

MEMORIAL RESOLUTIONS
Adopted Unanimously

Doris Gorka Bartuska, MD
Introduced by Pennsylvania

Whereas, Doris Gorka Bartuska, MD, passed away Sunday, August 4, 2013 in Philadelphia (Pennsylvania) at the age of 84, or as she always stated, "39 and holding;" and was laid to rest in her birthplace of Nanticoke, PA; and

Whereas, Dr Bartuska graduated from Bucknell University in 1949 and received her medical degree from the Women's Medical College of Pennsylvania in 1954; and

Whereas, Dr Bartuska was president of The Philadelphia County Medical Society from 1988-1990; president of the American Medical Women's Association in 1988 and the Philadelphia Endocrine Society; was a founding board member of the American Association of Clinical Endocrinology and one of the first female voting members of our American Medical Association (AMA) House of Delegates; and

Whereas, Dr Bartuska was a loyal AMA member for her entire career as well as throughout her retirement; and

Whereas, Dr Bartuska spent her entire professional career in Philadelphia as a board-certified endocrinologist at Women's Medical College, and later the Medical College of Pennsylvania and Drexel University College of Medicine, as Emeritus Professor of Medicine, she was Assistant and Associate Dean of Medicine at MCP and Director of the Division of Endocrinology, Diabetes and Metabolism as well as the Endocrine Fellowship Training Program at Drexel; and

Whereas, Dr Bartuska was the recipient of numerous awards including the Lindback Distinguished Teaching Award; the Pennsylvania Medical Society Distinguished Service Award; the Strittmatter Award for highest scientific achievement; Master of the American College of Endocrinology; Outstanding Educator of America Award; Distinguished Daughter of Pennsylvania; the Shaffrey Award from St. Joseph's University; Honorary Doctor of Science from Wilkes University; Alumni Achievement Award from Bucknell University; a NIH fellowship in molecular medicine; and

Whereas, Dr Bartuska shall be remembered for being proud of her Polish heritage; her kindness and compassionate patient care; her elegance and style (including her famous hats); her love of dance and her accomplishments as a musician, having studied piano, organ and coloratura voice; and

Whereas, Dr Bartuska, having balanced her career with raising six beautiful daughters, is hailed as a mother, grandmother, scientist, researcher, educator, mentor, clinician par excellence and community servant who will forever be loved and missed by everyone who knew her; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the many contributions of Doris G. Bartuska, MD to her profession and to organized medicine; and be it further

RESOLVED, That a copy of this resolution be recorded in the Proceedings of the 2013 Interim Meeting of the AMA House of Delegates and be forwarded to her family with an expression of the House's deepest sympathy.

Robert D. Burton, MD
Introduced by Michigan

Whereas, Robert D. Burton, MD, a longtime advocate for the use of seatbelts in automobiles, passed away on February 15, 2013; and

Whereas, Doctor Burton, an otolaryngologist in Grand Rapids, Michigan, chaired the Michigan Coalition for Safety Belt Use, which was instrumental in enacting Michigan laws mandating seat belt use and primary enforcement of seat belt use; and

Whereas, Doctor Burton devoted his life to his patients for more than 40 years and to the countless people whose lives he may have saved through the mandatory use of seat belts; and

Whereas, Doctor Burton served as president of the Kent County Medical Society (1977-78) and the Michigan State Medical Society (1991-92) and as a member of the American Medical Association House of Delegates for 20 years (1976-1995); therefore be it

RESOLVED, That our American Medical Association recognize the lifelong service of Doctor Robert D. Burton to his community, patients, and profession; and be it further

RESOLVED, That our AMA convey this resolution and its deepest sympathy to the surviving family members of Doctor Robert D. Burton.

William C. Collins, MD
Introduced by Georgia

Whereas, William C. Collins, MD, a very dear and long-time friend and esteemed colleague passed away on February 25, 2013 in Sandy Springs, Georgia; and

Whereas, Dr. Collins graduated from the Medical College of Georgia in 1962, where he served as President of Phi Rho Sigma and was elected to Alpha Omega Alpha; and

Whereas, After completing an internship at Floyd Hospital in Rome, Georgia, Dr. Collins served in the United States Air Force from 1963 to 1965 followed by a residency in orthopedics at Georgia Baptist and Scottish Rite hospitals and a hand surgery fellowship at Duke University Medical Center; and

Whereas, Dr. Collins became one of the first orthopedists in Sandy Springs and at Northside Hospital when he opened Northside Orthopedic Clinic in 1970; and

Whereas, Dr. Collins was committed to organized medicine and was a leader, serving as the Chairman of the Board and the President of the Medical Association of Georgia; the President of the Medical Association of Atlanta; the Co-Chair of the Academy of Medicine Restoration Committee; a member of the Executive Committee of Northside Hospital; Chief of Staff of the Atlanta Outpatient Surgery Center; President and Founder of the Michael Hoke Society; President of the Georgia Orthopedic Society; President and Co-Founder of the Southern Orthopedic Association; President of the Orthopedic Research and Education Foundation; and President of the Medical College of Georgia Alumni Association; and

Whereas, Dr. Collins dedicated 16 years to organized medicine in different roles at the American Medical Association, including his role as alternate delegate beginning in 1990 and then serving as a delegate from 2000 to 2006; and

Whereas, He is remembered as a caring and devoted physician, and friend through his many accomplishments, good humor, enthusiasm for life, love of family, and his extraordinary kindness to everyone; and

Whereas, Dr. Collins treasured his family and is survived by Jan Williams Collins, his wife of 53 years, and their children and children-in-law and six grandchildren to whom he was a loving and involved father and grandfather; therefore be it

RESOLVED, That our American Medical Association recognize the lifelong service and dedication of Dr. William C. Collins to organized medicine and especially the AMA; and be it further

RESOLVED, That our AMA express its deepest sympathy to the surviving family members of Dr. William C. Collins.

David A. Paulus, MD
Introduced by Florida

Whereas, David A. Paulus, MD, Professor of Anesthesiology at the University of Florida College of Medicine, and a Florida Medical Association Delegate and Alternate Delegate to our AMA House of Delegates since 2002, passed away unexpectedly at his home in Gainesville, Florida on December 12, 2012; and

Whereas, Dr. Paulus was also a Professor of Mechanical Engineering at the University of Florida College of Engineering, and as a native of Vermont initially earned degrees in mechanical engineering at the University of Vermont and University of Wisconsin, then earned his Doctor of Medicine degree at the University of Vermont in 1976, completing postgraduate education and training in surgery and anesthesiology at the University of Florida, University of Kentucky, and the Texas Heart Institute; and

Whereas, Dr. Paulus' unique background in medicine and mechanical engineering made him a tremendous asset as a leader throughout his distinguished career in academic medicine, where his accomplishments included serving as Chief of Cardiovascular Anesthesiology in the Department of Anesthesiology at the University of Florida College of Medicine, Medical Director of the Operating Room at Shands Teaching Hospital, and Medical Director of Shands HomeCare; and

Whereas, Dr. Paulus served organized medicine in numerous important capacities including as President of the Alachua County Medical Society, Chair and Vice Chair of the Florida Medical Association's Council on Medical Education and Science, an important member on key committees of the American Society of Anesthesiology, and as medical school representative for the University of Florida College of Medicine to our AMA; and

Whereas, As a teacher, lecturer, and author and co-author of many books, articles, and research papers, Dr. Paulus significantly helped his profession improve the quality of patient care, reduce medical errors, evaluate new medical procedures, and advance research in biomedical science; and

Whereas, As a Professor of Anesthesiology, Dr. Paulus had the distinct privilege of training and working in his own words with the brightest minds in medicine, serving as the faculty advisor to the medical students at the University of Florida College of Medicine, the Medical Student Section of the Florida Medical Association and our AMA's Medical Student Section; and

Whereas, Dr. Paulus is survived by his devoted wife, Mrs. Louise Paulus, and their children, Eric, Matthew, and Lizzie; therefore be it

RESOLVED, That our American Medical Association's House of Delegates recognize the many contributions of our dear friend, physician, colleague, and mentor, David A. Paulus, MD, to his profession of medicine, organized medicine, medical education, and patient care; and be it further

RESOLVED, That a copy of this resolution be recorded in the Proceedings of the 2013 Interim Meeting of our AMA House of Delegates and be forwarded to the wife and family of David A. Paulus, MD with the expression of our House of Delegates' deepest sympathy and best wishes.

