Organized Medical Staff Section

33rd Interim Meeting
Walt Disney World Swan and Dolphin Resort
Orlando, Fla.

November 10-12, 2016
Please find enclosed the handbook for the 2016 AMA-OMSS Interim Meeting, which will be held November 10-12 at the Walt Disney World Swan and Dolphin Resort in Orlando, Fla. Additional meeting materials—such as education program slides—will be made available electronically via the Interim Meeting webpage as they become available: www.ama-assn.org/go/OMSSInterim.

We have planned an exciting three days of education programming, networking opportunities, policy discussions, and more. Below are a few highlights:

**Interactive education programs**

The meeting will feature a series of innovative and interactive education programs on today's most pressing medical staff matters. You can find complete program details in the Education Guide. We hope that you will come to the meeting prepared to discuss the following questions and more with your fellow medical staff peers:

- What are the most pressing challenges your medical staff faces?
- How does your organization seek to improve patient experience?
- How does your medical staff identify and develop future physician leaders?
- How does your medical staff go about ensuring that independent and employed members alike are fully engaged in your efforts to improve patient care?

**Networking breakfasts**

- Friday, November 11, 7-7:45 am, Swan Ballroom Foyer
  Whether you are a medical staff leader, a hospital administrator, an independent member of the medical staff, or something else, there are many other OMSS meeting attendees like you! Meet them and share your experiences at this informal networking breakfast.
• Saturday, November 12, 7-7:45 am, Swan Ballroom
  Didn’t get the opportunity to ask a question at the end of an education program? Come to this informal networking breakfast to meet and chat with many of the OMSS education program speakers.

Policy discussions

The meeting will present a variety of opportunities for attendees to discuss and take action on issues vital to organized medical staffs and their members. Please be sure to review the Policy portion of the handbook in advance of the meeting.

Additionally, we would like to encourage all AMA members, whether able to attend the meeting or not, to submit testimony on AMA-OMSS resolutions and reports via the AMA Online Member Forum (www.ama-assn.org/go/OMSSForum), which will be open through November 8.

First-time meeting attendees

All first-time meeting attendees are invited to attend the AMA-OMSS Orientation (Thursday, November 10, 1-1:30 pm, Peacock). Learn more about the Section, and about how our meetings run.

First-time meeting attendees will also be assigned an Advisor (an experienced member of the AMA-OMSS), who will be available to you throughout the meeting. Watch your email for details.

Questions?

If you have any questions about the meeting or the enclosed materials, please contact the Department of Organized Medical Staff Services at (312) 464-5622 or omss@ama-assn.org.

We look forward to seeing you in Orlando!
AMA Organized Medical Staff Section

2016 Interim Meeting
Walt Disney World Swan and Dolphin Resort
November 10-12

All events will be held at the Swan Hotel unless noted otherwise.

Thursday, November 10

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<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>10 am - 6 pm</td>
<td>Registration</td>
<td>Dolphin Hotel Convention Foyer</td>
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<tr>
<td>10 am - 5 pm</td>
<td>OMSS Credentialing</td>
<td>Swan Ballroom 5</td>
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<tr>
<td>11 am - 1:15 pm</td>
<td>OMSS caucus meetings</td>
<td>TBA</td>
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<tr>
<td>1 - 1:30 pm</td>
<td>OMSS orientation</td>
<td>Peacock</td>
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<td>1:30 - 2:30 pm</td>
<td>OMSS Assembly opening session</td>
<td>Swan Ballroom 5</td>
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<tr>
<td>2:30 - 5 pm</td>
<td>OMSS Reference Committee hearing</td>
<td>Swan Ballroom 5</td>
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<tr>
<td>5:45 - 6:45 pm</td>
<td>OMSS reception</td>
<td>Swan Ballroom 5</td>
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Friday, November 11

