The WSMA believes that when two or more physicians, who are partners in the practice of medicine, terminate the relationship, any question regarding the possession of the patients' clinical records should be determined on the basis of what is best for each patient, consistent with any contractual arrangements that may have been made. (JC 7.05-87)

PHYSICIAN RIGHTS AND RESPONSIBILITIES

The WSMA encourages and supports collaborative specialty development and review of any appropriateness criteria, practice guidelines, technical standards, and accreditation programs, and supports the AMA Code of Ethics as the guiding principle in the development of such programs. (Res C-14, A-05)

The WSMA actively and strongly opposes efforts by private payers, hospitals, Congress, state legislatures, and the Administration to impose policies designed to control utilization and costs of medical services unless those policies can be proven to achieve cost savings and improve quality while not curtailing appropriate growth and without compromising patient access or quality of care. (Res C-14, A-05)

Agreement Restricting the Practice of Medicine

The WSMA understands that there is no ethical proscription against suggesting or entering into a reasonable agreement not to practice within a certain area for a certain time, if it is knowingly made, understood, and consistent with local law. Whether it is advisable as being in the best interest of the public depends on all of the surrounding facts. (JC 9.02-87)

Civil Rights and Responsibilities

The WSMA is in favor of equality of opportunity in medical society activities, medical education and training, employment, and all other aspects of medical professional endeavors regardless of race, color, religion, creed, ethnic affiliation, national origin, or sex.

The WSMA is unalterably opposed to the denial of membership privileges and responsibilities in county medical societies and state medical associations to any duly licensed physician because of race, color, religion, creed, ethnic affiliation, national origin, or sex.

The WSMA calls upon the medical profession and all individual members of the WSMA to exert every effort to end any instances in which equal rights, privileges, or responsibilities are denied. (JC 9.03-87)

Conflict of Interest – Physician Self-Referral

1) Physician investment in health-care facilities can provide important benefits for patient care. However, when physicians refer patients to facilities in which they have an ownership interest, a potential conflict of interest exists. In general, physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility.

2) Physicians may invest in and refer to an outside facility, whether or not they provide direct care or services at the facility, if there is a demonstrated community need for the facility and alternative financing is not available. There may be situations in which a needed facility would not be built if referring physicians were prohibited from investing in the facility. Need might exist when there is no facility of reasonable quality in the community or when use of existing facilities is onerous for patients. In such cases, the following requirements should also be met:

a) Individuals who are not in the position to refer patients to the facility must be given a bona fide opportunity to invest in the facility, and they must be able to invest on the same terms that are offered to referring physicians. The terms on which investment interests are offered to physicians must not be related to the past or expected volume of referrals or other business from the physicians.

b) There is no requirement that any physician investor make referrals to the entity or otherwise generate business as a condition for remaining an investor.

c) The entity must not market or furnish its name or services to referring physician investors differently than to other investors.

d) The entity must not loan funds or guarantee a loan for physicians in a position to refer to the entity.

e) The return on the physician's investment must be tied to the physician's equity in the facility, rather than to the volume of referrals.

f) Investment contracts should not include "non-competition clauses" that prevent physicians from investing in other facilities.

g) Physicians must disclose their investment interest to their patients when making a referral. Patients must be given a list of effective alternative facilities if any such facilities become reasonably available, informed that they have the option to use one of the alternative facilities, and assured that they will not be treated differently by the physician if they do not choose the physician-owned facility. These disclosure requirements also apply to physician investors who directly provide care or services to their patients in facilities outside their office practice.

h) The physician's ownership interest should be disclosed, when requested, to third-party payers.

i) An internal utilization review program must be established to ensure that investing physicians do not exploit their patients in any way, as by inappropriate or unnecessary utilization.

j) When a physician's financial interest conflicts so greatly with the patient's interest as to be incompatible, the physician must make alternative arrangements for the care of the patient.

3) With regard to physicians who invested in facilities under the council's prior opinion, it is recommended that they reevaluate their activity in accordance with this opinion and comply with the guidelines to the fullest extent possible. If compliance with the need and alternative investor criteria investor is not practical, it is essential that the identification of reasonably available alternative facilities be provided. (JC Rpt D, A-93)

Domestic Violence

The WSMA believes in assisting state physicians in learning how to recognize, treat and prevent domestic violence. (Res B-11, A-93)

Due Process

The WSMA strongly believes the basic principles of a fair and objective hearing should always be accorded to the physician whose professional conduct is being reviewed. The fundamental aspects of a fair hearing are: a listing of specific charges, adequate notice of the right to a hearing, and the

opportunity to present a defense. These principles apply when the hearing body is a medical society tribunal or a hospital committee composed of physicians. (JC 9.05-87)

Entertaining Expenses

The WSMA believes there are circumstances in which a physician may ethically entertain other physicians. The propriety of such matters must be determined on a case-by-case basis. (JC 9.12-87)

Expert Witness Standards

The WSMA supports the following qualifications for expert witnesses and standards for expert testimony:

Qualifications

1. Possess a current, valid and unrestricted license in the state in which he/she practices.
2. Fully trained in the specialty and a diplomate in a relevant ABMS recognized specialty board and demonstrated competence in the subject of the case
3. Be familiar with the clinical practice of the specialty or the subject matter of the case, and be actively involved in the clinical practice of the specialty for at least 3 of the previous 5 years at the time of the testimony.

