MEMORIAL RESOLUTIONS
Adopted unanimously

Amy Belser
Introduced by the California, Florida, Michigan, New York, North Carolina and Texas Delegations

Whereas, On February 10, 2012, a kind, generous, loving and dear friend who for many years has served as confidant and advisor to so many of us in this, our American Medical Association House of Delegates, was taken too soon; and

Whereas, Amy was a compassionate and tireless advocate for organized medicine, serving with dedication and intelligence; and

Whereas, Amy was a respected medical executive having served for more than 25 years with the California Medical Association, responsible for communications activities for the association, and providing campaign management and candidate support for the California Delegation to the AMA; and

Whereas, Amy's assistance was highly valued by physicians and medical executives with whom she frequently interfaced, and her expertise, humor and warm disposition were widely known and cherished among her colleagues in California and throughout the Federation; and

Whereas, Amy was loved by her colleagues both at the state and national levels and will be deeply missed; therefore be it

RESOLVED, That our American Medical Association recognize the long and dedicated service and invaluable contributions of Amy Belser to the AMA and physicians across the country; and be it further

RESOLVED, That our AMA acknowledge with deep gratitude the lifelong work performed by Amy Belser, on behalf of organized medicine; and be it further

RESOLVED, That our AMA extend its heartfelt condolences to the family of Amy Belser, and to all who feel her loss; and be it further

RESOLVED, That our AMA convey this resolution and its deepest sympathy to the surviving family members of Amy Belser, and extend our gratitude for sharing with us this remarkable, caring and much beloved woman.

Carl L. Brumback, MD, MPH
Introduced by the Florida Delegation and the American Association of Public Health Physicians

Whereas, One of the most prominent physicians in the history of public health in the United States, Carl L. Brumback, MD, MPH, passed away at age 97 in Palm Beach Gardens, Florida on January 12, 2012; and

Whereas, Dr. Brumback was the founding Director of the Palm Beach County Health Department in 1950, where he instituted many innovations and built modern health department facilities and clinics to serve the general population and those with special health needs such as migrant workers in the Everglades; and

Whereas, Dr. Brumback was recognized for his landmark achievements in community and environmental health by his inclusion in one of the leading national public health textbooks, and whose projects were always started by consulting and working first with the physicians in his community through the Palm Beach County Medical Society, and at the state level with the Florida Medical Association, serving for many years as the Chair of the Florida Medical Association's Committee on Public Health; and

Whereas, Dr. Brumback received numerous awards for his public health work including the AMA's prestigious Dr. Nathan Davis Award for Outstanding Government Service, the American Public Health Association's Sedgwick Medal, the Florida Public Health Association's Meritorious Service Award, the Palm Beach County Medical Society's Heroes in Medicine Award for Lifetime Achievement, and the Florida Medical Association's highest award, the Certificate of Merit; and

Whereas, After graduating from the University of Kansas Medical School and serving 16 months in Europe in the US Army during World War II, Dr. Brumback received his Master of Public Health degree from the University of Michigan and became at an early age the medical director at the US Atomic Energy Commission in Oakridge; and

Whereas, Dr. Brumback was a founding member of the American Association of Public Health Physicians in 1954, later served as an AAPHP President, and also received AAPHP's Lifetime Achievement Award in 2000 for his remarkable leadership, dedication and outstanding contributions to preserving and enhancing the health of the public; and

Whereas, Dr. Brumback created the first Preventive Medicine/Public Health Residency program in a county health department soon after arriving at the Palm Beach County Health Department in 1950 where he served as Director for thirty-six years; therefore be it

RESOLVED, That our American Medical Association recognize the many significant contributions of Carl L. Brumback, MD, MPH to public health and the practice of medicine; and be it further

RESOLVED, That a copy of this resolution be recorded in the proceedings of the 2012 Annual Meeting of the House of Delegates and be forwarded to Dr. Brumback's family with an expression of the House of Delegates' appreciation of his distinguished service to the health of the public, deepest sympathy and best wishes.

Alvin J. Thompson, MD, MACP
Introduced by the Washington Delegation

Whereas, In May 2012, a tireless advocate for the professionalism of medicine and the art and science of patient care, Dr. Alvin J. Thompson, unexpectedly passed away; and

Whereas, Dr. Thompson devoted his life to the pursuit of excellence in medicine in all its aspects, mentoring countless young physicians; and

Whereas, Dr. Thompson sought to bring care to those without access by a variety of creative means, as well as successfully leading the creation of a broadly based association to promote ethical biomedical animal research; and

Whereas, Dr. Thompson challenged his colleagues throughout his career to put the patient first and to be good stewards of care; pushing us all to use the capabilities of organized medicine to further the public health; and

Whereas, Dr. Thompson served as a progressive president of his county medical society and the Washington State Medical Association, and as a member of the AMA House of Delegates, mediating numerous points of view in his kind, courtly and gentlemanly way; therefore be it

RESOLVED, That our American Medical Association recognize the lifelong service of Dr. Alvin J. Thompson to his community, patients, profession and organized medicine; and be it further

RESOLVED, That our AMA convey this resolution and its deepest sympathy to the surviving family members of Dr. Alvin J. Thompson.

R. Robert Tyson, MD
Introduced by the Pennsylvania Delegation

Whereas, R. Robert Tyson, MD, a respected colleague and champion for organized medicine passed away on November 6, 2011; and

Whereas, Dr. Tyson was born on December 14, 1920, graduated from William Penn Charter School in 1938, earned a bachelor's degree at Dartmouth College in 1942 and earned his medical degree from the University of Pennsylvania in 1944; and

Whereas, Following medical duty in the Navy from 1946 to 1948, Dr. Tyson completed his residency at Temple University Hospital in 1951 and joined Temple University Medical School in 1952 as an instructor in surgery; and

Whereas, In 1962 Dr. Tyson was named a full professor at Temple University Medical School and chief of the vascular surgery section at Temple University Hospital; and

Whereas, Dr. Tyson was Chief of Surgery at Temple University Hospital in Philadelphia, Pennsylvania from 1973 to 1983; and

Whereas, Dr. Tyson was a consultant to the nationwide pre-surgical screening panel of Cornell Medical Center in 1981; and

Whereas, Dr. Tyson was president of the Philadelphia County Medical Society in 1972-1973; president of the Pennsylvania Medical Society in 1986-1987; and board chair of Pennsylvania Blue Shield from 1988-1992; and

Whereas, Dr. Tyson was the author of 78 scientific articles and five films about vascular surgery; and

Whereas, Dr. Tyson was a fellow of the College of Physicians of Philadelphia and the Philadelphia Academy of Surgery; and

Whereas, Dr. Tyson served this House as an Alternate Delegate from 1969-1978 and as a Delegate from 1979-1987; therefore be it

RESOLVED, That our American Medical Association's House of Delegates recognize the many contributions of R. Robert Tyson, MD, to his profession and to organized medicine; and be it further

RESOLVED, That a copy of this resolution be recorded in the Proceedings of the 2012 Annual Meeting of the House of Delegates and be forwarded to his family with an expression of the House of Delegates' deepest sympathy.

RESOLUTIONS

Note: Testimony on each item is summarized in the reference committee reports. Items considered on the reaffirmation calendar do not appear in the reference committee reports and were handled as part of the Committee on Rules and Credentials Supplementary Report on Sunday, June 17. The following resolutions were handled on the reaffirmation calendar: 124, 206, 208, 211, 224, 227, 232, 304, 308, 318, 322, 326, 406, 408, 416, 419, 424, 430, 506, 519 and 720.

1. HPV VACCINATION FOR MINORS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association develop and support model state legislation allowing unemancipated minors to consent to HPV vaccination.

2. USING TAX RETURNS TO IDENTIFY ORGAN DONATION STATUS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association study the implementation of a national database of organ donors that utilizes state and/or federal tax returns as a means to identify organ donors.

3. SUPPORTING VOLUNTARY ORGAN DONATION FROM DEATH ROW PRISONERS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association reexamine the issue of lethal injection and organ retrieval from executed prisoners and report on its findings at the 2013 AMA Annual Meeting.

4. EDUCATING MEDICAL PROVIDERS AS FIRST-LINE RESPONDERS TO STOP HUMAN TRAFFICKING
Introduced by Illinois Delegation

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association adopt policy consistent with the encouragement of physicians to act as first responders in addressing human trafficking; and be it further

RESOLVED, That our AMA encourage the creation of a curriculum to screen for and identify victims of human trafficking and increase awareness of the resources available to help restore basic human rights and dignity to those victims currently in captivity; and be it further

RESOLVED, That the AMA develop guidelines on how to intervene, with the purpose of educating and empowering medical students, physicians, and all health care professionals as first-line responders against human trafficking.

5. SHARED STEWARDSHIP OF HEALTH CARE COSTS
Introduced by Wisconsin Delegation

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: POLICIES H-155.966, H-373.997, AND H-450.938 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work to promote the concept of shared stewardship of health care costs by promoting transparency of prices, true costs, Medicare reimbursements, Medicaid payments for services, drugs, procedures and treatments available at the time of service so there could be shared responsibility for the decisions at the patient physician visit; and be it further

RESOLVED, That our AMA promote the concept of shared stewardship of health care costs by working to have available to physicians and patients at the time of service true evaluations of the safety, complications, and proven clinical effectiveness of services, drugs, procedures and treatments in so far as that knowledge is available; and be it further

RESOLVED, That our AMA work to develop new CPT codes to reimburse the physician for the time spent in shared stewardship visits; and be it further

RESOLVED, That our AMA promote tort protection for decisions made in a shared responsibility/shared stewardship patient physician relationship.

6. HPV VACCINE AND CERVICAL CANCER PREVENTION WORLDWIDE
Introduced by American Congress of Obstetricians and Gynecologists and American Medical Women's Association

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED
See Policy H-440.872

RESOLVED, That American Medical Association Policy H-440.872, HPV Vaccine and Cervical Cancer Prevention Worldwide, be amended by addition of 3(c) as follows:

Our AMA recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

7. SURROGATE CONSENT FOR LIVING ORGAN DONATION
Introduced by Maryland Delegation

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-370.964

RESOLVED, That our AMA oppose the practice of surrogate consent for living organ donation from patients in a persistent vegetative state.

8. THE RECOGNITION AND PROTECTION OF HUMAN TRAFFICKING VICTIMS
Introduced by Michigan Delegation

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association encourage editors and publishers of medical training literature to include human trafficking screening questions in recommendations and guidelines for conducting a medical history as put forth by the US Department of Health and Human Services' campaign to rescue and restore the victims of human trafficking; and be it further

RESOLVED, That our AMA work with the US Department of Health and Human Services and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of human trafficking and to better address all of the victim's needs including medical, legal, and social aspects.

9. FEMALE GENITAL MUTILATION (FGM) – REDEFINING AMA POLICY H-525.980
Introduced by Michigan Delegation

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-525.980

RESOLVED, The AMA (1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the procedure; ~~and~~ (4) supports that physicians who are requested to perform female genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with changing societal mores; (5) will work to ensure that medical students, residents and practicing physicians are made aware of the continued practice and existence of FGM in the United States, its physical effects on patients, and any requirements for reporting FGM; and (6) is in opposition to the practice of female genital mutilation by any physician or licensed practitioner in the United States.

101. TRANSPORTATION AND ACCESSIBILITY TO FREE MEDICAL CLINICS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICY H-130.954 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association encourage initiatives that address transportation as a barrier to utilization of those institutions addressing the healthcare needs of the underserved in local communities.

102. IMPROVING MENTAL HEALTH SERVICES FOR PREGNANT AND POSTPARTUM MOTHERS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-420.953

RESOLVED, That our American Medical Association support improvements in current mental health services for women during pregnancy and postpartum; and be it further

RESOLVED, That our AMA support advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; and be it further

RESOLVED, That our AMA support appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and be it further

RESOLVED, That our AMA continue to advocate for funding programs that address perinatal and postpartum depression through research, public awareness, and support programs.

103. ON-SITE EMPLOYER-SPONSORED MEDICAL CLINICS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy D-160.937

RESOLVED, That our American Medical Association study the effect of on-site employer-sponsored medical clinics on employee preventive health benefits and health access benefits; and be it further

RESOLVED, That our AMA develop guidelines for the operation of on-site employer-sponsored medical clinics, ensuring that employee privacy, safety, and access to preventive health are not compromised and that such clinics are staffed by MD/DOs, or health care practitioners who have direct access to and supervision by MD/DOs, as consistent with state laws.

104. VALUE-BASED INSURANCE DESIGN
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-185.984

RESOLVED, That our American Medical Association study value-based insurance design as a modality for enhancing patient care and reducing health care costs.

105. STRATEGIES TO IMPROVE CARE FOR UNDERINSURED PATIENTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-160.940 AND D-165.957 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association study successful strategies for improving patient access to quality and timely health care, and report back at the 2012 Interim Meeting with examples of successful models and recommendations for expanding these models nationally.

106. STUDYING SOCIOECONOMIC STATUS AS A DETERMINANT OF HEALTH
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICY H-350.974 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association study dynamic mechanisms to monitor the impact of socioeconomic status on health-related risk factors, quality of care, and access to intervention.

107. REDUCING BARRIERS TO PREVENTIVE HEALTH CARE DELIVERY AND COMPENSATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-165.840, H-185.954 AND H-425.987 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support both the reduction of financial barriers to the delivery of cost effective preventive health care services, and the implementation of financial incentives for cost-effective preventive medical care; and be it further

RESOLVED, That our AMA conduct a study examining the effects of improvements in financial incentives for the delivery of cost-effective preventive care, and to make information from such study available through avenues including but not limited to the AMA Web site to better educate physicians and the public about the benefits of preventive health care services.