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<thead>
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<tbody>
<tr>
<td>7 am - 6 pm</td>
<td>Registration</td>
<td>Dolphin Hotel Convention Foyer</td>
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<tr>
<td>7 am - 5 pm</td>
<td>OMSS Credentialing</td>
<td>Swan Ballroom 5</td>
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<tr>
<td>8 - 9 am</td>
<td>Education program -- Emerging issues in medical staff affairs</td>
<td>Swan Ballroom 5</td>
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<tr>
<td>9:15 - 10:15 am</td>
<td>Education program -- Creating a culture of excellence to deliver value and restore joy and resiliency to the practice of medicine</td>
<td>Swan Ballroom 5</td>
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<tr>
<td>10:45 - 11:45 am</td>
<td>OMSS State and Caucus Chairs Meeting</td>
<td>Swan Ballroom 4</td>
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<tr>
<td>12 - 1:30 pm</td>
<td>OMSS Caucus Meetings</td>
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<tr>
<td>1:45 - 2:45 pm</td>
<td>Education program -- Preparing for MACRA/Washington update</td>
<td>Swan Ballroom 5</td>
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<td>3 - 4:30 pm</td>
<td>OMSS Assembly Business Meeting</td>
<td>Swan Ballroom 5</td>
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<tr>
<td>4:30 - 5:30 pm</td>
<td>OMSS Open Forum</td>
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**Saturday, November 12**

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<td>Registration</td>
<td>Dolphin Hotel Convention Foyer</td>
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| 8 - 9 am        | Education program - Mentorship in medicine  
                    *Co-sponsored by OMSS and the Young Physicians Section* | Swan Ballroom 5           |
| 9:15 - 10:15 am | Education program - Leading through effective communication                              | Swan Ballroom 5           |
| 10:30 - 11:30 am| Education program - Engaging independent and employed physicians  
                    *Co-sponsored by OMSS and the Integrated Physician Practice Section* | Swan Ballroom 5           |
| 12:30 - 1:30 pm | Physician employment discussion group  
                    *Co-sponsored by OMSS, the Resident and Fellow Section, and the Young Physicians Section* | Swan Ballroom 5           |
| 2 - 6 pm        | House of Delegates (HOD) opening session                                                | Pacific A-B (Dolphin)     |

**Sunday, November 13**

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<tr>
<td>6:45 - 7:45 am</td>
<td>OMSS briefing and strategy session for HOD reference committee hearings</td>
<td>Toucan 1</td>
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<tr>
<td>8 - 8:30 am</td>
<td>HOD second opening session</td>
<td>Pacific A-B (Dolphin)</td>
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| 8:30 am - noon  | HOD Reference Committee hearings:  
                    Reference Committee B - Southern Hemisphere 2  
                    Reference Committee C - Southern Hemisphere 4–5  
                    Reference Committee F - Pacific A–B  
                    Reference Committee J - Southern Hemisphere 3  
                    Reference Committee K - Southern Hemisphere 1 | Various Dolphin Hotel locations (see left) |
| 1 - 2 pm        | OMSS debriefing session for HOD reference committee hearings                              | Toucan 1                  |
| 3 - 5 pm        | Litigation Center open meeting                                                          | Northern Hemisphere E 1–2 (Dolphin) |
Get connected with the AMA Meetings app

The AMA Meetings app will be a vital resource center as well as a hub for networking opportunities with fellow attendees. Take advantage of this powerful tool to:

• Control privacy settings
• Build your schedule and export it to your calendar
• Find colleagues and text message fellow attendees
• Access reports, resolutions and Policy Finder
• Take notes and share photos from sessions
• Share #AMAmtg activity on Twitter and Facebook

AMA Meetings app basics

Where can I download the mobile app?

The "AMA Meetings" mobile app is available for iPhone and Android devices in Apple's App Store and the Google Play store. You can find the app in either store by searching for "AMA Meetings."

The app is asking me to log in. Why do I need to log-in?

Once you log in to the mobile app, you will be able to access the same schedules, bookmarks, reminders, notes, and contacts on your phone, tablet, and desktop.
Where can I get my log-in information?

The log-in process is largely self-managed. Follow the steps below to log in from your device:

- **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.
- **Enter your info:** You'll be prompted to enter your first and last name. Tap Next. Enter an email address, then tap Next again.
- **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.

