HB 808

AMERICAN OSTEOPATHIC ASSOCIATION POLICIES – ONLINE/TELEMEDICINE AND PHYSICIAN/PATIENT RELATIONSHIP

LATE TESTIMONY

H250-A/08 ONLINE MEDICINE

The American Osteopathic Association adopts the following policy white paper regarding Online Medicine (2003) **POLICY IS BEING REVIEWED**:

AOA POLICY STATEMENT ONLINE MEDICINE

The identification and treatment of medical problems is no longer restricted to the doctor's office. The development of websites that allow consumers to receive medical information over the Internet is growing rapidly. Over 100 million Americans have utilized the Internet to answer medical questions; this information has had a profound effect on how patients view their health.[30] There are a number of methods by which doctors are reaching their patients through this technology. Some doctors have utilized e-mail as a way to conduct online consultation; others are opting for medical software that is designed to help patients identify symptoms and narrow down diagnoses. However, each method poses its own difficulties for patients and doctors. The AOA recognizes the benefits of online technology to the medical field, and its ability to assist many patients who would not normally have access to medical care, but the AOA also acknowledges the special challenge for osteopathic physicians whose philosophy of a hands-on approach is hindered by the use of Internet technology. The AOA strives to put in place a policy that promotes wellness and safety for patients, and remains concerned over some practices that raise legal and ethical problems arising out of the use and misuse of online technology as a substitute for face-to-face care. The capabilities of the Internet offer many great opportunities to help doctors and patients, but it should always enhance an established doctor-patient relationship, not replace it.

Liability for Treatment and Diagnosis

In a case where direct treatment and consultation through online technology might result in the appearance of a medical error, questions of liability are likely. The hospital, the doctor, or both could subject to a medical malpractice suit.[31] Medical malpractice is any act or failure to act by a medical professional, resulting in harm, injury, distress, or death to a patient while under their care. As such, anything a physician may say or do can be used as evidence to establish the validity of a medical malpractice claim.

There is some concern that online consultation opens physicians up to liability by allowing them to make decisions about a patient's health without actually examining the patient. Doctors who are promoting online medical information or consultation are quick to distinguish their program from one that provides diagnoses over the web; however, it is not always clear where to draw the line. For example, one program, EasyDiagnosis.com, utilizes online software that allows consumers to select one major complaint or symptom, and then answer 20-25 questions related to that complaint.[32] The

system supplies patients with a number of possible diagnoses ranked in order of probability.[33] The site does not recommend a course of treatment, and there is no e-mail access to doctors.

Doctors who support these programs seem to suggest that by not recommending a course of treatment, they are not practicing medicine online. This does not appear to be a safe assumption, especially when injured patients are contemplating a lawsuit. Doctors argue that the disclaimers on sites clearly state they are not giving out medical advice. However, given the current crisis surrounding liability insurance, taking such risks is not necessarily a prudent move for doctors already straining to hold on to their practices. Additionally, while disclaimers are a necessary policy, they do not protect patients from taking online information as gospel, and misapplying it to themselves. One solution is that online consultations should only occur after a previously established doctor-patient relationship.[34] However, it would be extremely difficult – if not impossible – to keep consumers who are not current patients from accessing a physician's web page without instituting extreme security measures.

Liability of Individuals

Proponents argue that e-mail is a viable option for scheduling appointments, requesting prescription refills, and follow-up questions after an initial visit. However, it also raises the possibility of doctors extending the use of consultation through email or software to patients with whom they have no prior relationship. E-mail consultation has become a high-tech addition for computer-savvy doctors looking to address the overwhelming number of questions received regarding consumers' health concerns. Doctors can clarify treatment plans and provide guidance to consumers who are confused by the medical information that is already available online. Supporters see this technological advance as giving power to consumers through easily accessible information. The hope is that the resource will create better dialogue between doctors and patients.

Another Internet-aided program that is particularly troublesome for individual doctors is called MyDoc.com. MyDoc.com is advertised as the "first fully-integrated, 24 hour online healthcare service providing everything from physician-directed assessment and treatment recommendations to prescriptions and follow-up care."[35] This web-based service is targeted to individuals who are sick, or those responsible for caring for sick people; this means that the program is actually marketing itself to consumers without any contact with physicians who have actually seen the patient. MyDoc.com provides "symptom-based *diagnosis* (emphasis added) with the option of immediate on-line treatment by a board certified physician including prescription services."[36]

This program may save consumers time, but clearly places their health at risk. Physicians who support this technology say that they are not giving diagnoses and therefore, they are not practicing medicine. However, advertising by MyDoc.com tells a different story. Licensed physicians monitor patients, and may request further information before diagnosing, but there is no requirement that the physicians actually see the patients.[37] Physicians may be risking a sanction in their respective states because of unsafe practice. On October 15, 2002, the Illinois Department of Professional Regulation (DPR) took action to stop the company from treating patients.[38] The DPR alleged that MyDoc.com violated Illinois law because the site was providing diagnosis and treatment without a prior physician-patient relationship and without physically examining the patient.[39] Furthermore, the

DPR said MyDoc's program violates the Illinois Medical Practice Act because persons not licensed as physicians were providing these services.[40]

Liability for Companies

Both individual physicians and groups using these high tech methods of bringing health information to patients have cause for concern. The creators of the software for EasyDiagnosis.com developed and market their web-based software as an interactive medical decision-making software for consumers and health care providers.[41] The company warns that the "reliability of the program obviously depends on the information supplied by the physician and/or patient," and provides a disclaimer that it is not making diagnoses, however, many patients could be easily misguided by such a program. The company even goes as far as to disclaim any liability for "misdiagnosis, damages, injury, or death occurring to any patient whose findings are entered herein."[42] Disclaimers such as these are commonplace and necessary, but rarely shield a company from liability. Patients consistently look for the deep pockets, and EasyDiagnosis.com is an appealing target.

Some doctors started utilizing online technology believing it would be more time efficient; unfortunately, they are finding just the opposite.[43] While online technology has certainly emerged as a useful tool in health care, several studies have suggested deficiencies in the quality and usefulness of Internet-based health information for some purposes. One study, by the University of Michigan at Ann Arbor, found that e-mails did not help decrease the number of phone calls from patients, and missed appointments occurred just as frequently in the non-email group compared to the e-mail group.[44] Given the risks involved with treating, diagnosing, and prescribing medications without an established relationship, and the fact that studies undermine the quality of Internet-based health information, it is clear that the benefit of saving time does not outweigh the risks involved. A policy needs to be developed that supports patient safety over efficiency, and addresses the issues surrounding liability.