Standards for Testimony

1. Thoroughly review the medical information in the case and testify to its content fairly and impartially.
2. Review the standards of practice prevailing at the time of the occurrence.
3. Be prepared to state the basis of the testimony presented, and whether it is based on personal experience, specific clinical references, or generally accepted opinion in the specialty field.
4. The expert witness is expected to be impartial, and should not adopt a position as an advocate.
5. Compensation should be reasonable and commensurate with the time and effort given to preparing for deposition and court appearance. An expert witness may not link compensation to outcome of the case.
6. Testimony is public record and subject to peer review.
7. Make a clear distinction between malpractice and adverse outcomes. Assess the relationship of the alleged substandard practice to the patient's outcome.

(JC Rpt A, A-05)

Expert Witness Testimony - Revelation of Financial Arrangements

The WSMA supports the introduction of legislation in the state of Washington that would permit revelation, to judges and juries, of prior experiences and financial arrangements of expert witnesses and would prohibit payment of contingent fees for all types of medical-legal consultations, including management services provided by firms engaged in locating physician consultants. (Res 3, C-89)

Family Violence

Because of its prevalence and medical consequences, abuse must be considered by physicians in the differential diagnosis for a number of medical complaints, particularly when treating women, children, and elderly persons.

Physicians who are likely to have the opportunity to detect abuse in the course of their work have an obligation to familiarize themselves with (1) protocols for diagnosing and treating family violence, (2) state reporting requirements and protective services, and (3) community resources for victims of abuse.

Physicians also have a duty to be aware of societal misconceptions about family violence and prevent these from affecting the diagnosis and management of abuse. Such misconceptions include the belief

that abuse is a rare occurrence; that "normal" individuals are not abusive; that family violence is a private problem best resolved without outside interference; and that victims are responsible for abuse.

The medical profession must demonstrate commitment to ending family violence and helping its victims. Physicians must play an active role in advocating increased services for victims and abusers. Protective services for abused children and elders need to be better funded and staffed, and follow-up services should be expanded. Shelters and safe homes for battered women and their children must be expanded and better funded. Mechanisms to coordinate the range of services, such as legal aid, employment services, welfare assistance, daycare, and counseling, should be established in every community. Mandatory arrest of abusers and greater enforcement of protection orders are important law enforcement reforms that should be expanded to more communities. There should be more research into the effectiveness of rehabilitation and prevention programs for abusers.

Informed consent for intervention should be obtained from competent victims of abuse. For minors who are not deemed mature enough to give informed consent, consent for emergency interventions need not be obtained from their parents. Physicians can obtain authorization for further interventions from a court order or a court appointed guardian.

Physicians should inform patients of a child abuse diagnosis and they should inform an elderly patient's representative when the patient clearly does not possess the capacity to make health care decisions. Safety of the child or elderly person must be ensured prior to disclosing the diagnosis when the parents or caretakers are potentially responsible for the abuse. For competent adult victims, physicians must not disclose an abuse diagnosis to caregivers, spouses or other third party without the consent of the patient. (JC Rpt F, A-93)

Free Choice

Free choice of physicians is the right of every individual. The individual may select and change at will the physicians who serve him/her, or he/she may choose a medical care plan such as that provided by a closed panel or group practice, or he/she may choose to obtain medical care by becoming a subscriber of a health maintenance or service organization. The freedom of the individual to select his/her preferred system of medical care and free competition among physicians and alternative systems of medical care are prerequisites of ethical practice and optimal medical care.

Although the concept of free choice assures that an individual can generally choose a physician, likewise a physician may decline to accept that individual as a patient. (JC 9.06-87; EC 2/95)

Gifts From Industry

Many gifts to physicians by companies in the pharmaceutical, device and medical equipment industries serve an important and socially beneficial function. For example, companies have long provided funds for educational seminars and conferences. However, there has been growing concern about certain gifts from industry to physicians. Some gifts that reflect customary practices of industry may not be consistent with principles of medical ethics. To avoid the acceptance of inappropriate gifts, physicians should observe the following guidelines:

- 1) Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantive value. Accordingly, textbooks, modest meals and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted.
- 2) Individual gifts of minimal value are permissible as long as the gifts are related to the physician's work (e.g., pens and notepads).
- 3) Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the

giving of a subsidy directly to a physician by a company's sales representative may create a relationship which could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor who in turn can use the money to reduce the conference's registration fee. Payments to defray the costs of the conference should not be accepted directly from the company by the physicians attending the conference.

4) Subsidies from industry should not be accepted to pay for the costs of travel, lodging or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of the conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging and meal expenses. Token consulting or advisory arrangements cannot be used to justify compensating physicians for their time or their travel, lodging and other out-of-pocket expenses.

5) Scholarships or other special funds to permit medical students, residents and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents or fellows who will receive the funds is made by the academic or training institution.

6) No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physicians' prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods and materials should belong to the organizers of the conferences or lectures. (JC Rpt B, A-93)

Harassment

The WSMA condemns the physical and mental harassment and intimidation of any physician engaged in the lawful practice of medicine. (Res A-3, A-93)

Medical Testing

The WSMA believes that it is ethical for physicians to perform all appropriate testing deemed necessary, with customary patient consent, according to sound medical judgment on all patients in order to define appropriate treatment. (Res 1, B-90)

Patent for Surgical or Diagnostic Instrument

The WSMA believes that a physician may patent a surgical or diagnostic instrument he/she has discovered and developed. The laws governing patents are based on the sound doctrine that one is entitled to protect his/her discovery. (JC 9.08-87)

Patient Safety

The WSMA strongly endorses the JCAHO's progressive Patient Safety program. (Res B-1, A-04)

Professional Corporations

The WSMA believes it is ethically permissible for physicians to form professional corporations. The ethical principles for the medical practice conducted under the form of a professional service corporation are exactly the same as for the individual physicians. The professional service corporation and each physician member of the professional service corporation should observe the Principles of Medical Ethics. (JC 9.11-87)

Refusal to Serve a Class of Patients

The WSMA upholds that the ethical physician shall not refuse treatment to any class of patients based solely on their race, religion, sex, or national origin. The choice of patients is left up to the individual

physician and vice versa provided there is not neglect or abandonment. However, it is unethical for an individual physician or a group of physicians to refuse to serve a class of patients, per se.

