

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1001
(I-17)

Introduced by: International Society of Hair Restoration Surgery
American Academy of Cosmetic Surgery

Subject: Reaffirmation of AMA Policy on the Use of Unlicensed Personnel to Perform
Surgery, with Attention to Hair Restoration Surgery

Referred to: Reference Committee B
(Ralph J. Nobo, Jr., MD, Chair)

1 Whereas, The surgery of hair restoration involves an incision or excision on a patient for the
2 purpose of manipulating, transferring, or removing full thickness skin grafts, hair follicles or skin
3 for redistribution or restoration whether by follicular unit extraction, follicular unit transplantation,
4 scalp reduction, scalp flap, scalp expansion surgery, or similar procedures; and
5

6 Whereas, Our AMA has existing policy regarding the practice of medicine by non-physicians
7 (AMA Policy H-160.949, "Practicing Medicine by Non-Physicians") and by unlicensed personnel,
8 and regarding the delegation of surgical duties to surgical assistants who are not licensed
9 physicians (H-475.986, "Surgical Assistants other than Licensed Physicians"); and
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11 Whereas Hair restoration surgery is practiced by physicians of multiple different specialties,
12 allied health professionals and non-physician providers working within their individual scope of
13 practice, and
14

15 Whereas, The International Society of Hair Restoration Surgery is dedicated to the ethical and
16 responsible care of patients and fosters education and training to all licensed physicians (MD
17 and DO); and
18

19 Whereas, Unlicensed personnel and non-physicians practicing outside their scope of practice
20 are performing critical-to-quality surgical aspects of hair restoration surgery such as treatment
21 planning, donor scalp harvesting, local anesthetic dosing, and recipient site creation;¹ and
22

23 Whereas, The Florida Medical Board has issued a Declaratory Statement "*the Board is of the*
24 *opinion that Section 458.3485, Florida Statutes, does not authorize the Petitioner to delegate*
25 *the task of harvesting follicular units consisting of the excision of skin, subcutaneous tissue and*
26 *hair follicles by use of a scalpel, micro-punch, motorized surgical extraction device or similar*
27 *surgical instrument or device and incising the scalp for transplanting such grafts, to a medical*
28 *assistant, or any other person who is not licensed as a health care practitioner and appropriately*
29 *trained or otherwise experienced in the performance of such surgical procedures, in an office*
30 *setting*";² and
31

32 "Whereas, The Florida Medical Association has adopted resolution 16-310 opposing the use of
33 unlicensed personnel and/or medical assistants to perform critical-to-quality steps of hair

¹ ISHRS White Paper sent to Medical Boards in USA, Concerns Over Unlicensed Personnel Performing Hair Transplant Surgery,
Nov. 2013

² State of Florida Medical Board: Final Order on Petition for Declaratory Statement, Issued June 2016

1 restoration surgery, such as redistribution planning, donor harvesting of follicular units either via
2 follicular unit extraction (FUE) or strip methods, and creation of recipient sites";³ and

3
4 Whereas, The American Academy of Dermatology Advisory Board adopted resolution AADA
5 012 opposing the use of practitioners other than physicians and NPP's to perform critical-to-
6 quality steps of hair restoration surgery, such as redistribution planning, donor harvesting of
7 follicular units either FUE or strip methods, and creation of recipient sites;⁴ and

8
9 Whereas, Unlicensed personnel and non-physicians practicing medicine and surgery outside
10 their scope of practice are making medical diagnoses regarding hair loss and making medical
11 decisions regarding medication use during hair restoration surgery; and

12
13 Whereas, Unlicensed personnel and non-physicians possess no credentials as nurse
14 practitioners, surgical assistants, or physician assistants; and

15
16 Whereas, Use of non-physicians or unlicensed personnel practicing outside their scope of
17 practice to make medical decisions and perform surgery places patients at risk of bodily harm
18 and inappropriate, sub-optimal, or harmful treatment; and

19
20 Whereas, Patients are not informed of the use of such unlicensed personnel to perform surgical
21 hair restoration and/or diagnosis of hair disorders;⁵ and

22
23 Whereas, Such unlicensed personnel do not carry professional liability insurance; and

24
25 Whereas, The practice of medicine by non-physicians practicing outside their scope of practice
26 is counter to the policies of our AMA and the official position of the International Society of Hair
27 Restoration Surgery⁶, the AAD's position statement on the Practice of Dermatology⁷ and the
28 American Society of Plastic Surgeons,⁸ and constitutes a serious risk to the health and safety of
29 patients; therefore be it

30
31 RESOLVED, That our American Medical Association reaffirm Policies H-160.949 and E10.5
32 concerning the practice of medicine by non-physicians, and allied health professionals
33 practicing within the individual's scope of practice. (Reaffirm HOD Policy); and be it further

34
35 RESOLVED, That our AMA reaffirm Policies H-475.986, and H-475.983 to affirm that only
36 licensed physicians with appropriate education, training, experience and demonstrated current
37 competence should perform surgical procedures. (Reaffirm HOD Policy)

Fiscal Note: Minimal – less than \$1,000.

Received: 11/06/17

³ Florida Medical Association Annual Meeting July 29-31; Orlando Florida resolution 16-310 opposing the use of unlicensed personnel and/or medical assistants to perform critical-to-quality steps of hair restoration surgery.

⁴ 2017 Advisory Board Resolutions Reference Committee Recommendations, March 5, 2017.

⁵ ISHRS Consumer Alert, Be Sure a Properly trained, licensed physician is responsible for your treatment, Oct. 2014. Available at: <http://www.ishrs.org/article/consumer-alert>

⁶ ISHRS Continuing Education Committee, Subcommittee Expert Panel; ISHRS Best Practices Survey Project: Who Does What. Hair Transplant Forum International, Vol. 25 (4) 2015.

⁷ AADA Letter to The Florida Senate Committee on Health Policy in support of SB 974, January 2016.

⁸ American Society of Plastic Surgery Letter to The Florida Senate Committee on Health Policy in support of SB 974, January 2016.

RELEVANT AMA POLICY

Surgical Assistants other than Licensed Physicians H-475.986

Our AMA: (1) affirms that only licensed physicians with appropriate education, training, experience and demonstrated current competence should perform surgical procedures;

(2) recognizes that the responsible surgeon may delegate the performance of part of a given operation to surgical assistants, provided the surgeon is an active participant throughout the essential part of the operation. Given the nature of the surgical assistant's role and the potential of risk to the public, it is appropriate to ensure that qualified personnel accomplish this function;

(3) policy related to surgical assistants, consistent with the American College of Surgeons' Statements on Principles states:(a) The surgical assistant is limited to performing specific functions as defined in the medical staff bylaws, rules and regulations. These generally include the following tasks: aid in maintaining adequate exposure in the operating field, cutting suture materials, clamping and ligating bleeding vessels, and, in selected instances, actually performing designated parts of a procedure.

(b) It is the surgeon's responsibility to designate the individual most appropriate for this purpose within the bylaws of the medical staff. The first assistant to the surgeon during a surgical operation should be a credentialed health care professional, preferably a physician, who is capable of participating in the operation, actively assisting the surgeon.

(c) Practice privileges of individuals acting as surgical assistants should be based upon verified credentials and the supervising physician's capability and competence to supervise such an assistant. Such privileges should be reviewed and approved by the institution's medical staff credentialing committee and should be within the defined limits of state law. Specifically, surgical assistants must make formal application to the institution's medical staff to function as a surgical assistant under a surgeon's supervision. During the credentialing and privileging of surgical assistants, the medical staff will review and make decisions on the individual's qualifications, experience, credentials, licensure, liability coverage and current competence.

(d) If a complex surgical procedure requires that the assistant have the skills of a surgeon, the surgical assistant must be a licensed surgeon fully qualified in the specialty area. If a complication requires the skills of a specialty surgeon, or the surgical first assistant is expected to take over the surgery, the surgical first assistant must be a licensed surgeon fully qualified in the specialty area.

(e) Ideally, the first assistant to the surgeon at the operating table should be a qualified surgeon or resident in an education program that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) and/or the American Osteopathic Association (AOA). Other appropriately credentialed physicians who are experienced in assisting the responsible surgeon may participate when a trained surgeon or a resident in an accredited program is not available. The AMA recognizes that attainment of this ideal in all surgical care settings may not be practicable. In some circumstances it is necessary to utilize appropriately trained and credentialed unlicensed physicians and non-physicians to serve as first assistants to qualified surgeons.

Citation: (BOT Rep. 32, A-99; Reaffirmed: Res. 240, 708, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 16, A-13)

Practicing Medicine by Non-Physicians H-160.949

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;

(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;

(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and

(6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation

Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.

Citation: (Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 224, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Res. 107, A-14; Appended: Res. 324, A-14)

Definition of Surgery H-475.983

Our AMA adopts the following definition of 'surgery' from American College of Surgeons Statement ST-11:

Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel.

Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards.

Citation: Res. 212; A-07; Reaffirmed: BOT Rep. 16, A-13

10.5 Allied Health Professionals

Physicians often practice in concert with optometrists, nurse anesthetists, nurse midwives, and other allied health professionals. Although physicians have overall responsibility for the quality of care that patients receive, allied health professionals have training and expertise that complements physicians. With physicians, allied health professionals share a common commitment to patient well-being.

In light of this shared commitment, physicians' relationships with allied health professionals should be based on mutual respect and trust. It is ethically appropriate for physicians to:

- (a) Help support high quality education that is complementary to medical training, including by teaching in recognized schools for allied health professionals.
- (b) Work in consultation with or employ appropriately trained and credentialed allied health professionals.
- (c) Delegate provision of medical services to an appropriately trained and credentialed allied health professional within the individual's scope of practice.

[AMA Principles of Medical Ethics: I,V,VII](#)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1002
(I-17)

Introduced by: New York

Subject: Health Insurance Company Purchase by Pharmacy Chains

Referred to: Reference Committee B
(Ralph J. Nobo, Jr., MD, Chair)

- 1 Whereas, The concentration within the health insurance market place is ongoing; and
2
3 Whereas, There is but one major health insurance plan offering insurance products within many
4 markets throughout the country; and
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6 Whereas, It has been shown that the outcomes for cardiovascular disease are directly related to
7 the number of health insurance plans, but not the number of individual product choices with a
8 single health insurance plan's offerings; and
9
10 Whereas, Prescription drugs are a major driver of health care costs in the United States; and
11
12 Whereas, In spite of the magnitude of purchasing power, Medicare does not negotiate for
13 discounts or other cost savings for prescription drugs on behalf of their beneficiaries; and
14
15 Whereas, Medicare Part D policies relegate individual products to one of five tiers; and
16
17 Whereas, Tier 4 drugs are deemed "non-covered;" and the entire prescription cost rests with the
18 beneficiary; and
19
20 Whereas, Tier 5 drugs are deemed to be "specialty drugs" and are charged a 33.3% copay cost
21 to the beneficiary; and
22
23 Whereas, The copay may exceed \$1500/ month for two injections of a Tier 5 drug to treat
24 Crohn's and other diseases; and
25
26 Whereas, The copay may exceed \$4500/ month for daily injections of 0.15 ml of a Tier 5 drug to
27 treat short bowel syndrome; and
28
29 Whereas, An appeal mechanism is required by Medicare to be in place for Part D insurance
30 companies to consider the appeal for a change of tier designations; and
31
32 Whereas, The internal review panel states that the health insurance plan, "Does not consider
33 the application for a request of change of Tier designation for a given Tier 5 drug;" and
34
35 Whereas, If the beneficiary requests an appeal of the health insurance plan's internal review,
36 the request is transmitted to the health insurance plan's external "Review entity;" and

1 Whereas, The external review entity upholds the health insurance plan’s internal decision by
2 restating that the health insurance plan, “Does not consider the application for a request of
3 change of Tier designation for a given Tier 5 drug;” and
4

5 Whereas, Health insurance plans currently restrict dispensing of many Tier 5 drugs to a limited
6 number of “specialty pharmacies;” and
7

8 Whereas, Many specialty pharmacies are owned by a major drug store chain; and
9

10 Whereas, Health insurance plans restrict completion through this restrictive distribution process;
11 and
12

13 Whereas, The number of drugs with Tier 4 and Tier 5 shift the burden of cost to the beneficiary;
14 and
15

16 Whereas, The recent announcement that the drug store chain CVS made an offer to buy the
17 Aetna Health Care Insurance Plan; and
18

19 Whereas, If such purchase would be allowed the access to drugs within the formulary of Aetna
20 can be manipulated by the new parent, CVS; and
21

22 Whereas, The manipulations can result in expansion of the number of drugs relegated into Tier
23 4 and Tier 5; and
24

25 Whereas, There is no appeal mechanism now in place to address such a manipulation; and
26

27 Whereas, Any such expansion of the Tier 4 and Tier 5 drug lists will result in an increased cost
28 to the beneficiary; therefore be it
29

30 RESOLVED, That our American Medical Association object to any purchase of a health
31 insurance plan by any drug store or pharmacy chain and that our AMA work with other
32 stakeholders, including the American Osteopathic Association and specialty colleges, to
33 advocate for protection against such a purchase. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 11/01/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1003
(I-17)

Introduced by: American College of Gastroenterology

Subject: AMA Advocacy Efforts for Emergency Medicaid Funding and Assistance -
Puerto Rico

Referred to: Reference Committee B
(Ralph J. Nobo, Jr., MD, Chair)

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- 1 Whereas, The objects of the American Medical Association are to promote the science and art
2 of medicine and the betterment of public health¹; and
3
4 Whereas, The AMA Foundation's Physician Disaster Recovery Fund directly supports
5 physicians impacted by natural disasters and has created the Physician Disaster Recovery
6 Fund to assist recovery efforts for both Texas and Florida²; and
7
8 Whereas, The people of Puerto Rico lack sufficient health care resources to facilitate their
9 complete recovery from the devastation of Hurricanes Irma and Maria; and
10
11 Whereas, Physicians and health care providers in Puerto Rico continue to struggle to maintain
12 operations to provide necessary medical care to the people of Puerto Rico; and
13
14 Whereas, Puerto Ricans are natural-born U.S. citizens, with nearly 3.4 million U.S. citizens
15 residing on the island; roughly one in two Puerto Ricans, or 49% of the total population, are
16 enrolled in the island's Medicaid program; the 2016 median income is \$20,078 in Puerto Rico,
17 compared to national average of \$57,617 for all other U.S. states; roughly 46% of Puerto Ricans
18 are below the federal poverty level, compared to 15% of residents in all other U.S. states³; and
19
20 Whereas, The federal matching rate for Medicaid and CHIP is capped at a fixed rate of 55%,
21 despite that the federal matching rate traditionally ranges from 50-83% based on a state's per
22 capita income⁴; and
23
24 Whereas, It is imperative that federal funding for Puerto Rico's Medicaid program provides the
25 local government support to meet the worsening medical and public health needs of its
26 residents during these trying times and subsequent to Hurricanes Irma and Maria; and
27
28 Whereas, Many of Puerto Rico's health care facilities and physician practices are still unable to
29 access electricity, clean water, and face shortages of critical and life-saving medicines and
30 medical devices⁵; and

¹ [American Medical Association Constitution and bylaws \(July 2017\)](#)

² [AMA News: Hurricane-relief effort aims to get practices back online ASAP](#)

³ [Henry J. Kaiser Foundation: Puerto Rico Fast Facts \(October 2, 2017\)](#)

⁴ [Henry J. Kaiser Foundation: Puerto Rico Fast Facts \(October 2, 2017\)](#)

⁵ [Statement by FDA Commissioner Scott Gottlieb, M.D. on medical device manufacturing recovery in Puerto Rico \(October 20, 2017\)](#)

1 Whereas, The United States Congress is debating legislation to increase the statutory cap on
2 Puerto Rico's Medicaid program to the Administration's requested level of roughly \$1.6 billion
3 for a period of at least five years, as well as hurricane relief efforts⁶; therefore be it
4

5 RESOLVED, That our American Medical Association urge and advocate the U.S. Congress to
6 quickly pass legislation to fund Puerto Rico's Medicaid Program of roughly \$1.6 billion over five
7 years (Directive to Take Action); and be it further
8

9 RESOLVED, That our AMA urge and advocate for the Centers for Medicare and Medicaid
10 Services to implement temporary emergency regulatory Medicare and Medicaid funding waivers
11 to help restore access to health care services in Puerto Rico. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 11/02/17

RELEVANT AMA POLICY

Domestic Disaster Relief Funding D-130.966

1. Our American Medical Association lobby Congress to a) reassess its policy for expedited release of funding to disaster areas; b) define areas of disaster with disproportionate indirect and direct consequences of disaster as "public health emergencies"; and c) explore a separate, less bureaucratic process for providing funding and resources to these areas in an effort to reduce morbidity and mortality post-disaster.
2. Our AMA will lobby actively for the recommendations outlined in the AMA/APHA Linkages Leadership Summit including: a) appropriate funding and protection of public health and health care systems as critical infrastructures for responding to day-to-day emergencies and mass causality events; b) full integration and interoperable public health and health care disaster preparedness and response systems at all government levels; c) adequate legal protection in a disaster for public health and healthcare responders and d) incorporation of disaster preparedness and response competency-based education and training in undergraduate, graduate, post-graduate, and continuing education programs.

Res. 421, A-11; Reaffirmation A-15

Health System Security for Disasters H-130.999

The AMA calls to the attention of the governors of the several states, and other officials, both state and local, under whose guidance the protection of the public is instituted, that the maintenance of medical treatment facilities and the care of all patients and hospital personnel in the event of a disaster is of prime basic importance, and that preliminary planning to provide such protection should be a part of every disaster program.

Res. 77, A-68; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CLRPD Rep. 1, A-08

Status Report on Expanding Health Care Coverage to all Individuals, with an Emphasis on the Uninsured D-165.955

1. Our AMA will continue to: (1) place a high priority on expanding health insurance coverage for all; (2) pursue bipartisan support for individually selected and owned health insurance through the use of adequately funded federal tax credits as a preferred long-term solution for covering all; and (3) explore and support alternative means of ensuring health care coverage for all.

2. Our AMA Board of Trustees will consider assisting Louisiana, and other Gulf Coast States if they should desire, in developing and evaluating a pilot project(s) utilizing AMA policy as a means of dealing with the impending public health crisis of displaced Medicaid enrollees and uninsured individuals as a result of the recent natural disasters in that region.

CMS Rep. 1, I-05; Reaffirmed in lieu of Res. 101, A-13

⁶ [Letter from Governor Rosselló Nevares to Congressional Leadership-Puerto Rico Health Care Situation](#)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1004
(I-17)

Introduced by: American Academy of Family Physicians
American Academy of Pediatrics
American Congress of Obstetricians and Gynecologists
American College of Physicians

Subject: Preserving Tax Deductibility of Student Loan Interest Payments and High
Medical Expenses

Referred to: Reference Committee B
(Ralph J. Nobo, Jr., MD, Chair)

1 Whereas, Tax reform legislation was introduced in the House of Representatives on
2 November 2, 2017 that includes provisions that could have a major adverse impact on
3 physicians and patients; and
4
5 Whereas, One of the provisions would eliminate the tax deductibility of student loan payments;
6 and
7
8 Whereas, This would adversely and disproportionately affect medical students, residents, and
9 practicing physicians who on average graduate with \$190,000 in student debt after completion
10 of medical school, by further increasing the cost of those loans if their interest payments could
11 no longer be deducted; and
12
13 Whereas, Another provision would eliminate the tax deductibility of high medical expenses,
14 adversely and disproportionately affecting patients in need of extended skilled nursing,
15 custodial, medical and hospital care, such as children with special needs and patients with
16 Alzheimer's disease, effectively raising their out-of-pocket costs and making care unaffordable
17 for many of them; and
18
19 Whereas, These changes would take place without any time for those affected to alter their
20 financial planning to take into account the increased cost of their student loans and/or medical
21 expenses; and
22
23 Whereas, House Speaker Paul Ryan has said a bill with these provisions may be voted on by
24 the House of Representatives by Thanksgiving; and
25
26 Whereas, The Senate may soon take up a similar bill; and
27
28 Whereas, The timing of congressional action requires an immediate and urgent policy response
29 from our AMA to urge Congress to eliminate these adverse provisions from the legislation;
30 therefore be it
31
32 RESOLVED, That our American Medical Association immediately and strongly urge Congress
33 to preserve the tax deductibility of student loan interest payments and high medical expenses in
34 any tax reform legislation that will be considered and voted on by the House and Senate.
35 (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000.
Received: 11/10/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1005
(I-17)

Introduced by: American Academy of Neurology, American College of Cardiology,
American College of Rheumatology, American Society of
Echocardiology, American Society of Clinical Oncology, The Heart
Rhythm Society, Society of Cardiovascular Angiography and
Intervention

Subject: Implementation of Score Assessment for Cost Under MACRA MIPS

Referred to: Reference Committee B
(Ralph J. Nobo, Jr., MD, Chair)

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- 1 Whereas, On November 2, 2017, CMS released the Quality Payment Program (QPP) Final Rule
2 under MACRA for CY 2018; and
3
4 Whereas, The MACRA CY 2018 Final Rule included surprising changes, particularly that of the
5 weighting of the Cost score category of the Merit Incentive Payment System (MIPS) at 10%,
6 with plan to increase to 30% at CY 2019¹; and
7
8 Whereas, Prior CMS communications as recently as Summer 2017 indicated a zero-weight for
9 MIPS Cost citing immaturity of risk adjustment mechanisms and clinical episode definitions^{2,3};
10 and
11
12 Whereas, The MACRA CY 2018 Final Rule contains no innovations for Cost either in risk
13 adjustment⁴ or clinical episodes⁵, and will base Cost calculations on Per Capita and Medicare
14 Spending per Beneficiary (MSPB) figures alone; and
15
16 Whereas, CMS has explicitly communicated that weighting of Cost for CY 2018 was driven
17 primarily by inflexibility in the MACRA statute⁶; and

¹ Department of Health and Human Services, Center for Medicare & Medicaid Services. Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year (to be codified at 42 CFR Part 414), 29. (This document is scheduled to be published in the Federal Register on 11/16/2017 and available online at <https://federalregister.gov/d/2017-24067>)

² Quality Payment Program: Proposed Rule for Quality Payment Program Year 2. Centers for Medicare and Medicaid Services. 20 June 2017. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Proposed-rule-fact-sheet.pdf>

³ Medicare Program; CY 2018 Updates to the Quality Payment Program, 82 Federal Register 125, 30010-30500 (June 30, 2017) (to be codified at 42 CFR Part 414), 30120-30123.

⁴ Department of Health and Human Services, Center for Medicare & Medicaid Services. Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year (to be codified at 42 CFR Part 414), 280. (This document is scheduled to be published in the Federal Register on 11/16/2017 and available online at <https://federalregister.gov/d/2017-24067>)

⁵ Department of Health and Human Services, Center for Medicare & Medicaid Services. Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year (to be codified at 42 CFR Part 414), 29. (This document is scheduled to be published in the Federal Register on 11/16/2017 and available online at <https://federalregister.gov/d/2017-24067>)

⁶ Department of Health and Human Services, Center for Medicare & Medicaid Services. Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year (to be codified at 42 CFR Part 414), 275. (This document is scheduled to be published in the Federal Register on 11/16/2017 and available online at <https://federalregister.gov/d/2017-24067>)

1 Whereas, Poorly adjusted risk mechanisms will have substantial impacts for resource-intensive
2 medical and surgical specialties, especially without the mitigating factor of episode-based cost
3 measures; therefore be it
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5 RESOLVED, That our American Medical Association work with the Centers for Medicare and
6 Medicaid Services to ensure sound methodologies for risk adjustment for physicians with patient
7 populations at risk for high resource use (Directive to Take Action); and be it further
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9 RESOLVED, That our AMA urgently lobby the Congress and the federal government to
10 expedite development of an equitable, validated patient-specific risk adjustment mechanism and
11 not include a cost score in the Merit Based Incentive Payment System (MIPS) until such time as
12 it can be developed. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000.

