

REPORTS OF THE BOARD OF TRUSTEES

The following reports, 1–10, were presented by Steven J. Stack, MD, Chair:

1. SPECIALTY SOCIETY REPRESENTATION REQUIREMENTS

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

See Policies [G-600.020](#) and [G-600.022](#).

At the 2012 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted policy D-600.959 Specialty Society Representation in the House of Delegates – Five-Year Review and policy D-600.984 Specialty Organizations Seated in our AMA House of Delegates. The five-year review included 17 national medical specialty organizations and one professional interest medical association and recommended:

That the Academy of Physicians in Clinical Research, American Medical Directors Association, American Society for Reproductive Medicine, American Society of Bariatric Physicians, American Society of General Surgeons, American Society of Neuroradiology, American Thoracic Society, College of American Pathologists, Congress of Neurological Surgeons, Contact Lens Association of Ophthalmologists, International College of Surgeons – US Section, Renal Physicians Association, Society for Investigative Dermatology, Inc., Society for Medical Consultants to the Armed Forces, Society of Interventional Radiology and the United States and Canadian Academy of Pathology retain representation in the American Medical Association House of Delegates.

That the American Pediatric Surgical Association and the Korean American Medical Association representation in the HOD be terminated at the conclusion of the 2012 Annual Meeting.

That the BOT undertake a study of membership requirements with respect to the five-year review process given a declining membership in the organization.

This report discusses the current membership requirements for national medical specialty organizations and professional interest medical associations and makes recommendations regarding those requirements including adjusting the requirements for professional interest medical associations represented in the HOD to be the same as those of national medical specialty organizations.

AMA POLICY

Policy G-600.020 establishes criteria for specialty society representation in the AMA House of Delegates, which, among other requirements, provides that a society must meet one of the following criteria related to AMA membership:

- (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
- (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty-five percent (25%) of its physician members who are eligible for AMA membership are members of the AMA;
or
- (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty-five percent (25%) of its physician members who are eligible for AMA membership are members of the AMA.

At the AMA's 2008 Interim Meeting, the membership requirement for national medical specialty societies was adjusted from thirty-five percent (35%) to twenty-five percent (25%) and a minimum of 250 members to a minimum of 100 members. Professional interest medical associations must meet the same requirements for admission to the

HOD with the exception of the membership numbers; that requirement remained at thirty-five percent (35%) and a minimum of 250 members. The BOT recognizes that these are different types of organizations but believes the membership requirements should be the same.

AMA Bylaws establish responsibilities for the process of the five-year review and provide direction should a society not be compliant. If the specialty organization or the professional interest medical association is found to be noncompliant with the current Guidelines for Representation in the HOD, or the responsibilities under Section 8.5 of these Bylaws, the House may take one of the following actions:

B-8.5521 The House of Delegates may continue the representation of the specialty organization or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Section 8.551.

B-8.5522 The House of Delegates may terminate the representation of the specialty organization or the professional interest medical association in the House of Delegates. The specialty organization or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty organization or the professional interest medical association may apply for reinstatement in the AMA House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

DISCUSSION

The discussions at the AMA's 2012 Annual Meeting regarding the five-year review highlighted two factors related to specialty society representation requirement. First, while the will of the HOD is to be inclusive, there was a consensus that there should be a membership threshold for organizations to be seated in the HOD. Second, if an organization can demonstrate that it has made every effort to comply, then it should be allowed to remain in the HOD.

The majority of testimony regarding the organizations slated to lose their representation was in favor of allowing them to remain in the HOD. While the organizations did not meet the membership requirement, they all demonstrated that they had met the other requirements and responsibilities of organizations represented in the HOD, including working with the AMA to increase AMA membership. AMA Bylaws, as referenced earlier, provide the HOD with the option to continue the representation of the specialty organization or the professional interest medical association in the HOD, if after a year of probation the organization still fails to meet the membership requirement. In fact, history has demonstrated that when faced with the possibility of eliminating organizations, the HOD has opted to retain the organizations as long as they have been able to demonstrate that they have made efforts to recruit for AMA membership.

Additional testimony was presented that the current membership requirements should be examined to determine if the membership requirement is an appropriate threshold. Testimony was provided indicating that AMA membership is declining, and, thus the requirement should be lowered. Contrary to the testimony, AMA membership increased in 2011 and year-to-date results indicate an expected increase in 2012. Decreasing the requirement, or lowering the bar, is counter-productive to promoting membership growth. A lower threshold does not support the membership recruitment responsibilities of national medical specialty organizations and professional interest medical associations as outlined in the AMA Bylaws.

The Board believes a threshold of twenty-five percent (25%) AMA membership is a reasonable expectation for national medical specialty organizations and professional interest medical associations to meet. Furthermore, the Board strongly supports the responsibility of national medical specialty organizations to cooperate with the AMA to increase their AMA membership. Several organizations have demonstrated that achieving the needed membership numbers is attainable when these organizations work closely with the AMA membership staff and make every effort to recruit AMA members. Moreover, when the effort has been made and the numbers have not been achieved, the HOD has recognized the effort with continued representation.

The BOT thinks the following recommendations will provide membership requirements that are reflective of the national membership environment.

RECOMMENDATION

The Board of Trustees believes that the current requirements for national medical specialty society representation in the House of Delegates remain appropriate, and recommends the following be adopted to make the requirements for national medical specialty societies and professional interest medical associations consistent, and the remainder of the report be filed:

That American Medical Association Policy G-600.022 [1c] be amended by addition and deletion to read as follows:

(i) the organization must demonstrate that it has 1,000 or more AMA members; or (ii) the organization must demonstrate that it has a minimum of ~~250~~ 100 AMA members and that ~~thirty-five percent (35%)~~ twenty percent (20%) of its physician members who are eligible for AMA membership are members of our AMA; or (iii) that the organization was represented in the House of Delegates at the 1990 Annual Meeting and that ~~thirty-five percent (35%)~~ twenty percent (20%) of its physician members who are eligible for AMA membership are members of our AMA.

That American Medical Association Policy G-600.020 [3] be amended by addition and deletion to read as follows:

(3) The organization must meet one of the following criteria: (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that ~~twenty-five percent (25%)~~ twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that ~~twenty-five percent (25%)~~ twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA;

APPENDIX

B-8.20 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations.

Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.20 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

8.201 To cooperate with the AMA in increasing its AMA membership.

8.202 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.

8.203 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.

8.204 To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.

8.205 To provide information and data to the AMA when requested.

B-8.50 Periodic Review Process.

Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.50 Periodic Review Process. Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.20. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society or the professional interest medical association has discharged the responsibilities required under Bylaw 8.20.

8.51 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the

representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting, or may take such other action as it deems appropriate.

8.52 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.20, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.53 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.20 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period. 8.531 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.20, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.532 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.20, the House may take one of the following actions: 8.5321 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.531.

8.5322 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

G-600.020 Admission of Specialty Organizations to our AMA House

The following guidelines shall be utilized in evaluating specialty society applications for representation in our AMA House of Delegates (new specialty organization applications will be considered only at Annual Meetings of the House of Delegates):

- 1) The organization must not be in conflict with the Constitution and Bylaws of our AMA with regard to discrimination in membership;
- 2) The organization must:
 - a) represent a field of medicine that has recognized scientific validity;
 - b) not have board certification as its primary focus; and
 - c) not require membership in the specialty organization as a requisite for board certification;
- 3) The organization must meet one of the following criteria:
 - a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty-five percent (25%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty-five percent (25%) of its physician members who are eligible for AMA membership are members of the AMA;
- 4) The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application;
- 5) Physicians should comprise the majority of the voting membership of the organization.
- 6) The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office;
- 7) The organization must be active within its field of medicine and hold at least one meeting of its members per year;
- 8) The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states;
- 9) The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization;
- 10) If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

G-600.022 Admission of Professional Interest Medical Associations to our AMA House

- 1) Professional Interest Medical Associations (PIMAs) are organizations that relate to physicians along dimensions that are primarily ethnic, cultural, demographic, minority, etc., and are neither state associations nor specialty societies. The following guidelines will be utilized in evaluating PIMA applications for representation in our AMA House of Delegates (new applications will be considered only at Annual Meetings of the House of Delegates):
 - a) the organization must not be in conflict with the Constitution and Bylaws of our AMA;

- b) the organization must demonstrate that it represents and serves a professional interest of physicians that is relevant to our AMA's purpose and vision and that the organization has a multifaceted agenda (i.e., is not a single-issue association);
 - c) the organization must meet one of the following criteria:
 - i) the organization must demonstrate that it has 1,000 or more AMA members; or
 - ii) the organization must demonstrate that it has a minimum of 250 AMA members and that thirty-five percent (35%) of its physician members who are eligible for AMA membership are members of our AMA; or
 - iii) that the organization was represented in the House of Delegates at the 1990 Annual Meeting and that thirty-five percent (35%) of its physician members who are eligible for AMA membership are members of our AMA;
 - d) the organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application;
 - e) physicians should comprise the majority of the voting membership of the organization;
 - f) the organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office;
 - g) the organization must be active within the profession, and hold at least one meeting of its members per year;
 - h) the organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states;
 - i) the organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization; and
 - j) if international, the organization must have a US branch or chapter, and this chapter must meet the above guidelines.
- 2) The process by which PIMAs seek admission to the House of Delegates includes the following steps:
- a) a PIMA will first apply for membership in the Specialty and Service Society (SSS);
 - b) using specific criteria, SSS will evaluate the application of the PIMA and, if the organization meets the criteria, will admit the organization into SSS;
 - c) after three years of participation in SSS, a PIMA may apply for representation in our AMA House of Delegates;
 - d) SSS will evaluate the application of the PIMA, determine if the association meets the criteria for representation in our AMA House of Delegates, and send its recommendation to our AMA Board of Trustees;
 - e) the Board of Trustees will recommend to the House how the application of the PIMA should be handled;
 - f) the House will determine whether or not to seat the PIMA; and
 - g) if the application of a PIMA for a seat in the House is rejected, the association can continue to participate in SSS as long as it continues to meet the criteria for participation in SSS. (CLRPD Rep. 1, A-99; Modified: CLRPD Rep. 3, A-00; Consolidated: CLRPD Rep. 3, I-01; Reaffirmed: CC&B Rep. 2, A-11)

2. SURVEYING VIOLENCE IN THE NON-HOSPITAL WORK ENVIRONMENT

Reference committee hearing: see report of [Reference Committee B](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

See Policies [H-515.966](#) and [H-515.982](#).

INTRODUCTION

At the American Medical Association (AMA) Annual Meeting in 2011, Policy D-515.918, "Surveying Violence in the Non-Hospital Work Environment," was adopted and states that:

Our AMA will survey its membership regarding violence and threats directed toward physicians and health care personnel in the non-hospital work environment, and a report will be ready for the 2012 Interim Meeting with suggested solutions including advocating for legislative action to help protect patients, health care personnel, and physicians from violent and threatening work environments.

Previous reports have been developed by the Council on Science and Public Health in 2010 and the Young Physicians Section in 1995 on the topic of workplace violence in the Emergency Department (ED). In this report, the American Medical Association (AMA) Board of Trustees specifically examines the problem of workplace violence against health care providers in the non-hospital setting. Notably, this report uses the term "assault" to indicate both criminal assaults and criminal batteries, as the terms are not used consistently amongst the states.

METHODS

Research was conducted with information coming from state criminal statutes, state labor statutes, state labor regulations, as well as materials from the Occupational Safety and Health Administration (OSHA), the Emergency Nurses Association (ENA) and the American Nurses Association (ANA). This information was analyzed in conjunction with AMA survey data, as well as information received from a survey conducted of state medical societies.

AMA POLICY STATEMENTS

At the 2011 AMA Annual Meeting, testimony on AMA Policy D-515.918 noted above was limited. Supporters of the underlying resolution highlighted an increased incidence of threats directed toward physicians and health care personnel.

In addition, there is relevant AMA policy on the matter to be considered in any future recommendations:

H-515.966 Violence and Abuse Prevention in the Healthcare Workplace

Our AMA encourages all healthcare facilities to adopt policies to reduce and prevent workplace violence and abuse and to develop policies to manage reported occurrences of workplace violence and abuse. (Res. 424, I-98; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09)

H-515.982 Violent Acts Against Physicians

Our AMA (1) condemns acts of violence against physicians involved in the legal practice of medicine; and (2) will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians as a result of the physician's acting in a professional capacity. (Res. 605, A-92; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09)

SURVEY OF MEMBER PHYSICIANS

Survey Description

A brief electronic survey was emailed to all practicing patient-care member physicians on the opt-in list (35,548). Permission was granted by the Emergency Nurses Association to modify the survey questions used in a recent survey. The subject line of the email was "Survey on Workplace Violence."

Screening questions at the beginning of the survey were used to ensure that only practicing physicians that work at least part-time in one of the following practice settings were surveyed:

- Physician's office, solo practice;
- Physician's office, single specialty group practice;
- Multi-specialty group practice or clinic;
- Skilled nursing facility;
- Hospice; or
- Urgent care facility.

The initial invitation was sent on June 28, a reminder was sent was sent July 5, and the survey closed July 13. Responses were obtained from 857 member physicians.

The physicians who responded are likely to be concerned about and/or have experienced workplace violence. Thus, the results cannot be interpreted as representative of the entire population of non-hospital based member physicians. Nevertheless, they are informative.

Incidence and Types of Violence

Twelve percent of the survey respondents reported that they were the victim of at least one incident of workplace violence in the past eighteen months; five percent were victims more than once in the past 18 months. More than two-thirds of the total incidents were categorized as verbal (70%), rather than emotional (19%) or physical (11%).

Most commonly, the violent offender was a patient (74%) rather than a co-worker (14%), visitor (1%), or other (11%). In 57 percent of the incidents, the causal factor was related to a patient's care rather than billing/payment (11%) or other (32%) issues.

Twenty-nine percent of the respondents witnessed or heard of a co-worker, colleague or employee victimized by violence in the workplace in the past eighteen months. Over two-thirds of these incidents were categorized as verbal (68%), rather than physical (22%), or emotional (10%). Most commonly, the violent offender was a patient (57%), rather than a co-worker (25%), visitor (9%), or other (9%). In 49 percent of the incidents, the causal factor was related to a patient's care rather than billing/payment (13%) or other (38%) issues.

Members' Stories about Workplace Violence

Respondents who had experienced or witnessed workplace violence were asked to describe the instances. Some representative descriptions are presented below.