I've requested log-in information, but I never received an email.

If you haven't received your log-in information, one likely culprit may be your spam filter. We try to tailor our email communications to avoid this filter, but some emails end up there anyway. Please first check the spam folder of your email client. The sender may be listed as CrowdCompass or AMA Meetings.

I lost my log-in info, and I forgot my confirmation code. How do I log myself back in?

To have a verification email resent to you, start by accessing the sign-in page.

- **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.
- **Enter your info:** You'll be prompted to enter your first and last name. Tap Next.
- **Click on Forgot Code:** If you've already logged in before, the app will already know your email address and will send a verification email to you again.
- **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.

How do I create my own schedule?

- **Open the Schedule.** After logging in, tap the Schedule icon.
- **Browse the Calendar.** Switch days by using the date selector at the top of the screen. Scroll up and down to see all the sessions on a particular day.
- **See something interesting?** Tap the plus sign to the right of its name to add it to your personal schedule.

How can I export my schedule to my device's calendar?

- **Access your schedule.** After logging in, tap the hamburger icon in the top right, then My Schedule.
Here you'll see a personalized calendar of the sessions you'll be attending. You can tap a session to see more details.

Export it. Tap the download icon at the top right of the screen. A confirmation screen will appear. Tap Export and your schedule will be added directly to your device's calendar.

How do I allow notifications on my device?

Allowing Notifications on iOS:

- **Access the Notifications menu.** From the home screen of your phone, tap Settings, then Notifications.
- **Turn on Notifications for the app.** Find the AMA Meetings app on the list and tap its name. Switch Allow Notifications on.

Allowing Notifications on Android:  
Note: Not all Android phones are the same. The directions below walk you through the most common OS, Android 5.0.

- **Access the Notification menu.** Swipe down on the home screen of your phone, then click the gear in the top right. Tap Sounds and notifications.
- **Turn on Notifications for the AMA Meetings app.** Scroll down and tap App notifications. Find the AMA Meetings app on the list. Switch notifications from off to on.

How do I manage my privacy within the app?

Set Your Profile to Private...

- **Access your profile settings.** If you’d rather have control over who can see your profile, you can set it to private.
- After logging in, tap the hamburger icon in the top left, then tap your name at the top of the screen.
- **Check the box.** At the top of your Profile Settings, make sure that the box next to "Set Profile to Private" is checked.

...Or Hide Your Profile Entirely

- **Access the Attendee List.** Rather focus on the conference? Log in, open the Event Directory, and tap the Attendees icon.
- **Change your Attendee Options.** Click the Silhouette icon in the top right to open Attendee Options.
- **Make sure the slider next to "Show Me On Attendee List" is switched off.** Fellow attendees will no longer be able to find you on the list at all.

How do I message other attendees within the app?

- **Access the Attendee List.** After logging in, tap the Attendees icon.
- **Send your message.** Find the person you want to message by either scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon to start texting.
- **Find previous chats.** If you want to pick up a chat you previously started, tap the hamburger icon in the top right, then *My Messages.*

**How do I block a person from chatting with me?**

- **Access the Attendee List.** Rather focus on the conference? Just as before, log in and tap the Attendees icon.
- **Block the person.** Find the person you'd like to block about by scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon. But, don't type anything, instead tap Block in the top right.

**I want to network with other attendees. How do I share my contact info with them?**

- **Access the Attendee List.** After logging in, tap the Attendees icon.
- **Send a request.** Find the person you want to share your contact information by either scrolling through the list or using the search bar at the top of the screen.
  - Tap their name, then the plus icon to send a contact request. If they accept, the two of you will exchange info.

**I want to schedule an appointment with other attendees. How do I do that?**

- **Navigate to My Schedule.** Tap the hamburger icon in the top left, then My Schedule.
- **Create Your Appointment.** In the top right corner of the My Schedule page you'll see a plus sign.
  - Tap on it to access the Add Activity page.
- **Give your appointment a name, a start and end time, and some invitees.** When you're finished, tap Done. Invitations will be immediately sent to all relevant attendees.