The AOA supports a policy that online consultation done without establishing a doctor-patient relationship, or without a licensed independent practitioner to receive the consultative opinion (who has established an appropriate relationship with the patient), is the practice of medicine, and does not meet an acceptable standard of medical practice. The absence of an appropriate established doctor-patient relationship may place physicians and the companies providing these services at risk for liability. A doctor-patient relationship can only be established through at least one face-to-face meeting. A consultation may occur when a licensed physician who has not met the patient in a face-to-face meeting is called upon to give his or her treatment advice to another licensed practitioner who is treating the patient within their scope of practice.

Online Prescribing

One of the emerging issues within medical practice via the Internet is online prescribing, encompassing both the prescriptive power of doctors and the distributive power of pharmacists. Part of the difficulty in regulating the sale of pharmaceuticals on the Internet is the wide variety of federal agencies that have partial authority over online prescribing. One action the federal government has taken is to establish task forces to prosecute licensed physicians who distribute drugs without prescriptions across state lines.[45] Still, most of the regulation of online prescribing is left to states.

Under existing law in the majority of states, prescribing drugs to patients living or residing outside the state where physicians are licensed is considered the unlicensed practice of medicine.[46] Because prescription drugs can have potentially harmful side effects and dangerous contraindications when taken with other prescriptions or over-the-counter medications without proper instruction or follow-up, most states' laws require establishing a physician-patient relationship before prescribing drugs to patients. Unfortunately, state medicine boards cannot regulate or prevent all forms of online prescribing.

> It is the AOA's position that prescription drugs should only be prescribed over the Internet by a physician who has been directly involved in the patient's physical evaluation, has knowledge of the patient's medical history, and has knowledge of the other medications that the patient is currently taking. Allowing a physician to diagnose, prescribe, and dispense medications to a patient via the Internet without having taken a history and completing a physical examination is unethical and places the patient in a position of unnecessary risk, and the physician in the position of unnecessary liability. The AOA therefore supports legislative and regulatory efforts that require establishing an appropriate doctor-patient relationship, as defined by the individual state boards of medicine and osteopathic medicine, before diagnosing and prescribing medicines online.

Several states have taken various approaches to regulating online prescribing.[47] **Colorado's** medical board disciplines doctors who prescribe medications without seeing patients, **Illinois** has passed a law requiring an Illinois pharmacy license for any Internet site that ships to patients in Illinois, and **Nevada's** Board of Medical Examiners prevents physicians from prescribing over the Internet unless they have seen the patient.[48] Also, some state attorneys general have taken action to prevent the sale of pharmaceuticals in their states.[49] However, before 1999, very few doctors or pharmacists have been punished for Internet prescribing.[50] Since 1999, **Arizona, California, Connecticut, Michigan, Missouri, Kansas, New Jersey, Pennsylvania, and Texas** have taken legal action against individuals and companies that conduct online dispensing of prescription drugs.[51]

Actions Against Illegal Prescribing

Cases are starting to emerge demonstrating the states' strong reaction towards prescribing drugs without first examining the patients.

> On May 28, 2002, California Governor Gray Davis announced that the California State Board of Pharmacy had fined pharmacists $88 million for alleged violations of a California Internet prescription law passed 18 months previously. The law requires that Internet pharmacies fill prescriptions only after a patient receives a medical examination from a licensed California physician. The State of California alleged that over 3,500 prescriptions were written based on online patient questionnaires.[52]
>
> On May 29, 2002, an Oklahoma doctor involved with the now-closed Nationpharmacy.com was sentenced by a U.S. District Court to 51 months in a federal prison, ordered to forfeit $660,000 in illegal gains, and will likely have his medical license revoked in June after being convicted of the federal crime of conspiracy to distribute controlled drugs. The Department of Justice alleged that the

doctor had been giving prescriptions for controlled drugs over the Internet to patients who had not undergone physical examinations.[53]

The states are not the only ones concerned about these cases; the private sector has also attempted to regulate prescribing over the Internet. Since 1999, the National Association of Boards of Pharmacy (NABP) Verified Internet Pharmacy Practice Sites has certified Internet pharmacies. Certification is available to pharmacies that follow the licensing requirements for their states and for each state to which they ship drugs.[54]

Licensure Concerns

While the majority of doctors who favor the use of online technology insist they are not practicing medicine by engaging in Internet-based consultations, others have argued to the contrary. If the pro-Internet doctors who use this technology are found to be practicing medicine, then they may face serious licensing issues. Since internet technology has allowed the practice of medicine across state and sometimes, international lines, several licensure problems can arise. A doctor who maintains a site in Illinois could easily reach patients who are accessing the system from another part of the country. In this case, there are questions as to where the doctor who maintains the site should be licensed; should a doctor be licensed in the state where he is located, or the state where the patient is accessing the information?

Licensure of medical professionals and facilities was intended to accomplish several goals, but most importantly, establish an acceptable standard of care in the medical community that will ensure the welfare of the state's residents. The FSMB has remained true to this goal throughout the growth of telemedicine. Since 1994, at least 24 states have passed laws addressing licensure for physicians utilizing telemedicine technology; these are: **Alabama, Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Indiana, Illinois, Kansas, Mississippi, Montana, Nevada, New Mexico, North Carolina, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Utah,** and **West Virginia**.[55] In 1996, the FSMB adopted model legislation to require doctors who want to practice medicine across state lines by means of internet technology to obtain a special license with reduced price, examination, and credentialing requirements.[56] So far, only six states from the above list enacted legislation consistent with the FSMB, these are: **Alabama, California, Montana, Oregon, Tennessee,** and **Texas**.[57]

In 2000, the FSMB adopted model guidelines stating they expect "physicians who provide medical care, electronically or otherwise to maintain acceptable standards of practice."[58] Therefore, in a case where direct treatment and consultation through online technology results in poor outcomes, the hospital, the doctor, or both could be professionally liable, and possibly risk losing their licenses.[59]

Licensing groups have looked at several options such as the use of a consulting exception to the licensing law, endorsement of physicians in other states with equivalent standards, and limited licensure to name a few.[60] In effect, a particular state would recognize the out-of-state license if equivalent standards for licensing existed between the states.[61] Many states are skeptical about allowing a special license for the practice of medicine across state lines via the Internet. Opponents argue that doctors should have a full and unrestricted license in every state in which they practice.