The WSMA believes that there is no ethical restraint on individual physicians or groups of physicians pointing out to directors of programs, such as Medicaid, that program restrictions (substandard fees, restrictions on services, etc.) have an inevitable effect on the choice of patients made by the individual physician. However, pronouncements by an individual physician or by a group of patients would be unethical. (JC 9.07-87)

Sexual Harassment

The WSMA has adopted the Webb definition of sexual harassment which states that, "*the behavior must be: (1) deliberate and/or repeated; (2) sexual or sex-based; (3) not welcome, not asked for and not returned. The first qualifier is: the less severe behavior is, the more times it must be repeated; the more severe behavior is, the fewer times it must be repeated. The second qualifier is: the less severe behavior is, the more responsibility the receiver has to speak up and make it known that it is offensive or unwelcome; the more severe behavior is, the less responsibility the receiver has to speak up, and the more responsibility the perpetrator has to know better than to engage in that behavior in the first place;*". WSMA policy states that sexual harassment, regardless of gender, is always inappropriate. (BT Rpt H, A-95)

Sexual Misconduct

The WSMA has adopted the following guidelines regarding sexual misconduct:

- 1) Sexual contact which occurs concurrent with the physician-patient relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients or key third parties detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well being.
- 2) If a physician has reason to believe that non-sexual contact with a patient may be perceived as or may lead to sexual contact, then he or she should avoid the non-sexual contact.
- 3) At a minimum, the physician's ethical duties include terminating the physician-patient relationship before initiating a dating, romantic, or sexual relationship with a patient or a key third party.
- 4) Sexual or romantic relationships between a physician and a former patient or key third party may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients or key third parties are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship. (JC Rpt C, A-94)
- 5) Key third parties include, but are not limited to, spouses or partners, parents siblings, children, guardians, and proxies. (JC Rpt B, A-01)

Surgical Procedures Donated for Charity Auction

The WSMA has adopted the following opinion regarding surgical procedures donated for charity auction: The decision to perform any surgical procedure should be made only after an appropriate examination of the patient and a consultation regarding the procedure's risks and benefits. Auctioning surgical procedures may create unrealistic expectations for patients who are not appropriate candidates for the procedure. The auctioning of surgical procedures may place the physician in a difficult position to objectively assess whether the patient who won the auction is an appropriate candidate for the auctioned procedure. Therefore, it is inappropriate and unethical for physicians to offer or provide

a surgical procedure or significant medical intervention as an auction prize (for charitable or commercial purposes) when such a procedure or treatment requires informed consent. (JC Rpt A, A-01)

Treatment of Immediate Family

The WSMA has adopted the following guidelines regarding treatment of immediate family members:

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should be especially avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency situations or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems.

Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members. (JC Rpt C, A-01)

PHYSICAL THERAPISTS

The WSMA supports the modification of the Physical Therapist Act to include provisions holding physical therapists to the same standard of care as physicians for the services they provide, to allow physicians to hire physical therapist assistants or allow physician assistants to perform similar services, to include reverse mandated provider provisions and to prevent physical therapists from referring to themselves as providers of sports medicine. (BT 1/91)

POLITICAL ACTION

The WSMA is committed to the maintenance of a strong, active presence in the governmental and legislative arenas. The WSMA is committed to a legislative agenda advocating the medical profession as one in which the priority is patient health and safety. The WSMA encourages physicians and auxiliaries to support WAMPAC and participate in the entire political process.

The WSMA further encourages specialty society representatives – either through the already established Interspecialty Council or other mechanisms that may be developed – to support a united medical front on political and legislative issues. (GA Rpt G, '88)

Campaign Finance Reform

The WSMA endorses campaign finance reform at the State level and supports campaign spending limitations. (EC 5/92)

PRESCRIBING PRACTICES

The WSMA supports the physician's legal right to diagnose illnesses and injuries, prescribe a method of treatment, and dispense prescription medication.

The WSMA endorses the use of triplicate prescription forms, as a condition for initial or re-licensure, when asked to do so by the Board of Medical Examiners Disciplinary Board, in order to facilitate investigation of allegations of misuse or over-prescriptive practices. (Res 26, D-83; PA Rpt B, '83; PA Rpt F, '83; PA Rpt F, '85; Res 38, C-87)

The WSMA believes it unethical for a physician to be influenced in the prescribing of drugs or devices by his/her direct or indirect financial interest in a pharmaceutical firm or other supplier.