Delmar R. Tonge, MD
Introduced by California

Whereas, Family, friends, patients and colleagues are saddened by the September 27, 2013 passing of Doctor Delmar R. Tonge; and

Whereas, Having been born in Los Angeles and moved with his family to Africa where his parents were active missionaries, his father being a physician and a medical missionary with the responsibility of organizing and building hospitals for the medical care of the people of Africa; and

Whereas, Following completion of his internship, residency, two years service in the United States Navy, Commander Tonge had the honor of practicing medicine in Modesto in 1963 with his father and two brothers; and

Whereas, Doctor Tonge practiced medicine for 50 years in Modesto, California endearing himself to his colleagues, staff, friends and patients for his devotion to the principles and ethics of this profession; and

Whereas, Doctor Tonge's contributions to organized medicine include service in multiple leadership positions at the local, state and national levels; serving as delegate and alternate delegate to the American Medical Association, on the California Medical Association board of trustees, as a delegate to the CMA, CALPAC board of directors, president of the Stanislaus County Medical Society, board member of the Physicians Service Bureau and trustee of the Stanislaus Foundation for Medical Care; and

Whereas, Doctor Tonge held many professional affiliations of note such as diplomat of the Board of Obstetrics/Gynecology, Fellow of American College of Obstetrics & Gynecology, Fellow of American College of Surgeons, Assistant Clinical Professor UC Davis School of Medicine for obstetrics and gynecology; and

Whereas, Doctor Tonge took his philanthropic endeavors earnestly, having been president of the Modesto Arts Foundation, president of the Archie Tonge Education Foundation, serving on the board of trustees of Pacific Union College, serving on the board of directors of Modesto Symphony Orchestra and on the California Office of State Wide Health Planning & Development; and

Whereas, Doctor Tonge was selected by his peers in 2001 to receive the John Darroch Memorial Award for Physician of the Year, in recognition of the contribution he had made locally to his patients, the practice of medicine and the quality of medical care in Stanislaus County; and

Whereas, Doctor Tonge was considered an expert among his colleagues with molding the qualities of being an excellent physician to many who practiced medicine locally and throughout California and the United States. A physician and teacher who cared and lived his life for others, Doctor Tonge earned the respect of all of those who worked with him; therefore be it

RESOLVED, That our American Medical Association recognize the distinguished life of Delmar R. Tonge, MD, who made enumerable contributions to the practice of medicine and enhanced the lives of his colleagues, patients, family, friends and the public at large; and it be further

RESOLVED, That our AMA convey its deepest sympathy for the passing of Delmar R. Tonge, MD, to his family, friends and colleagues who had the privilege to be associated with him during his distinguished life and medical career.

RESOLUTIONS

Note: Testimony on each item is summarized in the reference committee reports. Items considered on the reaffirmation calendar do not appear in the reference committee reports and were handled as part of the Committee on Rules and Credentials Supplementary Report on Sunday, Nov. 17. The following resolutions were handled on the reaffirmation calendar: 203, 210, 213, 215, 803, 809, 810, 908 and 918.

1. TUBAL LIGATION AND VASECTOMY CONSENTS

Introduced by American Congress of Obstetricians and Gynecologists, Women Physicians Section

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

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy [D-75.994](#)

RESOLVED, That our American Medical Association work closely with the American Congress of Obstetricians and Gynecologists, the American Urological Association, and any other interested organizations, to advocate to Congress for the legislative or regulatory elimination of the required 30 day interval between informed consent and a permanent sterilization procedure; and further be it

RESOLVED, That our AMA work with the Centers for Medicare & Medicaid Services to eliminate the time restrictions on informed consent for permanent sterilization procedures; and further be it

RESOLVED, That our AMA study the current ramifications of the existing regulations mandating a waiting period for informed consents for Medicaid patients undergoing tubal ligations and vasectomies, specifically noting potential financial costs regarding bureaucratic enforcement, unintended pregnancies, public health and ethical considerations and concomitant health care inequity/disparity issues and report back to the AMA House of Delegates at the 2014 Annual Meeting.

2. RIGHT OF CONSCIENCE

Introduced by Washington

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

**HOUSE ACTION: POLICY [H-225.950](#) AMENDED AS FOLLOWS
IN LIEU OF RESOLUTION 2**

H-225.950 AMA Principles for Physician Employment

1. Addressing Conflicts of Interest

- a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
- b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
- c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

- d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
 - (i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and
 - (ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.
- e) Assuming a title or position that may remove a physician from direct patient-physician relationships – such as medical director, vice president for medical affairs, etc. – does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

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

2. Advocacy for Patients and the Profession

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

3. Contracting

- a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
- b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
- c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
- d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary

for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

- e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges.
- f) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
- g) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

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

4. Hospital Medical Staff Relations

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

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

5. Peer Review and Performance Evaluations

- a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
- b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
- c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians – not lay administrators – should be ultimately responsible for all peer review of medical services provided by employed physicians.
- d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the

opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.

- e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
- f) Unless specified otherwise in the employment agreement, upon termination of employment with or without cause, an employed physician should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws.

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

6. Payment Agreements

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

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

3. HOSPITAL MERGERS AND REPRODUCTIVE HEALTH CARE Introduced by Washington

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

HOD ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy [H-215.969](#)

RESOLVED, That our American Medical Association work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services.

4. REPRODUCTIVE PARITY
Introduced by Washington

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

HOD ACTION: ADOPTED AS FOLLOWS
See Policy [H-185.937](#)

RESOLVED, That our American Medical Association support legislation and policies that require any health insurance products offering maternity services to include all choices in the management of reproductive medical care.

5. OPPOSITION TO RESTRICTIONS ON PHYSICIAN/PATIENT FREE SPEECH
Introduced by California

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

**HOD ACTION: POLICIES [H-5.989](#) AND [H-373.995](#) REAFFIRMED
IN LIEU OF THE FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association oppose any and all attempts to restrict physician discussion with patients of any issue relevant to the patient's health and safety.

6. RESTRICTIONS ON MARKETING IN HOSPITALS AND MEDICAL CENTERS
Introduced by California

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

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association support policies, duly adopted by a medical staff or facility governing body within its scope of authority: (1) that govern the level and content of contact between physicians and pharmaceutical, device and other medical product representatives in hospital and medical center settings in order to minimize undue external influence over medical judgment and patient care as necessary and appropriate for the particular medical staff or facility; and (2) that promote education, training, operative orientation and coaching as the focus of such contact; and be it further

RESOLVED, That our AMA urge the American Hospital Association to support such policies.