They fear that limited licenses will lead many out-of-state doctors to be less qualified to practice in a state than their in-state counterparts.[62] Alternatively, disallowing special or consultant licensure could be construed as interfering with the power of states to regulate health care workers and a barrier to interstate commerce. The U.S. Constitution permits states the authority to regulate activities that affect the health, safety, and welfare of their citizens, including the regulation of physicians' activity.[63] However, opponents to this type of regulation could argue that limiting or controlling physician licensure when physicians are practicing interstate is a *violation* of the Constitution because it places a restraint on interstate trade. While the argument presents an interesting defense, courts have not yet addressed the issue of whether a state's decision to limit the practice of medicine in their state to physicians licensed in that state is in fact a restraint on trade.

The question of what constitutes a legal practice of medicine is in many ways left up to each state's interpretation. Still, most states still require full licensure in the practicing state.[64] **Indiana** and **Texas** specifically include electronic consultations in their definition of what constitutes the "practice of medicine". In Indiana, consultations with a doctor through "electronic communications" on a "regular, routine, and non-episodic basis" are considered to be the practice of medicine.[65] Consequently, in order for a doctor located outside the state of Indiana to consult with a patient within the state, the doctor must be licensed to practice medicine in Indiana. The definition in Texas works somewhat differently. In Texas, any type of patient care, including interpreting an x-ray through the use of internet-technology devices, is the practice of medicine. However, doctors located in a state other than Texas may provide episodic consultation along side another doctor who practices in the same medical specialty as long as the doctor licensed in Texas supervises the patient.[66]

California has taken another approach by allowing physicians to practice consultation through online technology as long as they are licensed in one of the fifty states; however, there are some restrictions. The physician must obtain verbal and written consent from the patient who must be informed of all the risks involved in online consultation.[67] Unlike **Indiana** and **Texas**, **California's** laws seem to promote the use of online technology. The statute requiring informed patient consent does not apply to phone or e-mail consultations.[68] Instead, the law seems to protect only those patients who communicate through other computerized means. A second statute in **California** specifically allows consultation from a doctor licensed and located in another state as long as the consultation does not suggest a place to meet patients, and as long as there is a primary care physician who is ultimately responsible, licensed in the state of California.[69]

Often, state laws vary greatly in regards to the use of online technology, and the requirement that physicians obtain a full-unlimited license from each state to practice medicine via the Internet is perceived as overly restrictive. This is particularly relevant to physicians practicing in rural markets and medically underserved areas that are aided through the advancements in online technology. The AOA believes a physician should be licensed in all states in which they practice, and therefore, recommends a policy that decreases licensure barriers that limit access to care, while maintaining necessary health and safety protections. **The AOA supports and recommends a policy that provides for the practice of medicine via the Internet and that State Medical Boards grant reciprocity for licensure between fellow State Medical Boards whose license regulating the practice of medicine via the Internet, meets equivalent licensing standards.**

Reimbursement

The added cost of online consultations and Internet-based software has sparked an interest in reimbursement for online services. In the past, many doctors provided online consultation free of charge during its start-up phase, but they have realized that the cost, which is not covered by many insurance carriers, must be passed on to patients.[70] However, survey data suggests that patients are willing to foot the bill for the service; 90% of those polled want online communication with their doctors, and 37% said that they were willing to pay for it. The price can be high; e-mail consultation can range from $20-$25 per consultation.[71] Additionally, consumers could pay $25 for an annual subscription to medical software that would give patients a list of possible diagnoses for a set of symptoms.[72]

Still, states are realizing that as costs for these services increase, fewer people can afford the option. As a result, legislative interest in policies that address reimbursement for online services has been growing. Some states, such as **California** and **Texas**, have begun reimbursement programs of their own. One statute in **California** recognizes an intent to support the practice of medicine via the Internet as a legitimate avenue for a patient to access medical care without in person contact.[73] The law authorizes the Medi-Cal program to reimburse consultations utilizing online methods as long as those consultations are done other than by fax or phone.[74] On a federal level, the Balanced Budget Act of 1997 allowed Medicare payments for medical consultation via an online system for those in rural areas. However, the amount of coverage was subject to Medicare co-payments and deductibles.[75] In 2000, President Clinton signed a law that expanded reimbursement in this area. The law will cover rural areas *and* existing Medicare demonstration sites. In addition, the law creates more eligible online services that can be billed to Medicare. E-mail consultation between a doctor and patient is not covered. The bill became effective on October 1, 2001.

Advocates of online consultation expect that more insurers will expand coverage for these services when they recognize that demand is steadily increasing. Currently, very few insurers are agreeing to this arrangement. Blue Shield of California and First Health Group pay their physicians a small amount for consultations, but Medem, a web service started by the American Medical Association, expects patients to pay the full cost for its consultations.[76]

> The AOA supports a policy that encourages more state action and legislation supporting the reimbursement by insurance and other third-party reimbursement for appropriate services utilizing online technology, online consultations, and Internet-based health programs.

Privacy Issues

Privacy is a huge concern when looking at programs utilizing on-line medical technology. Since large amounts of data are being transmitted both within and out-of-state, medical professionals need to be particularly vigilant and attentive to patients' privacy rights. In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA).[77] It includes a provision that is meant to protect the privacy of patients whose identifiable health information is transmitted by electronic means. The Act also allows for the preemption of any less stringent state laws regarding privacy. This means that if a state passes any law that effects patient's privacy and it does not meet a higher

federal standard, that law will not be controlling.[78] As a result, hospitals and medical professionals need to be very careful when implementing such programs.

> The AOA supports a policy that acknowledging the importance of maintaining patients' privacy and encourages states to adopt strict standards and procedures to protect any medical information that is transmitted through electronic means.

