

AMA "Thwarts" Other Professions Practice Expansion and a Challenge to CAM-IM Fields

Contributed by John Weeks

AMA to "Thwart" Other Professions' Scope Expansion, and a Challenge to CAM-IM Fields

The American Medical Association has engaged a formal effort to stop allied health professions, including CAM disciplines, from expanding their scopes of practice. Top targets appear to be psychologists and nurse anesthesiologists, according to an American Medical News story (May 13, 2006) cited in an AMA backgrounder on the issue. The "partial list of legislative initiatives shows that bills of chiropractors, midwives and naturopathic doctors are also clearly in their sights. A March press release from the American Psychiatric Association (APA) speaks of the goal as "thwarting" non-MD practice expansion. The APA stimulated formation of the coalition which is being engaged through an AMA Scope of Practice Steering Committee.

The target is the "growing threat of expansion of scope of practice for allied health professions," according to the APA release. The AMA "partnership" plans to "coordinate research to help medical specialty societies and state medical associations fight expansions in non-medical scope of practice and improve information sharing among those groups." A

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particular focus for the psychiatric profession is the effort of psychologists to develop and expand prescribing rights for psych meds.

Michael Maves, MD, executive vice president and CEO of the AMA is quoted as saying that the effort will focus on sharing "legislative strategies allied health groups are using nationally." The fund will also be used to directly combat scope exansions. A core message will be that these are "not turf issues for one or another specialty but are concerns of the profession of medicine."

The founding members of the coalition are medical societies of Massachusetts, Colorado, Texas, California, New Mexico and Maine plus six medical specialty societies the American Academy of Orthopedic Surgeon, American Society of Anesthesiologists, American Society of Plastic Surgeons, American Academy of Otolaryngology, and the American Academy of Opthamology.

The APA release notes that "every medical specialty has concerns with a group of allied health professionals seeking privileges generally reserved for physicians." A particularly active state coalition is in Texas, where 10 societies are linked, entitled the PatientsFirstCoalition.

The AMA "partnership" aims to expand to all 50 states. Each partner has, or will, ante in \$25,000, for an initial \$300,000

fund. The one piece of hard evidence of patient harm cited in the materials reviewed by the IBN&R for this article was a negative study of outcomes of nurse anesthesiology in Medicare patients.

Comment and a challenge: The novelist, naturalist and Buddhist, Peter Matthiessen (At Play in the Fields of the Lord, Snow Leopard, Far Tortuga, etc.) recently told a Seattle audience that his basic belief remains that we humans have poorly distinguished ourselves from our animal natures. The legislative practice by health care professions of urinating in a circle to claim and protect turf - all in the interest of patients, of course - is first-order evidence that supports Matthiessen's conclusion. The image of organized health groups behaving in such a manner raises an ugly, public health stench. One anticipates such animal behavior when it comes to control of petroleum reserves. This soul's remaining soft tissues are still seared in recollecting that the participants in this behavior have all sworn oaths to patient service.

The APA's hoarding of prescription rights on psych pharmaceuticals may be written off as an adverse effect of that profession's multiple generations of drug-dependency. But the AMA is well-known as the nasty power forward in these fights, swinging its elbows under the figurative boards to control as much cash as it can grab which may rebound out of health care policy and practice.

Yet a lesser known fact-of-the-matter is that the minor league elbows of the CAM-IM professions tend to swing with as much ferocity, if less amplitude - and for the some magnanimous, patient-centered purpose. Cases in point are the successful restriction on MD practice of acupuncture in Hawaii, and the significant opposition to naturopathic licensing from the AOM and chiropractic professions. Professional power corrupts and power that can raise \$300,000 this quickly corrupts awfully.

Some professions may, from time-to-time, have the evidence and the discretionary ability to make the case for "thwarting" another discipline's move toward increased scope. But it is fair to say that the average political actor for a health profession would meet the why fight it question about another discipline's scope with the same non-rational finality with which British mountain climber George Mallory responded when asked why climb Mount Everest: "Because it's there." Happily, these inter-disciplinary battles are not likely to ever be captured on I-MAX.

We are not without road-maps of better ways for professions to behave. My colleague Pamela Snider, ND, introduced me many years ago to the 1989-1998 Pew Commission on Health Professions and the related and ongoing work of UCSF expert on health professions Edward O'Neil, MPA, PhD. O'Neil headed the commission. Through the Pew-funded effort, we have guidance toward a competency-based system.

Some in the CAM-IM argue that there is something in the whole-person, holistic belief systems of the CAM-IM fields which makes them more likely to respond in a humane

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way to the actions of others. The efforts of the Acupuncture and Oriental Medicine Alliance to bring together the diverse disciplines involved in that field, through the 1998 Seattle Statement and other activities, may be the outstanding example of such human behavior. Still, this seems the exception. Here is a challenge for you:

- How has your discipline ever responded affirmatively to a scope expansion of another field which may be seen as coming into your own turf?

- What is your profession presently doing, in this moment, which indicates a more collaborative and human nature?

We call for reform of our refracted and fragmented system. Yet it is easiest to point our fingers at factors less in our control - the payment system, for instance, or the general reactivity to disease rather than focusing on strategies for prevention and health creation. Fashioning new relationships between the disciplines is a necessary part of health reform. This is something inside our power to effect. So what are we doing between and inside our own fields that shows we are capable of leading a sustainable healthcare reform?