201. REPEAL OF THE MCCARRAN-FERGUSON ACT
Introduced by Maryland

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

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association work legislatively to repeal of the McCarran-Ferguson Act of 1945.

202. DECREASING MEDICARE PAYMENT RECOVERY PERIOD
Introduced by Maryland

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

**HOD ACTION: POLICY [H-70.926](#) REAFFIRMED
 IN LIEU OF THE FOLLOWING RESOLUTION**

RESOLVED, that our American Medical Association work to decrease the payment recovery period of Medicare and all insurers to six months after submission.

**203. NATIONWIDE PROHIBITION OF THE SALE OF TOBACCO PRODUCTS IN BUSINESSES
 THAT PROVIDE HEALTH CARE AND HEALTH CARE RELATED SERVICES**
Introduced by Maryland

Considered on reaffirmation calendar.

**HOUSE ACTION: POLICIES [H-495.977](#), [H-495.986](#) AND [D-495.994](#) REAFFIRMED
 IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, that our American Medical Association work to enact national legislation to prohibit the sale of tobacco products in businesses that provide health care and health-care related services.

204. IMPROVING THE AFFORDABLE CARE ACT
Introduced by Indiana

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

HOUSE ACTION: REFERRED WITH REPORT BACK AT THE 2014 ANNUAL MEETING

RESOLVED, That our American Medical Association consider the following recommendations related to the ACA:

1. Replace the individual mandate with a refundable tax credit that could only be used to purchase health insurance.
2. Repeal the employer mandate. Businesses, as well as individuals, should be allowed to purchase health insurance with pretax dollars.
3. Allow health insurance to be sold across state lines. Health-insurance should be portable and should follow the individual from job to job and state to state.
4. Allow small businesses to self-insure or purchase insurance through small business health plans or association health plans. Currently, this option is available only to large businesses.
5. Improve health-related savings accounts and consumer-driven health care plans by allowing higher deductibles and higher savings account contributions.
6. Allow and encourage states to develop alternatives to Medicaid by using federal funds granted by the Health and Human Services Secretary under provisions of the ACA.
7. Restore funds cut from traditional Medicare.
8. Avoid reducing Medicare Advantage funding. This insurance is highly popular with seniors.
9. Eliminate the unaccountable and unpopular Independent Payment Advisory Board.
10. Eliminate involvement in the ACA by the Internal Revenue Service.
11. Maintain the guaranteed insurability, full coverage of preventative services and elimination of lifetime benefit caps under the ACA.
12. Continue the family insurance coverage of children living in a household until age 26.
13. Eliminate the taxes on medical devices and pharmaceuticals and health insurance companies since this added expense would only be passed on to our patients.
14. Repeal and replace the sustainable growth rate formula.
15. Enact meaningful medical liability reform.

16. Expand the funding of medical schools and residency programs in order to increase the number of physician providers.
17. Cancel all current ACA waivers, exemptions, subsidies and discounts except for those based on patient income under provisions of the ACA. Prohibit any of these in the future unless they are based on income of the patient.
18. Prohibit any future insurance plans that are alternatives to the ACA for all federal employees, members of Congress, federal judges and the president, as well as their dependents.
19. Due to the complexity of improving the ACA, its implementation should be delayed at least one year.
20. Finally, Congress should be asked to appoint a committee with a majority membership of health care providers and AMA leadership with a mandate to revise Medicare and to produce a plan that would allow its long-term viability and adequate health benefits for seniors and the disabled. The same committee would also work to identify the changes that would effectively improve the ACA and allow for its long-term vitality.

205. ALLEVIATING THE FINANCIAL BURDENS ASSOCIATED WITH ICD-10 IMPLEMENTATION

Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont

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

HOUSE ACTION: ADOPTED

See Policy [D-70.951](#)

RESOLVED, That our American Medical Association seek federal legislative and regulatory reform to require funding assistance be provided to physician practices to alleviate the financial burdens associated with the implementation costs, upgrades and staff training necessitated as part of the transition to ICD-10.

206. FDA TO EXTEND REGULATORY JURISDICTION OVER ALL NON-PHARMACEUTICAL NICOTINE AND TOBACCO PRODUCTS

Introduced by American Association of Public Health Physicians

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

HOUSE ACTION: ADOPTED WITH CHANGE IN TITLE

See Policy [H-495.973](#)

RESOLVED, That our American Medical Association urge the US Food and Drug Administration (FDA) to immediately implement the deeming authority written into the FDA tobacco law to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the FDA tobacco law.

RESOLUTION 207 WAS NOT CONSIDERED AT THE INTERIM MEETING

RESOLUTION 208 WAS NOT CONSIDERED AT THE INTERIM MEETING

RESOLUTION 209 WAS WITHDRAWN

**210. SUPPORT FEE FOR SERVICE AS THE MOST APPROPRIATE WAY
TO REIMBURSE PHYSICIANS**
Introduced by Florida

Considered on reaffirmation calendar.

**HOUSE ACTION: POLICIES, [H-385.989](#), [H-385.926](#), [H-390.844](#) and [D-380.997](#) REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association strongly support “Fee For Service” as the most appropriate way to reimburse physicians; and be it further

RESOLVED, That our AMA actively oppose all legislation that would unfairly impact a physician’s ability to enter, or not enter, into contractual relationships with patients for medical services; and be it further

RESOLVED, That our AMA reaffirm its commitment to the Medicare Patient Empowerment Act.

211. PATIENT’S CHOICE OF MANAGEMENT OF END OF LIFE CARE
Introduced by Washington

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

**HOUSE ACTION: POLICY [H-140.966](#) REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support creating model state legislation to ensure that no insurance policy sold in the state be allowed to block a patient’s choice regarding health care during the end of life; and be it further

RESOLVED, That our AMA craft this model legislation keeping the Right of Conscience intact for physicians.

**212. PHYSICIAN-LED, SINGLE AND MULTI-SPECIALTY, ORGANIZED
GROUP PRACTICE MODELS**
Introduced by American Medical Group Association

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

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy [H-390.843](#)

RESOLVED, That our American Medical Association recognize that physician-led, single and multi-specialty group practices, integrated delivery systems, and other organized systems of care demonstrating the following attributes: (i) efficient provision of services, (ii) organized system of care, (iii) quality measurement and improvement activities, (iv) care coordination, (v) use of IT and evidence-based medicine, (vi) compensation practices that promote all aforementioned attributes, and (vii) accountability, are credible models for providing coordinated, comprehensive, accountable, cost-effective, patient-centered care.

213. AMA ADVOCATE FOR THE PHYSICIAN-LED, MULTI-SPECIALTY, ORGANIZED, GROUP PRACTICE MODEL AS A VIABLE OPTION FOR PRACTICE SELECTION COINCIDENT WITH SGR REFORM
Introduced by American Medical Group Association

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-160.912, H-390.844, D-390.961 AND D-405.988 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for the physician-led, multi-specialty, organized group practice model as a viable option for practice selection and reimbursement as part of SGR reform.

214. MEANINGFUL USE NO LONGER MEANINGFUL
Introduced by J. Gregory Cooper, MD, Delegate, Kentucky

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

HOUSE ACTION: POLICY H-478.991 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for suspension of the Meaningful Use component of the HITECH Act; and be it further

RESOLVED, That our AMA advocate for elimination of the Medicare payment penalties, provided for in the HITECH Act, for not meeting Meaningful Use requirements.