The WSMA believes that a patient is entitled to a copy of his/her prescription for glasses, drugs, or devices and he/she has the privilege of having the prescription filled wherever he/she wishes. (JC 8.06-87)

Conscientious Refusal to Fill a Legal Prescription

The WSMA believes that individual pharmacists or pharmacy chains should be required to fill legally valid prescriptions, to contact the prescribing physician promptly for clarification, or to provide immediate referral to an appropriate alternative dispensing pharmacy without interference. In the event that an individual pharmacist or pharmacy chain refers a patient to an alternative dispensing source, the individual pharmacist or the pharmacy chain is required to notify the prescribing physician of the referral. (Res C-1, A-06)

Denial of Prescribed Pharmaceuticals

The WSMA encourages state payers of medical services to cover physician-prescribed pharmaceuticals unless a state-physician review provides evidence that a substitution is equivalent, safe and cost effective. (Res B-1, A-08)

The WSMA believes that if prerequisites for coverage are established by state payers, the burden of proof is on the payers to assure that such prerequisites are paid for and demonstrated available to the insured within 20 business days of any denial. (Res B-1, A-08)

PRESCRIPTION DRUGS

Formulary

The WSMA supports a study of the feasibility of the implementation of a universal, statewide formulary for access to prescription drugs. (BT Rpt J, A-01; EC Rpt F, A-02)

Pharmaceutical Coverage

The WSMA supports prescription drugs being covered benefits in all public and private programs. Pharmacy benefits should be added only after the delivery system has been financially stabilized. In

public programs, coverage should be needs based. Coverage should be paid for from the general fund and should not be funded on the back on any segment of the delivery systems. (EC 9/00)

Pricing of Pharmaceuticals

The WSMA opposes price caps or price setting. The Legislature, or other government bodies, should not set or fix prices for prescription drugs or any other health care service beyond its own specific programs. (EC 9/00)

Purchasing by Government

The WSMA will not interfere in the government's prudent purchasing strategies of prescription drugs for its own specific programs unless the proposals adversely affect appropriate patient care (Therapeutic Substitution), interfere with the physician and patient relationship (Disease Management), or cause undue administrative burden on physician practices (Rebates with Prior Authorization). (EC 9/00)

PRISONS

Choke and Sleeper Holds

The WSMA does not regard the choke and sleeper holds as casually applied and easily reversible tranquilizers, but should be considered the use of deadly force with the potential to kill.

The WSMA believes that with, or as soon as thereafter as possible, all incidents involving the application of choke and sleeper holds there should be medical surveillance of the inmate. (Res 4, B-83)

Hepatitis-C

The WSMA supports legislation or regulation which would result in all prison inmates being offered testing for and education about Hepatitis-C. (Res C-1, A-98)

The WSMA recommends the Washington State Prison system establish a policy with regard to the management of Hepatitis-C. (Res C-2, A-98)

PROFESSIONAL REVIEW ORGANIZATION

Administrative

The WSMA believes that the actions of PRO/W must not violate individual due process rights of physicians and that decisions are made in accordance with accepted standard of care. The WSMA will continue to be a resource for physicians who may be subject to inappropriate PRO/W review and sanction.

The WSMA urges PRO/W to re-establish the practice of permitting a WSMA ombudsman to attend Quality Assurance Council meetings. (PA Rpt B, '91; PA Rpt B, '89; PA Rpt B, '90)

Communication

The WSMA urges PRO/W to enhance communication with physicians regarding pertinent rules, regulations, review criteria and program changes. Similarly, the WSMA urges the PRO/W to enhance the physician education program by conducting regional seminars at times and locations conducive to physician attendance and participation. (PA Rpt B, '91; PA Rpt B, '89; PA Rpt B, '90)

Confidentiality

The WSMA regards the release of medical records of non-Medicare patients, not covered by insurers with which the PRO has a contractual peer review agreement, by a practitioner or institution to be an unethical compromise of patient confidentiality committed by the practitioner or institution. (PA Rpt B, '89; PA Rpt B, '90)

The WSMA urges the AMA to seek revocation of Regulation 42CFR476.11(C) which grants a PRO access to information from the records of non-Medicare patients, without patient consent. (Res 18, C-89)

Dues

The WSMA believes that membership in PRO/W should not be contingent upon the payment of dues. (PA Rpt B, '89; PA Rpt B, '90)

Membership

The WSMA urges PRO/W to increase its efforts to attract more physician members so it is truly representative of the physicians of the state, and that no cap be placed on the number of active members. (PA Rpt B, '89; PA Rpt B, '90)

PUBLIC HEALTH**Community Health Clinics**

The WSMA encourages the legislature and state agencies to provide assistance where requested for promoting or continuing community health clinics. (Res 31, A-90)

DDT

The WSMA supports efforts by the World Health Organization and the US Agency for International Development to get the world to reconsider using DDT responsibly. (Res A-5, A-07)

Fast Flux Test Facility

The WSMA opposes restart of the Fast Flux Test Facility (FFTF) based on the current public health impact resulting from Hanford's existing storage facilities, and the potential for further adverse public health consequences as a result of restarting the FFTF reactor. (EC 1/98)

Fertilizers, Labeling

The WSMA encourages the appropriate regulatory agencies to develop appropriate labeling of fertilizers as it has encouraged appropriate labeling of other commercial products in the past. (Res A-5, A-97)

Funding

The WSMA supports enactment of a statewide system of stable, dedicated funding for essential public health services designed to assure that all local health jurisdictions have sufficient resources to fully meet the Standards for Public Health as published in the 2000 Public Health Improvement Plan. (Res A-7, A-02)

Harmful Chemicals in Consumer Products

The WSMA supports Washington State legislative efforts to protect the public, particularly children, from harmful chemicals in consumer products, to reduce the burden of toxic exposure and improve public health for Washington's citizens. (Res C-10, A-07)