Received: 11/11/17

RELEVANT AMA POLICY

Preserving a Period of Stability in Implementation of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) D-390.950

1. Our AMA will advocate that Centers for Medicare and Medicaid Services (CMS) implement the Merit-Based Payment Incentive Payment System (MIPS) and Alternative Payment Models (APMs) as is consistent with congressional intent when the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) was enacted.
2. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA, which includes assurances that CMS has conducted appropriate testing, including physicians' ability to participate and validation of accuracy of scores or ratings, and has necessary resources to implement provisions regarding MIPS and APMs.
3. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA that includes a suitable reporting period. (Res. 242, A-16)

MACRA and the Independent Practice of Medicine H-390.837

1. Our AMA, in the interest of patients and physicians, encourages the Centers for Medicare and Medicaid Services and Congress to revise the Merit-Based Incentive Payment System to a simplified quality and payment system with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care.
2. Our AMA will advocate for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the MACRA program.
3. Our AMA will urge CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients. (Sub. Res. 206, A-17)

REFERRAL CHANGES AND OTHER REVISIONS (I-17)

REVISED RESOLUTIONS

- Resolution 222 – Appropriate Use of Objective Tests for Obstructive Sleep Apnea

RESOLUTIONS WITH ADDITIONAL SPONSORS*

- Resolution 214 – APRN Compact (American Society of Anesthesiologists, Mississippi, American Clinical Neurophysiology Society, American Society for Radiation Oncology, Georgia, Ohio, American Academy of Cosmetic Surgery, Louisiana, Kentucky, South Carolina, New Jersey, American College of Legal Medicine, American College of Radiology, Illinois, American College of Emergency Physicians, American Academy of Orthopaedic Surgeons, Texas, North Carolina, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, Florida, Virginia, Washington, American Academy of Otolaryngology-Head and Neck Surgery)
- Resolution 220 - Preserving Protections of the Americans with Disabilities Act of 1990 (American Academy of Physical Medicine and Rehabilitation, American Association of Neuromuscular & Electrodiagnostic Medicine)
- Resolution 225 - Oppose Inclusion of Medicare Part B Drugs in QPP/MIPS Payment Adjustment (American Society of Clinical Oncology, American College of Rheumatology, American Academy of Ophthalmology, American Academy of Neurology)
- Resolution 802 – Opposition to Medicaid Work Requirements (Medical Student Section, American Congress of Obstetricians and Gynecologists)
- Resolution 808 - Opposition to Reduced Payment for the 25 Modifier (American Academy of Dermatology, American Society for Dermatologic Surgery Association, American College of Mohs Surgery, American Society of Dermatopathology, Society for Investigative Dermatology, American College of Allergy, Asthma and Immunology, Florida, Pennsylvania, American College of Surgeons, Kentucky)
- Resolution 819 - Consultation Codes and Private Payers (American College of Rheumatology, American Academy of Allergy, Asthma & Immunology, Infectious Diseases Society of America, Georgia, District of Columbia, New Jersey, American College of Allergy, Asthma and Immunology)
- Resolution 911 - State Maternal Mortality Review Committees (American Congress of Obstetricians and Gynecologists, Colorado, Connecticut, Delaware, Maine, Massachusetts, Michigan, Nevada, Oregon, Pennsylvania, Tennessee, Washington, West Virginia)
- Resolution 914 - Support of Training, Ongoing Education, and Consultation In Order to Reduce the Health Impact of Pediatric Environmental Chemical Exposures (American Academy of Pediatrics, American Congress of Obstetricians and Gynecologists)

* Additional sponsors underlined.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Supplementary Report of Committee on Rules and Credentials

Presented by: Michael B. Hoover, MD, Chair
Sunday, November 12, 2017

1 Mister Speaker, Members of the House of Delegates:

2
3 The Committee on Rules and Credentials met Saturday, November 11, to discuss Late
4 Resolution(s). Sponsors of Late Resolutions are informed of the time the Committee on
5 Rules and Credentials meets to consider Late Resolutions, 8:30 a.m. on Saturday, and are
6 given the opportunity to present for the Committee's consideration the reasons the
7 resolutions could not be submitted in a timely fashion and the urgency of consideration by
8 the House of Delegates at this meeting. Sponsor(s) of Late Resolution(s) 1001-1004
9 appeared to discuss their resolutions.

10 11 (1) LATE RESOLUTIONS

12
13 Your Committee is including its recommendations on a consent calendar based upon
14 whether or not the resolutions met the criteria for consideration as a Late Resolution.

15 16 CONSENT CALENDAR

17
18 Recommended for acceptance:

- 19
- 20 1. Late 1002 - Health Insurance Company Purchase by Pharmacy Chains
- 21 2. Late 1003 - AMA Advocacy Efforts for Emergency Medicaid Funding and
22 Assistance - Puerto Rico
- 23 3. Late 1004 - Preserving Tax Deductibility of Student Loan Interest Payments and
24 High Medical Expenses
- 25 4. Late 1005 - Implementation of Score Assessment for Cost Under MACRA MIPS
- 26

27 Recommended not be accepted:

- 28
- 29 1. Late 1001 - Reaffirmation of AMA Policy on the Use of Unlicensed Personnel to
30 Perform Surgery, with Attention to Hair Restoration Surgery
- 31

32 (2) REAFFIRMATION RESOLUTIONS

33
34 The Speakers asked the Committee on Rules and Credentials to review the
35 recommendations for placing resolutions introduced at this meeting of the House of
36 Delegates on the Reaffirmation Calendar. Reaffirmation of existing policy means that the
37 policies reaffirmed remain active policies within the AMA policy database and therefore are
38 part of the body of policy that can be used in setting the AMA's agenda. It also resets the
39 "sunset clock," so that such policies will remain viable for ten years from the date of
40 reaffirmation. The Committee recommends that current policy be reaffirmed in lieu of the
41 following resolutions (current policy and AMA activities are listed in the Appendix to this
42 report):

- 43
- 44 • Resolution 001 – Disaggregation of Data Concerning the Status of Asian-Americans
- 45 • Resolution 204 – EHR Vendors Responsible for Health Information Technology
- 46 • Resolution 205 – Health Plan, Pharmacy, Electronic Health Records Integration

Supplementary Report of Committee on Rules and Credentials
Page 2

- 1 • Resolution 210 – MIPS and Small Practices
- 2 • Resolution 219 – Certified EMR Companies Practices of Charging Fees for Regulatory
- 3 Compliance
- 4 • Resolution 221 – House of Representatives Bill HR 2077, Restoring Patient's Voice Act
- 5 • Resolution 225 – Oppose Inclusion of Medicare Part B Drugs in QPP
- 6 • Resolution 228 – Drug Discount Cards
- 7 • Resolution 804 – Prior Authorization
- 8 • Resolution 806 – Mandate Transparency by Pharmacy Benefit Managers
- 9 • Resolution 807 – Structural Barriers to Achieving Better Health Care Efficiency and
- 10 Outcomes: ACOs and Physician Employment by Hospitals
- 11 • Resolution 809 – Expansion of Network Adequacy Policy
- 12 • Resolution 815 – Pediatric Representation for E/M Documentation Guideline Revision
- 13 • Resolution 817 – Addressing the Site of Service Differential
- 14 • Resolution 819 – Consultation Codes and Private Payers
- 15 • Resolution 821 – Hormonal Contraception as a Preventive Service
- 16 • Resolution 822 – Elimination of All Cost-Sharing for Screening Colonoscopies
- 17 • Resolution 915 – Easing Barriers to Medical Research on Marijuana Derivatives
- 18 • Resolution 958 – Sex and Gender Based Medicine in Clinical Medical Education
- 19

20 Mister Speaker, this concludes the Supplementary Report of the Committee on Rules and
21 Credentials. I would like to thank Robert L. Allison, MD, Floyd A. Buras, MD, Jerome C.
22 Cohen, MD, Pino D. Colone, MD, Stuart M. Greenstein, MD, Nestor Ramirez-Lopez, MD,
23 and on behalf of the Committee, those who appeared before the Committee.

Robert L. Allison, MD*
South Dakota

Stuart M. Greenstein, MD*
American Society of Transplant Surgeons

Floyd A. Buras, Jr., MD
Louisiana

Nestor Ramirez-Lopez, MD
Illinois

Jerome C. Cohen, MD
New York

Michael B. Hoover, MD, Chair
Indiana

Pino D. Colone, MD
Michigan

* Alternate Delegate

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU, WITH CURRENT AMA POLICY AND ACTIVITIES – PAGE 3

- Resolution 001 – Disaggregation of Data Concerning the Status of Asian-Americans
 - Health Initiatives on Asian-Americans and Pacific Islanders H-350.966
 - Improving the Health of Minority Populations H-350.961
 - Strategies for Eliminating Minority Health Care Disparities D-350.996

- Resolution 204 – EHR Vendors Responsible for Health Information Technology
 - National Health Information Technology D-478.995
 - Physician Time Spent with Patients and with Hospital Documentation D-450.980
 - Information Technology Standards and Costs D-478.996

- Resolution 205 – Health Plan, Pharmacy, Electronic Health Records Integration
 - Cost of Prescription Drugs H-110.996
 - Price Transparency D-155.987

- Resolution 210 – MIPS and Small Practices
 - Preserving Patient Access to Small Practices Under MACRA D-390.949
 - MIPS and MACRA Exemption H-390.838
 - The AMA already has policy that asks the AMA to advocate for an exemption from MIPS and MACRA for small practices. The AMA has continually advocated for an exemption for small practices, and reduced reporting requirements for small practices under MIPS. In addition, in the 2018 Quality Payment Program proposed rule, the Centers for Medicare and Medicaid Services increased the low volume threshold to exclude all physicians with less than or equal to \$90,000 in Medicare Part B allowed charges, or that provide care for 200 or fewer Part B-enrolled Medicare beneficiaries. This exclusion will ensure a large number of small practices do not have to participate in the Quality Payment Program in 2018.

- Resolution 219 – Certified EMR Companies Practices of Charging Fees for Regulatory Compliance
 - Maintenance Payments for Electronic Health Records D-478.975
 - Information Technology Standards and Costs D-478.996

- Resolution 221 – House of Representatives Bill HR 2077, Restoring Patient's Voice Act
 - Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans H-320.948
 - Approaches to Increase Payer Accountability H-320.968
 - Emerging Trends in Utilization Management H-320.958
 - External Grievance Review Procedures H-320.952
 - In addition, AMA has advocated strongly for utilization management to be non-intrusive, to reduce administrative burdens, and to allow for adequate input by the medical profession. Furthermore, existing policy requires that review entities respond within 48 hours to patient or physician requests for prior authorization and expedited review mechanism should be created for urgent medical conditions. In fact, AMA used this policy to write a letter of support in May 2017 for the Restoring the Patient's Voice Act of 2017 (H.R. 2077), which is the reason for this resolution. AMA also released Prior Authorization Principles (which was supported by over 100 stakeholder groups) that already cover the salient points of the resolution.

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU, WITH CURRENT AMA POLICY AND ACTIVITIES – PAGE 4

- Resolution 225 – Oppose Inclusion of Medicare Part B Drugs in QPP
 - Measurement of Drug Costs to Assess Resource Use Under MACRA, H-385.911
 - Our AMA already has policy explicitly stating that the AMA will work with Congress and CMS to exempt all Medicare Part B drug costs from any resource use measurement mechanisms, including MIPS. Recently, AMA urged Congress to “clarify that Medicare Part B drugs and other items and services outside the physician fee schedule are not included in the application of MIPS payment adjustments and determination of MIPS eligibility.”

- Resolution 228 – Drug Discount Cards
 - Non-Formulary Medication and the Medicare Part D Coverage Gap, H-125.977
 - Please note that due to the Affordable Care Act, the doughnut hole will close in 2020 and it is unlikely that legislation would pass and be implemented before 2020 since the 2020 cost year call for bids will go out in early 2019.

- Resolution 804 – Prior Authorization
 - Prior Authorization and Utilization Management Reform H-320.939
 - Eliminating Precertification H-320.950
 - Abuse of Preauthorization Procedures H-320.945
 - Third Party Payer Quantity Limits H-185.942
 - Payer Accountability H-320.982
 - Approaches to Increase Payer Accountability H-320.968
 - Insurance Coverage Appeals D-320.993
 - Administrative Simplification in the Physician Practice D-190.974
 - In addition, the AMA has been very active in advocating for a reduction in both the number of physicians subjected to prior authorization (PA) and the overall volume of PA. The AMA convened a workgroup of state and specialty medical societies, national provider associations and patient representatives to create a set of best practices related to prior authorization and other utilization management requirements. The workgroup identified the most common provider and patient complaints associated with utilization management programs and developed the attached Prior Authorization and Utilization Management Reform Principles, which address the intent of Resolution 804. The principles have gained widespread support since their release, with over 100 stakeholder organizations signing on in support of their objectives. The AMA also fielded a quantitative physician survey on PA in 2016. The AMA Council on Medical Service has been very active on this issue as well, having presented Council on Medical Service Report 8-A-17, “Prior Authorization and Utilization Management Reform,” and Council on Medical Service Report 7-A-16, “Prior Authorization Simplification and Standardization.”

- Resolution 806 – Mandate Transparency by Pharmacy Benefit Managers
 - Pharmaceutical Costs H-110.987
 - Price of Medicine H-110.991

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU, WITH CURRENT AMA POLICY AND ACTIVITIES – PAGE 5

- Resolution 807 – Structural Barriers to Achieving Better Health Care Efficiency and Outcomes: ACOs and Physician Employment by Hospitals
 - Urge AMA to Release a White Paper on ACOs D-160.923
 - Accountable Care Organization Principles H-160.915
 - Physician Decision-Making in Health Care Systems H-285.954
 - Payment Variations Across Outpatient Sites of Service D-240.994
 - Appropriate Payment Level Differences by Place and Type of Service H-330.925
 - Appropriate Payment Level Differences by Place and Type of Service D-330.997
 - Value-Based Decision-Making in the Health Care System H-450.938
 - In addition, the AMA’s recent Outpatient Prospective Payment System (OPPS) comments asked for neutral payment policy between ambulatory surgical centers and hospital outpatient departments. That AMA letter further stated that CMS is limited in adopting a payment policy to address differentials in payment between Medicare inpatient and outpatient facilities by statutory provisions and distinguishes between the Inpatient Prospective Payment System (IPPS) and OPSS as fundamentally different payment systems with one making a single payment for all services the hospital provides and the other making multiple payments depending on the services provided. Moreover, the AMA commented that payment under IPPS should be higher as it is paying for room and board, which are not costs that are expected to be incurred by hospitals under OPSS.

- Resolution 809 – Expansion of Network Adequacy Policy
 - Amendments to Managed Care Contracts H-285.952
 - Qualifications and Credentialing of Physicians Involved in Managed Care H-285.991
 - In addition, AMA model state legislation, the AMA-revised National Association of Insurance Commissioners Model Network Adequacy Act, includes a 60-day policy specifically on network terminations, which reads: “A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before the provider is removed or leaves the network without cause or a health carrier moves the provider to another tier in the same network.”

- Resolution 815 – Pediatric Representation for E/M Documentation Guideline Revision
 - AMA CPT Editorial Panel and Process H-70.973

- Resolution 817 – Addressing the Site of Service Differential
 - Payment Variations Across Outpatient Sites of Service D-240.994
 - Appropriate Payment Level Differences by Place and Type of Service H-330.925
 - Appropriate Payment Level Differences by Place and Type of Service D-330.997
 - Intrusion by Hospitals into the Private Practice of Medicine H-240.979
 - Discontinuance of Federal Funding for Ambulatory Care Centers H-240.993
 - Uncompensated Care H-160.971
 - Offsetting the Costs of Providing Uncompensated Care H-160.923
 - Physician-Focused Alternative Payment Models: Reducing Barriers H-385.908
 - Physician-Focused Alternative Payment Models H-385.913
 - EHR Interoperability D-478.972
 - Information Technology Standards and Costs D-478.996

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU, WITH CURRENT AMA POLICY AND ACTIVITIES – PAGE 6

- Resolution 819 – Consultation Codes and Private Payers
 - Medicare's Proposal to Eliminate Payments for Consultation Service Coded D-70.953
 - Consultation Follow-Up and Concurrent Care of Referral for Principal Care H-390.917
 - Payment Mechanisms for Physician-Led Team-Based Health Care H-160.908
 - Physician-Focused Alternative Payment Models: Reducing Barriers H-385.908
 - Physician-Focused Alternative Payment Models H-385.913
 - Definition of Consultation: CMS vs. CPT 4 Coding Manual H-70.939
 - Support for Coverage of the Consultation by a Physician Prior to Screening Colonoscopy D-330.950

- Resolution 821 – Hormonal Contraception as a Preventive Service
 - Coverage of Prescription Contraceptives by Insurance H-180.958
 - Support for Access to Preventive and Reproductive Health Services H-425.969

- Resolution 822 – Elimination of All Cost-Sharing for Screening Colonoscopies
 - Preventive Medical Care Coverage for All H-165.840
 - Coverage for Certain Types of Well Care Examinations by Health Insurers H-185.954
 - Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans H-185.960
 - Preventive Medicine Services H-425.987
 - Coverage of Preventive Medical Services by Medicare H-425.992
 - In addition, AMA advocacy efforts have called for requiring Medicare to waive the coinsurance for colorectal screening tests, regardless of whether therapeutic intervention is required during the procedure. For example, the AMA submitted letters to sponsors of relevant legislation in both the House of Representatives and the Senate.

- Resolution 915 – Easing Barriers to Medical Research on Marijuana Derivatives
 - Cannabis for Medicinal Use H-95.952

- Resolution 958 – Sex and Gender Based Medicine in Clinical Medical Education
 - An Expanded Definition of Women's Health H-525.976
 - Medical Education and Training in Women's Health H-295.890

**ORDER OF BUSINESS
SECOND SESSION**

**Sunday, November 12, 2017
8:00 AM**

- 1. Report of the Committee on Rules and Credentials - Michael Hoover, MD, Chair**
- 2. Presentation, Correction and Adoption of Minutes of 2017 Annual Meeting**
- 3. Remarks of the Speaker - Susan R. Bailey, MD**
- 4. Announcement of Changes in Reference Committees**
- 5. Report(s) of the Board of Trustees - Gerald E. Harmon, MD, Chair**
 - 01 Redefining AMA's Position on ACA and Healthcare Reform (Info. Report)
 - 02 2017 AMA Advocacy Efforts (Info. Report)
 - 03 Removing Restrictions on Federal Funding for Firearms Violence Research (Info. Report)
 - 04 Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care (Info. Report)
 - 05 Effective Peer Review (Amendments to C&B)
 - 06 Electronically Prescribed Controlled Substances Without Added Processes (B)
 - 07 Medical Reporting for Safety-Sensitive Positions (Amendments to C&B)
 - 08 2018 Strategic Plan (Info. Report)
 - 09 Parental Leave (Info. Report)
 - 10 High Cost to Authors for Open Source Peer Reviewed Publications (F)
 - 11* Anti-Harassment Policy (Info. Report)
 - 12# Specialty Society Representation in the House of Delegates - Five-Year Review (Amendments to C&B)
 - 13# Certified Translation Services (Info. Report)
- 6. Report(s) of the Council on Constitution and Bylaws - Colette R. Willins, MD, Chair**
 - 01* Amended Bylaws - Specialty Society Representation - Five Year Review (Amendments to C&B)
- 7. Report(s) of the Council on Ethical and Judicial Affairs - Dennis S. Agliano, MD, Chair**
 - 01* Competence, Self-Assessment and Self-Awareness (Amendments to C&B)
 - 02 Ethical Physician Conduct in the Media (Amendments to C&B)
 - 03 Supporting Autonomy for Patients with Differences of Sex Development (DSD) (Amendments to C&B)
 - 04* Mergers of Secular and Religiously Affiliated Health Care Institutions (Amendments to C&B)
- 8. Opinion(s) of the Council on Ethical and Judicial Affairs - Dennis S. Agliano, MD, Chair**
 - 01 Amendment to E-2.3.2, "Professionalism in Social Media" (Info. Report)
- 9. Report(s) of the Council on Long Range Planning and Development - Glenn A. Loomis, MD, Chair**
 - 01* Senior Physicians Section Five-Year Review (F)
- 10. Report(s) of the Council on Medical Education - Lynne M. Kirk, MD, Chair**
 - 01* Promoting and Reaffirming Domestic Medical School Clerkship Education (K)
 - 02 A National Continuing Medical Education Repository (Info. Report)
 - 03* Impact of Immigration Barriers on the Nation's Health (Info. Report)

11. Report(s) of the Council on Medical Service - Paul A. Wertsch, MD, Chair

- 01* Affordable Care Act Section 1332 Waivers (J)
- 02* Hospital Surveys and Health Care Disparities (J)
- 03 Non-Physician Screening Tests (J)
- 04* Health Insurance Affordability: Essential Health Benefits and Subsidizing the Coverage of High-Risk Patients (J)
- 05 Reaffirmation of AMA Policy Opposing Caps on Federal Medicaid Funding (J)

12. Report(s) of the Council on Science and Public Health - Robert A. Gilchick, MD, Chair

- 01 Universal Color Scheme for Respiratory Inhalers (K)
- 02 Targeted Education to Increase Organ Donation (K)
- 03 Neuropathic Pain as a Disease (K)
- 04 National Drug Shortages Update (K)
- 05* Clinical Implications and Policy Considerations of Cannabis Use (K)

13. Report(s) of the HOD Committee on Compensation of the Officers - Brooks F. Bock, MD, Chair

- 01# Report of the House of Delegates Committee on Compensation of the Officers (F)

14. Joint Report(s)

- CMS/CSAPH 01* Payment and Coverage for Genetic/Genomic Precision Medicine (J)

15. Report(s) of the Speakers - Susan R. Bailey, MD, Speaker; Bruce A. Scott, MD, Vice Speaker

- 01 Recommendations for Policy Reconciliation (Info. Report)

--EXTRACTION OF INFORMATIONAL REPORTS--

16. Unfinished business

17. New Business (Introduction of Resolutions)

- 001 Disaggregation of Data Concerning the Status of Asian-Americans (Amendments to C&B)
- 002 Intimate Partner Violence Policy and Immigration (Amendments to C&B)
- 003 Revision of AMA Policy Regarding Sex Workers (Amendments to C&B)
- 004 Tissue Handling (Amendments to C&B)
- 005* Protection of Physician Freedom of Speech (Amendments to C&B)
- 006* Physicians' Freedom of Speech (Amendments to C&B)
- 007# Giving Rights to Ectopic Pregnancies (Amendments to C&B)
- 201 Improving FDA Expedited Approval Pathways (B)
- 202 Sexual Assault Survivors' Rights (B)
- 203 Bidirectional Communication for EHR Software and Pharmacies (B)
- 204 EHR Vendors Responsible for Health Information Technology (B)
- 205 Health Plan, Pharmacy, Electronic Health Records Integration (B)
- 206 Defending Federal Child Nutrition Programs (B)
- 207 Redistribution of Unused Prescription Drugs to Pharmaceutical Donation and Reuse Programs (B)
- 208 Increased Use of Body-Worn Cameras by Law Enforcement Officers (B)
- 209 Government Mandated Sequester (B)