108. OUT-OF-NETWORK BENEFITS AND STANDARDIZATION OF PLAN TERMINOLOGY
Introduced by Illinois Delegation

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-165.838, H-285.973 AND H-320.968 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate that every group health benefit plan provide out-of-network coverage; and be it further

RESOLVED, That our AMA work with public and private payers to develop standard terminology and definitions for use in contracts, network administration manuals, plan benefit descriptions, and estimations of benefits clarifying ambiguous language and promoting transparency.

109. DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDERS
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-165.846, H-165.856 AND D-90.995 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association reaffirm policy D-90.995; and be it further

RESOLVED, That our AMA support adequate reimbursement by Medicaid and private insurers for clinically appropriate and evidence informed testing by properly trained and credentialed diagnosticians (including developmental-behavioral pediatricians, clinical psychologists, pediatric neurologists, and child/adolescent psychiatrists) to diagnose autism spectrum disorders; and be it further

RESOLVED, That our AMA oppose the practice by Medicaid and private insurers of excluding coverage for autism treatment services, since this practice is inconsistent with mental health parity and current health care reform initiatives that prohibit denial of coverage for pre-existing conditions; and be it further

RESOLVED, That our AMA study existing and proposed state and federal programs for funding of autism treatment services determined clinically appropriate by the American Academy of Pediatrics and the National Research Council, with particular attention to early intervention and reducing disparity in access of care, and report back to the House of Delegates at the 2013 Annual Meeting with recommendations for appropriate action at a state and federal level.

110. A NATIONAL TOOLBOX ON ACCESS TO AND DISTRIBUTION OF PHYSICIAN SERVICES
Introduced by Wisconsin Delegation

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy D-200.980

RESOLVED, That our American Medical Association advocate for the creation of a national repository of innovations and experiments, both successful and unsuccessful, in improving access to and distribution of physician services to government-insured patients (National Access Toolbox).

111. TRANSPARENCY IN HEALTH CARE COSTS
Introduced by Louisiana Delegation

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association seek and\or support legislation and\or rules and regulations that will: (1) disclose physician payment (fee) schedules in contracts, (AMA Policies H-185.975, H-285.946, D-385.976), and (2) make available, upon request of physician or patient, the contracted discounts for medical providers (i.e., hospitals, imaging, lab, DME, medications, physicians etc.) (H-330.960, H-155.960, H-155.966, H-155.998, H-210.996, H-450.938, H-185.981, D-155.994); and be it further

RESOLVED, That our AMA seek to assure that health plans be required to provide prospective enrollees/patients with information regarding: (1) coverage provisions and exclusions; (2) prior authorization or other review requirements; (3) financial arrangements that would limit the services offered, restrict referral options, and establish incentives not to deliver certain services; (4) plan limitations and the impact of any limitations upon an enrollee; (5) enrollee satisfaction statistics, and (6) a simple comparison of health plans (perhaps similar to Medicare's MediGap plans) (H-185.984, Toll-Free 24-Hour Insurance Information, and H-320.995, Medical Necessity Determinations); and be it further

RESOLVED, That our AMA encourage the Centers for Medicare & Medicaid Services (CMS) to assume a leadership role in providing cost (and quality) information available to patients and physicians, (H-450.938, D-155.994); and be it further

RESOLVED, That our AMA seek assistance by CMS so that Medicare patients be provided incentives for economical choices in health care, i.e., via HSAs funded with debit cards provided on economic sliding scale, lower premiums for healthy lifestyle choices (weight, annual examinations and tests, regular exercise, etc.), and higher premiums for poor lifestyle choices (smoking, alcohol, obesity, vaccinations, poor compliance with prescriptive medications, etc.) (H-373.998, Patient Information and Choice).

112. HEALTHCARE SPENDING CONTROL AND AMBULATORY SURGERY CENTERS
Introduced by Florida Delegation

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: FIRST RESOLVE OF FOLLOWING SUBSTITUTE RESOLUTION
REFERRED FOR DECISION
SECOND AND THIRD RESOLVES REFERRED

RESOLVED, That our American Medical Association seek legislation that requires third party payers to allow their plans' participating physicians to perform outpatient procedures at the appropriate site of service (hospital outpatient department, ambulatory surgical center, office-based facility, or physician's office), chosen by the physician and the patient; and be it further

RESOLVED, That our AMA seek legislation requiring third party payers to require equal facility copayments for alternative sites of service (hospital outpatient department, accredited ambulatory surgical center, or accredited office-based facility) for the delivery of outpatient procedures; and be it further

RESOLVED, That our AMA draft model state legislation to require third party payers to permit physicians and patients to choose the appropriate site of service at which to perform outpatient procedures, and to require equal facility copayments for alternative sites of service.

Resolution 113 was considered with Board of Trustees Report 12.
See Board of Trustees Report 12.

114. REIMBURSEMENT FOR COST OF SIGN LANGUAGE INTERPRETERS
Introduced by New York Delegation

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-160.992

RESOLVED, That our American Medical Association seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care.

115. OBESITY SHOULD BE CONSIDERED A CHRONIC MEDICAL DISEASE STATE
Introduced by Illinois Delegation

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association recognize obesity and overweight as a chronic medical condition (de facto disease state) and urgent public health problem; and be it further

RESOLVED, That our AMA recommend that providers receive appropriate financial support and payment from third-party payers, thus ensuring that providers have an incentive to manage the complex diseases associated with obesity; and be it further

RESOLVED, That our AMA work with third-party payers and governmental agencies to recognize obesity intervention as an essential medical service; and be it further

RESOLVED, That our AMA support the development of a comprehensive ICD code for medical services to manage and treat obese and overweight patients.

116. MAINTAINING MENTAL HEALTH SERVICES BY STATE
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont Delegations and American College of Emergency Physicians

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy H-345.975

RESOLVED, That our American Medical Association support maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services; and be it further

RESOLVED, That our AMA support state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions; and be it further

RESOLVED, That our AMA support increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness; and be it further

RESOLVED, That our AMA support enforcement of the Mental Health Parity Act at the federal and state level and; be it further

RESOLVED, That our AMA take these resolves into consideration when developing policy on essential benefit services.

117. PATIENT COST-SHARING REQUIREMENTS FOR HOSPITAL INPATIENT AND OBSERVATION SERVICES
Introduced by Pennsylvania Delegation

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED WITH CHANGE IN TITLE
See Policy H-185.941

RESOLVED, That our American Medical Association advocate that patients be subject to the same cost-sharing requirements whether they are admitted to a hospital as an inpatient, or for observation services.

118. PAYMENT RATE PARITY IN AMBULATORY CARE SETTINGS
Introduced by Pennsylvania Delegation

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association advocate with Medicare, and all payers, that they pay similar amounts for similar services across all ambulatory care settings.

119. VALUE-BASED PAYMENT MODIFIER
Introduced by Iowa, Minnesota and Nebraska Delegations

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-390.849, H-400.984, AND D-400.985 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support accurate quality and cost measurement in further development and improvement of the Value-Based Payment Modifier for physician groups who agree to be collectively accountable, granting individual physicians the ability to opt out of the Value-Based Payment Modifier Program; and be it further

RESOLVED, That our AMA determine an accurate methodology for price adjustment that would take into account the actual costs of physician practice.

120. POLITICAL PROPOSALS FOR REDUCING THE COST OF HEALTHCARE
Introduced by Iowa and Minnesota Delegations

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICY H-165.888 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association ask politicians who make proposals to reduce healthcare costs to answer more specific questions to detail the potential impact on all Americans.

121. PATIENT ACCESS TO THERAPEUTICS
Introduced by Michigan Delegation

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy D-185.985

RESOLVED, That our American Medical Association work with other interested parties to ensure that payment for prescription medications and durable medical equipment not be denied based solely on the use of a properly suffixed institutional Drug Enforcement Agency number or similar identifier.

122. MEDICARE PRICE ADJUSTMENT METHODOLOGY
Introduced by Iowa, Minnesota and Nebraska Delegations

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-390.849, H-400.984, H-400.988, D-390.963 AND D-400.985 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association: 1) do a thorough review of the Medicare Economic Index and, in particular, analyze the Bureau of Economic Analysis data and other evidence to determine accurate weighting for the components of practice expenses; 2) use actual physician practice survey data, such as yearly MGMA surveys, to determine whether the geographic practice cost index (GPCI) rent index relativity (currently based on apartment rental data) is actually over 300% from highest to lowest regions and recommend the most accurate methodology for the Practice Expense GPCI; 3) determine the best method to measure the actual cost of physician labor for determination of the Work GPCI – unless the AMA determines that the Work GPCI should be eliminated (i.e., affirm equal pay for equal work); and 4) assess data needed to best represent organized medicine in payment and payment methodology proposals and recommend best methods for collecting such data; and be it further

RESOLVED, That our AMA: 1) oppose any use of price adjustment methodology that involves geographic practice cost indices, and 2) support using the actual cost of physician labor (the actual dollars paid to physicians) for cost measurement in the Value-Based Payment Modifier Program and other Medicare payment programs.

123. MEDICARE-MEDICAID DUAL ELIGIBLE DEMONSTRATION PROGRAM
Introduced by American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Academy of Facial Plastic & Reconstructive Surgery, American Society of General Surgeons, American Gastroenterological Association, American Society of Cataract and Refractive Surgery, American Urological Association, North American Spine Society and California, Delaware, Georgia, New Jersey and South Carolina Delegations

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policies H-290.968 and D-290.980

RESOLVED, That our American Medical Association strongly support efforts to better coordinate the care of those individuals who are dually eligible for Medicare and Medicaid, and who often face barriers to getting the right care in the right setting; and be it further

RESOLVED, That our AMA advocate that the Centers for Medicare & Medicaid Services and the states delay implementation of the Medicare-Medicaid dual eligible demonstration program for at least one year to allow beneficiaries and provider stakeholders to better understand and evaluate and comment on the "State Demonstrations to Integrate Care for Dual Eligible Individuals" initiative; and be it further

RESOLVED, That, because Medicare-Medicaid dual eligibles often have complex medical and social needs, our AMA advocate to CMS and the states that established patient-provider relationships and current treatment plans will not be disrupted by the dual eligible Financial Alignment Initiative so as to preserve robust, patient-centered continuity of care; and be it further

RESOLVED, That our AMA advocate to CMS and the states that the Medicare-Medicaid dual eligibles Financial Alignment Initiative should operate as a true demonstration program, and therefore it should not enroll a majority of dual eligibles in any state, and there must be a rigorous evaluation plan to be consistent with the design of a demonstration that can provide useful information to policymakers; and be it further

RESOLVED, That our AMA advocate to CMS and states against automatically enrolling Medicare-Medicaid dual eligibles in a coordinated care program without their prior approval or consent; and be it further

RESOLVED, That our AMA work with CMS and the states to ensure that the Medicare-Medicaid dual eligibles Financial Alignment Initiative demonstrates potential ways of achieving efficiencies in organizing the care of dual eligibles, and any savings from coordination of care to dual eligibles should arise from better health outcomes and efficiencies gained by reducing duplicative, unnecessary, or inappropriate care. The Initiative should not be employed as a policy lever simply to reduce provider payment rates, which could significantly harm beneficiary access.

124. USE OF THE TERM PAYMENT INSTEAD OF REIMBURSEMENT WHEN APPROPRIATE
Introduced by Maryland Delegation

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-385.922 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association use, when appropriate, the word "payment" instead of "reimbursement" in all communications that relate to financial transactions between physicians and third-party payers.

125. ONCOFERTILITY AND FERTILITY PRESERVATION TREATMENT
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-165.856 AND D-330.918 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support coverage payment for standard fertility preservation therapy by all payers when iatrogenic infertility may be caused, directly or indirectly, by medical treatments necessitated as determined by a licensed physician; and be it further

RESOLVED, That our AMA advocate for appropriate legislation requiring payment coverage for fertility preservation therapy services when iatrogenic infertility may be caused, directly or indirectly, by medical treatments necessitated as determined by a licensed physician.

126. MEDICARE FINANCING OPTIONS
Introduced by Alabama and Louisiana Delegations and American College of Radiology

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED WITH CHANGE IN TITLE
See Policy D-330.916

RESOLVED, That our American Medical Association refine its policy regarding Medicare financing options, including a defined contribution program that would allow beneficiaries to purchase traditional Medicare or a private health insurance plan through a marketplace of competing health plans approved by the US Department of Health and Human Services or its designee. Our AMA should consider mechanisms to adjust contributions in order to ensure that health insurance coverage remains affordable for all beneficiaries; and be it further

RESOLVED, That our AMA report back to the House of Delegates at the 2012 Interim Meeting.

201. SUPPORT FOR DRUG COURTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-100.955

RESOLVED, That our American Medical Association support the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; and be it further

RESOLVED, That our AMA encourage legislators to establish drug courts at the state and local level in the United States.

202. SUPPORT FOR MEDICAL AMNESTY POLICIES FOR UNDERAGE ALCOHOL INTOXICATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-30.938

RESOLVED, That our American Medical Association support efforts among universities, hospitals, and legislators to establish medical amnesty policies that protect underage drinkers from punishment for underage drinking when seeking emergency medical attention for themselves or others.

203. PPACA EDUCATION DIRECTIVE
Introduced by Virginia Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-165.835

RESOLVED, That our American Medical Association educate the physicians of these United States in the details and implementation of the PPACA legislation.

Resolution 204 was not submitted for consideration.

