

AMWA Connections

The Vision and Voice of Women in Medicine

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JULY, 2005

AMWA hosts roundtable discussion on vitamin D and health for men and women over age 50

AMWA widens welcome & membership reach

The AMWA Board of Directors and additional leadership met June 24-26, 2005. Recognizing the changed "face" of medicine, and the expanding range of professionals who make up today's health care provider team, the AMWA Board voted to widen AMWA's membership reach and welcome.

Embracing AMWA's new 501(c)(3) status, making membership dues and contributions fully tax deductible as a charitable or business expense, the AMWA Board also established a new price structure.

Effective immediately, AMWA's membership categories are:

Voting Membership (gender neutral and includes physicians and non physicians):

Member: \$150 per year

Resident: \$125 (one time payment)

Student: \$75 (one time payment)

AMWA Circles of Honor members are an elite group of AMWA members supporting AMWA at a membership rate of \$225 per year and higher.

AMWA welcomes all donor members who embrace our mission and vision, though voting rights accrue only to membership donation levels of \$150 and above.

At the concluding Board meeting on Sunday, June 26, 2005, AMWA Leadership pledged in excess of \$20,000 in personal contributions. They also included pledges for more than 350 additional new memberships, which include gift memberships for their interdisciplinary professional colleagues, friends and family members.

In support of AMWA's 90th year birthday celebration of great achievements – while acknowledging that our work is not yet done – all of our readers are encouraged to visit AMWA's Web site at www.amwa-doc.org or fax/mail a 90th year tax-deductible membership contribution.

Leading osteoporosis and bone health experts participating in AMWA's roundtable, "An In-Depth Discussion of Vitamin D for Men & Women Over 50," examined the latest research on vitamin D's relationship to health.

AMWA hosted the discussion in New York City on June 9, 2005, to analyze contradicting scientific data regarding vitamin D deficiency, draw conclusions from these findings, and develop specific guidelines for vitamin D intake to improve health, especially bone health, that primary care physicians can utilize in their medical practices.

The panel's consensus of recommendations to be released shortly is expected to call for physicians to reassess some commonly held standards of practice regarding daily current requirements.

AMWA member **Felicia Cosman, MD**, moderated the discussion. Dr. Cosman is clinical director of the National Osteoporosis Foundation, medical director of the Clinical Research Center at Helen Hayes Hospital in West Haverstraw, N.Y., and associate professor of clinical medicine at Columbia University School of Medicine.

Other discussants included: **Henry Bone, MD**, director of the Michigan Bone and Mineral Clinic, head of the Endocrinology Division of St. John Hospital and Medical Center, both in Detroit, and chairman of the Endocrine and Metabolic Drugs Advisory Committee of the U.S. Food and Drug Administration; **Michael Holick, PhD, MD**, professor of medicine and physiology and chief of endocrinology, metabolism and nutrition at Boston University School of Medicine; **Risa Kagan, MD**, co-medical director, The Foundation for Osteoporosis Research and Education, Oakland, Calif., and associate clinical professor, Department of Obstetrics and Gynecology and Reproductive Sciences, University of California, San Francisco; **Ethel S. Siris, MD**, professor of clinical medicine, College of Physicians and Surgeons of Columbia University, and the Director of the Toni Stabile Osteoporosis Center of the Columbia-Presbyterian Medical Center, both in N.Y.; and AMWA member **Kimberly Templeton, MD**, associate professor of orthopedic surgery at the University of Kansas, director of the musculoskeletal oncology service, Department of Orthopedic Surgery, University of Kansas Medical Center, and chair of the U.S. Bone and Joint Decade's (USBJD) Public Education Committee.



Felicia Cosman, MD, roundtable moderator



Ethel Siris, MD (left), and Kimberly Templeton, MD (right), roundtable participants

Merck & Co., Inc., provided an educational grant for this event.

For more on vitamin D, please turn to page 2.

AMWA's employment connection

AMWA's "Employment Connection" provides a venue for the leading hospitals, academic institutions, and employment recruiters to reach the best and brightest women physicians from across the country with professional opportunities in the medical and research specialties. Current employment opportunities are included in AMWA Connections and in AMWA's weekly NEWSFlash or <http://www.amwa-doc.org/careerdevelopment/employmentconnection>.