- Patient who was threatening because he did not receive what he wanted, a narcotic prescription that was not medically necessary.
- Recently a patient came in for an appointment and he was saying mean and offensive things to other patients in the waiting room. We tried to redirect him and talk to him and he started verbally assaulting myself and the staff. We ended up calling the police to remove him from the facility.
- Patient became verbally abusive after being discharged from the practice.
- Another patient was verbally inappropriate, frustrated that physicians including myself, were not prescribing him pain medication.
- Angry patient threatening to harm me and even calling back to threaten me and my staff.
- Patient screaming, cursing and threatening. Police called. I had to restrain him until police arrived.

Opinions About Employee Safety from Workplace Violence

Eighty-two percent of respondents rated their practice as safe from workplace violence, while only three percent rated the workplace as not safe. Sixty-nine percent of respondents were satisfied with the safeguards and rules put into place for employee safety from workplace violence, while seven percent were not satisfied.

Over three-quarters of respondents (78%) felt that workplace violence stayed the same over the past 18 months; 17 percent felt it increased and 5 percent felt it decreased.

Twenty percent of the respondents indicated their practice has mandatory training courses on workplace violence and diffusion, and another 13 percent have voluntary training courses available in their practice.

EXISTING WORKPLACE VIOLENCE LAWS

State and Federal Laws to Protect Physicians in the Workplace

The Occupational Health and Safety Administration (OSHA) provides overall guidelines to states to ensure a safe working environment. OSHA provides additional recommendations for health care facilities, recognizing the additional risks that health care workers face. These recommendations include engineering controls to minimize unnecessary contact between health care workers and potentially violent individuals, administrative changes including increased staffing to reduce the chances of an assault, and additional training for health care workers in violence prevention. While not all the guidelines are applicable to the non-hospital environment, the full OSHA guidelines are available at: www.osha.gov/Publications/OSHA3148/osh3148.html.

Under OSHA's General Duty Clause, Section 5(a)(1), employers are required to provide their employees with a place of employment that "is free from recognizable hazards that are causing or likely to cause death or serious harm to employees." Courts have interpreted OSHA's general duty clause to mean that an employer has a legal obligation to provide a workplace free of conditions or activities that either the employer or industry recognizes as hazardous and that cause, or are likely to cause, death or serious physical harm to employees when there is a feasible method to abate the hazard.

An employer that has experienced acts of workplace violence, or becomes aware of threats, intimidation, or other indicators showing that the potential for violence in the workplace exists, would be on notice of the risk of workplace violence and should implement a workplace violence prevention program. Violations of OSHA's general duty clause result in employer fines.

OSHA recommendations do not however, address criminal penalties for when a physician is attacked in the workplace. Rather, criminal laws are administered at the state level and the majority of states have some kind of enhanced criminal penalty for assaults that occur when the victim is a health care provider. The enhanced penalty is not applied uniformly to all health care providers and depends on whether or not the provider is a physician or a non-physician, as well as whether the provider is rendering care in an emergency or a non-emergency setting.

Existing Workplace Protections on a State Level

Most states have implemented the OSHA guidelines generally, with health care facilities that employ the minimum number of employees being included within those employers that have to follow workplace safety plans. In many cases, this does not include physicians' private offices, as they employ too few employees and there is comparatively less risk of violence to health care workers.

A small number of states that has adopted workplace safety rules specific to hospitals, non-hospital health care facilities, and other health care entities licensed by the state. Six states (CA, IL, NJ, NY, OR and WA) have all adopted labor statutes requiring that hospitals and non-hospital health care facilities adopt workplace safety plans. Those non-hospital health care facilities that must develop workplace safety plans specific to the risks of the health care field include nursing homes, home health and home care agencies, hospice and ambulatory surgery centers. All but California either implicitly or explicitly exclude "other health care entities," which is how physicians in private practice are generally defined, from those health care workplaces that need to develop a workplace safety plan.

Existing Criminal Laws on a State Level

Most states' worker protection statutes focus on the emergency room setting, with some states extending penalties to attacks committed against providers in psychiatric wings or other locations where violence is more likely. Some state laws provide for higher penalties for assault of health care personal-- specifically including nurses and non-physician emergency medical personnel. Of those states that do not limit the application of the enhanced penalty for assaults on health care providers to nurses and emergency personnel, most will specify the location of the assault as occurring in a clinic, a licensed health care facility, or some other health care entity licensed by the state. The minority of states allow for an enhanced penalty for assaults on health care providers generally. These states will apply the penalty regardless of the location where the assault occurred.

The higher penalty usually consists of changing a misdemeanor to a felony, or raising the degree of the felony so as to result in a longer prison term, a higher fine, or both. Some states elevated the definition of the type of crime that was committed, e.g., making a simple assault an aggravated assault if the victim was a health care provider.

CONCLUSIONS

Even though survey respondents were more likely to be concerned about workplace violence than the average member physician in a non-hospital setting, the vast majority of respondents felt their workplace was safe. Respondents did not feel that workplace violence had increased recently. Most were satisfied with federal and state regulations, as well as the guidelines of their respective workplaces. The respondents also indicated that the violent acts that had occurred were typically not physical attacks but verbal assaults.

Furthermore, states have adopted criminal statutes protecting health care workers acting in an emergency capacity without prompting by state medical societies and our AMA. However, most of these statutes do not reach the private physician's office.

Finally, state medical societies do not seem to be actively lobbying on the issue of workplace violence against health care workers in the non-hospital setting. While many states have adopted laws addressing violence in EDs, there has been little activity related to workplace violence outside of the hospital setting.

RECOMMENDATIONS

The Board of Trustees recommends the following recommendations be adopted and the remainder of the report filed.

1. That our American Medical Association modify Policy H-515.966 Violence and Abuse Prevention in the Healthcare Workplace by addition to read as follows:

Our AMA encourages all healthcare facilities to adopt policies to reduce and prevent all forms of workplace violence and abuse and to develop policies to manage reported occurrences of workplace violence and abuse and that our AMA advocate that training courses on workplace violence prevention and reduction be more widely available.

2. That our AMA reaffirm Policy H-515.982, continuing to condemn violence against physicians.
3. That our AMA continue to monitor state legislative efforts on increased criminal penalties for assaults against health care providers and continue to work with interested state and national medical specialty societies through all appropriate avenues, including state legislatures, when issues related to workplace violence inside and outside of the emergency department arise.

3. PHYSICIAN EDUCATION TO SUPPORT PATIENT ADHERENCE TO TREATMENT

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

See Policy [D-450.965](#).

At the 2011 Interim Meeting, the American Medical Association's (AMA) House of Delegates (HOD) adopted Policy D-450.965, which calls for our AMA to:

study the feasibility of developing a physician education program to promote physician knowledge of obstacles to adherence and opportunities to intervene with patients to improve adherence and report back to the House of the results of such study (Policy D-450.965[3]).

THE PROBLEM OF ADHERENCE

Adherence is defined as the extent to which patients follow the recommendations of health care professionals—by taking medication, following diets, or executing other lifestyle changes, etc. [1]

As Board of Trustees Report 8-I-11 noted, a multitude of factors influence patients' adherence to treatment. The World Health Organization identified five:

- social and economic factors, such as low level of education;
- features of the health care system, such as reliability of reimbursement by health insurers;
- condition-related factors, such as severity of symptoms;
- therapy-related factors, such as complexity of the therapeutic regimen; and
- patient-related factors, such as motivation to manage illness or misunderstanding of treatment instructions. [2]

Of the nearly 200 variables that have been studied to date, none are consistently related to adherence or fully predictive.[3]

TOOLS & RESOURCES TO SUPPORT ADHERENCE

Extensive resources are available to physicians through a variety of channels to help them support patients in improving adherence. For its own part, the AMA is currently involved in several activities and initiatives to improve patient adherence. The AMA Foundation's [Health Literacy Toolkit](#) offers information for physicians and other

health care professionals. The AMA Center for Patient Safety offers tools for medication reconciliation, including a mobile application for patients, [My Medications](#).

The AMA is an organizational member of the board of the National Center for Patient Information and Education (NCPIE), for which the AMA developed physician [guidelines for counseling patients about prescription medications](#) in 2004. NCPIE's "[Adult Medication](#)" initiative offers strategies to help physicians address each of the five dimensions of adherence, as well as tools to help physicians assess patient health literacy, medication knowledge, readiness for change, and functional social support; information for patients; and links to additional resources.

The AMA has also engaged with the National Consumer League's Medication Adherence Campaign, whose [Script Your Future](#) website offers patients educational materials and other resources, such as action plans, worksheets, and guides for "building questions" to review with their physician, to support patients in adhering to medications.

A variety of other resources, both free and commercial, are available online to support adherence, as well. For example:

- [B-Smart Medication Optimization](#) – tips to identify and address barriers to adherence;
- [MedActionPlan](#) – customized support materials for patients;
- [Memotext](#) – assessment and coaching tools;
- [iReminder](#) – automated medication reminders and other messaging;
- [InsigniaHealth](#) – patient activation assessment tools; and
- [Healthwise](#) – patient education and engagement tools.

Educational programs for physicians on issues in patient adherence are available through venues such as [Medscape](#) or the [Interstate Postgraduate Medical Association](#), among others, in addition to extensive educational offerings from a variety of providers designed to enhance physicians' communication skills, such as Georgetown University's [National Center for Cultural Competence](#), or resource links available through the [Agency for Healthcare Quality and Research](#).

FOCUSING AMA IMPACT

Poor adherence remains a significant challenge worldwide.[2] It can result in adverse consequences for patients, such as disease progression, complications, and reduced functional ability, and for health care systems. In the U.S., it has been estimated to cost approximately \$177 billion a year in direct and indirect health care costs.[4]

However, in light of the AMA's existing activities to improve patient adherence and the extensive additional resources available to physicians to support patient adherence, it is unlikely that continuing general efforts on AMA's part to educate physicians will contribute significantly in this area. Rather, the AMA could expect to have greater impact by considering how best to improve patient adherence around one or more particular clinical or patient-reported outcome(s) selected as part of its strategic initiative on Improving Health Outcomes.

RECOMMENDATION

Therefore, the Board of Trustees recommends that Policy D-450.965 be amended by addition and deletion to read as follows and the remainder of the report be filed:

D-450.965 Patients' Responsibilities for Health Care Outcomes

Our AMA will: (1) continue to support the development of resources for patients and physicians to promote adherence through its partnerships with the National Council on Patient Information and Education and National Consumer League National Medication Adherence Campaign; (2) publicize existing resources for physicians to help patients adhere to treatment through its website; and (3) examine issues of patient adherence as part of its strategic initiative on Improving Health Outcomes and, if appropriate, will develop with others targeted education and resources to support patient adherence. will study the feasibility of a physician education program to promote physician knowledge of obstacles to adherence and opportunities to intervene with patients to improve adherence and report back to the House of Delegates on results of such study; and (4) will continue to seek opportunities to collaborate with other members of the health care team, such as nurses, pharmacists, and social workers, to develop resources to support patient adherence.

REFERENCES

1. Haskard Zolnierok KB, DiMatteo MR. Physician communication and patient adherence to treatment: a meta-analysis. *Medical Care*. 2009;47:826–834.
2. World Health Organization. Adherence to Long-Term Therapies: Evidence for Action. Geneva: World Health Organization; 2003. Available at www.who.int/chp/knowledge/publications/adherence_full_report.pdf. Accessed July 30, 2012.
3. Vermeire E, Hearnshaw H, Van Royen P, Denekens J. Patient adherence to treatment: three decades of research. A comprehensive review. *Journal of Clinical Pharmacy and Therapeutics*. 2001;26:331–342.
4. National Council on Patient Information and Education. Enhancing Prescription Medication Adherence: A National Action Plan. Rockville, MD: NCIPIE; 2007. Available at www.talkaboutrx.org/documents/enhancing_prescription_medicine_adherence.pdf. Accessed July 30, 2012.

**4. SINGLE-SIGNATURE CONTRACTS AND RIGHT TO “OPT OUT”
(RESOLUTION 830-I-11)**

Reference committee hearing: see report of [Reference Committee J](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 830-A-11 AND
REMAINDER OF REPORT FILED**
See Policies [H-225.964](#) and [H-383.997](#).

BACKGROUND

At the 2011 Interim Meeting, the AMA House of Delegates (HOD) referred Resolution 830-I-11 to the Board of Trustees. Resolution 830-I-11 was sponsored by the Organized Medical Staff Section (OMSS) and asked that the AMA adopt new policy that would: (i) support the right of a physician member of an independent practice association (IPA), physician-hospital organization (PHO), physician organization (PO), or other similar organization to “opt out” of a single-signature contract without repercussion or penalty from the organization; and (ii) support the right of a physician member of an IPA, PHO, PO, or other similar organization who does not wish to participate in a particular single-signature contract to retain membership in the organization without participating in that contract.

The resolution was prompted by concerns that under the governing instruments of PHOs, IPAs and other physician and physician practice organizations (collectively “physician organizations”—but not intended to include group practices), individual physicians typically have no ability to opt out of individual payer contracts entered into by the physician organization on behalf of all of its physician members (so-called “single-signature” contracts). As a result, if a physician finds the terms and conditions of a particular payer contract to be unacceptable, the physician has but two options: accept the contract as negotiated or resign from the organization, neither of which is an attractive alternative.

The resolution prompted concerns about whether vesting individual physician or practice members of a physician organization with authority to “opt out” of single-signature contracts, particularly payer contracts, might interfere with the bona fides of the clinical and/or financial integration of physicians in the organization that may be necessary to avoid antitrust risk associated with joint contracting with payers on behalf of physicians in the organization.

The reference committee recommended referral of Resolution 830-I-11, and the House voted for referral.

DISCUSSION

Single-signature contracts with payers are contracts negotiated and signed on behalf of all members of a physician organization, usually pursuant to a “physician organization participation agreement” between the organization and its members. The scope of the agent’s authority to do more than simply sign the contract on behalf of individual physician members, such as negotiate the fees and other terms and conditions of the payer contract, is established by the physician organization participation agreement signed by the physician.

The physician organization participation agreement will answer the question “who will be bound by the single-signature contracts with payers, once negotiated by the physician organization?” Some physician organization participation agreements allow physician members to opt out of single-signature payer contracts negotiated by the physician organization, under specified and sometimes limited circumstances. Other physician organization participation agreements require the physician members to accept the single-signature payer contracts negotiated by the physician organization and provide no opportunity for opt out.

If a physician joins a physician organization that binds all members to its single-signature contracts, the physician is left with the choice of accepting all single-signature contracts negotiated by the physician organization on behalf of its members, or resigning from the physician organization. Accordingly, it is important for individual physicians to evaluate whether they are willing to accept such an arrangement at the time they agree to join the physician organization.