205. REFORM THE US FARM BILL TO IMPROVE US PUBLIC HEALTH AND FOOD SUSTAINABILITY
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICY D-150.978 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association actively lobby for reform of the US Farm Bill to reflect pre-existing AMA policy goals; and be it further

RESOLVED, That our AMA recommend US Farm Bill budget cuts be directed through a newly created advisory board that includes, among other stakeholders, physicians and public health officials.

206. US FARM SUBSIDIES
Introduced by Resident and Fellow Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-150.937, H-150.944 AND D-150.978 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work with legislators to redirect subsidies that perpetuate calorie-dense, nutrition-poor products toward programs aimed at combating obesity.

207. CLEAR AND CONVINCING EVIDENCE
Introduced by Kentucky Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association support the application of a clear and convincing evidence standard to all medical liability cases; and be it further

RESOLVED, That our AMA develop model state malpractice legislation that would include the principle of clear and convincing evidence for utilization in state malpractice actions.

208. REINSTATEMENT OF CONSULTATION CODES
Introduced by Wisconsin Delegation

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-70.939 AND D-70.953 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association intensify its advocacy to achieve the reversal of decisions to eliminate the use of service codes for consultation services.

209. SUPPORT OF THE LEGAL RIGHT OF CIVIL MARRIAGE BETWEEN ANY TWO CONSENTING ADULTS
Introduced by Wisconsin Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICY H-65.973 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association recognize that denying civil marriage based on sexual orientation is discriminatory and contributes to health care disparities affecting same-sex households; and be it further

RESOLVED, That our AMA support the legal recognition of civil marriage between any two consenting adults; and be it further

RESOLVED, That our AMA oppose laws that restrict the rights, benefits, privileges, and responsibilities granted to married couples based on one's gender and sexual orientation; and be it further

RESOLVED, That our AMA discuss these measures for support and adoption at the 2012 Annual Meeting.

210. STIMULATE ANTIBIOTIC RESEARCH AND DEVELOPMENT
Introduced by Illinois Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-100.954

RESOLVED, That our American Medical Association support legislation requiring the re-evaluation of FDA guidelines for clinical trials of antibiotics, including an increase in the period of market exclusivity.

211. ALLOW PURCHASE OF OVER-THE-COUNTER DRUGS USING HEALTH SAVINGS ACCOUNT FUNDS WITHOUT A PRESCRIPTION
Introduced by Illinois Delegation

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-100.957 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work with the US Department of the Treasury to revise the definition of "qualified medical expenses" under health savings accounts, medical savings accounts, flexible spending arrangements, and health reimbursement arrangements to include FDA-approved over-the-counter drugs with or without a prescription.

212. MEDICARE RECORDS RETENTION AND OVERPAYMENT RECOUPMENT
Introduced by Illinois Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-390.874

RESOLVED, That our American Medical Association communicate to the US Department of Health and Human Services its strong objection to the proposed plan to collect overpayment of Medicare services within 60 days of discovery, regardless of how this might affect the cash flow and the solvency of a medical practice; and be it further

RESOLVED, That our AMA express to the US Department of Health and Human Services its strong objection to the proposed rule which would require practices or auditors to report any overpayments that were discovered within ten years of the date the funds were received instead of the current six-year requirement, due to the burden this would place on physicians' practices, which in essence is another unfunded mandate.

Resolution 213 was considered with Resolutions 239 and 243.
See Resolution 239.

214. REPEAL OF CMS' 2012 MPPR RULE
Introduced by American College of Radiology and American College of Emergency Physicians

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-390.956

RESOLVED, That our American Medical Association actively support legislation to repeal the 25% MPPR recently implemented by the Centers for Medicare & Medicaid Services (CMS) as part of its 2012 Fee Schedule; and be it further

RESOLVED, That our AMA work to prevent further broadening of CMS multiple procedure payment reduction proposals until thoroughly studied by CMS.

215. PROTECTING PHYSICIANS WITH MULTIPLE TAX ID NUMBERS
Introduced by New York Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-383.989

RESOLVED, That our American Medical Association support legislation and/or regulation to prevent managed care organizations from requiring physicians to participate under all of their Tax ID Numbers if they participate under one Tax ID Number.

216. TIME LIMITS FOR RECOVERY AUDIT CONTRACTOR REVIEWS
Introduced by New York Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-70.953

RESOLVED, That our American Medical Association petition the Centers for Medicare & Medicaid Services to limit Recovery Audit Contractor reviews to less than one year from payment of claims.

217. EXPRESSION OF CONCERNS REGARDING IMPLEMENTATION OF COOP PROGRAM
Introduced by New York Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-165.882

RESOLVED, That our American Medical Association offer advice or assistance to states in advocating that the Consumer Operated and Oriented Plan (COOP) advisory board and HHS ensure that new insurance issuers, including those with physician involvement, benefit from start-up loans.

218. PHARMACIST PRESCRIBING
Introduced by Robert R. Orford, MD, Delegate

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 240
See Policies H-405.992, D-35.987 and D-405.991

RESOLVED, That our American Medical Association oppose federal and state legislation allowing pharmacists to independently prescribe or dispense prescription medication without a valid order by, or under the supervision of, a licensed doctor of medicine, osteopathy, dentistry or podiatry; and be it further

RESOLVED, That our AMA oppose federal and state legislation allowing pharmacists to dispense medication beyond the expiration of the original prescription; and be it further

RESOLVED, That our AMA reaffirm AMA Policies D-405.991 and H-405.992 on the Definition of a Physician; and be it further

RESOLVED, That our AMA oppose the inclusion of Doctors of Pharmacy (PharmD) among those health professionals designated as a "Physician" by the Centers for Medicare and Medicaid services.

219. PHYSICIAN MANDATE TO CHECK PATIENTS CONTROLLED SUBSTANCE USAGE
Introduced by New York Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-95.990

RESOLVED, That our American Medical Association oppose any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances.

220. EXTENSION OF STARK LAW EXCEPTION AND ANTI-KICKBACK STATUTE SAFE HARBOR FOR DONATION OF EHR PRODUCTS AND SERVICES
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont Delegations
American Congress of Obstetricians and Gynecologists

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-478.994

RESOLVED, That our American Medical Association adopt policy supporting the indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of Electronic Health Record (HER) products and services; and be it further

RESOLVED, That our AMA advocate for federal regulatory reform that will allow for indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of EHR products and services.

221. PRESCRIPTION DRUG MONITORING PROGRAM CONFIDENTIALITY
Introduced by Kentucky and West Virginia Delegations

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy H-95.946

RESOLVED, That our American Medical Association: (1) advocate for the placement and management of state-based prescription drug monitoring programs with a state agency whose primary purpose and mission is heath care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial; (2) encourage all state agencies responsible for maintaining and managing a prescription drug monitoring program (PDMP) to do so in a manner that treats PDMP data as health information that is protected from release outside of the health care system; and (3) advocate for strong confidentiality safeguards and protections of state databases by limiting database access by non-health care individuals to only those instances in which probable cause exists that a unlawful act or breach of the standard of care may have occurred.

222. WORK-RELATED ABUSES OF IMG PHYSICIANS WORKING UNDER THE CONRAD-30 PROGRAM
Introduced by American College of Physicians
International Medical Graduates Program
Wisconsin Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association develop a mechanism by which physicians working under the Conrad-30 program encountering work-related abuses may report this information directly to our American Medical Association without fear of retribution for purposes of data collection for advocacy support; and be it further

RESOLVED, That our AMA aggressively investigate reports of possible work-related abuses encountered by IMG physicians under the Conrad-30 program; and be it further

RESOLVED, That our AMA advocate for legislative and regulatory changes to the Conrad-30 program if deemed necessary to prevent work-related abuses of IMG physicians.

223. PRESCRIPTION DRUG DIVERSION, MISUSE AND ADDICTION
Introduced by American Society of Addiction Medicine

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-95.945

RESOLVED, That our American Medical Association support permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; and be it further

RESOLVED, That our AMA consider PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; and be it further

RESOLVED, That our AMA recommend that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; and be it further

RESOLVED, That our AMA recommend that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and be it further

RESOLVED, That our AMA promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.

224. REPEAL IPAB AND REPLACE IT WITH A BODY WITH ADEQUATE PHYSICIAN REPRESENTATION
Introduced by Michigan Delegation

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-165.833 AND H-165.838 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association diligently work toward repealing the Independent Payment Advisory Board that has been created by the Patient Protection and Affordable Care Act.

225. SEPARATE PALLIATIVE DEATHS FROM THE MORTALITY STATISTICS
Introduced by Michigan Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services to develop a separate mortality statistic for hospital patients receiving comfort care so that mortality data reported in the quality reporting sites depicts the actual quality of care delivered.

226. THREE-DAY PAYMENT WINDOW RULE
Introduced by Pennsylvania Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-390.846

RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services (CMS) to request a further delay in implementation of the 3-day Payment Window rule beyond the current delay of July 1, 2012; and be it further

RESOLVED, That our AMA thoroughly investigate all legislative and regulatory actions taken by Congress and CMS associated with the 3-Day Payment Window during this delay and determine whether additional legislative and/or regulatory actions are warranted to include overturning the current Rule; and be it further

RESOLVED, That our AMA work with other appropriate stakeholders to continue seeking a delay or modification of the three-day payment window rule; encourage CMS to clarify to whom and how this rule applies; and communicate the specifics about this rule to the physician community.

227. FEDERAL MEDICAL ASSISTANCE PERCENTAGE FOR MEDICAID FOR GUAM
Introduced by Guam Delegation

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY D-290.986 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work through its legislative lobbying branch to lobby Congress to correct the inequitable disparity, concerning the Match Rate for Medicaid Dollars, to the United States Citizens who reside in Guam, and to require parity for Guam with such states as West Virginia and Alabama , and with the District of Columbia when it comes to the Federal Match Rate for Medicaid Dollars.

228. CLINICAL DECISION SUPPORT AND MALPRACTICE RISK
Introduced by Maryland Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-435.944

RESOLVED, That our American Medical Association advocate in interested states for legislation that would create a "safe harbor" for physicians who use a consensus-based drug-drug interaction list in their clinical decision support software package; and be it further

RESOLVED, That our AMA communicate to governmental authorities in interested states that patients, physicians, hospitals, and the government will all lose out if a "safe harbor" for physicians who use a consensus-based drug-drug interaction list in their clinical decision support software package is not developed.

229. PHYSICIANS' ABILITY TO NEGOTIATE AND UNDERGO PRACTICE CONSOLIDATION
Introduced by Maryland Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-383.988

RESOLVED, That our American Medical Association pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; and be it further

RESOLVED, That our AMA work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and be it further

RESOLVED, That our AMA find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare.

230. REDUCING ECONOMIC DAMAGES AS A DRIVER OF MEDICAL LIABILITY CASES
Introduced by Charles Rothberg, MD, Delegate
and Robert A. Scher, MD, Delegate

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association advocate for legislation and regulation to provide Medicare and Medicaid health benefits for adults and children disabled in an encounter subject to a medical malpractice award or settlement—so that these medical payments will be both guaranteed and secure and will no longer need to be litigated nor become the obligation of the states; and be it further

RESOLVED, That our AMA advocate for modification of the collateral source rule to allow for the defendant to introduce evidence of medical payments made or expected to be made on behalf of plaintiff for past and future medical expenses; and be it further

RESOLVED, That our AMA advocate for legislation or regulation to repeal that portion of Medicare as Secondary Payer Manual, section 10.6 so that Medicare will no longer be secondary to a medical liability insurance settlement/award and that under current law makes such award 'lien-able.

231. ESTABLISHMENT OF LIMITED POPULATION ANTIBACTERIAL DRUG (LPAD) APPROVAL PATHWAY
Introduced by Infectious Diseases Society of America
American Association of Hip and Knee Surgeons, American College of Medical Quality,
American College of Rheumatology and American Thoracic Society

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-100.953

RESOLVED, That our American Medical Association support establishment of the Limited Population Antibacterial Drug (LAPD) mechanism to provide a predictable and feasible Food and Drug Administration approval pathway for pharmaceutical companies seeking to develop antibacterial drugs to treat serious and life-threatening infections where there is a lack of sufficient or satisfactory therapeutic options, through legislative or regulatory means; and be it further

RESOLVED, That should the LPAD be established, our AMA shall work with IDSA, other medical societies, and the health care community to educate providers about LPAD products, including their benefits and risks.

232. TRICARE HEALTH INSURANCE ACCEPTANCE BY PHYSICIANS
Introduced by New Jersey Delegation

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-40.969, H-385.921, D-40.991 AND D-40.992 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association encourage its members to support veterans, citizen soldiers and their families' health needs; and be it further

RESOLVED, That our AMA lobby Congress to improve benefits under TRICARE so that more physicians can accept and treat veterans, citizen soldiers and their families.

233. PHYSICIAN PAYMENTS SUNSHINE ACT
Introduced by New Jersey Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED WITH CHANGE IN TITLE IN LIEU OF RESOLUTIONS 233 AND 238
See Policy H-140.848

RESOLVED, That our American Medical Association continue its efforts to minimize the burden and unauthorized expansion of the Sunshine Act by CMS; and be it further

RESOLVED, That our AMA recommend to the CMS that a physician comment section be included on the "Physician Payments Sunshine Act" public database.

234. OPPOSE LEGISLATION TO EXEMPT CIGARS FROM FDA OVERSIGHT
Introduced by American Thoracic Society

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-495.988

RESOLVED, That our American Medical Association strongly oppose legislation which would undermine the Food and Drug Administration's authority to regulate tobacco products; and be it further

RESOLVED, That our AMA encourage state medical associations to contact their state delegations to oppose legislation which would undermine the Food and Drug Administration's authority to regulate tobacco products.

