

DISCLAIMER

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-07)

Report of Reference Committee K

M. Leroy Sprang, MD, Chair

1 In keeping with Resolution 601 (A-96), the Reference Committee recommends the
2 following consent calendar for acceptance:

3
4 **RECOMMENDED FOR ADOPTION**

- 5
6 1. Council on Medical Service Report 4 – Trends in Employer-Sponsored Health
7 Insurance
8
9 2. Council on Medical Service Report 2 – Health Insurance Coverage for High-Risk
10 Patients
11
12 3. Council on Medical Service Report 1 – Cost Sharing Arrangements for
13 Prescription Drugs
14
15 4. Resolution 809 - Standardized Pharmacy Telephone Answering Machines
16
17 5. Resolution 820 – Insurance Company Economic Profiling of Physicians
18
19 6. Resolution 828 - Principles for Strengthening the Physician-Hospital Relationship
20

21 **RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED**

- 22
23 7. Board of Trustees Report 2 - Consequences of Accepting Hospital and Health
24 Care System Based EMRs/EHRs (Res. 832, I-06)
25
26 8. Resolution 808 - Electronic Medical Records (EMR) Assistance
27
28 9. Council on Science and Public Health Report 1 – AMA Policy on Smoke-Free
29 Environments and Workplaces
30
31 10. Resolution 801 - Patient Safety Curricula in Undergraduate Medical Education
32
33 11. Resolution 811 - Medical Students Obtaining Access to Health Care Facilities
34
35 12. Resolution 819 – Patient Access to Off-Label Use of Avastin
36

1 13. Resolution 815 – Joint Commission Interpretations of Medication Reconciliation

2

3 14. Resolution 817 – Oppose Sale of Tobacco Where Patients Receive Health Care

4

5

6 **RECOMMENDED FOR REFERRAL**

7

8 15. Resolution 804 - Communication and Clinical Teaching Curricula

9

10 16. Resolution 821 – Residency Program At-Home Call Criteria

11 Resolution 825 - Monitoring of At-Home Call Implementation by Residency

12 Programs

13

14 17. Resolution 813 – Improving Medical Practice and Patient/Family Education to

15 Reverse the Epidemic of Prescription Drug Misuse and Addiction

16

17 18. Resolution 824 - Time Limited License Reciprocity in Times of Disaster

18

19 19. Resolution 816 – Tiering System for Third Party Payers

20

21 **RECOMMENDED FOR REFERRAL FOR DECISION**

22

23 20. Resolution 826 - Confidentiality of Medical Staff Members' Personal Proprietary

24 Financial Information

25

26 **RECOMMENDED FOR REAFFIRMATION IN LIEU OF**

27

28 21. Resolution 818 – Health Information Technology Legislation

29

30 22. Resolution 823 – Constitutional Basis for Advocacy

31

1 (1) COUNCIL ON MEDICAL SERVICE REPORT 4 - TRENDS
2 IN EMPLOYER-SPONSORED HEALTH INSURANCE
3

4 RECOMMENDATION:
5

6 Mr. Speaker, your Reference Committee recommends that
7 the recommendation in Council on Medical Service Report
8 4 be adopted and that the remainder of the report be filed.
9

10 **HOD ACTION: Recommendation in Council on Medical**
11 **Service Report 4 adopted and the remainder of the report**
12 **filed.**
13

14 Council on Medical Service Report 4 recommends that our AMA encourage employers
15 to: promote greater individual choice and ownership of plans; enhance employee
16 education regarding how to choose health plans that meet their needs; offer information
17 and decision-making tools to assist employees in developing and managing their
18 individual health care choices; support increased fairness and uniformity in the health
19 insurance market; and promote mechanisms that encourage their employees to pre-fund
20 future costs related to retiree health care and long-term care.
21

22 Testimony on this item was limited to an introduction of the report by a member of the
23 Council on Medical Service. Your Reference Committee recommends adoption of the
24 recommendation in the report.
25

26 (2) COUNCIL ON MEDICAL SERVICE REPORT 2 - HEALTH
27 INSURANCE COVERAGE OF HIGH-RISK PATIENTS
28

29 RECOMMENDATION:
30

31 Mr. Speaker, your Reference Committee recommends that
32 the recommendations in Council on Medical Service
33 Report 2 be adopted and that the remainder of the report
34 be filed.
35

36 **HOD ACTION: Recommendations in Council on Medical**
37 **Service Report 2 adopted and the remainder of the report**
38 **filed.**
39

40 Council on Medical Service Report 2 recommends reaffirmation of Policy H-165.856 [3],
41 which supports the principle that risk-related subsidies such as subsidies for high-risk
42 pools, reinsurance, and risk adjustment should be financed through general tax
43 revenues rather than through strict community rating or premium surcharges. The report
44 also asks the AMA to support the principle that health insurance coverage of high-risk
45 patients be subsidized through direct risk-based subsidies such as high-risk pools, risk
46 adjustment, and reinsurance, rather than through indirect methods that rely heavily on
47 market regulation, and to support state-based demonstration projects to subsidize
48 coverage of high-risk patients through mechanisms such as high-risk pools, risk
49 adjustment, reinsurance, and other risk-based subsidies.
50

1 Your Reference Committee heard mixed but generally supportive testimony on Council
2 on Medical Service Report 2. Some speakers expressed concerns that the report did
3 not address issues such as the high cost of health insurance, the ability of government
4 to finance subsidies for high-risk patients, quality of care, limitations in benefits
5 coverage, and pre-existing condition limitations. A representative of the Council on
6 Medical Service testified that the focus of the report is specifically on solving the problem
7 of financing coverage of high-risk patients, which requires a particular set of solutions.
8 The report demonstrates the advantages of direct risk-based subsidy mechanisms over
9 the alternatives for financing the coverage of high-risk patients, namely requiring high-
10 risk patients to bear the full cost of their own care or spreading the cost of their care
11 through higher premiums. Your Reference Committee was pleased that the Council on
12 Medical Service also testified that it will continue to study the range of issues related to
13 broader health system reform and expanding health insurance coverage.

14
15 A representative of the Senior Physicians Group Governing Council suggested adding a
16 recommendation that would ask our AMA to study the effects of medical bankruptcy,
17 however, your Reference Committee is concerned that this is beyond the scope of the
18 report, and believes this issue would more appropriately be addressed as a separate
19 effort. Accordingly, your Reference Committee recommends adoption of the
20 recommendations in Council on Medical Service Report 2 as written.

21
22 (3) COUNCIL ON MEDICAL SERVICE REPORT 1 - COST-
23 SHARING ARRANGEMENTS FOR PRESCRIPTION
24 DRUGS

25
26 RECOMMENDATION:

27
28 Mr. Speaker, your Reference Committee recommends that
29 the recommendations in Council on Medical Service
30 Report 1 be adopted and the remainder of the report be
31 filed.

32
33 **HOD ACTION: Recommendations in Council on Medical
34 Service Report 1 adopted and the remainder of the report
35 filed.**

36
37 Council on Medical Service Report 1 recommends that our AMA establish policy stating
38 that cost-sharing arrangements for prescription drugs should be designed to encourage
39 the judicious use of health care resources, rather than simply shifting costs to patients;
40 and that cost-sharing requirements should be based on considerations such as: unit
41 cost of medication; availability of therapeutic alternatives; medical condition being
42 treated; personal income; and other factors known to affect patient compliance and
43 health outcomes. Also recommends supporting the development and use of tools and
44 technology that enable physicians and patients to determine the actual price and out-of-
45 pocket costs of individual prescription drugs prior to making prescribing decisions, so
46 that physicians and patients can work together to determine the most efficient and
47 effective treatment for the patient's medical condition.

48
49 Testimony on this item was limited. The author of the resolution that generated this
50 report testified that the report does not adequately address the relationship between

1 cost-sharing systems and increasing drug prices. He emphasized that increasing patient
2 awareness of drug costs – via using a coinsurance rather than co-payment system -
3 would help reduce the power of and reliance on insurers and pharmacy benefit
4 managers to control costs. While your Reference Committee appreciates the
5 importance of this information, we believe that the report presents a strong case that the
6 relative effects of a co-payment or coinsurance arrangement will depend on a variety of
7 circumstances. Your Reference Committee concurs with the recommendation in the
8 report that supports cost sharing structures that take a variety of factors into
9 consideration, including treatment costs, availability of therapeutic alternatives, medical
10 condition being treated, and patient income. Your Reference Committee appreciates the
11 efforts of the Council on Medical Service to recommend ways to encourage the
12 appropriate use of health care resources, and concurs with testimony in support of the
13 report as written.

