POLICY & PRACTICE

Guidelines on Organ Donation

The American Medical Association at its annual meeting adopted new resolutions to guide physicians involved in transplanting organs from living donors. The resolutions recommend that living donors be assigned an "advocate" team whose primary concern will be the well-being of the donor. Physician support is also needed to develop and maintain a national database of living donor outcomes, the new language stated. "Over the past 10 years, the number of living organ donors has more than doubled, and these living donors, who give the gift of life, require special protection," said AMA Trustee Peter Carmel, M.D. The AMA claims these are the first national guidelines to be developed on this issue. In another measure, the House of Delegates voted to encourage and support pilot studies that investigate the effectiveness of presumed consent and mandated choice for organ donation.

The Cost of Smoking Deaths

Smoking deaths cost the nation $92 billion in lost productivity on an annual basis, from 1997 to 2001, the Centers for Disease Control and Prevention reported. This reflects an increase of about $10 billion from the annual mortality losses for the years 1995 through 1999. During the same period, an estimated 438,000 premature deaths occurred each year as a result of smoking and exposure to secondhand smoke. To reduce the toll, "we must provide the 32 million smokers who say they want to quit with the tools and support to do it successfully," CDC Director Julie Gerberding, M.D., said in a statement. In an independent action, the AMA's House of Delegates took measures at its annual meeting to discourage tobacco use, voting to support increases in federal, state, and local excise taxes on tobacco. Such increases in the excise taxes should be used to fund the treatment of those with tobacco-related illness and to support counteradvertising efforts, the resolution stated.

Health Insurance Statistics

The ranks of the uninsured appear to be leveling off, according to a survey conducted by the CDC's National Center for Health Statistics. In 2004, 42 million Americans of all ages were without health insurance, about the same level as in 1997, the first year this survey began tracking these statistics. In addition, one in five adults aged 18-64 years were without health insurance last year, a number that had been steadily rising in recent years, but also leveled off in 2004. The survey showed continued improvements in coverage for children: 7 million children under 18 years of age were without health insurance in 2004, compared with 10 million children in 1997.

Uneasy Retirement

Baby boomers are concerned about their financial and health security—and would favor setting aside a portion of their earnings in a special account to save for future medical expenses, a report from the Commonwealth Fund stated. In a nationally representative sample of 2,000 adults aged 50-70, very few thought they would have enough income and savings for retirement, and three of five adults in this age group worry that they will not be able to afford medical care in the future. More than 50% of those working or with a working spouse said they would not have job-based retiree health benefits when they retire. These fears are somewhat warranted: 12 million older adults are currently uninsured or have had histories of unstable coverage. The survey reflected a strong interest among older adults in a Medicare health account that would allow people to add to savings as well as receive the traditional Medicare benefit.

Medicaid's Public Support

Most people think Medicaid is a "very important program" and should not be cut to balance state budgets, the results of a poll of more than 1,200 adults conducted by the Kaiser Family Foundation showed. In fact, the majority thought the federal government should maintain (44%) or increase (36%) federal spending on Medicaid. Only 12% thought cuts to Medicaid should take place. "We expected Medicaid to be relatively unpopular with the public, much like welfare was," said Mollyann Brodie, Ph.D., Kaiser's vice president and director of public opinion and media research. The fact that many of the respondents (56%) reported having some interaction with Medicaid could explain why the program ranked closely with such other popular programs as Medicare and Social Security, she said.

NIH Extends Disclosure Deadline

Officials at the Department of Health and Human Services are giving employees at the National Institutes of Health more time to report prohibited financial interests and to divest stock investments. In its announcement of the extension, HHS wrote that the department is considering issuing revisions to its current ethics regulations. In February, the agency issued regulations prohibiting NIH employees from engaging in consulting relationships with organizations that are substantially affected by NIH decisions. And NIH employees who are required to file financial disclosure statements are prohibited from acquiring or holding financial interests, such as stocks, in these affected organizations. NIH employees now have until Oct. 3, 2005, to file financial disclosure reports and until Jan. 2, 2006, to divest prohibited financial interests. This is the second extension offered to NIH employees. "There's no doubt in my mind that at the end of the day, the advice that NIH gives has to be completely untainted, completely unimpeachable, and completely trusted," NIH Director Elias A. Zerhouni, M.D., said during a teleconference sponsored by the Kaiser Family Foundation.