235. OPPOSITION OF FDA'S RX TO OTC PARADIGM SHIFT
Introduced by American Thoracic Society

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-120.938

RESOLVED, That our American Medical Association: (1) submit comments during the public comment period expressing our concerns with the Food and Drug Administration's (FDA's) proposed paradigm shift; (2) continue to monitor FDA's action on this issue; (3) encourage the FDA to study the cost implications switching prescription drugs to over-the-counter status will have on patient out of pocket costs; and (4) strongly encourage the FDA to initiate a formal public comment process before reclassifying any prescription drug to over-the-counter status.

236. EVALUATION OF ICD-11 AS A NEW DIAGNOSTIC CODING SYSTEM
Introduced by Georgia Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-70.952

RESOLVED, That our American Medical Association evaluate the feasibility of moving from ICD-9 to ICD-11 as a an alternative to ICD-10 and report back to the House of Delegates.

237. PENALTIES FOR NON-ADOPTION OF HIT TECHNOLOGY
Introduced by Nevada Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICIES H-478.991, H-478.993 AND H-478.994 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association oppose any regulation requiring financial penalties for physicians who do not adopt these technologies.

Resolution 238 was considered with Resolution 233.
See Resolution 233.

239. CONTINGENCY TO ADVOCATE FOR MEDICAL CARE OF THE AMERICAN PEOPLE
Introduced by TEXAS DELEGATION

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS IN LIEU OF RESOLUTIONS 213 AND 243
See Policies H-140.984, H-155.960, H-165.833, H-165.838, H-165.841, H-165.845, H-165.852, H-165.856, H-165.865, H-165.882, H-165.904, H-165.920, H-165.985, and H-180.978

RESOLVED, That our American Medical Association reaffirm the following House of Delegates Policies:

H-165.833 Amend the Patient Protection and Affordable Care Act (PPACA);
H-165.865 Principles for Structuring a Health Insurance Tax Credit;
H-165.985 Opposition to Nationalized Health Care;
H-165.920 Individual Health Insurance;
H-165.882 Improving Access for the Uninsured and Underinsured;
H-140.984 Physicians' Involvement in Commercial Ventures:
H-165.845 State Efforts to Expand Coverage to the Uninsured;
H-165.856 Health Insurance Market Regulation;
H-165.904 Universal Health Coverage;
H-165.852 Health Savings Accounts;
H-165.838 Health System Reform Legislation;
H-180.978 Access to Affordable Health Care Insurance through Deregulation of State Mandated Benefits; and
H-165.841 Comprehensive Health System Reform; and be it further

RESOLVED, That, should the Supreme Court of the United States declare the individual mandate unconstitutional, our AMA evaluate House of Delegates Policy H-165.856, Sections 7 and 8, relating to our support for guaranteed issue in the context of the individual mandate, and recommend necessary policy changes at our 2012 Interim Meeting; and be it further

RESOLVED, That our AMA reaffirm our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution; and be it further

RESOLVED, That our AMA, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system; and be it further

RESOLVED, That our AMA begin preparation for advocacy of alternate federal health care reform options should the Supreme Court take action to strike any or all of the Patient Protection and Affordable Care Act (ACA), including development of materials or a report for review by our House of Delegates at our 2012 Interim Meeting.

Resolution 240 was considered with Resolution 218.
See Resolution 218.

241. PATIENT PROTECTION AND AFFORDABLE CARE ACT NONDISCRIMINATION LANGUAGE
Introduced by Arizona Delegation
American Society of Anesthesiologists

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-35.968

RESOLVED, That our American Medical Association promptly initiate a specific lobbying effort and grassroots campaign to repeal the provider portion of the Patient Protection and Affordable Care Act's "Non-Discrimination in Health Care" language, including direct collaboration with other interested components of organized medicine.

RESOLVED, That our AMA report back at the 2012 Interim Meeting on the specific activities and any outcomes that have occurred regarding AMA Policy H-35.968.

242. PRACTICE DRIFT
Introduced by Mississippi Delegation

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-410.952

RESOLVED, That our American Medical Association study the issue of physician drift and report back with recommendations include, but not limit, to: (1) whether AMA policy or the AMA Code of Ethics should be modified, and (2) model language, if appropriate, to amend state truth in advertising laws to ensure patients are properly informed when making healthcare decisions about a physician's training.

Resolution 243 was considered with Resolutions 213 and 239.
See Resolution 239.

244. ELECTRONIC PRESCRIPTIONS FOR CONTROLLED SUBSTANCES
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-120.958

RESOLVED, That our American Medical Association investigate regulatory barriers to electronic prescription of controlled substances so that physicians may successfully submit electronic prescriptions for controlled substances; and be it further

RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services to eliminate from any program (e.g., the Physician Quality Reporting System, meaningful use, and e-Prescribing) the requirement to electronically prescribe controlled substances, until such time that the necessary protocols are in place for electronic prescribing software vendors and pharmacy systems to comply.

301. INCREASED EMPHASIS ON EDUCATION IN MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN MEDICAL SCHOOL
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS WITH CHANGE IN TITLE
See Policy H-345.984

RESOLVED, That our American Medical Association amend policy H-345.984 by insertion and deletion to read as follows:

Awareness, Diagnosis and Treatment of Depression and Other Mental Illnesses: (1) Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, ~~both when it occurs by itself and when it occurs~~ either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings. (2) Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.

302. SECURING QUALITY EDUCATION SITES FOR US-ACCREDITED SCHOOLS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy D-295.320

RESOLVED, That our American Medical Association advocate for federal and state legislation or regulations to oppose any extraordinary compensation for clinical clerkship sites by medical schools or other clinical programs that would result in displacement or otherwise limit the training opportunities of United States LCME/COCA students in clinical rotations.

303. INVESTIGATING ADVERSE HEALTH OUTCOMES RELATING TO CHRONIC GRADUATE MEDICAL EDUCATION FUNDING SHORTAGES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: POLICY D-305.967 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association encourages appropriate stakeholder organizations to study and quantify the public health impacts of cuts to graduate medical education funding sources, including, but not limited to, the effects on the physician shortage, spending on public health initiatives, and availability and quality of care.

304. LESBIAN, GAY, BISEXUAL, AND TRANSGENDERED PATIENT-SPECIFIC TRAINING FOR HEALTHCARE PROVIDERS
Introduced by Medical Student Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-160.991 AND H-295.878 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support the training of healthcare providers in cultural competency as well as in physical health needs for lesbian, gay, bisexual, and transgender patient populations.

305. MEDICAL STUDENT SUMMER RESEARCH COMPENSATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy H-460.982

RESOLVED, That our American Medical Association amend AMA Policy H-460.982 by insertion and deletion as follows:

H-460.982 Availability of Professionals for Research – (1) In its determination of personnel and training needs, major public and private research foundations, including the Institute of Medicine of the National Academy of Sciences, should consider the future research opportunities in the biomedical sciences as well as the marketplace demand for new researchers. (2) The number of physicians in research training programs should be increased by expanding research opportunities during medical school, through the use of short-term training grants and through the establishment of a cooperative network of research clerkships for students attending less research-intensive schools. ~~The number of physicians~~ Participation in research training programs should be increased by providing financial incentives for research centers, academic physicians, and medical students. (3) The current annual production of PhDs trained in the biomedical sciences should be maintained into the 1990s. (4) The numbers of nurses, dentists, and other health professionals in research training programs should be increased. (5) Members of the industrial community should increase their philanthropic financial support to the nation's biomedical research enterprise. Concentration of support on the training of young investigators should be a major thrust of increased funding. The pharmaceutical and medical device industries should increase substantially their intramural and extramural commitments to meeting postdoctoral training needs. A system of matching grants should be encouraged in which private industry would supplement the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration sponsored Career Development Awards, the National Research Service Awards and other sources of support. (6) Philanthropic foundations and voluntary health agencies should continue their work in the area of training and funding new investigators. Private foundations and other private organizations should increase their funding for clinical research faculty positions. (7) The National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration should modify the renewal grant application system by lengthening the funding period for grants that have received high priority scores through peer review. (8) The support of clinical research faculty from the National Institutes of Health Biomedical Research Support Grants (institutional grants) should be increased from its current one percent. (9) The academic medical center, which provides the multidisciplinary research environment for the basic and clinical research faculty, should be regarded as a vital medical resource and be assured adequate funding in recognition of the research costs incurred.

306. PRELIMINARY YEAR PROGRAM PLACEMENT
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy H-310.910

RESOLVED, That our American Medical Association encourage the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.

307. INCREASING ORGAN DONATION DISCUSSIONS THROUGH MEDICAL EDUCATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association compile current materials into a comprehensive resource available for the development of a continuing medical education course educating physicians on how to conduct organ donation discussions with patients; and be it further

RESOLVED, That our AMA support the development of billing codes for physician-patient organ donation discussions.

308. HEALTH POLICY EDUCATION IN MEDICAL SCHOOL AND RESIDENCY
Introduced by Resident and Fellow Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-295.924 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work with interested organizations to develop and incorporate a health policy curriculum into medical school and residency training that is based on a list of core topics integral to the fundamental understanding of health policy.

309. PRESERVING THE OPPORTUNITY TO MOONLIGHT
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-310.955

RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA) and graduate medical education programs to allow resident and fellow physicians who are in good standing with their programs the opportunity for internal and external moonlighting that complies with current ACGME or AOA policy.

310. AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD MEMBER ENROLLMENT IN MAINTENANCE OF CERTIFICATION
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-275.919

RESOLVED, That our American Medical Association recommend to the American Board of Medical Specialties that all physician members of those boards governing the Maintenance of Certification (MOC) process be required to participate in the MOC process.

311. EARLY CAREER PHYSICIAN REPRESENTATION ON AMERICAN BOARD OF MEDICAL SPECIALTIES BOARDS
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy H-275.931

RESOLVED, That our American Medical Association strive to place early career physicians onto American Board of Medical Specialties (ABMS) member specialty boards overseeing the Maintenance of Certification (MOC) process.

312. THE DEFICIENCY IN MEDICAL EDUCATION RELATING TO AUTOPSY
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: POLICY H-85.993 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association continue to work with all relevant organizations to advocate for participation in an autopsy during medical school or residency training; and be it further

RESOLVED, That our AMA continue to work with all relevant organizations to overcome legislative and other barriers to improve autopsy rates; and be it further

RESOLVED, That our AMA work with all relevant parties to develop a model curriculum or teaching module on discussion of autopsy, obtaining consent, and autopsy results as part of a patient care specialty.

313. COSTS OF ASSESSING CLINICAL COMPETENCE
Introduced by Wisconsin Delegation

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: POLICIES H-275.923, H-275.924, H-275.936, H-275.956, H-300.982, H-405.974, D-270.989 AND D-275.971 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support the concept that any method used to determine clinical competence be supported by evidence of effectiveness in determining clinical competence; and be it further

RESOLVED, That our AMA work in the federation of medicine to promote that all specialties only use tests of clinical competence that have been proven effective or set up pilot projects to test for effectiveness; and be it further

RESOLVED, That our AMA work to have all state licensing boards agree to only use methods to test clinical competence that have been proven effective; and be it further

RESOLVED, That our AMA observe methods used by specialties to determine clinical competence to be sure they are truly testing clinical competence and not tools being used in turf battles; and be it further

RESOLVED, That our AMA keep our legislators informed on the effect these maintenance of certification and maintenance of licensure efforts might have on medical workforce by aggravating the shortages of physicians in critical specialties through making it more difficult and expensive to continue to practice medicine.

314. SUPPORTING TWO-INTERVAL GRADING SYSTEMS FOR MEDICAL EDUCATION
Introduced by Wisconsin Delegation

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-295.866

RESOLVED, That our American Medical Association acknowledge the benefits of a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum.

315. ADVANCEMENTS IN ADVOCACY AND MEDICAL CARE OF PERSONS WITH DEVELOPMENTAL DISABILITIES
Introduced by Wisconsin Delegation

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy H-90.972

RESOLVED, That our American Medical Association (1) encourage clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with Developmental Disabilities; (2) encourage medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (3) encourage medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with Developmental Disabilities, will improve quality in clinical care; (4) encourage the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with Developmental Disabilities so as to improve health outcomes; and (5) support a cooperative effort between physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with Developmental Disabilities.

316. ECONOMIC GROWTH AND DISTRIBUTION OF GME FUNDING
Introduced by California Delegation

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-305.958

RESOLVED, That our American Medical Association work with key organizations, such as the US Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to support development of reports on the economic multiplier effect of each residency slot by geographic region and specialty; and be it further

RESOLVED, That our AMA work with other key organizations, such as the US Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to investigate the impact of GME funding on each state and its impact on that state's health care workforce and health outcomes.

317. PHYSICIAN WORKFORCE SHORTAGES
Introduced by Oklahoma Delegation

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association work diligently with the Centers for Medicare & Medicaid Services and the US Congress to create a supplemental private funding opportunity in addition to current funding sources to help develop additional residency training positions with private donations to cope with the critical shortage of primary care physicians in our country.

318. RESIDENT WORK HOURS
Introduced by Illinois Delegation

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES D-310.955, D-310.964, D-310.973, D-310.978 AND D-310.987 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association undertake careful, rigorous and continuous evaluation of current Accreditation Council for Graduate Medical Education policy regarding resident work hours, outcomes of this policy, and consequences to patient care and training goals; and be it further

RESOLVED, That our AMA further encourage adoption of resident work hour standards that are practical and meet both patient and provider needs.

319. LESS COSTLY ALTERNATIVES TO MAINTENANCE OF SPECIALTY BOARD CERTIFICATION
Introduced by New York Delegation

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-275.971

RESOLVED, That our American Medical Association actively work to enforce existing policies to reduce current costs and effort required for the maintenance of certification and to work to control future charges and expenses.