14
15 (4) RESOLUTION 809 - STANDARDIZED PHARMACY
16 TELEPHONE ANSWERING MACHINES

17
18 RECOMMENDATION:

19
20 Mr. Speaker, your Reference Committee recommends that
21 Resolution 809 be adopted.

22
23 **HOD ACTION: Resolution 809 adopted.**

24
25 Resolution 809 asks that our AMA work with pharmacy executives of companies which
26 have a multi-state presence, to standardize the pharmacy voice-mail message which
27 would allow the physician caller to bypass the entire message and select the choice to
28 phone in a prescription.

29
30 Your Reference Committee heard testimony in support of Resolution 809 and
31 recommends its adoption.

32
33 (5) RESOLUTION 820 - INSURANCE COMPANY
34 ECONOMIC PROFILING OF PHYSICIANS

35
36 RECOMMENDATION:

37
38 Mr. Speaker, your Reference Committee recommends that
39 Resolution 820 be adopted.

40
41 **HOD ACTION: Resolution 820 adopted.**

42
43 Resolution 820 asks that our AMA take all appropriate steps to actively oppose all efforts
44 by third party payers to rank, profile or otherwise “score” physicians purely for corporate
45 cost containment purposes; and widely publicize insurance industry economic profiling
46 practices and how they impact patient care and access.

47
48 There was supportive testimony on the intent of this resolution, and several speakers
49 noted that our AMA has related policies on this issue (e.g., H-450.941) and is already
50 aggressively working to oppose efforts to tier or profile physicians based on cost

1 considerations. Your Reference Committee notes that informational Board of Trustees
 2 Report 4, presented at this meeting, offers an analysis of two physician profiling systems
 3 being used by insurers, and compares them to the AMA's Principles for Pay for
 4 Performance Programs. The report states that, "it is anticipated that additional analyses
 5 and reports of other major physician profiling programs will be prepared in the future."
 6 This resolution is consistent with current AMA activities, and your Reference Committee
 7 recommends its adoption.

8
 9
 10 (6) RESOLUTION 828 - PRINCIPLES FOR
 11 STRENGTHENING THE PHYSICIAN-HOSPITAL
 12 RELATIONSHIP

13
 14 RECOMMENDATION:

15
 16 Mr. Speaker, your Reference Committee recommends that
 17 Resolution 828 be adopted.

18
 19 **HOD ACTION: Resolution 828 adopted.**

20
 21 Resolution 828 asks that our AMA join with other physician groups in the Federation of
 22 Medicine to advocate for improved physician-hospital relationships in discussions with
 23 the American Hospital Association, The Joint Commission and the Centers for Medicare
 24 and Medicaid Services. It also asks that the following twelve principles be adopted as
 25 AMA policy:

26
 27 PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

- 28
 29 1. The organized medical staff and the hospital governing body are responsible for
 30 the provision of quality care, providing a safe environment for patients, staff and
 31 visitors, and working continuously to improve patient care and outcomes, with the
 32 primary responsibility for the quality of care rendered and for patient safety
 33 vested with the organized medical staff. These activities depend on mutual
 34 accountability, interdependence, and responsibility of the organized medical staff
 35 and the hospital governing body for the proper performance of their respective
 36 obligations.
 37
 38 2. The organized medical staff, a self-governing organization of professionals,
 39 possessing special expertise, knowledge and training, discharges certain
 40 inherent professional responsibilities by virtue of its authority to regulate the
 41 professional practice and standards of its members, and assumes primary
 42 responsibility for many functions, including but not limited to: the determination of
 43 organized medical staff membership; performance of credentialing, privileging
 44 and other peer review; and timely oversight of clinical quality and patient safety.
 45
 46 3. The leaders of the organized medical staff, with input from the hospital governing
 47 body and senior hospital managers, develop goals to address the healthcare
 48 needs of the community and are involved in hospital strategic planning as
 49 described in the medical staff bylaws.
 50

- 1 4. Ongoing, timely and effective communication, by and between the hospital
2 governing body and the organized medical staff, is critical to a constructive
3 working relationship between the organized medical staff and the hospital
4 governing body.
5
- 6 5. The organized medical staff bylaws are a binding, mutually enforceable
7 agreement between the organized medical staff and the hospital governing body.
8 The organized medical staff and hospital bylaws, rules and regulations should be
9 aligned, current with all applicable law and accreditation body requirements and
10 not conflict with one another. The hospital bylaws, policies and other governing
11 documents do not conflict with the organized medical staff bylaws, rules,
12 regulations and policies, nor with the organized medical staff's autonomy and
13 authority to self govern, as that authority is set forth in the governing documents
14 of the organized medical staff. The organized medical staff, and the hospital
15 governing body/administration, shall, respectively, comply with the bylaws, rules,
16 regulations, policies and procedures of one another. Neither party is authorized
17 to, nor shall unilaterally amend the bylaws, rules, regulations, policies or
18 procedures of the other.
19
- 20 6. The organized medical staff has inherent rights of self governance, which
21 includes but are not limited to:
22
 - 23 a. Initiating, developing and adopting organized medical staff bylaws, rules
24 and regulations, and amendments thereto, subject to the approval of the
25 hospital governing body, which approval shall not be unreasonably
26 withheld. The organized medical staff bylaws shall be adopted or
27 amended only by a vote of the voting membership of the organized
28 medical staff.
29
 - 30 b. Identifying in the medical staff bylaws those categories of medical staff
31 members that have voting rights.
32
 - 33 c. Identifying the indications for automatic or summary suspension, or
34 termination or reduction of privileges or membership in the organized
35 medical staff bylaws, restricting the use of summary suspension strictly
36 for patient safety and never for purposes of punishment, retaliation or
37 strategic advantage in a peer review matter. No summary suspension,
38 termination or reduction of privileges can be imposed without organized
39 medical staff action as authorized in the medical staff bylaws and under
40 the law.
41
 - 42 d. Identifying a fair hearing and appeals process, including that hearing
43 committees shall be composed of peers, and identifying the composition
44 of an impartial appeals committee. These processes, contained within
45 the organized medical staff bylaws, are adopted by the organized medical
46 staff and approved by the hospital governing board, which approval
47 cannot be unreasonably withheld nor unilaterally amended or altered by
48 the hospital governing board or administration. The voting members of
49 the organized medical staff decide any proposed changes.
50

- 1 e. Establishing within the medical staff bylaws: 1) the qualifications for
2 holding office, 2) the procedures for electing and removing its organized
3 medical staff officers and all organized medical staff members elected to
4 serve as voting members of the Medical Executive Committee, and 3) the
5 qualifications for election and/or appointment to committees, department
6 and other leadership positions.
7
- 8 f. Assessing and maintaining sole control over the access and use of
9 organized medical staff dues and assessments, and utilizing organized
10 medical staff funds as appropriate for the purposes of the organized
11 medical staff.
12
- 13 g. Retaining and being represented by legal counsel at the option and
14 expense of the organized medical staff.
15
- 16 h. Establishing in the organized medical staff bylaws, the structure of the
17 organized medical staff, the duties and prerogatives of organized medical
18 staff categories, and criteria and standards for organized medical staff
19 membership application, reapplication credentialing and criteria and
20 processing for privileging. The standards and criteria for membership,
21 credentialing and privileging shall be based only on quality of care criteria
22 related to clinical qualifications and professional responsibilities, and not
23 on economic credentialing, conflicts of interest or other non-clinical
24 credentialing factors.
25
- 26 i. Establishing in the organized medical staff bylaws, rules and regulations,
27 clinical criteria and standards to oversee and manage quality assurance,
28 utilization review and other organized medical staff activities, and
29 engaging in all activities necessary and proper to implement those bylaw
30 provisions including, but not limited to, periodic meetings of the organized
31 medical staff and its committees and departments and review and
32 analysis of patient medical records.
33
- 34 j. The right to define and delegate clearly specific authority to an elected,
35 Medical Executive Committee to act on behalf of the organized medical
36 staff. In addition, the organized medical staff defines indications and
37 mechanisms for delegation of authority to the Medical Executive
38 Committee and the removal of this authority. These matters are specified
39 in the organized medical staff bylaws.
40
- 41 k. Identifying within the organized medical staff bylaws a process for
42 election and removal of elected Medical Executive Committee members.
43
- 44 l. Defining within the organized medical staff bylaws the election process
45 and the qualifications, roles and responsibilities of clinical department
46 chairs. The Medical Executive Committee must appoint any clinical chair
47 that is not otherwise elected by the vote of the general medical staff.
48
- 49 m. Enforcing the organized medical staff bylaws, regulations and policies
50 and procedures.