210 Merit-Based Incentive Payment System and Small Practices (B)
211 Exclusive State Control of Methadone Clinics (B)
213 Barriers to Price Transparency (B)
214 APRN Compact (B)
215 Relieve Burden for Living Organ Donors (B)
216 Relationship with US Department of Health and Human Services (B)
217 Regulations Regarding Medical Tool and Instrument Repair (B)
218* Health Information Technology Principles (B)
219* Certified EMR Companies' Practice of Charging Fees for Regulatory Compliance (B)
220* Preserving Protections of the Americans with Disabilities Act of 1990 (B)
221* House of Representative Bill HR 2077, Restoring the Patient's Voice Act of 2017 (B)
222# Appropriate Use of Objective Tests for Obstructive Sleep Apnea (REVISED) (B)
223* Treating Opioid Use Disorder in Correctional Facilities (B)
224* Modernizing Privacy Regulations for Addiction Treatment Records (B)
225* Oppose Inclusion of Medicare Part B Drugs in QPP / MIPS Payment Adjustment (B)
226* Prescription Drug Importation for Personal Use (B)
227# Communication and Resolution Program (B)
228# Drug Discount Cards (B)
229# Opposition to Licensing for Individuals Holding the Degree of Doctor of Medical Science (B)
230# Oppose Physician Assistant Independent Practice (B)
231# Electronic Prescription Cancellation (B)
232# Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare (B)
233# Pharmacists Cannot and Should Not be Making Medical Decisions (B)
601 Physician Burnout and Wellness Challenges (F)
604# Physician and Physician Assistant Safety Net (F)
605# Identification and Reduction of Physician Demoralization (F)
801 Chronic Care Management Payment for Patients Also on Home Health (J)
802 Opposition to Medicaid Work Requirements (J)
803 Air Ambulance Regulations and Reimbursements (J)
804 Prior Authorization (J)
805 A Dual System for Universal Health Care in the United States (J)
806 Mandate Transparency by Pharmacy Benefit Managers (J)
807 Structural Barriers to Achieving Better Health Care Efficiency and Outcomes: ACOs and Physician Employment by Hospitals (J)
808 Opposition to Reduced Payment for the 25 Modifier (J)
809 Expansion of Network Adequacy Policy (J)
810 Pharmacy Benefit Managers and Prescription Drug Affordability (J)
811 Update OBRA Nursing Facility Preadmission Screening Requirements (J)
812 Medicare Coverage of Services Provided by Proctored Medical Students (J)
813 Sustain Patient-Centered Medical Home Practices (J)
814* Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-Related Impairments (J)
815* Pediatric Representation for E/M Documentation Guideline Revision (J)
816* Social Determinants of Health in Payment Models (J)

- 817* Addressing the Site of Service Deferential (J)
- 818* On-Call and Emergency Services Pay (J)
- 819* Consultation Codes and Private Payers (J)
- 820* Elimination of the Laboratory 14-Day Rules Under Medicare (J)
- 821* Hormonal Contraception as a Preventive Service (J)
- 822# Elimination of All Cost-Sharing for Screening Colonoscopies (J)
- 823# Unconscionable Generic Drug Pricing (J)
- 824# Payment for Dementia Treatment in Hospitals and Other Psychiatric Facilities (J)
- 825# Support for VA Health Services for Women Veterans (J)
- 826# Improving Affordability of Insulin (J)
- 827# Hospital Accreditation Programs and Medical Staffs (J)
- 901 Harmful Effects of Screen Time in Children (K)
- 902 Expanding Expedited Partner Therapy to Treat Trichomoniasis (K)
- 903 Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (K)
- 904 Educating Physicians About the Importance of Cervical Cancer Screening for Female-to-Male Transgender Patients (K)
- 905 Addressing Social Media Usage and its Negative Impacts on Mental Health (K)
- 906 Opioid Abuse in Breastfeeding Mothers (K)
- 907 Addressing Healthcare Needs of Foster Children (K)
- 908 Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability (K)
- 909 Expanding Naloxone Programs (K)
- 910 Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination (K)
- 911* State Maternal Mortality Review Committees (K)
- 912* Corrective Statements Ordered to be Published by Tobacco Companies for the Violation of the Racketeer Influenced and Corrupt Organizations Act (K)
- 913* Increased Death Rate and Decreased Life Expectancy in the United States (K)
- 914* Support of Training, Ongoing Education, and Consultation in Order to Reduce the Health Impact of Pediatric Environmental Chemical Exposures (K)
- 915# Easing Barriers to Medical Research on Marijuana Derivatives (K)
- 916# Hospital Disaster Plans and Medical Staffs (K)
- 952 Implicit Bias, Diversity and Inclusion in Medical Education and Residency Training (K)
- 953 Fees for Taking Maintenance of Certification Examination (K)
- 954 Developing Physician Led Public Health / Population Health Capacity in Rural Communities (K)
- 955 Minimization of Bias in the Electronic Residency Application Service Residency Application (K)
- 956 House Physicians Category (K)
- 957 Standardization of Family Planning Training Opportunities in OB-BYN Residencies (K)
- 958 Sex and Gender Based Medicine in Clinical Education (K)
- 959* Lifestyle Medicine Education in Medical School Training and Practice (K)
- 960# Medical Student Involvement and Validation of the Standardized Video Interview Implementation (K)

18. Presentation of Recommendations for Items of Business to Not be Considered at Interim Meeting

- 212 Physician Identification (Not for consideration)
- 602 Creation of LGBTQ Health Specialty Section Council (Not for consideration)

603 A Guide for Best Health Practices for Seniors Living in Retirement Communities (Not for consideration)

951 Financial Protections for Doctors in Training (Not for consideration)

19. Report of the Committee on Rules and Credentials - Michael Hoover, MD, Chair

** contained in the Handbook Addendum*

contained in the Sunday Tote

ORDER OF BUSINESS

Reference Committee on Amendments to Constitution and Bylaws (I-17)
Edmund R. Donoghue, Jr., MD, Chair

November 11, 2017
312

Hawaii Convention Center
Hawaii

1. Board of Trustees Report 05 – Effective Peer Review
2. Board of Trustees Report 07 – Medical Reporting for Safety-Sensitive Positions
3. Board of Trustees Report 12 – Specialty Society Representation in the House of Delegates – Five-Year Review
4. Council on Constitution and Bylaws Report 01 – Amended Bylaws – Specialty Society Representation – Five-Year Review
5. Council on Ethical and Judicial Affairs Report 01 – Competence, Self-Assessment and Self-Awareness
6. Council on Ethical and Judicial Affairs Report 02 – Ethical Physician Conduct in the Media
7. Council on Ethical and Judicial Affairs Report 03 – Supporting Autonomy for Patients with Difference of Sex Development
8. Council on Ethical and Judicial Affairs Report 04 – Mergers of Secular and Religiously Affiliated Health Care Institutions
9. *Resolution 001 – Disaggregation of Data Concerning the Status of Asian-Americans*
10. Resolution 002 – Intimate Partner Violence Policy and Immigration
11. Resolution 003 – Revision of AMA Policy Regarding Sex Workers
12. Resolution 004 – Tissue Handling
13. Resolution 007 – Giving Rights to Ectopic Pregnancies
14. Resolution 005 – Protection of Physician Freedom of Speech
15. Resolution 006 – Physicians’ Freedom of Speech

Note: Items in italics were originally placed on the reaffirmation consent calendar, were recommended against consideration, or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

During the reference committee hearing, supplemental materials may be sent to RC@ama-assn.org or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.

ORDER OF BUSINESS

Reference Committee B (I-17)
Ralph J. Nobo, Jr., MD, Chair

November 12, 2017
313C

Hawaii Convention Center
Honolulu

1. Board Report 6 - Electronically Prescribed Controlled Substances without Added Processes
2. Resolution 201 - Improving FDA Expedited Approval Pathways
3. Resolution 202 - Sexual Assault Survivors' Rights
4. *Resolution 203 - Bidirectional Communication for EHR Software and Pharmacies*
Resolution 205 - Health Plan, Pharmacy, Electronic Health Records Integration
5. *Resolution 204 - EHR Vendors Responsible for Health Information Technology*
6. Resolution 218 - Health Information Technology Principles
7. *Resolution 219 - Certified EMR Companies' Practice of Charging Fees for Regulatory Compliance*
8. Resolution 231 - Electronic Prescription Cancellation
9. Resolution 206 - Defending Federal Child Nutrition Programs
10. Resolution 207 - Redistribution of Unused Prescription Drugs to Pharmaceutical Donation and Reuse Programs
11. Resolution 208 - Increased Use of Body-Worn Cameras by Law Enforcement Officers
12. Resolution 209 - Government Mandated Sequester
13. *Resolution 210 - Merit-Based Incentive Payment System and Small Practices*
14. *Resolution 225 - Oppose Inclusion of Medicare Part B Drugs in QPP/MIPS Payment Adjustment*
15. *Resolution 211 - Exclusive State Control of Methadone Clinics*
16. Resolution 213 - Barriers to Price Transparency
17. Resolution 214 - Advanced Practice Registered Nurse Compact
18. Resolution 222 - The Clinical Use of a Home Sleep Apnea Test
19. Resolution 229 - Opposition to Licensing for Individuals Holding Degree of Doctor of Medical Science
20. Resolution 230 - Oppose Physician Assistant Independent Practice
21. *Late Resolution 1001 - Reaffirmation of AMA Policy on the Use of Unlicensed Personnel to Perform Surgery, with Attention to Hair Restoration Surgery*
22. Resolution 215 - Relieve Burden for Living Organ Donors
23. Resolution 216 - Relationship with US Department of Health and Human Services
24. Resolution 217 - Regulations Regarding Medical Tool and Instrument Repair
25. Resolution 220 - Preserving Protections of the Americans with Disabilities Act of 1990
26. *Resolution 221 - House of Representative Bill HR 2077, Restoring the Patient's Voice Act of 2017*
27. Resolution 223 - Treating Opioid Use Disorder in Correctional Facilities
28. Resolution 224 - Modernizing Privacy Regulations for Addiction Treatment Records
29. Resolution 226 - Prescription Drug Importation for Personal Use
30. Resolution 227 - Communication and Resolution Program

31. *Resolution 228 - Drug Discount Cards*
32. Resolution 232 - Presence and Enforcement Actions on Immigration and Customs Enforcement (ICE) in Healthcare Facilities
33. Resolution 233 - Pharmacists Cannot and Should Not Be Making Medical Decisions
34. *Late Resolution 1002 - Health Insurance Company Purchase by Pharmacy Chains*
35. *Late Resolution 1003 - AMA Advocacy Efforts for Emergency Medicaid Funding and Assistance - Puerto Rico*
36. *Late Resolution 1004 - Preserving Tax Deductibility of Student Loan Interest Payments and High Medical Expenses*
37. *Late Resolution 1005 - Implementation of Score Assessment for Cost Under MACRA MIPS*

Note: Items in italics were originally placed on the reaffirmation consent calendar or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

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ORDER OF BUSINESS

Reference Committee F (I-17)
Julia V. Johnson, MD, Chair

November 12, 2017
Kalakaua Ballroom

Hawaii Convention Center
Hawaii

1. Report of the House of Delegates Committee on Compensation of the Officers
2. Board of Trustees Report 10 – High Cost to Authors for Open Source Peer Reviewed Publications
3. Council on Long Range Planning and Development Report 1 – Senior Physicians Section Five-Year Review
4. Resolution 601 – Physician Burnout and Wellness Challenges
5. *Resolution 602 – Creation of LGBTQ Health Specialty Section Council*
6. *Resolution 603 – A Guide for Best Practices for Seniors Living in Retirement Communities*
7. *Resolution 604 – Physician and Physician Assistant Safety Net*
8. *Resolution 605 – Identification and Reduction of Physician Demoralization*

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During the reference committee hearing, supplemental materials may be sent to steve.currier@ama-assn.org or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearing.

ORDER OF BUSINESS

Reference Committee J (I-17)
Dolleen Mary Licciardi, MD, Chair

November 11, 2017
Room 313A

Hawaii Convention Center
Hawaii

1. Council on Medical Service Report 1 - Affordable Care Act Section 1332 Waivers
2. Council on Medical Service Report 4 - Health Insurance Affordability: Essential Health Benefits and Subsidizing the Coverage of High-Risk Patients
3. Resolution 805 - A Dual System for Universal Health Care in the United States
4. Council on Medical Service Report 2 - Hospital Surveys and Health Care Disparities
5. Council on Medical Service Report 3 - Non-Physician Screening Tests
6. Council on Medical Service Report 5 - Reaffirmation of AMA Policy Opposing Caps on Federal Medicaid Funding
7. Resolution 802 - Opposition to Medicaid Work Requirements
8. Joint Report of the Council on Medical Service and the Council on Science and Public Health - Payment and Coverage for Genetic/Genomic Precision Medicine
9. Resolution 808 - Opposition to Reduced Payment for the 25 Modifier
10. Resolution 814 - Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-Related Impairments
11. *Resolution 815 - Pediatric Representation for E/M Documentation Guideline Revision*
12. *Resolution 807 - Structural Barriers to Achieving Better Health Care Efficiency and Outcomes: ACOs and Physician Employment by Hospitals*
13. Resolution 813 - Sustain Patient-Centered Medical Home Practices
14. Resolution 816 - Social Determinants of Health in Payment Models
15. *Resolution 806 - Mandate Transparency by Pharmacy Benefit Managers*

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During the reference committee hearing, supplemental materials may be sent to RC@ama-assn.org or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.

- Resolution 810 - Pharmacy Benefit Managers and Prescription Drug Affordability
Resolution 823 - Unconscionable Generic Drug Pricing
16. Resolution 826 - Improving Affordability of Insulin
 17. Resolution 812 - Medicare Coverage of Services Provided by Proctored Medical Students
 18. *Resolution 817 - Addressing the Site of Service Differential*
 19. Resolution 820 - Elimination of the Laboratory 14-Day Rule under Medicare
 20. Resolution 801 - Chronic Care Management Payment for Patients Also on Home Health
 21. Resolution 811 - Update OBRA Nursing Facility Preadmission Screening Requirements
 22. Resolution 824 - Payment for Dementia Treatment in Hospitals and Other Psychiatric Facilities
 23. *Resolution 804 - Prior Authorization*
 24. *Resolution 809 - Expansion of Network Adequacy Policy*
 25. *Resolution 819 - Consultation Codes and Private Payers*
 26. *Resolution 821 - Hormonal Contraception as a Preventive Service*
 27. *Resolution 822 - Elimination of All Cost-Sharing for Screening Colonoscopies*
 28. Resolution 825 - Support for VA Health Services for Women Veterans
 29. Resolution 803 - Air Ambulance Regulations and Reimbursements
 30. Resolution 818 - On-Call and Emergency Services Pay
 31. Resolution 827 - Hospital Accreditation Programs and Medical Staffs

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ORDER OF BUSINESS

Reference Committee K (I-17)
L. Samuel Wann, MD, Chair

November 12, 2017
Room 311

Hilton Hawaiian Village
Hawaii

1. Council on Medical Education Report 1 – Promoting and Reaffirming Domestic Medical School Clerkship Education
2. *Resolution 951 – Financial Protections for Doctors in Training*
3. Resolution 952 – Implicit Bias, Diversity and Inclusion in Medical Education and Residency Training
4. Resolution 955 – Minimization of Bias in the Electronic Residency Application Service Residency Application
5. Resolution 956 – House Physicians Category
6. Resolution 957 – Standardization of Family Planning Training Opportunities in OB-GYN Residencies
7. *Resolution 958 – Sex and Gender Based Medicine in Clinical Medical Education*
8. Resolution 959 – Lifestyle Medicine Education in Medical School Training and Practice
9. Resolution 954 – Developing Physician Led Public Health/Population Health Capacity in Rural Communities
10. Resolution 953 – Fees for Taking Maintenance of Certification Examination
11. Resolution 960 – Medical Student Involvement and Validation of the Standardized Video Interview Implementation
12. Resolution 914 – Support of Training, Ongoing Education, and Consultation in Order to Reduce the Health Impact of Pediatric Environmental Chemical Exposures
13. Council on Science and Public Health Report 1 – Universal Color Scheme for Respiratory Inhalers
14. Council on Science and Public Health Report 2 – Targeted Education to Increase Organ Donation
15. Council on Science and Public Health Report 3 – Neuropathic Pain as a Disease
16. Council on Science and Public Health Report 4 – National Drug Shortages: Update
17. Resolution 907 – Addressing Healthcare Needs of Foster Children
18. Resolution 901 – Harmful Effects of Screen Time in Children
19. Resolution 905 – Addressing Social Media Usage and its Negative Impacts on Mental Health
20. Resolution 902 – Expanding Expedited Partner Therapy to Treat Trichomoniasis
21. Resolution 903 – Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals

Note: Items in italics were originally placed on the reaffirmation consent calendar, were recommended against consideration, or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

During the reference committee hearing, supplemental materials may be sent to ReferenceCommitteeK@gmail.com or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.

22. Resolution 904 – Educating Physicians About the Importance of Cervical Cancer Screening for Female-to-Male Transgender Patients
23. Resolution 906 – Opioid Abuse in Breastfeeding Mothers
24. Resolution 909 – Expanding Naloxone Programs
25. Resolution 908 – Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability
26. Resolution 916 – Hospital Disaster Plans and Medical Staffs
27. Resolution 910 – Improving Treatment and Diagnosis of Maternal Depression through Screening and State-Based Care Coordination
28. Resolution 911 – State Maternal Mortality Review Committees
29. Resolution 913 – Increased Death Rate and Decreased Life Expectancy in the United States
30. Resolution 912 – Corrective Statements Ordered to be Published by Tobacco Companies for the Violation of the Racketeer Influenced and Corrupt Organizations Act
31. Council on Science and Public Health Report 5 – Clinical Implications and Policy Considerations of Cannabis
Resolution 915 – Easing Barriers to Medical Research on Marijuana Derivatives

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During the reference committee hearing, supplemental materials may be sent to ReferenceCommitteeK@gmail.com or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

- 05 Effective Peer Review
- 07 Medical Reporting for Safety-Sensitive Positions
- 12# Specialty Society Representation in the House of Delegates - Five-Year Review

CC&B Report(s)

- 01* Amended Bylaws - Specialty Society Representation - Five Year Review

CEJA Report(s)

- 01* Competence, Self-Assessment and Self-Awareness
- 02 Ethical Physician Conduct in the Media
- 03 Supporting Autonomy for Patients with Differences of Sex Development (DSD)
- 04* Mergers of Secular and Religiously Affiliated Health Care Institutions

Resolution(s)

- 001 Disaggregation of Data Concerning the Status of Asian-Americans
- 002 Intimate Partner Violence Policy and Immigration
- 003 Revision of AMA Policy Regarding Sex Workers
- 004 Tissue Handling
- 005* Protection of Physician Freedom of Speech
- 006* Physicians' Freedom of Speech
- 007# Giving Rights to Ectopic Pregnancies

* included in the Handbook Addendum

included in Sunday Tote

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-I-17

Subject: Specialty Society Representation in the House of Delegates -
Five-Year Review

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donaghue, Jr, MD, Chair)

1 The Board of Trustees (BOT) has completed its review of the specialty organizations seated in
2 the House of Delegates (HOD) scheduled to submit information and materials for the 2017
3 American Medical Association (AMA) Interim Meeting in compliance with the five-year
4 review process established by the House of Delegates in Policy G-600.020, "Summary of
5 Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw
6 8.5, "Periodic Review Process."

7
8 Organizations are required to demonstrate continuing compliance with the guidelines
9 established for representation in the HOD. Compliance with the five responsibilities of
10 professional interest medical associations and national medical specialty organizations is also
11 required as set out in AMA Bylaw 8.2, "Responsibilities of National Medical Specialty
12 Societies and Professional Interest Medical Associations."

13
14 The following organizations were reviewed for the 2017 Interim Meeting:

15
16 American Academy of Sleep Medicine
17 American Association of Neuromuscular & Electrodiagnostic Medicine
18 American College of Rheumatology
19 American Society for Dermatologic Surgery, Inc.
20 American Society of Clinical Oncology
21 American Society of Cytopathology
22 American Society of Maxillofacial Surgeons
23 American Society of Plastic Surgeons
24 Radiological Society of North America
25 Society of Nuclear Medicine and Molecular Imaging
26 Society of Thoracic Surgeons

27
28 The American Academy of Sleep Medicine, American Society of Cytopathology and the
29 American Society of Plastic Surgeons were reviewed at this time because they failed to meet the
30 requirements of the review in 2016.

31
32 Each organization was required to submit materials demonstrating compliance with the
33 guidelines and requirements along with appropriate membership information. A summary of
34 each group's membership data is attached to this report (Exhibit A). A summary of the
35 guidelines for specialty society representation in the AMA HOD (Exhibit B), the five
36 responsibilities of national medical specialty organizations and professional medical interest

1 associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-
2 year review process (Exhibit D) are also attached.

3
4 The materials submitted indicate that: the American Association of Neuromuscular &
5 Electrodiagnostic Medicine, American College of Rheumatology, American Society for
6 Dermatologic Surgery, Inc., American Society of Clinical Oncology, American Society of
7 Maxillofacial Surgeons, American Society of Plastic Surgeons, Radiological Society of North
8 America and the Society of Thoracic Surgeons meet all guidelines and are in compliance with
9 the five-year review requirements of specialty organizations represented in the HOD.

10
11 The materials submitted also indicated that: the Society of Nuclear Medicine & Molecular
12 Imaging, American Academy of Sleep Medicine and the American Society of Cytopathology
13 did not meet all guidelines and are not in compliance with the five-year review requirements of
14 specialty organizations represented in the HOD.