320. INTRODUCING QUALITY AND PATIENT SAFETY EDUCATION CURRICULUM IN UNDERGRADUATE MEDICAL EDUCATION
Introduced by Ohio Delegation

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-295.942

RESOLVED, That our American Medical Association encourage the Liaison Committee on Medical Education to include patient safety and quality of patient care curriculum within the core competencies of medical education in order to instill these fundamental skills in all undergraduate medial students.

321. MEDICAL SCHOOL STUDENT LOANS
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-305.975

RESOLVED, That our American Medical Association encourage the National Health Services Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.

322. STRATEGIES TO INCREASE THE NUMBER OF AMERICAN INDIANS/ALASKA NATIVES APPLYING TO AND ENTERING US MEDICAL SCHOOLS
Introduced by Minority Affairs Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-350.981 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association lobby for the support for Title VII, Health Careers Opportunity Program to assist American Indian/Alaska Native students who want to enter a health profession; and

RESOLVED, That our AMA provide funding to support preadmission workshops administered by the Association of American Indian Physicians.

323. ARBITRARY PREVENTION OF J-1 VISA IMGS FROM REENTRY INTO THE US
Introduced by International Medical Graduates Section
American Association of Physicians of Indian Origin

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-255.991

RESOLVED, That our American Medical Association study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training; and be it further

RESOLVED, That our AMA, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

324. GRADUATE MEDICAL EDUCATION
Introduced by International Medical Graduates Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: POLICIES H-310.917 AND D-305.967 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association lobby Congress for funding for more residency training positions in the US; and be it further

RESOLVED, That our AMA advocate for more residency training positions in the US to accommodate the need for more physicians in the workforce to address the physician shortage.

325. CURRICULA FOR PAIN EDUCATION
Introduced by American Academy of Pain Medicine

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association work with all agencies, government bodies and other stakeholder organizations associated with developing, coordinating, and maintaining curricula for pain education, in cooperation with relevant medical specialty societies, to provide education about pain neurobiology, evaluation and treatment to all medical students.

326. HEALTHCARE REFORM'S EFFECT ON PHYSICIAN WORKFORCE SHORTAGE
Introduced by International Medical Graduates Section
American Association of Physicians of Indian Origin

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-255.987 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work with the appropriate organizations such as the American Association of Medical Colleges, Committee on Graduate Medical Education and the Institute of

Medicine to develop a plan to address the important issue of utilizing international medical graduates to alleviate the physician workforce shortages, particularly in primary care specialties; and be it further

RESOLVED, That our AMA lobby Congress to remove the immigration barriers prohibiting IMGs from entering the US and increase the number of IMGs entering residency training positions in order to assist with the impending physician workforce needs; and be it further

RESOLVED, That our AMA report back at the 2012 Interim Meeting with a plan to address the strategies to increase the number of international medical graduates in the US workforce.

327. RETENTION AND AVAILABILITY OF CONTINUING MEDICAL EDUCATION PARTICIPATION RECORDS
Introduced by Michigan Delegation

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association work with the Accreditation Council for Continuing Medical Education (ACCME) and continuing medical education (CME) providers that it accredits to ensure that each CME provider will make available to a central data repository a transcript of all CME credits earned by a physician from the CME provider, including date, credits earned, and program title; and be it further

RESOLVED, That our AMA work with the ACCME to make physician continuing medical education transcripts available to the physician online and in real time in a format suitable for submission to licensing and other organizations without cost to the physician.

328. THE CHANGING TRAINING ENVIRONMENT: ACCESS TO PROCEDURAL TRAINING FOR RESIDENTS AND FELLOWS
Introduced by Minnesota and Nebraska Delegations
Minority Affairs Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association study the trends in numbers of residency training sites that also employ mid-level providers and/or concurrently train students of these midlevel programs; and be it further

RESOLVED, That our AMA more clearly define a physician-in-training's role in the hospital and specifically make it a high educational priority for trainees to receive the needed exposure to procedures required for them to master competency in their specialty and that these exposures are not delegated to midlevel providers and mid-level provider trainees; and be it further

RESOLVED, That our AMA study the financial impact for institutional training sites of hiring more mid-level providers versus investing in a physician training program.

329. GOING FORWARD WITH REFORMING GME FINANCING
Introduced by Mississippi Delegation

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association work with all available internal data and other available sources to craft a new national model for sustainable funding of graduate medical education (GME) programs, which includes not only the Centers for Medicare & Medicaid Services (CMS) funding, but also private funding sources as well; and be it further

RESOLVED, That our AMA will urgently work to implement via legislation and other means this new model for funding GME programs in the United States.

330. PROPOSAL FOR A RETROSPECTIVE WORKFORCE STUDY
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association collaborate with governmental entities and other appropriate organizations to complete a 30-year, retrospective analysis of how the workforce in health care has readjusted to absorb the influx of workers who are not directly or indirectly involved in patient care. This analysis should pay particular attention to the numbers/proportion of those in the health care workforce who take direct care of patients now, as compared to past decades, and those who support that effort, even indirectly; and be it further

RESOLVED, That our AMA report back at the 2013 Annual Meeting.

331. IMPROVING PATIENT SAFETY THROUGH COLLABORATION IN RESIDENT AND FELLOW EDUCATION
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy D-310.955

RESOLVED, That our American Medical Association partner with stakeholder organizations including the ACGME (Accreditation Council on Graduate Medical Education) and AOA (American Osteopathic Association) to encourage partnership in the development and revision of residency and fellowship accreditation standards in order to better align the educational experience of allopathic and osteopathic residents and fellows with the overall goal of assuring patient safety.

401. REDUCTION OF ELECTRONIC AGGRESSION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS WITH CHANGE IN TITLE
See Policy H-515.959

RESOLVED, That our American Medical Association urge social networking platforms to adopt terms of service that define and prohibit electronic aggression, which may include any type of harassment or bullying, including but not limited to that occurring through email, chat room, instant messaging, website (including blogs) or text messaging.

402. REDUCING SUICIDE RISK AMONG LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUESTIONING YOUTH THROUGH COLLABORATION WITH ALLIED ORGANIZATIONS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy H-60.927

RESOLVED, That our American Medical Association partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

403. STIGMATIZATION OF MENTAL HEALTH DISORDERS WITHIN THE MEDICAL PROFESSION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association investigate how the stigmatization of mental health disorders in medical professionals by medical professionals has developed and persists; and be it further

RESOLVED, That our AMA address the stigmatization of mental health disorders in medical professionals by medical professionals by taking an active role in activities such as developing and/or encouraging programming to promote awareness about and reduce this stigmatization.

404. HELMET SAFETY
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-470.974

RESOLVED, That American Medical Association Policy H-470.974 be amended by substitution to read as follows:

Athletic Helmets. 1. Our AMA urges the Consumer Product Safety Commission and other appropriate agencies and organizations to establish standards to ensure that athletic and recreational equipment produced or sold in the United States provide protection against head and facial injury. 2. Our AMA: (a) supports requiring the use of head and facial protection by children and adolescents while engaged in potentially dangerous athletic and

recreational activities; (b) encourages the use of head and facial protection for adults while engaged in potentially dangerous athletic and recreational activities; (c) encourages physicians to educate their patients about the importance of head and facial protection while engaged in potentially dangerous athletic and recreational activities; and (d) encourages the availability of rental helmets at all commercial settings where potentially dangerous athletic and recreational activities take place.

405. TOBACCO SALES AMENDMENT
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: FOLLOWING POLICY D-495.994 AMENDED IN LIEU OF RESOLUTIONS 405 AND 420
See Policy D-495.994

D-495.994, Oppose Sale of Tobacco Products in Pharmacies
Our AMA: (1) specifically and publicly opposes the sale and marketing of tobacco products, including cigarettes, in pharmacies ~~pharmacy~~; (2) will communicate with appropriate federal agencies, including the Bureau of Alcohol, Tobacco And Firearms, many public health groups, various pharmacy trade groups, and media outlets, in seeking their help in removing tobacco products, including cigarettes, from pharmacy shelves; ~~and~~ (3) will work to pass legislation at the local, state and federal levels to accomplish the goal of banning tobacco sales in pharmacies nationwide; (4) work with Federation members and national organizations concerned about tobacco use to develop a recognition program for pharmacies that voluntarily agree to eliminate the sale of tobacco; 5) work with state and local medical societies to disseminate information on these recognized pharmacies to their membership; and 6) work through its Advocacy Resource Center to provide that list to organizations interested in preventive healthcare.

406. SPORTS DRINKS AND ENERGY DRINKS FOR CHILDREN AND ADOLESCENTS: ARE THEY APPROPRIATE?
Introduced by American Academy of Pediatrics

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-150.953, H-440.859 AND D-150.987 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association actively educate physicians, parents and the public that energy drinks are not appropriate for children and adolescents; and be it further

RESOLVED, That our AMA work with other appropriate organizations to educate physicians, parents and the public that when selecting a beverage to hydrate before, during, or after exercise and outside of physical activity, careful consideration must be given to prevention of excessive sugar and caloric intake in order to prevent dental erosion, overweight, and obesity

Resolution 407 was considered with Council on Science and Public Health Report 5.
See Council on Science and Public Health Report 5.

408. SUPPORTING MINORITY WOMEN'S CHOICE TO BREASTFEED
Introduced by American Academy of Pediatrics

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-245.982, H-420.960 AND H-420.979 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association encourage all physicians to support all women, and especially minority women who choose to breastfeed by supporting: (1) prenatal education and continuing education throughout infancy about the impact of breastfeeding on health outcomes; (2) that physicians and hospitals avoid perceived conflicts of interest with pharmaceutical or formula companies; (3) that hospital policies should include written protocols to facilitate breastfeeding for both term and preterm newborns. If mother and newborn are separated, hospitals will provide pumps for milk expression; and (4) policies that support maternity leave and that support provision of time and a private clean place for expressing milk for breastfeeding women who return to the workforce.

409. AMA SUPPORT FOR BREASTFEEDING
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: FOLLOWING POLICY H-245.982 AMENDED IN LIEU OF RESOLUTIONS 409 AND 410
See Policy H-245.982

H-245.982, AMA Support for Breastfeeding
(1) Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the ~~2005~~ 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places. (2) Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician. (3) Our AMA: (a) support the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by

continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.

Resolution 410 was considered with Resolution 409.
See Resolution 409.

411. ENDING DISCRIMINATION AGAINST PHYSICIANS PARTICIPATING IN PHYSICIAN HEALTH PROGRAMS
Introduced by American Society of Addiction Medicine

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association advocate that physicians who experience medical board disciplinary action as a result of their actions associated with a diagnosed substance use disorder (SUD), but who are fully compliant with their Physician Health Program (PHP) monitoring contracts requiring total abstinence from any use of alcohol or other drug of abuse, with verification via by intensive and comprehensive monitoring, are considered to be alcohol- and drug- free, and should not be arbitrarily subject to increased professional liability insurance premiums, removal from health insurance provider panels, loss of hospital credentials and privileges, loss of professional society membership, and loss of specialty board certification, solely on the basis of public medical board actions taken on their license what were related to their diagnosed SUD; and be it further,

RESOLVED, That our AMA support the Federation of State Medical Board's "Impaired Physician Guidelines" of April 2011 which encourage state medical licensure boards to make full use of the option of referring physicians with diagnosed SUDs or mental disorders to their state PHP in lieu of taking adverse/public disciplinary action on said physician's license; and be it further

RESOLVED, That our AMA support the principles outlined in the public policy statements of the American Society of Addiction Medicine on professionals with potentially impairing illness and consistently speak out against discrimination against physicians with potentially impairing SUDs and mental disorders.

412. REAFFIRMING COMMITMENT TO PHYSICIAN HEALTH AND WELLBEING
Introduced by American Society of Addiction Medicine

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: POLICIES H-275.949, H-405.961, D-405.990 AND D-405.992 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association reaffirm its commitment to physician health and wellbeing and combat discrimination against physicians who have potentially impairing health conditions for which they have received treatment and been involved in ongoing monitoring by a state Physician Health Program; and be it further

RESOLVED, That our AMA House of Delegates reaffirm AMA Policy D-405.992 by which this House of Delegates considers the concept of physician wellness as an element of the AMA Strategic Plan; and be it further

RESOLVED, That our AMA reaffirm Policy D-405.990; and be it further

RESOLVED, That our AMA recommend that the Federation of State Medical Boards, the Federation of State Physician Health Programs, the American Psychiatric Association, the American Academy of Addiction Psychiatry,

the American Society of Addiction Medicine, and the AMA Alliance be invited to join the AMA in a Consortium on Physician and Family Wellbeing that would, among other activities, work to: (a) fully implement AMA Policy D-405.996 which calls for a web-based database of information about state and provincial physician health programs in the US and Canada and how physicians, family members, and others can easily access these programs; (b) align policies among the seven organizations to support state Physician Health Programs in their activities to protect the public safety, to reduce the incidence of medical errors and professional liability claims, to advocate as appropriate for physician re-entry into practice after a health condition or its treatment have resulted in a span of time away from practice, and to provide education to physicians, health care provider systems, and the general public regarding the activities and benefits of Physician Health Programs; (c) encourage and assist every medical school accredited by the Liaison Committee on Medical Education to have an operational Student Assistance Program and Faculty Assistance Program to meet the needs of students and faculty and their family members and to provide liaison to and from their relevant state Physician Health Programs; and (d) encourage and assist every state Physician Health Program to have an operational and easily accessible structure and process to support the spouses and life partners of physicians who have a potentially impairing health condition which has affected or could affect the physician's practice, including medical families which have been impacted by physician suicide.