Acknowledgement

Leah Dickstein, MD, acknowledges with gratitude the contributions of Coline Cady Stanton and Marsha Weinstein to the acquisition of Elizabeth Blackwell's desk that Dr. Dickstein recently donated to the Smithsonian's National Museum of American History. The May 2005 *AMWA Connections* featured Dr. Dickstein's story regarding how she acquired Dr. Blackwell's desk.

MANAGING PHYSICIAN MEDICAL SERVICES DIVISION PERSONNEL DEPARTMENT Salary: \$148,937+ Annually

The City of Los Angeles is seeking two experienced physicians to perform administrative and clinical duties, including the development of policies, procedures and protocols, and other duties as needed. (1) Director of Correctional Care: Responsible for the oversight and supervision of the medical care provided in the City Jail Clinics. The City jail clinics are small ambulatory care clinics in which a limited range of medical services may be provided and are open 24 hours per day, every day. The Managing Physician will work various shifts and hours based on need. (2) Occupational Health Services: Responsible for the oversight and supervision of medical services provided by the City's Occupational Health Section. The Managing Physician will work a regular day shift.

REQUIREMENTS: Current physician's license issued by the State of California; Supervisory experience preferred. Additional requirements for Position (1) above: Current Board Certification (in one of the specialty areas listed below) and a minimum of three years of work experience in correctional care or one of the following specialty areas: family practice, internal medicine, or emergency medicine. Additional requirements for Position (2) above: Current Board Certification in Occupational Health and a minimum of three years of work experience in occupational health. Visit website www.lacity.org/PER for full recruitment profile.

APPLY: Interested applicants may send a cover letter, resume (including salary history) and a list of five work-related references to: Susan H. Ioka, Senior Executive Recruiter; 700 E. Temple Street, Room 100; Los Angeles, CA 90012; FAX (213) 847-9262; ExecSearch@per.lacity.org.

APPLY IMMEDIATELY. THESE POSITIONS ARE OPEN UNTIL FILLED.

What's the latest on vitamin D?

Vitamin D appeared in the spotlight again recently when two studies conducted in the United Kingdom and published in *The Lancet* and *The British Journal of Medicine* stated that elderly patients with osteoporosis are not protected from future fractures by vitamin D and calcium supplementation, findings contrary to those reported by American researchers.

AMWA's panel of physician experts analyzed research to assess the importance of vitamin D for men and women over age 50, the prevalence of vitamin D inadequacy, methods to determine vitamin D intake levels, and misconceptions regarding toxicity from increasing vitamin D intake. They discussed the effectiveness of vitamin D intake from fortified foods, the sun, and supplements.

Although bone health was the primary focus of the discussion, the roundtable reviewed other studies published in the last few months that reflect vitamin D's ability to possibly protect against (and in some cases treat) lymphoma and cancers of the prostate, breast, lung, colon, and skin. Some recent publications reported vitamin D's benefit in treating premenstrual syndrome, depression, and autoimmune diseases, such as multiple sclerosis, Type 1 diabetes, rheumatoid arthritis, and psoriasis.

Each of these topics led to the discussion of vitamin D inadequacy. What patient groups are at highest risk? What are the negative effects of low vitamin D levels? How aware are physicians and patients about the high percentage of people over age 50 who are vitamin D deficient? How should physicians best determine vitamin D levels? Are there risks associated with increasing daily vitamin D recommendations? What are the best ways to ensure that patients meet vitamin D requirements?

All vertebrates require calcium for muscle and skeletal function and vitamin D for maintaining calcium homeostasis in the bloodstream. When a person is vitamin D deficient because of reduced dietary intake or lack of sun exposure, the parathyroid hormone mobilizes calcium stored in bones to maintain the calcium balance in the bloodstream, thus lowering bone mineral density that causes bones to be porous and brittle.

Women and men over age 50 receive only 10-30 percent of their daily vitamin D requirement from food and very little from sunlight, especially if they spend most of their time indoors. Although physicians rarely suspect that patients are vitamin D deficient, recent studies report that more than 50 percent of the population in this age group is vitamin D deficient. Also, dark-skinned people are more prone to vitamin D deficiency.

Meeting daily requirements through food and fortified milk is impossible, and supplements are problematic. Vitamin A, often combined with vitamin D in supplements, is thought to be detrimental to bone health. Most fortified foods when tested in laboratories did not contain the actual amount of vitamin D listed on the food labels. Furthermore, the sun is under attack for causing skin cancers, and sunscreens inhibit vitamin D production because they enable 7-dehydrocholesterol in the skin to absorb ultraviolet B photons. Even if scientists conclude that some sunshine renders much needed vitamin D production, most of the working and elderly populations stay inside all day or live in northern climates with less available sunrays.