Conclusion

While the American Osteopathic Association recognizes the ever-expanding nature of medicine and the growth in the practice of online technology in the health care field, it equally recognizes the need to protect patients from dangerous practices that may compromise their health and safety. To this end, the AOA supports a policy that will set limits on treatment, diagnosis, and prescribing over the Internet allowing such practice only when a clear doctor-patient relationship has been established. Furthermore, because licensure is greatly affected by individuals practicing medicine via the Internet, the AOA supports and recommends a policy that State Medical Boards issue a license for the practice of medicine via the Internet, and that State Medical Boards grant reciprocity for such licensure between fellow State Medical Boards whose license regulating the practice of medicine via the Internet meets equivalent licensing standards. In addition, the AOA supports a policy that encourages more state action and legislation supporting the reimbursement by insurance and other third-party providers for appropriate services utilizing online technology, online consultations, and Internet-based health programs. The AOA supports a policy acknowledging the maintenance of patients' privacy and encouraging states to adopt strict standards and procedures to protect the confidentiality of any medical information that is transmitted through electronic means. 2003

Citations

[30] P. Greg Gulick, *E-Health And The Future Of Medicine: The Economic, Legal, Regulatory, Cultural, And Organizational Obstacles Facing Telemedicine And Cybermedicine Programs.* 12 Alb. L.J. Sci & Tech. 351, 351 (2002).

[31] *Id.*

[32] Tyler Chin, *Web Site Lets Patients Narrow Diagnosis on Their Own,* American Medical News, June 10, 2002. (http://www.ama-assn.org/sci-pubs/amnews/pick_02/bisb0610.htm).

[33] *Id.*

[34] Chin, *supra* note 3 at 5.

[35] *See* http://www.mydoc.com

[36] *Id.*

[37] *Id.*

[38] Tyler Chin . *Firm Treating Strangers by Web Shut Out by Illinois Directive, State regulators move to ice online Consultation Company MyDoc.com,* American Medical News, November 4, 2002., Found at (http://www.ama-assn.org/sci-pubs/amnews/pick_02/bise1104.htm).

[39] *Id.*

[40] *Id.* see also 225 ILCS 60/1 et seq. (2002).

[41] *See* http://www.easydiagnosis.com/about.html.

[42] *Id.*

[43] Tyler Chin, *Patients E-mail-But They Still Keep Calling,* American Medical News, June 10, 2002. (http://www.ama-assn.org/sci-pubs/amnews/pick_02/bil20610.htm.

[44] *Id.*

[45] Gulick, *supra* note 1 at 368.

[46] American Medical Association, *Internet Prescribing* (1999) (http://www.ama-assn.org/meetings/public/annual99/reports/onsite/bot/rtf/bot35.rtf)

[47] Regulation through laws: **Arkansas, California, Illinois, Indiana, Nevada, New Hampshire, New York, Texas, and Virginia**. Teresa Floridi, *Online Pharmacies*, Issue Brief, Health Policy Tracking Service, July 1, 2002. Regulation through state boards: **Arizona, Colorado, Connecticut, Illinois, Nevada, New Jersey, Ohio, Texas, Washington, and Wyoming**. American Medical Association, *Internet Prescribing* (1999) <http://www.ama-assn.org/meetings/public/annual99/reports/onsite/bot/rtf/bot35.rtf>

[48] American Medical Association, *supra* note 30.

[49] P. Greg Gulick, *supra* note 1 at 369.

[50] Naftali Bendavid, *Prescriptions via Internet Pose Dangers*, Chicago Tribune, June 16, 1999, at A1.

[51] Teresa Floridi, *Online Pharmacies*, Issue Brief, Health Policy Tracking Service, July 1, 2002.

[52] Arent Fox Kintner Plotkin & Kahn, PLLC, *Penalties Handed Down in Internet Prescription Cases*, June 16, 2002. (*See* http://www.arentfox.com).

[53] *Id.*

[54] *Id.*

[55] Stephanie Norris,. *Telehealth.* Issue Brief: Health Policy Tracking Service, December 31, 2001. (http:www.hpts.org).

[56] *Id.*

[57] *Id.*

[58] Federation of State Medical Boards, Special Committee on Professional Conduct and Ethics. *Model Guidelines for The Appropriate Use of the Internet in Medical Practice* Found at (http://www.fsmb.org/Policy%20Documents%20and%20White%20Papers/internet_use_guidelines.htm).

[59] *Id.*

[60] Ross Silverman, *The Changing Face of Law and Medicine in the New Millennium: Regulating Medical Practice in the Cyber Age,* 26 Am. J.L. and Med. 255 (2000).

[61] *Id.*

[62] Norris, *supra* note 11.

[63] Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982).

[64] Norris, *supra* note 11.

[65] *Id.* See Ind. Code Ann. 25-22.5-1-1.1(a)(4)(A) & (B) (Michie 1999).

[66] Gulick, *supra* note 1 at 366. See Tex. Occ. Code Ann. 151.056(b)(1)

[67] Cal. Bus. & Prof. Code 2290..5(a)(1)& (b)(c) (West 1990 & Supp. 2002).

[68] *Id.* at 2290.5(a)(1).

[69] Cal. Bus. & Prof. Code 2060 (West 1999 & Supp. 2002)

[70] Tyler Chin. *Online Consultation: What is it Worth?* American Medical News, June 10, 2002. (http://www.ama-assn.org/sci-pubs/amnews/pick_02/bisa0610.htm.

[71] *Id.*

[72] Chin, *supra* note 3.

[73] Cal. Wel. & Inst. 14132.72 (a) (West 2001).

[74] *Id.* at 14132.72(d)

[75] Rubin, *supra* note 7.

[76] Rita Rubin. *The Virtual Doctor Will See You Now, But Have Your Credit Card Ready,* USA Today, June 10, 2002. (http://www.usatoday.com/usatonline).

[77] 42 U.S.C. 1320d-2

[78] Silverman, *supra* note 26.

H301-A/05 AOA HEALTH POLICY STATEMENT

The American Osteopathic Association is dedicated to putting patients first and protecting the patient/physician relationship, and as such, provides the following guiding policies and principles:

1. The American Osteopathic Association will work with Congress, the Administration, the states, and the private sector to ensure that Americans have access to the highest quality medical care in the world. Addressing the issue of professional liability insurance is central to this goal. The AOA will continue working to ensure that osteopathic physicians have the freedom to practice medicine.

2. The American Osteopathic Association will work with Congress and the Administration to implement provisions set forth in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173).