215. NATIONAL HIE AND EHR USABILITY AND INTEROPERABILITY
Introduced by California

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES D-478.981, D-478.995 AND D-478.996 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support the development of a secure, interoperable, nationwide health information exchange (HIE) network; and be it further

RESOLVED, That our AMA support efforts to harmonize standards and specifications that would enable usability and interoperability of electronic health records (EHR) systems and facilitate the exchange of health information among health care providers; and be it further

RESOLVED, That our AMA support improving usability and interoperability of EHR systems with physician input on how they directly impact patient care and physician workflow; and be it further

RESOLVED, That our AMA support that the Office of the National Coordinator for Health Information Technology (ONC) should address EHR usability and interoperability concerns raised by physicians and add usability and interoperability criteria to the EHR certification process; and be it further

RESOLVED, That our AMA support legislation to mandate that all EHR systems include meaningful interoperability, to be defined as a user-friendly implementation of ONC standards in a manner allowing the simple electronic transfer of fully structured medical information between EHR users and ensuring the confidentiality of protected patient information.

216. PAYMENT OF PENALTIES AND INTEREST TO PHYSICIANS FOR RAC AUDITS
Introduced by California

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

HOUSE ACTION: ADOPTED

See Policy [D-320.991](#)

RESOLVED, That our American Medical Association advocate for penalties and interest to be imposed on the auditor and payable to the physician when a RAC audit or appeal for a claim has been found in favor of the physician.

217. PRIMARY CARE PHYSICIAN SUPPLY
Introduced by California

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

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED

See Policy [D-35.980](#)

RESOLVED, That our American Medical Association continue to work with interested stakeholders to gather and disseminate data regarding the primary care physician supply.

218. FDA REGULATION OF OFF-LABEL DRUG PROMOTION
Introduced by California

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

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association support the Food and Drug Administration's authority to prohibit medication off-label detailing.

219. DRUG ENFORCEMENT AGENCY LICENSURE FEES
Introduced by Georgia

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

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy [D-100.970](#)

RESOLVED, That our AMA work through appropriate channels to freeze DEA licensure fees for physicians.

220. DELAY OR CANCELING OF ICD-10
Introduced by Georgia

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

HOUSE ACTION: ADOPTED
See Policy [H-70.916](#)

RESOLVED, That our American Medical Association support delaying or canceling the implementation of ICD-10.

221. ELIMINATING PROPOSED PENALTIES FOR NOT ACHIEVING MEANINGFUL USE
Introduced by Georgia

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

HOUSE ACTION: POLICY [H-478.991](#) REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association seek the termination of the “meaningful use” standards of the Centers for Medicare & Medicaid Services from medical practice and that the proposed penalties beginning in 2015 should be eliminated immediately and an effort made to gradually integrate tomorrow’s technological advances into health care in a safer, more efficient manner.

222. SAFETY OF EHR
Introduced by Georgia

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

HOUSE ACTION: POLICY [H-478.991](#) REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for physicians to have the option to choose either EHR or paper charts without penalty; and be it further

RESOLVED, That our AMA, through appropriate channels, influence national policy to remove the penalties for not using an EHR system.

223. MEDICARE’S TWO-MIDNIGHT RULE
Introduced by Congress of Neurological Surgeons, American Association of Neurological Surgeons, American Academy of Facial Plastic and Reconstructive Surgery, Alabama, District of Columbia, New Jersey, American Society of General Surgeons, Minnesota, Georgia

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policies [D-160.932](#) and [D-320.991](#)

RESOLVED, That our American Medical Association petition the Centers for Medicare & Medicaid Services to repeal the August 19 rule regarding Hospital Inpatient Admission Order and Certification; and be it further

RESOLVED, That our AMA reaffirm Section 5 of AMA Policy D-320.991, Creating a Fair and Balanced Medicare and Medicaid RAC Program, which states: “Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS

to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians.”

RESOLUTION 224 WAS NOT CONSIDERED AT THE INTERIM MEETING**225. MAINTENANCE PAYMENTS FOR ELECTRONIC HEALTH RECORDS**
Introduced by Organized Medical Staff Section

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

HOUSE ACTION: ADOPTED

See Policy [D-478.975](#)

RESOLVED, That our American Medical Association advocate for inclusion of payment supplements in the current and proposed payment systems specifically to cover the costs of maintaining (including upgrades of) electronic health records (EHRs) at a national level by whatever means available; and be it further

RESOLVED, That our AMA evaluate and monitor the cost to physicians and their practices of maintaining and upgrading EHRs.

226. SUSTAINABLE GROWTH RATE REPEAL
Introduced by Organized Medical Staff Section

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

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED

See Policies [H-450.947](#), [D-390.953](#) and [D-450.981](#)

RESOLVED, That our American Medical Association reaffirm AMA Policy D-450.981, Protecting Patients Rights, and continue to strongly advocate for the repeal of the flawed sustainable growth rate (SGR) formula and for our AMA’s principles for pay-for-performance; and be it further

RESOLVED, That our AMA reaffirm AMA Policy H- 450.947, Pay-for-Performance Principles and Guidelines; and be it further

RESOLVED, That our AMA support SGR repeal and continue to strongly advocate for the AMA’s Pay-for-Performance Principles and Guidelines (AMA Policy H-450.947); and be it further

RESOLVED, That our AMA advocate with CMS and Congress for alternative payment models, developed in concert with specialty and state medical organizations, including private contracting as an option; and be it further

RESOLVED, That our AMA will continue to advocate for future positive updates in the Medicare physician fee schedule.

227. HOSPITAL INPATIENT ADMISSION ORDER AND CERTIFICATION
Introduced by Organized Medical Staff Section

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

HOUSE ACTION: RESOLVED CLAUSES 1 AND 3 ADOPTED
RESOLVED CLAUSE 2 REFERRED FOR DECISION
See Policy [H-160.907](#)

RESOLVED, That our American Medical Association support the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital as a condition for payment for inpatient services; and be it further

RESOLVED, That our AMA adopt as policy that upon admission of any patient to a hospital for inpatient services, the admitting/attending physician should be furnished by the hospital with appropriate information – for example the Geometric Mean Length of Stay (GMLOS) – to help the physician plan appropriately for the services that will be required to care for that particular patient; and be it further

RESOLVED, That our AMA inform the Centers for Medicare and Medicaid Services as soon as possible of the AMA's policy calling for the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital, and take appropriate action to enact this policy.

228. EHR STARK EXEMPTION
Introduced by Virginia

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

HOUSE ACTION: POLICY [D-478.994](#) REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association petition both the Centers for Medicare & Medicaid Services and the Office of the Inspector General to extend the EHR Stark Exemption and Anti-Kickback Safe Harbor to December 31, 2016.

601. REGULATIONS IN TIMES OF ARMED CONFLICT
Introduced by Medical Student Section

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

HOUSE ACTION: POLICY [H-520.998](#) REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association endorse the World Medical Association's "Regulation in Times of Armed Conflict" as policy on the topic of medical neutrality; and be it further

RESOLVED, That our AMA advocate that the United States use its voice in international affairs to protect medical neutrality.

RESOLUTION 602 WAS NOT CONSIDERED AT THE INTERIM MEETING

RESOLUTION 603 WAS NOT CONSIDERED AT THE INTERIM MEETING

RESOLUTION 604 WAS NOT CONSIDERED AT THE INTERIM MEETING**605. CRIMINALIZATION OF ERRORS IN MEDICAL DOCUMENTATION**
Introduced by New York*Reference committee hearing: see report of [Reference Committee F](#).***HOUSE ACTION: POLICY [H-160.954](#) REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association submit an amicus curiae brief supporting the petition for certiorari of John Natale, MD, seeking review of the ruling in US v. Natale, 719F.3d719.