Therefore, what should you as a doctor recommend to your patients? AMWA will release the consensus report in *NewsFlash*, and *AMWA Connections* and post on AMWA's Web site in the near future. We expect considerable media attention to this report, as well.

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The Vision and Voice of Women in Medicine

PREVENTION

THE SMART FUTURE STRATEGY

February 16-19, 2006 Tucson, AZ

Clarita Herrera Wins Seat on WPC Governing Council

AMWA congratulates **Clarita E. Herrera, MD**, AMWA Past President (1999-2000) and former AMWA Foundation Board Chair (2002-2004), for her election to the AMA's Women Physician's Congress (WPC) Governing Council, which works to increase the number of women physicians in leadership roles and strengthen the voice of women in organized medicine. An internist practicing in New York City, Dr. Herrera was chief of the Drug and Alcohol Dependency Program, New York VA Medical Center (1973-1983) and recently concluded her term as the president of the New York County Medical Society (2003-2004).

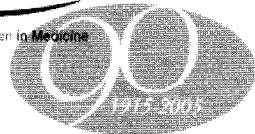


Reminder: Keep Your Data Up-To-Date

To AMWA Residents, Graduating Medical Students, and anyone anticipating an e-mail/address change, please send your new street and e-mail address to "member@amwa-doc.org" so you will continue receiving your weekly e-mail *AMWA NewsFlash* and the *AMWA Connections*. Also, AMWA is working on an online, members-only directory to help you stay in touch with your friends and colleagues after graduation/residency. So, be sure your contact information is up-to-date! Please don't forget to include your old street and e-mail address, as well as the new ones, to ensure the correct substitutions.



The Vision and Voice of Women in Medicine



Gender equity and medical women – have we come a long way, baby?

When AMWA was founded 90 years ago, women were an under-represented minority in medicine and in medical schools. Now women comprise half of all U.S. medical school classes.

When I entered medical school, my class with 17 women had the second highest percentage of women medical students in the country. We were second only to Women's Medical College in Philadelphia who then enrolled only women. The year after I graduated, women were 5.1 percent of U.S. graduates. In 2003-2004, women were 45.9 percent of graduates and 49.7 percent of the first year students. Women went from 354 graduates in 1961 to 7280 in 2004. (By the way, I was only the second youngest in my class. My roommate was 17 when we entered medical school after finishing college.)

It may be easy for women medical students to have a false sense of security because of the number of women in their classes. Perhaps they and we should look at the number of women faculty in the higher ranks and at the number of women in leadership roles in medical schools and hospitals. Now, at the medical school where I work, the executive director, the medical director, the chair of pathology, the director of pathology, and the president of the medical staff at the hospital are all women. Yet, just look at the photographs and paintings of deans and medical board presidents on display to see how far we still have to go.

I can share with you some of the data from the Association of American Medical Colleges (AAMC) Faculty Roster for 2004 (www.aamc.org). Data is displayed according to:

The theme for the AMWA Annual Meeting in Tucson February 17-19, 2006, is "Prevention—the Smart Future Strategy." Please mark your calendar. I hope to see you and your family there. Support AMWA.Carolyn Webber, MD

distribution of faculty by sex, race, Hispanic origin, appointment rank, representation of academic full-time faculty by gender, rank, and tenure, women in decanal positions, and distribution of residents by specialty in 1993 compared to 2003. Of the 108,000 faculty in U.S. medical schools in 2004, 70 percent were men and 30 percent were women. Women were 14 percent of full professors and 25 percent of associate professors. Women accounted for 53 percent of obstetrics and gynecology residents

in 1993 and 74.4 percent in 2003. Also, the site shows funding support for Women in Medicine programs at medical schools; Harvard gave the most.

Now I am president of the American Medical Women's Association, an organization of physicians and medical students with a long history of working toward advancing women in medicine and improving women's health by providing and developing leadership, advocacy, education, expertise, mentoring, and strategic alliances. I invite you to participate in our Physician-Get-A-Physician program to strengthen our collective voice. Make a commitment to advance women in medicine in leadership roles; make a contribution, visit our Web site, attend our annual meeting, take our online educational courses, read *AMWA NewsFlash* and *AMWA Connections*, and become a mentor and an AMWA leader.