The physician’s right to accept or decline payer contracts has obvious benefits for the physician: it affirms the physician’s business autonomy and gives the physician a degree of control over the economics of the practice. If a payer’s reimbursement schedule is deemed by the physician to be economically disadvantageous, he or she would be able to decline the contract if that is in the best interests of the economic health of the practice.

While the benefits of an opt out right may be clear for the individual physician participating in an organization with single-signature authority, the opt out right may produce negative effects that affect all of the physicians in the organization. Requiring all physicians to participate in every payer contract signed by the organization can help the organization achieve important goals such as a consistent network of physicians, high participation of physicians in clinical integration programs, implementation of quality improvement and incentive programs across all physicians in the network, and cost-effective reporting of performance and/or outcome measure. High opt out rates in a network potentially could impair the efficiency, competitiveness and economic health of the network.

Additionally, how the Federal Trade Commission (FTC) may apply the 1996 DOJ/FTC Healthcare Antitrust Statements to IPAs, PHOs and other physician organizations needs to be considered. As a general matter, joint negotiation of fees on behalf of physicians who compete with one another exposes physicians to risk of price fixing claims under federal antitrust laws. Antitrust liability can be avoided, however, if the organization conducting the joint contracting can demonstrate either financial integration or clinical integration of the participating physicians. Under current antitrust law, physician organizations that are not financially integrated (such as IPAs and PHOs) are permitted to engage in joint contracting with payers only if the overall arrangement is deemed likely to benefit consumers through increased efficiencies such as those gained by clinical integration. Moreover, the joint contracting must be reasonably necessary to achieve the efficiencies. The degree of clinical integration necessary to satisfy antitrust concerns and justify joint contracting as a reasonable ancillary restraint has been subject of several FTC Advisory Opinions and enforcement actions.¹

While the FTC has given conditional approval to joint contracting and single-signature authority where the participating practices have demonstrated sufficient clinical integration, the FTC Advisory Opinions do not make clear whether physicians’ right to opt out of payer contracts executed under single-signature contract authority necessarily promotes or hinders clinical integration. In a 2009 Advisory Opinion, however, the FTC expressed reservations about whether clinical integration can be achieved if physicians have the right to opt out of payer contracts. In that opinion, the FTC gave conditional approval to a PHO structure that prohibited physician members of the PHO from opting out of participating in individual contracts. The FTC noted that “...while it might be theoretically possible to have a program without joint contracting on behalf of all physicians in the program, such an approach appears likely to be far more difficult, and potentially could compromise [the PHO’s] ability to effectively integrate its physician members’ provision of care, and to achieve the program’s potential efficiencies.” See Letter from Marcus H. Meier, Assistant Director, Health Care Services and Products, Bureau of Competition, Federal Trade Commission, to Christi J. Braun, April 13, 2009, available at www.ftc.gov/os/closings/staff/090413tristatealetter.pdf

A physician organization with an “opt out” policy could find it difficult to demonstrate that its joint contracting was reasonably necessary to achieve efficiencies. Consequently, it is possible that a physician organization engaged in joint contracting could compromise its antitrust compliance if it allows its physician or physician practice members to opt out of individual payer contracts. Apart from the foregoing antitrust considerations, an “opt out” right could potentially impair the ability of physician organizations to contract effectively with third parties. An opt out right

would deprive third parties of certainty as to who will be bound by a contract if, following completion of negotiations, individual physicians or practices have the ability to opt out.

The AMA has existing policy that, while not directly on point, urges that all hospital-employed or contracted physicians participate in or be informed about allocation of physician payment components of payments received by a hospital.

H-225.964 Hospital Employed/Contracted Physicians Reimbursement

AMA policy states that: (1) all hospital employed/contracted physicians be prospectively involved if the hospital negotiates for them for capitation and global billing contracts; (2) hospital employed/contracted physicians be informed about the actual payment amount allocated to the physician component of the total hospital payment received by the contractual arrangement; and (3) all potential hospital/contracted physicians request a bona fide hospital plan which delineates the actual payment amount allocated to the employed or contracted physicians.

The AMA also has policy that establishes principles that should be applied to contracts between hospitals and hospital-based physicians, including the right of physicians to negotiate their portions of agreements with managed care organizations and to reject or renegotiate unfavorable provisions.

H-383.997 Hospital-Based Physician Contracting

(1) It is the policy of the AMA that agreements between hospitals and hospital-based physicians should adhere to the following principles: (a) Physicians should have the right to negotiate and review their own portion of agreements with managed care organizations. (b) Physicians should have the right to set the parameters and acceptable terms for their contracts with managed care plans in advance of contract negotiations. (c) Physicians representing all relevant specialties should be involved in negotiating and reviewing agreements with managed care organizations when the agreements have an impact on such issues as global pricing arrangements, risks to the physician specialists, or expectations of special service from the specialty. (d) Physicians should have the opportunity to renegotiate contracts with the hospital whenever the hospital enters into an agreement with a managed care plan that materially impacts the physician unfavorably. (e) The failure of physicians to reach an agreement with managed care organizations should not constitute a breach of its agreement with the hospital, nor serve as grounds for termination. (f) Physicians should seek a provision that allows them to opt out from managed care plans that pose unacceptable professional liability risks. (g) Physicians should seek a provision to refuse to contract with, to modify contracts with, and/or to terminate contracts with managed care plans that are showing financial instability, or should seek a guarantee from the hospital that the plan will make timely payments. (h) Physicians should receive advance notice of the hospital's intent to enter into any package or global pricing arrangements involving their specialties, and have the opportunity to advise the hospital of their revenue needs for each package price. (i) Physicians should have the opportunity to request alternative dispute resolution mechanisms to resolve disputes with the hospital concerning managed care contracting. (j) If the hospital negotiates a package pricing arrangement and does not abide by the pricing recommendations of the physicians, then the physicians should be entitled to a review of the hospital's actions and to opportunities to seek additional compensation. (k) Physicians should be entitled to information regarding the level of discount being provided by the hospital and by other participating physicians.

(2) Our AMA urges physicians who believe hospitals are negotiating managed care contracts on their behalf without appropriate input, and who feel coerced into signing such contracts, to contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel.

(3) Our AMA encourages physicians to avail themselves of the contracting resources available through their relevant specialty societies, as well as the AMA Model Medical Services Agreement, and the Young Physician Section pamphlet entitled "Contracts: What You Need to Know," to evaluate and respond to contract proposals.

Policies H-225.964 and H-383.997 are focused on hospital-based physicians and are not directly pertinent to single-signature contracts in the context of IPAs, PHOs and other similar physician organizations. While they may provide some directional guidance, there is insufficient data to allow a determination of whether, on balance, the right to opt out of contracts negotiated by IPAs, PHOs or other physician organizations, pursuant to single-signature authority, benefits or hurts physicians as a whole. The lack of data on this issue is compounded by the early stage evolution of various models of Accountable Care Organizations (ACOs). Depending on how ACOs are structured and clinically

integrated, a participating physician's right to opt out of payer contracts may enhance or impair the performance of the ACO. Therefore, more data is needed before the AMA can make a determination of whether it should support physicians' opt out rights in settings where the physician has granted single-signature authority to the organization.

RECOMMENDATION

In the absence of clearer information about the effect of physician opt out rights across all physician organizations, the Board of Trustees recommends Policies H-225.964 and H-383.997 be reaffirmed in lieu of Resolution 830-I-11 and the remainder of the report be filed.

REFERENCES

¹ See FTC Staff Letter regarding MedSouth, Inc. (June 18, 2007), available at www.ftc.gov/bc/adops/070618medsouth.pdf
 FTC Staff Letter regarding Greater Rochester Independent Practice Association, Inc. (September 17, 2007), available at www.ftc.gov/bc/adops/gripa.pdf
 FTC Staff Letter regarding Suburban Health Organization, Inc. (March 28, 2006), available at www.ftc.gov/os/2006/03/SuburbanHealthOrganizationStaffAdvisoryOpinion03282006.pdf
 FTC Staff Letter regarding TriState Health Partners, Inc. (April 2009), available at www.ftc.gov/os/closings/staff/090413tristatealetter.pdf

5. NATIONAL DATABASE FOR J-1 VISA WAIVER PROGRAM

Reference committee hearing: see report of [Reference Committee K](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

See Policy [D-255.985](#).

INTRODUCTION

At the 2011 American Medical Association (AMA) Interim Meeting, Policy D-255.993[5] was adopted by the House of Delegates. This policy calls for the AMA to work with state medical societies to study and report back on the feasibility of having a national data repository of J-1 visa waiver statistics so that unfilled J-1 visa waiver positions could be transferred to states as needed in order to treat underserved communities and to monitor the success of this program.

Reference committee testimony suggested that the development of a national data repository including information about unfilled J-1 visa waiver slots could help streamline the process for international medical graduates (IMGs) obtaining J-1 visa waivers. This streamlined process would in turn help increase access to care in underserved communities nationwide. Some concerns were expressed during the reference committee hearing about the mechanics of the proposal and the details and potential unintended consequences of transferring unfilled slots from one state to another.

BACKGROUND

Foreign national IMGs who are completing their graduate medical education (GME) in the US on J-1 visas (exchange visitor program) may have their two-year return-home requirement waived (after completion of their GME programs) if they agree to work in shortage or underserved areas designated as such by the US Department of Health and Human Services (HHS). These designated areas have a shortage of health care professionals, are medically underserved areas or serve medically underserved populations.

The J-1 Visa Waiver Program was enacted in 1994 following the passage of legislation introduced by Senator Kent Conrad of North Dakota. The program permitted each state health agency to recommend waivers of the return-home requirement for up to 20 new physicians per fiscal year to alleviate shortages in rural and underserved states by attracting IMGs to work there. The program began on a pilot basis, and although it has since been expanded to 30 waiver positions per state, it continues to be reauthorized on a temporary rather than permanent basis.

Under the current program, now known as the Conrad 30 program, each state may recommend up to 30 new J-1 visa waivers for physicians per fiscal year and decide which specialists the state needs based on the needs of the state's underserved communities. States may use up to 10 of their 30 recommendations for physicians who will practice outside of HHS-designated shortage areas; these slots are called "FLEX slots." Each state administers its own application process and establishes its own acceptance criteria for its Conrad 30 program, which is administered by a designated person or office within the state's department of health or primary care or rural care office. Unused slots are lost for that fiscal year. Currently, states do not have the authority or mechanism to transfer unused slots to another state that needs more slots, nor is the federal government authorized to redistribute Conrad 30 slots among states. Additionally, there is no mechanism or solution to distribute unused slots fairly between states.

Although such data would be of great value to IMGs, states, and other stakeholders, there is currently no comprehensive national database of J-1 visa waiver statistics, such as the number of applicants, number of positions filled and unfilled, etc. Lists can be found on immigration attorney websites, and one retrospective listing has been compiled by the administrator of the Texas Conrad 30 program.

Study design

To determine the feasibility of developing a comprehensive, AMA-maintained database of J-1 visa waiver statistics, staff from the AMA Departments of International Medical Graduate Services and Market Research developed and distributed a short online survey to each of the 53 Conrad 30 program administrators from 50 states plus the District of Columbia, the US Virgin Islands, and Puerto Rico. (Although the policy directs the AMA to work with state medical societies to determine the feasibility of a national database of J-1 visa waiver statistics, the appropriate entities with whom to collaborate are in fact the administrators of state J-1 visa waiver programs.)

The survey primarily sought to determine whether these administrators would be willing to share their states' Conrad 30 program statistics with the AMA. The survey also collected general demographic information, asked questions about program effectiveness and implementation (including obstacles), and elicited open-ended suggestions for program improvements.

To distribute the online survey, AMA staff worked with the Texas Department of Health Services staff, who work closely with many of the other state Conrad 30 program administrators. The survey was distributed through a Yahoo! Group managed by the Texas Department of Health Services staff. The Yahoo! Group serves as a communication link through which state Conrad 30 programs, interested government agencies, various federal offices, and the Educational Commission for Foreign Medical Graduates (ECFMG) share information, best practices, data and discuss various topics of interest. This discussion group is not open to physicians, attorneys, recruiters or associations, but is used solely for technical assistance and communications between the state and federal programs.

Key findings

After three weeks in the field, 42 online surveys were completed (79 percent response rate). All of the 42 participating states indicated that they would be willing to share their Conrad 30 program information, such as the number of open and filled slots, with the AMA for publishing purposes. This information could be delivered to the AMA on a quarterly or ad hoc basis.

A majority of respondents indicated that the Conrad 30 programs were effective in their states, despite the fact that most of these states do not fill all 30 slots each year. States that could not fill all 30 slots cited such reasons as undesirable geographic area, complicated requirements and application processes, and employer hesitation due to the short, required duration of their program commitment. When asked for suggestions about how to improve the Conrad 30 program, respondents noted a lack of communication and information sharing between state administrators, employers, United States Citizenship and Immigration Services (USCIS) and the ECFMG. Many administrators commented on how cumbersome and confusing the entire J-1 visa waiver process can be for everyone involved. A few states commented that unfilled positions from other states should be given to those states that need more than 30 positions. On the other hand, one state administrator responded "...I am opposed to sharing unused slots with states that max out. I believe that some of the docs that we get through this program, we would not get if they had the option of going to [other states]."

DISCUSSION

Although detailed information about the use and availability of J-1 visa waivers would benefit IMGs and help alleviate healthcare shortages in rural and underserved areas, there is currently no comprehensive national database of J-1 visa waiver statistics. Survey results indicated that state Conrad 30 administrators are willing to share this information with the AMA thus making feasible an AMA-maintained database of J-1 visa waiver statistics. The AMA would be well served to collect this information and make it available to IMGs and other interested stakeholders.

The survey also identified a lack of information and communication about the Conrad 30 program and about J-1 visa waivers in general. As a recognized authority on IMG issues, the AMA is well positioned to develop informational resources, such as an FAQ, to inform IMGs, legislators, Conrad 30 administrators, employers, and other stakeholders about the J-1 visa waiver program. The AMA is also positioned to work with the ECFMG, of which the AMA is an organizational member, and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, and various government entities.

Finally, current AMA policy advocates for the redistribution of unfilled Conrad 30 positions to other states (AMA Policy D-255.985). However, the survey uncovered an unintended consequence to an existing AMA policy under which unfilled Conrad 30 positions can be transferred between states. For example, a physician could choose not to apply for a waiver from State A, knowing that the position would likely remain unfilled and would subsequently be transferred to State B, where the physician prefers to work. In particular, this policy could undermine the ability of the Conrad 30 program to increase access to care in the states where access is most limited. Rather than continuing to advocate this position, the AMA should amend its policy to call for an overall increase in the number of Conrad 30 positions available to each state.