**801. PRIVACY ISSUES FOR MINORS REGARDING INSURANCE
COMPANY EXPLANATION OF BENEFITS**
Introduced by Medical Student Section*Reference committee hearing: see report of [Reference Committee J](#).***HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association advocate for maintaining privacy regarding the doctor patient relationship for adults and dependents who are insured through their spouse, parent, or guardian; and be it further

RESOLVED, That our AMA advocate against allowing insurance companies to send Explanations of Benefits containing sensitive medical information regarding both adults and dependents to anyone other than the patient or their health care provider; and be it further

RESOLVED, That our AMA advocate that Explanations of Benefits be made available only if an insurance claim has been denied, and in this case for the information to be sent directly to the (adult or dependent) patient, who may then choose to discuss it with their physician or share it with their spouse, parent, or guardian.

**802. UPDATING AMA HOD POLICY ON REQUIREMENTS FOR AND
PRESCRIPTION OF DURABLE MEDICAL EQUIPMENT**
Introduced by Nebraska and South Dakota*Reference committee hearing: see report of [Reference Committee J](#).***HOUSE ACTION: POLICIES [H-330.945](#) AND [H-330.955](#) AMENDED AS FOLLOWS
IN LIEU OF RESOLUTION 802****H-330.945 Durable Medical Equipment Requirements**

The AMA will: (1) continue to seek legislation to prohibit unsolicited contacts by durable medical equipment suppliers that recommend medically unnecessary durable medical equipment to Medicare beneficiaries; and (2) affirm the concept that members of a physician-led interprofessional health care team be enabled to perform delegated medical duties, including ordering durable medical equipment, that they are capable of performing according to their education, training and licensure and at the discretion of the physician team leader; (3) advocate that the initiators of orders for durable medical equipment should be a physician, or a nurse practitioner or physician assistant supervised by a physician within their care team, consistent with state scope of practice laws; and (4) reaffirm the concept that physicians are ultimately responsible for the medical needs of their patients and should be the initiators of orders for durable medical equipment.

H-330.955 Prescription of Durable Medical Equipment

(1) The AMA continues to voice its objection to CMS regarding its onerous requirement that physicians initiate and complete the entire certification of medical necessity form for durable medical equipment. (2) The AMA advocate that additional members of a physician-led health care team be permitted to complete the certification of medical necessity form for durable medical equipment, according to their education, training and licensure and at the discretion of the physician team leader, but require that the final signature authorizing the prescription for the durable medical equipment be the responsibility of the physician. (3) The AMA calls for CMS to revise its interpretation of the law to permit that the physician's prescription be the only certification of medical necessity needed to initiate an order for and to secure Medicare payment for durable medical equipment. (34) The AMA calls on physicians to be aware of the abuses caused by product-specific advertising by manufacturers and suppliers of durable medical equipment, the impact on the consumers of inappropriate promotion, and the contribution such promotion makes to unnecessary health care expenditures.

803. ELECTRONIC PAYMENT AND RECORD ACCESS
Introduced by Maryland

Considered on reaffirmation calendar.

**HOUSE ACTION: POLICIES [H-190.978](#), [H-190.983](#) AND [H-190.992](#) REAFFIRMED
 IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, that our American Medical Association evaluate the adoption of a national voluntary system of immediate electronic medical claims filing, adjudication, and payment.

804. REIMBURSEMENT FOR EATING DISORDERS
Introduced by Indiana

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

**HOUSE ACTION: POLICIES [H-185.974](#), [H-345.981](#) AND [D-345.997](#) REAFFIRMED
 IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association seek federal legislation requiring full insurance coverage for ALL eating disorders, including inpatient and outpatient care, as well as maintenance care.

805. PHYSICIAN SATISFACTION
Introduced by Washington

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy [D-405.985](#)

RESOLVED, That our American Medical Association study current tools and develop metrics to measure physician professional satisfaction.

806. IMPROVING THE HCAHPS RATING SYSTEM
Introduced by Florida

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

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policies [H-406.991](#), [D-385.958](#) and [D-450.960](#)

RESOLVED, That our American Medical Association urge the Centers for Medicare & Medicaid Services to modify the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scoring system so that it assigns a unique value for each rating option available to patients; and be it further

RESOLVED, That our AMA reaffirm Policies H-406.991 and D-385.958, which emphasize that patient satisfaction surveys should be used to help improve patient care and not for the purpose of determining physician payment.

807. ROLE OF CRITICAL ACCESS HOSPITALS
Introduced by Mississippi

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

HOUSE ACTION: POLICY [H-465.990](#) REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work to modify federal laws, rules, and regulations to reimburse all hospital billed physician services and their facilities at equal rates.

808. REFERENCE PRICING
Introduced by Louisiana

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

HOUSE ACTION: REFERRED

RESOLVED, That the term “Reference Pricing” be substituted for the term “Benefit Payment Schedule” in American Medical Association policy; and be it further

RESOLVED, That our AMA advocate for inclusion of the option of “Reference Pricing” in a pluralistic approach to Health System Reform.

809. CENTERS FOR MEDICARE & MEDICAID SERVICES PROPOSED CHANGE CIRCUMVENTS
THE AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE PROCESS
Introduced by American College of Radiology, American Society of Anesthesiologists, College of American Pathologists, National Association of Medical Examiners, American Society of Cytopathology, American Society for Clinical Pathology

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES [H-70.980](#), [H-390.992](#) AND [H-400.969](#) REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association continue to support the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee’s (RUC’s) work of identifying potentially misvalued CPT codes for physician work, practice expense, and/or professional liability relative values; and be it further

RESOLVED, That our AMA continue to support the RUC's recommendations methodologies and processes of the reassessment of physician work, practice expense, and professional liability relative values; and be it further

RESOLVED, That our AMA actively engage vested organizations in opposition to any proposed limitations upon the Medicare RBRVS from other payment methodologies or fee schedules; and be it further

RESOLVED, That our AMA actively engage vested organizations in opposition to any mandatory bundling initiatives for Medicare or Medicaid payment policies without AMA and CPT Editorial Panel physician expert analysis and endorsement.

810. MEDICARE ECONOMIC INDEX INACCURACY

Introduced by Iowa

Considered on reaffirmation calendar.

**HOUSE ACTION: POLICIES [H-400.966](#), [D-390.963](#) AND [D-400.985](#) REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association ask the Centers for Medicare & Medicaid Services to immediately make their Bureau of Economic Activity (BEA) office expense and purchased services category weighting methodology and figures available (transparent) so everyone can judge the accuracy of this Medicare Economic Index (MEI) weighting; and be it further

RESOLVED, That our AMA study and report back at the 2014 Annual Meeting regarding all aspects of the MEI, including: 1) using the best national data currently available, a determination of more accurate cost categories and weighting; 2) whether the 2002 BEA data has been accurately used to determine the categories of rent, furniture, movable capital and other expense categories for the MEI; and 3) recommendations for the future use of some specific survey data to establish physician practice costs, including the MEI category weighting and potential geographic differences.

811. REVIEW OF SELF-ADMINISTERED DRUG LIST ALTERATIONS UNDER MEDICARE PART B

Introduced by American College of Rheumatology

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

HOUSE ACTION: ADOPTED
See Policy [D-335.983](#)

RESOLVED, That our American Medical Association seek regulatory or legislative changes to require that any alterations to Self-Administered Drug lists made by Medicare Administrative Contractors shall be subject to Carrier Advisory Committee review and advisement.