3. The American Osteopathic Association will work with Congress to ensure high priority consideration of the osteopathic graduate medical education program within physician workforce planning and financing legislation.

4. The American Osteopathic Association will work with Congress and the Administration to support research that advances medical science.

The Distinctiveness of the Osteopathic Physician

The osteopathic profession was founded more than 100 years ago on the basis that the osteopathic physician would treat the patient holistically. This is accomplished by the osteopathic physician using

the traditional tools of medicine along with the additional modality of osteopathic manipulative treatment.

In general, there are four principles of osteopathic philosophy: (1) a person is comprised of body, mind and spirit; (2) the body is capable of self-regulation, self-healing and health maintenance; (3) the structure and function of the body are reciprocally related; and (4) rational medical treatment is based upon an understanding and integration of these three principles along with the use of evidence-based medicine.

Osteopathic manipulative treatment is a complement to the patient in an osteopathic physician's practice and treats both structure and function. When structure is improved, function is also improved; and when function is improved structure also improves. This process maintains and improves the body's self-regulation and healing. These philosophical and practice training commitments are the principles that distinguish osteopathic physicians (DO) from allopathic physicians (MD).

Primary Care and Under Served Communities

Since its inception in the late 1800s, more than 60% of osteopathic physicians practice in primary care fields. Unlike any other physician training paradigm, after completing osteopathic medical school, graduates are required to complete a one-year internship through which they gain experience in the areas of primary care and surgery. After completion of the internship, the osteopathic physician chooses to continue residency training in either primary care or in one of the 42 or more specialty and sub-specialty areas. All osteopathic physicians are grounded first in the primary care of patients.

Stemming from the principle of putting patients first, osteopathic physicians represent a significant portion of the physicians practicing in rural communities where attracting physicians is a common challenge. For example, while osteopathic physicians comprise a small percentage of the nation's physicians, they represent a significant percent of all the physicians practicing in rural, underserved areas. For many underserved communities, osteopathic physicians are the sole physicians providing complete healthcare within multiple county areas.

It is in the spirit of this distinctiveness that the American Osteopathic Association submits its statement on health care policies and principles:

1. **High Quality Medical Care – Health Systems Change, Access, Reliability, Patient Protections**: The American Osteopathic Association strives to improve the quality and accessibility of healthcare services delivered to America's patients.

   a) **<u>The Uninsured</u>**

- The AOA supports universal healthcare coverage in which all Americans have access to health care coverage. Coverage can be provided through federal and state programs, private programs, or a combination of the two. Universal care should not be confused with single payer healthcare systems.
- The AOA supports the use of the tax code (tax credits and deductions), new purchasing agreements, and the limited expansion of existing federal and/or state programs (including Medicare, Medicaid, and SCHIP) to accomplish this goal.
- The AOA opposes the establishment of a single payer healthcare system in which the federal, state, or local government is the primary source of funding for healthcare services, excluding any existing federal or state programs, such as Medicare, Medicaid, and SCHIP.
- The AOA opposes attempts by the government to mandate healthcare coverage through a defined benefit or defined contribution program.
- The physician-patient relationship must be protected.
- Physicians, in cooperation with their patients, must maintain a high level of autonomy to control the healthcare services provided. Federal policies must not interfere with laws governing patient protections or healthcare rights.
- Policies should support the ability of physicians, hospitals, and other healthcare providers to provide care to patients. Physician compensation for care provided must not be jeopardized by federal, state, or local policies.

b) <u>Managed Care</u>

- The American Osteopathic Association first created a "Patient's Bill of Rights" in 1981 and has updated it continually to ensure the advancement of quality and consumer protections within the healthcare system. Built on the principle that patients have the right to humane and dignified treatment, the AOA's Patient's Bill of Rights is the foundation upon which the osteopathic medical profession continues to advance what America accepts as essential patient protections. Among these assurances are:

  1. The patient's right to secure medical treatment from the physician of one's choice. With more than 100 million patient visits per year made to osteopathic physicians, millions of patients across the country make that choice daily, and must be empowered to continue to do so.
  2. The patient's right to seek emergency department services based on the patient's belief that he/she is in medical peril. Known as the "prudent layperson" standard, the AOA believes that a health plan does not have the right to deny reimbursement to such patients and, therefore, we support the prohibition of health plans requiring "prior approval" for emergency medical services.

3. The patient's right to receive, in layman's terms, complete and current information about treatment options and the expected outcomes of each.

4. The patient's right to accept or reject treatment options after being fully informed by the physician. Integral to fully informing a patient, the AOA supports the patient's right to know the cost of the treatments. In addition, the AOA supports the patient's right to a free exchange of medical or benefit information with a physician. The AOA opposes any practice that would impede patient/physician communication either through contractual expression or by arbitrary termination of the physician as a provider.

5. The patient's right to expect that his/her medical records will be kept confidential and that these medical records be made available to the patient as guaranteed under the Health Insurance Portability and Accountability Act of 1996.

c) Patient Safety

The American Osteopathic Association is dedicated to improving the quality of the nation's healthcare delivery system. The AOA recognizes that medical errors and adverse events occur and is committed to reducing these occurrences.

The AOA believes that it is the current healthcare delivery system and not physicians alone that are the source of these events. We support the implementation of systemic procedures and policies that improve the quality of the healthcare delivery system.

The AOA supports the establishment of a databank designed to evaluate adverse events from across the country and produce reports designed to assist others in preventing similar occurrences. The reporting of such events could be either voluntary or mandatory, but the AOA believes that any information reported should be exempt from discovery and contain legal protections for all parties involved. Additionally, the AOA believes that all information reported should be exempted from discovery under the Freedom of Information Act (FOIA).

d) Professional Liability Insurance Reform

The American Osteopathic Association continues to seek solutions to reduce the high costs of professional liability insurance through the passage of tort reform legislation. The AOA supports the right of patients to be provided with legal redress when their employer-sponsored health insurers' treatment rules and coverage determinations cause them harm.

Like the physician community at-large, many osteopathic physicians have stopped delivering obstetrical care and other high-risk procedures because of exorbitant

professional liability insurance premiums associated with delivering such care. The AOA believes that relief can be found in tort reforms such as limitations on non-economic damage awards, equity on joint and several liability, limiting attorney contingency fees, periodic payments, reductions in statutes of limitation, and the reform of the collateral source rule.