- 1 n. Establishing in medical staff bylaws, medical staff involvement in
2 contracting relationships, including exclusive contracting, medical
3 directorships and all hospital-based physician contracts, that affect the
4 functioning of the medical staff.
5
- 6 7. Organized medical staff bylaws are a binding, mutually enforceable agreement
7 between the organized medical staff and the hospital governing body, as well as
8 between those two entities and the individual members of the organized medical
9 staff.
10
- 11 8. The self-governing organized medical staff determines the resources and
12 financial support it requires to effectively discharge its responsibilities. The
13 organized medical staff works with the hospital governing board to develop a
14 budget to satisfy those requirements and related administrative activities, which
15 the hospital shall fund, based upon the financial resources available to the
16 hospital.
17
- 18 9. The organized medical staff has elected appropriate medical staff member
19 representation to attend hospital governing board meetings, with rights of voice
20 and vote, to ensure appropriate organized medical staff input into hospital
21 governance. These members should be elected only after full disclosure to the
22 medical staff of any personal and financial interests that may have a bearing on
23 their representation of the medical staff at such meetings. The members of the
24 organized medical staff define the process of election and removal of these
25 representatives.
26
- 27 10. Individual members of the organized medical staff, if they meet the established
28 criteria that are applicable to hospital governing body members, are eligible for
29 full membership on the hospital governing body. Conflict of interest policies
30 developed for members of the organized medical staff who serve on the
31 hospital's governing body are to apply equally to all individuals serving on the
32 hospital governing body.
33
- 34 11. Well-defined disclosure and conflict of interest policies are developed by the
35 organized medical staff which relate exclusively to their functions as officers of
36 the organized medical staff, as members and chairs of any medical staff
37 committee, as chairs of departments and services, and as members who
38 participate in conducting peer review or who serve in any other positions of
39 leadership of the medical staff.
40
- 41 12. Areas of dispute and concern, arising between the organized medical staff and
42 the hospital governing body, are addressed by well-defined processes in which
43 the organized medical staff and hospital governing body are equally represented.
44 These processes are determined by agreement between the organized medical
45 staff and the hospital governing body.
46

47 Your Reference Committee heard extensive testimony on this resolution indicating that
48 these principles have been in development for several years, and have been carefully
49 vetted by numerous stakeholders and legal counsel. Although some speakers
50 expressed concern about the length of the resolution – and the short time in which the

1 delegates had to review it – your Reference Committee was persuaded by testimony
2 indicating that this is a timely issue that needs to be resolved now. Your Reference
3 Committee is confident that the Organized Medical Staff Section has developed these
4 principles carefully, and recommends their adoption.
5
6

7 (7) BOARD OF TRUSTEES REPORT 2 - CONSEQUENCES
8 OF ACCEPTING HOSPITAL AND HEALTH CARE
9 SYSTEM BASED EMRS/EHRS (RES. 832, I-06)

10
11 RECOMMENDATION A:

12
13 Mr. Speaker, your Reference Committee recommends that
14 Recommendation 1 in Board of Trustees Report 2 be
15 amended by insertion on page 4 lines 12 - 13 to read as
16 follows:
17

18 RESOLVED, That our American Medical Association
19 develop a ~~model contract~~ contracting guidelines for
20 physicians considering accepting or donating Electronic
21 Medical Records and Electronic Health Records systems
22 (EMRs/EHRs) from or to hospitals and health care
23 systems; and be it further
24

25
26 RECOMMENDATION B:

27
28 Mr. Speaker, your Reference Committee recommends that
29 the recommendations in Board of Trustees Report 2 be
30 adopted as amended and the remainder of the report be
31 filed.
32

33 **HOD ACTION: Recommendations in Board of Trustees**
34 **Report 2 adopted as amended and the remainder of the**
35 **report filed.**
36

37 The original recommendation in Board of Trustees Report 2 recommends that the first
38 resolve of Resolution 832 (I-06) be amended by addition and deletion to read as follows:
39

40 RESOLVED, That our American Medical Association develop a ~~model contract~~
41 contracting guidelines for physicians considering accepting Electronic Medical
42 Records and Electronic Health Records systems (EMRs/EHRs) from hospitals
43 and health care systems; and be it further
44

45 Board of Trustees Report 2 also recommends that Resolution 832 (I-06) be adopted as
46 amended. The remaining resolves of Resolution 832 asks that our AMA educate
47 physicians regarding the potential adverse consequences of receiving EMRs/EHRs from
48 hospitals and health care systems; and encourage interoperability of information
49 systems used by hospitals and health care facilities.
50

1 There was extensive testimony on this report, although the majority of the testimony
2 addressed general concerns about the purchasing and implementation of health
3 information technology that were beyond the scope of the report. A member of the
4 Board of Trustees noted that the report was prepared in response to a resolution that
5 specifically asked our AMA to develop a set of guidelines to help physicians evaluate the
6 issues associated with accepting EMR systems from hospitals and health care systems.
7 The Board member clarified that, if the report is adopted, the AMA HIT Advisory
8 Committee will be actively engaged in implementing the recommendations. Your
9 Reference Committee heard specific concerns regarding recertification requirements,
10 physician ownership of and access to data, and data security, and urges the Board and
11 the Task Force to address these issues in the contracting guidelines.

12
13 Your Reference Committee believes the report addresses the issues raised in the
14 referred resolution, and concurs with testimony that recommended expanding the
15 directive to make it applicable to physicians who might be donating EMR systems, as
16 well as those considering accepting them.

17
18
19 (8) RESOLUTION 808 - ELECTRONIC MEDICAL RECORDS
20 (EMR) ASSISTANCE

21
22 RECOMMENDATION A:

23
24 Mr. Speaker, your Reference Committee recommends that
25 Resolution 808 be amended by insertion on lines 18 – 19
26 to read as follows:

27
28 RESOLVED, That our AMA seek a full refundable federal
29 tax credit or equivalent financial mechanism to indemnify
30 physician practices for the cost of purchasing and
31 implementing clinical information technology, including
32 electronic medical record systems, e-prescribing and other
33 clinical information technology tools, in compliance with
34 applicable safe harbors.

35
36
37 RECOMMENDATION B:

38
39 Mr. Speaker, your Reference Committee recommends that
40 Resolution 808 be adopted as amended.

41
42
43 RECOMMENDATION C:

44
45 Mr. Speaker, your Reference Committee recommends that
46 the title of Resolution 808 be changed to read as follows:

47
48 CLINICAL INFORMATION TECHNOLOGY ASSISTANCE
49

1 **HOD ACTION: Resolution 808 adopted as amended with**
2 **change in title.**

3
4 Resolution 808 asks that our AMA seek a full refundable federal tax credit or equivalent
5 financial mechanism to indemnify physician practices for the cost of purchasing and
6 implementing electronic medical record systems.

7
8 Your Reference Committee heard generally supportive testimony on Resolution 808,
9 and notes that 79% of members who responded to a Member Connect survey on this
10 resolution supported its intent. The Committee agrees with testimony that the reference
11 to “electronic medical records” is somewhat limiting, and recommends the amended
12 language along with the title change to ensure applicability to a wide range of clinical
13 information technology resources.

14
15 The Committee also notes that health information technology is a complex and rapidly
16 changing field, and appreciates the Board of Trustee’s vigilance – through our AMA’s
17 HIT Advisory Committee and other groups – in monitoring and advocating on HIT issues
18 as they arise.