**How do I take notes within the app?**

**Write Your Thoughts...**

- **Find your Event Item.** After logging in, find the session, speaker, or attendee you'd like to create a note about by tapping on the appropriate icon in the Event Directory, then scrolling through the item list. Once you've found the item you're looking for, tap on it.
- **Write your note.** Tap the pencil icon to bring up a blank page and your keyboard. Enter your thoughts, observations, and ideas. Tap Done when you've finished.

...Then Export Them

- **Navigate to My Notes.** Tap the hamburger icon in the top right, then "My Notes. Here you'll find all the notes you've taken organized by session.
- **Choose where to send your notes.** Tap the share icon in the top right and the app generates a draft of an email that contains all your notes. Enter an email address, then tap Send.
**Features:**

- 10,000 square foot sound booth running along the side of both ballrooms
- Programmable lighting and hang points in ceiling
- Extensive ventilation system permitting indoor pyrotechnics
- Drive-in freight elevator: 23’L x 10’W x 12’H; load limit: 12,000 lbs.
- Fully scalable DS-3 class Internet service, delivered via our fiber-optic and Ethernet backbone, available in the ballrooms and foyers
- Wireless access available throughout the ballrooms and foyers
- Salon B and Salon D in the Hemispheres Ballroom cannot stand alone
- Built-in A/V booth in Americas Seminar Room
- Complimentary house phone in Americas Seminar Room
- Convention network infrastructure managed by on-site technicians
- On-site audio/visual services department
FEATURES:

- Both fluorescent and incandescent adjustable lighting
- Simultaneous recording of presentation through a central audio mixer
- Each room includes four solid walls with bulletin board wall to maximize sound proofing, built-in A/V screen, and patches for microphone and video
- Drive-in freight elevator: 23’L x 10’W x 12’H; load limit: 12,000 lbs.
- Fully scalable DS-3 class Internet service, delivered via our fiber-optic and Ethernet backbone, available in all meeting rooms and foyers
- Wireless access available throughout all meeting rooms and foyers
- Complimentary house phone in meeting rooms
- Australia Boardroom
  - Projection display system and upgraded A/V system with touchpad control
  - Warm, modern décor with luxurious blonde wood paneling
  - Executive board table for 16 with over-sized ergonomic leather chairs
  - Private entry area
  - Connected his/hers lavatories
AMA-OMSS Governing Council, 2016-2018

David Welsh, MD, Chair
Dr. Welsh is a general surgeon in solo practice in Batesville, Ind., and the OMSS representative for Margaret Mary Health and Decatur County Memorial Hospital.

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John Spurlock, MD, Vice Chair
Dr. Spurlock is a gynecologist in solo practice in Bethlehem, Penn., and the OMSS representative for St. Luke’s Hospital.

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Nancy Church, MD, Secretary
Dr. Church is an obstetrician and gynecologist in solo practice in Chicago, Ill., and the OMSS representative for Advocate Christ Medical Center.

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Lee Perrin, MD, Delegate
Dr. Perrin is an anesthesiologist with CAP Anesthesia, PC, in Boston, Mass., and the OMSS representative for Steward St. Elizabeth's Medical Center.

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Matthew Gold, MD, Alternate Delegate
Dr. Gold is a neurologist in solo practice in Winchester, Mass., and the OMSS representative for Highland Healthcare Associates.

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Hoyt Burdick, MD, Member-at-Large
Dr. Burdick is an internist, pulmonologist, intensivist, and Senior Vice President and Chief Medical Officer at Cabell Huntington Hospital in Huntington, W.Va., for which he also serves as the OMSS representative.

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John Flores, MD, Member-at-Large
Dr. Flores is an internist with Little Elm Medical Clinic in Little Elm, Tx., and the OMSS representative for Centennial Medical Center.

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Arthur Snow, Jr., MD, Chair
Dr. Snow is a family physician and gerontologist in solo practice in Shawnee Mission, Kan., and the OMSS representative for Shawnee Mission Medical Center.