AMWA's efforts brought about parity in medical school classrooms across our nation; now, we must work more diligently than ever to ensure that women hold half the leadership positions in medicine, as well. We still have a long way to go, baby!

President's perspective



Carolyn Webber, MD
AMWA President

AMWA offers student loans

With the costs of medical school education continuing to escalate, student loans help provide students with much needed financial assistance when they face huge resource needs. AMWA's commitment to medical student education dates back to 1923.

Applicants may apply for loans of either \$2,500 or \$5,000. A maximum of \$5,000 can be granted during your medical school tenure. The deadline for receipt of completed applications is April 30 yearly. Supporting documentation (letters of recommendation, etc.) will be accepted until May 15 each year.

Applicants may apply for loans of either \$2,500 or \$5,000. Interest (currently 5 percent) begins the December 15th after graduation. Repayment commences the January 15th after graduation. Payment is to be completed within a three-year period.

Download the student application form at <http://www.amwa-doc.org>. Click on Students – Loans – Applying for a Loan.

A personal interview or phone interview with a woman physician is required. A personal interview with an AMWA physician member is preferred although a personal interview with a non-member or a phone interview is acceptable. The completed Interview Report Form may be faxed or mailed to the AMWA National Office.

You are responsible for arranging the interview. If the physician is not a member of AMWA, download the membership information and application, and give to the interviewer for her consideration. Ask the physician to complete the interview report form during the interview and fax the completed form to AMWA at (703) 549-3864.

Med Students: Take It TODAY!

Only a few weeks remain to participate in the AMWA-sponsored Medical Student Women's Health online survey...Take It TODAY! The survey requests information on women's health and gender-specific teaching at your medical school, will which assist AMWA in developing policies regarding these topics. Please encourage second through fourth year AMWA medical students, including non-AMWA members and male colleagues to complete the survey. Visit <http://www.actionreaction.net/whs/>.

Announcing new UCLA pre-medical AMWA chapter

Women students at the University of California, Los Angeles (UCLA), recently formed a pre-medical AMWA chapter. Chapter president, Behnaz Esther Behmanesh, a third year biology major, organized the chapter when she realized that none of the school's pre-medical clubs supported women in medicine.

"The need for such a club became apparent to me when I saw many of my female pre-medical friends and peers abandon their plans to enter medical school, partly as a result of this lack of support," said Ms. Behmanesh, chapter president. "Many of these students believed that a woman could not possibly raise a family and be a doctor at the same time. Personally, I did not agree with these ideas, and when I found out about AMWA I knew that I had to begin a pre-medical chapter at UCLA. My goal in starting this group was to provide support and encouragement for the advancement of women in medicine."

The photograph includes chapter officers and Jo Anne Dawson, MD, who spoke on the changing roles of women in medicine at the first meeting.



L to R, back row: Karen Tenenblatt, Wai-Yin Chu, Christine Shumka, Jo Ann Dawson, MD; Jila Dayani, MD; Behnaz Esther Behmanesh, president.

L to R, front Row: Charlene Torkan, Agnes Zapata, Tejal Shaw.

Attend the MWIA Northern European Congress in Iceland

The XV Northern European Congress of the Medical Women's International Association (MWIA) meets in Reykjavik, Iceland, September 28 through October 1, 2005. Sessions will focus on women's health, specifically progress made in women's health care in Iceland, and the role of women as leaders in medicine. The congress will include keynote speakers, lunch symposia on women's mental health and heart and lung diseases in women. Also planned is a pre and post congress in dermatology.

Visit www.fkli.is/congress/ for more information regarding the programs and registration.



Women, education, and debt

Hind Benjelloun, MD, psychiatry resident, Georgetown University School of Medicine

Incurred debt is a significant obstacle for women partaking of higher education. On average, women when compared with men take almost three times longer to pay their postgraduate debt. Furthermore, women's wages are only 65 percent of men's earnings. Subsequently, with a comparable educational background and qualifications, a woman on average earns about \$210,000 less over a lifetime than a man for the same work performed.