The WSMA supports policy changes requiring businesses and manufacturers to disclose the chemical contents of consumer products in order to provide consumers with essential right-to-know information and the capacity to make informed decisions that impact health. (Res C-5, A-08)

Lead

The WSMA supports state and federal policy changes that reduce and eliminate harmful exposures to lead in toys and other children's products, including urging policies that set standards for lead in toys and other children's products at an American Academy of Pediatrics maximum of 40 ppm. (Res C-5, A-08)

WSMA supports legislation to establish a "Lead Poisoning Registry" to be maintained by the Washington Poison Center Network. The registry would contain reports of any elevated blood lead levels (in excess of 10 micrograms %) as mandated by the legislature to be filed by any private or public laboratory operating in the state and conducting or contracting to have conducted such determination of lead levels. Such reports would be shared with city, county and state health departments to assure appropriate protection of the public's health. (Res 19, A-92)

Needles and Syringes

The WSMA supports the removal of barriers to purchase sterile syringes and needles. (Res A-5, A-99)

Obesity

The WSMA recognizes obesity as a major endemic health problem and, as such, the WSMA will:

- (1) urge physicians as well as managed care organizations and other third-party payers to recognize obesity as a complex disorder involving [behavior], appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;
- (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;
- (3) urge federal support of research to determine:
 - (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance;
 - (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery;
 - (c) effective interventions to prevent obesity in children and adults; and
 - (d) the effectiveness of weight loss counseling by physicians;
- (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;
- (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;
- (6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;
- (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and
- (8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.

(Res A-6, A-03)

Oral Health of Children

The WSMA supports the identification and treatment of oral health problems in mothers and children by primary care physicians within the limits of their knowledge and skills by supporting education and advocacy efforts aimed at reducing the burden of disease in low-income and high-risk families. (Res A-5, A-02)

Polybrominated Diphenyl Ethers (PBDEs)

The WSMA endorses Governor Locke's Executive Order to phase out and eliminate the use of polybrominated diphenyl ethers (PBDEs) in Washington State while maintaining existing fire safety standards. (Res A-3, A-04)

Public Health Department

The WSMA encourages county medical societies to help local health departments through activities such as testifying on budget issues, in order to obtain necessary personnel and funding to provide needed health care services. Additionally, the WSMA attempts to lobby at the state level for adequate funding of public health departments. (Res 32, A-90)

School Based Health Care

The WSMA supports legislation that would create a state-funded program to enable local communities to provide health care service, referrals, or both, to school-aged teenagers in communities where a need is perceived and at locations where services will be utilized to most effectively provide health education and general health care. The WSMA believes such legislation should provide for maximum local control of such programs in a fashion consistent with local needs and shared values. (Res 1, A-87)

Sickle Cell Anemia

The WSMA endorses mandated universal screening for sickle cell disease as part of the existing newborn screen with the assurance that appropriate funding for expansion of genetic counseling centers be provided. (EC 9/90; Res 53, A-89; Res 22, A-87; Res 2, A-90)

Sleep Disorder Screening

The WSMA supports the creation of initiatives for increasing physician and patient awareness of screening and treatment of sleep disorders, especially for those who hold commercial drivers licenses, operate a motor vehicle, or operate other heavy machinery such as boats, cranes, aircraft, and lifts. (Res C-3, A-08)

Translators/Interpreters

The WSMA urges physicians, hospitals, and other health care providers to develop skilled language services that can be utilized in working with non-English speaking patients in areas where the need exists. (Res 19, A-87)

Tuberculosis Control

The WSMA supports development of a statewide strategic plan for enhanced control of tuberculosis in Washington state that identifies gaps in current TB control programs, establishes measurable performance standards linked to specific funding sources, and encourages expanded state funding for TB control efforts. (Res A-6, A-07)

Washington State Public Health Report

The WSMA endorses continued use of the Washington State Public Health Report by state agencies in preparing budgets and executive requested legislation, as instructed by the Washington State Legislature. The WSMA also urges the use of the report as an accountability tool and efficiency measure of state agency performance in implementing the state priority health goals. The WSMA

urges state agencies to use the action strategies contained in the 1994 Washington State Public Health Report as a blueprint for efforts to improve the public's health. (EC 1/95)

RESEARCH

The WSMA resolved to establish a medical practice research and support program to assist member physicians by providing them with information about new practice developments and consultation services, thereby enabling physicians to make informed choices in the best interests of their patients. (Res 10, C-83)

RETIRED PHYSICIANS

CME Fees

The WSMA supports reduced CME Course fees for retired physicians. (EC 10/91)

Licensure Fees

The WSMA supports continuation of current state licensure standards and fees for retired physicians. (EC 10/91)

RURAL HEALTH CARE

The WSMA supports promoting financial incentives to make rural practice a viable and desirable option for physicians. (EC Rpt C, A-92; BT Rpt I, A-97; BT Rpt H, A-98; BT Rpt H, A-99; BT Rpt H, A-00; BT Rpt G, A-01)

The WSMA supports Washington Rural Health Association as an advocacy group for rural health care issues and concerns, and encourages its members to join and actively participate in the WRHA. (EC Rpt C, A-92; BT Rpt I, A-97; BT Rpt H, A-99; BT Rpt H, A-00; BT Rpt G, A-01)

The WSMA endorses the formation by the Washington State Legislature of a State Office of Rural Health, and strives to have input into the structure and mission of an Office of Rural Health. (Res 33, C-88; Res 34, C-88)