812. HEALTH EXCHANGE BENEFIT DESIGNS AND TAX DEDUCTIBILITY OF OUT-OF-POCKET EXPENSES

Introduced by California

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

**HOUSE ACTION: POLICIES [H-165.839](#) AND [H-165.846](#) REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support efforts to develop benefit designs in the health benefit exchange that appeal to the young and healthy as a means to reduce acuity in the risk pool and better stabilize premiums; and be it further

RESOLVED, That our AMA support legislation allowing full federal and state income tax deductibility of all out of pocket health care expenses.

813. HEALTH INSURANCE EXCHANGE AND 90-DAY GRACE PERIOD
Introduced by California

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

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED

See Policies [H-165.838](#), [H-165.839](#), [H-185.938](#), [H-185.981](#) and [D-185.999](#)

RESOLVED, That our American Medical Association reaffirm Policy H-165.838, which states that insurance coverage options offered in a health insurance exchange should not require provider participation; and be it further

RESOLVED, That our AMA reaffirm Policies H-165.839 and D-185.999, which support standards to provide physicians with accurate and real time verification of patient eligibility, co-payment due, deductible payable information, and claims processing; and be it further

RESOLVED, That our AMA reaffirm Policy 185.981, which supports a standardized, national health benefits verification system that includes an obligation on the part of the insurer or managed care plan to pay physicians for any services rendered to patients whose eligibility for benefits have been verified erroneously; and be it further

RESOLVED, That our AMA oppose the preemption of state law by federal laws relating to the federal grace period for subsidized health benefit exchange enrollees; and be it further

RESOLVED, That our AMA advocate that health plans be required to notify physicians that a patient is in the federal grace period for subsidized health benefit exchange enrollees upon an eligibility verification check by the physician. The notification must specify which month of the grace period a patient is in. Failure to notify physicians of patient grace period status would result in a binding eligibility determination upon the insurer.

814. RETRO-AUTHORIZATION FOR TESTS / PROCEDURES
Introduced by California

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

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy [H-285.931](#) and [H-285.940](#)

RESOLVED, That our American Medical Association support a requirement that payers provide a retro-authorization process, with reasonable timeframes for submission and consideration and with reasonable procedural standards for all tests, procedures, treatments, medications and evaluations requiring authorization; and be it further

RESOLVED, That our AMA reaffirm Policy H-285.940, which opposes health plans refusing to pay for the provision of covered services for the sole reason that required notification of these services was not reported in a timely manner; and be it further

RESOLVED, that our AMA reaffirm Policy H-285.931, which states that physicians and patients of a health plan should have access to a timely, expeditious internal appeals process.

815. VULNERABLE PATIENT ACCESS AND PROTECTION
Introduced by Georgia

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

**HOUSE ACTION: POLICIES [H-160.952](#), [H-285.911](#), [H-373.999](#), [D-165.989](#) AND [D-285.972](#)
 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association promote access to appropriate care for all patients; and be it further

RESOLVED, That our AMA promote special access for vulnerable patients if appropriate care cannot be provided within a patient's insurance provider network; and be it further

RESOLVED, That our AMA oppose any health care delivery model, public or private, that restricts patient access to physicians adequately experienced in their disease.

**816. INAPPROPRIATE INTERFERENCE WITH HOSPITAL ADMISSIONS
 BY PATIENT MANAGEMENT CONTRACTORS**
Introduced by New Mexico

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

HOUSE ACTION: ADOPTED
See Policy [D-320.989](#)

RESOLVED, That our American Medical Association study whether contracted patient management personnel are inappropriately making medical management decisions about hospital admissions outside of an established physician-patient relationship and without being duly licensed and privileged to do so, and make recommendations for new policy to address this issue.

817. RANDOM DRUG SCREENING
Introduced by North Carolina

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

HOUSE ACTION: ADOPTED
See Policies [H-95.984](#) and [D-235.986](#)

RESOLVED, That our American Medical Association develop model medical staff bylaws addressing random drug testing of medical staffs; and be it further

RESOLVED, That our AMA reaffirm current Policy H-95.984, "Issues in Employee Drug Testing."

818. CLAIMS BASED DATA AS A FLAWED QUALITY OF CARE MEASURE
Introduced by Pennsylvania

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policies [H-406.988](#), [H-450.942](#) and [D-450.965](#)

RESOLVED, That our American Medical Association strongly urge insurance companies to not use claims or other administrative data as the sole determinant of quality of care rendered or physician payment; and be it further

RESOLVED, That our AMA reaffirm Policies H-450.942 and D-450.965, which address patient adherence to treatment plans.

819. HEALTH INSURANCE CANCELLATIONS
Introduced by Pennsylvania

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

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED

See Policy [H-165.830](#)

RESOLVED, That our American Medical Association support urgent efforts to maintain coverage while facilitating a smooth transition to alternative coverage options which offer “meaningful coverage” as defined in Policy H-165.848 for individuals who have received cancellation notices from their health insurance companies as a result of the Affordable Care Act.

AMENDMENT J-9 REFERRED FOR DECISION WITH [REPORT](#) BY DEC. 15, 2013.

Health Insurance Exchange and 90 Day Grace Period

Recommend that Resolution 813 be amended by addition to read as follows:

RESOLVED, That our AMA develop a whitepaper/guide for AMA members that clearly delineates the responsibilities and options for our members for those patients who are in the vulnerable 31 to 90 day grace period for policies covered under marketplace options under the ACA. The whitepaper would address:

- a. possible mechanism for physicians to verify whether a patient is in fact in the grace period as well as confirm the number of days at the time of the request;
- b. contract compliance implications and remedial strategies as to issues that include, but not limited to, timely access, deferral of care until the patient has binding coverage under their ACA contract, and abandonment; and
- c. other remedial strategies such as reinsurance for delinquent premium payments provided by the state exchange.

RESOLVED, That this is extremely time urgent and that the AMA make available the whitepaper/guide for AMA members no later than December 15, 2013.

RESOLUTION 820 WAS NOT CONSIDERED AT THE INTERIM MEETING

**821. QUALIFICATIONS, SELECTION, AND ROLE OF HOSPITAL MEDICAL DIRECTORS
AND OTHERS PROVIDING MEDICAL MANAGEMENT SERVICES**
Introduced by Organized Medical Staff Section

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

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association amend Policy H-235.981 by substitution to read as follows:

H-235.981 – Qualifications, Selection, and Role of Medical Directors, Chief Medical Officers, Vice Presidents for Medical Affairs, and Others Employed by or Under Contract with Hospitals/Health Systems to Provide Medical Management Services

1. Our AMA supports the following guidelines regarding the qualifications and selection of individuals employed by or under contract with a hospital/health system to provide medical management services:
 - a. The hospital governing body, management, and medical staff should jointly:
 - i. determine if there is a need to employ or contract with one or more individuals to provide medical management services;
 - ii. establish the purpose, duties, and responsibilities of these positions;

- iii. establish the qualifications for these positions; and
- iv. provide a mechanism for input from the elected leaders of the medical staff into the selection, evaluation, and termination of individuals holding these positions.
- b. An individual employed by or under contract with 1 a hospital/health system to provide medical management services should be a licensed physician.
- c. An individual employed by or under contract with a hospital/health system to provide medical management services at a single hospital should be a member in good standing of the medical staff at that hospital.
- d. An individual employed by or under contract with a multi-hospital health system to provide medical management services at the system level need not be a member of the medical staff of each hospital within the system, provided that he or she
 - i. is a member in good standing of at least one of the hospitals within the system, and
 - ii. works in collaboration with elected medical staff leaders throughout the system and with any individuals who provide medical management services at the hospital level.