15
16 **RECOMMENDATIONS**

17
18 The Board of Trustees recommends that the following be adopted and the remainder of this
19 report be filed:

- 20
21 1. That the American Association of Neuromuscular & Electrodiagnostic Medicine,
22 American College of Rheumatology, American Society for Dermatologic Surgery, Inc.,
23 American Society of Clinical Oncology, American Society of Maxillofacial Surgeons,
24 American Society of Plastic Surgeons, Radiological Society of North America and the
25 Society of Thoracic Surgeons retain representation in the American Medical
26 Association House of Delegates. (Directive to Take Action)
27
28 2. Having failed to meet the requirements for continued representation in the AMA House
29 of Delegates as set forth in AMA Bylaw B-8.5, the Society of Nuclear Medicine &
30 Molecular Imaging be placed on probation and be given one year to work with AMA
31 membership staff to increase their AMA membership. (Directive to Take Action)
32
33 3. Having failed to meet the requirements for continued representation in the AMA House
34 of Delegates as set forth in AMA Bylaw B-8.5 after a year's grace period to increase
35 membership, the American Academy of Sleep Medicine and the American Society of
36 Cytopathology not retain representation in the House of Delegates. (Directive to Take
37 Action)

Fiscal Note: Less than \$500

APPENDIX

Exhibit A - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
American Academy of Sleep Medicine	871 of 5,061 (17%)
American Association of Neuromuscular & Electrodiagnostic Medicine	778 of 3,214 (24%)
American College of Rheumatology	1,111 of 5,981 (19%)
American Society for Dermatologic Surgery, Inc.	1,001 of 3,455 (29%)
American Society of Clinical Oncology	2,363 of 12,588 (19%)
American Society of Cytopathology	220 of 1,194 (18%)
American Society of Maxillofacial Surgeons	102 of 392 (26%)
American Society of Plastic Surgeons	1,001 of 5,189 (19%)
Radiological Society of North America	2,240 of 18,263 (12%)
Society of Nuclear Medicine and Molecular Imaging	243 of 1,452 (17%)
Society of Thoracic Surgeons	935 of 4,438 (21%)

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

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
 - (a) represent a field of medicine that has recognized scientific validity;
 - (b) not have board certification as its primary focus; and
 - (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
 - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C

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

- 8.2.1** To cooperate with the AMA in increasing its AMA membership.
- 8.2.2** To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.
- 8.2.3** To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.
- 8.2.4** To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
- 8.2.5** To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

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

8.5 Periodic Review Process. Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

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

8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(I-17)

Introduced by: Young Physicians Section

Subject: Giving Rights to Ectopic Pregnancies

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr., MD, Chair)

1 Whereas, On 2 November 2017, Representative Kevin Brady introduced H.R. 1, the “Tax Cuts
2 and Jobs Act” to the U.S. House of Representatives Committee on Ways and Means¹; and
3

4 Whereas, Under subtitle C. “Simplification and Reform of Education Incentives,” section 12.04
5 “Repeal of other provisions relating to education,” H.R. 1 specifically states that: “the provision
6 provides that an unborn child may be treated as a designated beneficiary or an individual under
7 section 529 plans. An unborn child means a child in utero. A child in utero means a member of
8 the species homo sapiens, at any stage of development, who is carried in the womb;” and
9

10 Whereas, such language appears to be ambiguous as to how it may or may not cover:

- 11
- 12 -Molar pregnancies;
- 13 -Cervical ectopic pregnancies;
- 14 -Intramural pregnancies (within the uterine wall);
- 15 -Cornual pregnancies;
- 16 -Ectopic pregnancies in Cesarean section scars;
- 17

18 all of which are potentially life-threatening conditions, that may also be considered by a
19 layperson to be a pregnancy “in the womb”; and
20

21 Whereas, Personhood USA quotes the Centers for Disease Control and Prevention and other
22 reputable sources to support the notion that an ectopic pregnancy can somehow be implanted
23 elsewhere and develop into a viable child;² and
24

25 Whereas, This kind of misinformation is incredibly dangerous and could lead to patients
26 requesting inappropriate therapy, including possible requests to (a) “reimplant” an ectopic
27 pregnancy or (b) not appropriately treat a molar pregnancy, both of which have the potential to
28 be life-threatening to the patient; and
29

30 Whereas, The American Society for Reproductive Medicine (ASRM) Position Statement on
31 Personhood Measures³ states that “ASRM will oppose any personhood measure that is unclear,
32 confusing, ambiguous, or not based on sound scientific or medical knowledge, and which
33 threatens the safety and effective treatment of patients;” and

¹ H.R. 1 “Tax Cuts and Jobs Act” at
https://waysandmeansforms.house.gov/uploadedfiles/tax_cuts_and_jobs_act_section_by_section_hr1.pdf

² “Ectopic Personhood” by Bill Fortenberry (updated 11 March 2015) at <http://www.personhoodinitiative.com/ectopic-personhood.html>

³ ASRM Position Statement on Personhood Measures at
http://www.asrm.org/ASRM_Position_Statement_on_Personhood_Measures/

- 1 Whereas, Our AMA does not currently have a similar position statement; therefore, be it
2
3 RESOLVED, That our American Medical Association oppose any policies that may potentially
4 give probate, inheritance, social security, or other legal rights to ectopic pregnancies (including
5 but not limited to cervical, intramural, cornual, interstitial, ampullary, ovarian, and Cesarean scar
6 ectopic pregnancies) and/or molar pregnancies (New HOD Policy); and be it further
7
8 RESOLVED, That our AMA oppose any personhood measure that is not based on sound
9 scientific or medical knowledge, or which threatens the safety and effective treatment of patients
10 (New HOD Policy); and be it further
11
12 RESOLVED, That our AMA oppose any imposition on medical decision-making or the
13 physician-patient relationship by changes in tax codes or in the definitions of beneficiaries. (New
14 HOD Policy)

Fiscal Note: Minimal – less than \$1,000.

Received: 11/10/17

RELEVANT AMA POLICY

The Criminalization of Health Care Decision Making H-160.946

The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.

(Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12)

Criminalization of Medical Judgment H-160.954

(1) Our AMA continues to take all reasonable and necessary steps to insure that errors in medical decision-making and medical records documentation, exercised in good faith, do not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties.

(Sub. Res. 223, I-93; Reaffirmed: Res. 227, I-98; Reaffirmed: Res. 237, A-99; Reaffirmed and Appended: Sub. Res. 215, I-99; Reaffirmation A-09; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation: I-12; Modified: Sub. Res. 716, A-13; Reaffirmed in lieu of Res. 605, I-13)

Opposition to Criminalizing Health Care Decisions D-160.999

Our AMA will educate physicians regarding the continuing threat posed by the criminalization of healthcare decision-making and the existence of our model legislation "An Act to Prohibit the Criminalization of Healthcare Decision-Making."

(Res. 228, I-98; Reaffirmed: BOT Rep. 5, A-08; Reaffirmation: I-12)

Reference Committee B

BOT Report(s)

06 Electronically Prescribed Controlled Substances Without Added Processes

Resolution(s)

- 201 Improving FDA Expedited Approval Pathways
- 202 Sexual Assault Survivors' Rights
- 203 Bidirectional Communication for EHR Software and Pharmacies
- 204 EHR Vendors Responsible for Health Information Technology
- 205 Health Plan, Pharmacy, Electronic Health Records Integration
- 206 Defending Federal Child Nutrition Programs
- 207 Redistribution of Unused Prescription Drugs to Pharmaceutical Donation and Reuse Programs
- 208 Increased Use of Body-Worn Cameras by Law Enforcement Officers
- 209 Government Mandated Sequester
- 210 Merit-Based Incentive Payment System and Small Practices
- 211 Exclusive State Control of Methadone Clinics
- 213 Barriers to Price Transparency
- 214 APRN Compact
- 215 Relieve Burden for Living Organ Donors
- 216 Relationship with US Department of Health and Human Services
- 217 Regulations Regarding Medical Tool and Instrument Repair
- 218* Health Information Technology Principles
- 219* Certified EMR Companies' Practice of Charging Fees for Regulatory Compliance
- 220* Preserving Protections of the Americans with Disabilities Act of 1990
- 221* House of Representative Bill HR 2077, Restoring the Patient's Voice Act of 2017
- 222# Appropriate Use of Objective Tests for Obstructive Sleep Apnea (REVISED)
- 223* Treating Opioid Use Disorder in Correctional Facilities
- 224* Modernizing Privacy Regulations for Addiction Treatment Records
- 225* Oppose Inclusion of Medicare Part B Drugs in QPP / MIPS Payment Adjustment
- 226* Prescription Drug Importation for Personal Use
- 227# Communication and Resolution Program
- 228# Drug Discount Cards
- 229# Opposition to Licensing for Individuals Holding the Degree of Doctor of Medical Science
- 230# Oppose Physician Assistant Independent Practice
- 231# Electronic Prescription Cancellation
- 232# Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare
- 233# Pharmacists Cannot and Should Not be Making Medical Decisions

* included in the Handbook Addendum

included in Sunday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(I-17)

Introduced by: American Academy of Sleep Medicine

Subject: Appropriate Use of Objective Tests for Obstructive Sleep Apnea

Referred to: Reference Committee B
(Ralph J. Nobo, Jr., MD, Chair)

1 Whereas, Obstructive sleep apnea (OSA) is a chronic medical disease that involves the
2 collapse or near collapse of the upper airway during sleep despite an ongoing effort to breathe;
3 and
4

5 Whereas, AMA policy recognizes OSA as a major public health issue (Policy D-440.943); and
6

7 Whereas, Untreated OSA is a potentially lethal disease that has a detrimental impact on health
8 and well-being, increasing the risk of high blood pressure, cardiovascular disease, stroke, Type
9 2 diabetes, depression and mortality¹; and
10

11 Whereas, Polysomnography (PSG) and a home sleep apnea test (HSAT) are objective tests
12 that may be used for the diagnosis of OSA or primary snoring in patients presenting with signs
13 and symptoms that indicate an increased risk of OSA²; and
14

15 Whereas, It is AMA policy to ensure that non-physician scope of practice is determined by
16 training, experience, and demonstrated competence (D-35.996); and
17

18 Whereas, Determining appropriateness of, ordering and interpreting objective tests for OSA and
19 primary snoring have been challenged by non-physicians without training, experience, and
20 demonstrated competence^{3,4}; therefore be it
21

22 RESOLVED, That it be policy of our American Medical Association that (1) ordering and
23 interpreting objective tests aiming to establish the diagnosis of obstructive sleep apnea (OSA) or
24 primary snoring constitutes the practice of medicine; (2) the need for, and appropriateness of,
25 objective tests for purposes of diagnosing OSA or primary snoring or evaluating treatment
26 efficacy must be based on the patient's medical history and examination by a licensed
27 physician; and (3) objective tests for diagnosing OSA and primary snoring are medical
28 assessments that must be ordered and interpreted by a licensed physician. (New HOD Policy)
29

Fiscal Note: Minimal - less than \$1,000.

Received: 10/27/17

¹ Punjabi NM. The epidemiology of adult obstructive sleep apnea. Proc Am Thorac Soc. 2008;5(2):136–143.

² Kapur VK, Auckley DH, Chowdhuri S, et al. Clinical practice guideline for diagnostic testing for adult obstructive sleep apnea: an American Academy of Sleep Medicine clinical practice guideline. J Clin Sleep Med. 2017;13(3):479–504.

³ DORA Colorado. Colorado Dental Board Stakeholder Meeting (Sleep apnea #1). YouTube website. <https://www.youtube.com/watch?v=PZrbaHUQkfw&feature=youtu.be>. Published April 7, 2017.

⁴ Texas Medical Association. TMA Opposes Dental Board's Sleep Apnea Treatment Rules. Texas Medical Association website. <https://www.texmed.org/Template.aspx?id=36189>. Published May 2, 2016.

RELEVANT AMA POLICY

Obstructive Sleep Apnea D-440.943

Our AMA: (1) recognizes Obstructive Sleep Apnea (OSA) as a major public health issue; (2) encourages a national public education campaign by appropriate federal agencies and relevant advocacy groups; (3) encourage research into the association of OSA with metabolic, cardiovascular, respiratory, and other diseases; and (4) encourages that all physicians become knowledgeable about the diagnosis and management of OSA.

Res. 521, A-09; Reaffirmed: Res. 107, A-14

Scope of Practice Model Legislation D-35.996

Our AMA Advocacy Resource Center will continue to work with state and specialty societies to draft model legislation that deals with non-physician independent practitioners' scope of practice, reflecting the goal of ensuring that non-physician scope of practice is determined by training, experience, and demonstrated competence; and our AMA will distribute to state medical and specialty societies the model legislation as a framework to deal with questions regarding non-physician independent practitioners' scope of practice.

Res. 923, I-03; Reaffirmed: BOT Rep. 28, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(I-17)

Introduced by: Georgia

Subject: Communication and Resolution Program

Referred to: Reference Committee B
(Ralph J. Nobo, Jr., MD, Chair)

- 1 Whereas, The current predominant professional malpractice defense is “deny and defend”; and
2
3 Whereas, The “deny and defend” process hinders open communication between patients and
4 providers, resulting in the lack of transparency in hospitals of personnel and system errors. This
5 results in an impedance of any improvement in the quality of care in our healthcare delivery
6 system; and
7
8 Whereas, The “deny and defend” process is increasing costs to physicians in time, preparation,
9 and malpractice premiums; and
10
11 Whereas, Physicians involved in a medical malpractice suit frequently suffer major depression,
12 adjustment disorders, and increased morbidity with physical health; and
13
14 Whereas, A Medscape survey found 36 percent of female physicians and 26 percent of male
15 physicians said it was “one of the worst experiences in my life”, while 20 percent of all
16 physicians said “it was disruptive and humiliating”; and
17
18 Whereas, The current malpractice environment encourages the practice of defensive medicine
19 that results in an increase of total health care costs that does not contribute and can potentially
20 hurt patients’ health outcome; and
21
22 Whereas, The concept of alternative programs to medical malpractice suits will never
23 completely end the principle of the “right by trial by jury” when there is a grievance. Alternative
24 programs need to be studied and assessed as to their effectiveness in decreasing the negative
25 consequences for patients, physicians, total health care cost, and quality of care using “deny
26 and defend”; and
27
28 Whereas, One such alternative is the Communication and Resolution program (CRP) which is
29 typically composed of six general components:
30
31 1. Hospital policy requires full disclosure when an unexpected bad outcome occurs; and
32
33 2. Staff report unexpected adverse outcomes they observe to Risk Management and Quality
34 Improvement Departments; staff also encourage patients to report to Risk Management any
35 unexpected bad outcome the patient experienced; and
36
37 3. Risk Management reports all cases that are notified to them to the Quality Improvement
38 Department for evaluation of errors and possible correction of system errors or personnel
39 errors; and

1 4. The patient and family, with an attorney if desired, meet with Risk Management
2 representatives and describe their concerns/experience. The hospital investigates and
3 reports back to the patient/family. The hospital and physician makes a full disclosure of their
4 analysis; and

5
6 5. If a medical injury occurred due to medical error by the physician, he/she will give full
7 disclosure to the patient with an attorney if desired. If the hospital committed the medical
8 injury, Risk Management representatives will provide the full disclosure when a hospital
9 error occurred. Full disclosure includes an explanation, an apology, and an exploration of
10 ways to prevent the injury from occurring in future to others. The hospital asks how the
11 patient would like to resolve the case and pay appropriate compensation if requested; and

12
13 6. If no medical error resulting in an injury occurred, no compensation is offered. The patient
14 may proceed to litigation if desired. The hospital vigorously defends any claim filed when
15 there is no evidence of medical error; and

16
17 Whereas, Studies of CRP show decrease defense costs, settlement costs, number of claims
18 filed, and time interval to resolve a claim; and

19
20 Whereas, Several studies have demonstrated that CRP is more successful in a closed system
21 (physicians are employed and insured by hospital), than open settings (physicians are not
22 employed nor insured by hospital). However, one study demonstrated success in a hospital with
23 a majority of physicians were not employed by the hospital and no physician was insured by this
24 hospital; and

25
26 Whereas, Another study showed a reduction in diagnostic testing and imaging after
27 implementation of CRP. These findings suggest defensive medicine practice is decreased using
28 CRP as opposed to deny and defend; and

29
30 Whereas, Though patients still have the right to litigate, when CRP was initiated in one hospital
31 study, in 43 percent of cases, the patient's needs were met with an explanation and apology
32 while the remaining 57 percent received financial compensation in addition to an explanation
33 and apology. No health care bills were submitted to patient or their insurance company if a
34 medical error resulted in injury to the patient; and

35
36 Whereas, One study demonstrated a concordance rate between compensation and medical
37 error of 99.6 percent; and

38
39 Whereas, This system would encourage hospitals to implement patient safety initiatives. The
40 resultant improvement in quality of care would result in less adverse outcomes due to medical
41 error. This could result in physicians experiencing a decreased incidence in reports to the
42 National Practitioner Data Bank (NPDB), the state's medical board, and the physician's hospital
43 review board; and

44
45 Whereas, More study and vetting is needed to assess if CRP has a place in lowering liability
46 outcomes, decrease the practice of defensive medicine, improve quality of care, and decrease
47 the stress to the patient and physicians when an adverse outcome occurs; therefore be it

48
49 RESOLVED, That our American Medical Association urgently research the Communication and
50 Resolution Program as a viable option to settle disputes, prior to litigation. (Directive to Take
51 Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 10/24/17

RELEVANT AMA POLICY

Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability H-435.969

Our AMA: (1) reaffirms its support for investigating promising Alternative Dispute Resolution (ADR) mechanisms, in the context of demonstration projects designed to evaluate whether they resolve medical liability claims fairly and in a more timely and cost-effective manner. (2)The AMA strongly recommends that if cost containment goals are to be achieved, ADR proposals designed to provide greater access to legal process must incorporate effective mechanisms to: (a) identify non-meritorious claims and dispose of them; (b) decrease the proportion of cases being litigated; (c) increase the portion of any settlement payment received by the patient; and (d) identify appropriate guidelines for the payment of damages; and (3) continues to monitor and disseminate information to state and component medical societies about state and federal initiatives that address the issue of protections from liability risks for physicians who provide volunteer activities and care of the indigent, as well as the effectiveness of those initiatives. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform.

Citation: BOT Rep. M, I-92; BOT Rep. I-93-53; Modified: Sub. Res. 205 and Reaffirmation A-00; Reaffirmation A-04; Reaffirmation A-06; Reaffirmed in lieu of first resolve of Res. 214, I-15

Enterprise Liability H-435.968

The AMA: (1) affirms its position that effective medical liability reform based on California's MICRA model is integral to health system reform, and must be included in any comprehensive health system reform proposal that hopes to be effective in containing costs, providing access to health care services and promoting the quality and safety of health care services; (2) opposes any proposal that would mandate or impose enterprise liability concepts. Federal funding to evaluate the comparative advantages and disadvantages of enterprise liability may be best spent studying the operation, effect on liability costs and patient safety/injury prevention results of liability channeling systems that already exist and function as close analogs to the enterprise liability model (BOT Rep. I-93-53); and (3) supports strong patient safety initiatives and the investigation of alternative dispute resolution models, appropriate uses of practice parameters in medical liability litigation and other reform ideas that have the potential to decrease defensive medicine costs and more fairly and cost-effectively compensate persons injured in the course of receiving health care services.

Citation: BOT Rep. III, A-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmation A-04; Reaffirmed: BOT Rep. 19, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(I-17)

Introduced by: Georgia
Subject: Drug Discount Cards
Referred to: Reference Committee B
(Ralph J. Nobo, Jr., MD, Chair)

1 Whereas, The price of prescription medications is a well-recognized reason for patient non-
2 compliance with self-administered medications in the United States; and
3
4 Whereas, The Centers for Medicare & Medicaid Services (CMS) prohibits the use of drug
5 discount cards from pharmaceutical companies to reduce or eliminate out-of-pocket expenses
6 citing their use as a violation of the anti-kick statues governing Medicare and Medicaid; and
7
8 Whereas, Eliminating or reducing out-of-pocket expenses for medication would encourage
9 better compliance with self-administered medications, which has been demonstrated to reduce
10 emergency room visits and hospitalizations due to failure to take prescribed medications; and
11
12 Whereas, Eliminating said emergency room visits and hospitalizations would save Medicare and
13 Medicaid millions of dollars in unnecessary medical expenses; therefore be it
14
15 RESOLVED, That our American Medical Association advocate to the Centers for Medicare &
16 Medicaid Services to have Congress eliminate the “doughnut hole” in Medicare Part D plans, as
17 part of the ongoing Congressional debate on evolving the health care system. (New HOD
18 Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 10/24/17

RELEVANT AMA POLICY

Non-Formulary Medications and the Medicare Part D Coverage Gap H-125.977

Our AMA will advocate for: (1) the inclusion of out of pocket, non-formulary, prescription medication expenses in calculating a patient's contributions toward the Medicare Part D coverage gap, after which coverage resumes; and (2) economic assistance, including coupons (and other discounts), for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured.
Res. 826, I-14; Reaffirmation I-15

Reducing Prescription Drug Prices D-110.993

Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to

contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.

CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation A-14; Reaffirmed in lieu of Res. 229, I-14

Certifying Indigent Patients for Pharmaceutical Manufacturers' Free Drug Programs H-120.975

Our AMA: (1) supports Pharmaceutical Research and Manufacturers of America (PhRMA) programs for indigent patients and the development of a universal application process, eligibility criteria and form for all prescription drug patient-assistance programs to facilitate enrollment of patients and physicians; (2) encourages PhRMA to provide information to physicians and hospital medical staffs about member programs that provide pharmaceuticals to indigent patients; (3) urges drug companies to develop user-friendly and culturally sensitive uniform centralized policies and procedures for certifying indigent patients for free or discounted medications; and (4) opposes the practice of charging patients to apply for or gain access to pharmaceutical assistance programs.

Sub. Res. 105, I-92; Sub. Res. 507, A-96; Appended: Sub. Res. 513, I-97; Reaffirmation I-98; Reaffirmation I-00; Reaffirmation A-01; Amended: Res. 513, A-02; Reaffirmed and Appended: Sub. Res. 705, I-03; Reaffirmed and Modified: BOT Rep. 13, A-04; Reaffirmation I-04; Modified: CSAPH Rep. 1, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(I-17)

Introduced by: Georgia

Subject: Opposition to Licensing for Individuals Holding the Degree of Doctor of Medical Science

Referred to: Reference Committee B
(Ralph J. Nobo, Jr., MD, Chair)

-
- 1 Whereas, Ensuring access to quality medical care is unquestionably a challenge in Georgia and
2 across the country; and
3
4 Whereas, Physician education and training is rigorous and reliably tested through our SHELF
5 exams, Step Exams, and our Board exams; and
6
7 Whereas There has been an influx of non-physician providers who wish to practice independent
8 of physician supervision or collaboration, ostensibly to help fill the need for medical care in
9 underserved areas; and
10
11 Whereas, It has been shown that non-physician providers do not, indeed, practice in
12 underserved areas in any greater numbers than physicians do; and
13
14 Whereas, A new degree, the “Doctor of Medical Science”, has been created by a single
15 university, and is intended to allow Physician Assistants a pathway to fully independent practice
16 of medicine; and
17
18 Whereas, This “Doctor of Medical Science” degree is not yet recognized by any state as valid
19 for producing a competent, independent medical practitioner; and
20
21 Whereas, We believe that all patients deserve to be treated by a fully trained medical physician
22 (MD or DO); therefore be it
23
24 RESOLVED, That our American Medical Association develop model legislation for states that
25 would oppose the holders of the degree of Doctor of Medical Science from being recognized as
26 a new category of health care practitioners licensed for the independent practice of medicine.
27 (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 10/24/17

RELEVANT AMA POLICY

Scope of Practice Model Legislation D-35.996

Our AMA Advocacy Resource Center will continue to work with state and specialty societies to draft model legislation that deals with non-physician independent practitioners? scope of practice, reflecting the goal of ensuring that non-physician scope of practice is determined by training, experience, and

demonstrated competence; and our AMA will distribute to state medical and specialty societies the model legislation as a framework to deal with questions regarding non-physician independent practitioners' scope of practice.

Res. 923, I-03; Reaffirmed: BOT Rep. 28, A-13

Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners H-270.958

1. It is AMA policy that state medical boards shall have authority to regulate the practice of medicine by all persons within a state notwithstanding claims to the contrary by nonphysician practitioner state regulatory boards or other such entities.

2. Our AMA will work with interested Federation partners: (a) in pursuing legislation that requires all health care practitioners to disclose the license under which they are practicing and, therefore, prevent deceptive practices such as nonphysician healthcare practitioners presenting themselves as physicians or "doctors"; (b) on a campaign to identify and have elected or appointed to state medical boards physicians (MDs or DOs) who are committed to asserting and exercising the state medical board's full authority to regulate the practice of medicine by all persons within a state notwithstanding efforts by nonphysician practitioner state regulatory boards or other such entities that seek to unilaterally redefine their scope of practice into areas that are true medical practice.

BOT Action in response to referred for decision Res. 902, I-06; Reaffirmed: BOT Rep. 06, A-16

Physician and Nonphysician Licensure and Scope of Practice D-160.995

Our AMA will: (1) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (2) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (3) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.

CME Rep. 1, I-00; Reaffirmed: CME Rep. 2, A-10; Modified: CCB/CLRPD Rep. 2, A-14

Practicing Medicine by Non-Physicians H-160.949

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;

(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;

(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and

(6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.

Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 224, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Res. 107, A-14; Appended: Res. 324, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(I-17)

Introduced by: Pennsylvania, American Academy of Dermatology, American Association of Neurological Surgeons, American College of Mohs Surgery, American College of Radiology, American Society for Dermatologic Surgery Association, American Society of Anesthesiologists, American Society of Dermatopathology, Arizona, Arkansas, Congress of Neurological Surgeons, Florida, Kentucky, Maryland, Georgia, Alabama, New Jersey, District of Columbia, New York, Virginia, Michigan, Mississippi, Society for Investigative Dermatology, South Carolina, Tennessee, Wisconsin, American College of Emergency Physicians, American College of Surgeons

Subject: Oppose Physician Assistant Independent Practice

Referred to: Reference Committee B
(Ralph J. Nobo, Jr., MD, Chair)

-
- 1 Whereas, The American Academy of PA (AAPA) House of Delegates adopted “*Optimal Team*
2 *Practice*” policy that seeks to eliminate provisions in laws and regulations that require a
3 physician assistant to have a supervisory, collaborative or other specific relationship with a
4 physician as a condition or component of licensure; and
5
6 Whereas, Previously adopted AAPA policy promotes exclusive use of the term “PA” instead of
7 “Physician Assistant” to remove reference to other health care disciplines within their title;
8 remove from legislation and regulation the concept that the physician assistant is the agent of
9 the physician; create a separate and independent physician assistant regulatory board; and
10 allow insurers to reimburse physician assistants directly; and
11
12 Whereas, AAPA model legislation removes language stipulating that physician assistant scope
13 of practice is determined by physician delegation, and instead, physician assistants should be
14 permitted to provide any medical service within the physician assistant’s education, training, and
15 experience; and
16
17 Whereas, States have begun to enact expanded scope of practice for physician assistants and
18 more state medical associations should be prepared for proposals for either independent or
19 collaborative practice in future legislative sessions; and
20
21 Whereas, Physician education and training includes at a minimum medical school and
22 residency with 10,000 hours, however, the current physician assistant education model is 2
23 years with 2000 hours of clinical care and no residency; and
24
25 Whereas, In a survey conducted by the Physician Assistant Education Association, the large
26 majority (86%) of physician assistant educators responded that the current physician assistant
27 educational model does not prepare graduates to practice without a supervisory, collaborating,
28 or other specific relationship with a physician¹; and

¹ Physician Assistant Education Association. OTP Task Force. Optimal Team Practice: The Right Prescription for New PA Graduates? May 8, 2017.

1 Whereas, Physician-led team based care remains at the center of AMA policy, and physician
2 supervision and responsibility help assure that the highest quality of care is provided to every
3 patient; and
4

5 Whereas, Our AMA recently adopted policy in support of maintaining the authority of medical
6 licensing and regulatory boards to regulate the practice of physician assistants; and
7

8 Whereas, Although our AMA has policy that states physician assistants should be supervised
9 and that only physicians should practice independently, our AMA policy does not specifically
10 state that physician assistants should not practice independently; and
11

12 Whereas, Affirmative policy to oppose physician assistant independent practice would be helpful
13 as our AMA responds to the new AAPA policy statement on "*Optimal Team Practice*;" therefore,
14 be it
15

16 RESOLVED, That our American Medical Association adopt policy to oppose legislation or
17 regulation that allows physician assistant independent practice. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 10/20/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(I-17)

Introduced by: Oregon
Subject: Electronic Prescription Cancellation
Referred to: Reference Committee B
(Ralph J. Nobo, Jr., MD, Chair)

1 Whereas, The reduction in medication errors has been a stated goal throughout all levels of
2 medicine; and
3
4 Whereas, The inability to simply discontinue or invalidate an old or changed prescription creates
5 the potential for errors at multiple levels; and
6
7 Whereas, Up to 1.4% of discontinued medications were refilled inappropriately in retrospective
8 review¹. Previously discontinued medicines can still be sent to the patient from mail-order
9 pharmacies, and with automated refill systems there is no financial incentive to not send
10 medications to patients; and
11
12 Whereas, The simple changing of a medication dose creates two valid prescriptions for the
13 same medication. Patient may be given one or both doses of the medication or patients can
14 continue to pick up the discontinued dose of medication from local pharmacies until the original
15 prescription is a year old; and
16
17 Whereas, Patients may be given the new dose of medication until their refills run out and then
18 the old dose is still available and may be incorrectly restarted; and
19
20 Whereas, These errors are increased by the use of multiple pharmacies, including having a
21 local and a mail-order pharmacy; and
22
23 Whereas, The electronic medical record has not only contributed to the existing problem, it has
24 created a new potential error unique to the EMR. A previously changed or discontinued
25 medication can be requested from a pharmacy electronically and, because the discontinued
26 status is not recognized by the system, a simple click of a button can refill the medication and
27 put the medication back on the patient's active medication list; and
28
29 Whereas, A system for sending medication cancellations already exists but has not been
30 adopted by most pharmacies or practices; and
31
32 Whereas, This problem is both a local and national problem; therefore be it
33
34 RESOLVED, That our American Medical Association support the creation, standardization, and
35 implementation of electronic prescription cancellation from all electronic medical record vendors
36 and that these orders be accepted by pharmacies and pharmacy benefit managers. (New HOD
37 Policy)

Fiscal Note: Minimal - less than \$1,000.
Received: 11/02/17

¹ Allen AS, Sequist TD. Pharmacy Dispensing of Electronically Discontinued Medications. Ann Intern Med. 2012;157:700–705. doi: 10.7326/0003-4819-157-10-201211200-00006

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(I-17)

Introduced by: Medical Student Section

Subject: Presence and Enforcement Actions of Immigration and Customs
Enforcement (ICE) in Healthcare

Referred to: Reference Committee B
(Ralph J. Nobo, Jr., MD, Chair)

1 Whereas, U.S. Immigration and Customs Enforcement (ICE) policy states that enforcement
2 actions, including interviews, searches, apprehensions, or arrests, should not occur at sensitive
3 locations, including healthcare facilities and medical treatment centers, such as hospitals, health
4 clinics, doctors' offices, and emergent or urgent care facilities;^{1,2} and

5
6 Whereas, Recent efforts by ICE's outreach program have involved approaching a hospital on
7 the grounds of establishing a partnership to "develop potential sources of information" and enlist
8 healthcare facilities in sharing patient information, or even conducting enforcement actions at
9 hospitals, effectively undermining the explicit designation of this and other sites as sensitive
10 locations;^{3,4,5} and

11
12 Whereas, The current Presidential administration has requested \$1 billion to accelerate and
13 expand the detention and deportation of undocumented immigrants, and the number of ICE
14 arrests made in the first 100 days of the current administration reflects an increase of 37.6%
15 over the same 100-day period from January to April in 2016;^{6,7} and

16
17 Whereas, The establishment of partnerships, or even the fear of partnerships, between ICE and
18 community health care facilities, and the corresponding increases in detention and deportation
19 efforts have been shown to increase deportation fears among immigrants, erode immigrant trust
20 in community health institutions, and lead to poorer health outcomes for both documented and
21 undocumented immigrants;^{4,5,8,9,10,11,12} and

¹ FAQ on Sensitive Locations and Courthouse Arrests. Official Website of the
Department of Homeland Security. 2017. Available at: <https://www.ice.gov/ero/enforcement/sensitive-loc>. Accessed August 28, 2017.

² U.S. Immigration and Customs Enforcement, Morton J. Enforcement Actions at or Focused on Sensitive Locations. Policy number: I0029.2. FEA
Number: 306-112-002b

³ Gross R. ICE outreach to hospitals stirs concern about patient data. Southern California Public Radio.
<http://www.scpr.org/news/2017/08/09/74485/ice-homeland-security-outreach-program-ignites-con/>. Published August 9, 2017. Accessed August 22,
2017.

⁴ Swettlitz I. Immigrants, fearing Trump's deportation policies, avoid doctor visits. PBS. <http://www.pbs.org/newshour/rundown/immigrants-trump-deportation-doctor/>. Published February 25, 2017. Accessed September 4, 2017.

⁵ Barajas M. Woman Arrested at Gynecologist Appointment Could Face Deportation. Houston Press. 2017. Available at:

<http://www.houstonpress.com/news/woman-arrested-at-gynecologist-appointment-could-face-deportation-7754827>. Accessed September 18, 2017.

⁶ Fandos N. Trump's Border Wall Gets Billions in Budget Proposal. The New York Times. <https://www.nytimes.com/2017/03/16/us/politics/donald-trump-border-wall-budget.html?mcubz=0>. Published March 16, 2017. Accessed September 4, 2017.

⁷ Hacker K, Chu J, Leung C, et al. The Impact of Immigration and Customs Enforcement on Immigrant Health: Perceptions of Immigrants in Everett, Massachusetts, USA. *Social science & medicine* (1982). 2011;73(4):586-594. doi:10.1016/j.socscimed.2011.06.007.

⁸ Hacker K, Chu J, Arsenault L, Marlin RP. Provider's Perspectives on the Impact of Immigration and Customs Enforcement (ICE) Activity on Immigrant Health. *Journal of health care for the poor and underserved*, 2012;23(2):651-665.

⁹ Hacker K, Chu J, Leung C, et al. The Impact of Immigration and Customs Enforcement on Immigrant Health: Perceptions of Immigrants in Everett, Massachusetts, USA. *Social science & medicine* (1982). 2011;73(4):586-594. doi:10.1016/j.socscimed.2011.06.007.

¹⁰ Cavazos-Rehg PA, Zayas LH, Spitznagel EL. Legal Status, Emotional Well-Being and Subjective Health Status of Latino Immigrants. *Journal of the National Medical Association*, 2007;99(10): 1126-1131.

¹¹ Toomey RB, Umaña-Taylor AJ, Williams DR, Harvey-Mendoza E, Jahromi LB, Updegraff KA. Impact of Arizona's SB 1070 Immigration Law on Utilization of Health Care and Public Assistance Among Mexican-Origin Adolescent Mothers

¹² Queally J. Latinos are reporting fewer sexual assaults amid a climate of fear in immigrant communities, LAPD says. Los Angeles Times. <http://www.latimes.com/local/lanow/la-me-ln-immigrant-crime-reporting-drops-20170321-story.html>. Published March 21, 2017. Accessed September 4, 2017.

1 Whereas, Section 164.512 of the Health Insurance Portability and Accountability Act of 1996
2 (HIPAA) permits disclosure of protected health information only in instances that involve
3 averting a serious threat to health or safety, when there was a violation of the law involving a
4 crime that occurred on the premises or required emergency health care, or if the patient was the
5 victim of a crime;¹³ and
6

7 Whereas, Ongoing subversion of the sensitive location policy by ICE has prompted pending
8 congressional legislation to codify this policy into law and thereby ensure that undocumented
9 immigrants are able to access health care, among other social services, without fear of
10 deportation;^{14,15} and
11

12 Whereas, Existing AMA policy calls for our AMA “to support protections that prohibit law
13 enforcement agencies from utilizing information from medical records to pursue immigration
14 enforcement actions against patients who are undocumented” (H-315.966); and
15

16 Whereas, Existing AMA policy calls for our AMA to advocate “for policies to make available and
17 effectively deploy resources needed to eliminate health disparities affecting immigrants,
18 refugees or asylees” (H-350.957); therefore be it
19

20 RESOLVED, That our American Medical Association advocate for and support legislative efforts
21 to designate healthcare facilities as sensitive locations by law (New HOD Policy); and be it
22 further
23

24 RESOLVED, That our AMA work with appropriate stakeholders to educate medical providers on
25 the rights of undocumented patients while receiving medical care, and the designation of
26 healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement
27 (ICE) enforcement actions should not occur (Directive to Take Action); and be it further
28

29 RESOLVED, That our AMA encourage healthcare facilities to clearly demonstrate and promote
30 their status as sensitive locations (New HOD Policy); and be it further
31

32 RESOLVED, That our AMA oppose the presence of ICE enforcement at healthcare facilities.
33 (New HOD Policy)

Fiscal Note: Modest – between \$1,000 - \$5,000.

Received: 11/11/17

¹³ §164.512 Uses and Disclosures for Which an Authorization or Opportunity to Agree or Object Is Not Required. U.S. Government Publishing Office. 2017. Available at: https://www.ecfr.gov/cgi-bin/textidx?SID=1455cc08c2160a30ce353445dbe0b9d1&mc=true&node=se45.1.164_1512&rgn=div8. Accessed August 28, 2017.

¹⁴ H.R. 1815 - Protecting Sensitive Locations Act <https://www.congress.gov/bill/115th-congress/house-bill/1815/text>

¹⁵ S. 845 Protecting Sensitive Locations Act. 115th Congress. <https://www.congress.gov/bill/115th-congress/senate-bill/845/text>

RELEVANT AMA POLICY

Patient and Physician Rights Regarding Immigration Status H-315.966

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

(Res. 018, A-17)

Medical Care Must Stay Confidential H-270.961

Our AMA will strongly oppose any federal legislation requiring physicians to establish the immigration status of their patients.

(Res. 214, A-04; Reaffirmed: CEJA Rep. 8, A-14)

Addressing Immigrant Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

(Res. 804, I-09; Appended: Res. 409, A-15)

Racial and Ethnic Disparities in Health Care H-350.974

Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

The AMA emphasizes three approaches that it believes should be given high priority:

(1) Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

(2) Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

(3) Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decisionmaking process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA

supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

(CLRPD Rep. 3, I-98; Appended and Reaffirmed:: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12)

Police, Payer, and Government Access to Patient Health Information H-315.975

(1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define "health care operations" narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.

(2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.

(3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.

(4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.

(5) Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.

(Res. 246, A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: BOT Rep. 22, A-17)

See also: [Patient Privacy and Confidentiality H-315.983](#)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(I-17)

Introduced by: Organized Medical Staff Section

Subject: Pharmacists Cannot and Should Not Be Making Medical Decisions

Referred to: Reference Committee B
(Ralph J. Nobo, Jr., MD, Chair)

- 1 Whereas, Our AMA opposes the practice of pharmacies and pharmacists denying medically
2 necessary and legitimate therapeutic treatments to patients (AMA Policy D-35.981); and
3
4 Whereas, Our AMA supports legislation that requires individual pharmacists or pharmacy chains
5 to fill legally valid prescriptions or to provide immediate referral to an appropriate alternative
6 dispensing pharmacy without interference (AMA Policy H-120.947); and
7
8 Whereas, CVS Caremark recently announced that it will roll out an enhanced opioid utilization
9 management approach for all commercial, health plan, employer, and Medicaid clients as of
10 February 1, 2018; and
11
12 Whereas, This program will in part limit the supply of opioids dispensed for certain acute
13 prescriptions for patients who are new to therapy to seven days; and
14
15 Whereas, Our AMA has been a vocal critic of pharmacy programs that limit the quantity and
16 strength of pain prescriptions, averring that one-size-fits-all approaches are not ideal and that
17 the decision about a specific treatment alternative is best left to the physician and his or her
18 patient; therefore be it
19
20 RESOLVED, That our American Medical Association take steps to implement AMA Policies
21 H-120.947 and D-35.981 that prescriptions must be filled as ordered by physicians or other duly
22 authorized/licensed persons, including the quantity ordered (Directive to Take Action); and be it
23 further
24
25 RESOLVED, That our AMA seek out those bodies overseeing the nation's pharmacies and
26 advocate that actions be taken to prohibit pharmacists from making medical decisions outside
27 the scope of their practice (Directive to Take Action); and be it further
28
29 RESOLVED, That our AMA report back at the 2018 Annual Meeting on actions taken to
30 preserve the purview of physicians in prescription origination. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000.

Received: 11/11/17

RELEVANT AMA POLICY

H-120.947 Preserving Patients' Ability to Have Legally Valid Prescriptions Filled

1. Our AMA reaffirms our policies supporting responsibility to the patient as paramount in all situations and the principle of access to medical care for all people; and supports legislation that requires individual pharmacists or pharmacy chains to fill legally valid prescriptions or to provide immediate referral to an appropriate alternative dispensing pharmacy without interference. In the event that an individual pharmacist or pharmacy chain refers a patient to an alternative dispensing source, the individual pharmacist or the pharmacy chain should return the prescription to the patient and notify the prescribing physician of the referral.
2. Our AMA supports the concept of advance prescription for emergency contraception for all women in order to ensure availability of emergency contraception in a timely manner.

D-35.981 AMA Response to Pharmacy Intrusion Into Medical Practice

1. Our AMA deems inappropriate inquiries from pharmacies to verify the medical rationale behind prescriptions, diagnoses and treatment plans to be an interference with the practice of medicine and unwarranted.
2. Our AMA will work with pharmacy associations such as the National Association of Chain Drug Stores to engage with the Drug Enforcement Administration, the federal Department of Justice, and other involved federal regulators and stakeholders, for the benefit of patients, to develop appropriate policy for pharmacists to work with physicians in order to reduce the incidence of drug diversion and inappropriate dispensing.
3. If the inappropriate pharmacist prescription verification requirements and inquiry issues are not resolved promptly, our AMA will advocate for legislative and regulatory solutions to prohibit pharmacies and pharmacists from denying medically necessary and legitimate therapeutic treatments to patients.

Reference Committee F

BOT Report(s)

10 High Cost to Authors for Open Source Peer Reviewed Publications

CLRPD Report(s)

01* Senior Physicians Section Five-Year Review

HOD Comm on Compensation of the Officers

01# Report of the House of Delegates Committee on Compensation of the Officers

Resolution(s)

601 Physician Burnout and Wellness Challenges

604# Physician and Physician Assistant Safety Net

605# Identification and Reduction of Physician Demoralization

* included in the Handbook Addendum

included in Sunday Tote

REPORT OF THE HOUSE OF DELEGATES COMMITTEE
ON THE COMPENSATION OF THE OFFICERS

Report -I-17

Subject: Report of the House of Delegates Committee on Compensation of the Officers

Presented by: Brooks F. Bock, MD, Chair

Referred to: Reference Committee F
(Julia V. Johnson, MD, Chair)

1 This report by the Committee at the 2017 Interim Meeting presents one recommendation. It also
2 documents the compensation paid to Officers for the period July 1, 2016 thru June 30, 2017 and
3 includes the 2016 calendar year IRS reported taxable value of benefits, perquisites, services, and
4 in-kind payments for all Officers.

5
6 BACKGROUND

7
8 At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on
9 Trustee Compensation, currently named the Committee on Compensation of the Officers, (the
10 "Committee"). The Officers are defined in the American Medical Association's (AMA)
11 Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the
12 HOD, Article V refers simply to "Officer," which includes all 21 members of the Board among
13 whom are President, President-Elect, Immediate Past President, Secretary, Speaker of the HOD and
14 Vice Speaker of the HOD, collectively referred to in this report as Officers). The composition,
15 appointment, tenure, vacancy process and reporting requirements for the Committee are covered
16 under the AMA Bylaws. Bylaws 2.13.4.5 provides:

17
18 The Committee shall present an annual report to the House of Delegates recommending the
19 level of total compensation for the Officers for the following year. The recommendations of
20 the report may be adopted, not adopted or referred back to the Committee, and may be
21 amended for clarification only with the concurrence of the Committee.

22
23 At A-00, the Committee and the Board jointly adopted the American Compensation Association's
24 definition of total compensation which was added to the Glossary of the AMA Constitution and
25 Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an
26 individual for work performance including: (a) all forms of money or cash compensation; (b)
27 benefits; (c) perquisites; (d) services; and (e) in-kind payments.

28
29 Since the inception of this Committee, its reports document the process the Committee follows to
30 ensure that current or recommended Officer compensation is based on sound, fair, cost-effective
31 compensation practices as derived from research and use of independent external consultants,
32 expert in Board compensation. Reports beginning in December 2002 documented the principles
33 the Committee followed in creating its recommendations for Officer compensation.

1 At A-08, the HOD approved changes that simplified compensation practices with increased
2 transparency and consistency. At A-10, Reference Committee F requested that this Committee
3 recommend that the HOD affirm a codification of the current compensation principle, which
4 occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base
5 its recommendations for Officer compensation on the principle of the value of the work performed,
6 consistent with IRS guidance and best practices as recommended by the Committee's external
7 independent consultant, who is expert in Board compensation.

8
9 At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation
10 with that of all other Officers (excluding Presidents and Chair) because these positions perform
11 comparable work.

12
13 Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves
14 Group, to update his 2007 research by providing the Committee with comprehensive advice and
15 counsel on Officer compensation. The updated compensation structure was presented and approved
16 by the HOD at I-11 with an effective date of July 1, 2012.

17
18 The Committee's I-13 report recommended and the HOD approved the Committee's
19 recommendation to provide a travel allowance for each President to be used for upgrades because
20 of the significant volume of travel in representing our AMA.

21
22 At I-16, based on results of a comprehensive compensation review conducted by Ms. Becky Glantz
23 Huddleston an expert in Board Compensation with Willis Towers Watson, the Committee
24 recommended and the HOD approved modest increases to the Governance Honorarium and Per
25 Diems for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. A-
26 17's report, approved by the HOD, modified the Governance Honorarium and Per Diem definition
27 so that Internal Representation, in excess of eleven days, receives a per diem.

28 29 CASH COMPENSATION SUMMARY

30
31 The cash compensation of the Officers shown in the following table will not be the same as
32 compensation reported annually on the AMA's IRS Form 990 because Form 990s are based on a
33 calendar year. The total cash compensation in the summary is compensation for the days these
34 Officers spend away from home on AMA business approved by the Board Chair. The total cash
35 compensation in the summary includes work as defined by the Governance Honorarium and Per
36 Diem for Representation including conference calls with groups outside of the AMA, totaling 2
37 hours or more per calendar day as approved by the Board Chair. Detailed definitions are located in
38 the Appendix.

1 The summary covers July 1, 2016 to June 30, 2017

AMA Officers	Position	Total Compensation	Total Days
Maya A Babu, MD, MBA	Resident Officer	\$ 71,700	59.5
Susan R Bailey, MD	Speaker, House of Delegates	\$ 77,700	65.5
David O Barbe, MD, MHA	President-Elect	\$ 274,000	128.5
Willarda V Edwards, MD, MBA	Officer	\$ 63,300	40
Jesse M Ehrenfeld, MD, MPH	Young Physician Officer	\$ 98,700	80.5
Andrew W Gurman, MD	President	\$ 279,000	161.5
Gerald E Harmon, MD	Chair-Elect	\$ 199,500	72.5
Patrice A Harris, MD, MA	Chair	\$ 269,500	124
William E Kobler, MD	Officer	\$ 78,900	57.5
Russell WH Kridel, MD	Officer	\$ 65,100	52.5
Omar Z Maniya, MBA	Medical Student Officer	\$ 72,300	57.5
Barbara L McAneny, MD	Officer	\$ 87,900	71.5
William A McDade, MD, PhD	Officer	\$ 75,900	56
S Bobby Mukkamala, MD	Officer	\$ -	2.5
Albert J Osbahr, III, MD	Officer	\$ 84,300	62.5
Stephen R Permut, MD, JD	Immediate Past Chair	\$ 95,700	81.5
Jack Resneck, Jr, MD	Secretary	\$ 83,700	67.5
Ryan J Ribeira, MD, MPH	Resident Officer	\$ -	2
Karthik V Sarma, MS	Medical Student Officer	\$ -	2
Bruce A Scott, MD	Vice Speaker, House of Delegates	\$ 63,900	41
Carl A Sirio, MD	Officer	\$ 104,100	77
Steven J Stack, MD	Immediate Past President	\$ 274,000	96.5
Georgia A Tuttle, MD	Officer	\$ 84,900	64
Kevin W Williams	Public Board Member Officer	\$ 61,500	48

2

3 President, President-Elect, Immediate Past President and Chair

4 In 2016-2017, each of these positions received an annual Governance Honorarium which was paid
5 in monthly increments. These four positions spent a total of 510.5 days on approved Assignment
6 and Travel, or 127.6 days each on average.

7

8 Chair-Elect

9 This position received a Governance Honorarium of approximately 75% of the Governance
10 Honorarium provided to the Chair.

11

12 All other Officers

13 All other Officers received cash compensation, which included a Governance Honorarium of
14 \$61,500 paid in monthly installments. The remaining cash compensation is for Assignment and
15 Travel Days that are approved by the Board Chair to externally represent the AMA. These days
16 were compensated at a per diem rate of \$1,200.

17

18 Assignment and Travel Days

19 The total Assignment and Travel Days for all Officers (excluding the President, President-Elect,
20 Immediate Past President and Chair) were 1061; this includes reimbursement for telephonic
21 representation meetings for external organizations that are 30 minutes or longer during a calendar
22 day and total 2 or more hours. These are reimbursed at ½ of the current per diem rate. During this
23 reporting period, there were 27 reimbursed calls, representing 13.5 per diem days.