SCOPE OF PRACTICE

The WSMA opposes the adoption of any public policy by the Washington State Legislature or any regulatory agency which would encourage the delivery of health care services which are substantially outside of the recognized and accepted standards prevailing in the medical community. (Res 17, A-89)

The WSMA seeks to establish clearly defined scopes of practice for the various types of health care providers. The WSMA will actively work to achieve changes in public policy to see that those providers authorized to practice independently only deliver services clearly within the scopes of practice for the various disciplines. (Res 17, A-89; Res 43, B-88)

Acupuncture

The WSMA believes acupuncture is within the scope of practice of a medical doctor (MD) and a doctor of osteopathy (DO) actively licensed to practice medicine in the state of Washington. (Res B-13, A-99)

Certified Technologists

The WSMA supports working with the Board of Medical Examiners to allow Certified Technologists, working under the direct supervision and in the presence of a physician, to carry out the usual assistance function for which they are trained. (Res 10, B-90)

Licensed Midwives

The WSMA supports the clarification of existing law so that the scope of practice of licensed midwives explicitly excludes high risk deliveries, except when the licensed midwife is acting under the supervision of a physician licensed under RCW 18.57 or 18.71. (EC Rpt E, A-94)

Manual and Manipulative Procedures

The WSMA supports the concept that manual and manipulative procedures are clearly within the scope of practice of practicing allopathic and osteopathic physicians and surgeons when such procedures are performed for purposes other than chiropractic. (Res B-1, A-97)

Neuromuscular Electrodiagnostic Medicine Consultation

The WSMA has adopted the policy that the performance of Neuromuscular Electrodiagnostic Medicine Consultation, including the following studies: needle electromyography, nerve conduction studies, repetitive stimulation for the elevation of the neuromuscular junction, single fiber electromyography, somatosensory evoked potentials and motor evoked potentials is clearly within the scope of medicine and to be performed by or under the direct on-site supervision of a MD or DO. (Res 25, A-92)

Nurse Practitioners

The WSMA opposes expanding the prescriptive authority for nurse practitioners without clear physician oversight and credentialing by the Board of Medical Examiners. (EC 2/90)

Physician Assistants

The WSMA supports amendment of RCW 18.71A to allow physician assistants to provide podiatric services. The WSMA opposes the hiring of physician assistants by podiatrists. (EC 11/91)

Physical Therapists

The WSMA supports the modification of the Physical Therapist Act to include provisions holding physical therapists to the same standard of care as physicians for the services they provide, to allow physicians to hire physical therapist assistants or allow physician assistants to perform similar services, to include reverse mandated provider provisions and to prevent physical therapists from referring to themselves as providers of sports medicine. (BT 1/91)

Prescriptive Authority

The WSMA opposes the expansion of non-physician practitioners' prescriptive authority from current standards. (EC 11/91)

SEXUALLY TRANSMITTED DISEASES (STDs)

The WSMA encourages continued research on innovative strategies for sexually transmitted infection (STI) control, particularly in patients for whom Patient-Delivered Partner Therapy is not currently a well-accepted strategy. (Res A-2, A-04)

Chlamydia Screening

The WSMA supports the current Washington State Department of Health recommendations regarding chlamydia screening: “the provider should screen all sexually active women aged 25 years and

younger at least annually and assure adequate treatment of all positives and their contacts;”
(Res A-5, A-04)

The WSMA recommends that providers offer screening to all pregnant women for chlamydia at the first prenatal visit, and should repeat a chlamydia screening test during the third trimester of pregnancy if the pregnant patient is under age 25, or has a new sex partner, or has more than one sex partner.
(Res A-5, A-04)

The WSMA recommends that providers offer rescreening of all women with chlamydial infections 3-4 months after treatment, and whenever they next present for care within the following 12 months regardless of whether the woman believes that her sex partners were treated. (Res A-5, A-04)

Patient-Delivered Partner Therapy

The WSMA endorses the current Washington State Department of Health recommendations regarding patient-delivered partner therapy (PDPT): “the provider should inform the patient that it would be best to have all partners exposed during the previous 60 days come into a clinic for examination, testing and treatment. However, if treatment is not otherwise assured, the patient should be provided antibiotics for their partners.” (Res A-2, A-04)

The WSMA encourages physicians in Washington state to offer the option of PDPT to appropriate patients when treating them for gonorrhea or chlamydial infection if treatment of their sex partners is not otherwise assured. (Res A-2, A-04)

SPECIALISTS

The WSMA believes a physician may choose to limit his/her practice to a specialty or to a certain specialized service. He/she may also choose to provide services as a consultant to other physicians, or to patients at a hospital with which he/she has a contractual arrangement. He/she may choose to decline patients sent to him/her by licensed limited practitioners or by laymen.

The WSMA upholds that where the specialist provides diagnostic services to a patient recommended to him/her by a licensed limited practitioner or by a layman, and the results indicate the possible need for surgical or drug treatment, the specialist has a professional responsibility to inform the patient. A physician-patient relationship exists under these circumstances between the specialist and the person receiving diagnostic services. (JC 3.05-87)

SPORTS

Boxing

The WSMA believes boxing in any form should be banned whether in schools or amateur competition, or as a profession. The WSMA supports legislation to ban the competition of boxing in Washington State. (Res 3, A-84)

Physician Role in

The WSMA believes that the rules and conditions governing amateur and professional contact sports such as football and hockey, and the extent to which the risks of bodily injury shall be acceptable to society, require informed decision-making in which the medical profession has an essential role.