CONCLUSION

Comprehensive information about the use and availability of J-1 visa waivers is not currently available. This information gap presents the AMA, through its IMG Services Department, with an opportunity to provide current and useful information to its constituents and other stakeholders, a task which the results of the survey deem both necessary and feasible. The AMA should also increase efforts to provide general information about the Conrad 30 program to IMGs and other stakeholders and should further use its influence in the IMG community to facilitate better communication among those entities at both the state and federal levels responsible for administering J-1 visa waivers.

Analysis of the issue of redistributing waiver slots between states identified a potential unintended consequence of policy currently championed by the AMA. Namely, it is conceivable that a policy allowing the transfer of unfilled J-1 visa waiver positions from one state to another state (that may be more preferred by the physician) could further exacerbate healthcare access problems in underserved areas. This AMA policy should be amended to ensure that the AMA advocates for the expansion of state Conrad 30 program while ensuring that it supports solutions that are most likely to maximize the ability of the program to achieve its intended goal of increasing access to healthcare in underserved areas.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That our American Medical Association (AMA) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program.
2. That our AMA advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage.
3. That AMA Policy D-255.985, "Conrad 30 - J-1 Visa Waivers" be amended by deletion to read as follows:

Our AMA will: (1) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (2) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (3) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; and ~~(4) advocate for redistribution of the unoffered Conrad 30 J-1 Visa waiver slots for those states that could use more than 30 slots to serve in their health professional shortage areas, medically underserved areas and populations.~~

4. That our AMA work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department.
5. That our AMA continue to communicate with the Conrad 30 administrators and IMGs members to share information and best practices in order to fully utilize and expand the Conrad 30 program.

APPENDIX - Relevant AMA Policies

D-255.985 Conrad 30 - J-1 Visa Waivers

Our AMA will: (1) lobby for the reauthorization of the Conrad 30 J-1 Visa waiver program; (2) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (3) advocate for expansion of the J-1 Visa waiver program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; and (4) advocate for redistribution of the unoffered Conrad 30 J-1 Visa waiver slots for those states that could use more than 30 slots to serve in their health professional shortage areas, medically underserved areas and populations. (Res. 233, A-06; Appended: CME Rep. 10, A-11; Appended: Res. 303, A-11; Reaffirmation I-11)

D-255.993 J-1 Visas and Waivers

1. Our AMA shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program. 2. If the USDA does not continue in its role as an interested government agency (IGA), the AMA encourage HHS to expand its J-1 visa waiver program. 3. Our AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians' service requirements through the J-1 waiver and Conrad-30 programs with a report back at A-03. 4. Our AMA will work towards regulation and/or legislation to allow physicians on H-1B visas for their J-1 visa waiver, who are limited to serving in medically underserved areas, to continue to care for their patients who require hospitalization in the closest appropriate medical facility which may not be in the underserved area. 5. Our AMA will work with state medical societies to study and report back on the feasibility of having a national data repository of J-1 Visa Waiver statistics so that J-1 Visa Waiver unoffered positions can be transferred to states as needed to treat underserved communities and to monitor the success of this program. (BOT Rep. 11, I-02; Appended: Res. 324, A-11; Appended: Res. 904, I-11)

6. AMA PRINCIPLES FOR PHYSICIAN EMPLOYMENT (RESOLUTION 724-A-12)

Reference committee hearing: see report of [Reference Committee Amendments to Constitution and Bylaws](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 724-A-12 AND REMAINDER OF REPORT FILED

See Policies [H-225.950](#) and [D-225.977](#).

At its 2011 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted policy directing the AMA to “develop ‘Principles for Physician Employment’ that address the relationships between and among employed physicians, hospitals, integrated delivery systems, and hospital medical staffs” (AMA Policy D-225.977). The Board of Trustees (BOT) assigned this task to the Department of Organized Medical Staff Services, which, in consultation with the Organized Medical Staff Section (OMSS) Governing Council and the Office of the General Counsel (OGC), had already begun to develop such principles.

The Principles for Physician Employment were first presented for the consideration of the HOD as OMSS-sponsored Resolution 724-A-12, “AMA Principles for Physician Employment.” Citing the complexity and length of the Principles and the limited time available for their review, the HOD referred Resolution 724-A-12 to the Board.

BACKGROUND

Physicians are increasingly entering into employment and other contractual relationships with hospitals, group practices, and other health care organizations and delivery systems. The American Hospital Association estimates that physician employment by hospitals has increased by 32 percent over the last ten years. This trend toward employment is expected to continue, as indicated by a recent Merritt Hawkins survey that found that 32 percent of final-year residents preferred hospital employment over any other practice option. Many more physicians are employed by group practices and other health care delivery systems.

Employment and contractual arrangements can benefit physicians and their patients, but employed physicians face a unique set of challenges as they seek to protect their professional, ethical, and financial interests while maintaining the inviolability of the patient-physician relationship. The AMA strives to become the “lead association” for employed physicians and to that end has pledged to “represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities” (AMA Policy G-615.105). The AMA’s commitment to meeting the needs of employed physicians is underscored by the organization’s strategic focus on improving physician satisfaction within current and evolving practice environments.

The AMA has developed a range of products and services to help physicians understand and manage their employment and contractual relationships. For example, the AMA has published annotated model physician employment agreements that address the needs of physicians who are preparing to negotiate employment contracts with hospitals, group practices, or related entities. Additionally, the AMA offers a unique member service through which individual physicians may consult with AMA staff experts on issues such as employment and contracting, credentialing, peer review, due process, medical staff self governance, and more. (Visit www.ama-assn.org/go/employment for a complete listing of AMA employment-related resources.) A comprehensive set of Principles for Physician Employment would make a valuable addition to this growing collection of resources.

DISCUSSION

Development of the Principles

The Principles for Physician Employment were initially envisioned as a simple compendium of existing AMA policy on physician employment and related topics. However, a comprehensive review of AMA policy revealed that existing policy is silent on many vital employment-related issues and only tangentially addresses many more (see Appendix). Thus, in addition to drawing from existing AMA policy, the proposed Principles draw extensively from sources such as the AMA Annotated Model Physician-Hospital Employment Agreement, the AMA Annotated Model Physician Employment Agreement, the AMA Physician’s Guide to Medical Staff Organization Bylaws, the California Medical Association Model Employment Contract, related statutory and case law, and the knowledge of a number of physicians, healthcare law attorneys, and other individuals with experience in this area.

A preliminary draft of the Principles for Physician Employment was completed in early 2012 and forwarded to the leadership of each of the AMA sections and special groups and to AMA Ethics Policy staff for review. A number of these groups provided insightful comments and suggestions which were incorporated into the document before its consideration by the HOD at the 2012 Annual Meeting. Following the 2012 Annual Meeting, Resolution 724-A-12 was critically reviewed by an OGC-convened Healthcare Law Advisory Panel composed of seven practicing attorneys with specific expertise in representing physician clients. The comments of the panel were particularly helpful in ensuring that the proposed Principles appropriately balance the AMA’s strong advocacy for the rights of employed physicians with the realities of contract law and with widespread employment/contractual practices.

Scope of the Principles

The Principles for Physician Employment are intended to help physicians, those who employ physicians, and their respective advisors identify and address some of the unique challenges to professionalism and the practice of medicine arising in the face of physician employment. The Principles are not intended to serve as a comprehensive listing of the professional and ethical obligations of employed physicians; such obligations – which are the same for all physicians, regardless of employment status – are more fully delineated in the *AMA Code of Medical Ethics*. Nor are the Principles a comprehensive treatment of contractual matters such as work hours, compensation models,

employee benefits, and other issues typically the subject of negotiation between physicians and employers; such issues are addressed elsewhere in the body of AMA policy and in the AMA's model employment agreements. Rather, it is hoped that the Principles for Physician Employment, in addressing select, potentially problematic aspects of the employer-employee relationship, will provide broad guidance for employed physicians and their employers as they collaborate to provide safe, high-quality, and cost-effective patient care.

CONCLUSION

Physicians entering into employment and contractual relationships with hospitals, group practices, and other health care delivery systems face unique challenges to their professional, ethical, and financial interests. The AMA is well positioned to help employed physicians identify and address these challenges and, to that end, offers a variety of employment-related resources. The Principles for Physician Employment presented in this report will add significantly to this portfolio, will solidify the AMA's position as the lead association for employed physicians, and will ultimately help the AMA achieve its strategic goal of improving physician satisfaction.

RECOMMENDATION

The Board of Trustees recommends that the following statements be adopted in lieu of Resolution 724-A-12 and the remainder of this report be filed:

1. That the following Principles for Physician Employment be adopted:

AMA Principles for Physician Employment

(1) Addressing Conflicts of Interest

- (a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
- (b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
- (c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
- (d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
- (e) Assuming a title or position that may remove a physician from direct patient-physician relationships—such as medical director, vice president for medical affairs, etc.—does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA *Code of Medical Ethics* for further guidance on conflicts of interest.

(2) Advocacy for Patients and the Profession

- (a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
- (b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

(3) Contracting

- (a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
- (b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
- (c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
- (d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his / her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
- (e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges.
- (f) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
- (g) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

(4) Hospital Medical Staff Relations

- (a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
- (b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
- (c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
- (d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

(5) Peer Review and Performance Evaluations

- (a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
- (b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
- (c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians – not lay administrators – should be ultimately responsible for all peer review of medical services provided by employed physicians.
- (d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
- (e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
- (f) Unless specified otherwise in the employment agreement, upon termination of employment with or without cause, an employed physician should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

(6) Payment Agreements

- (a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
- (b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee. (New HOD Policy)

2. That AMA Policy D-225.977 be amended by addition and deletion to read as follows:

D-225.977 Physician Independence and Self-Governance

~~Our AMA will: (1) develop "Principles for Physician Employment" that address the relationships between and among employed physicians, hospitals, integrated delivery systems and hospital medical staffs; (2) update its Physician's Guide to Medical Staff Organization Bylaws and other relevant resources as necessary to reflect the needs and concerns of employed physicians and to ensure the continuing self-governance of the medical staff and the clinical decision-making autonomy of all physicians in the face of rising physician employment; and (3)~~ (1) continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; and (2) promote physician collaboration, teamwork, ~~and~~ partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care.

3. That our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to the American Hospital Association and Medical Group Management Association.

References for this report are available from the AMA Department of Organized Medical Staff Services.

APPENDIX - Related AMA Policy

H-140.978 Financial Incentives to Limit Care - Ethical Implications for HMOs and IPAs

(1) Physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward, or the avoidance of financial penalties (2) Patients must have the necessary information to make informed decisions about their care. Physicians therefore have an ethical obligation to assure the disclosure of medically appropriate treatment alternatives, regardless of cost. (3) Physicians must assure that any agreement or understanding (explicit or implicit) restricting referral or treatment options is disclosed to patients. (4) Physicians must assure disclosure of any financial inducements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or that may tend to limit patients' overall access to care. (5) Physicians may satisfy their disclosure obligations by assuring that the managed care plan makes adequate disclosure to patients enrolled in the plan. Physicians in groups, health care delivery systems or closed hospital departments may satisfy their disclosure obligations by assuring that the group, health care delivery system or hospital, respectively, makes adequate disclosure to patients of that practice setting. (6) Physicians should promote an effective program of peer review to monitor and evaluate the quality and appropriateness of the patient care services provided within their practice setting. (CEJA Rep. B, A-90; Reaffirmed: Sub. Res. 702, I-94; Reaffirmation A-00; Reaffirmed in lieu of Res. 901, I-05; Modified: BOT Rep. 38, A-06; Reaffirmation A-07)

H-215.979 Unilateral Imposition of Employee Status on Physicians by Hospitals

The AMA strongly opposes hospitals' unilateral coercion of any physician or physician group, hospital based or otherwise, to enter into an employment or contractual relationship essentially making the physicians or physician group employees of the hospitals.

H-215.981 Hospital Employed Physicians

Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.

D-215.994 Possible Anti-Competitive and Ethical Implications of Integrated Hospital System Referral Expectations

Our AMA will study the possible anti-competitive and ethical implications of an expectation that referrals among health care providers remain within an integrated hospital system physician group, regardless of whether such an expectation is directly stated or indirectly implied or rewarded. This study should focus on situations in which there is a choice in referrals among equally competent, competing physicians, and such choice is not precluded by insurance coverage restrictions. Recommendations for new policy, legislation or regulations should be included. (Res. 721, A-05)

H-225.964 Hospital Employed/Contracted Physicians Reimbursement

AMA policy states that: (1) all hospital employed/contracted physicians be prospectively involved if the hospital negotiates for them for capitation and global billing contracts; (2) hospital employed/contracted physicians be informed about the actual payment amount allocated to the physician component of the total hospital payment received by the contractual arrangement; and (3) all potential hospital/contracted physicians request a bona fide hospital plan which delineates the actual payment amount allocated to the employed or contracted physicians.

D-225.979 Guaranteeing Due Process for Employed Physicians

Our American Medical Association will (1) study the unique employment arrangements of physicians employed or contracted by health care organizations; (2) seek legal advice for producing model language for inclusion in employment contracts and medical staff bylaws that would provide the greatest possible protection for physicians against denial of due process by health care organizations; and (3) design, produce, and make available to all members, an educational package that helps physicians negotiate contracts and formulate staff bylaws that provide the greatest possible protection from denial of due process following termination of employment or premature termination of contracts by health care organizations.