1 EXPENSES

2

3 Total expenses paid for the period, July 1, 2016 – June 30, 2017, \$844,506 compared to \$881,137
4 for the previous period, representing a 4.2% decrease. This includes \$730 in upgrades for
5 Presidents’ travel per the approved Presidential Upgrade Allowance of \$2,500 per position per
6 term.

7

8 BENEFITS, PERQUISITES, SERVICES AND IN-KIND PAYMENTS

9

10 Officers are able to request benefits, perquisites, services and in-kind payments, as defined in the
11 “AMA Board of Trustees Standing Rules on Travel and Expenses.” These non-taxable business
12 expense items are provided to assist the Officers in performing their duties:

13

- 14 • AMA Standard laptop computer or iPad
- 15 • iPhone
- 16 • American Express card (for AMA business use)
- 17 • Combination fax/printer/scanner
- 18 • An annual membership to the airline club of choice offered each year during the Board
19 member’s tenure
- 20 • Personalized AMA stationery, business cards and biographical data for official use.

21

22 Additionally, all Officers are eligible for \$300,000 term life insurance and are covered under the
23 AMA’s \$500,000 travel accident policy and \$10,000 individual policy for medical costs arising out
24 of any accident while traveling on official business for the AMA. Life insurance premiums paid by
25 the AMA are reported as taxable income.

26

27 Secretarial support, other than that provided by AMA’s Board office, is available up to defined
28 annual limits as follows: President, during the Presidential year, \$15,000; \$5,000 each for the
29 President-Elect, Chair, Chair-Elect and Immediate Past president per year. Secretarial expenses
30 incurred by other Officers in connection with their official duties are paid up to \$750 per year per
31 Officer. This is reported as taxable income.

32

33 Travel expenses incurred by family members are not reimbursable, with the exception of the family
34 of the incoming President at the Annual Meeting of the HOD.

35

36 Calendar year taxable life insurance and taxable secretarial fees reported to the IRS totaled \$27,558
37 and \$30,500 respectively for 2016. An additional \$7,500 was paid to third parties for secretarial
38 services during 2016.

39

40 FINDINGS

41

42 As stated earlier, Officers are eligible for \$300,000 term life insurance. This insurance is provided
43 by AMA Insurance Agency. The Agency offered a global medical emergency assistance program
44 to physicians, including AMA Officers, who are participants in specific Agency sponsored group
45 plans which include the Life Insurance Plan. The Agency will no longer be providing this offering
46 as part of its insurance and service package for physicians effective January 1, 2018.

47

48 Given the amount of travel Officers make in representing our AMA, global medical emergency
49 assistance is important to have should the need arise. As such, an alternative was sought. The
50 Standard, the group life insurance provider for AMA employees offers Travel Assistance when

1 traveling more than 100 miles from home or internationally. The Standard is willing to extend this
2 coverage to AMA Officers provided the Officers enroll in a \$5000 term life insurance policy. The
3 total cost of a \$5000 term life insurance coverage for each of our 21 Officers totals \$150 per year
4 for all Officers. This will increase the total term life insurance available to all Board members to
5 \$305,000.

6
7 RECOMMENDATIONS

8
9 The Committee on Compensation of the Officers recommends the following recommendations be
10 adopted and the remainder of this report be filed:

- 11
12 1. That there be no change to the current Definitions effective July 1, 2017 as they appear in the
13 Travel and Expenses Standing Rules for AMA Officers for the Governance Honorarium, Per
14 Diem for External Representation and Telephonic Per Diem for External Representation
15
16 2. That the Travel and Expense Standing Rules for AMA Officers, Rule I Section C9, Standard
17 Benefits Package be changed to \$305,000 term life insurance.
18
19 3. Except as noted above, there be no other changes to the Officers compensation for the period
20 beginning January 1, 2018. (Directive to Take Action)

Fiscal Note: Estimated annual cost of Recommendation 2, is \$150 as noted in the Findings.

APPENDIX

POSITION	GOVERNANCE HONORARIUM
President	\$279,000
Immediate Past President & President-Elect	\$274,000
Chair	\$269,500
Chair-Elect	\$199,500
Other Officers	\$65,000

Definition of Governance Honorarium Effective July 1, 2017:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted up to eleven (11) Internal Representation day.

Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation day above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather related travel delays. Per Diem for Chair-assigned representation and related travel is \$1,300 per day.

Definition of Telephonic Per Diem for External Representation effective July 1, 2017:

Officers, excluding the Board Chair and the Presidents, who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for these meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem or \$650.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(I-17)

Introduced by: Oregon
Subject: Physician and Physician Assistant Safety Net
Referred to: Reference Committee F
(Julia V. Johnson, MD, Chair)

- 1 Whereas, The American Foundation for Suicide Prevention has documented facts about
2 physician depression and suicide¹; and
3
4 Whereas, Physicians have higher rates of burnout, depressive symptoms, and suicide risk than
5 the general population; and
6
7 Whereas, Physicians and trainees can experience high degrees of mental health distress, and
8 are less likely than other members of the public to seek mental health treatment²; and
9
10 Whereas, Psychologists and psychiatrists have received feedback from physician patients that
11 they are reluctant to call national or local suicide hotlines³; therefore be it
12
13 RESOLVED, That our American Medical Association study a safety net, such as a national
14 hotline, that all United States physicians and physician assistants can call when in a suicidal
15 crisis. Such safety net services would be provided by doctorate level mental health clinicians
16 experienced in treating physicians (Directive to Take Action); and be it further
17
18 RESOLVED, That our AMA advocate that funding for such safety net program be sought from
19 such entities as foundations, hospital systems, medical clinics, and donations from physicians
20 and physician assistants. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000.

Received: 11/02/17

¹ Schernhammer, E. S., & Colditz, G. A. (2004). Suicide Rates Among Physicians: A Quantitative and Gender Assessment (Meta-Analysis). *American Journal of Psychiatry AJP*, 161(12), 2295-2302. doi:10.1176/appi.ajp.161.12.2295
² Mata, D. A., Ramos, M. A., Bansal, N., Khan, R., Guille, C., Angelantonio, E. D., & Sen, S. (2015). Prevalence of Depression and Depressive Symptoms among Resident Physicians. *JAMA*, 314(22), 2373. doi:10.1001/jama.2015.15845
³ Gold KJ, Sen A, Schwenk TL. Details on suicide among U.S. physicians: Data from the National Violent Death Reporting System. *General hospital psychiatry*. 2013;35(1):45-49. doi:10.1016/j.genhosppsych.2012.08.005.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(I-17)

Introduced by: Organized Medical Staff Section

Subject: Identification and Reduction of Physician Demoralization

Referred to: Reference Committee F
(Julia V. Johnson, MD, Chair)

- 1 Whereas, Physicians who report being overworked, excessively scrutinized, or overburdened
2 with unnecessary or unfulfilling tasks are often labeled with “burnout,” a “resilience deficiency,”
3 or even as “disruptive;” and
4
5 Whereas, “Burnout” and similar labels imply that physicians who experience professional
6 dissatisfaction have some inherent flaw or weakness that impairs their ability to remain
7 functional; and
8
9 Whereas, Eliminating the word “burnout” from the lexicon and recognizing that the high rate of
10 physician demoralization is the result of systemic organizational failures in medicine would
11 effectively place the onus on health systems to reduce occupational stresses for physicians and
12 promote overall medical staff wellness; and
13
14 Whereas, Although Joint Commission standards require hospital medical staffs to implement
15 organizational processes to promote physician health, there is little guidance available on how
16 to address staff wellness proactively, rather than reactively; therefore be it
17
18 RESOLVED, That our American Medical Association recognize that physician demoralization,
19 defined as a consequence of externally imposed occupational stresses, including but not limited
20 to EHR-related and administrative burdens imposed by health systems or by regulatory
21 agencies, is a problem among medical staffs (New HOD Policy); and be it further
22
23 RESOLVED, That our AMA advocate that hospitals be required by accrediting organizations to
24 confidentially survey physicians to identify factors that may lead to physician demoralization
25 (Directive to Take Action); and be it further
26
27 RESOLVED, That our AMA develop guidance to help hospitals and medical staffs implement
28 organizational strategies that will help reduce the sources of physician demoralization and
29 promote overall medical staff wellness (Directive to Take Action).

Fiscal Note: Modest – between \$1,000 - \$5,000.

Received: 11/11/2017

Reference Committee J

CMS Report(s)

- 01* Affordable Care Act Section 1332 Waivers
- 02* Hospital Surveys and Health Care Disparities
- 03 Non-Physician Screening Tests
- 04* Health Insurance Affordability: Essential Health Benefits and Subsidizing the Coverage of High-Risk Patients
- 05 Reaffirmation of AMA Policy Opposing Caps on Federal Medicaid Funding

Joint Report(s)

- CMS/CSAPH 01* Payment and Coverage for Genetic/Genomic Precision Medicine

Resolution(s)

- 801 Chronic Care Management Payment for Patients Also on Home Health
- 802 Opposition to Medicaid Work Requirements
- 803 Air Ambulance Regulations and Reimbursements
- 804 Prior Authorization
- 805 A Dual System for Universal Health Care in the United States
- 806 Mandate Transparency by Pharmacy Benefit Managers
- 807 Structural Barriers to Achieving Better Health Care Efficiency and Outcomes: ACOs and Physician Employment by Hospitals
- 808 Opposition to Reduced Payment for the 25 Modifier
- 809 Expansion of Network Adequacy Policy
- 810 Pharmacy Benefit Managers and Prescription Drug Affordability
- 811 Update OBRA Nursing Facility Preadmission Screening Requirements
- 812 Medicare Coverage of Services Provided by Proctored Medical Students
- 813 Sustain Patient-Centered Medical Home Practices
- 814* Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-Related Impairments
- 815* Pediatric Representation for E/M Documentation Guideline Revision
- 816* Social Determinants of Health in Payment Models
- 817* Addressing the Site of Service Differential
- 818* On-Call and Emergency Services Pay
- 819* Consultation Codes and Private Payers
- 820* Elimination of the Laboratory 14-Day Rules Under Medicare
- 821* Hormonal Contraception as a Preventive Service
- 822# Elimination of All Cost-Sharing for Screening Colonoscopies
- 823# Unconscionable Generic Drug Pricing
- 824# Payment for Dementia Treatment in Hospitals and Other Psychiatric Facilities
- 825# Support for VA Health Services for Women Veterans
- 826# Improving Affordability of Insulin
- 827# Hospital Accreditation Programs and Medical Staffs

* included in the Handbook Addendum

included in Sunday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 822
(I-17)

Introduced by: Georgia

Subject: Elimination of All Cost-Sharing for Screening Colonoscopies

Referred to: Reference Committee J
(Peter C. Amadio, MD, Chair)

- 1 Whereas, Colorectal cancer is the third most common cancer diagnosed in both men and
2 women in the U.S., and the third-leading cause of cancer death in the state of Georgia; and
3
4 Whereas, Colorectal cancer is preventable and highly curable when found early; however about
5 one in three adults still do not receive their recommended screenings; and
6
7 Whereas, Patients are more likely to complete colorectal screening when presented with options
8 on the different screening modalities, including stool-based tests, by their health professionals;
9 and
10
11 Whereas, Colorectal cancer screening has received an A rating from the USPSTF and is a
12 covered benefit under the Affordable Care Act (ACA); and
13
14 Whereas, Despite this benefit, patients still can be unexpectedly burdened by cost-sharing for a
15 screening colonoscopy under three different scenarios: 1) when a polyp is detected and
16 removed during a screening colonoscopy (in Medicare and “grandfathered” plans only), 2) when
17 a colonoscopy is not classified as part of the screening continuum following a positive stool
18 blood test, and 3) for patients with an increased risk and who require more frequent or early
19 screening intervals (this applies to patients under 50 with an increased risk and or are over 50
20 and require more frequent intervals of screening); and
21
22 Whereas, National and state organizations and agencies, including the National Colorectal
23 Cancer Roundtable (NCCRT) and the Georgia Office of Insurance and Safety Fire
24 Commissioner have issued policy briefings and directives outlining the number of benefits for
25 health professionals, health plans, and patients when all cost-sharing is removed; and
26
27 Whereas, While the Medical Association of Georgia (MAG), the American College of Physicians
28 (ACP), Georgia Chapter, and the Georgia Colorectal Cancer Roundtable (GCCRT),
29 acknowledge the health insurance companies, including those with both commercial and
30 Medicare Advantage products lines, who have adopted policies that reduce cost-sharing that
31 result from screening colonoscopies, ambiguity still exists regarding which situations will result
32 in out of pocket expenses; and
33
34 Whereas, 75 percent of individuals who are not screened do have health insurance coverage,
35 yet cite cost concerns as their primary reason for not being screened as shown in a national
36 survey conducted by the Henry J. Kaiser Family Foundation where 20 percent of individuals
37 cited they “postponed” preventive services due to cost; and

1 Whereas, The elimination of all cost-sharing for screening colonoscopies would contribute to
2 reaching the 80 percent by 2018 goal in Georgia, preventing 468 premature deaths per year;
3 therefore be it
4

5 RESOLVED, That the American Medical Association develop model national policy that
6 supports the voluntarily removal of all cost-sharing associated with screening colonoscopies in
7 all commercial and Medicare Advantage product lines and advocates for the adoption of these
8 policies nationwide. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000.

Received: 10/24/17

RELEVANT AMA POLICY

Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans H-185.960

Our AMA supports health plan coverage for the full range of colorectal cancer screening tests. Res. 726, I-04; Reaffirmation I-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: Res. 123, A-17

Support for Coverage of the Consultation by a Physician Prior to Screening Colonoscopy D-330.950

Our AMA will support coverage under Medicare benefits for the consultation in advance of the procedure by a physician to evaluate the patient and discuss the need for screening, risks and benefits and preparation for colonoscopy.

Res. 721, I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 823
(I-17)

Introduced by: Georgia
Subject: Unconscionable Generic Drug Pricing
Referred to: Reference Committee J
(Peter C. Amadio, MD, Chair)

1 Whereas, Recent dramatic price increases on off-patent prescription medications have affected
2 patient access to essential medications; and
3

4 Whereas, Some examples include:
5 – Doxycycline increased from \$20 to \$1849 per 500 pills
6 – Albuterol increased by 4000%
7 – Naloxone increased by 600%
8 – Hydroxyprogesterone increased from \$200 to \$30,000 per pregnancy; and
9

10 Whereas, There have been efforts by multiple companies to engage in monopolistic practices
11 that lead to price gouging on these older off-patent medications; and
12

13 Whereas, Legislation to prohibit price gouging could provide relief to patients who are suffering
14 from lack of access to their formerly inexpensive medications; and
15

16 Whereas, The Maryland General Assembly recently passed legislation that allows the attorney
17 general to prosecute companies that engage in price increases in noncompetitive markets on
18 these medications if these increases meet the legal definition of unconscionable; and
19

20 Whereas, The Maryland legislation could serve as a model for price relief in Georgia; now
21 therefore be it
22

23 RESOLVED, That our American Medical Association advocate for national legislation that will
24 prohibit price gouging on off-patent medications where there are fewer than three manufacturers
25 and where there have been no external factors to justify the price increase (New HOD Policy);
26 and be it further
27

28 RESOLVED, That our AMA report back at the 2018 Annual Meeting on the results of the *AMA*
29 *Truth in Rx Campaign* designed to bring attention to the rising prices of prescription drugs and
30 the status of any proposed legislation on drug pricing transparency, price gouging, and
31 expedited review of generic drug applications as called for in AMA Policy H-110.987. (Directive
32 to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 10/24/17

RELEVANT AMA POLICY

Pharmaceutical Cost H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.

CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17

Cost of Prescription Drugs H-110.997

Our AMA:

- (1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;
- (2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;
- (3) encourages physicians to stay informed about the availability and therapeutic efficacy of

generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;

(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;

(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;

(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and

(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep.3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of: Res. 207, A-17

Maximum Allowable Cost of Prescription Medications H-155.962

Our AMA opposes the use of price controls in any segment of the health care industry, and continues to promote market-based strategies to achieve access to and affordability of health care goods and services.

CMS Rep. 2, A-07; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed: CMS Res. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 824
(I-17)

Introduced by: Georgia

Subject: Payment for Dementia Treatment in Hospitals and Other
Psychiatric Facilities

Referred to: Reference Committee J
(Peter C. Amadio, MD, Chair)

- 1 Whereas, Dementing illnesses including Alzheimer’s disease, Lewy body dementia, vascular
2 dementia and others often present with behavioral symptoms, including agitation, wandering,
3 delusions, hallucinations and depression; and
4
5 Whereas, Dementing illnesses are increasingly an expensive and urgent cause of
6 hospitalizations; and
7
8 Whereas, These symptoms will prompt emergency room physicians, neurologists, primary care
9 physicians, families and others to refer these patients to psychiatric facilities for evaluation and
10 treatment; and
11
12 Whereas, These patients with such symptoms cannot be managed in general medical hospital
13 environments which do not have controlled access units or trained behavioral health personnel;
14 and
15
16 Whereas, It requires trained psychiatric physicians to be able to distinguish which symptoms
17 may be due to dementia versus other psychiatric illness, and to manage the medications and
18 interventions necessary to safely improve a patient’s condition; and
19
20 Whereas, The Diagnostic and Statistical Manual of Psychiatric Illnesses lists the various
21 dementias as illnesses treated by psychiatric physicians; and
22
23 Whereas, The Centers for Medicare and Medicaid Services currently denies reimbursement for
24 treatment of people with dementias treated in a psychiatric facility when it is a primary
25 diagnosis; therefore be it
26
27 RESOLVED, That our American Medical Association urgently convene a task force with all
28 interested stakeholders to promote appropriate payment by the Centers for Medicare and
29 Medicaid Services and other third-party payers for treatment for all types of dementias when
30 patients are treated in a Joint Commission accredited facility, whether a free-standing or part of
31 a general medical facility, even when dementia is the primary diagnosis for admission. (Directive
32 to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 10/24/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 825
(I-17)

Introduced by: Pennsylvania

Subject: Support for VA Health Services for Women Veterans

Referred to: Reference Committee J
(Peter C. Amadio, MD, Chair)

1 Whereas, The active component of the Armed Forces is now 14 percent female and the reserve
2 component is 18 percent female who, as they transition into veteran status, are now making up
3 the fastest growing cohort within the veteran community¹; and
4

5 Whereas, By 2020, women will comprise nearly 11% of the total veteran population^{1,2}; and
6

7 Whereas, Over the last decade alone, the number of women veterans using Veteran Affairs
8 (VA) health care has nearly doubled^{1,2}; and
9

10 Whereas, The National Survey of Women Veterans reports that about 40% of women veterans
11 who served in the recent conflicts in Iraq and Afghanistan incorrectly believe that only those with
12 service connected disability are eligible for VA health care²; and
13

14 Whereas, A 2014 membership survey of Iraq and Afghanistan Veterans of America (IAVA)
15 found that only 58% of women veterans reported being contacted by the Veteran's Affairs health
16 care or seeing VA advertisements about women's eligibility for VA services and benefits³; and
17

18 Whereas, Cross-sectional analysis of data provided by 286 female veterans of Operation Iraqi
19 Freedom and/or Operation Enduring Freedom found that 76% of women veterans who were
20 prescribed drugs by VA health care providers had not been warned about risks of medication-
21 induced birth defects⁴; and
22

23 Whereas, The Study of Barriers for Women Veterans to VA Health Care Final Report published
24 by the VA found that 19% of women veterans who utilize VA health care services reported
25 avoiding the VA because of past sexual trauma, citing the historically male dominated culture
26 and patient base in VA facilities as a factor^{5,6}; and
27

28 Whereas, Only 30% of facilities provided Substance Use Disorder (SUD) women specific
29 groups, and only 14% provided women specific SUD-Posttraumatic Stress Disorder groups⁷;
30 and

¹ VA Women Veterans Task Force. 2012 report. "Strategies for Serving Our Women Veterans."

² Friedman SA, Phibbs CS, Schmitt SK, Hayes PM, Herrera L, Frayne SM, *New Women Veterans in the VHA: A Longitudinal Profile*, Womens Health Issues. 2011

³ IAVA (2014) Fulfill the promise to today's veterans: 2014 policy agenda. Retrieved from <http://media.iava.org/policy-agenda-2015.pdf>

⁴ Schwarz, E.B., Mattocks, K., Brandt, C., Borrero, S., Zephyrin, L.C., Bathulapalli, H., & Haskell, S. *Counseling of Female Veterans about Risks of Medication-Induced Birth Defects*. Journal of General Internal Medicine 2013.

⁵ Study of Barriers for Women Veterans to VA Health Care Final Report. www.va.gov/vetdata. Web. April 2015

⁶ Kehle-Forbes, S.M., Harwood, E.M., Spont, M.R., Sayer, N.A., Gerould, H., & Murdoch, M. *Experiences with VHA care: a qualitative study of U.S. women veterans with self-reported trauma histories*. BMC Women's Health 2017.

⁷ Timko, C., Hoggatt, K.J., Wu, F.M., Tjemsland, A., Cucciari, M., Rubin, A., & Simpson, T.L. *Substance Use Disorder Treatment Services for Women in the Veterans Health Administration*. Women's Health Issues. 2017 1-7.

1 Whereas, Women veterans with a history of military sexual assault and/or posttraumatic stress
2 symptomatology perceive that they are not receiving the same quality of care as male
3 veterans^{4,8}; and

4
5 Whereas, Only 58% of VA sites offer gynecological services and, of those, only 25% offer
6 infertility treatment^{9,10}; and

7
8 Whereas, In a study of women veterans who reported using the VA system, 72% indicate that
9 they do not utilize the nearest VA facility for primary care, with the most common reason being
10 “the women’s services I need are not available [at the facility]”¹¹; therefore be it

11
12 RESOLVED, That the American Medical Association recognize the disparity in access to care
13 for women veterans (New HOD Policy); and be it further

14
15 RESOLVED, That our AMA encourage research to address this population’s specific needs to
16 improve patient outcomes. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 10/20/17

⁸ Ziobrowski H, Sartor CE, Tsai J, Pietrzak RH., *Gender differences in mental and physical health conditions in U.S. veterans: Results from the National Health and Resilience in Veterans Study*. J Psychosom Res. 2017

⁹ Seelig MD, Yano EM, Bean-Mayberry B, Lanto AB, Washington DL. *Availability of gynecologic services in the Department of Veterans Affairs*. Women’s Health Issues. 2008;

¹⁰ Mattocks, Kristin et al. “Infertility Care Among OEF/OIF/OND Women Veterans in the Department of Veterans Affairs.” *Medical care*: S68–S75. *PMC*. Web. 6 Sept. 2017.