The patterns of enrollment and economic profiles of women differ from those of men and should send warning signals to student aid analysts and college officials. Women, for example, drastically exceed men as adult, part-time, independent, and unclassified students (groups most likely excluded from a majority of financial aid programs). Women more often attend low-cost institutions, outnumbering men in public undergraduate four-year and two-year colleges, while men outnumber women in high-cost private institutions. Women are more likely to enter careers paying the lowest salaries. The more noteworthy differences between genders emerge in discretionary programs like college work-study, academic merit scholarships, research assistantships, and corporate benefit programs that pay tuition.

Statistics on poverty rates, hourly wages, and lifetime earnings make increased years of schooling imperative for women. Two out of every three adults in poverty are women. Although poverty rates diminish with additional years of education, women's salaries still lag behind those of men even with additional years of schooling.

Faced with ever-increasing tuition bills and engrossed in a civilization of promissory notes and postponed fulfillment, the sphere of indebtedness weighs heavily on the physician-in-training. Medical student debt has increased significantly over the past decade, making the debt load unmanageable.

According to a recent report published by the American Association of Medical Colleges (AAMC), current medical education debt is five times higher than it was twenty years ago, growing well beyond the consumer price index. Nationally, 10 years ago, 11 percent of medical students had debt exceeding \$100,000. Today, 21 percent have debt greater than \$150,000.

Graduating with an average of \$100,000 in outstanding school loans, medical students are among the hardest hit by the rising cost of tuition. Over the past twenty years, median medical school tuition and fees have increased by 165 percent in private schools and by 312 percent in public schools. From 2002 to 2003, students encountered the largest tuition increases in history; private school tuition increased by 5.7 percent while public school tuition increased by 17.7 percent. Importantly, funding for medical education has been compromised, predominantly for public

schools, considering the recent slump in the economy and the resultant reduction of federal and state budgets. This provoked varying reactions including the rescinding of scholarships, and record increases in tuition, as well as the initiation of mid-year and retroactive tuition hikes.

On July 1, 2005, the federal student loan rate changes; borrowers may face a rate hike of 2.0-2.5 percent over the current rate. Loan consolidation allows borrowers to bundle several student loans into one, with an interest rate calculated from the average rate of the underlying loans, and to extend repayment from the usual 10 years to as long as 30 years. (MSN Money, 2/14/05)

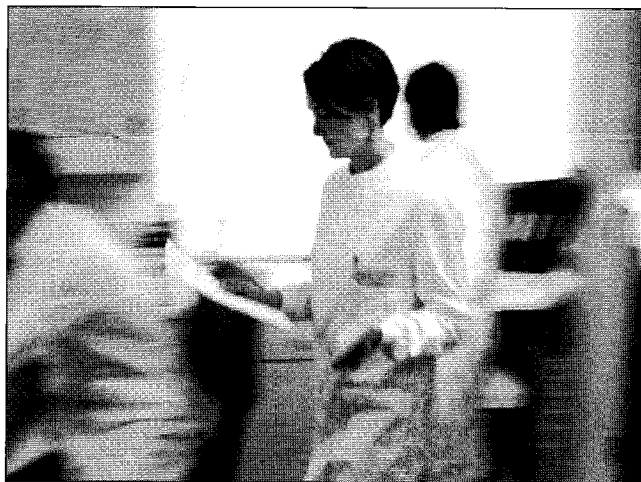
More and more, female medical students are in quest of a balance in their personal and professional lives with great emphasis and attention placed on momentarily rising student loan debt. Consequentially, awareness is mounting in specialties like psychiatry and dermatology for which the financial remuneration is not as great as that of the hospital-based specialties such as emergency medicine, radiology, and anesthesiology, specialties that offer stable incomes. Given the present numbers on income and debt burden, a starting primary care doctor pays between 8 and 15 percent of her income solely to manage debt.

On a similar note, fewer female students are choosing primary care, general surgery, internal medicine, and other medical professions associated with an uncontrollable lifestyle. This alarms health specialists, who caution about a serious shortage of primary care physicians. The trend has serious ramifications for our country's health care. Statistics indicate that the U.S. must train 3,000 to 10,000 more physicians a year in order to meet the growing medical needs of the aging, wealthy nation. Considering the 10-year training interval, if this prediction

is true, the nation would have a shortage of 85,000 to 200,000 doctors in 2020.