The American Osteopathic Association recognizes that physicians are not alone in making treatment determinations for their patients. In the case of employer-sponsored health plans, which set forth treatment rules and coverage determinations, both patients and physicians must live and practice within a framework established by a healthcare plan, and not by a physician. Because of this leverage, third party payers and health plans are able to place controls on patient treatment. Once patient care is completed, physicians maintain the entire liability for these treatment decisions. The osteopathic profession believes that the responsibility for patient care decisions should be more equitably placed.

e) <u>Women's Health</u>

The American Osteopathic Association is dedicated to advancing federal policies that ensure appropriate attention to the unique medical needs of women. The AOA recognizes that women's health issues have not received adequate attention in the past. The osteopathic profession supports policies that ensure access to comprehensive care across a woman's life span, including prenatal care and preventive health services.

Therefore, the osteopathic profession supports increases in federal funding that (1) advance research into women's health issues, such as preventive measures and cures for breast and cervical cancer, osteoporosis, and cardiovascular disease in women; (2) improve the delivery of comprehensive quality healthcare to female patients of all ages; and (3) expand undergraduate and graduate medical education on women's issues.

f) <u>Racial and Ethnic Disparities in Healthcare</u>

Minority populations in America often experience difficulty in obtaining access to needed healthcare services. The AOA supports (1) initiatives that increase access to healthcare services for all Americans regardless of race or socioeconomic class; (2) efforts to expand outreach to culturally diverse populations, including enhancing research efforts and improving healthcare options in communities where incidents of certain healthcare conditions are more prevalent than in the community as a whole; (3) increased funding for programs targeted at minority populations, which decrease infant mortality rates and increase immunization and access to other preventive healthcare services; and (4) early intervention and treatment programs for minorities suffering from breast cancer, hypertension, diabetes, prostate cancer, alcoholism, and other diseases that disproportionately affect minority populations.

g) **Prescribing**

The American Osteopathic Association supports the ability of physicians to advocate on behalf of their patients without unfair or unwanted influence from outside agencies. The AOA believes that restrictive formularies and reimbursement policies that attempt to limit reimbursement, coverage, or other information about all available pharmaceutical treatment options violate the physician-patient relationship.

h) **Non-Physician Clinicians**

The American Osteopathic Association acknowledges the role of non-physician clinicians in the healthcare delivery system, but continues to advocate for direct physician supervision. Attempts by non-physician clinician groups to expand their defined scope of practice beyond the accepted levels are opposed. Additionally, we strongly oppose attempts by any non-physician clinician group to place itself in a position of primary contact or serve as primary care providers.

i) **HIV/AIDS**

The AIDS crisis in Africa, the United States, and elsewhere has grown exponentially during the past twenty years and reverberations will continue to be felt around the world for decades to come. The American Osteopathic Association supports private and governmental efforts to address HIV/AIDS globally. Osteopathic physicians and osteopathic medical colleges provide medical expertise and financial support to assist distressed populations, particularly in Africa.

j) **Regulatory Reform**

The American Osteopathic Association is committed to reducing the regulatory burden placed upon physicians by Medicare and its contractors. The governing documents of Medicare currently exceed 130,000 pages and present a compliance quandary for physicians. The AOA believes that osteopathic physicians should be focused on patient care and not on complying with excessive federal mandates.

k) **Office of the Surgeon General**

The American Osteopathic Association supports the efforts of the Surgeon General, the nation's leading spokesperson on matters of public health, to protect and advance the health of the American people. The AOA will work with the Surgeon General and the staff of the Office of the Surgeon General to advocate for effective health promotion and disease prevention programs, participate in activities sponsored by the Office of the Surgeon General, and provide the expertise of osteopathic physicians.

2. **Medicare and Medicaid**: The American Osteopathic Association strives to ensure that affordable, high quality medical care is available to all Americans, particularly vulnerable and uninsured populations such as senior and disabled Americans. As the Medicare and Medicaid programs ensure access to medical care for senior citizens, the disabled, children, and low-

income individuals, the AOA supports these programs and pledges its cooperation in ensuring the continued availability of quality medical care at a reasonable cost.

a) **Medicare Physician Payments**

The American Osteopathic Association supports legislative proposals to reform the Medicare physician payment formulas to reflect the costs of providing care and reduce the unpredictable nature of the current payment formulas. The current system, based largely upon projections and trends, should be altered to reflect actuarially sound data that limits the volatility of the formulas on a year-to-year basis.

Additionally, the AOA supports revisions to Medicare payment policies that reflect equity in payments for rural and urban providers.

b) **Private Contracting**

The osteopathic profession believes that physicians and Medicare beneficiaries have the right to contract privately for medical services otherwise covered by Medicare. The Balanced Budget Act of 1997 gives physicians this right. However, the law restricts the practical application of this right by mandating that physicians who enter into private contracts with Medicare beneficiaries must opt out of the Medicare system for two years. The AOA supports legislative efforts that would make private contracting an immediate, viable option. The AOA supports the inclusion of specific patient protections in private contracting legislation.

c) **Medicaid/SCHIP**

The Medicaid program has made significant inroads into improving the quality of healthcare available to vulnerable Americans, such as indigent pregnant women and their dependent children, terminally ill, and disabled populations. The AOA supports the Medicaid program, but remains concerned that it is under funded. The AOA supports efforts by the federal government to work with the states to increase funding for Medicaid and ensure that a standard of high quality, accessible care is available to all Medicaid patients.

3. **Osteopathic Graduate Medical Education**: The American Osteopathic Association is committed to working with Congress to ensure that osteopathic graduate medical education residency training positions are protected within federal law.

Osteopathic and allopathic physicians are educated, trained and certified on separate but parallel tracks. Both physician professions have their own medical school accreditation entity, postgraduate training authority, and certification boards that are equally recognized by the U.S. Department of Education and the Centers for Medicare and Medicaid Services.

Given the distinct contribution to American healthcare made by osteopathic physicians, any graduate medical education reform must take special care to preserve and strengthen the osteopathic system of training physicians. Any reforms of the graduate medical education system must be made with a full understanding of their impact on the osteopathic graduate medical education system. Because osteopathic training is different, there is a true risk of inadvertent harm when federal legislators and regulators fail to recognize the impact of their reforms on the osteopathic graduate medical education system.