2. Our AMA supports the following guidelines regarding the role of the organized medical staff vis-à-vis individuals employed by or under contract with hospitals/health systems to provide medical management services:

- a. The purpose, duties, and responsibilities of individuals employed by or under contract with the hospital/health system to provide medical management services should be included in the medical staff bylaws and in the hospital/health system corporate bylaws.
- b. The organized medical staff should maintain overall responsibility for the quality of care provided to patients by the hospital, including the quality of the professional services provided by individuals with clinical privileges, and should have the responsibility of reporting to the governing body.
- c. The chief elected officer of the medical staff should represent the medical staff to the administration, governing body, and external agencies.
- d. Government regulations that would mandate that any individual not elected or appointed by the medical staff would have authority over the medical staff should be opposed.

822. PREPAYMENT REVIEW BY THIRD PARTY PAYERS

Introduced by Colorado

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

HOUSE ACTION: ADOPTED

See Policy [H-190.991](#)

RESOLVED, That our American Medical Association work with all payers to ensure that they stop the practice of delaying payments by asking for documentation to review, prior to payment; and be it further

RESOLVED, That our AMA work with payers to establish rules to continue to allow the payer to conduct prepayment documentation review if the payer has performed a post payment documentation review and proven that the provider has been submitting incorrect claims; and be it further

RESOLVED, That if efforts to work with payers to end the practice of delaying payments without reasonable justification fail, our AMA seek legislation that would accomplish this.

RESOLUTION 901 WAS NOT CONSIDERED AT THE INTERIM MEETING

902. MEDICAL ETHICS GUIDELINES FOR UNDERGRADUATE MEDICAL EDUCATION
Introduced by Medical Student Section

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

**HOUSE ACTION: POLICY [H-295.961](#) REAFFIRMED
 IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association recognize the importance of addressing the disparity between current outcomes and the ideal status of undergraduate medical education in bioethics and humanities; and be it further

RESOLVED, That our AMA, in partnership with the AMA Medical Student Section, leverage its internal resources and its relationships with professional society stakeholders to create suggested guidelines for undergraduate medical education of bioethics and humanities guided by LCME requirements and the American Society for Bioethics and Humanities Task Force; and be it further

RESOLVED, That our AMA advocate for the national adoption of a set of suggested guidelines for undergraduate medical education in bioethics and humanities by allopathic and osteopathic medical schools.

903. FIREARM SAFETY COUNSELING IN PHYSICIAN-LED HEALTH CARE TEAMS
Introduced by Medical Student Section

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

**HOUSE ACTION: ADOPTED AS FOLLOWS
 WITH CHANGE IN TITLE
 See Policy [H-145.976](#)**

RESOLVED, That our American Medical Association amend Policy H-145.976 by insertion and deletion as follows:

H-145.976 Censorship of Physician Discussion of Firearm Risk

Our AMA: (1) will oppose any restrictions on physicians' and other members of the physician-led health care team's being able ability to inquire and talk about firearm safety issues and risks with their patients; and (2) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about guns firearms as an intrusion into medical privacy; and be it further

RESOLVED, That our AMA encourage dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

904. EVALUATION OF STANDARDIZED CLINICAL SKILLS EXAMS
Introduced by Medical Student Section

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

**HOUSE ACTION: ADOPTED AS FOLLOWS
 See Policy [D-295.960](#)**

RESOLVED, That our American Medical Association evaluate the cost/value equation, benefits, and consequences of the implementation of standardized clinical exams as a step for licensure, along with the barriers to more meaningful examination feedback for both examinees and US medical schools, and provide recommendations based on these findings; and be it further

RESOLVED, That our AMA evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills exam and their implications for US medical students and international medical graduates.

905. ATHLETE CONCUSSION MANAGEMENT AND CHRONIC TRAUMATIC ENCEPHALOPATHY PREVENTION
Introduced by Medical Student Section

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy [H-470.957](#)

RESOLVED, That our American Medical Association support the adoption of evidence-based guidelines for the evaluation and management of concussions by all athletic organizations; and be it further

RESOLVED, That our AMA encourage further research in the diagnosis, treatment, and prevention of chronic traumatic encephalopathy.

906. EXPLORING THE FEASIBILITY OF CLINIC-BASED RESIDENCY PROGRAMS
Introduced by International Medical Graduate Section

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

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy [D-310.953](#)

RESOLVED, That our American Medical Association advocate that key stakeholders, such as the Accreditation Council for Graduate Medical Education, explore the feasibility of extending residency programs through a pilot study placing medical graduates in integrated physician-led practices in order to expand training positions and increase the number of physicians providing healthcare access; and be it further

RESOLVED, That our AMA encourage that pilot studies of clinic-based residency program expansion be funded by private sources.

907. MODERN CHEMICAL CONTROLS POLICY
Introduced by Minority Affairs Section, National Medical Association

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

HOUSE ACTION: POLICY [D-135.976](#) AMENDED AS FOLLOWS
IN LIEU OF RESOLUTION 907

D-135.976 Modernization of the Federal Toxic Substances Control Act (TSCA) of 1976

Our AMA will: (1) support collaborate with relevant stakeholders to advocate for modernizing the Toxic Substances Control Act (TSCA) to require chemical manufacturers to provide adequate safety information on all chemicals and give federal regulatory agencies reasonable authority to regulate hazardous chemicals in order to protect the health of all individuals, especially vulnerable populations; (2) support the public disclosure of chemical use, exposure and hazard data in forms that are appropriate for use by medical practitioners, workers, and the public; and (3) work with members of the Federation to promote a reformed TSCA that is consistent with goals of Registration, Evaluation, Authorisation, and Restriction of Chemicals (REACH).

908. HYDRAULIC FRACTURING
Introduced by Maryland

Considered on reaffirmation calendar.

**HOUSE ACTION: POLICY D-135.976 REAFFIRMED
 IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, that our American Medical Association work for adoption of a common national standard regarding access to and use of information regarding toxic chemicals by a physician who is treating a patient suspected of toxic chemical exposure.

RESOLUTION 909 NOT CONSIDERED AT THE INTERIM MEETING

RESOLUTION 910 NOT CONSIDERED AT THE INTERIM MEETING

**911. PROMOTING HEALTH AWARENESS AND PREVENTIVE SCREENINGS
 IN INDIVIDUALS WITH DISABILITIES**

Introduced by American Academy of Physical Medicine and Rehabilitation, American Association of Neuromuscular and Electrodiagnostic Medicine, American Academy of Family Physicians, American College of Rheumatology, American Academy of Neurology, American College of Radiology, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy [H-425.970](#)

RESOLVED, That our American Medical Association work closely with relevant stakeholders to advocate for equitable access to health promotion and preventive screenings for individuals with disabilities.