While tuition and debt continue to outpace inflation, physician incomes have not kept pace, especially for women. This has made medical education less and less affordable to students and their families. Whether the debt carried by women students affects their choice of specialty remains unclear. While there is no pragmatic confirmation illustrating the exact association between debt level and specialty selection, intuition leads many to accept the hypothesis that there is a notable, authentic relationship. The American Medical Student's Association supports the belief that the debt burden may be moderately responsible for the quantifiable reduction in females entering primary care fields in favor of more profitable specialties.

To learn more about consolidating your student loans, visit <http://www.amwa-doc.org/students/debtmanagement>



Medical student debt has increased significantly over the past decade, making the debt load unmanageable.

A physician's responsibility to protect children from their parent's genetic disease

Mikaela Rossman, 3rd Year Law Student, University of Maryland School of Law

Genetic testing allows physicians to predict a person's lifetime medical prognosis. Unlike the majority of medical information that affects only a particular patient, genetic information has potentially far reaching implications. Because genetic information is familial in nature, physicians must now decide what to do when a parent is diagnosed with a genetic disease. There are currently no statutes addressing minor children's rights to learn about their genetic disposition to disease. In light of such uncertainty, what duty should a physician have to a minor child with whom there is no established physician-patient relationship?

Testing a child for genetic diseases requires careful consideration because a genetic predisposition cannot foretell the moment at which a disease will take effect, or even if a child will develop the condition within her lifetime. Testing of children "for adult onset diseases should not be undertaken unless direct medical benefit will accrue to the child and this benefit would be lost by waiting until the child has reached adulthood."¹

When disclosure trumps confidentiality

The Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") promulgated under Health Insurance Portability and Accountability Act of 1996, requires consent for disclosure of any individually identifying medical information.¹ However, the Privacy Rule creates exceptions to the strict nondisclosure policy when there is a "serious and imminent threat" to an identifiable third party and the physician has the ability to provide information to avert the harm.¹ For example, many states have enacted statutes that specifically allow a physician to disclose a patient's HIV or AIDS status to persons at risk of contracting the disease, "[placing] physicians squarely in the position of weighing the patient's right to confidentiality against the potential risk to third parties."¹

Disclosing genetic information is even more crucial than disclosing communicable diseases because the risk is unavoidable—it already exists within the family. Oftentimes, early diagnosis and treatment is the only hope for avoiding a disease's consequences.² The Hippocratic Oath places a premium on curing people, saying, "I will prevent disease whenever I can, for prevention is preferable to cure."² In the case of a genetic disease that is curable only when discovered early, keeping that information confidential may be tantamount to preventing a cure. A physician should make a good faith assessment whether the test results will stigmatize a child without any hope of treatment or cure, or indicate the need for treatment without which a child will suffer unnecessarily, and recommend testing accordingly.²

Who protects the children?

Courts have established some circumstances in which a physician has a duty to warn at-risk third parties using information obtained within the physician-patient relationship.¹ Thus far, few cases directly address genetic diseases. In *Pate v. Threlkel*,³ the adult daughter of a woman with medullary thyroid cancer sued

her mother's doctors alleging that the physicians knew about the likelihood that she would inherit the condition, and therefore that the physicians had a duty to warn the mother to test her children. The daughter asserted that had she been tested as a child, she would have taken preventative action and likely would have been diagnosed when the disease was still curable.⁴ The court held that the duty to warn runs to not only patients in privity with the physician, but also to identifiable third parties that are the intended beneficiary of the standard of care.⁴

When genetic testing is medically indicated, parental refusal to provide adequate medical care may constitute child abuse.³ The AMA guidelines state, "[i]f parents unreasonably request or refuse testing of their child, the physician should... use legal means to override the parents' choice."³ Therefore, when a physician has knowledge that a patient's minor child is at risk of developing a genetic disease that is treatable when detected early, a physician's duty is two-fold. First, a physician should warn the parents about risks the genetic disease poses to the child. Second, the physician should see to it that the child gets tested. A physician's duty in this situation is only discharged once the parents have taken appropriate medical action, or the physician has reported the parents to the appropriate authorities for child neglect.

Conclusion

Advances in medical technology allow physicians to use genetic information to predict future illnesses. Genetic information discovered within a physician-patient relationship may also be helpful in monitoring and protecting family members from the harmful effects of the genetic predisposition. The fact that the genetic information is familial in nature places two competing duty in tension: the duty of confidentiality for patient information and the duty to warn identifiable third parties about imminent danger. When an inheritable disease is treatable or curable if caught early, new case law suggests that physicians have a duty to warn the children of their patients with genetic diseases and see that the children get tested. If parents refuse to test their children when medically indicated, the physician has a duty to report the parents for child abuse and neglect. Anything less would be professionally irresponsible and perhaps costly.