413. SETTING DOMESTIC AND INTERNATIONAL PUBLIC HEALTH PREVENTION TARGETS FOR PER CAPITA ALCOHOL CONSUMPTION AS A MEANS OF REDUCING THE BURDEN ON NON-COMMUNICABLE DISEASES ON HEALTH STATUS

Introduced by American Society of Addiction Medicine

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-30.937

RESOLVED, That our American Medical Association continue to address the role of alcohol use on health status and the impact of behaviorally-associated chronic illnesses (including obesity, diabetes, heart disease, chronic respiratory diseases, and many cancers) on the overall burden of disease and the costs of health care services in America; and be it further

RESOLVED, That our AMA encourage federal health services planning agencies and public health authorities to address the role of alcohol and tobacco consumption on health and to promote environmental interventions including evidence based tobacco control and alcohol control policies to improve the health status of Americans; and be it further

RESOLVED, That our AMA encourage the World Health Organization to continue its work on the impact of Non Communicable Diseases (NCDs) on health status and to include targets for reduced per capita alcohol consumption among its major proposed interventions in developed and developing nations to reduce the incidence of, prevalence of, and rates of disability and premature deaths attributable to chronic non-communicable diseases.

414. APPLICANTS FOR LICENSURE, HOSPITAL PRIVILEGES, PROFESSIONAL SOCIETY MEMBERSHIP, AND SPECIALTY BOARD CERTIFICATION BY PHYSICIANS PARTICIPATING IN PHYSICIAN HEALTH PROGRAMS

Introduced by American Society of Addiction Medicine

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association advocate the removal of language on application forms for initial licensure, credentialing, membership, or certification or for renewal of licensure, credentials, membership, or certification which require, without individualized cause, the applicant to declare the presence of a diagnosis of substance use disorder, treatment for substance use disorder, or participation in a state Physician Health Program.

415. TASKFORCE ON MEDICAL DISASTER RESPONSE AND INDIGENT CARE
Introduced by California Delegation

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association form a taskforce to collect information about, and address, coordination issues among existing medical disaster response teams and plans, including those of state component medical societies, hospitals, the medical reserve, and federal and state-sponsored disaster medical assistance teams; and be it further

RESOLVED, That this AMA taskforce work to define the AMA's and local medical societies' roles in response to a disaster; that it prepare recommendations for improved coordination among the various teams and plans that involve physician participation and that it investigate liability coverage issues for participating physicians; and be it further

RESOLVED, That this AMA taskforce also address the separate issue of physicians volunteering to fill unmet medical needs of indigent persons, including liability coverage for physician volunteers.

416. MARKETING OF UNHEALTHY FOOD AND BEVERAGES TO CHILDREN
Introduced by California Delegation

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-60.972, H-150.935 AND H-485.998 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support efforts to regulate the advertising and marketing of unhealthy food and beverages to children; and be it further

RESOLVED, That our AMA discourage the advertising and marketing of unhealthy food and beverages in public places frequently visited by children or adolescents, such as schools; and be it further

RESOLVED, That our AMA encourage media education programs to reduce harmful health influences of food and beverage marketing to children and to promote the consumption of healthy foods.

417. TAX INCENTIVES AND FILMS DEPICTING TOBACCO
Introduced by California Delegation

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED WITH CHANGE IN TITLE
See Policy H-495.974

RESOLVED, That our American Medical Association urge that no tax incentives be given for any motion picture production that depicts any tobacco product or non-pharmaceutical nicotine delivery device or its use, associated paraphernalia, related trademarks or promotional material, unless the film depicts the tobacco use of historical persons or unambiguously portrays the dire health consequences of tobacco use.

418. MILD TRAUMATIC BRAIN INJURY AWARENESS
Introduced by California Delegation

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-10.965

RESOLVED, That our American Medical Association promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.

419. PROTECTING OUR CHILDREN FROM SKIN CANCER
Introduced by Oklahoma Delegation

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY D-440.969 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association adopt a policy recommending that minors should not use indoor tanning bed equipment because indoor tanning devices emit UVA and UVB radiation and overexposure to UV radiation can lead to the development of skin cancer; and be it further

RESOLVED, That our AMA support US Congressional, Regulatory and Judicial efforts to ban the use by minors of indoor tanning bed equipment.

Resolution 420 was considered with Resolution 405.
See Resolution 405.

421. ADVOCATING FOR DISCLOSURE OF NICOTINE LEVEL PER CIGARETTE AT POINT OF SALE
Introduced by Louisiana Delegation

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: POLICY H-495.981 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for the introduction of legislation which will require tobacco companies to accurately label their products specifically indicating the nicotine content of their products (including cigarettes) in easily understandable and meaningful terms consistent with AMA Policy H-495.989, Tobacco Product Labeling.

Resolution 422 was not submitted for consideration.

423. HEALTHY LIFESTYLES
Introduced by American College of Preventive Medicine

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED WITH CHANGE IN TITLE
See Policy H-425.972

RESOLVED, That our American Medical Association recognize the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the *Journal of the American Medical Association* in 2010; and be it further

RESOLVED, That our AMA urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and be it further

RESOLVED, That our AMA work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.

424. REAUTHORIZATION OF FUNDING FOR THE SPECIAL DIABETES PROGRAM FOR INDIANS
Introduced by Minority Affairs Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-350.976 AND H-350.977 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support the reauthorization and funding of the Special Diabetes Program for Indians.

425. HEAD INJURY PREVENTION IN HOCKEY
Introduced by New York Delegation

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-470.958

RESOLVED, That our American Medical Association encourage that all levels of hockey effectively prevent head hits and dangerous checking.

426. PREVENTION OF OBESITY THROUGH INSTRUCTION IN PUBLIC SCHOOLS
Introduced by Pennsylvania Delegation

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-170.961

RESOLVED, That our American Medical Association urge appropriate agencies to, and support legislation that would, require meaningful yearly instruction in nutrition, including instruction in the causes, consequences, and prevention of obesity, in grades 1 through 12 in public schools, and that our AMA encourage physicians to volunteer their time to assist with such an effort.

427. PROVIDING PHYSICAL FITNESS GUIDELINES
Introduced by Pennsylvania Delegation

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association coordinate with the appropriate national specialty societies to seek the development of a jointly endorsed checklist designed to help identify underlying risk factors in patients interested in beginning or resuming physical fitness activities; and be it further

RESOLVED, That our AMA offer non-legal guidance regarding the liability associated with signing releases for patients' participation in physical fitness activities; and be it further

RESOLVED, That our AMA maintain a current resource for its members as data becomes available regarding evidence based recommendations that would be appropriate for their patients.

428. ELECTRONIC GAMES AND HEALTH PROMOTION
Introduced by Maryland Delegation

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy D-170.993

RESOLVED, That our American Medical Association review and report on health-related use of electronic games, types of games that are available and games that could be recommended by physicians for targeted patient populations.

429. ENDING DISCRIMINATION AGAINST PHYSICIANS PARTICIPATING IN PHYSICIAN HEALTH PROGRAMS
Introduced by Maryland Delegation

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association advocate that physicians who experience medical board disciplinary action as a result of behavior associated with a diagnosed Substance Use Disorder (SUD) but are fully compliant with their Physician Health Program (PHP) contracts requiring total abstinence from any use of alcohol or other drug of abuse that is verified by intensive and comprehensive monitoring not be arbitrarily subject to increased liability premiums, removal from insurance provider panels, loss of hospital credentials and privileges, loss of professional society membership and loss of specialty board certification based solely on public medical board actions taken on their license that were related to their diagnosed SUD; and be it further

RESOLVED, That our AMA support the Federation of State Medical Board's "Impaired Physician Guidelines" of April 22, 2011 which encourage state medical licensure boards to make full use of the option of referring physicians with diagnosed SUDs or a mental disorder to their state PHP in lieu of taking adverse/public disciplinary action on said physician's license.

430. AUTO SAFETY
Introduced by Michigan Delegation

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-15.990 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association promote through the appropriate agency and/or congressional channels, requirements for controls to ensure a driverless vehicle cannot be in gear.

431. APPLICANTS FOR LICENSURE, HOSPITAL PRIVILEGES, PROFESSIONAL SOCIETY MEMBERSHIP AND SPECIALTY BOARD CERTIFICATIONS BY PHYSICIANS PARTICIPATING IN PHYSICIAN HEALTH PROGRAMS
Introduced by Maryland Delegation

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association advocate for the removal of language on application forms for initial medical licensure, hospital credentialing, specialty medical society membership, specialty certification or for renewal of licensure, credentials, membership, or certification which, absent individualized cause, require the applicant to declare the presence of a diagnosis of Substance Use Disorder, treatment for Substance Use Disorder or participation in a state Physician Health Program.

432. AGE-BASED ALCOHOL POLICIES
Introduced by New York Delegation

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association engage in opening discussion regarding federal and state age based alcohol policies including review of the positive and negative consequences of these policies and ways to reduce harm from age appropriate and underage drinking; and be it further

RESOLVED, That such discussion include review of the research literature and other appropriate evidence in light of the recent increase in underage binge drinking and adverse consequences of underage binge drinking.

433. PREVENTING DEATHS AND INJURIES FROM DISTRACTED WALKING
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy D-10.992

RESOLVED, That our American Medical Association, as a champion of public health, include distracted walking as one of the preventable hazards in its published and distributed materials on lifestyle medicine; and be it further

RESOLVED, That our AMA utilize established channels of communication with internal and external media to increase public awareness of the hazards caused by distracted walking; and be it further

RESOLVED, That our AMA write to appropriate federal and state agencies encouraging them to reevaluate the safety of the roads and intersections for the walking public in their respective jurisdictions; and further

RESOLVED that our AMA report back at the 2013 Annual Meeting summarizing actions which are likely to make walking safer for our people.

434. AMA'S SUPPORT FOR EVIDENCE BASED OBESITY PREVENTION STRATEGIES
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: POLICIES H-150.953, H-440.902 AND D-470.993 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association, as a champion of public health, help promote evidence based initiatives by the Centers for Disease Control and Prevention and others to attack our nation's obesity epidemic; and be it further

RESOLVED, That our AMA support initiatives and legislative efforts providing tax incentives or tax credits to developers who include environmentally friendly features in their developments such as walking trails, playgrounds, bike paths and sidewalks which create opportunities for residents of all ages to exercise and help combat obesity and many chronic illnesses; be it further

RESOLVED, That our AMA report back at the 2014 Annual Meeting the progress made in its efforts to reduce obesity across our nation.

435. HEALTHY MEALS FOR CHILDREN
Introduced by Arizona Delegation

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: POLICY H-150.935 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association encourage appropriate entities to promote voluntary adherence to appropriate nutritional standards in accordance with best scientific information for meals marketed specifically to children.

501. STUDY OF CANCER INCIDENCE IN 9/11 RESPONDERS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED WITH CHANGE IN TITLE
See Policy H-55.974

RESOLVED, That our American Medical Association encourage further study of the association between post-September 11, 2001 World Trade Center attack exposure and cancer incidence.

502. REDUCED INCARCERATION AND IMPROVED TREATMENT OF INDIVIDUALS WITH MENTAL ILLNESS OR ILLICIT DRUG DEPENDENCE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: FOLLOWING POLICY H-430.997 AMENDED IN LIEU OF FOLLOWING RESOLUTION
See Policy H-430.997

H-430.997, Standards of Care for Inmates of Correctional Facilities
Our AMA believes that correctional and detention facilities should provide medical, psychiatric and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

503. PROMOTING PREVENTION OF FATAL OPIOID OVERDOSE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: FOLLOWING POLICY D-95.987 AMENDED IN LIEU OF FOLLOWING RESOLUTION
See Policy D-95.987

D-95.987, ~~Intranasal~~ Naloxone Administration for Prevention of Opioid Overdose
Our AMA: (1) recognizes the great burden that ~~opiate~~ opioid addiction and prescription drug abuse place~~s~~ on patients and society alike and reaffirms its support for the compassionate treatment of such patients ~~with opiate addiction~~; (2) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; (3) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (4) will continue to monitor the progress of such ~~intranasal naloxone studies~~ initiatives and respond as appropriate ~~report back as needed~~.

504. REGULATIONS ON THE PATENTING OF ENDOGENOUS HUMAN DNA
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: FOLLOWING POLICY H-140.855 AMENDED IN LIEU OF FOLLOWING RESOLUTION
See Policy H-140.855

H-140.855, Gene Patents and Accessibility of Gene Testing
Our AMA: (1) opposes patents on ~~human genes and their~~ naturally-occurring human DNA or RNA sequences ~~mutations~~; (2) supports legislation requiring that existing gene patents be broadly licensed so as not to limit access through exclusivity terms, excessive royalties or other unreasonable terms; and (3) supports legislation that would exempt from claims of infringement those who use patented genes for medical diagnosis and research.

505. DIRECT-TO-CONSUMER ADVERTISING OF DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES
Introduced by North Carolina Delegation

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association pursue legislation or regulation as appropriate to require that direct-to-consumer advertisements for durable medical equipment (DME) and other medical supplies in any media: (1) include a disclaimer statement to the effect that eligibility for and coverage of the illustrated product is subject to specific criteria and that only a physician can determine if a patient meets those criteria; and (2) whenever feasible list the actual criteria (or a summary thereof) from the appropriate Certificate of Medical Necessity; and (3) note that patients who knowingly obtain DME or other supplies without meeting the eligibility criteria and the physicians who inappropriately certify such patients may be subject to civil and/or criminal penalties for fraud; and (4) refrain from statements to the effect that only a physician order or signature is required to obtain the desired items.