¹¹ National Center for Veterans Analysis and Statistics. *America’s Women Veterans: Military Service History and VA Benefit Utilization Statistics*.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 826
(I-17)

Introduced by: American Association of Clinical Endocrinologists
Endocrine Society

Subject: Improving Affordability of Insulin

Referred to: Reference Committee J
(Peter C. Amadio, MD, Chair)

-
- 1 Whereas, The number of people in the United States with diabetes is increasing at an alarming
2 rate; 30 million currently have Type 1 or Type 2 diabetes and it is estimated that 1 in 3
3 Americans will have diabetes by 2050; and
4
- 5 Whereas, Of these 30 million Americans, 8.4 million use insulin to effectively manage the
6 disease; and
7
- 8 Whereas, For people with Type 1 diabetes, insulin must be administered daily to prevent death; and
9
- 10 Whereas, Insulin is frequently prescribed to people with Type 2 diabetes when other
11 medications have been unsuccessful at controlling blood glucose levels; and
12
- 13 Whereas, People with diabetes must adhere to their treatment plan to prevent complications
14 such as blindness, cardiovascular disease, end-stage kidney disease, or amputations; and
15
- 16 Whereas, The cost of insulin is prohibitive for many people; insulin costs have more than tripled
17 between 2002 and 2013, from \$231 to \$736 per vial; and
18
- 19 Whereas, An increase in high-deductible health plans further magnifies the impact of the rising
20 cost of insulin on people with diabetes as they are required to pay the full price of their
21 medication until a deductible of at least \$1,300 is met; and
22
- 23 Whereas, Research found that adherence falls for people on basal insulin when they are required to
24 pay more than \$75 and for people on rapid-acting insulin when they must pay more than \$40; and
25
- 26 Whereas, The increase in price can likely be attributed to a number of factors across the supply
27 chain, which includes pharmaceutical manufacturers, pharmacy benefits managers, and
28 insurance companies; and
29
- 30 Whereas, A lack of transparency about how prices are set, and rebates and discounts are
31 applied, makes it difficult for a patient and their physician to make an informed decision on
32 which insulin product is right for the patient; and
33
- 34 Whereas, Medicare, Medicaid, and private insurers' formularies can change multiple times
35 throughout a plan year based on a decrease or increase in cost resulting in a change of covered
36 insulin products. Non-medical switching of insulin is disruptive to a patient's care plan, creates
37 confusion and necessitates additional office visits; therefore be it

- 1 RESOLVED, That our American Medical Association work with relevant medical specialty
2 societies to convene a summit with participation by patients, clinicians, manufacturers, PBMs,
3 insurers and the appropriate federal representatives to highlight the dramatic increase in insulin
4 costs and identify potential solutions (Directive to Take Action); and be it further
5
6 RESOLVED, That our AMA pursue solutions to reduce patient cost-sharing for insulin and
7 ensure patients benefit from rebates at the point of sale (Directive to Take Action); and be it
8 further
9
10 RESOLVED, That our AMA work with health insurance companies and federal agencies to
11 stabilize drug formularies and reduce non-medical switching by encouraging plans to cover
12 insulin products at the same cost listed on a drug formulary throughout the entire plan year
13 (Directive to Take Action); and be it further
14
15 RESOLVED, That our AMA encourage insulin price and cost transparency among
16 pharmaceutical companies, pharmacy benefit managers and health insurance companies (New
17 HOD Policy); and be it further
18
19 RESOLVED, That our AMA work with electronic medical record vendors and insurance
20 companies to integrate current formularies and price information into all systems so physicians
21 and patients can make informed decisions on insulin products to reduce cost burdens on
22 patients. (Directive to Take Action)

Fiscal Note: Estimated cost of \$17,000 to implement resolution.

Received: 10/31/17

RELEVANT AMA POLICY

Pharmaceutical Cost H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.

CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17

[See also: Drug Formularies and Therapeutic Interchange H-125.991](#)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 827
(I-17)

Introduced by: Organized Medical Staff Section

Subject: Hospital Accreditation Programs and Medical Staffs

Referred to: Reference Committee J
(Peter C. Amadio, MD, Chair)

1 Whereas, Historically, The Joint Commission and the Healthcare Facilities Accreditation
2 Program (HFAP) were the primary accreditation programs authorized by CMS to survey
3 hospitals for compliance with the Medicare Conditions of Participation (CoPs); and
4
5 Whereas, In 2008 and 2013, respectively, Det Norske Veritas Healthcare, Inc. (DNV) and the
6 Center for Improvement in Healthcare Quality (CIHQ) were also authorized by CMS to survey
7 hospitals for compliance with the CoPs; and
8
9 Whereas, The option to choose among these and other accreditation options may offer
10 hospitals the opportunity and flexibility to tailor their quality systems and develop programs
11 focused on specific needs; and
12
13 Whereas, However, these accrediting bodies also offer noticeably different approaches to
14 deemed status—for example, DNV doesn't supplement the CoPs with any additional patient care
15 standards or patient safety goals; and
16
17 Whereas, Despite varying accreditation standards, meeting any regulatory agency's
18 expectations will continue to require strong medical staff and hospital leadership to integrate
19 compliance with the basics of safe, quality care into the hospital's strategic priorities; therefore
20 be it
21
22 RESOLVED, That our American Medical Association engage accrediting organizations to
23 ensure that their hospital accreditation standards acknowledge the medical staff's essential role
24 in the provision of high quality care, and otherwise appropriately position the medical staff to
25 fulfill its responsibility to provide leadership and work collaboratively with the health care
26 organization's administration and governing body to continuously improve patient care and
27 outcomes. (Directive to Take Action)

Fiscal Note: Modest – Between \$1,000 and \$5,000

Received: 11/11/2017

Reference Committee K

CME Report(s)

01* Promoting and Reaffirming Domestic Medical School Clerkship Education

CSAPH Report(s)

01 Universal Color Scheme for Respiratory Inhalers

02 Targeted Education to Increase Organ Donation

03 Neuropathic Pain as a Disease

04 National Drug Shortages Update

05* Clinical Implications and Policy Considerations of Cannabis Use

Resolution(s)

901 Harmful Effects of Screen Time in Children

902 Expanding Expedited Partner Therapy to Treat Trichomoniasis

903 Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals

904 Educating Physicians About the Importance of Cervical Cancer Screening for Female-to-Male Transgender Patients

905 Addressing Social Media Usage and its Negative Impacts on Mental Health

906 Opioid Abuse in Breastfeeding Mothers

907 Addressing Healthcare Needs of Foster Children

908 Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability

909 Expanding Naloxone Programs

910 Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination

911* State Maternal Mortality Review Committees

912* Corrective Statements Ordered to be Published by Tobacco Companies for the Violation of the Racketeer Influenced and Corrupt Organizations Act

913* Increased Death Rate and Decreased Life Expectancy in the United States

914* Support of Training, Ongoing Education, and Consultation in Order to Reduce the Health Impact of Pediatric Environmental Chemical Exposures

915# Easing Barriers to Medical Research on Marijuana Derivatives

916# Hospital Disaster Plans and Medical Staffs

952 Implicit Bias, Diversity and Inclusion in Medical Education and Residency Training

953 Fees for Taking Maintenance of Certification Examination

954 Developing Physician Led Public Health / Population Health Capacity in Rural Communities

955 Minimization of Bias in the Electronic Residency Application Service Residency Application

956 House Physicians Category

957 Standardization of Family Planning Training Opportunities in OB-BYN Residencies

958 Sex and Gender Based Medicine in Clinical Education

959* Lifestyle Medicine Education in Medical School Training and Practice

960# Medical Student Involvement and Validation of the Standardized Video Interview Implementation

* included in the Handbook Addendum

included in Sunday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 915
(I-17)

Introduced by: Georgia

Subject: Easing Barriers to Medical Research on Marijuana Derivatives

Referred to: Reference Committee K
(L. Samuel Wann, MD, Chair)

- 1 Whereas, Legislative efforts will continue to be made to expand the legalization of medical
2 cannabis; and
3
- 4 Whereas, Legislators or voters should not decide what medical conditions should be treated by
5 a non-standardized, un-tested, un-dosed drug, namely artisanal THC Oil and related marijuana
6 products, and then base treatment on non-scientific anecdotal information; and
7
- 8 Whereas, A superior approach to the medical use of the chemical components of marijuana is
9 currently before the U.S. Congress urging easing of some of the barriers to medical research to
10 identify new medicines proven safe and effective in clinical trials and approved by the FDA; and
11
- 12 Whereas, The following medical associations oppose the use of artisanal medical cannabis:
13 American Academy of Pediatrics, American Cancer Society, American College of Physicians,
14 American Academy of Neurology, American Epilepsy Society, American Glaucoma Foundation,
15 American Medical Association, American Psychiatric Association, American Society of Addiction
16 Medicine, Georgia Society of Addiction Medicine, National Eye Institute, National Institutes of
17 Health, and the National Multiple Sclerosis Society, and many more; and
18
- 19 Whereas, THC has been contraindicated for use in treatment of conditions of children in studies
20 by Children’s Hospital Colorado, Boston Children’s Hospital, Harvard Medical School and Duke
21 University; and
22
- 23 Whereas, Physicians in many states do not need to possess a DEA license to certify patients for
24 marijuana; and
25
- 26 Whereas, Calling marijuana “medical cannabis” or “low THC oil” does not alter its psychoactive,
27 neurotoxic, and addictive effects. Marijuana at THC levels of 3 percent, 4 percent, or 5 percent
28 has resulted in hundreds of thousands of Americans experiencing cannabis use dependence
29 since the 1980s; and
30
- 31 Whereas, Fatal road crashes involving marijuana doubled in Washington state between 2013
32 and 2014 following recreational legalization there (AAA Foundation for Safety, 2016) and
33 increased by 51 percent in Colorado between 2012 and 2015 (Colorado HIDTA, Supplement to
34 the Legalization of Marijuana in Colorado: The Impact, 2016); therefore be it
35
- 36 **RESOLVED**, That our American Medical Association work with the National Institutes of Health
37 to advocate for easing the barriers to medical research regarding chemical components of
38 marijuana such as cannabidiol that show great promise. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 10/24/17

RELEVANT AMA POLICY

Cannabis for Medicinal Use H-95.952

(1) Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. (2) Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product. (3) Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support. (4) Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions.

CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01; Modified: CSAPH Rep. 3, I-09; Modified in lieu of Res. 902, I-10; Reaffirmed in lieu of Res. 523, A-11; Reaffirmed in lieu of Res. 202, I-12; Reaffirmed: CSAPH Rep. 2, I-13

Cannabis - Expanded AMA Advocacy D-95.976

1. Our AMA will educate the media and legislators as to the health effects of cannabis use as elucidated in CSAPH Report 2, I-13, A Contemporary View of National Drug Control Policy, and CSAPH Report 3, I-09, Use of Cannabis for Medicinal Purposes, and as additional scientific evidence becomes available.
2. Our AMA urges legislatures to delay initiating full legalization of any cannabis product until further research is completed on the public health, medical, economic and social consequences of use of cannabis and, instead, support the expansion of such research.
3. Our AMA will also increase its efforts to educate the press, legislators and the public regarding its policy position that stresses a "public health", as contrasted with a "criminal," approach to cannabis.
4. Our AMA shall encourage model legislation that would require placing the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States."

Res 213, I-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 916
(I-17)

Introduced by: Organized Medical Staff Section
Subject: Hospital Disaster Plans and Medical Staffs
Referred to: Reference Committee K
(L. Samuel Wann, MD, Chair)

1 Whereas, Hospitals are required by laws, regulations and accreditation requirements to plan for
2 natural and other disasters; and
3
4 Whereas, These plans require extensive involvement from medical staff physicians, who have
5 an individual and collective obligation to provide urgent medical care during such disasters
6 (AMA Ethical Opinion 8.3); and
7
8 Whereas, However, research has shown that medical staffs are often confronted with numerous
9 barriers that impact their ability and willingness to report to work during and following natural
10 and other disasters; and
11
12 Whereas, Factors shown to influence staff decisions to report include perceived emergency
13 preparedness of the organization, perceived importance of one's role during a disaster, the
14 strength of an individual's sense of professional duty—even prior experience with disasters has
15 been shown to influence hospital evacuation and disaster response decisions; and
16
17 Whereas, The ability to address these barriers in advance allows hospitals to better plan and
18 prepare for predictable problems and increase the likelihood of being able to ensure adequate
19 staffing to provide timely access to care following a natural or other disaster; therefore be it
20
21 **RESOLVED**, That our American Medical Association: (1) work with appropriate stakeholders to
22 examine the barriers and facilitators that medical staffs encounter following a natural or other
23 disaster; and (2) encourage hospitals to incorporate, within their hospital disaster plans,
24 workplace and personal preparedness efforts that reduce barriers to staff response during a
25 natural or other disaster, both within their institutions and across the community. (Directive to
26 Take Action)

Fiscal Note: Moderate – Between \$5,000 and \$10,000

Received: 11/11/2017

RELEVANT AMA POLICY

H-130.946 AMA Leadership in the Medical Response to Terrorism and Other Disasters

Our AMA: (1) Condemns terrorism in all its forms and provide leadership in coordinating efforts to improve the medical and public health response to terrorism and other disasters.
(2) Will work collaboratively with the Federation in the development, dissemination, and evaluation of a national education and training initiative, called the National Disaster Life Support Program, to provide physicians, medical students, other health professionals, and other emergency responders with a fundamental understanding and working knowledge of their integrated roles and responsibilities in disaster management and response efforts.

(3) Will join in working with the Department of Homeland Security, the Department of Health and Human Services, the Department of Defense, the Federal Emergency Management Agency, and other appropriate federal agencies; state, local, and medical specialty societies; other health care associations; and private foundations to (a) ensure adequate resources, supplies, and training to enhance the medical and public health response to terrorism and other disasters; (b) develop a comprehensive strategy to assure surge capacity to address mass casualty care; (c) implement communications strategies to inform health care professionals and the public about a terrorist attack or other major disaster, including local information on available medical and mental health services; (d) convene local and regional workshops to share "best practices" and "lessons learned" from disaster planning and response activities; (e) organize annual symposia to share new scientific knowledge and information for enhancing the medical and public health response to terrorism and other disasters; and (f) develop joint educational programs to enhance clinical collaboration and increase physician knowledge of the diagnosis and treatment of depression, anxiety, and post traumatic stress disorders associated with exposure to disaster, tragedy, and trauma.

(4) Believes all physicians should (a) be alert to the occurrence of unexplained illness and death in the community; (b) be knowledgeable of disease surveillance and control capabilities for responding to unusual clusters of diseases, symptoms, or presentations; (c) be knowledgeable of procedures used to collect patient information for surveillance as well as the rationale and procedures for reporting patients and patient information; (d) be familiar with the clinical manifestations, diagnostic techniques, isolation precautions, decontamination protocols, and chemotherapy/prophylaxis of chemical, biological, and radioactive agents likely to be used in a terrorist attack; (e) utilize appropriate procedures to prevent exposure to themselves and others; (f) prescribe treatment plans that may include management of psychological and physical trauma; (g) understand the essentials of risk communication so that they can communicate clearly and nonthreateningly with patients, their families, and the media about issues such as exposure risks and potential preventive measures (e.g., smallpox vaccination); and (h) understand the role of the public health, emergency medical services, emergency management, and incident management systems in disaster response and the individual health professional's role in these systems.

(5) Believes that physicians and other health professionals who have direct involvement in a mass casualty event should be knowledgeable of public health interventions that must be considered following the onset of a disaster including: (a) quarantine and other movement restriction options; (b) mass immunization/chemoprophylaxis; (c) mass triage; (d) public education about preventing or reducing exposures; (e) environmental decontamination and sanitation; (f) public health laws; and (g) state and federal resources that contribute to emergency management and response at the local level.

(6) Believes that physicians and other health professionals should be knowledgeable of ethical and legal issues and disaster response. These include: (a) their professional responsibility to treat victims (including those with potentially contagious conditions); (b) their rights and responsibilities to protect themselves from harm; (c) issues surrounding their responsibilities and rights as volunteers, and (d) associated liability issues.

(7) Believes physicians and medical societies should participate directly with state, local, and national public health, law enforcement, and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals, and practices in preparation for terrorism and other disasters.

(8) Urges Congress to appropriate funds to support research and development (a) to improve understanding of the epidemiology, pathogenesis, and treatment of diseases caused by potential bioweapon agents and the immune response to such agents; (b) for new and more effective vaccines, pharmaceuticals, and antidotes against biological and chemical weapons; (c) for enhancing the shelf life of existing vaccines, pharmaceuticals, and antidotes; and (d) for improving biological chemical, and radioactive agent detection and defense capabilities.

(BOT Rep. 26, I-01 Reaffirmed: BOT Rep. 3, I-02 Modified: CSA Rep. 1, I-03 Reaffirmed: CME Rep. 1, I-11 Reaffirmation A-15)

Ethical Opinion 8.3 Physicians' Responsibilities in Disaster Response & Preparedness

Whether at the national, regional, or local level, responses to disasters require extensive involvement from physicians individually and collectively. Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This obligation holds even in the face of greater than usual risks to physicians' own safety, health, or life.

However, the physician workforce is not an unlimited resource. Therefore, when providing care in a disaster with its inherent dangers, physicians also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future.

With respect to disaster, whether natural or manmade, individual physicians should:

- (a) Take appropriate advance measures, including acquiring and maintaining appropriate knowledge and skills to ensure they are able to provide medical services when needed.

Collectively, physicians should:

- (b) Provide medical expertise and work with others to develop public health policies that:
 - (i) are designed to improve the effectiveness and availability of medical services during a disaster;
 - (ii) are based on sound science;
 - (iii) are based on respect for patients.
- (c) Advocate for and participate in ethically sound research to inform policy decisions.

AMA Principles of Medical Ethics: V, VI, VII, VIII

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 960
(I-17)

Introduced by: Medical Student Section

Subject: Medical Student Involvement and Validation of the Standardized Video Interview Implementation

Referred to: Reference Committee K
(L. Samuel Wann, MD, Chair)

1 Whereas, The AMA has made it a high priority to “study how costs to students of medical
2 education can be reduced” (H-305.928); and
3

4 Whereas, The AMA has existing policy to “better inform applicants about the National
5 Residency Matching Program (NRMP) matching process”, “make recommendations for
6 improvements as the need arises,” and to “limit disparities within the residency application
7 process” (D-310.977), but no similar regarding the Electronic Residency Application System
8 (ERAS); and
9

10 Whereas, Beginning in 2017, the Association of American Medical Colleges (AAMC)
11 implemented a mandatory Standardized Video Interview (SVI) for students applying to
12 emergency medicine residency programs through the private company HireVue; and
13

14 Whereas, The SVI is designed to evaluate professionalism and interpersonal/communication
15 skills through video-based responses to questions that are numerically scored by third-
16 party independent professional raters at HireVue;¹ and
17

18 Whereas, The SVI is limited to interaction with a computer where questions are displayed for 30
19 seconds and followed by a maximum 3-minute response period;¹ and
20

21 Whereas, The AAMC has proposed expansion of the SVI program to applicants of various
22 specialties beginning in 2018; and
23

24 Whereas, The AAMC has not provided any data to support its claim that the SVI fulfills students'
25 desire for the application to be holistically reviewed;² and
26

27 Whereas, The AAMC is unable to show that the costs related to the SVI and HireVue will not be
28 passed on to medical students as the program is expanded past this year;¹ and
29

30 Whereas, The AAMC reports that it is expected that the process of human-review would likely
31 be replaced by computer-based analysis should the SVI expand to other specialties;¹ and
32

33 Whereas, Neither the AAMC nor HireVue has demonstrated that computer-based analysis of
34 video-responses is non-inferior to human rating; and
35

36 Whereas, The AMA has made it a high priority to “study how costs to students of medical
37 education can be reduced” (H-305.928); and

1 Whereas, The AMA has existing policy to “better inform applicants about the National
2 Residency Matching Program (NRMP) matching process”, “make recommendations for
3 improvements as the need arises,” and to “limit disparities within the residency application
4 process” (D-310.977), but no similar regarding the Electronic Residency Application System
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16 seconds and followed by a maximum 3-minute response period;¹ and
17

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19 specialties beginning in 2018;² and
20

21 Whereas, The AAMC has not provided any data to support its claim that the SVI fulfills students’
22 desire for the application to be holistically reviewed;² and
23

24 Whereas, The AAMC is unable to show that the costs related to the SVI and HireVue will not be
25 passed on to medical students as the program is expanded past this year;¹ and
26

27 Whereas, The AAMC reports that it is expected that the process of human-review would likely
28 be replaced by computer-based analysis should the SVI expand to other specialties;¹ and
29

30 Whereas, Neither the AAMC nor HireVue has demonstrated that computer-based analysis of
31 video-responses is non-inferior to human rating; and
32

33 Whereas, The AAMC reports that the research pilot showed that the SVI “measures something
34 different than academic competency,” but so far no correlations have been demonstrated between
35 SVI scores and residency placement, performance in residency, or performance in the target
36 competencies;² and
37

38 Whereas, Data from the research pilot indicates that there are racial/ ethnic disparities in the
39 scores on the SVI, with Hispanic and Asian interviewees scoring more poorly than white
40 interviewees;² and
41

42 Whereas, The AAMC has stated that the content-based rubrics according to which evaluators
43 will score student responses will not be provided to residency programs;³ and

¹ AAMC Standardized Video Interview Frequently Asked Questions. AAMC Students, Applicants and Residents. <https://students-residents.aamc.org/attending-medical-school/article/aamc-standardized-video-interview-faqs/>. Published April 3, 2017. Accessed September 4, 2017.

² AAMC Standardized Video Interview Update. https://aamc-orange.global.ssl.fastly.net/production/media/filer_public/c7/6f/c76f2e9f-ccd4-428e-9710-e9bdcea2a9d0/standardized_video_interview_summary_2017_gsa.pdf. Published May 2017.

³ Standardized Video Interview Update for Applicants Webinar. AAMC Students, Applicants and Residents. https://students-residents.aamc.org/video/svi-update-applicants-webinar/?edit_off. Published June 6, 2017. Accessed September 5, 2017.

1 Whereas, There is no data that SVI scores correlate with other measurements of
2 professionalism and interpersonal/communication as assessed by the Medical Student
3 Performance Evaluation (Dean's Letter), ACGME Milestones, or during in-person residency
4 interviews; and

5
6 Whereas, The AAMC has not announced any plans to release data from the operational pilot;²
7 and

8
9 Whereas, Medical students have not been invited to participate in the AAMC Emergency
10 Medicine Standardized Video Interview Working Group;² and

11
12 Whereas, It is in the interest of all stakeholders that the necessity, benefit, cost, and value of
13 new ERAS requirements be well understood and justified before being widely implemented;
14 therefore be it

15
16 RESOLVED, That our American Medical Association work with the Association of American
17 Medical Colleges and its partners to advocate for medical students and residents to be
18 recognized as equal stakeholders in any changes to the residency application process,
19 including any future working groups related to the residency application process (Directive to
20 Take Action); and be it further

21
22 RESOLVED, That the AMA advocate for delaying expansion of the Standardized Video
23 Interview until data demonstrates the Association of American Medical Colleges' stated goal of
24 predicting resident performance, and make timely recommendations regarding the efficacy and
25 implications of the Standardized Video Interview as a mandatory residency application
26 requirement. (New HOD Policy)

Fiscal Note: Modest – between \$1,000 - \$5,000.

Received: 11/11/17

RELEVANT AMA POLICY

[Proposed Revisions to AMA Policy on Medical Student Debt H-305.928](#)

[National Resident Matching Program Reform D-310.977](#)

[USMLE Scores not Sole Criteria for Residency Selection H-255.980](#)

[The Grading Policy for Medical Licensure Examinations H-275.953](#)

Informational Reports

BOT Report(s)

- 01 Redefining AMA's Position on ACA and Healthcare Reform
- 02 2017 AMA Advocacy Efforts
- 03 Removing Restrictions on Federal Funding for Firearms Violence Research
- 04 Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care
- 08 2018 Strategic Plan
- 09 Parental Leave
- 11* Anti-Harassment Policy
- 13# Certified Translation Services

CEJA Opinion(s)

- 01 Amendment to E-2.3.2, "Professionalism in Social Media"

CME Report(s)

- 02 A National Continuing Medical Education Repository
- 03* Impact of Immigration Barriers on the Nation's Health

Report of the Speakers

- 01 Recommendations for Policy Reconciliation

* included in the Handbook Addendum

included in Sunday Tote

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-I-17

Subject: Certified Translation and Interpreter Services

Presented by: Gerald E. Harmon, MD, Chair

1 At the 2017 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy
2 D-385.957, “Certified Translation and Interpreter Services,” which calls on our American Medical
3 Association (AMA) to “work to relieve the burden of the costs associated with the translation
4 services implemented under Section 1557 of the Affordable Care Act (ACA)” and “advocate for
5 legislative and/or regulatory changes to require that payers including Medicaid programs and
6 Medicaid managed care plans cover interpreter services and directly pay interpreters for such
7 services.” The policy also requires a progress report at the 2017 Interim Meeting of the AMA
8 HOD. This report serves to satisfy that aspect of the resolution as well as provide a brief overview
9 of the language access provisions of Section 1557.