19
20 (9) **COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT**
21 **1 - AMA POLICY ON SMOKE-FREE ENVIRONMENTS**
22 **AND WORKPLACES**

23
24 **RECOMMENDATION A:**

25
26 Mr. Speaker, your Reference Committee recommends that
27 the recommendation in Council on Science and Public
28 Health Report 1 be amended by insertion on page 2 line
29 39 to read as follows:

30
31 (5) advocates that all American hospitals ban tobacco and supports working
32 toward legislation and policies to promote a ban on smoking and use of tobacco
33 products in, or on the campuses of, hospitals, health care institutions, retail
34 health clinics, and educational institutions, including medical schools;

35
36 **RECOMMENDATION B:**

37
38 Mr. Speaker, your Reference Committee recommends that
39 the recommendation in Council on Science and Public
40 Health Report 1 be adopted as amended and the
41 remainder of the report be filed.

42
43 **HOD ACTION: Recommendation in Council on Science and**
44 **Public Health Report 1 adopted as amended and the**
45 **remainder of the report filed.**

46
47 Council on Science and Public Health Report 1 recommends that Policy H-490.913 be
48 amended by addition, deletion, and renumbering to read as follows:

49
50 H-490.913 Smoke-Free Environments and Workplaces

1 On the issue of the health effects of environmental tobacco smoke (ETS) and
2 passive smoke exposure in the workplace and other public facilities, our AMA:

3
4 (1) (a) supports classification of ETS as a known human carcinogen; (b)
5 concludes that passive smoke exposure is associated with increased risk of
6 sudden infant death syndrome and of cardiovascular disease; (c) encourages
7 physicians and medical societies to take a leadership role in defending the health
8 of the public from ETS risks and from political assaults by the tobacco industry;
9 and (d) encourages the concept of establishing smoke-free campuses for
10 business, labor, education, and government;

11
12 (2) (a) honors companies and governmental workplaces that go smoke-free; (b)
13 will petition the Occupational Safety and Health Administration (OSHA) to adopt
14 regulations prohibiting smoking in the workplace, and will use active political
15 means to encourage the Secretary of Labor to swiftly promulgate an OSHA
16 standard to protect American workers from the toxic effects of ETS in the
17 workplace, preferably by banning smoking in the workplace; (c) encourages state
18 medical societies (in collaboration with other anti-tobacco organizations) to
19 support the introduction of local and state legislation that prohibits smoking
20 around the public entrances to buildings and in all indoor public places,
21 restaurants, bars, and workplaces; and (d) will update draft model state
22 legislation to prohibit smoking in public places and businesses, which would
23 include language that would prohibit preemption of stronger local laws.

24 (3) (a) encourages state medical societies to: (i) support legislation for states and
25 counties mandating smoke-free schools and eliminating smoking in public places
26 and businesses and on any public transportation; (ii) enlist the aid of county
27 medical societies in local anti-smoking campaigns; and (iii) through an advisory
28 to state, county, and local medical societies, urge county medical societies to join
29 or to increase their commitment to local and state anti-smoking coalitions and to
30 reach out to local chapters of national voluntary health agencies to participate in
31 the promotion of anti-smoking control measures; (b) urges all restaurants,
32 particularly fast food restaurants, and convenience stores to immediately create a
33 smoke-free environment; (c) strongly encourages the owners of family-oriented
34 theme parks to make their parks smoke-free for the greater enjoyment of all
35 guests and to further promote their commitment to a happy, healthy life style for
36 children; (d) encourages state or local legislation or regulations that prohibit
37 smoking in stadia and encourages other ball clubs to follow the example of
38 banning smoking in the interest of the health and comfort of baseball fans as
39 implemented by the owner and management of the Oakland Athletics and others;
40 (e) urges eliminating cigarette, pipe, and cigar smoking in any indoor area where
41 children live or play, or where another person's health could be adversely
42 affected through passive smoking; (f) urges state and county medical societies
43 and local health professionals to be especially prepared to alert communities to
44 the possible role of the tobacco industry whenever a petition to suspend a
45 nonsmoking ordinance is introduced and to become directly involved in
46 community tobacco control activities; and (g) will report annually to its
47 membership about significant anti-smoking efforts in the prohibition of smoking in
48 open and closed stadia;

49

1 (4) calls on corporate headquarters of fast-food franchisers to require that one of
2 the standards of operation of such franchises be a no smoking policy for such
3 restaurants, and endorses the passage of laws, ordinances and regulations that
4 prohibit smoking in fast-food restaurants and other entertainment and food
5 outlets that target children in their marketing efforts;
6

7 (5) advocates that all American hospitals ban tobacco and supports working
8 toward legislation and policies to promote a ban on smoking and use of tobacco
9 products in, or on the campuses of, hospitals, health care institutions, and
10 educational institutions, including medical schools;
11

12 ~~(6) supports the development and dissemination of model language to~~
13 ~~administrators of American hospitals and the membership of the AMA Hospital~~
14 ~~Medical Staff Section to emphasize and facilitate the importance of a smoke-free~~
15 ~~hospital environment, and as a matter of high priority, the incorporation of this~~
16 ~~requirement by the Joint Commission on Accreditation of Healthcare~~
17 ~~Organizations and the American Hospital Association;~~
18

19 ~~(7) In hospitals where smoking has not been banned, our AMA encourages~~
20 ~~hospitals and physicians to support the following guidelines with respect to~~
21 ~~smoking in hospitals: (a) Physicians should take a leadership role in promoting~~
22 ~~the development of nonsmoking policies and programs in hospitals; (b) Smoking~~
23 ~~should be prohibited in areas where oxygen or flammable materials are stored or~~
24 ~~in use; (c) Smoking should be prohibited in all corridors, elevators, and acute~~
25 ~~care areas; (d) Bedridden patients should not be permitted to smoke; (e)~~
26 ~~Smoking on patient floors by visitors, hospital staff, and ambulatory patients~~
27 ~~should be restricted to designated, well-ventilated areas equipped to meet fire~~
28 ~~standards; (f) If smoking is permitted in cafeterias, other dining areas, employee~~
29 ~~lounges, waiting areas, and library facilities, there should be separate sections~~
30 ~~for smokers and nonsmokers. Where segregation is not feasible, smoking should~~
31 ~~be prohibited; (g) Smoking should be prohibited in all hospital staff meetings,~~
32 ~~Board meetings, and conferences (e.g., Grand Rounds); (h) Hospitals should ask~~
33 ~~all patients prior to or upon admission about their preference for a smoke-free~~
34 ~~room and should guarantee that preference; (i) Hospitals should seriously~~
35 ~~consider designating one or more entire floors as completely nonsmoking; (j) No~~
36 ~~tobacco products should be sold in hospitals or on hospital grounds; (k) Signs~~
37 ~~should be posted at entrances to the hospital and in all nonsmoking areas to~~
38 ~~inform patients, staff and visitors where smoking is prohibited. When indicated,~~
39 ~~the signs should be multilingual or should make use of symbols; (l) Designated~~
40 ~~smoking areas should not be interpreted as approval of smoking by the institution~~
41 ~~and its physicians; (m) Hospitals should develop, implement, enforce, and~~
42 ~~maintain a formal written smoking policy, to be distributed to all staff, visitors, and~~
43 ~~patients; (n) Either directly or in conjunction with other community agencies,~~
44 ~~hospitals should make smoking education and cessation programs, literature and~~
45 ~~other materials available to patients, employees, and the community; (o)~~
46 ~~Hospitals that restrict or eliminate smoking within the institution should initiate~~
47 ~~discussions with their fire and casualty insurance carriers to consider reductions~~
48 ~~in insurance premiums; and (p) Hospital administrators should be aware of all of~~
49 ~~the hazards of smoking and should take the necessary steps to reduce these~~
50 ~~hazards. Administrators should utilize appropriate nonsmoking resource~~

1 materials (e.g., those of the American Hospital Association) in developing
2 policies on nonsmoking;

3
4 (86) will work with the Department of Defense to explore ways to encourage a
5 smoke-free environment in the military through the use of mechanisms such as
6 health education, smoking cessation programs, and the elimination of discounted
7 prices for tobacco products in military resale facilities; and

8
9 (97) encourages and supports local and state medical societies and tobacco
10 control coalitions to work with (1) Native American casino and tribal leadership to
11 voluntarily prohibit smoking in their casinos; and (2) legislators and the gaming
12 industry to support the prohibition of smoking in all casinos and gaming venues.
13 (CSA Rep. 3, A-04; Appended: Sub. Res. 426, A-04)

14
15 Testimony fully supported and recognized the need to update AMA policy on smoke-free
16 environments and workplaces. The Joint Commission noted they are currently studying
17 the issue of smoking on healthcare campuses as they have already banned smoking in
18 facilities. Some suggestions were offered for additional amendments related to
19 expanding the definition of smoke free campuses, opposing the sale of tobacco in
20 hospital gift shops, urging our AMA to avoid contracting with hotels that allow in-room
21 smoking, and addressing local ordinances that currently permit smoking on
22 thoroughfares or smoke-free campuses. Several of these concepts are already
23 addressed in AMA Policy (e.g., H-495.986, G-630.140). AMA Policy does not address
24 smoking in retail health clinics, and, accordingly, your Reference Committee has
25 recommended an additional amendment to expand the scope of the policy to include this
26 specific health care setting.