506. COMPOSITION OF THE US PREVENTIVE SERVICES TASK FORCE
Introduced by Missouri Delegation

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-410.955 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association encourage proportional representation of clinical specialists on the US Preventive Services Task Force.

507. DIAGNOSTIC ULTRASOUND UTILIZATION AND EDUCATION
Introduced by American Institute of Ultrasound in Medicine,
American Academy of Otolaryngology–Head and Neck Surgery,
American Academy of Pain Medicine, American Academy of Physical Medicine and Rehabilitation,
American Association of Clinical Endocrinologists,
American Association of Neuromuscular & Electrodiagnostic Medicine,
American College of Chest Physicians, American College of Emergency Physicians,
American College of Rheumatology, American College of Surgeons, American Urological Association,
Renal Physician Association, Society for Vascular Surgery, and
Georgia, Maryland and South Carolina Delegations

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
WITH CHANGE IN TITLE
See Policy H-480.950

RESOLVED, That our American Medical Association affirms that ultrasound imaging is a safe, effective, and efficient tool when utilized by, or under the direction of, appropriately trained physicians; and be it further

RESOLVED, That our AMA support the educational efforts and widespread integration of ultrasound throughout the continuum of medical education.

508. MEDICAL DEVICE "USE BEFORE DATES"
Introduced by American College of Cardiology and Heart Rhythm Society

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS WITH CHANGE IN TITLE
See Policy D-480.977

RESOLVED, That our American Medical Association encourage the US Food and Drug Administration to clearly define and interpret the definition and meaning of the "use before date" for medical devices.

Resolution 509 was considered with Council on Science and Public Health Report 7.
See Council on Science and Public Health Report 7.

Resolution 510 was considered with Council on Science and Public Health Report 7.
See Council on Science and Public Health Report 7.

511. MEDICAL VS LEGAL SOLUTIONS TO DRUG ABUSE
Introduced by California Delegation

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association encourage the federal government to re-examine the enforcement-based approach to illicit drug issues ("war on drugs") and to prioritize and implement policies that treat drug abuse as a public health threat and drug addiction as a preventable and treatable disease.

512. NANOPARTICLE TESTING, MONITORING AND REGULATION
Introduced by California Delegation

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association recognize both the benefits and the potential risks to public health and the environment from the widespread use of nanoparticles; and be it further

RESOLVED, That our AMA endorse responsible regulation of existing or new nanoparticles prior to their introduction in industrial or consumer products, such as, but not limited to, standardized research, toxological testing, biomonitoring and product labeling.

513. TRICLOSAN ANTIMICROBIALS
Introduced by California Delegation

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy D-440.938

RESOLVED, That our AMA encourage the Food and Drug Administration to finalize the triclosan antimicrobial monograph first drafted in 1978 and updated in 1994 which found evidence for the safety and effectiveness of only alcohol and iodine-based topical products in health care use; and be it further

RESOLVED, That our AMA encourage the education of members on the issue of the importance of proper hand hygiene and the preferential use of plain soap and water or alcohol-based hand sanitizers in health care settings, consistent with the recommendations of the Centers for Disease Control and Prevention.

514. SYNTHETIC GASIFICATION
Introduced by Illinois Delegation

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-135.977

RESOLVED, That our American Medical Association encourage study of the health effects of clean coal technologies including synthetic gasification plants.

515. MODERNIZATION OF THE FEDERAL TOXIC SUBSTANCES CONTROL ACT (TSCA) OF 1976
Introduced by American College of Preventive Medicine

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-135.976

RESOLVED, That our American Medical Association support modernizing the Toxic Substances Control Act (TSCA) to require chemical manufacturers to provide adequate safety information on all chemicals and give federal regulatory agencies reasonable authority to regulate hazardous chemicals; and be it further

RESOLVED, That our AMA support the public disclosure of chemical use, exposure and hazard data in forms that are appropriate for use by medical practitioners, workers, and the public; and be it further

RESOLVED, That our AMA work with members of the Federation to promote a reformed TSCA that is consistent with goals of Registration, Evaluation, Authorisation, and Restriction of Chemicals (REACH).

516. WARNING NEW YORK STATE CITIZENS OF PRODUCTS KNOWN TO CAUSE CANCER, BIRTH DEFECTS OR OTHER REPRODUCTIVE HARM
Introduced by New York Delegation

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association study California Proposition 65 which requires warning labels on products to inform citizens about products known to contain chemicals which are carcinogenic or teratogenic and report back to the AMA House of Delegates at the 2013 Annual Meeting regarding the appropriateness of encouraging similar legislation in the United States.

517. RECOMMENDATIONS BY THE USPSTF
Introduced by American Urological Association and American Association of Clinical Urologists

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED WITH CHANGE IN TITLE IN LIEU OF RESOLUTIONS 517 AND 527 AND POLICIES H-410.955 AND H-410.967 REAFFIRMED
See Policy D-425.992

RESOLVED, That our American Medical Association expresses concern regarding recent recommendations by the United States Preventive Services Task Force (USPSTF) on screening mammography and prostate specific antigen (PSA) screening and the effects these USPSTF recommendations have on limiting access to preventive care for Americans; and be it further

RESOLVED, That our AMA encourage the USPSTF to implement procedures that allow for meaningful input on recommendation development from specialists and stakeholders in the topic area under study.

518. PAIN AS A MAJOR HEALTH CARE PROBLEM
Introduced by American Academy of Pain Medicine

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: POLICIES H-280.958, D-120.976 AND D-160.981 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association recognize pain as a major health care problem and support all reasonable efforts to promote expanding pain-related educational, research and advocacy opportunities for all health care providers.

519. SUPPORT FOR DECREASING POLLUTION FROM ENERGY SOURCES
Introduced by Pennsylvania Delegation

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-135.977 AND H-135.998 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support energy sources which decrease environmental risks to the public health from particulate emissions, gases, radiation and chemical pollutants.

520. GUIDELINES ON NEONATAL RESUSCITATION
Introduced by Iowa, Minnesota and Nebraska Delegations

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED WITH CHANGE IN TITLE
See Policy H-245.968

RESOLVED, That our American Medical Association support programs designed to educate health care professionals who treat premature infants, as well as parents and caregivers of premature infants, on evidence-based guidelines on neonatal resuscitation, especially with regard to premature infants born at the cusp of viability.

521. PHYSICIAN AWARENESS AND EDUCATION ABOUT PHARMACEUTICAL AND BIOLOGICAL RISK EVALUATION AND MITIGATION
Introduced by Michigan Delegation

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-100.971

RESOLVED, That our American Medical Association work with the pharmaceutical and biological industries to increase physician awareness of Risk Evaluation and Mitigation Strategies as a means to improve patient safety; and be it further

RESOLVED, That our AMA work with the e-prescribing and point of care resource industries to increase physician awareness of Risk Evaluation and Mitigation Strategies as a means to improve patient safety by including current Risk Evaluation and Mitigation Strategy information in their products.

522. LEAD FREE WHEEL WEIGHTS
Introduced by Michigan Delegation

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: POLICY H-135.959 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association seek either policy or legislation that would ban lead wheel weights in the United States; and be it further

RESOLVED, That our AMA join and support the National Lead Free Wheel Weight Initiative.

523. APPROPRIATE USE OF ANTIPSYCHOTIC MEDICATIONS IN NURSING HOME PATIENTS WITHOUT PENALTY
Introduced by Michigan Delegation

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-120.951

RESOLVED, That our AMA meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed; and be it further

RESOLVED, That our AMA ask CMS to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis.

Resolution 524 was considered with Council on Science and Public Health Report 7.
See Council on Science and Public Health Report 7.

Resolution 525 was considered with Council on Science and Public Health Report 7.
See Council on Science and Public Health Report 7.

526. SUPPORT EPA'S CARBON EMISSIONS STANDARD
Introduced by American Thoracic Society

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: POLICIES H-135.934 AND H-135.949 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support the Environmental Protection Agency's (EPA's) effort to establish green house gas new source performance standards for fossil fuel electric generating units; and be it further

RESOLVED; That our AMA oppose any efforts by Congress to delay or impede EPA's authority to issue or enforce regulations on green house gas emissions from fossil fuel electric generating units.

Resolution 527 was considered with Resolution 517.
See Resolution 517.

601. AMA TRUTH SQUAD
Introduced by New York Delegation

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: POLICY H-445.995 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association, working in conjunction and coordination with its communications department, form a "Truth Squad" whose purpose is to act expeditiously in setting the record straight, publicly, forthrightly, and professionally, as it relates to any negative publicity, comments or statements which may be viewed as derogatory and/or, anti-physician.

Resolution 602 was withdrawn.

603. AMA – MY MEDICATIONS APP
Introduced by New York Delegation

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That, as a means of promoting the core values, vision and mission of our American Medical Association, while also helping to "brand" the AMA in a more positive light among physicians and patients, our AMA Board of Trustees be urged to consider making the "My Medications" App (which enables patients to store, carry and share their critical medical information on their iPhone, iPad, and iPod Touch), available at no charge to all interested patients who utilize the services of an AMA member physician.

604. AMA PRIORITIES AND PRIVATE, SOLO, AND SMALL GROUP PRACTICE
Introduced by New York Delegation

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED WITH CHANGE IN TITLE
See Policy D-405.988

RESOLVED, That our American Medical Association utilize its resources to protect and support the continued existence of solo and small group medical practice, and to protect and support the ability of these practices to provide quality care.

605. USE OF VIRTUAL REFERENCE COMMITTEES BY THE AMERICAN MEDICAL ASSOCIATION
Introduced by Louisiana Delegation

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association House of Delegates direct a review of the issues surrounding the use of "virtual reference committees" and to report its review at the 2012 Interim Meeting.

Resolution 606 was withdrawn.

607. AMA ONLINE PHYSICIAN PLATFORM
Introduced by Michigan Delegation

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association not exclusively offer a single laboratory information system/electronic health record solution as part of its online physician platform.

608. VIOLENCE OR INTIMIDATION DIRECTED TOWARD OR BY MEDICAL PROFESSIONALS
Introduced by Maryland Delegation

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: POLICY H-515.982 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association condemn any form of violence or intimidation directed toward or by medical professionals.

609. HEALERS AND HEROES PROGRAM
Introduced by New Jersey Delegation

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association institute a national program based on the Healers and Heroes Program, or Vet2Vet program, that will confidentially connect military personnel returning from deployment with physician volunteers who have previous military service to provide counsel for their healthcare needs.

610. PARTICIPATION IN CPT PROCESS
Introduced by American Association of Neurological Surgeons and Congress of Neurological Surgeons

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association Board of Trustees, in its oversight capacity, review the CPT Editorial Panel process -- including the implications of industry involvement -- and make recommendations to the Panel to assure the integrity of the process; and be it further

RESOLVED, That, similar to the RBRVS Update Committee (RUC), our AMA Board of Trustees consider encouraging the AMA CPT Editorial Panel to minimize any inappropriate influence on the CPT Editorial Process; and be it further

RESOLVED, That our AMA Board of Trustees consider recommending to the CPT Editorial Panel inclusion in the introduction to the CPT code book a clarification of the role of specialty society CPT Advisors in the CPT process, such as: “All proposed changes to the CPT code set will be considered by the CPT Editorial Panel, in consultation with medical specialty societies, as represented by the Health Care Professionals Advisory Committee (“HCPAC”), and other interested parties.”; and be it further

RESOLVED, That our AMA Board of Trustees consider recommending to the CPT Editorial Panel that it strive to have the support of at least one medical specialty society before implementing a code change and that the AMA Board urge medical societies and other interested parties to avail themselves of the process for seeking reconsideration of an action taken by the CPT Editorial Panel where there is concern that the Panel did not properly take into account specialty society input regarding a proposed new or revised CPT code.

611. UNIFORMITY OF CPT DISCLOSURE AND CONFIDENTIALITY POLICIES
Introduced by North American Spine Society

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association Board of Trustees encourage the CPT Editorial Panel to implement and enforce a uniform disclosure and confidentiality policy for all participants in the CPT process.

612. AMA MEETING SCHEDULE
Introduced by Texas Delegation

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED IN LIEU OF RESOLUTIONS 612 AND 615
See Policy G-600.125

RESOLVED, That our AMA convene as a pilot a combined interim policy-making meeting and National Advocacy Conference; and be it further

RESOLVED, That the combined meetings be held at a location in the Washington, DC metropolitan area and at an appropriate time to avoid incurring contractual penalties; and be it further

RESOLVED, That the pilot take place within a reasonable timeframe, and with adequate notice to the members of the House of Delegates; and be it further

RESOLVED, That our AMA sections be afforded the opportunity to meet immediately prior to and in close proximity to the meetings of the AMA House of Delegates.

613. TRIAGE OF AMA RESOLUTIONS
Introduced by Arizona Delegation

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association evaluate a mechanism to encourage consideration of resolutions that are clearly relevant to promoting the art and science of medicine and the betterment of public health; and be it further

RESOLVED, That our AMA establish a method of determining the impact on patients and physicians similar to that already in place with regard to fiscal impact.

614. AMA LEADERSHIP TRANSPARENCY
Introduced by Arizona Delegation

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That, except for explicit legal constraints of confidentiality, the deliberations (minutes) of and decision-making votes of all American Medical Association Councils, Committees, and Boards should be made available to the general membership on a regular basis.

Resolution 615 was considered with Resolution 612.
See Resolution 612.

701. EFFECT OF COMPUTERS IN THE EXAM ROOM ON PHYSICIAN-PATIENT COMMUNICATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association study the effect of electronic devices, including but not limited to computers and tablets, in the exam room on doctor-patient communication with an emphasis on alternatives and modifications that might improve the physician-patient relationship.