Sources.

1. Neil Holtzman, M.D., MPH & Michael S. Watson, Ph.D., *Final Report of the Task Force on Genetic Testing: Promoting Safe and Effective Genetic Testing in the United States*, at 23 (1997). Available at: <http://biotech.law.lsu.edu/research/fed/tfgt/>. Retrieved May 12, 2005.
2. 45 CFR 164.510 (2005). See also American Society of Human Genetics Social Issues Subcommittee on Familial Disclosure, *ASHG Statement: Professional Disclosure of Familial Genetic Information*, 62 Am. J. Hum. Genetics 474 (1998) (Explaining that medical information includes genetic information).
3. Kenneth Offit, MD, MPH et al., *The "Duty to Warn" a Patient's Family Members About Hereditary Disease Risks*, 292:12 JAMA 1469, 1471 (2004).
4. *Heidi Pate and James Pate v. James B. Threlkel, et al.*, S.Ct. of FL, 661 So. 2d 278 (1995).

Advocacy

News from Capitol Hill

News from Capitol Hill, an update on health and medical issues before the U.S. Senate and House of Representatives.

Teresa Dyer, Legislative Specialist
Brownstein Hyatt & Farber, PC

Specialty Hospitals

Much national debate centers on physician-owned specialty hospitals. Currently, about 130 specialty hospitals are operating in 20 states. Capitol Hill gave much attention to issues regarding specialty hospitals and community hospitals, partly because the 2003 Medicare Modernization Act included an 18-month moratorium on physician referrals to new specialty hospitals. That moratorium became effective in December of 2003 and expired on June 8, 2005.

Two of Washington's most influential health care groups are leading the fight in Congress and in the states. The American Medical Association supports the physician-owned specialty hospitals and the American Hospital Association and the Federation of American Hospitals supports the community hospitals. Lobbying groups formed to support these two groups include the American Surgical Hospital Association and two of the largest specialty hospital companies, MedCath and National Surgical Hospitals. Community hospitals formed the Coalition of Full-Service Community Hospitals and have received support from the National Rural Health Association, the U.S. Chamber of Commerce, and the National Black Chamber of Commerce.

Legislation was introduced by Senator Chuck Grassley (R-Iowa) that would ban physician referrals of Medicare and Medicaid patients to new specialty hospitals they own, retroactive to June 8, 2005. Senator Tom Coburn (R-Oklahoma), an obstetrician and advocate for competition, has placed a hold on that bill. On the House side, Congressman Joe Barton (R-Texas), Chairman of the Energy and Commerce Committee and a supporter of specialty hospitals, has stated that the committee will not pass a bill to extend the moratorium and will block efforts to add extension language to an appropriations bill.

"Patient Navigator Outreach and Chronic Disease Prevention Act of 2005"

The House of Representatives recently passed the "Patient Navigator Outreach and Chronic Disease Prevention Act of 2005," a bill that would help low-income patients learn about and take advantage of health care resources. H.R.1812, sponsored by Congressman Robert Menendez (D-New Jersey), would authorize \$25 million over five years to "patient navigator" programs. The programs would let patients know about opportunities for government aid and financial assistance. The navigators would be established at health care centers, hospitals, and non-profit facilities to teach patients about options for treatment, provide information on clinical trials, and obtain health care referrals. The legislation is modeled after successful programs such as the Harlem Navigator Program at Harlem Hospital in New York and the Washington Hospital Center's Cancer Preventorium.

In the Senate, a companion bill, S.898, sponsored by Senator Kay Bailey Hutchison (R-Texas), was approved at the end of April by the Senate Health, Education, Labor and Pensions Committee

and will soon be voted on by the full Senate. "This legislation, based on proven models, helps our neediest patients understand the health care options available," said Senator Hutchison. The American Medical Association, the American Cancer Society, and the American Diabetes Association promote this legislation.

Health care and the uninsured

With Census Bureau figures showing that in 2003 there were 45 million people who lacked health insurance, and with Congress locked in partisan battles over this crisis, several different groups are meeting and taking action to develop their own solutions.