10 11 BACKGROUND ON SECTION 1557

12
13 The U.S. Department of Health & Human Services (HHS) Office of Civil Rights (OCR) issued a
14 final rule implementing Section 1557 of the ACA in May 2016, which became effective in July
15 2016. Section 1557 makes it unlawful for any health care provider who receives funding from the
16 federal government to refuse to treat an individual—or to otherwise discriminate against the
17 individual—based on race, color, national origin, sex, age, or disability. It builds upon longstanding
18 nondiscrimination laws and provides some new civil rights protections. As such, many of the rule’s
19 provisions are familiar to physicians, while others may require physicians to implement new
20 policies and procedures. The rule applies to physicians and other entities receiving federal financial
21 assistance from HHS; however, it does not apply to physicians who participate only in Medicare
22 Part B.

23
24 Under Section 1557, a covered physician must take reasonable steps to provide meaningful access
25 to each individual with limited English proficiency (LEP) eligible to be served or likely to be
26 encountered in their practice. Covered physicians must provide language assistance services free of
27 charge, in an accurate and timely manner, and must protect the privacy and independence of the
28 individual with LEP. Required language assistance services include offering a qualified interpreter
29 to an individual with LEP for oral interpretation and a qualified translator when translating written
30 content in paper or electronic form. Specifically, covered physicians may not:

- 31
- 32 • Require an individual with LEP to provide his or her own interpreter;
 - 33 • Rely on an adult accompanying an individual with LEP to interpret, except:
 - 34 • In an emergency situation involving an imminent threat to the safety or welfare of an
35 individual or the public where there is no qualified interpreter for the individual with
36 LEP immediately available; or
 - 37 • Where the individual with LEP specifically requests that the accompanying adult
38 interpret or facilitate communication, the accompanying adult agrees to provide such
39 assistance, and reliance on that adult for such assistance is appropriate;

- 1 • Rely on a minor child to interpret or facilitate communication, except:
 - 2 • In an emergency involving an imminent threat to the safety or welfare of an individual or
 - 3 the public where there is no qualified interpreter for the individual with LEP immediately
 - 4 available;
- 5 • Rely on unqualified staff members to communicate with individuals with LEP; or
- 6 • Utilize poor-quality video interpreting services to provide language assistance services.

7 8 FEDERAL ADVOCACY EFFORTS

9
10 The AMA has taken a number of steps to educate physicians about Section 1557's language
11 translation and interpretation requirements, including the development of a fact sheet posted on the
12 AMA's website and a presentation by OCR leadership for members of the Federation. The AMA
13 has maintained a regular dialogue with OCR to relay that physicians often struggle with the costs
14 of language assistance services and asked for strategies we could provide to physicians to address
15 this concern. Based on OCR's responses, we incorporated some cost-sharing strategies into our
16 Section 1557 fact sheet—for example, a group of covered physicians could contract with a
17 telephonic translation service and pay for the services on a pro-rated basis, and covered physicians
18 may try to negotiate with translation service providers whether the provider must pay a charge in
19 the event that the patient is late or does not show up for his or her appointment.

20
21 Additionally, AMA members have reported to the AMA that individuals with LEP often bring
22 trusted adults with them to an appointment to facilitate communication. However, as noted above,
23 Section 1557 regulations state that a physician may rely on an adult accompanying an individual
24 with LEP to interpret or facilitate communication only if reliance on that adult for such assistance
25 is "appropriate under the circumstances." This standard remains unclear to physicians, causing
26 them to take on the additional burden and expense of interpreters out of an abundance of caution
27 when it may not be always necessary to do so. Accordingly, the AMA has spoken with OCR in
28 attempt to clarify the circumstances in which a physician may rely on an adult accompanying a
29 patient to interpret or facilitate communication. For example, when a physician sees an adult male
30 patient presenting with flu-like symptoms, who is accompanied by his brother, and the patient
31 requests that his brother translate, a physician may find this request appropriate under the
32 circumstances. Conversely, if a female patient presenting with a broken arm is accompanied by her
33 husband, the physician may have concerns about domestic abuse. In this case, it may be
34 inappropriate to rely on the husband to provide accurate interpretation services. The AMA intends
35 to draft a suggested "Frequently Asked Question" (FAQ) addressing this matter for OCR to post on
36 its website as a resource for physicians. While OCR cautioned that such a posting may not be
37 possible, the AMA will nevertheless urge OCR to issue guidance on this topic in light of the Trump
38 Administration's stated goals of physician burden reduction and regulatory relief.

39
40 Finally, in its comments on the proposed 2018 Medicare Physician Fee Schedule (PFS) and
41 Medicare Hospital Inpatient Prospective Payment Systems (IPPS) rules, the AMA included
42 information about the burden of providing language assistance services absent reimbursement for
43 such services. The AMA requested that the Centers for Medicare & Medicaid Services (CMS)
44 work with OCR to clarify the circumstances under which an adult accompanying an individual
45 with LEP may interpret or facilitate communication. The AMA submitted the same language to the
46 U.S. House of Representatives Committee on Ways and Means in response to its call for regulatory
47 and legislative relief requests, and to senior staff in the HHS Secretary's office and the White
48 House. The AMA will continue to pursue opportunities to advance this issue, including cost
49 burdens on physicians, both on Capitol Hill and within the administration.

1 OUTREACH TO STATES AND SPECIALTIES

2

3 From a state and specialty perspective, the AMA has recently reached out to the Federation of
4 Medicine to determine which, if any, state and specialty societies are interested in working on this
5 issue from a state regulatory perspective. Indiana, Vermont, the American Academy of
6 Otolaryngology–Head and Neck Surgery, and the American Academy of Orthopaedic Surgeons all
7 expressed interest. The AMA convened a call with the interested groups to discuss the scope of the
8 problem, the opportunities at both the federal and state levels, and potential resources and
9 collaborations. While some groups (e.g., Indiana) have had success in mandating coverage for
10 interpreters under their Medicaid managed care program, all groups agreed that broader coverage
11 was an uphill battle and not a top priority for them this year. It was determined that states would
12 collaborate with the AMA and specialty societies when an opportunity to advance the issue at the
13 state level arose, and model contract language from successful Medicaid Managed Care coverage
14 efforts was circulated along with additional AMA resources. The groups were also appreciative,
15 and interested in supporting, the AMA’s related request to CMS in its Medicare PFS and IPFS
16 comments.

17

18 CONCLUSION

19

20 The AMA will continue to identify opportunities to work with Congress and the administration to
21 implement Policy D-385.957, “Certified Translation and Interpreter Services.” The AMA will urge
22 OCR to issue guidance on the ways in which adults accompanying LEP patients may facilitate
23 communication, and will support the efforts of state and specialty societies to advance the issue at
24 the state level by providing model language for Medicaid Managed Care coverage and other needs
25 as identified by the societies.

Not for consideration

Resolutions not for consideration

- 212 Physician Identification
- 602 Creation of LGBTQ Health Specialty Section Council
- 603 A Guide for Best Health Practices for Seniors Living in Retirement Communities
- 951 Financial Protections for Doctors in Training

* included in the Handbook Addendum

included in Sunday Tote

Report of the AMPAC Board of Directors

Presented by: Vidya S. Kora, MD
Chair

On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates regarding our activities preparing for the 2018 Congressional Elections. Our mission is to provide physicians with a tangible means of advocating for organized medicine. On behalf of our physician members, AMPAC supports candidates who have demonstrated their support for organized medicine, including a willingness to work with physicians to strengthen our ability to care for America's patients. We work hand-in-hand with our state medical society PAC partners to carry out this mission. In addition, we strive to involve more physician advocates in our political education programs, which include intensive training sessions to give participants the tools necessary to successfully work on a campaign or run for office themselves.

AMPAC Membership Fundraising

In the 2016 election cycle, AMPAC raised nearly \$2.4 million dollars and played a significant role in influencing 2016 election outcomes. In total, AMPAC invested nearly \$2 million in the 2016 cycle and achieved a 91 percent success rate of supported candidates. As we head into the final stretch of the 2017 fundraising cycle, overall AMPAC has raised \$1,042,848. With the 2018 midterm elections well underway, it is critical that AMPAC's participation be at an all-time high in order to remain effective this election cycle.

After last year's record breaking year of HOD AMPAC participation, we are happy to report that participation for 2017 stands at 77 percent, surpassing last year's record. For those of you who contributed to AMPAC in 2017—thank you! Out of the 77 percent of HOD members that contribute to AMPAC, 63 percent participate at the Capitol Club level. HOD Capitol Club participation has 242 members including 25 Platinum members, 96 Gold members and 121 Silver members. If you have not made a 2017 contribution to AMPAC yet, we need your support now more than ever as we head into an important election year. I strongly encourage you to stop by the AMPAC booth today to join or renew your membership for 2018.

AMPAC is also excited to announce the winner of its 2017 Festival of Fall Colors Sweepstakes during the opening session of the House of Delegates. The winner will receive accommodations for 4 days/3 nights at Twin Farms Resort and Spa in Barnard, Vermont in September 2018. All 2017 Platinum, Gold and Silver contributors were automatically entered into the drawing for the sweepstakes.

Political Action

This year, health care was once again the focus of Capitol Hill and brought forward issues of keen interest to medicine. Votes and discussions on health system reform, MACRA, drug price transparency, and the ongoing opioid epidemic are highlighting the integral role the AMA and AMPAC have in helping to ensure medicine has a seat at the table. With these and other important issues in mind, we are preparing for another robust election cycle in 2018. AMPAC

has already made \$185,200 in political contributions so far this year. The AMPAC Board's Congressional Review Committee will soon be working to set a comprehensive budget for all House and Senate candidates running this cycle. Medicine-friendly candidates, lawmakers in positions of leadership or on committees that deal with medicine's top issues, in addition to those legislators who are otherwise in unique positions to favorably impact key legislation are our top priorities.

In a political landscape that seems increasingly volatile and uncertain, AMPAC is dedicated to remaining a reliable constant for medicine and continues to be involved with important U.S. House and Senate races all over the country.

Political Education Programs

Utilizing a new programmatic model, this year's two political education programs were an overwhelming success. In February, 22 physicians and medical students took part in the 2017 Candidate Workshop held in Washington, DC. During the one and a half day program, participants learned from a bi-partisan group of political experts how and when to make the decision to run; the importance of a disciplined campaign plan; the secrets of effective fundraising and what kinds of media advertising are right for your campaign. And the program has already had its first success story - I am pleased to report that one of those participants, Dr. Kay Kirkpatrick, won her special election race for Georgia state Senate.

More recently, on October 26-29, 21 physicians and medical students took part in AMPAC's 2017 Campaign School, held at the AMA's Washington, DC headquarters. Participants were provided a hands-on learning experience featuring political experts from both sides of the aisle providing expert instruction on how to run a winning campaign. Sessions included topics such as: crisis management, public speaking, social media utilization, and, in general, how to run a disciplined and effective campaign.

Both of these programs have received excellent feedback from the physicians who took part and building on that success, AMPAC is proud to announce the dates for the 2018 Candidate Workshop: March 2-4 at the AMA Washington, D.C. office. Running for political office can be an overwhelming task, and our team of political veterans gives participants expert advice about the nature of politics and the sacrifices needed to mount a competitive campaign. The AMPAC Candidate Workshop continues to be a valuable tool, equipping physicians to be successful in their campaigns.

For more information on any of the Political Education Programs please stop by the AMPAC and AMA Grassroots booths during this meeting, or visit ampaonline.org.

Conclusion

On behalf of the AMPAC Board of Directors, I would like to thank all members of the House of Delegates for your continued support of AMPAC. Your involvement in political and grassroots activities ensures organized medicine continues to have a powerful voice in Washington, DC.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Richard D. Baltz, MD

Introduced by Pennsylvania

Whereas, Richard D. Baltz, MD passed away on Sunday, December 11, 2016 at the age of 83; and

Whereas, Dr. Baltz faithfully served his fellow physician colleagues as President of the Dauphin County Pennsylvania Medical Society for two terms in 1985 and again in 1991, and was the only physician in the history of the society to do this; and

Whereas, Dr. Baltz was a member of the Pennsylvania Medical Society for 48 years, and also served on its Board of Trustees from October 16, 2005 until October 28, 2012, and participated numerous times as a delegate from the Dauphin County Medical Society to the Pennsylvania Medical Society House of Delegates and as a Delegate to the American Medical Association, helping to shape health policy at both the state and national levels; and

Whereas, Dr. Baltz was also a longstanding member of the American Academy of Pediatrics as well as its Pennsylvania Chapter; and

Whereas, Dr. Baltz's contributions to the health of his community were legion, including service as President of the Harrisburg Hospital Medical Staff, Director of Pediatrics at Polyclinic Hospital, Medical Director of Utilization Review for Harrisburg Hospital, Co-Chair of the Pennsylvania Bar Association/Pennsylvania Medical Society Task Force on Child Abuse and Neglect, consultant to the West Shore School District Nurse Practitioner Program, collaborator in the creation of a Central Pennsylvania clinic dedicated to treatment of persons afflicted with sickle cell disease, member of the Healthy Mothers Healthy Babies Fluoridation Coalition, consultant to the Pennsylvania Department of Public Welfare Bureau of Quality Review, Review Consultant for KePRO, member of the Pennsylvania Chapter American Academy of Pediatrics School Health Committee, and member of the American Academy of Pediatrics Committee on Quality Improvement; and

Whereas, Dr. Baltz honorably served his country as a Captain in the United States Air Force; and

Whereas, Dr. Baltz advanced the science of medicine with peer-reviewed publications by the American Cancer Society and the *Journal of Nuclear Medicine*; and

Whereas, Dr. Baltz shared his extensive medical wisdom with medical students and residents as Clinical Associate Professor of Pediatrics at Hershey Medical Center; and

Whereas, Dr. Baltz completed his internship and residency in the specialty of pediatrics at Harrisburg Hospital, completed a Fellowship at the Children's Hospital of Philadelphia, and went on to serve countless families in pediatric practice at Baltz and Fromme Pediatric Associates and then Pinnacle Health Children's Health Clinic; and

Whereas, Dr. Baltz is survived by his wife of more than 58 years, Alice (Turner) Baltz; a son, Richard E. Baltz and wife Janice of Burke, VA; a daughter, Karen B. Anderson and husband Dean of Camp Hill; five grandchildren: Matthew R. Baltz, Timothy M. Baltz, Allison M. Baltz, Erik R. Anderson, and Grant R. Anderson; and several nieces and nephews; and

Whereas, Dr. Baltz will long be remembered as a role model by his colleagues for his professional excellence, multiple medical accomplishments, superb teaching skills, extensive community service, and remarkable bonhomie; therefore be it

RESOLVED, That our American Medical Association House of Delegates observe a moment of silence, recognizing our appreciation for Dr. Baltz's many years of service to the medical community, his patients, and our county and state societies; and be it further

RESOLVED, That Dr. Baltz's memorial resolution be recorded in the minutes of the 2017 Interim Meeting of the AMA House of Delegates and a copy sent to his family, the Pennsylvania Medical Society and the Dauphin County Pennsylvania Medical Society.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Angelo S. Carrabba, MD

Introduced by Connecticut

Whereas, Family, friends, and colleagues were deeply saddened by the sudden passing of Angelo S. Carrabba, MD, on June 24, 2017; and

Whereas, Dr. Carrabba dedicated his life to the profession of medicine; and

Whereas, Dr. Carrabba was a prominent Obstetrician-Gynecologist in the greater Hartford, Connecticut area and was a valued member of the St. Francis Hospital & Medical Center where he practiced for over 35 years and where he served as a Board member and President of the medical staff, also serving as a mentor to many of the faculty and residents in the Department of Obstetrics and Gynecology; and

Whereas, Dr. Carrabba also served as the only two-term President of the Connecticut State Medical Society, as well as serving as a Board member and President of Hartford County Medical Association, and as a Board member and Secretary/Treasurer of MedServ of Connecticut, Inc.; and

Whereas, Dr. Carrabba was a dedicated delegate to the American Medical Association from 2005 to 2011 and served as President to the New England Delegation of the AMA; and

Whereas, He committed his time to helping other physicians in need of assistance in his role as President and Chairman of the Board of H.A.V.E.N. (Health Assistance interVention Education Network) and in prominent roles for several other charitable organizations; and

Whereas, Above all, Dr. Carrabba relished spending time with his family and his ten beloved grandchildren; and

WHEREAS. Dr. Carrabba's passing is a tremendous loss to his patients, his family and the medical community; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the tremendous contributions made by Angelo S. Carrabba, MD to the medical profession through his advocacy and commitment to his patients and to the medical community; and be it further

RESOLVED, That our American Medical Association House of Delegates express its condolences and sympathy to the family of Angelo S. Carrabba, MD, and present them with a copy of this resolution.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Donald C. Jones

Introduced by the American Association of Clinical Endocrinologists

Whereas, Donald Chapman Jones passed away peacefully on July 22, 2017, following a brief illness; and

Whereas, Mr. Jones dedicated more than 47 years of his professional career to managing organized medical associations, including the last 20 years as CEO of the American Association of Clinical Endocrinologists (AACE) until his retirement on May 7; and

Whereas, Mr. Jones previously served as Executive Director and CEO of the Florida Medical Association where he spent the first 29 years of his career, as well as on the Advisory Committee to the Executive Vice President of the American Medical Association (AMA) from 1983 to 1990, and as President of the American Association of Medical Society Executives (AAMSE) in 1989; and

Whereas, His leadership and commitment to ethical standards of management earned him the AMA Medical Executive Lifetime Achievement Award in 2001, as well as the immeasurable respect of his colleagues; and

Whereas, Mr. Jones demonstrated utmost pride and dedication in all facets of his work, family, and interests, including his love of American history, his commitment to tradition, and his tireless zeal as a self-described “workaholic”; and

Whereas, On January 15, 2009, Mr. Jones became a member of the fraternity of survivors when he was one of 155 people aboard the US Airways Flight 1549 that landed in the Hudson River in New York, known as the “Miracle on the Hudson”; and

Whereas, Mr. Jones will be greatly missed by his family, his colleagues at AACE, and the medical community; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the contributions made by Mr. Donald C. Jones to organized medicine and his dedication to the many medical professionals and colleagues with whom he worked, and be it further

RESOLVED, That our AMA extend its most heartfelt condolences to Mr. Jones' family, and present them with a copy of this resolution.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

William W. Lander, MD

Introduced by Pennsylvania

Whereas, William W. Lander MD, a well-known, respected and admired family physician who was dedicated to the human spirit and taking care of his patients, passed away on Friday, January 6; and

Whereas, Dr. Lander, an internist, served his patients, the community, and his profession with honor and diligence for more than 60 years; the medical community lost a pioneer in family medicine and a mainstay at Bryn Mawr Hospital (Montgomery County, PA); and

Whereas, Dr. Lander was an experienced and revered member of the organized medicine community, serving in a number of leadership roles that spanned several decades within Bryn Mawr Hospital, Montgomery County Medical Society (MCMS), Pennsylvania Medical Society (PAMED) and our American Medical Association (AMA); and

Whereas, Dr. Lander received his medical degree from the University of Pennsylvania in 1949 and served as a lieutenant in the U.S. Navy while stationed in the First Marine Division on the front line at the Chosin Reservoir during the Korean Conflict from 1950-1951; and

Whereas, Dr. Lander, following his internal medicine residency at Bryn Mawr Hospital, was a solo practitioner who maintained his office in Bryn Mawr, Pennsylvania from 1953 until his death; and

Whereas, Dr. Lander served as president of Bryn Mawr Hospital medical staff from 1979-1981 and served as head of Bryn Mawr Hospital's Family Medicine Service for 25 years; and

Whereas, Dr. Lander served in many roles within MCMS, PAMED and our AMA, including president of MCMS in 1990 and PAMED in 2005 and hospital representative to the AMA; and

Whereas, In June 2017, Dr. Lander was honored by his county medical society for his legacy by renaming its medical student scholarship award after him and created the William "Bill" Lander Excellence in Primary Care Award that recognizes a worthy Montgomery County primary care physician who embodied the legacy of Dr. William Lander; and

Whereas, Dr. Lander's primary love for compassionate treatment of his patients resulted in long hours in the office, frequent house calls and friendly greetings during hospital rounds at night; and

Whereas, Dr. Lander was an active and faithful member of the Church of the Good Shepherd in Rosemont, PA, where his father was a rector for 29 years; and

Whereas, Dr. Lander loved gardening, growing beautiful roses and hearty vegetables and listening to jazz; and

Whereas, Dr. Lander is survived by his three sons, Bill, David and John; 13 grandchildren and five great-grandchildren: and

Whereas, Dr. Lander's dedication to his profession, patients and many friends will be greatly missed; therefore be it

RESOLVED, That our American Medical Association House of Delegates observe a moment of silence, recognizing our appreciation for Dr. Lander's many years of service to the medical community, his patients, and our county and state societies; and be it further

RESOLVED, That Dr. Lander's memorial resolution be recorded in the minutes of the 2017 Interim Meeting of the AMA House of Delegates and a copy sent to his family, the Pennsylvania Medical Society and the Montgomery County Pennsylvania Medical Society.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Rajendra N. Seth, MD, FACC, FACP

Introduced by Pennsylvania

Whereas, Rajendra N. Seth, MD, FACC, FACP, passed away on Saturday, June 24, 2017 at his residence in Elkins Park, Philadelphia, PA, at the age of 78; and

Whereas, Dr. Seth was born and educated in India, receiving his MD from King George Medical College; a degree of Doctor of Medicine in Pathology and Bacteriology from the University of Lucknow, India; completed a Fellowship in Pathology at Philadelphia General Hospital; Residency in Internal Medicine at Episcopal Hospital, Philadelphia; and was Senior Fellow in Cardiology at Philadelphia General Hospital; Diplomate of the American Board of Internal Medicine; Board Certified in Cardiology and Vascular Diseases; and a Fellow of the American College of Physicians; and

Whereas, Dr. Seth was a dedicated member of the Philadelphia County Medical Society (PCMS), Pennsylvania Medical Society (PAMED), and American Medical Association (AMA); member of the PCMS Board of Directors; Delegate to PAMED and the AMA; and Chair of the PCMS and PAMED International Medical Graduates Sections, where he led the fight for the rights of all IMGs to practice medicine in the United States; and

Whereas, Dr. Seth played an integral role on the PCMS and PAMED Membership and Public Health Committees, where he raised awareness regarding the benefits of membership in organized medicine for medical students, resident/fellows, and physicians, recruiting hundreds of health care professionals to join PCMS, PAMED, and the AMA; and

Whereas, Dr. Seth was a proven leader in coordinating continuing medical education programs and lectured and served on numerous committees and councils around the world, including most recently the 11th World Congress on Clinical Preventive Cardiology and Imaging in Rajasthan, India and the 20th Asian Pacific Society of Cardiology Congress in Abu Dhabi; therefore be it

RESOLVED, That our American Medical Association House of Delegates observe a moment of silence, recognizing our appreciation for Dr. Seth's many years of service to the medical community, his patients, and our county and state societies; and be it further

RESOLVED, That Dr. Seth's memorial resolution be recorded in the minutes of the 2017 Interim Meeting of the AMA House of Delegates and a copy sent to his family, the International Medical Graduate's Section of the AMA, the Pennsylvania Medical Society and the Philadelphia County Pennsylvania Medical Society.