The WSMA believes the professional responsibility of the physician who serves in a medical capacity at an athletic contest or sporting event is to protect the health and safety of the contestants. The desire

of spectators, promoters of the event or even the injured athlete that he/she should not be removed from the contest should not be controlling. (JC 3.06-87)

SURGERY/INVASIVE PROCEDURES

The WSMA recognizes that the decision to perform an invasive procedure which has the potential of placing the health care team at risk deserves and requires consideration of the medical necessity of the procedure and the benefit to the patient. The WSMA favors policies or standards which consider the risk to the health care team involved with invasive procedures. (Res 35, A-90)

Definition of

Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel.” (Res B-12, A-08)

Laser Surgery

The WSMA believes that laser surgery should be performed only by individuals licensed to practice medicine and surgery, or by those categories of practitioners currently licensed by the state to perform surgical services. (Res 5, B-91)

TAX REFORM

The WSMA supports the concept of fair and equitable taxation in our state, including the implementation of a constitutionally limited income tax when used to reduce/eliminate/modify the sales tax and B & O tax as is otherwise appropriate and fair, and the WSMA resolved to participate in a coalition to this end.

The WSMA believes physicians (MD/DO) should be provided the same B & O tax treatment as hospitals. (Res C-4, A-99; EC Rpt A, A-01)

The WSMA supports taxation to achieve adequate financing of health and social programs. (Res 28, C-87; Res 9, C-88)

Tax on Alcohol

The WSMA supports legislation increasing an excise tax on alcoholic beverages, with the revenue dedicated to help support victims of alcohol abuse and educational efforts to prevent alcohol abuse. (Res 44, C-89)

TELEVISION

The WSMA urges the media to remember their social responsibility to minimize the depiction of violence which negatively impacts society. (Res 19, A-90)

TOBACCO

The WSMA supports the Tobacco Addiction Coordinating Council (TACC) and its work toward the legislative adoption of the following proposals:

- 1) Requiring a special license for merchants to sell tobacco; the merchants could then be fined or their licensed revoked for selling to a minor;
- 2) Enforcing the state law prohibiting the sale of tobacco products to minors (less than age 18);
- 3) Banning cigarette vending machines;
- 4) Banning the sale of tobacco products without the appropriate federally mandated warning labels (e.g. single cigarettes);
- 5) Banning the distribution of free samples of tobacco products;
- 6) Continued tax increases on tobacco products, with revenues to be used for developing a statewide tobacco health education program;
- 7) Restrictions on smoking in the workplace;
- 8) Further restrictions on smoking in enclosed public spaces;
- 9) Banning smoking in health care facilities.
(Res 12, A-91; Res 23, C-90; Res 39, A-90; Res 7, A-89; Res 16, C-88; Res 6, A-86)

Addiction Treatment

The WSMA endorses the efforts of pro-health groups to include tobacco addiction treatment in coverage by all insurance carriers. (Res A-3, A-95)

Advertising

The WSMA supports the American Medical Association's call for a total ban on tobacco advertising. Additionally, the WSMA recommends that the Washington State legislature, counties, communities, and municipalities ban tobacco advertising.

The WSMA encourages counties, communities and municipalities to adopt the operating principle of not accepting money from tobacco companies or their subsidiaries for the support of sports or other entertainment events. (Res 41, A-90)

The WSMA encourages physicians to not distribute magazines and other materials containing cigarette advertising to their patient waiting areas. The WSMA magazine subscription service will clearly identify on their ordering form those magazines that do not accept tobacco advertising. (Res 33, A-89)

The WSMA opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products. (Res 6, A-86)

Cessation Programs

The WSMA encourages its members to strongly advise their smoking patients about tobacco cessation. (Res A-3, A-95)

The WSMA has established a priority of preventing tobacco-related infant mortality and illness by endorsing and actively promoting the development of programs to assist pregnant women with smoking cessation programs. (Res A-4, A-95)

Definition

The WSMA defines tobacco products as toxic and noxious substances in all forms. (Res A-2, A-93)

Education

The WSMA supports strong educational programs, from kindergarten through the 12th grade, to help pre-teens, adolescents, and young adults avoid the use of tobacco products, including smokeless tobacco. The WSMA encourages appropriate school authorities to prohibit the use of all tobacco products by students, faculty, and coaches during the school day and during other school related activities. (Res 6, A-86)

The WSMA endorses and promotes the development of programs that educate teenage women from initiating tobacco use. (Res A-4, A-95)

Labeling

The WSMA opposes labeling of any tobacco product as “reduced exposure” without clear scientific evidence of reduced risk. (Res C-14, A-08)

Legislation

The WSMA endorses legislation that restricts youth exposure to environmental tobacco smoke, restricts the advertising and promotion of tobacco products to youth, bans vending machines and free sampling of tobacco products, and bans illegal sales of tobacco products to minors. In addition, the WSMA endorses legislation that will dedicate long-term funding for a comprehensive statewide tobacco prevention and education program directed toward our youth. (Res A-4, A-95)

Non-Profit Corporations

The WSMA supports legislative measures requiring, as a condition of non-profit corporation licensure by private clubs and organizations (which permit smoking within its facilities), a bi-annual closed ballot vote of the membership as to whether the organization should prohibit smoking within its facilities. (Res 39, A-90)