912. CRISIS IN MEDICATION SHORTAGES
Introduced by New Jersey

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

**HOUSE ACTION: POLICY H-100.956 AMENDED AS FOLLOWS
 IN LIEU OF RESOLUTION 912**

Policy H-100.956[6] amended by addition and deletion, to read as follows:

H-100.956 National Drug Shortages

1. Our AMA supports the recommendations of the 2010 Drug Shortage Summit convened by the American Society of Health System Pharmacists, American Society of Anesthesiologists, American Society of Clinical Oncology and the Institute for Safe Medication Practices and work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
2. Our AMA supports requiring all manufacturers of Food and Drug Administration approved drugs and, including FDA approved drugs with recognized off-label uses, to give the agency advance notice (at least 6 months prior or otherwise as soon as practicable) of anticipated voluntary or involuntary, permanent or temporary, discontinuance of the manufacture or marketing of such a product.

3. Our AMA supports authorizing the Secretary of Health and Human Services to expedite facility inspections, and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA supports the creation of a task force to enhance the HHS Secretary's response to preventing and mitigating drug shortages and to create a strategic plan to: (a) enhance interagency coordination; (b) address drug shortage possibilities when initiating regulatory actions (including the removal of unapproved drug products from the market); (c) communicate with stakeholders; and (d) consider the impact of drug shortages on research and clinical trials.
5. Our AMA will advocate that the U.S. Food and Drug Administration and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
6. The Council on Science and Public Health shall continue to evaluate the drug shortage issue and report back at least annually to the House of Delegates on progress made in addressing drug shortages as appropriate.
7. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors, including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. The Council will monitor and evaluate the forthcoming report on drug shortages from the Government Accountability Office and report back on its findings.
8. Our AMA urges that procedures be put in place: (1) for the FDA to monitor the availability of Schedule II controlled substances; (2) for the FDA to identify the existence of a shortage that is caused or exacerbated by existing production quotas; and, (3) for expedited DEA review of requests to increase aggregate and individual production quotas for such substances.
9. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
10. Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies allow for more reasonable and sustainable payment rates for prescription drugs.

913. PRE MEDICAL SCHOOL SHADOWING
Introduced by Washington

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

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association promote the development of programs that assist physicians in providing pre-medical shadowing opportunities; and be it further

RESOLVED, That our AMA communicate to the Association of American Medical Colleges that for medical schools which have the pre-medical shadowing requirement, aiding these underprivileged students in getting their shadowing is an obligation of the medical school.

914. CHANGE RURAL AND OFF SITE RURAL TRAINING TRACK REQUIREMENTS IN ORDER TO PRESERVE AND ENCOURAGE INTEREST IN RURAL RESIDENCY PROGRAMS
Introduced by Mississippi

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

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services to allow for up to one month in the second post graduate year and one month in the third post graduate year of an ABMS/AOA approved Family Medicine, General Internal Medicine or General Pediatric residency to occur in the office of a primary care physician who is listed and meets the qualifications for adjunct faculty of the sponsoring institution; and

RESOLVED, That our AMA work with the Accreditation Council of Graduate Medical Education Residency Review Committee for Family Medicine and other specialties to adjust GME program requirements so that the patient encounters during this experience may count toward the continuity requirements for the completion of a residency.

915. JOINT COMMISSION ACCREDITATION STANDARD FOR PAIN ASSESSMENT
Introduced by Mississippi

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

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policies [H-220.931](#) and [D-220.970](#)

RESOLVED, That our American Medical Association urge The Joint Commission to reevaluate its accreditation standard for pain assessment, including evidence on whether the standard improves pain management practices, in order to ensure that the standard supports physician's abilities to select the most appropriate treatment options for their patients; and be it further

RESOLVED, That Policy H-220.931, which asks that standards and performance measure set forth by The Joint Commission be supported by the best available evidence, be reaffirmed.

916. SUPPORT STRICTER OSHA SILICA PERMISSIBLE EXPOSURE LIMIT STANDARD
Introduced by American Thoracic Society

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

HOUSE ACTION: ADOPTED
See Policy [D-135.974](#)

RESOLVED, That our American Medical Association support the Department of Labor's Occupational Safety and Health Administration's (OSHA's) proposed rule to establish a stricter permissible exposure limit (PEL) for respirable crystalline silica; and be it further

RESOLVED, That our AMA support OSHA's proposed rule to establish a stricter standard of exposure assessment and medical surveillance requirements to identify adverse health effects in exposed populations of workers; and be it further

RESOLVED, That our AMA submit comments, in collaboration with respiratory and occupational health medical societies, in support of a stricter silica PEL.

**917. CULTURALLY, LINGUISTICALLY, COMPETENT MENTAL HEALTH CARE
AND OUTREACH FOR AT-RISK COMMUNITIES**
Introduced by California

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy [H-345.974](#)

RESOLVED, That our American Medical Association support adequate attention and funds being directed towards culturally and linguistically competent mental health direct services for the diverse, multi-ethnic communities at greatest risk; and be it further

RESOLVED, That our AMA encourage greater cultural and linguistic-competent outreach to ethnic communities including partnerships with ethnic community organizations, health care advocates, and respected media outlets.

918. HIV SCREENING, CONTINUUM OF CARE AND MAINTENANCE OF FUNDING
Introduced by California

Considered on reaffirmation calendar.

**HOUSE ACTION: POLICIES [H-20.899](#), [H-20.907](#), [H-20.922](#) AND [D-20.992](#) REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support, and encourage physicians to follow, the recommendations of the Centers for Disease Control and Prevention and the US Preventive Services Task Force, to offer voluntary, opt-out HIV screening to all adolescents and adults, so that all infected persons in the US population can be identified and offered care and treatment; and be it further

RESOLVED, That our AMA support public health efforts and public-private partnerships that strive to assure that all persons who test positive for HIV are linked to care and treatment, provided with antiretroviral treatment, retained in care, and enabled to suppress the virus for their own benefit and to significantly reduce transmission; and be it further

RESOLVED, That our AMA support the maintenance of funding for those HIV services currently provided under the Ryan White CARE Act, which will not be covered by the Patient Protection and Affordable Care Act (PPACA); including HIV care and treatment for persons categorically ineligible for the PPACA, and support and ancillary services that help patients to remain in treatment and to avoid infecting others.

919. HIGH COST OF RECERTIFICATION
Introduced by Georgia

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

**HOUSE ACTION: POLICIES [H-275.923](#), [H-275.924](#), [D-275.969](#) AND [D-275.971](#) REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association request an investigation into the high cost of recertification and, if such investigation warrants reduction of recertification fees, that our AMA urge/advocate for a reduction by the ABMS of recertification fees.

920. TELEMEDICINE LICENSURE
Introduced by Georgia

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

**HOUSE ACTION: POLICIES [H-480.969](#) AND [D-480.999](#) REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support the continuation of telemedicine licensure by individual states and opposes efforts to change such to federal licensure of telemedicine.

921. GUN VIOLENCE
Introduced by Pennsylvania

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy [H-145.997](#)

RESOLVED, That our American Medical Association strongly urge US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

922. EXAMINING THE CHANGING NATURE OF US MEDICAL RESIDENCIES
Introduced by Young Physicians Section

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

HOUSE ACTION: ADOPTED
See Policy [H-200.954](#)

RESOLVED, That our American Medical Association continue to study the effect of ever increasing match participants and the stagnant growth of US residency positions with a report back at the 2014 Annual Meeting.

923. CMS DEFINITION OF “RESIDENT PHYSICIAN”
Introduced by Resident and Fellow Section

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

HOUSE ACTION: REFERRED WITH REPORT BACK AT THE 2014 ANNUAL MEETING

RESOLVED, That our American Medical Association advocate, in conjunction with appropriate stakeholders, that the Centers for Medicare & Medical Services use our AMA definition of Resident when formulating rules and regulations.