The AOA supports the investigation and debate of GME payment policies that reflect the contributions of parties other than the federal government. While the AOA believes that GME is an inherent 'public good' and that the federal government should continue to subsidize the training of physicians, we recognize that other parties benefit as well. To this end, we continue to encourage debate focused on the potential establishment of alternate GME financing mechanisms that rely upon all parties involved with a majority of funding continuing to be provided by the federal government.

The AOA Bureau of Osteopathic Education (BOE) reports to the Board of Trustees on behalf of its two subordinate councils: the Council on Postdoctoral Training (COPT) and the Council on Continuing Medical Education (CCME). The COPT has two subordinated committees: the Committee on Osteopathic Training Institutions (COPTI) and the Program and Trainee Review Committee (PTRC). With respect to the accreditation of osteopathic postdoctoral training institutions, the BOE is the final accrediting body. The Commission on Osteopathic College Accreditation (COCA), formerly the Bureau of Professional Education, is the entity within the AOA that is recognized by the U.S. Secretary of Education as the accreditation agency for colleges of osteopathic medicine (COMs) in the United States. With respect to the college accreditation function, the COCA is the final approval authority for COM accreditation standards and procedures and the COCA handbook.

a) Osteopathic Postdoctoral Training Institutions

Changes in the healthcare environment prompted the AOA Board of Trustees in 1995 to approve a new system for structuring and accrediting osteopathic GME, a system through which physicians are trained to practice medicine in all healthcare delivery environments.

The new osteopathic GME system is centered upon the Osteopathic Postdoctoral Training Institution (OPTI). Each OPTI is a consortium that includes one or more AOA-accredited osteopathic hospitals and at least one college of osteopathic medicine. OPTIs have the flexibility to provide opportunities for training in ambulatory healthcare facilities and non-traditional training sites that will be drawn into the many OPTI consortia. The OPTI system will encompass the osteopathic internship programs and the more than 500 residency programs already in place. With the goal of achieving the highest possible quality and efficacy in physician training, the OPTI draws on the strength of the traditional GME structure while adding to it the depth of the academic infrastructure and the variety of non-traditional training sites.

The osteopathic medical profession is committed to working with Congress and the U.S. Department of Health and Human Services to achieve the full implementation of its Osteopathic Postdoctoral Training Institutes consortia project.

4. **Research**: The American Osteopathic Association is committed to advancing research within the osteopathic profession. It is also committed to working with Congress, the Administration, and private organizations to support research that benefits the advancement of medical science and the delivery of healthcare.

The University of North Texas Health Science Center at Fort Worth-Texas College of Osteopathic Medicine houses the profession's Osteopathic Research Center. The Center conducts research on the effectiveness of osteopathic manipulative treatment (OMT), develops collaborative medicine, and trains students and clinicians in osteopathic research. 2005

H209-A/05 CONFIDENTIALITY OF PATIENT RECORDS

The American Osteopathic Association opposes invasion of privacy of the patient record by any unauthorized person or agency; and endorses reasonable programs which seek to protect patient/physician relationships and guarantee confidentiality of patient records. 1980; revised 1985, 1990, 1995; 2000, 2005

H205-A/04 FEDERAL HEALTH POLICIES AND PRINCIPLES

The American Osteopathic Association: (1) pledges to work with Congress to ensure that Americans have access to high quality medical care and protecting the relationship between the patient and the physician is central to this goal; (2) will work with all levels of government to ensure that osteopathic graduate medical education residency training positions are protected within federal lap; (3) will work with federal lawmakers to ensure that the osteopathic medical profession's full and distinct potential is realized within healthcare delivery systems and federal medical policy-making bodies; and (4) will work with all levels of government to ensure that osteopathic physicians have the freedom to practice medicine and receive compensation for appropriate osteopathic medical, surgical and manipulative treatment. 1998; reaffirmed 2004 – **PART OF SUNSET FOR 2009**

H236-A/08 MANAGED CARE--PHYSICIAN-PATIENT RELATIONSHIP AND

The American Osteopathic Association believes that it is the responsibility of the osteopathic physician to advocate for the rights of his/her patients, regardless of any contractual relationship and that the osteopathic physician-patient relationship shall not be altered by any system of healthcare practice, including managed care entities, which may place economic considerations above the interest of patients. 1998, reaffirmed 2003; 2008

H239-A/08 MEDICAL RECORDS-POLICY/ GUIDELINES FOR THE MAINTENANCE, RETENTION, AND RELEASE OF

The American Osteopathic Association urges osteopathic physicians to become familiar with the applicable laws, rules, or regulations on retention of records and patient access to medical records in their states; and approves the following Policy/ Guidelines for the Maintenance, Retention, and Release of Medical Records:

POLICY/GUIDELINES FOR THE MAINTENANCE, RETENTION, AND RELEASE OF MEDICAL RECORDS

A. ***Release of Records:*** The record is a confidential document involving the osteopathic physician-patient relationship and shall not be communicated to any other person or entity without the patient's prior written consent, unless required by law. Notes made in treating a patient are primarily for the osteopathic physician's own use and constitute his or her personal property. Under The Health Insurance Portability and Accountability Act of 1996 (HIPAA), patients have the right to request access to review and copy certain information in their medical records. In addition, HIPAA provides patients with the right to request an amendment to health information in their medical records. HIPAA also provides patients with the right to request an "accounting of disclosures" of their protected health information. Upon written request of the patient, an osteopathic physician shall provide a copy of, or a summary of, the record to the patient or to another physician, an attorney, or other person or entity authorized by the patient as provided by law. Medical information shall not be withheld because of an unpaid bill for medical services.

B. ***Records Upon Retirement or Departure from a Group:*** 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. When an osteopathic physician retires or dies, patients shall be timely notified and urged to find a new physician and shall 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 shall be retained consistent with the privacy requirements under federal and/or state laws and regulations, either by the treating osteopathic physician, or such other person lawfully permitted to act as a custodian of the

records. The patients of an osteopathic physician who leaves a group practice must be notified that the osteopathic physician is leaving the group. It is unethical to withhold the address of the departing osteopathic physician if requested by the patient or his or her authorized designee. If the responsibility for notifying patients falls to the departing osteopathic physician rather than to the group, the group shall not interfere with the discharge of these duties by withholding patient lists or other necessary information.