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AMA-OMSS Staff

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American Medical Association
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Chicago, IL 60611

Fax:
(312) 464-2450
### AMA-OMSS Committees
#### 2016 Interim Meeting

**Education Committee**

<table>
<thead>
<tr>
<th>Name</th>
<th>State</th>
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<tbody>
<tr>
<td>Matt Gold, MD, Chair</td>
<td>Massachusetts</td>
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<tr>
<td>Peter Aran, MD</td>
<td>Oklahoma</td>
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<tr>
<td>Nancy Church, MD</td>
<td>Illinois</td>
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<td>John Flores, MD</td>
<td>Texas</td>
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<tr>
<td>Alan Klitzke, MD</td>
<td>New York</td>
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<td>Michael Lew, MD</td>
<td>Massachusetts</td>
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<td>Frederick Ridge, Jr, MD</td>
<td>Indiana</td>
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<tr>
<td>Arthur Snow, Jr, MD</td>
<td>Kansas</td>
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<tr>
<td>David Welsh, MD</td>
<td>Indiana</td>
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**Reference Committee**

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<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Richard Butcher, MD, Chair</td>
<td>California</td>
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<tr>
<td>Thomas Whiteman, MD</td>
<td>Indiana</td>
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<tr>
<td>Donald Timmerman, MD</td>
<td>Connecticut</td>
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<td>Alison Jones, MD</td>
<td>Illinois</td>
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**Committee on Late Resolutions**

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<tr>
<td>Ajoy Kumar, MD, Chair</td>
<td>Florida</td>
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<tr>
<td>Edgar Boyd, Jr, MD</td>
<td>Oklahoma</td>
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<tr>
<td>Matthew Gold, MD</td>
<td>Massachusetts</td>
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<td>Judd Kline, MD</td>
<td>Massachusetts</td>
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<td>Nancy Mueller, MD</td>
<td>New Jersey</td>
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**Tellers Committee**

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<tr>
<td>Nancy Fan, MD, Chair</td>
<td>Delaware</td>
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<td>Michael Lew, MD</td>
<td>Massachusetts</td>
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<td>Peggy Barjenbruch, MD</td>
<td>Missouri</td>
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<tr>
<td>Name</td>
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<tr>
<td>Hoyt Burdick, MD</td>
<td>West Virginia</td>
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<td>Lee Perrin, MD</td>
<td>Massachusetts</td>
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<td>Stephen House, MD</td>
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<td>Raj Lal, MD</td>
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<td>Bob Tortolani, MD</td>
<td>Vermont</td>
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<td>Martin Trichtinger, MD</td>
<td>Pennsylvania</td>
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A list of OMSS meeting registrants will be available at the meeting.
Items of Business

Resolutions

Resolution 1 - Limitation on Reports by Insurance Carriers to the National Practitioner Data Base Unrelated to Patient Care
Resolution 2 - Closing the Loop on Pharmaceuticals
Resolution 3 - Revisiting the E-Cigarette Scourge

Governing Council Reports

Whereas, The purpose of legislation establishing the National Practitioner Data Base (NPDB) was to create a record of physicians whose medical treatment of a patient resulted in harm;

Whereas, The regulations and NPDB Guidebook interpreting when a report should be filed have expanded beyond the goal and intended purpose of the legislation to include reports by malpractice carriers of physicians who were not involved in patient care;

Whereas, Medical malpractice carriers may err on the side of reporting to the NPDB because of the penalties that may be levied for failure to report; and

Whereas, Reports to the NPDB are damaging to a physician’s reputation, employment status, hospital medical staff privileges, and future employment opportunities; therefore be it

RESOLVED, That our American Medical Association formally request that the Health Resources and Services Administration (HSRA) clarify that reports of medical malpractice settlements by physicians are contingent upon treatment, the provision of or failure to provide healthcare services, of the plaintiff; and be it further

RESOLVED, That our American Medical Association formally request that HSRA audit the NPDB for reports on physicians who were not involved in the treatment of a plaintiff, but were reported as a result of a healthcare entity’s settlement of a claim that included the name of the physician in his/her administrative role at the entity; and be it further

RESOLVED, That HSRA should be compelled to remove the name of any physician from the NPDB who was reported by a medical malpractice carrier as the result of the settlement of a claim by a healthcare entity where the physician was not involved in the treatment of the plaintiff.