27
28 (10) RESOLUTION 801 - PATIENT SAFETY CURRICULA IN
29 UNDERGRADUATE MEDICAL EDUCATION

30
31 RECOMMENDATION A:

32
33 Mr. Speaker, your Reference Committee recommends that
34 Resolution 801 be amended by insertion and deletion on
35 lines 26 - 28 to read as follows:

36
37 RESOLVED, That our AMA explore the feasibility of asking the Liaison
38 Committee on Medical Education ~~including the requirement of~~ to encourage the
39 discussion of basic patient safety and quality improvement issues training in
40 medical school accreditation curricula.

41
42
43 RECOMMENDATION B:

44
45 Mr. Speaker, your Reference Committee recommends that
46 Resolution 801 be adopted as amended.

47
48 **HOD ACTION: Resolution 801 adopted as amended.**

49

1 Resolution 801 asks that our AMA explore the feasibility of the Liaison Committee on
2 Medical Education including the requirement of patient safety training in medical school
3 accreditation.

4
5 Testimony on this resolution highlighted the importance of ensuring that medical
6 students receive training on patient safety issues. A speaker suggested including quality
7 improvement as a related and equally important issue, but also expressed concern that
8 adding requirements to the accreditation process could be burdensome. Your
9 Reference Committee accordingly recommends amended language to address these
10 suggestions and concerns.

11
12
13 (11) RESOLUTION 811 - MEDICAL STUDENTS OBTAINING
14 ACCESS TO HEALTH CARE FACILITIES

15
16 RECOMMENDATION:

17
18 Mr. Speaker, your Reference Committee recommends that
19 Resolution 811 be amended by insertion on line 29 to read
20 as follows:

21
22 RESOLVED, That our AMA continue to work with the
23 Association of American Medical Colleges and other
24 national organizations to expedite, wherever possible, the
25 standardization of requirements in regards to training on
26 HIPAA, drug screening, and health requirements for
27 medical students, and resident and fellow physicians who
28 are being taught educated in hospitals and other health
29 care settings.

30
31 RECOMMENDATION B:

32
33 Mr. Speaker, your Reference Committee recommends that
34 Resolution 811 be adopted as amended.

35
36
37 RECOMMENDATION C:

38
39 Mr. Speaker, your Reference Committee recommends that
40 the title of Resolution 811 be changed to read as follows:

41
42 FACILITATING ACCESS TO HEALTH CARE FACILITIES
43 FOR TRAINING

44
45 **HOD ACTION: Resolution 811 adopted as amended with**
46 **change in title.**

47
48 Resolution 811 asks that our AMA continue to work with the Association of American
49 Medical Colleges and other national organizations to expedite, wherever possible, the
50 standardization of requirements in regards to training on HIPAA, drug screening, and

1 health requirements for medical students who are being taught in hospitals and other
2 health care settings.

3
4 Testimony on this resolution was generally favorable, with several speakers offering
5 examples of the complications and confusions associated with having to comply with
6 multiple requirements in order to train in various health care facilities. Although some
7 speakers expressed concern about our AMA's ability to influence such a diverse set of
8 institutions, the overall sentiment was that efforts to achieve standardization are
9 warranted. Your Reference Committee concurs with testimony suggesting that the
10 language be expanded to include resident and fellow physicians. Your Reference
11 Committee also suggests a title change to better clarify the intent of the resolution.

12
13
14 (12) RESOLUTION 819 - PATIENT ACCESS TO OFF-LABEL
15 USE OF AVASTIN

16
17 RECOMMENDATION A:

18
19 Mr. Speaker, your Reference Committee recommends that
20 Resolution 819 be amended by insertion and deletion on
21 lines 25 – 26 to read as follows:

22
23 RESOLVED, That our AMA oppose Genentech's efforts
24 ~~intent, as outlined in a letter to physicians dated October~~
25 ~~11, 2007,~~ to prevent compounding pharmacies from
26 directly purchasing Avastin (bevacizumab) in the interest of
27 patient access to off-label treatments as a "practice of
28 medicine" issue, as well as any interference by Genentech
29 in the physician-patient relationship; and be it further

30
31
32 RECOMMENDATION B:

33
34 Mr. Speaker, your Reference Committee recommends that
35 Resolution 819 be adopted as amended.

36
37 **HOD ACTION: Resolution 819 adopted as amended.**

38
39 Resolution 819 asks that our AMA oppose Genentech's intent, as outlined in a letter to
40 physicians dated October 11, 2007, to prevent compounding pharmacies from directly
41 purchasing Avastin (bevacizumab) in the interest of patient access to off-label
42 treatments as a "practice of medicine" issue, as well as any interference by Genentech
43 in the physician-patient relationship; express its opposition by means including but not
44 limited to sending a letter to Genentech and issuing a press release; and reaffirm Policy
45 H-120.988 (Patient Access to Treatments Prescribed by Their Physicians) that states it
46 is our AMA's position that "a physician may lawfully use an FDA approved drug product
47 or medical device for an unlabeled indication," and support efforts to ensure that ability.

48
49 Fully supportive testimony was offered on Resolution 819. Additional language was
50 proposed to discourage efforts to impede the off-label use of medications, but your

1 Reference Committee believes AMA policy (e.g., H-120.988, H-120.990) already
2 provides strong support for the off-label use of drugs and devices, and the right of
3 physicians to dispense drugs when it is in the best interest of patients. In addition, AMA
4 policy strongly supports the practice of pharmacy compounding, defined as the
5 preparation of individualized medications for specific patients pursuant to a prescription
6 from a physician (H-120.945). Your Reference Committee recommends the amended
7 language in order to streamline the first Resolved, and to emphasize Genentech's actual
8 efforts, rather than their intent.

9
10
11 (13) RESOLUTION 815 - JOINT COMMISSION
12 INTERPRETATIONS OF MEDICATION
13 RECONCILIATION

14
15 RECOMMENDATION A:

16
17 Mr. Speaker, your Reference Committee recommends that
18 Resolution 815 be amended on page 1 lines 34 - 35, and
19 page 2 line 1 to read as follows:

20
21 RESOLVED, That our AMA advocate that all Joint
22 Commission standards, including medication reconciliation
23 standards, be consistently interpreted by ~~The Joint~~
24 ~~Commission~~ its survey team members, hospitals, and
25 health care systems to improve patient safety; and be it
26 further

27
28 RESOLVED, That our AMA work with other interested
29 parties, including state and medical specialty societies, the
30 American Hospital Association, National Patient Safety
31 Foundation and The Joint Commission to standardize
32 interpretation and enforcement of Joint Commission
33 medication reconciliation policies, based on pre-
34 established, uniform, specific, and consistently interpreted
35 criteria.

36
37
38 RECOMMENDATION B:

39
40 Mr. Speaker, your Reference Committee recommends that
41 Resolution 815 be adopted as amended.