702. IMPROVED ADEQUACY OF TRANSLATION SERVICES IN HOSPITAL AND PHARMACY SETTINGS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policies H-215.982 and D-160.992

RESOLVED, That our American Medical Association amend Policy H-215.982 by deletion and insertion as follows:

H-215.982 ~~Translator~~ Interpretive Services ~~in Hospitals~~
Our AMA encourages hospitals and pharmacies that serve populations with a significant number of non-English speaking or hearing-impaired patients to provide trained ~~translator~~ interpretive services.

RESOLVED, That Policy D-160.992, Appropriate Reimbursement for Language Interpretive Services, be reaffirmed.

703. SUPPORT OF MULTILINGUAL ASSESSMENT TOOLS FOR MEDICAL PROFESSIONALS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy H-160.914

RESOLVED, That our American Medical Association encourage the publication and validation of standard patient assessment tools in multiple languages.

704. PHYSICIAN LED QUALITY IMPROVEMENT PROJECTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: POLICIES H-450.946, D-450.983 AND D-478.984 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association gather a repository of Quality Improvement Project (QIP) quality measures and financial benefits by identifying and contacting physician QIP leaders and inviting them to contribute their prior and ongoing data from QIP for analysis of QIP quality measures and financial benefits, with the goal of allowing other physicians, who practice in a wide range of practice settings and specialties, to review these quality measures and financial benefits and approximate how a similar project could benefit their own healthcare organization.

705. OPTING OUT OF HEALTH INFORMATION EXCHANGES
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: POLICIES H-315.983 AND D-478.988 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association include in its current ongoing study of health information exchanges, concern for potential risks to patient privacy and safeguards against compromise of patient information.

706. SUPPORTING THE VALUE AND ADOPTION OF POPULATION HEALTH MANAGEMENT STRATEGIES
Introduced by American College of Medical Quality

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: POLICIES H-155.960 AND H-160.919 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association affirm the value and effectiveness of physician-led, team-based care models employing population health management strategies to achieve the Triple Aim goals of better health, better care and reduced health care costs.

707. ADVOCACY FOR MEDICARE/MEDICAID COVERAGE OF MULTI-USE TECHNOLOGY PLATFORMS FOR AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICES
Introduced by Wisconsin Delegation

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association support promoting the medical application of consumer technologies through new strategies for reimbursing the functionality software for multi-use platforms, which will increase consumer choices in medical equipment and cost-savings while allowing for seamless integration of healthcare technology into daily living; and be it further

RESOLVED, That our AMA discuss these measures at the 2012 Annual Meeting.

708. ACCURATE EVALUATION OF PAIN CONTROL DURING HOSPITAL VISITS
Introduced by Illinois Delegation

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services to support the development of an accurate and meaningful evaluation tool to assess pain control and management during hospital and emergency department visits as well as remove reimbursement decisions that are related to such subjective surveys.

709. APPROPRIATE USE OF PREAUTHORIZATION
Introduced by American College of Radiation Oncology

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED WITH CHANGE IN TITLE IN LIEU OF RESOLUTIONS 709 AND 712
See Policies H-285.931, H-285.998, H-320.945, H-320.946, H-320.952, H-320.968 and D-320.990

RESOLVED, That our AMA notify state and specialty societies of the model legislation developed by the Advocacy Resource Center titled "Appropriate Use of Preauthorization Act"; and be it further

RESOLVED, That our AMA reaffirm the following policies:
- H-285.931 The Critical Role of Physicians in Health Plans and Integrated Delivery Systems;
- H-285.998 Managed Care;
- H-320.945 Abuse of Preauthorization Procedures;
- H-320.946 Radiology Benefits Manager;
- H-320.952 External Grievance Review Procedures; and
- H-320.968 Approaches to Increase Payer Accountability

710. SUPPORT INTEGRATION OF CARE FOR RETURNING MILITARY, VETERANS AND THEIR FAMILIES BY OPENING ACCESS TO THE STATES' PRESCRIPTION MONITORING PROGRAMS BY VA PRESCRIBING PROVIDERS
Introduced by Oklahoma Delegation

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association advocate to the Department of Veterans Affairs that VA health care providers be permitted to utilize Physician Monitoring Program sites, emphasizing that medical management by psychiatric and all other physicians is necessary for evidence-based mental health and substance abuse care and allows for more effective monitoring of controlled medications that include narcotics and benzodiazepines; and be it further

RESOLVED, That our AMA increase collaborations with the Department of Veterans Affairs and Veterans Service Organizations to encourage community-based efforts between VA and non-VA based physicians and state operated Physician Monitoring Programs.

711. WEB-BASED TELE-HEALTH INITIATIVES AND POSSIBLE INTERFERENCE WITH THE TRADITIONAL PHYSICIAN-PATIENT RELATIONSHIP
Introduced by New York Delegation

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association urge the US Department of Health and Human Services (DHHS) to review tele-health initiatives being implemented by major health insurance carriers (i.e., United Healthcare, Blue Cross Blue Shield) and others to assure that proper standards of care are maintained, that such initiatives and the physicians who work with them are adherent to professional practice standards and federal public health laws and regulations; and to take appropriate actions to eliminate such initiatives that do not meet acceptable standards and regulations; and be it further

RESOLVED, That our AMA seek regulatory guidance from the DHHS regarding the essential requirements of web-based tele-health technology and health care initiatives and the requirements of physicians and healthcare providers who engage in the delivery of such services.

Resolution 712 was considered with Resolution 709.
See Resolution 709.

713. TRANSPARENCY IN RECRUITING AND MARKETING TECHNIQUES FOR YOUNG PHYSICIANS
Introduced by Minnesota and Nebraska Delegations

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy D-200.976

RESOLVED, That our American Medical Association explore strategies to increase transparency in marketing techniques used to recruit physicians who are finishing their residency or fellowship to ensure that hospitals, clinics, or health plans are not using deceptive or anti-competitive recruiting techniques without fully disclosing all components of any contract with the physician being recruited; and be it further

RESOLVED, That our AMA work through its councils and sections to develop resources to assist physicians in training in career decision-making that provides them the full range of information concerning various practice models, including private practice.

714. ELECTRONIC HEALTH RECORD VENDOR CONTRACTING POLICIES
Introduced by Maryland Delegation

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: POLICIES D-478.995 AND D-478.996 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association study the issue of electronic health record (EHR) data conversions and all associated costs, and provide potential solutions to allow physicians to switch to a different EHR product without excessive cost, delay, or loss of patient data; and be it further

RESOLVED, That due to the CMS EHR incentive timeline, a report be brought back to the AMA 2012 Interim Meeting.

715. ELECTRONIC MEDICAL RECORD COMMUNICATION
Introduced by Michigan Delegation

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: POLICIES D-478.995 AND D-478.996 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association convene a meeting of electronic medical record (EMR) vendors to propose a method of communications among their EMR systems.

716. REMOVE FACE-TO-FACE INTERACTION REQUIREMENT FOR CERTIFICATION OF HOME HEALTH NEEDS
Introduced by Michigan Delegation

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED: That our American Medical Association work with the Centers for Medicare & Medicaid Services to study alternatives to the requirements for face-to-face interaction to certify the need for home health care services to better address the issue of patients who could benefit from these services but who may not be able to present at the doctor's office because of severity of illness or short time interval between the discharge process and obtaining an appointment at a busy office.

717. DOCTOR'S RATING WEBSITE AND ONLINE REPUTATION
Introduced by Michigan Delegation

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: POLICIES D-478.980 AND D-478.989 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association develop tools in a timely manner to help physicians defend their online reputation and help restore physicians' reputations.

718. STRENGTHENING MEDICOLEGAL DEATH INVESTIGATIONS
Introduced by College of American Pathologists, National Association of Medical Examiners, American Society for Clinical Pathology, American Society of Cytopathology and United States and Canadian Academy of Pathology

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policies H-85.960 and D-85.994

RESOLVED, That our American Medical Association reaffirm that the reporting of vital events is an integral part of patient care and public health and that physicians are the appropriate parties to certify cause of death (AMA Policy, H-85.960, Certification of Cause of Death); and be it further

RESOLVED, That our AMA work with interested states on legislation to facilitate the transition from coroner systems to medical examiner systems.

719. THE IMPORTANCE OF LOCAL CONTROL OF HOSPITALS
Introduced by New Mexico Delegation

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy H-225.951

RESOLVED, That our American Medical Association establish policy and advocate for local governing boards to continue to exist for individual hospitals within multi-hospital systems to ensure that community needs, the needs of local medical staff and patient care needs are met within those communities whenever possible.

720. MEDICARE AND THE INDEPENDENT MEDICAL STAFF
Introduced by New Mexico Delegation

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-35.996, H-225.957 AND H-360.987 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association continue to advocate for continued independence of hospital medical staffs and that leadership of the medical staff continue to rest in the hands of physicians (MD, DO), with other practitioners to practice in the hospital under the supervision and oversight of physicians and under rules established by the local medical staff.

Resolution 721 was considered with Board of Trustees Report 17.
See Board of Trustees Report 17.

722. COST AND BENEFIT ANALYSIS FOR ELECTRONIC HEALTH RECORD IMPLEMENTATION
Introduced by Texas Delegation

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association (1) conduct a comprehensive literature review and/or study to analyze the current cost and/or benefit of implementing an electronic health record (EHR) for physicians in the ambulatory setting to determine if practices are able to realize a financial return on investment and an increase in quality of care from their EHR, and (2) advocate for the position that the parties benefiting most financially from the implementation of EHRs must share fairly in the cost.

723. FACE TO FACE ENCOUNTER FORMS
Introduced by Arizona Delegation

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association seek, through all appropriate means, to require that the provider who actually discharges the patient from the hospital, rehabilitation facility or nursing home to home health care is responsible for completing the Face to Face Encounter form.

724. AMA PRINCIPLES FOR PHYSICIAN EMPLOYMENT
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association (AMA) adopt as policy the following AMA Principles for Physician Employment.

Preamble

Physicians are increasingly entering into employment and other contractual relationships with hospitals, group practices, and other health care delivery systems. While such arrangements can benefit physicians and their patients, 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 following Principles for Physician Employment are intended to help physicians and those who employ them identify and address some of the unique challenges to professionalism and the practice of medicine arising in the face of physician employment. These 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 these 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 our hope that the Principles for Physician Employment, in addressing 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.

AMA Principles for Physician Employment

(1) Conflicts of Interest

(a) A physician's paramount responsibility is to his or her patients. Additionally, however, an employed physician owes a legal duty of loyalty, including fiduciary responsibility, 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) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

(c) 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.

(d) Assuming a title or position that removes a physician from direct patient-physician relationships – such 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 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.

(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) 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, or whenever either party feels that such counsel is necessary.

(c) Employers retain the right to accept or reject patients and to determine which employed physicians will render services to particular patients. When a physician's compensation is related to the revenue he or she generates, or to similar factors, the physician should be clear in his or her understanding of the factors upon which compensation is based.

(d) Termination of the contractual employment relationship does not necessarily end the physician-patient relationship. Upon contract termination, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer. 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. 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 physicians from denial of due process following termination of employment or premature termination of contracts.

(f) Physicians are discouraged from entering into agreements that specify automatic termination of hospital medical staff membership or clinical privileges upon termination of employment or 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 non-discrimination provisions. No discrimination, however subtle, should occur against an employee based on race, creed, color, gender, religion, sexual preference, ethnic origin, national origin, age, disability, etc.

(h) 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) 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, and should conduct their professional activities according to the 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 with one or more physicians.

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 the evidence, and the opportunity to present a defense.

(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) Upon termination of employment with or without cause, employed physicians should not be required to resign their 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 employed physicians 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.

(b) Employed physicians should retain the right to review billing claims. 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.

725. UNDERSTANDING THE PITFALLS OF ELECTRONIC HEALTH RECORDS AND PROVIDING STRATEGIES FOR SUCCESS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association (AMA) survey a large number of physicians in private practice representing primary care physicians and a broad cross section of specialists with regard to:

1. Amount of time required per patient to complete the electronic medical record (EMR),
2. Reimbursement before and after the use of EMR,
3. Quality of life before and after EMR implementation,
4. Confidence in coding using an EMR,
5. Quality of office notes for their own use and the use of other physicians who may require those records,
6. Their use of templates and whether information is truly entered because of its importance vs. its importance in complying with billing and coding mandates, and
7. The use of "pertinent negatives" and the amount of data that is carried forward to save time and improve coding but in fact is not addressed at the time of the visit; and be it further

RESOLVED, That our AMA survey experienced EMR users with regard to strategies that have been effective in addressing the potential pitfalls of EMRs; and be it further

RESOLVED, That our AMA survey physicians who have used EMR scribes as a way of improving the use of the EMR, improving office efficiency, and more accurately and completely documenting patient visits; and be it further

RESOLVED, That our AMA make available the results of its surveys on physician experiences with EMRs, including a thorough report of various strategies including the use of scribes that have brought physicians closer to optimal use of an EHR with respect to quality, efficiency and reimbursement, and report back at the 2013 Annual Meeting.

726. MEDICAL EXAMINER PATIENT POSTMORTEM: CAUSE OF DEATH TRANSPARENCY
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy D-85.995

RESOLVED, That our American Medical Association (AMA) convene a study group to examine strategies to implement a postmortem process or standard for ongoing communication between the medical examiner, physicians, health care providers, and family members; and be it further

RESOLVED, That our AMA develop guidelines for hospital processes for communication between medical examiners, clinicians, families, medical staffs, and other key stakeholders to establish a postmortem management methodology that includes timely communication between all parties.