Fiscal Note: Not yet determined

Received: 9/29/2016
AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution: 2
(I-16)

Introduced by: Lee Ansel, MD
(Arizona)

Subject: Closing the Loop on Pharmaceuticals

Referred to: OMSS Reference Committee
(Richard Butcher, MD, Chair)

1 Whereas, There has been little to no organized public education on the safe and proper
disposal of drugs, pills, and other pharmaceuticals; and

2 Whereas, The American Medical Association (AMA) can take a leadership role in addressing
the growing and negative environmental impact on the nation’s water systems of improperly
disposing of these chemicals, drugs and their metabolites; and

3 Whereas, There have been reports in the media on drugs and their metabolites turning up in
major waste-water systems and in downstream effluent pools, such as cocaine in the fish of
Puget Sound, and hormones or their metabolites being found in fish and other amphibians; and

4 Whereas, The large, national chains and corporate conglomerates that dispense the drugs
make huge profits in selling, marketing, and taking other preliminary steps that result in the
improper disposal of these drugs and their metabolites; and

5 Whereas, The most effective way to combat this social problem is at the national level; therefore
be it

RESOLVED, That our American Medical Association (AMA) take a leadership role in educating
large, national chains and corporate conglomerates that dispense pharmaceutical drugs of the
need to address the growing and negative environmental impact caused by the improper
disposal of these pharmaceutical drugs and their metabolites; and be it further

RESOLVED, That our AMA urge federal agencies to mandate pharmaceutical companies and
retailers, including but not limited to CVS, Walgreens, Walmart, and Costco, to take on the
responsibility of taking back and properly disposing of outdated, expired, or unused drugs in an
environmentally responsible and proper way; and be it further

RESOLVED, That our AMA educate the public on the growing hazards and necessary methods
to deal with the threat to our water systems posed by the improper disposal of pharmaceutical
drugs and their metabolites.

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

Received: 10/3/2016
RELEVANT AMA POLICY

D-135.993 Contamination of Drinking Water by Pharmaceuticals and Personal Care Products
Our AMA supports the EPA and other federal agencies in engaging relevant stakeholders, which may include, but is not limited to the AMA, pharmaceutical companies, pharmaceutical retailers, state and specialty societies, and public health organizations in the development of guidelines for physicians and the public for the proper disposal of pharmaceuticals and personal care products to prevent contamination of drinking water systems. (Res. 403, A-06; Modified: CSAPH 01, A-16)

H-135.925 Medications Return Program
1. Our AMA supports access to safe, convenient, and environmentally sound medication return for unwanted prescription medications
2. Our AMA supports such a medication disposal program be fully funded by the pharmaceutical industry, including costs for collection, transport and disposal of these materials as hazardous waste.
3. Our AMA supports changes in federal law or regulation that would allow a program for medication recycling and disposal to occur. (Res. 214, A-16)
Whereas, The AMA has already lost the opportunity to be a leader in this important public health issue, unlike 50-60 years ago when it was at the forefront of the battle against cigarettes; and

Whereas, The public health stakes are still quite high with regard to the use of electronic nicotine delivery systems (ENDS); and

Whereas, Smoking is smoking, no matter what the smoke is, and is a public nuisance and potential hazard; and

Whereas, From the inception of ENDS technology, its main purpose and thrust in marketing, advertising, and targets has always been to grow a new population of nicotine-addicted people, which is a major public health issue; and

Whereas, The use of flavors, additives, oils, and other chemicals has been a “smoke” screen to obscure these underlying goals; and

Whereas, The mere fact that ads have, and apparently can appear in all forms of media that were/are outlawed for the classic/traditional form of nicotine delivery (cigarettes) by prior hard-won efforts, thereby allowing the industry to set the parameters of this new debate; therefore be it