D-225.978 The Physician's Right to Exercise Independent Judgment in All Organized Medical Staff Affairs

Our AMA Model Physician-Hospital Employment Agreement will be modified to incorporate a provision supporting the unfettered right of a physician to exercise his/her personal and professional judgment in voting, speaking and advocating on any matter regarding: [i] patient care interests; [ii] the profession; [iii] health care in the community; [iv] medical staff matters; [v] the independent exercise of medical judgment as appropriate interests to be incorporated into physician employment and independent contractor agreements; the right [vi] not to be deemed in breach of his/her employment or independent contractor agreement for asserting the foregoing enumerated rights; and [vii] not to be retaliated against by his/her employer in any way, including, but not limited to, termination of his/her employment or independent contractor agreement, commencement of any disciplinary action, or any other adverse action against him/her based on the exercise of the foregoing rights. (BOT Rep. 2, I-11)

H-225.985 Medical Staff Review of Quality of Care Issues Prior to Exclusive Contract

The AMA believes that the medical staff should review and make recommendations to the governing body related to exclusive contract arrangements, prior to any decision being made, in the following situations: (1) the decision to execute an exclusive contract in a previously open department or service; (2) the decision to renew or otherwise modify an exclusive contract in a particular department or service; (3) the decision to terminate an exclusive contract in a particular department or service; and (4) prior to termination of the contract the medical staff should hold a hearing, as defined by the medical staff and hospital to permit interested parties to express their views on the hospital's proposed action. (Res. 182, A-87; Res. 806, A-93; Reaffirmed: CMS Rep. 10, A-03)

H-235.963 Credentialed Physician Membership in Organized Medical Staff

1. Our American Medical Association advocates that all properly licensed and hospital credentialed physicians involved in patient care, be eligible for voice and vote in Organized Medical Staff self-governance. 2. AMA policy is that an existing medical staff should have the right to reorganize and redefine its own governance structure as appropriate per AMA Policy H-225.957. 3. The AMA Commissioners to The Joint Commission are urged to seek affirmation from The Joint Commission that the medical staff as a principle of self-governance, should be a direct democracy where the members personally participate with voice and vote in the decision-making and election of their representatives. 4. AMA policy is that the voting members of a medical staff should include at a minimum all actively practicing physicians who are credentialed and privileged as members of the medical staff as defined in their medical staff bylaws. (Res. 818, I-09; Res. 820, I-09)

H-235.999 All Physicians Employed by Hospitals Required to be on Staff

The AMA believes that physicians having contractual or financial arrangements with hospitals should be members of the organized medical staff and responsible to it, should be subject to the bylaws of the medical staff, and should conduct their professional activities according to the standards, rules and regulations adopted by it.

H-285.910 The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community

Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:

Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community

In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of his/her rights under this paragraph.

H-285.929 Patient Notification of Physician Contract Termination

Our AMA encourages medical groups and other corporate entities, such as physician practice management corporations and limited liability corporations, to include in the contract language governing notification of patients regarding termination of a physician's contract, wording which is in compliance with Council on Ethical and Judicial Affairs Opinion 7.03 and/or model language developed by state medical societies. (Res. 707, I-99; Reaffirmed: CEJA Rep. 8, A-09)

H-285.951 Financial Incentives Utilized in the Management of Medical Care

Our AMA believes that the use of financial incentives in the management of medical care should be guided by the following principles: (1) Patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated. (2) Physicians should have the right to enter into whatever contractual arrangements with health care systems, plans, groups or hospital departments they deem desirable and necessary, but they should be aware of the potential for some types of systems, plans, group and hospital departments to create conflicts of interest, due to the use of financial incentives in the management of medical care. (3) Financial incentives should enhance the provision of high quality, cost-effective medical care. (4) Financial incentives should not result in the withholding of appropriate medical services or in the denial of patient access to such services. (5) Any financial incentives that may induce a limitation of the medical services offered to patients, as well as treatment or referral options, should be fully disclosed by health plans to enrollees and prospective enrollees, and by health care groups, systems or closed hospital departments to patients and prospective patients. (6) Physicians should disclose any financial incentives that may induce a limitation of the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options. Physicians may satisfy their disclosure obligations by assuring that the health plans with which they contract provide such disclosure to enrollees and prospective enrollees. Physicians may also satisfy their disclosure obligations by assuring that the health care group, system or hospital department with which they are affiliated provide such disclosure to patients seeking treatment. (7) Financial incentives should not be based on the performance of physicians over short periods of time, nor should they be linked with individual treatment decisions over periods of time insufficient to identify patterns of care. (8) Financial incentives generally should be based on the performance of groups of physicians rather than individual physicians. However, within a physician group, individual physician financial incentives may be related to quality of care, productivity, utilization of services, and overall performance of the physician group. (9) The appropriateness and structure of a specific financial incentive should take into account a variety of factors such as the use and level of "stop-loss" insurance, and the adequacy of the base payments (not at-risk payments) to physicians and physician groups. The purpose of assessing the appropriateness of financial incentives is to avoid placing a physician or physician group at excessive risk which may induce the rationing of care. (10) Physicians should consult with legal counsel prior to agreeing to any health plan contract or agreeing to join a group, delivery system or hospital department that uses financial incentives in a manner that could inappropriately influence their clinical judgment. (11) Physicians agreeing to health plan contracts that contain financial incentives should seek the inclusion of provisions allowing for an independent annual audit to assure that the distribution of incentive payments is in keeping with the terms of the contract. (12) Physicians should consider obtaining their own accountants when financial incentives are included in health plan contracts, to assure proper auditing and distribution of incentive payments. (13) Physicians, other health care professionals, third party payers and health care delivery settings through their payment policies, should continue to encourage use of the most cost-effective care setting in which medical services can be provided safely with no detriment to quality. (CMS Rep. 3, I-96; Reaffirmed by CMS Rep. 15, A-98; Reaffirmation A-99; Reaffirmed: CMS Rep. 12, I-99; Reaffirmation A-00; Reaffirmation A-01; Reaffirmed in lieu of Res. 901, I-05; Modified: BOT Rep. 38, A-06)

H-285.954 Physician Decision-Making in Health Care Systems

AMA policy states: (1) That certain professional decisions critical to high quality patient care should always be the ultimate responsibility of the physician regardless of the practice setting, whether it be a health care plan, group practice, integrated or non-integrated delivery system or hospital closed department, whether in primary care or another specialty, either unilaterally or with consultation from the plan, group, delivery system or hospital. Such decisions include, but are not limited to, the following: (a) What diagnostic tests are appropriate. (b) When and to whom physician referral is indicated. (c) When and with whom consultation is indicated. (d) When non-emergency hospitalization is indicated. (e) When hospitalization from the emergency department is indicated. (f) Choice of service sites for specific services (office, outpatient department, home care, etc.). (g) Hospital length of stay. (h) Frequency/length of office/outpatient visits or care. (i) Use of out-of formulary medications. (j) When and what surgery is indicated. (k) When termination of extraordinary/heroic care is indicated. (l) Recommendations to patients for other treatment options, including non-covered care. (m) Scheduling on-call coverage. (n) Terminating a patient-physician relationship. (o) Whether to work with, and what responsibilities should be delegated to, a mid-level practitioner. (p) Determination of the most appropriate treatment methodology. (2) The AMA encourages state medical associations to consider development and wide dissemination of guidelines for the extent of practicing physician involvement in plan, group, system or hospital department medical decisions and policies. Such guidelines should be relevant to their jurisdiction, allow for variation in

plan, group, system or hospital department sponsorship and structure, and optimize patient care. (3) The AMA encourages organizations and entities that accredit or develop and apply performance measures for health plans, groups, systems or hospital departments to consider inclusion of plan, group, system or hospital department compliance with any applicable state medical association or medical staff-developed decision-making guidelines in their evaluation criteria. (4) The AMA encourages physicians in integrated health plans and systems to have a functioning medical staff structure in place. (CMS Rep. 5, I-96; Amended by CMS Rep. 12, A-97; Reaffirmation A-97; Reaffirmed by CMS Rep. 3, A-98; Reaffirmation A-99; Reaffirmed: Res. 538, A-04; Modified: BOT Rep. 38, A-06; Reaffirmation A-09)

H-285.983 Organized Medical Staffs in Medical Delivery Systems

The AMA supports expanding the concept of physician governance of medical delivery systems by recommending that: (1) Medical delivery systems establish self-governing medical staffs similar, if not identical, to those in hospitals; (2) The principles of self-governance should include, but not be limited to: (a) the development of medical staff bylaws which cannot be unilaterally changed by the governing board of a medical delivery system; (b) physician election of representatives to the governing board and other appropriate committees of medical delivery systems including credentialing, privileging, quality assurance and utilization review committees; (c) due process protections for physicians credentialed by a medical delivery system; and (d) full indemnification by medical delivery systems of physicians who, in good faith, serve as members of credentialing, quality assurance and utilization review committees of medical delivery systems; and (3) Policy of the AMA is that the establishment of guidelines, review of decisions, and the adjudication of patient care quality issues in managed care plans must be performed by participating practicing physicians. (Res. 706, A-94; CMS Rep. 4, I-95; Amended by BOT Rep. 14, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-285.987 Guidelines for Qualifications of Managed Care Medical Directors

The AMA has adopted the following “Guidelines for Qualifications of Medical Directors of Managed Care Organizations”: To the greatest extent possible, physicians who are employed as medical directors of managed care organizations shall: (1) hold an unlimited current license to practice medicine in one of the states served by the managed care organization, and where that Medical Director will be making clinical decisions or be involved in peer review that Medical Director should have a current license in each applicable state; (2) meet credentialing requirements equivalent to those met by plan providers; (3) be familiar with local medical practices and standards in the plan’s service area; (4) be knowledgeable concerning the applicable accreditation or “program approval” standards for preferred provider organizations and health maintenance organizations; (5) possess good interpersonal and communications skills; (6) demonstrate knowledge of risk management standards; (7) be experienced in and capable of overseeing the commonly used processes and techniques of peer review, quality assurance, and utilization management; (8) demonstrate knowledge of due process procedures for resolving issues between the participating physicians and the health plan administration, including those related to medical decision-making and utilization review; (9) be able to establish fair and effective grievance resolution mechanisms for enrollees; (10) be able to review, advise, and take action on questionable hospital admissions, medically unnecessary days, and all other medical care cost issues; and (11) be willing to interact with physicians on denied authorizations. The AMA strongly encourages managed care organizations and payer groups to utilize these guidelines in their recruitment and retention of medical directors. (CMS Rep. 6, I-93; Reaffirmed: CMS Rep. 7, A-05)

H-285.998 Managed Care

(1) Introduction The needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing. (2) Definition “Managed care” is defined as those processes or techniques used by any entity that delivers, administers, and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization, or costs and prices or outcomes of such services provided to a defined enrollee population. (3) Techniques Managed care techniques currently employed include any or all of the following: (a) prior, concurrent, or retrospective review of the quality, medical necessity, and/or appropriateness of services or the site of services; (b) controlled access to and/or coordination of services by a case manager; (c) efforts to identify treatment alternatives and to modify benefits for patients with high cost conditions; (d) provision of services through a network of contracting providers, selected and deselected on the basis of standards related to cost-effectiveness, quality, geographic location, specialty, and/or other criteria; (e) enrollee financial incentives and disincentives to use such providers, or specific service sites; and (f) acceptance by participating providers of financial risk for some or all of the contractually obligated services, or of discounted fees. (4) Case Management Health plans using the preferred provider concept should not use coverage arrangements which impair the continuity of a patient’s care across different treatment settings. With the increased specialization of modern health care, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by professional preparation to assume this leadership role. The primary goal of high-cost case management or benefits management programs should be to help to arrange for the services most appropriate to the patient’s needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient’s care. Any health plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient’s participation in the program or upon adherence to treatment recommendations. (5) Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed. A physician of the same specialty must be

involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field. A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions. All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan. All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient. When inordinate amounts of time or effort are involved in providing case management services required by a third party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage." Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring prior authorization are recommended by the physicians. In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process. (Joint CMS/CLRPD Rep. I-91; Reaffirmed: CMS Rep. I-93-5; Reaffirmed: Res. 716, A-95; Modified: CMS Rep. 3, I-96; Modified: CMS Rep. 4, I-96; Reaffirmation A-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed: CMS Rep. 9, A-98; Reaffirmed: Sub. Res. 707, A-98; Reaffirmed: CMS Rep. 13, I-98; Reaffirmed: Res. 717, A-99; Reaffirmation A-00; Reaffirmation A-02; Reaffirmation I-04; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11)

H-383.997 Hospital-Based Physician Contracting

(1) It is the policy of the AMA that agreements between hospitals and hospital-based physicians should adhere to the following principles: (a) Physicians should have the right to negotiate and review their own portion of agreements with managed care organizations. (b) Physicians should have the right to set the parameters and acceptable terms for their contracts with managed care plans in advance of contract negotiations. (c) Physicians representing all relevant specialties should be involved in negotiating and reviewing agreements with managed care organizations when the agreements have an impact on such issues as global pricing arrangements, risks to the physician specialists, or expectations of special service from the specialty. (d) Physicians should have the opportunity to renegotiate contracts with the hospital whenever the hospital enters into an agreement with a managed care plan that materially impacts the physician unfavorably. (e) The failure of physicians to reach an agreement with managed care organizations should not constitute a breach of its agreement with the hospital, nor serve as grounds for termination. (f) Physicians should seek a provision that allows them to opt out from managed care plans that pose unacceptable professional liability risks. (g) Physicians should seek a provision to refuse to contract with, to modify contracts with, and/or to terminate contracts with managed care plans that are showing financial instability, or should seek a guarantee from the hospital that the plan will make timely payments. (h) Physicians should receive advance notice of the hospital's intent to enter into any package or global pricing arrangements involving their specialties, and have the opportunity to advise the hospital of their revenue needs for each package price. (i) Physicians should have the opportunity to request alternative dispute resolution mechanisms to resolve disputes with the hospital concerning managed care contracting. (j) If the hospital negotiates a package pricing arrangement and does not abide by the pricing recommendations of the physicians, then the physicians should be entitled to a review of the hospital's actions and to opportunities to seek additional compensation. (k) Physicians should be entitled to information regarding the level of discount being provided by the hospital and by other participating physicians. (2) Our AMA urges physicians who believe hospitals are negotiating managed care contracts on their behalf without appropriate input, and who feel coerced into signing such contracts, to contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel. (3) Our AMA encourages physicians to avail themselves of the contracting resources available through their relevant specialty societies, as well as the AMA Model Medical Services Agreement, and the Young Physician Section pamphlet entitled "Contracts: What You Need to Know," to evaluate and respond to contract proposals. (CMS Rep. 3, A-00; Reaffirmed: BOT Rep. 13, I-06)

H-385.939 Hospital Billing on Behalf of Physicians

Our AMA: (1) advocates that personnel performing diagnostic and procedural coding of physicians' services provide that information, including itemized billing information, collection rates, procedures, and remittance information, to those physicians providing the coded services; (2) urges physicians to participate in the processes used by entities submitting claims for and receiving payment on behalf of physicians; (3) urges that any entity billing for physicians' services ensure that, when a physician's choice of CPT code has been changed, the physician be so notified and the recoder identified before submission of a bill; (4) encourages physicians to carefully evaluate their billing procedures upon selling their practice or contracting for billing services; (5) encourages physicians to establish billing practice policies and billing compliance programs that include monitoring and reviewing billing accuracy; and (6) encourages physicians who sell their practice or contract out billing services to establish a mechanism for continually reviewing the collection methods and procedures of the billing entity. (CMS Rep. 6, I-98; Reaffirmed: CMS Rep. 4, A-08)

E-1.001 Principles of Medical Ethics

PREAMBLE: The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

- I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
- II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
- V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
- VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
- VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
- IX. A physician shall support access to medical care for all people.