Public Places

The WSMA supports measures to prohibit smoking in all public buildings and in all public businesses including, in particular, restaurants. (Res 30, A-90; Res C-4, A-93)

The WSMA supports legislation prohibiting smoking and the sale of tobacco products in health care institutions. (Res 6, A-86)

The WSMA recommends that all hospitals be no-smoking zones. (Res 5, A-86; Res A-3, A-00)

The WSMA supports legislation to prohibit smoking on all public conveyances, meaning any vehicle of a privately or publicly owned common carrier providing passenger service and including air, rail, boat, ship or bus service. (Res 26, A-86)

Regulation

The WSMA believes that the most dangerous tobacco products, such as cigarettes, should be regulated with the utmost stringency, and that these products should be labeled with the most obvious and urgent warnings. (Res C-8, A-07)

The WSMA supports a prohibition on the sale of tobacco products from a business or facility that also operates a health clinic on the same premises. (Res C-2, A-08)

Taxes

The WSMA supports federal legislation to raise the federal excise tax on cigarettes, with revenues from the increase to be allocated to the Medicare program. (Res 6, A-86)

The WSMA also supports other increases in tobacco taxes, and urges allocation of tax revenues to be used for prevention and cessation of tobacco use and the general health care plan. (Res C-7, A-93)

Tobacco Settlement

The WSMA believes that all funds derived from the "tobacco settlement" be dedicated to tobacco related health care costs and prevention of tobacco use. (Res C-3, A-98)

WSMA Meetings

The WSMA prohibits smoking at all WSMA-sponsored meetings and supports active non-smoking policies for WSMA membership and staff. (Res 6, A-86)

The WSMA preferentially meets at establishments offering smokefree conference and meeting facilities and encourages county medical societies and other medical groups to do the same. (Res A-10, A-05; Res A-3, A-00)

The WSMA reaffirms existing policy opposing smoking. (Res A-6, A-02)

THE UNINSURED

The WSMA supports the implementation of the Washington Basic Health Plan beyond its pilot project status and the expansion of the Plan's availability to all working uninsured Washingtonians with income between 100% and 200% of the federal poverty level, with the necessary funding reflecting graded premiums and broadly based societal support.

The WSMA encourages the further development and implementation of community-rated small business plans to provide group "basic" health care coverage. Additionally, the WSMA supports the extension of tax relief – phased in over time – to employers who purchase the private "basic health care coverage" for full and part-time employees and their dependents.

The WSMA supports the amendment of ERISA or the federal tax code to equalize treatment of self-insured and insurance plans.

The WSMA supports an effective state risk pool, including a broader funding source to include self-insured and uninsured firms.

The WSMA supports the mandating of basic health care coverage for employees making above 200% of the federal poverty level and their dependents by the year 2,000 with penalties built into the law as a disincentive to employers who opt not to provide basic coverage for their employees. (EC Rpt P, A-89)

VETERANS MEDICAL CARE

The WSMA supports reform of the Veterans Administration Health Care Program in order to integrate the care provided V.A. beneficiaries with that enjoyed by the rest of the country. (Res 7, D-90)

VOLUNTEERISM

The WSMA supports the goals and structure of the Health Education Alliance which provides a platform for a unified, volunteer agency, health education forum. (Res 27, B-82; Rpt E, B-83)

WAR

Nuclear War/Weapons

The WSMA acknowledges that there can be no adequate medical preparedness for the devastating consequences of nuclear war, and prevention is the only reasonable medical response to the hazards posed by nuclear weapons. The WSMA endorses increased professional and public education about the medical consequences of nuclear war.

The WSMA does not support or endorse activities which imply that nuclear war is survivable.

The WSMA urges the federal government to continue emphasizing international dialogue on mutual disarmament. (Res 15, D-83)

The WSMA endorses the following statement as set forth by Physicians for Social Responsibility: "We call on the nations of the world, and especially on the nuclear weapon states, to enter immediately into negotiations to abolish nuclear weapons. We call on them to pledge to themselves to complete these negotiations by the year 2000 so that we can enter the new millennium with a treaty in place committing the world to a firm timetable for the permanent elimination of nuclear weapons."

The WSMA endorses efforts to plan for the consequences of nuclear incidents. (Res A-3, A-96)

WASHINGTON STATE BAR ASSOCIATION

The WSMA supports a collaborative effort with the Washington Bar Association to develop a Memorandum of Understanding to apply on a statewide basis. (Res 21, B-90)

WOMEN'S HEALTH CARE ISSUES

Mammography

The WSMA encourages the Washington State Hospital Association and any local cancer surveillance unit or hospital tumor registry to release to those interested radiologists, on a reason-to-know basis, the

names of breast cancer patients who have had mammography performed at that radiologist's facilities.
(Res 43, B-90)

Papanicolaou

The WSMA urges the American Cancer Society to reassess its recommendations concerning the interval of Papanicolaou smear screening. The WSMA recommends periodic health screening evaluations for women which may include pelvic examinations and Papanicolaou smears for patients in appropriate risk categories. (Res 2, A-86)

WRONGFUL BIRTH/WRONGFUL LIFE

The WSMA supports legislation modifying the 1982 Washington Supreme Court decision allowing parents to sue for wrongful birth and/or children to sue for wrongful life.
(CHS Rpt D, A-84)

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Abbreviations for House of Delegate Report Origination:

EC	Executive Committee
BT	Board of Trustees
CB	Constitution and Bylaws
CPA	Council on Professional Affairs
JC	Judicial Council
CHS	Community and Health Services