C. ***Sale of medical practice***: In the event that an estate of, or the practice of an osteopathic physician's medical practice is to be sold, the assets of such practice or estate, both hard and liquid, should be transferred in a mutually agreeable manner consistent between seller and buyer. If medical records of the estate or of the practicing physician are included in such sale they should be transferred between seller and buyer in accordance with state and federal guidelines to remain compliant with the confidentiality rules and regulations which govern the security of such records, allowing the buyer to have the opportunity to continue caring for those patients.

All active patients should be notified that the osteopathic physician (or the 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. Rather than destroy the records of a deceased osteopathic physician, it is better that they be transferred to a practicing physician who will retain them consistent with privacy requirements under federal and/or state laws and regulations and subject to requests from patients that they be sent to another physician. A reasonable charge may be assessed for the cost of duplicating records. Any sale of a medical practice should conform to IRS and federal guidelines.

D. ***Retention of Records:*** Osteopathic physicians have an obligation to retain patient records. The following guidelines are offered to assist osteopathic physicians in meeting their ethical and legal obligations:

1. Medical considerations are the principal basis for deciding how long to retain medical records. For example, operative notes and chemotherapy records should always be part of the patient's chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether an osteopathic physician would want the information if he or she were seeing the patient for the first time.
2. If a particular record no longer needs to be kept for medical reasons, the osteopathic physician should check state laws to see if there is a requirement that records be kept for a minimum length of time. Most states will not have such a provision. If they do, it will be part of the statutory code or state licensing board.
3. In all cases, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice claims. The statute of limitations may be three or more years, depending on the state law. State medical associations and insurance carriers are the best resources for this information. If a patient is a minor, the statute of limitations for medical malpractice claims may not begin to run until the patient reaches the age of majority.

4. Whatever the statute of limitations, an osteopathic physician should measure time from the last personal professional contact with the patient.

5. The records of any patient covered by Medicare or Medicaid must be kept in accordance with the respective regulations.

6. In order to preserve confidentiality when discarding old records, all documents should be destroyed. Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity. 1998; revised 2003; 2008

H233-A/06 PATIENT-PHYSICIAN RELATIONS

The American Osteopathic Association unalterably rejects any claim of a right to censorship of professional communication, in any regard, and for any reason; will work to secure enactment of legislation protecting these necessary rights of patients and physicians; and will continue to oppose any and all attempts to impede the nature of the patient-physician relationship. 1991; revised 1996, 2001; reaffirmed 2006

H246-A/04 PHARMACIES / PHARMACEUTICAL COMPANIES PARTNERSHIP

The American Osteopathic Association opposes any expansion in the scope of practice for pharmacists or pharmacy chains to conduct disease care management programs and will work to ensure that the physician-patient relationship is protected. 1999; revised 2004 **PART OF SUNSET FOR 2009**

H254-A/04 SALE OF HEALTH-RELATED PRODUCTS AND DEVICES

The American Osteopathic Association believes that it is (1) appropriate for physicians to derive reasonable monetary gain from the sale of health-related products or devices that are both supported by rigorous scientific testing or authoritative scientific data and, in the opinion of the physician, are medically necessary or will provide a significant health benefit and (2) inappropriate and unethical for physicians to use their physician/patient relationship to attempt to involve any patient in a program for the patient to distribute health related products or devices in which distribution results in a profit for the physician. 1999; revised 2004 **PART OF SUNSET FOR 2009**

H296-A/06 PHYSICIAN COMPARATIVE UTILIZATION & PROFILING

The American Osteopathic Association the AOA adopts the following principles on physician comparative utilization and physician profiling.

1. Comparative utilization or physician profiling should only be used to show conformity with evidence-based guidelines.
2. Comparative utilization or physician profiling data should only be disclosed to the physician involved. If comparative utilization or physician profiling data were to be made public, assurances should be in place that ensures rigorous evaluation of the measures to be used by practicing physicians and that only measures that are deemed sensitive and specific to the care being delivered are used.
3. Physicians should be compared to other physicians with similar practice mix in the same geographical area. Special consideration must be given to osteopathic physicians whose practices mainly focus on the delivery of osteopathic manipulative treatment (OMT). These physicians should be compared with other osteopathic physicians that provide OMT to their patients.
4. Matrix within the reports should be clearly defined and developed with broad input to avoid adverse consequences. Where possible, measure sets and/or data points should be evidenced-based and vetted by relevant physician specialty or professional societies.
5. Efforts to encourage efficient use of resources should not interfere with the delivery of appropriate, evidence-based, patient-centered health care. Furthermore, the program(s) should not adversely impact the physician-patient relationship or unduly intrude upon physicians' medical judgment. Additionally, consideration must be given to the potential overuse of resources as a result of the litigious nature of the health care delivery system (i.e., defensive medicine).
6. Practicing physicians must be involved in the development of measures and the reporting process. Clear channels of input and feedback for physicians must be established throughout the process regarding the impact and potential flaws within the measures and program.
7. All methodologies, including those used to determine case identification and measure definitions, should be transparent and readily available to physicians.
8. That all physicians shall have full access to their report cards to verify the accuracy of the data prior to the dissemination of information to patients and the public.
9. Use of appropriate case selection and exclusion criteria for process measures and appropriate risk adjustment for patient case mix and inclusion of adjustment for patient compliance/wishes in outcome measures, need to be included in any physician specific reports. To ensure statistically significant inferences, only physicians with an appropriate volume of cases should be evaluated. These factors influence clinical or financial outcomes.
10. The measure constructs should be evaluated on a timely basis to reflect validity, reliability and impact on patient care. In addition, all measures should be reviewed in light of evolving evidence to maintain the clinical relevance of all measures.
11. The osteopathic profession should have representation on any committee, commission, or advisory panel, duly charged with developing measures or standards to be used in this program. 2006

RE: HB 808
Friday 1_30_2009

LATE TESTIMONY

House Committee on Health.

From Jeffrey Akaka, MD
Support.

1-30-2009

Dear Representative Yamane and members of the House Health Committee:

For all of the reasons noted in Section I of HB 808, please vote yes on HB 808.

Thank you.

Jeffrey Akaka, MD
Community Psychiatrist