42
43 RECOMMENDATION C:

44
45 Mr. Speaker, your Reference Committee recommends that
46 the title of Resolution 815 be changed to read as follows:
47

1 JOINT COMMISSION INTERPRETATIONS OF
2 MEDICATION RECONCILIATION AND OTHER
3 STANDARDS
4

5 **HOD ACTION: Resolution 815 adopted as amended with**
6 **change in title.**
7

8 Resolution 815 asks that our AMA advocate that medication reconciliation standards be
9 consistently interpreted by The Joint Commission survey team members, hospitals, and
10 health care systems to improve patient safety; and work with other interested parties,
11 including the American Hospital Association, National Patient Safety Foundation and
12 The Joint Commission to standardize interpretation and enforcement of Joint
13 Commission medication reconciliation policies, based on pre-established, uniform,
14 specific, and consistently interpreted criteria.
15

16 Your Reference Committee heard supportive testimony on this resolution, and was
17 pleased to learn from a Joint Commission representative that the Commission is already
18 taking steps to address the issues raised in this resolution. The Joint Commission
19 recently sponsored a Summit on Medication Reconciliation, which was an opportunity for
20 our AMA and other organizations to discuss concerns about the medication
21 reconciliation standard. In addition, the Commission is conducting targeted training with
22 its surveyors to help them understand and implement the medication reconciliation
23 standard more effectively. A member of the Board of Trustees noted that all delegates
24 received a copy of a new AMA publication, "Physician's Role in Medication
25 Reconciliation," which offers guiding principles related to the medication reconciliation
26 process. Your Reference Committee agrees with testimony that suggested that the first
27 Resolved be expanded to call for consistency in implementation of all Joint Commission
28 standards, and also that the second Resolved be amended to include the involvement of
29 interested state and medical specialty societies in pursuing this important patient safety
30 issue. Your Reference Committee encourages adoption of the amended resolution.
31

32
33 (14) RESOLUTION 817 - OPPOSE SALE OF TOBACCO
34 WHERE PATIENTS RECEIVE HEALTH CARE
35

36 RECOMMENDATION A:
37

38 Mr. Speaker, your Reference Committee recommends that
39 Policy H-495.986 be amended by insertion and deletion to
40 read as follows:
41

42 H-495.986 Tobacco Product Sales and Distribution

43 Our AMA: (1) encourages the passage of laws, ordinances and regulations that
44 would set the minimum age for purchasing tobacco products at 21 years, and
45 urges strict enforcement of laws prohibiting the sale of tobacco products to
46 minors; (2) supports the development of model legislation regarding
47 enforcement of laws restricting children's access to tobacco, including but not
48 limited to attention to the following issues: (a) provision for licensure to sell
49 tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties
50 (e.g., fines, prison terms, license revocation) to deter violation of laws restricting

1 children's access to and possession of tobacco; (c) requirements for merchants
2 to post notices warning minors against attempting to purchase tobacco and to
3 obtain proof of age for would-be purchasers; (d) measures to facilitate
4 enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f)
5 requiring tobacco purchasers and vendors to be of legal smoking age; (3)
6 requests that states adequately fund the enforcement of the laws related to
7 tobacco sales to minors; (4) opposes the use of vending machines to distribute
8 tobacco products and supports ordinances and legislation to ban the use of
9 vending machines for distribution of tobacco products; (5) seeks a ban on the
10 production, distribution, and sale of candy products that depict or resemble
11 tobacco products; (6) opposes the distribution of free tobacco products by any
12 means and supports the enactment of legislation prohibiting the disbursement of
13 samples of tobacco and tobacco products by mail; (7) (a) publicly commends
14 (and so urges local medical societies) pharmacies and pharmacy owners who
15 have chosen not to sell tobacco products, and asks its members to encourage
16 patients to seek out and patronize pharmacies that do not sell tobacco products;
17 (b) encourages other pharmacists and pharmacy owners individually and through
18 their professional associations to remove such products from their stores; (c)
19 urges the American Pharmacists Association, the National Association of Retail
20 Druggists, and other pharmaceutical associations to adopt a position calling for
21 their members to remove tobacco products from their stores; and (d) encourages
22 state medical associations to develop lists of pharmacies that have voluntarily
23 banned the sale of tobacco for distribution to their members; (8) opposes the sale
24 of tobacco at any facility where health services are provided; and (89) supports
25 that the sale of tobacco products be restricted to tobacco specialty stores. (CSA
26 Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07)

27
28
29 RECOMMENDATION B:

30
31 Mr. Speaker, your Reference Committee recommends that
32 Policy H-495.986 be adopted as amended in lieu of
33 Resolution 817.

34
35 **HOD ACTION: Policy H-495.986 adopted as amended in**
36 **lieu of Resolution 817.**

37
38 Resolution 817 asks that our AMA oppose the sale of tobacco at any facility where
39 health care is delivered or where prescriptions are filled.

40
41 Testimony noted the continuing epidemic of tobacco-related deaths and illness, and the
42 incongruities associated with healthcare facilities profiting from the sale of tobacco
43 products. Your Reference Committee recommends amending current AMA Policy on
44 the sale of tobacco products to address the issues raised in Resolution 817.

1 (15) RESOLUTION 804 - COMMUNICATION AND CLINICAL
2 TEACHING CURRICULA

3
4 RECOMMENDATION:

5
6 Mr. Speaker, your Reference Committee recommends that
7 Resolution 804 be referred.

8
9 **HOD ACTION: Resolution 804 referred.**

10
11 Resolution 804 asks that our AMA establish policy supporting the development of
12 formalized medical teacher training for residents and attending faculty; explore the
13 feasibility of the Accreditation Council for Graduate Medical Education defining formal
14 requirements regarding the clinical teaching qualifications for faculty attending
15 physicians and residents; and work closely with appropriate organizations, including the
16 Alliance for Clinical Education, to establish a common framework for a formal medical
17 teaching training program for residents and attending faculty.

18
19 Your Reference Committee heard extensive testimony on this resolution. Speakers
20 were sympathetic to the importance of ensuring that medical students have a valuable
21 and positive educational experience, but most expressed significant concerns regarding
22 the potential burden that would be placed on residents, faculty and volunteer faculty if
23 the recommendations in the resolution were adopted. The sponsors of the resolution
24 acknowledged that their intent was to enhance the educational experience, rather than
25 impede it, and agreed with several other speakers that referral of the issue would be
26 appropriate so that the Board would have the opportunity to carefully consider the best
27 way to address the intent of the resolution. Accordingly, the Reference Committee
28 recommends referral.

29
30
31 (16) RESOLUTION 821 - RESIDENCY PROGRAM AT-HOME
32 CALL CRITERIA
33 RESOLUTION 825 – MONITORING OF AT-HOME CALL
34 IMPLEMENTATION BY RESIDENCY PROGRAMS

35
36 RECOMMENDATION:

37
38 Mr. Speaker, your Reference Committee recommends that
39 Resolutions 821 and 825 be referred.

40
41 **HOD ACTION: Resolutions 821 and 825 referred.**

42
43 Resolution 821 asks that our AMA urge the Accreditation Council for Graduate Medical
44 Education (ACGME) to collect additional evidence on the number of residency programs
45 nationwide that have changed prior in-house call rotations to at-home call since July
46 2003; and urge the ACGME to study, develop, and implement criteria under which a
47 residency program can establish at-home call, or change a prior in-house call rotation to
48 at-home call.

49

1 Resolution 825 asks that our AMA oppose the use of at-home call if being used to
2 circumvent the intent of current ACGME duty hour restrictions, and work with the
3 ACGME and other interested organizations to collect additional information on how
4 residency programs nationwide are using at-home call rotations; study the impact of at-
5 home call on resident well-being, sleep patterns, and patient safety, commenting on
6 issues such as, but not limited to, total hours worked, number of pages and phone calls
7 received, and hours of continuous sleep; and study and develop best practices for
8 implementing at-home call, in residency and fellowship programs.

9
10 There was mixed testimony on these resolutions, with several speakers noting that at-
11 home call practices vary among specialties, and it would be important to study the issue
12 on a specialty by specialty basis. In addition, there was concern that the first Resolved
13 of Resolution 825 could be inflammatory, although speakers agreed that it is important to
14 consider at-home call practices in the context of overall work-hour limits. Your
15 Reference Committee agrees with testimony indicating that the issue of at-home call
16 merits careful study, and recommends that these resolutions be referred.

17
18 (17) RESOLUTION 813 - IMPROVING MEDICAL PRACTICE
19 AND PATIENT/FAMILY EDUCATION TO REVERSE THE
20 EPIDEMIC OF PRESCRIPTION DRUG MISUSE AND
21 ADDICTION

22
23 RECOMMENDATION:

24
25 Mr. Speaker, your Reference Committee recommends that
26 Resolution 813 be referred.