—Jennifer Silverman

Panel Decides Not to Link On-Call Service to Medicare

BY JENNIFER SILVERMAN

Associate Editor, Practice Trends

WASHINGTON — On-call services should not be a condition for participating in Medicare, a federal advisory panel on the Emergency Medical Treatment and Labor Act has recommended.

While most panel members panned the idea of an on-call/Medicare link, they were divided over whether to turn their disapproval into a formal recommendation to the Centers for Medicare and Medicaid Services.

Ultimately, the measure to recommend that CMS not link on-call participation with Medicare participation was approved in a close vote (7-6 with one abstention).

The technical advisory group advises the Department of Health and Human Services and the administrator of the Centers for Medicare and Medicaid Services on issues related to the Emergency Medical Treatment and Labor Act (EMTALA).

Hospitals cannot force physicians to be on call, although individual hospital policies may require on-call services as a condition of privileges. To address the shortage of on-call physicians, hospital associations had floated a proposal to the technical advisory group to link on-call participation to Medicare participation or hospital privileges.

Technical advisory group members who voted against making a formal recommendation to CMS at this point said they "were concerned about angering or offending the hospital associations who brought the idea to begin with," said Carol Bayer, M.D., a panel member and vice president for medical affairs at East Jefferson General Hospital in Metairie, La.

If such a link were enacted, however, "physicians would quit Medicare in droves," Dr. Bayer told this newspaper. Participating in Medicare means "you abide by the rules and have to accept the payments, but it has never been linked to anything like this before."

Some panel members, such as Charlotte Yeh, M.D, an emergency physician and CMS regional administrator for Region I in Boston, thought the issue deserved further review by the technical advisory group's on-call subcommittee before making a recommendation to CMS.

"Given the multiple factors affecting availability of on call, and the importance of solutions that both meet patient care needs and yet are practical enough for both hospitals and physicians, taking the time for analysis will result in a stronger position," she said.

But James Nepola, M.D., an orthopedic trauma surgeon in Iowa City, and author of the recommendation, thought there was enough evidence to oppose a link between Medicare and on call.

"We've had testimony, we've had studies, and we've had surveys on both sides of this issue. Cultural changes are taking place in medicine right now that don't bode well for emergency medicine, Dr. Nepola said. "Young physicians are moving as quickly as they can to study fields that do not require emergency work at all. They are moving toward boutique practices, which I abhor."

For that reason, the technical advisory group should take affirmative actions "so that physicians can go in without this problem before them," Dr. Nepola said. The panel should also be addressing physician concerns such as liability reform and adequate resources and compensation for on-call services. "We need to move toward solutions like warnings for hospitals, not big penalties, and get rid of things that are not going to work."

'Young physicians are moving as quickly as they can to study fields that do not require emergency work at all. They are moving toward boutique practices.'

Physician and hospitals groups offered their own views about the Medicare/on-call link at the technical advisory group's June meeting. Requiring on-call services as a condition of participating in Medicare "would far exceed the scope of the EMTALA statute," the American College of Surgeons argued in written testimony.

Many neurosurgeons are already being required to provide continuous call 24 hours a day, 7 days a week, 365 days per year, the American Association of Neurological Surgeons and the Congress of Neurological Surgeons testified, reporting from a survey of more than 1,000 members.

Going beyond Medicare, the neurosurgeons requested that CMS adopt a rule that would prohibit hospitals from requiring around-the-clock call of physicians.

In its own surveys, the American Hospital Association illustrated a continued struggle to recruit specialists for on-call services. Nearly one-third of the hospitals surveyed reported paying physicians for specialty coverage, and 40% of the community hospitals had to place their emergency departments on diversion for some period of time, said Kathleen DeVine, chief executive officer of Saint Anthony Hospital in Chicago, who testified on behalf of the AHA.

"If CMS wants to deal with any more specificity around on-call coverage, then physicians, those whom hospitals rely on to provide on-call care, must be brought to the table," she said. "Hospitals cannot do it alone."

EMTALA was enacted in 1986 to ensure public access to emergency services regardless of ability to pay.

The Medicare Modernization Act of 2003 required that HHS establish a technical advisory group to review EMTALA regulations. It is required by law to meet at least twice a year. ■