E-4.04 Economic Incentives and Levels of Care

The primary obligation of the hospital medical staff is to safeguard the quality of care provided within the institution. The medical staff has the responsibility to perform essential functions on behalf of the hospital in accordance with licensing laws and accreditation requirements. Treatment or hospitalization that is willfully excessive or inadequate constitutes unethical practice. The organized medical staff has an obligation to avoid wasteful practices and unnecessary treatment that may cause the hospital needless expense. In a situation where the economic interests of the hospital are in conflict with patient welfare, patient welfare takes priority.

E-4.06 Physician-Hospital Contractual Relations

There are various financial or contractual arrangements that physicians and hospitals may enter into and find mutually satisfactory. A physician may, for example, be a hospital employee, a hospital-associated medical specialist, or an independent practitioner with staff privileges. The form of the contractual or financial arrangement between physicians and hospitals depends on the facts and circumstances of each situation. A physician may be employed by a hospital for a fixed annual amount, for a certain amount per hour, or pursuant to other similar arrangements that are related to the professional services, skill, education, expertise, or time involved.

E-7.03 Records of Physicians upon Retirement or Departure from a Group

A patient's records may be necessary to the patient in the future not only for medical care but also for employment, insurance, litigation, or other reasons. When a physician retires or dies, patients should be notified and urged to find a new physician and should be informed that upon authorization, records will be sent to the new physician. Records which may be of value to a patient and which are not forwarded to a new physician should be retained, either by the treating physician, another physician, or such other person lawfully permitted to act as a custodian of the records. The patients of a physician who leaves a group practice should be notified that the physician is leaving the group. Patients of the physician should also be informed of the physician's new address and offered the opportunity to have their medical records forwarded to the departing physician at his or her new practice location. It is unethical to withhold such information upon request of a patient. If the responsibility for notifying patients falls to the departing physician rather than to the group, the group should not interfere with the discharge of these duties by withholding patient lists or other necessary information. (IV) Issued prior to April 1977; Updated June 1994, June 1996 and February 2002.

E-8.021 Ethical Obligations of Medical Directors

Assuming a title or position that removes the physician from direct patient-physician relationships does not override professional ethical obligations. The term “medical directors,” as used here, refers to physicians who are employed by third party payers in the health care delivery system (i.e., insurance companies, managed care organizations, self-insured employers) or by entities that perform medical appropriateness determinations on behalf of payers. These types of medical directors have specific functions, such as making coverage determinations, which go beyond mere administrative responsibility. The following stem from this understanding. Whenever physicians employ professional knowledge and values gained through medical training and practice, and in so doing affect individual or group patient care, they are functioning within the professional sphere of physicians and must uphold ethical obligations, including those articulated by the AMA’s Code of Medical Ethics. Medical directors acting within the professional sphere, such as when making decisions regarding medical appropriateness, have an overriding ethical obligation to promote professional medical standards. Adherence to professional medical standards includes: (1) Placing the interests of patients above other considerations, such as personal interests (e.g., financial incentives) or employer business interests (e.g., profit). This entails applying the plan parameters to each patient equally and engaging in neither discrimination nor favoritism. (2) Using fair and just criteria when making care-related determinations. This entails contributing professional expertise to help craft plan guidelines that ensure fair and equal consideration of all plan enrollees. In addition, medical directors should review plan policies and guidelines to ensure that decision-making mechanisms are objective, flexible, and consistent, and apply only ethically appropriate criteria, such as those identified by the Council in Opinion 2.03, “Allocation of Limited Medical Resources.” (3) Working towards achieving access to adequate medical services. This entails encouraging employers to provide services that would be considered part of an adequate level of health care, as articulated in Opinion 2.095, “The Provision of Adequate Health Care.” (I, III, VII) Issued December 1999 based on the report “Ethical Obligations of Medical Directors,” adopted June 1999.

E-8.0321 Physicians’ Self-Referral

Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients’ medical interests can be in tension with physicians’ financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession. In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationship -- including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices -- are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must: (1) Ensure that referrals are based on objective, medically relevant criteria. (2) Ensure that the arrangement: (a) is structured to enhance access to appropriate, high quality health care services or products; and (b) within the constraints of applicable law: (i) does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation; (ii) does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and (iii) adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by non-referring physicians. (3) Take steps to mitigate conflicts of interest, including: (a) ensuring that financial benefit is not dependent on the physician-owner/investor’s volume of referrals for services or sales of products; (b) establishing mechanisms for utilization review to monitor referral practices; and (c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated. (4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral. Issued June 2009 based on the report “Physicians’ Self-Referral,” adopted November 2008.

E-8.05 Contractual Relationships

The contractual relationships that physicians assume when they join or affiliate with group practices or agree to provide services to the patients of an insurance plan are varied. Income arrangements may include hourly wages for physicians working part time, annual salaries for those working full time, and share of group income for physicians who are partners in groups that are somewhat autonomous and contract with plans to provide the required medical care. Arrangements also usually include a range of fringe benefits, such as paid vacations, insurance, and pension plans. Physicians may work directly for plans or may be employed by the medical group or the hospital that has contracted with the plan to provide services. In the operation of such plans, physicians should not be subjected to lay interference in professional medical matters and their primary responsibility should be to the patients they serve.

E-8.053 Restrictions on Disclosure in Health Care Plan Contracts

Despite ethical requirements demanding full disclosure of treatment options regardless of limitations imposed by plan coverage, some health care plans include clauses in their employment contracts that directly inhibit the ability of physicians to keep their patients fully informed. These types of contract clauses erect inappropriate barriers to necessary communications between physicians and patients, labeled “gag clauses” by some observers. Restrictive clauses of this type impact the ability of physicians to provide information to their patients and to act effectively as a patient advocate. They also threaten to undermine individual and public trust in the profession of medicine. (1) Health care plans have the right to protect proprietary information. However, physicians should oppose any such protection that inhibits them from disclosing relevant information to patients. For this reason, physicians should advocate for the elimination of contract clauses that could prevent them from raising or discussing matters

relevant to patients' medical care. (2) The right of patients to be informed of all pertinent medical information must be reaffirmed by the medical profession, and individual physicians must continue to uphold their ethical obligation to disclose such information. (3) Physicians, individually or through their representative, should review their contracts carefully to ensure that they are able to fulfill their ethical obligations to patients. (II, III, VI) Issued June 1998 based on the report "Restrictions on Disclosure in Managed Care Contracts," adopted June 1996; updated June 2002.

E-8.132 Referral of Patients: Disclosure of Limitations

Physicians should always make referral decisions based on the best interests of their patients, regardless of the financing and delivery mechanisms or contractual agreements between patients, health care practitioners and institutions, and third party payers. When physicians agree to provide treatment, they assume an ethical obligation to treat their patients to the best of their ability. If a physician knows that a patient's health care plan or other agreement does not cover referral to a non-contracting medical specialist or to a facility that the physician believes to be in the patient's best interest, the physician should so inform the patient to permit the patient to decide whether to accept the outside referral. Physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward, or the avoidance of financial penalties. Because patients must have the necessary information to make informed decisions about their care, physicians have an obligation to disclose medically appropriate treatment alternatives. Physicians should also promote an effective program to monitor and improve the quality of the patient care services within their practice settings. Physicians must ensure disclosure of any financial incentives that may limit appropriate diagnostic and therapeutic alternatives that are offered to patients or that may limit patients' overall access to care. This obligation may be satisfied if the health care plan or other agreement makes adequate disclosure to enrolled patients.

E-9.02 Restrictive Covenants and the Practice of Medicine

Covenants-not-to-compete restrict competition, disrupt continuity of care, and potentially deprive the public of medical services. The Council on Ethical and Judicial Affairs discourages any agreement which restricts the right of a physician to practice medicine for a specified period of time or in a specified area upon termination of an employment, partnership, or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients' choice of physician.

E-9.05 Due Process

The basic principles of a fair and objective hearing should always be accorded to the physician or medical student whose professional conduct is being reviewed. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right of a hearing, the opportunity to be present and to rebut the evidence, and the opportunity to present a defense. These principles apply when the hearing body is a medical society tribunal, medical staff committee, or other similar body composed of peers. The composition of committees sitting in judgment of medical students, residents, or fellows should include a significant number of persons at a similar level of training. These principles of fair play apply in all disciplinary hearings and in any other type of hearing in which the reputation, professional status, or livelihood of the physician or medical student may be negatively impacted. All physicians and medical students are urged to observe diligently these fundamental safeguards of due process whenever they are called upon to serve on a committee which will pass judgment on a peer. All medical societies and institutions are urged to review their constitutions and bylaws and/or policies to make sure that these instruments provide for such procedural safeguards.

7. POTENTIAL COMBINED HOD / NAC MEETING

Reference committee hearing: see report of [Reference Committee F](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

See Policy [G-600.125](#).

At the 2012 Annual Meeting, the House adopted Policy G-600.125, AMA Meeting Schedule, which reads:

1. Our AMA will convene as a pilot a combined interim policymaking meeting and National Advocacy Conference.
2. The combined meetings will be held at a location in the Washington, DC metropolitan area and at an appropriate time to avoid incurring contractual penalties.
3. The pilot will take place within a reasonable time frame and with adequate notice to members of the House of Delegates.
4. Our AMA sections will be afforded the opportunity to meet immediately prior to and in close proximity to the meetings of the House of Delegates.

This report summarizes findings from the Board's efforts to implement the policy and concludes that combining the National Advocacy Conference (NAC) and the Interim Meeting would be difficult to accomplish without adversely affecting the NAC in particular while yielding no financial or time savings for participating individuals and physician organizations. Nonetheless, the Board will continue to investigate options that will allow a combined meeting.

LOGISTICAL ISSUES

In pursuing a combined meeting, several elements were deemed necessary, including the value of advocacy early in the year, the availability of members of Congress for visits, and the location of the meeting venue.

Time of Year

Optimal timing of the NAC is affected by a number of issues that dictate a February or March date.

- Visits with members of Congress are integral to the NAC. This time frame makes it likely Congress will be in session, whereas other times of year are far less predictable, especially years in advance, as is necessary to secure meeting space.
- Visits early in the Congressional session when budgetary issues are being framed for the upcoming fiscal year are likely to have greater influence on the legislative process.
- Holding the combined meeting in November around the current schedule of Interim Meetings is not viable for the NAC portion of the meeting, because Congress will frequently not be in session, particularly in election years.

Meeting Days

Visits with members of Congress are best able to be scheduled Tuesday through Thursday given the usual Congressional activities. Members of Congress are most likely to be at the Capitol at that time, and mid-week meetings on the Hill would be facilitated by a combined meeting in which the House of Delegates (HOD) meeting is preceded by the section meetings and followed by the NAC portion of the combined meeting.

Meeting Venue

Experience with the NAC indicates that if members of Congress or the Administration are to appear at the meeting, it must be held in close proximity to the Capitol. In fact, to attract and confirm legislative speakers for the NAC, it is mandatory that the meeting be located conveniently to the Capitol so that speakers can quickly return to the Hill in the event of a vote. Legislators will not confirm speaking engagements that do not allow them this latitude.

Unfortunately the desire for a downtown location is at odds with the capabilities at hotels in the city. No single hotel within Washington, DC proper can accommodate a HOD meeting as it is currently structured, because the number of concurrent caucuses and meetings is too large. On a typical day at an HOD meeting, for example, some 130 separate meetings take place, with as many as 40 occurring concurrently.

PILOT OPTIONS

Given these considerations, a combined meeting would have to balance a number of competing interests. The following options represent the range of possibilities, but it should be noted that none fully meets the policy's directive to avoid contractual penalties.

1. The 2013 Interim Meeting, scheduled for November 16–19 at the Gaylord National in National Harbor, Maryland, would appear to present an early opportunity to test elements of a pilot combined meeting. Upon adjournment of the 2013 Interim Meeting, presentations on the AMA's advocacy agenda and briefings to prepare for visits to Capitol Hill could be offered on Tuesday afternoon (Nov. 19) and, if necessary, Wednesday morning (Nov. 20), before participants commute into Washington for visits with lawmakers.

However, this is not recommended based on the dates of the meeting and the hotel location. First, there is a significant risk that Congress will not be in session at that time. (Thanksgiving is Nov. 28.) Clearly this will

impact the efficacy of Hill visits and the opportunity to have members of Congress address the NAC. Second, the Gaylord National's location will adversely affect the quality of all speakers that the NAC will be able to attract. Based on AMA's experience with the NAC, reports from other groups that have met at the Gaylord and consultation with speakers' representatives, as well as Gaylord staff, the location is generally not a good venue for securing outside speakers. The Gaylord National is approximately 30-40 minutes from the Capitol, meaning travel time will also cut into attendees' ability to attend sessions should they be able to secure meetings with members of Congress. In addition travel back and forth will be an added expense and inconvenience for attendees. Buses with staggered departures would be required to accommodate the number of people, and departure times would have to be carefully coordinated with scheduled appointments. A final concern with this option is the great potential that many attendees of the HOD meeting will in fact leave once the House has adjourned and not stay for the NAC, thus undermining our advocacy activities.

2. A variation of Option 1 would have all participants transfer to a downtown Washington meeting location on Tuesday afternoon (Nov. 19) following adjournment of the 2013 Interim Meeting for presentations on the AMA's advocacy agenda and briefings to prepare for visits the next day on Capitol Hill. The group would return to the Gaylord for overnight accommodations, and on Wednesday morning (Nov. 20) participants would again commute into Washington for visits with lawmakers.

This option would resolve the issue of securing quality outside speakers, but all of the other obstacles noted in Option 1 remain.

3. Because the Gaylord National provides a suitable venue for the HOD meeting, another option would be to hold the HOD at that property in the February / March time frame and then move to a downtown hotel for the NAC. This would increase the chance of securing key speakers from Congress. However, it precludes the possibility of building a truly combined and coherent advocacy-focused meeting, and it gives rise to additional expense for and the nuisance of moving to a new location. Like the first, this option has the potential to diminish the advocacy program if participants abandon the NAC rather than change locations. At this time, it is unclear whether suitable dates can be secured at separate properties. The Gaylord National does have limited availability in the February / March time frame in 2016 and 2018.
4. A fourth option would involve using the Washington Convention Center (WCC) for the combined meeting in conjunction with one or more nearby hotels. However, the AMA's meeting does not meet the "city-wide meeting" standard required by the WCC to reserve space years in advance. To reserve space more than 18 months before an event that will take place during high demand times of the year, the WCC requires that a group utilize at least 2500 sleeping rooms on the peak night. While AMA meetings are attractive for a hotel, they are not large by industry standards, typically requiring no more than 1600 sleeping rooms on the peak night. This seriously affects our AMA's ability to plan future meetings. In addition, assuming the WCC can be secured, separate fees for rental of the property would be required, possibly in excess of \$200,000.