27
28 **HOD ACTION: Resolution 813 referred.**

29
30 Resolution 813 asks that our AMA collaborate with the American Academy of Pain
31 Medicine, the American Society of Addiction Medicine, the American Psychiatric Association,
32 the American College of Emergency Medicine, and others, to develop continuing medical
33 education curricula aimed at reducing the epidemic of misuse of and addiction to controlled
34 substances, especially by youth; encourage the Accreditation Council for Graduate Medical
35 Education and the American Association of Medical Colleges to incorporate appropriate
36 curricula into graduate and undergraduate medical education aimed at minimizing the
37 incidence of unauthorized/non-medical use of opioids, opioid receptor agonists,
38 benzodiazepines, and benzodiazepine receptor agonists; encourage medical specialty
39 societies to develop practice guidelines and performance measures that would increase the
40 likelihood of safe medical practice and targeted patient education around topics such as:

- 41 a. any practitioner writing a prescription for an opioid, an opioid receptor agonist, a
42 benzodiazepine, or a benzodiazepine receptor agonist would document that they have
43 screened for addiction before writing a prescription, by asking simple questions such as
44 "Have you ever had a problem with or received treatment for addiction to or withdrawal
45 from alcohol or other drugs?" or "Do you have a family history of alcohol or other drug
46 addiction?";
- 47 b. any practitioner writing a prescription for an opioid, an opioid receptor agonist, a
48 benzodiazepine, or a benzodiazepine receptor agonist would document that they have
49 educated their patient that there is the potential for the development of tolerance,
50 withdrawal, or addiction with the use of the therapeutic agent;

- 1 c. any practitioner writing a prescription for an opioid, an opioid receptor agonist, a
2 benzodiazepine, or a benzodiazepine receptor agonist would document that they have
3 educated their patient about the risk of youth or others diverting to their own use left-over
4 supplies of the therapeutic agent;
- 5 d. any practitioner writing a prescription for an opioid, an opioid receptor agonist, a
6 benzodiazepine, or a benzodiazepine receptor agonist would document that they have
7 advised their patient to protect controlled substances supplies from unintended use by
8 others, such as by using lock boxes or medicine cabinet locks akin to the way many
9 persons use kitchen or bathroom cabinet locks to prevent unintentional or otherwise
10 harmful use of home solvents or cleansers by infants or teens;
- 11 e. any practitioner writing a prescription for an opioid, an opioid receptor agonist, a
12 benzodiazepine, or a benzodiazepine receptor agonist would document that they have
13 educated their patient to protect controlled substances supplies from unintended use by
14 others, such as by advising the patient to safely dispose of any unused supplies rather
15 than keeping them in the home as an unwitting supply of agents for use by teenagers;
- 16 f. any practitioner writing prescriptions for an opioid, an opioid receptor agonist, a
17 benzodiazepine, or a benzodiazepine receptor agonist for medium-to-long term plans
18 of care, document their intended strategy for safe and effective opioid or sedative-
19 hypnotic discontinuation when the need for further medical treatment with such an
20 agonist is no longer present; and collaborate with the federal Centers for Substance
21 Abuse Prevention and Substance Abuse Treatment to develop any reasonable and
22 prospectively-effective strategy to actively involve physicians as being “a part of the
23 solution” to the epidemic of unauthorized/non-medical use of controlled substances.
24

25 The sponsor noted recent trends indicating an increase in the diversion and non-medical
26 use of prescription drugs, and an attendant increase in patients suffering from substance
27 use disorders, including dependence. This resolution attempts to focus renewed
28 attention on these problems and create corrective actions, including educational efforts
29 and the development of practice guidelines or performance measures with specific
30 attributes. Considerable testimony was offered in frank opposition to the resolution as
31 written. Several speakers sought referral, recognizing the important public health
32 implications of drug diversion, inappropriate prescribing, and non-medical prescription
33 drug use. Many who opposed the resolution were particularly concerned about the
34 prescriptive nature of the third Resolved, and the potential for impeding physician
35 performance. The Council on Science and Public Health offered amended language for
36 the third resolve that would eliminate many of these concerns and some sentiment was
37 offered in support of this approach. Other speakers noted that implementing this
38 Resolved as written would erect barriers to appropriate pain management or would not
39 be clinically relevant in many common situations. Still others reinforced the serious and
40 real nature of the issues raised by this resolution, and the need for the physician
41 community to directly address them or face more government oversight. Your
42 Reference Committee appreciates the need for the physician community to address the
43 issues raised in Resolution 813 and recommends referral to allow careful consideration
44 of the subject.
45

1 (18) RESOLUTION 824 - TIME LIMITED LICENSE
2 RECIPROCITY IN TIMES OF DISASTER
3

4 RECOMMENDATION:
5

6 Mr. Speaker, your Reference Committee recommends that
7 Resolution 824 be referred.
8

9 **HOD ACTION: Resolution 824 referred.**

10
11 Resolution 824 asks that our AMA support time limited interstate license reciprocity in
12 times of disaster so that volunteer physicians can be quickly mobilized to disaster areas
13 where state or federal emergency management agencies determine a need, and lobby
14 members of Congress for policies related to time limited interstate license reciprocity to
15 aid disaster victims during times of disaster where state or federal emergency
16 management agencies determine a need.
17

18 Testimony on Resolution 824 was mixed. Speakers generally agreed with the objective
19 of enabling physicians to respond swiftly to disasters. Some speakers provided
20 accounts of physicians who were not permitted to provide medical care in disaster areas
21 outside of the state or states in which they were licensed, though there was
22 disagreement about whether the wording of Resolution 824 would succeed in remedying
23 this problem. Other testimony maintained that existing regulations and procedures
24 already allow effective and appropriate license reciprocity in times of disaster. A
25 member of the Board of Trustees testified that our AMA already has extensive policy and
26 activity in the area of disaster preparedness, most notably the AMA Center for Public
27 Health Preparedness and Disaster Response which, in partnership with the Centers for
28 Disease Control and Prevention, has sponsored two National Congresses on Health
29 System Readiness. Based on the testimony presented, your Reference Committee
30 recommends referral to best assess the need to remove barriers facing physicians
31 attempting to provide medical assistance in disaster areas, and if so, the best means of
32 meeting this objective.
33

34 (19) RESOLUTION 816 - TIERING SYSTEM FOR THIRD
35 PARTY PAYERS
36

37 RECOMMENDATION:
38

39 Mr. Speaker, your Reference Committee recommends that
40 Resolution 816 be referred.
41

42 **HOD ACTION: Resolution 816 referred.**

43
44 Resolution 816 asks that our AMA develop a mechanism, for use by state medical
45 associations, to tier third party payers on value and performance. This information
46 should then be made available to individual and group purchasers of health care
47 coverage as a way to promote transparency and informed decision making in the
48 purchase of health insurance.
49

1 Your Reference Committee heard mixed testimony on Resolution 816. There was
2 general agreement that standardized evaluation of insurance company performance
3 would be of benefit to patients and physicians. Some speakers raised concerns about
4 the feasibility of evaluating insurers, and about the best methodology for doing so. One
5 speaker testified that the Massachusetts Medical Society has hired an independent
6 organization to evaluate health plans according to eleven principles that they have
7 developed. A substantial portion of testimony reflected frustration over the distinct but
8 related issue of insurer evaluation of physicians. Two speakers submitted background
9 materials on efforts in their states to establish fair standards of accuracy, disclosure, and
10 transparency of physician ranking programs, and another speaker proposed an
11 additional Resolved addressing oversight of physician profiling programs. Several
12 speakers testified that the title of the Resolution created confusion and recommended
13 use of the word “rating” rather than “tiering” when referring to evaluation of insurers.
14 Your Reference Committee notes that our AMA already has extensive policy on the
15 assessment of both insurer and physician performance, including Policies D-180.984, H-
16 450.961, D-450.985, H-185.979, and H-180.961. In fulfillment of D-180.984, adopted at
17 I-06, the AMA Private Sector Advocacy (PSA) unit is in the process of developing a tool
18 designed to assess the value and quality of health insurance companies, using input
19 from state medical associations, physician billing services and other groups. Given the
20 initiative already underway to develop an insurer assessment tool, your Reference
21 Committee believes that referral of Resolution 816 would enable AMA advocacy in this
22 area to be conducted in a coordinated fashion.

23
24 (20) RESOLUTION 826 - CONFIDENTIALITY OF MEDICAL
25 STAFF MEMBERS' PERSONAL PROPRIETARY
26 FINANCIAL INFORMATION

27
28 RECOMMENDATION:

29
30 Mr. Speaker, your Reference Committee recommends that
31 Resolution 826 be referred for decision.