The AFL-CIO has established "America's Agenda: Healthcare for All" whose ultimate goal is universal health care. This coalition plans to battle for adoption of universal health care at both the state and federal levels by using communications resources and grassroots and actual campaigns in targeted states. More information is on their Web site: www.AmericasAgenda.org

Another group of 24 leaders from corporations and unions, health care industry leaders, and conservative and liberal groups have been meeting secretly since October of 2004 to devise plans to expand coverage to as many uninsured people as possible. Their goal is to reach consensus by the end of the year and present their plan to President Bush and Members of Congress.

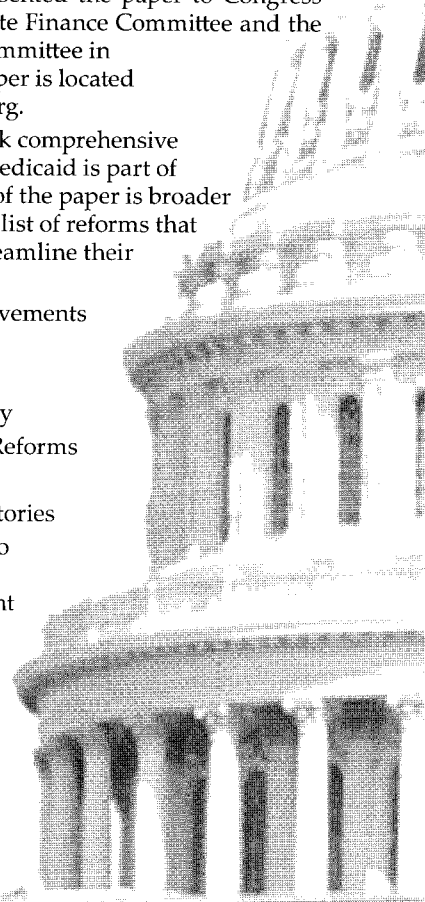
Medicaid reform

The National Governors Association (NAG) recently released a policy paper entitled "Medicaid Reform - A Preliminary Report." The paper is the result of work by a NGA task force of eleven governors with input from other governors and their Medicaid Directors. Governor Mark Warner of Virginia and Governor Mike Huckabee of Arkansas presented the paper to Congress during testimony before the Senate Finance Committee and the House Energy and Commerce Committee in mid-June. A copy of the policy paper is located on the NGA Web site, www.nga.org.

Policies in the paper do not seek comprehensive health care reform, but because Medicaid is part of the health care system, the scope of the paper is broader than just reform of Medicaid. The list of reforms that would give states flexibility to streamline their programs includes:

1. Prescription Drug Improvements
2. Asset Policy
3. Cost Sharing
4. Benefit Package Flexibility
5. Comprehensive Waiver Reforms
6. Judicial Reforms
7. Commonwealths & Territories

The paper also asks Congress to establish a "National Health Care Innovations Program" to implement ten to fifteen state-led demonstrations in health care reform over a three to five year period. States would work with the private sector on these demonstrations; financing would not be at the expense of Medicaid.



AMWA Calendar

August 13-14, 2005

Federation of Medical Women of Canada – "Optimizing Women's Health at Midlife and Beyond"
Edmonton, Alberta, Canada For information: www.fmwcc.ca/

September 28 - October 2, 2005

MWIA, Grand Hotel, Reykjavik, Iceland
For information: <http://stigur.vortex.is/fkli/congress/congress.htm>

February 16-19, 2006

AMWA Annual Meeting – "Prevention: The Smart Future Strategy"
Tucson, Arizona For information: www.amwa-doc.org

AMWA branches are encouraged to submit activities and meeting dates for the AMWA Calendar.



*****KATHRYN A WILLIAMS
70 LA CUESTA RD
ORINDA, CA 94563-2326
41
32
20495

Address Service Requested

American Medical Women's Association
801 North Fairfax Street, Suite 400
Alexandria, VA 22314-1774

AMWA Connections

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Carolyn Webber, MD, AMWA President

Linda D. Hallman, Executive Director

Adair Heyl, PhD, Editor

Pam Johnson, Assistant Editor

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703-838-0500 Fax 703-549-3864

E-mail: info@amwa-doc.org

Editorial Office: Eastern Virginia Medical School,
601 Colley Avenue, Suite 243, Norfolk, VA 23507-1627
757-446-5117 Fax 757-446-8998

E-mail: heyler@evms.edu

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