OTHER CONSIDERATIONS

A number of other considerations merit mention. Existing contractual obligations mean that no combined meeting can be piloted before 2016 without incurring substantial cancellation penalties (up to \$900,000 for Interim Meetings). The unfortunate reality, however, is that adequate space for a true combined meeting in a downtown Washington property is not available in 2016 or 2017. This includes use of the Washington Convention Center, which will not reserve space for the AMA meeting outside the 18 month window in any case. Dates in 2018 and later would require the use of multiple hotels if the combined meeting is to be situated in downtown Washington. Although the sections sometimes meet in hotels other than where the HOD meets, in this case, the combined meeting itself would require the use of multiple hotels in order to accommodate the number of ancillary meetings and caucuses.

Only the first option would permit a pilot, combined meeting before 2016, but every society in the Federation would incur increased expenses for such a meeting. The additional *per person per day* costs are estimated to be between \$254 and \$400, with the lower figure based on the federal government's *current* per diem and *maximum* sleeping room allowances for Washington, DC.¹ In addition, under this option, the 2014 NAC would meet as planned

¹ The General Services Administration determines the maximum rates for federal employee travel. See www.gsa.gov. The November 2011 lodging limit for the greater Washington area was \$183 (November 2012 is not available), and the current daily

because it cannot be canceled without incurring a \$100,000 penalty. If piloting a combined meeting in late-2013 as part of the already contracted 2013 Interim Meeting of the HOD leads to too few participants attending the 2014 NAC, attrition penalties could apply regardless.

The AMA website (www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/meeting-dates.page) lists dates and locations for HOD meetings through 2017, and in contracting with hotels in the meeting cities, some cost reductions were negotiated for such things as Internet service, audio-visual equipment rentals and catering. These cost reductions would have benefited both our AMA and societies hosting events during the HOD meeting, but were predicated on holding at least two HOD meetings in each city. These cost reductions could be lost in the event that a combined meeting in Washington becomes the norm before 2022. The overall value of the cost reductions was approximately \$600,000 through 2021.

The NAC currently has a registration fee for participants, but the proceeds do not cover the meeting costs. Our AMA budgets approximately \$246,000 to subsidize the event. There is no plan to eliminate the registration fee for the NAC. HOD meetings have never charged a registration fee, nor is there any intention of implementing one.

HURDLES TO A COMBINED MEETING

If a pilot meeting can be accomplished and the decision is made to permanently schedule a combined HOD-NAC meeting in Washington, DC on an annual basis in the February / March time frame, a number of scheduling and other considerations will need to be addressed.

- The time required to smoothly transition to a new meeting schedule could require up to a decade after the pilot. This is because of the number of meetings throughout the Federation (state and national specialty societies need time to adjust their scheduled meetings) and the availability (or lack thereof) of space in suitable hotels. Moving the Interim Meeting from December to November, for example, took seven years.
- The February / March time period is a popular meeting time in Washington, DC, which limits AMA's ability to negotiate sleeping room rates and benefits such as complimentary Internet service. In fact, over the last several years, the typical sleeping room rate for the NAC has been nearly \$100 per night more than the rates at the Annual and Interim Meetings.
- Likewise the costs of events such as caucuses and meals that are borne by societies will be higher in Washington than in many other locales. For many, the additional expenses associated with an extended stay for a combined meeting in Washington could match or even exceed the expense associated with a separate meeting in a typical HOD hotel.
- Under the parameters outlined in the policy, a combined meeting would get underway late-Thursday with section meetings. Those would conclude on Saturday, and the HOD would begin that afternoon and adjourn by Tuesday morning. The NAC portion of the meeting would then follow on Tuesday and Wednesday. Unfortunately, the elements of a combined meeting are such that concurrent sessions are not feasible; the HOD cannot meet during the section meetings, nor can the NAC convene while the HOD is in session. Consequently, a number of delegates would be absent from their offices for a week or possibly more if travel requires it. For at least some members, two shorter absences are more easily arranged than is a single, longer absence. Ultimately, the preferences and needs of the meeting participants will have to be determined. Using figures from the 2012 NAC and Annual Meetings, only 116 delegates or alternate delegates attended both meetings from a pool of 934 (approximately 12.4%); this includes those state presidents certified as additional alternate delegates under §2.35 of the Bylaws.
- If the preferred option is to host a combined meeting in downtown Washington, it would be necessary to use multiple hotels. This is due to both the time of year and the need for multiple concurrent caucuses and other meetings. Suburban locations, as noted earlier, will severely impact the ability to attract members of Congress to the NAC portion of a combined meeting.

allowance for meals and incidentals is \$71. Sleeping rooms are not necessarily available at the government rate, and hotels limit the number of rooms available at that price.

DISCUSSION

While the concept of a combined meeting is appealing, circumstances effectively preclude our AMA's ability to host such a meeting on an annual basis in Washington, DC. AMA's meetings are simultaneously too small to contract for a suitable venue and too large to fit into a single hotel within the city. To move to a suburban location for a combined meeting would at best merely diminish the value of the NAC, as it would mean that key Congressional leaders and members of the Administration would no longer be a part of the program. In addition relatively few delegates or alternate delegates attend the NAC, and the marginal expenses of meeting in Washington are significantly higher, yielding no savings across the Federation. Under these circumstances, the Board of Trustees cannot recommend further consideration of a combined meeting.

However, the Board also recognizes that a great deal of time, thought and effort have been placed in considering options for AMA meetings, particularly the Interim Meeting and NAC, over the past several years. The Board is committed to working with management to further study these options and the opinions expressed by delegates and the Federation. The Board will continue to look for new alternatives, and should they arise, bring them to the HOD for consideration.

RECOMMENDATION

While the concept of a combined meeting is appealing, the circumstances enumerated in this report effectively preclude our AMA's ability to host such a meeting in the near term.

The Board of Trustees therefore recommends that the following statements be adopted and the remainder of this report filed:

1. Our AMA will organize and implement the pilot specified in Policy G-600.125; and
2. A study and report on the feasibility and logistics of reorganized future meeting dates and schedules shall be developed and presented to the House of Delegates; and
3. State and specialty societies shall be queried on the potential number of members who would attend a new, revised Interim / NAC meeting.

8. PATIENT PROTECTION AND AFFORDABLE CARE ACT NONDISCRIMINATION LANGUAGE

Reference committee hearing: see report of [Reference Committee B](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

See Policy [H-35.968](#).

Policy H-35.968, Averting a Collision Course Between New Federal Law and Existing State Scope of Practice Laws, was amended at the 2012 Interim Meeting by the adoption of Resolution 241-A-12. The policy calls for the American Medical Association (AMA) to "promptly initiate a specific lobbying effort and grassroots campaign to repeal the provider portion of the Patient Protection and Affordable Care Act's (ACA) 'Non-Discrimination in Health Care' language, including direct collaboration with other interested components of organized medicine." The non-discrimination language in section 2706 of the ACA states that health plans may not discriminate with respect to participation in the plan or coverage against any health care provider who is acting within their scope of practice. The statute also specifically states that this is not an any willing provider requirement and that plans may establish varying reimbursement rates based on quality or performance measures.

Reference Committee B recommended that the existing Policy H-35.968 be reaffirmed in lieu of Resolution 241-A-12. That policy contains almost identical language to Resolution 241. At the 2012 annual meeting, however, the HOD voted to adopt Resolution 241 with the additional amendment that "our AMA report back at I-12 on the specific activities that have occurred regarding AMA Policy H-35.968."

At this time, no specific lobbying effort to repeal Section 2706 has been initiated. This is due to the lack of willingness by Congress to enact necessary improvements in the ACA at this time. The AMA will continue to closely monitor this issue and work to identify opportunities to repeal Section 2706.

SECTION 2706 OF THE AFFORDABLE CARE ACT

The language that is the subject of Resolution 241-A-12 was included in the Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), at the urging of Senator Tom Harkin (D-IA), long a champion of the non-physician provider community. The provision was included in the bill with the strong support of organizations representing those providers. Specifically, the language in question states:

(a) Providers. - A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

It is important to note the language specifically states that it is not to be interpreted as an "any willing provider" provision, nor does it allow for any provider to provide care that is not within their scope of practice.

EFFECT OF SECTION 2706

While the ultimate effect of Section 2706 is unknown, and no clarifying regulations have been issued, the statutory language is not without precedent.

42 U.S.C 1396u-2 is current law that regulates Medicaid managed care plans. Specifically, section 1932 (b)(7) of that statute reads:

Antidiscrimination. - A Medicaid managed care organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

Additionally, regulations governing the operation of Medicare Advantage plans address this same issue at 42 CFR §422.205, stating that:

Provider antidiscrimination rules. (a) General rule. Consistent with the requirements of this section, the policies and procedures concerning provider selection and credentialing established under §422.204, and with the requirement under §422.100(c) that all Medicare-covered services be available to MA plan enrollees, an MA organization may select the practitioners that participate in its plan provider networks. In selecting these practitioners, an MA organization may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification. If an MA organization declines to include a given provider or group of providers in its network, it must furnish written notice to the effected provider(s) of the reason for the decision. (b) Construction. The prohibition in paragraph (a)(1) of this section does not preclude any of the following by the MA organization:

(1) Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees (except for MA private-fee-for-service plans, which may not refuse to contract on this basis). (2) Use of different reimbursement amounts for different specialties or

for different practitioners in the same specialty. (3) Implementation of measures designed to maintain quality and control costs consistent with its responsibilities.

(See 42 CFR §422.205. See also the final rule implementing this language at 65 Fed. Reg. 126. June 29, 2000.)

While these provisions are substantially similar to the language of section 2706, they are not identical. Your Board of Trustees is unaware of any concerns raised by the Federation regarding either of these provisions, and continues to monitor all federal health care programs for inappropriate actions regarding credentialing or violations of state scope of practice statutes and regulations.

Despite the fact that the actual scope of section 2706 is limited, that fact has not prevented non-physician providers from attempting to use other similar federal statutes to justify inappropriate scope expansions at the state level. The AMA remains a leader, in partnership with state and national medical specialty societies, in ensuring that states do not inappropriately expand the scope of practice for non-physician providers beyond their training and expertise as well as promoting the importance of physician-led health care teams.

Additionally, the AMA remains engaged in state and national efforts to ensure all health care professionals—physicians and non-physicians—accurately and clearly disclose their training and qualifications to patients and that they do not promote health care services that are beyond their scope. These activities are ongoing through the Scope of Practice Partnership and are critical to ensuring that patients are properly educated as to the credentials and training of all of their providers of care.

REFINEMENTS TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Since the enactment of the ACA, the AMA has continued to seek legislative and regulatory refinements as directed by the HOD including: repeal of the Independent Payment Advisory Board (IPAB), medical liability reform, private contracting, and antitrust reforms (H-165.833); Non-Discrimination in Health Care language (H-35.968); and other provisions that are not consistent with existing AMA policy (H-165.835).

Given the highly partisan environment which currently surrounds the ACA, only a handful of opportunities have presented themselves to modify specific provisions of the law. In each instance, the AMA has engaged directly with members of Congress and through physician and patient grassroots to advance these priorities. Specifically, legislation to repeal the IPAB and enact medical liability reforms consistent with AMA policy has passed the House of Representatives with the strong support of the AMA and the Federation, but has failed to advance in the Senate. Additionally, the AMA has supported the efforts of members of Congress in introducing legislation to allow for private contracting consistent with AMA policy and separately, legislation to reform the antitrust laws. Neither of these provisions, however, has advanced in the 112th Congress. AMA continues to work with the sponsors of both bills to identify opportunities for their enactment.

At this time, there has been no effort by Congress to repeal section 2706 and seemingly little interest in Congress to do so at this time. Despite the efforts of the House of Representatives to repeal the highly controversial IPAB, and the successful effort to repeal the widely criticized Form 1099 reporting requirements, few other efforts have been made to target specific portions of the law. This is due primarily to a divide in Congress over how to deal with the ACA going forward. There are members of Congress who would like to enact improvements to the ACA that are widely agreed to be necessary. The ACA was adopted in a highly partisan atmosphere and under restrictive budgetary rules that allowed only limited improvements as the two houses of Congress reconciled their versions of the bill. Unfortunately, with the limited exceptions noted, opponents of the ACA have little incentive or desire to improve the bill prior to the 2012 elections. Some have argued that to do so would make the ACA more acceptable and therefore diminish the political will for repeal. This divide has left Congress generally unable and unwilling to make additional targeted changes, including repeal of section 2706.

Additionally, it must be recognized that the supporters of section 2706 are, in themselves, a significant political force with narrow and sharply defined interests, including preservation of section 2706. A survey of recent advocacy materials of physician organizations shows little activity within the Federation on this issue and therefore little interest by potential champions in Congress to put themselves between two powerful health care constituencies.

CONCLUSION

To date, no specific grassroots activities have taken place as directed by H-35.968 due to the lack of any legislative opportunity to advance repeal of section 2706. AMA staff, in collaboration with others in the Federation, will continue to seek out opportunities to advance this policy and will initiate specific efforts as soon is reasonable and practicable.

RECOMMENDATIONS

The Board of Trustees recommends that the following statements be adopted and the remainder of the report filed.

1. That our American Medical Association reaffirm Policy H-35.968.
2. That our AMA create and actively pursue legislative and regulatory opportunities to repeal the so called “Non-discrimination in Health Care” clause in Public Health Service Act Section 2706, as enacted in the Patient Protection and Affordable Care Act (PPACA).
3. That our AMA lead a specific lobbying effort and grassroots campaign in cooperation with members of the federation of medicine and other interested components of organized medicine to repeal the provider portion of PPACA’s “Non-Discrimination in Health Care” language.
4. That our AMA Board of Trustees report back at the 2013 AMA Annual Meeting.

9. 2013 STRATEGIC PLAN

Reference committee hearing: see report of [Reference Committee F](#).

HOUSE ACTION: FILED

Since its founding in 1847, the AMA has been dedicated to promoting the art and science of medicine and the betterment of public health. This high purpose has unified America’s physicians through 165 years of profound scientific, demographic, economic, technological and political change. The strategy by which the AMA carries out its mission is, by necessity, adaptive to the current environment while upholding the enduring mission.