32
33 **HOD ACTION: Resolution 826 referred for decision.**

34
35 Resolution 826 asks that our AMA urge its AMA Commissioners to The Joint
36 Commission to seek to add a standard to The Joint Commission Hospital Accreditation
37 Standards requiring that medical staff members' personal proprietary financial
38 information remain confidential, except for disclosure to those with a bona fide need for
39 access to such information (e.g., hospitals normally require disclosure of such
40 information before a physician is selected as a department chair or to serve on the
41 hospital's board of trustees) and be appropriately secured electronically; seek inclusion
42 of provisions requiring confidentiality and secure electronic storage of medical staff
43 members' personal proprietary information in the Medicare Conditions of Participation;
44 and develop model state and federal legislation and regulations that would require the
45 confidentiality and secure electronic storage of medical staff members' personal
46 proprietary information.

47
48 Your Reference Committee heard testimony in support of the intent of this resolution,
49 and several speakers acknowledged that the use and protection of physician proprietary
50 financial information is an important issue that should be addressed. However, there

1 was a sense that, because of its complexity, the issue ought to be considered more
2 thoroughly before a decision was made on the specific actions recommended in the
3 resolution.

4
5 (21) RESOLUTION 818 - HEALTH INFORMATION
6 TECHNOLOGY

7
8 RECOMMENDATION:

9
10 Mr. Speaker, your Reference Committee recommends that
11 Policies D-478.994, D-478.996, D-478.995, H-315.989 and
12 H-470.971 be reaffirmed in lieu of Resolution 818.

13
14 **HOD ACTION: Policies D-478.994, D-478.996, D-478.995, H-**
15 **315.989 and H-470.971 reaffirmed in lieu of Resolution 818.**

16
17 Resolution 818 asks that our AMA support existing state and federal measures directed
18 at promoting health information technology, with an emphasis on implementation being
19 technology neutral; and support regulations that promote stronger standardized security
20 measures such as encryption of data at rest.

21
22 Testimony on Resolution 818 was limited to a single speaker who expressed concern
23 that supporting legislation related to health information technology (HIT) promotion can
24 be an ineffective way to address HIT issues, since legislation often lags far behind the
25 rapidly changing HIT landscape. The Reference Committee notes that our AMA already
26 has several policies that address the issues in Resolution 818:

27
28 D-478.994 Health Information Technology

29 Our AMA will: (1) support legislation and other appropriate initiatives that provide
30 positive incentives for physicians to acquire health information technology (HIT);
31 (2) pursue legislative and regulatory changes to obtain an exception to any and
32 all laws that would otherwise prohibit financial assistance to physicians
33 purchasing HIT; and (3) support initiatives to ensure interoperability among all
34 HIT systems. (Res. 723, A-05; Reaffirmation A-07)

35
36 D-478.996 Information Technology Standards and Costs

37 Our AMA will: (1) encourage the setting of standards for health care information
38 technology whereby the different products will be interoperable and able to
39 retrieve and share data for the identified important functions while allowing the
40 software companies to develop competitive systems; (2) work with Congress and
41 insurance companies to appropriately align incentives as part of the development
42 of a National Health Information Infrastructure (NHII), so that the financial burden
43 on physicians is not disproportionate when they implement these technologies in
44 their offices; (3) review the following issues when participating in or commenting
45 on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b)
46 security of electronic records; and (c) the standardization of electronic systems;
47 (4) continue to advocate for and support initiatives that minimize the financial
48 burden to physician practices of adopting and maintaining electronic medical
49 records; and (5) continue its active involvement in efforts to define and promote
50 standards that will facilitate the interoperability of health information technology

1 systems. (Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06;
2 Reaffirmation A-07)

3
4 D-478.995 National Health Information Technology

5 Our AMA will closely coordinate with the newly formed Office of the National
6 Health Information Technology Coordinator all efforts necessary to expedite the
7 implementation of an interoperable health information technology infrastructure,
8 while minimizing the financial burden to the physician and maintaining the art of
9 medicine without compromising patient care. (Res. 730, I-04)

10
11 H-315.989 Confidentiality of Computerized Patient Records

12 The AMA will continue its leadership in protecting the confidentiality, integrity,
13 and security of patient-specific data; and will continue working to ensure that
14 computer-based patient record systems and networks, and the legislation and
15 regulations governing their use, include adequate technical and legal safeguards
16 for protecting the confidentiality, integrity, and security of patient data. (BOT Rep.
17 F, A-93; Reaffirmation I-99; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT
18 Rep. 19, A-07)

19
20 H-480.971 The Computer-Based Patient Record

21 The following steps will allow the AMA to act as a source of physician input to the
22 revolutionary developments in computer-based medical information applications,
23 as a coordinator, and as an educational resource for physicians. The AMA will:
24 (1) Provide leadership on these absolutely critical and rapidly accelerating issues
25 and activities. (2) Work, in cooperation with state and specialty associations, to
26 bring computer education and information to physicians. (3) Work to define the
27 characteristics of an optimal medical record system; the goal being to define the
28 content, format and functionality of medical record systems, and aid physicians in
29 evaluating systems for office practice computerization. (4) Focus on the CPR
30 aspect of human-computer interaction (the physician data input step) and work
31 with software vendors on the design of facile interfaces. (5) Provide guidance on
32 the use of computer diagnosis and therapeutic support systems. (6) Continue to
33 be involved in national forums on issues of electronic medical data control,
34 access, security, and confidentiality. (7) Continue to work to ensure that issues of
35 patient confidentiality and security of data are continually addressed with
36 implementation resolved prior to the implementation and use of a computer-
37 based patient record. (BOT Rep. 29, A-96; Reaffirmation A-04)

38
39 Your Reference Committee believes that these five policies address the intent of
40 Resolution 818, and recommend that they be reaffirmed in lieu of this resolution.

41
42
43 (22) RESOLUTION 823 - CONSTITUTIONAL BASIS FOR
44 ADVOCACY

45
46 RECOMMENDATION:

47
48 Mr. Speaker, your Reference Committee recommends that
49 Policy H-5.989 be reaffirmed in lieu of Resolution 823.

50

1 **HOD ACTION: Policy H-5.989 reaffirmed in lieu of**
2 **Resolution 823.**
3

4 Resolution 823 asks that our AMA take all appropriate measures to enable and
5 encourage open physician communications about quality of patient care and the
6 economic conditions under which physicians practice in order to align clinical with
7 financial interests within health care service delivery system.
8

9 Your Reference Committee heard mixed testimony on this item. In introductory
10 testimony, the sponsor elaborated on the intent of Resolution 823, which is to rectify the
11 impingement on physicians' rights to openly communicate in order to serve the best
12 interests of patients. The preponderance of testimony supported the sentiment of the
13 resolution but expressed concern that the resolution was unclear as written. Your
14 Reference Committee identified existing policy that seems to capture the intent of
15 Resolution 823, and, accordingly, recommends reaffirmation of the following policy in
16 lieu of adoption of the resolution:
17

18 H-5.989 Freedom of Communication Between Physicians and Patients. It is the
19 policy of the AMA: (1) to strongly condemn any interference by the government
20 or other third parties that causes a physician to compromise his or her medical
21 judgment as to what information or treatment is in the best interest of the patient;
22 (2) working with other organizations as appropriate, to vigorously pursue
23 legislative relief from regulations or statutes that prevent physicians from freely
24 discussing with or providing information to patients about medical care and
25 procedures or which interfere with the physician-patient relationship; (3) to
26 communicate to HHS its continued opposition to any regulation that proposes
27 restrictions on physician-patient communications; and (4) to inform the American
28 public as to the dangers inherent in regulations or statutes restricting
29 communication between physicians and their patients. (Sub. Res. 213, A-91;
30 Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96;
31 Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res.
32 203 and 707, A-98; Reaffirmed: Res. 703, A-00)

1 Mr. Speaker, this concludes the report of Reference Committee K. I would like to thank
2 Robyn F. Chatman, MD, Virgil H. Crowder, Jr., MD, Willarda Virginia Edwards, MD,
3 Hillary D. Johnson, MD, PhD, John D. Longwell, Jr., MD, Nancy L. Mueller, MD, and all
4 those who testified before the Committee.

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