As 2013 approaches, the AMA has set forth a multi-year strategy, defined during a period in which the future of health care appears particularly unsettled. This five-year plan looks forward--in a focused, bold, and integrated manner--to lead the profession through the challenges of today and to create a future in which our patients and our nation enjoy better health, enabled by a high-performing health care system that is led by physicians who uphold the AMA’s core values of leadership, excellence, and integrity and ethical behavior.



Three focus areas define the core of the strategy: improving health outcomes, accelerating change in medical education, and shaping delivery and payment models that promote practice sustainability and professional satisfaction. Collectively, these focus areas capture the approach to the AMA’s mission in today’s environment and respond to the imperative to achieve high, relevant impact for physicians, residents, medical students and patients.

The remainder of this report outlines the scope and approach for each focus area, followed by an overview of the organizational strategies that will be critical for success.

IMPROVING HEALTH OUTCOMES

Commitment to the quality of America's health and health care is central to the AMA mission. The AMA-convened Physician Consortium for Performance Improvement (PCPI®) was created as a national, physician-led initiative dedicated to enhancing quality and patient safety. Over the past decade, PCPI has become a national leader in the development of evidence-based performance measures that are clinically meaningful, meet the current and future needs of physicians, and are used in national accountability and quality improvement programs.

The AMA is now poised to bring a bolder, more forward-looking focus to its work in the quality arena. The escalating national imperative to improve both the quality and the cost of care, the growth of enabling data sources (such as registries), and the practical realization that process measures alone cannot drive better care, are among the factors that have directed AMA's strategy toward improving health outcomes. This work will build upon and complement the work of the PCPI.

Collaborating with other leaders in the outcomes arena, the AMA will work to demonstrate improvements in clinical outcomes, reduce health care disparities and unwarranted variation in care, advance the quality and safety of health care and contribute to the appropriate use of finite health care resources.

Toward these goals, the AMA will identify a focused set of health conditions and corresponding outcomes of high-potential impact on the US population, and set a course of innovation and action to develop, enhance and implement strategies aimed at reducing the disease and cost burden associated with the selected conditions. Our work will include:

- Selecting a set of clinical outcomes and associated metrics by which to measure them;
- Collaborating with leading organizations on improvement strategies and with stewards of data to determine population-level rates of these outcomes;
- Setting national goals for improvement of these outcomes;
- Identifying effective strategies which achieve the "triple aim:" Better health, healthy people/healthy communities, and affordable care;
- Validating, as needed, the identified leading practices/improvement strategies;
- Engaging physicians/care teams to facilitate adoption of effective strategies through tools, education and communication; and
- Tracking population-level outcomes to evaluate the impact on health, productivity and health care costs.

We anticipate that many intermediate outcomes, or milestones, will be steps along the critical pathway. And we take to heart the advice of national experts to think nationally, but act locally--to connect with practice sites, communities and patients.

When we are successful, we will be able to tie the AMA-promulgated change strategies to a demonstrated increase in health and health system effectiveness, including more cost-effective use of health care resources (in effect, advancing the "triple aim").

ACCELERATING CHANGE IN MEDICAL EDUCATION

Across the continuum of physician education, a gap persists between how physicians are currently being trained and the future needs of our health care system. Consistent with its historic leadership in physician education, ranging from setting the standards for medical education incorporated into the Flexner Report in 1910 to the more recent Initiative to Transform Medical Education, our AMA commits to achieving better alignment of education outcomes with the changing needs of our health care system.

In 2013, we will launch a new, multi-year program designed to catalyze a new evolution of undergraduate medical education (UME) through innovation with medical schools and other stakeholders. We will define criteria for focused innovation using a structured review process and, over the next five years, will establish relationships with select medical schools and health care systems to develop innovations supporting new, flexible and outcomes-based education.

At the same time, we will continue working to shape graduate medical education (GME). Ongoing efforts in this area will include working closely with the Accreditation Council on Graduate Medical Education (ACGME) and Residency Committees on GME standards, federal and state advocacy for GME financing, and solutions for workforce issues.

AMA's emphasis on innovation in UME is designed to enhance alignment with transitions across the continuum of medical education, including the new accreditation system being implemented by ACGME. Further, as cosponsor of the Liaison Council on Medical Education (LCME), our AMA has a solid platform for leadership in this effort. The strategy is designed to support dissemination of schools' successes by establishing a well-coordinated, criteria-based program of innovation to optimize visibility, recognition and momentum both within and across participating schools.

Finally, recognizing the ongoing learning needs of physicians, residents and students across the continuum of education, the AMA will facilitate electronic access to AMA and *JAMA* continuing medical education (CME) while developing and disseminating additional CME and other learning tools that support students, residents and practicing physicians

When we are successful, specified improvements to the approach to UME will have been tested, refined and adopted as "mainstream" options. The improvements will contribute in a meaningful way to the effectiveness of medical education, enabling the next generation of physicians to maintain the tradition of professional and clinical excellence even as the health care environment continues to evolve.

DELIVERY AND PAYMENT MODELS: PRACTICE SUSTAINABILITY AND PROFESSIONAL SATISFACTION

Transformative changes in health care delivery and payment structures have exacerbated professional uncertainty and even a sense of vulnerability among physicians. In response, our AMA has committed to helping physicians cope with and lead advances in how care is organized, delivered and paid for in the future.

In the near term and at the federal level, our work toward repeal and replacement of the sustainable growth rate (SGR) Medicare payment update regulation remains intense. This is essential to developing a high-performing Medicare program. Equally critical is defining and implementing a replacement that meets patients' health care needs--one in which Medicare invests and supports physician practice infrastructure and provides for payment updates that reflect progress on quality improvements and managing costs. This work continues to be guided by policies established by the House of Delegates, with ongoing input from AMA councils and advisory groups convened in collaboration with the Federation.

Our focus is sensitive to broader challenges in payment and delivery reform, including diversity in the level of care integration, many untested financial models, and sharp scrutiny of emerging public and private payment models. Physicians and markets are in different stages of integration and readiness to implement change. Therefore our focus involves facilitating transition for all physicians who are pursuing a new threshold of practice innovation. Our focus also involves influencing systemic change, such that public/private payers implement policies to reward physicians for improving care and patient health while bending the cost curve. We seek payment policies that reflect diversity of physician services, levels of clinical integration, and risk. We seek a range of options that allows physicians to choose models that fit their practice--including solutions that enable continued viability of small, privately owned physician practices.

The results we seek require a body of evidence from which to identify and showcase practice innovations that lead to greater physician professional satisfaction and a sense of long-term practice sustainability. Toward this end, we are embarking upon a new body of work that directly engages physicians who are experiencing the challenges of day-to-day practice. In 2013, we will study a cohort of practices representing a cross-section of specific delivery, payment, and practice attributes, and examine how those attributes correlate with physicians' perspective of satisfaction and sustainability. By probing patterns, correlations and insights, we aim to identify and develop models to be adopted/adapted by physicians in different practice situations. We undertake this work without any assumption that the best future model is represented in the best model that currently exists, or even that there is one "best" model. During 2013, we will create a set of case studies that capture degrees of "success" in various settings, including information about the success factors, pathways, tradeoffs, and even contraindications. This evidence base

will provide a foundation for activation of findings through physician tools and resources, education, federal and state policy advocacy, and systemic change that would touch payers, physicians, hospitals, systems and patients.

This effort will not displace traditional policy priorities, but will provide cohesion, momentum, and focus on charting an achievable and impactful course for America's physicians, residents, students and patients. We will have succeeded if:

- We have identified and continuously updated solutions that provide reasonable stability for physicians during coming transitions--which for some may take five to 10 years;
- The solutions are relevant across different specialties and different geographies; and
- The solutions include a spectrum of models that can be adopted/adapted serially over time by physicians as they gain knowledge about and capabilities for practice change options.

This effort links appropriately to the fundamental integrity of the profession, satisfaction of patients, and ability to attract the next generation's best and brightest to become physicians.

ORGANIZATIONAL SUCCESS FACTORS

This multi-year strategy brings to bear the strength of each and every component of the AMA Equation--the means by which we define our reach, influence and service to the practice of medicine:



As always, AMA's strategy is grounded in policy established by the House of Delegates as the voice of physician organizations. The strategy reinforces our AMA's commitment to the mission and to the professional needs of physicians, thus encouraging direct engagement through AMA membership. AMA's strategy emphasizes and sharpens our support of physicians with the tools they need to make decisions about--and then successfully implement--practice adaptations such as use of clinical data, practice structure, hospital and payer relationships, incentive programs, and other levers. AMA's strategy honors our historic leadership in research and education by developing an evidence base upon which to define and promote appropriate change. AMA's strategy calls upon our advocacy presence not only to fight counter-productive legislation, regulation or judicial precedent, but also to proactively shape change that is consistent with AMA policy. One prominent example is our ongoing advocacy to remove current restrictions in Medicare law to allow patients and physicians to enter into private contracts without penalty to either party.

Nevertheless, the plan will require a strategic shift for the AMA – focusing more on outcomes than process, and elevating our role from simply convening to partnering and doing. Other business and operational elements of this strategy call for greater focus and integration within and across components of the AMA Equation. For example:

- We will pursue refinements in the AMA portfolio of products and services to better align content and impact with our strategy. The goal, which includes achieving better appreciation among AMA members of the breadth and depth of AMA capabilities to serve them, requires AMA to develop a deeper understanding of the market segments we intend to serve. Deeper market knowledge is needed to increase the portfolio's relevance for physicians, inform decisions about the products and services, and ultimately, support the revenue stream needed to achieve the mission objectives.
- We will better integrate our activities internally to become more effective in how we develop and support products and services and how we deliver on the mission. For example, starting in 2013, AMA's nine *Archives* journals will be unified under the *JAMA* brand and marketed as part of the *JAMA* Network.
- We will cultivate productive partnerships and enlist active support not only with the state and specialty medical societies that comprise the Federation, but also with other organizations and health care sectors whose interests align with those of the AMA and whose collaboration is needed to achieve our strategic objectives.

- We will bring a tighter focus to what we do so that our efforts are concentrated on the long term and our work will have the greatest benefit for physicians and patients.

This rolling five-year plan is dynamic--to be refined and shaped by new information, insight and changes in the environment. Throughout the process, we will remain attuned to our mission to promote the art and science of medicine and the betterment of public health.

10. SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES - FIVE-YEAR REVIEW

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

See Policy [G-600.984](#).

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) scheduled to submit information and materials for the 2012 American Medical Association (AMA) Interim Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020 and AMA Bylaw 8.50.

Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of national medical specialty organizations is also required as set out in AMA Bylaw 8.20.

The following organizations were reviewed for the 2012 Interim Meeting:

- American Association of Neuromuscular and Electrodiagnostic Medicine
- American College of Rheumatology
- American Society for Dermatologic Surgery
- American Society of Clinical Oncology
- American Society of Maxillofacial Surgeons
- Radiological Society of North America
- Society of Nuclear Medicine and Molecular Imaging
- Society of Thoracic Surgeons

In addition, the following organizations were to be reviewed for having completed a one-year probationary period for having failed to meet the membership requirements when they were reviewed for the 2011 Interim Meeting:

- American Society for Radiation Oncology
- American Society for Surgery of the Hand
- American Society of Cytopathology
- Society for Vascular Surgery

Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are attached.

The materials submitted indicate that the: American Association of Neuromuscular and Electrodiagnostic Medicine, American College of Rheumatology, American Society for Dermatologic Surgery, American Society for Surgery of the Hand, American Society of Clinical Oncology, Radiological Society of North America and Society of Thoracic Surgeons meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that the: American Society for Radiation Oncology, American Society of Cytopathology, American Society of Maxillofacial Surgeons, Society of Nuclear Medicine and Molecular Imaging and Society for Vascular Surgery did not meet the membership requirements for specialty organizations represented in the HOD and therefore are not in compliance with the five-year review requirements.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

That the American Association of Neuromuscular and Electrodiagnostic Medicine, American College of Rheumatology, American Society for Dermatologic Surgery, American Society for Radiation Oncology, American Society for Surgery of the Hand, American Society of Clinical Oncology, American Society of Cytopathology, American Society of Maxillofacial Surgeons, Radiological Society of North America, Society of Thoracic Surgeons, Society for Nuclear Medicine and Molecular Imaging, and Society for Vascular Surgery retain representation in the American Medical Association House of Delegates.

APPENDIX

Exhibit A - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
American Association of Neuromuscular and Electrodiagnostic Medicine	1,007 of 3,671 (27%)
American College of Rheumatology	1,287 of 5,817 (22%)
American Society for Dermatologic Surgery	885 of 3,007 (29%)
American Society for Radiation Oncology	845 of 3,747 (23%)
American Society for Surgery of the Hand	501 of 1,918 (26%)
American Society of Clinical Oncology	2,567 of 11,948 (22%)
American Society of Cytopathology	317 of 1,374 (23%)
American Society of Maxillofacial Surgeons	173 of 713 (24%)
Radiological Society of North America	3,026 of 19,234 (16%)
Society of Nuclear Medicine and Molecular Imaging	601 of 2,467 (24%)
Society of Thoracic Surgeons	1,059 of 4,442 (24%)
Society for Vascular Surgery	380 of 1,913 (20%)

Exhibit B - Summary of Guidelines for Admission to the House (Policy G-600.020) Specialty Societies

- The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
- The organization must:
 - represent a field of medicine that has recognized scientific validity;
 - not have board certification as its primary focus; and
 - not require membership in the specialty organization as a requisite for board certification.
- The organization must meet one of the following criteria:
 - a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty-five percent (25%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty-five percent (25%) of its physician members who are eligible for AMA membership are members of the AMA.
- The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application.
- Physicians should comprise the majority of the voting membership of the organization.
- The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
- The organization must be active within its field of medicine and hold at least one meeting of its members per year.
- The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
- The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.

10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C - Responsibilities of National Medical Specialty Organizations (Bylaw 8.20)

1. To cooperate with the AMA in increasing its AMA membership.
2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organization so that the delegate can properly represent the organization in the House of Delegates.
3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.
4. To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
5. To provide information and data to the AMA when requested.

Exhibit D - AMA Bylaws on Specialty Society Periodic Review

Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.50 Periodic Review Process. Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.20. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society or the professional interest medical association has discharged the responsibilities required under Bylaw 8.20.

8.51 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting, or may take such other action as it deems appropriate.

8.52 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.20, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.53 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.20 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.531 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.20, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.532 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.20, the House may take one of the following actions:

8.5321 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.531.

8.5322 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.