RESOLVED, That our American Medical Association (AMA) promptly advocate against electronic nicotine delivery systems (ENDS), including e-cigarettes, and strongly urge federal lawmakers, by whatever means necessary, to impose the same restrictions for ENDS that are applicable to conventional cigarettes, including but not limited to marketing, advertising, age restrictions, and public space prohibitions; (Directive to Take Action) and be it further

RESOLVED, That our AMA provide a report back at the 2017 Annual Meeting detailing the progress of advocacy efforts to urge federal lawmakers to impose restrictions on the use of electronic nicotine delivery systems (ENDS) that are equivalent to those set forth for conventional cigarettes, including but not limited to marketing, advertising, age restrictions, and public space prohibitions. (Directive to Take Action)

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

Received: 10/7/2016
RELEVANT AMA POLICY

H-495.972 Electronic Cigarettes, Vaping, and Health: 2014 Update
1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly.
2. Our AMA encourages further clinical and epidemiological research on e-cigarettes.

H-495.986 Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes
Our AMA: (1) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors; (2) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age; (3) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors; (4) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products; (5) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products; (6) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail; (7) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; (8) opposes the sale of tobacco at any facility where health services are provided; and (9) supports that the sale of tobacco products be restricted to tobacco specialty stores. (CSA Rep. 3, A-04 Appended: Res. 413, A-04 Reaffirmation A-07 Amended: Res. 817, I-07 Reaffirmation A-08 Reaffirmation I-08 Reaffirmation A-09 Reaffirmation I-13 Reaffirmation A-14 Reaffirmation I-14 Reaffirmation A-15 Modified in lieu of Res. 421, A-15 Modified in lieu of Res. 424, A-15)
Governing Council Report A will be posted to the OMSS Interim Meeting webpage when it becomes available:

www.ama-assn.org/go/OMSSInterim
Emerging issues in medical staff affairs

Friday, November 11, 8-9 am
Swan Ballroom 5

The American Medical Association’s Organized Medical Staff Section (OMSS) is the only national, physician-led group dedicated to helping medical staffs improve patient care and otherwise effect positive change in their practice environments. Among other functions, the OMSS regularly surveys the healthcare environment to identify emerging trends in medical staff affairs, and produces resources to help medical staffs address such trends.

This program will provide an overview of a number of trends and include tips as to how medical staffs can effectively address these issues. Topics to be covered include:

- Criminal background checks and drug testing for medical staff members;
- Revised requirements for reporting adverse medical staff actions to the National Practitioner Data Bank (NPDB);
- Assessment of senior physician competency; and
- Problems arising in medical staffs composed of both hospital-employed and independent members (“mixed” medical staffs).

Upon completion of this activity the physician will be able to:

1. Describe how medical staffs can update their bylaws to accommodate criminal background checks and drug testing for medical staff members, if they wish to implement such requirements.
2. Identify how medical staffs should update their bylaws to ensure that members are appropriately protected following revisions to the NPDB reporting guidelines.
3. Explain why medical staffs are encouraged to implement a process to assess senior physician competency.
4. Define how mixed medical staffs can engage and ensure representation of the voices of both hospital-employed and independent physicians.

Faculty:

- Susan DuBois, CPCS, CPMSM, President-elect, National Association Medical Staff Services
- Arthur D. Snow, Jr., MD, Immediate Past Chair, AMA-OMSS Governing Council

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The American Medical Association designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Creating a culture of excellence to deliver value and restore joy and resiliency to the practice of medicine

Friday, November 11, 9:15-10:30 am
Swan Ballroom 5

American healthcare is in the midst of a transformation to address rising costs and suboptimal access. At the cornerstone of this transformation is a shift from the traditional fee-for-service payment structure to a value-based payment system which is rooted in providing desired outcomes, without harm, without waste, and with an excellent experience for the patients we have the privilege of serving. Regrettably, as a result of the rapid pace and suboptimal implementation of many of these changes, we are simultaneously witnessing an alarming increase in physician and caregiver burnout.

Fortunately, healthcare leaders are increasingly recognizing the need to create a culture of excellence to drive the improvements necessary to navigate the ongoing transformation successfully and without harm to patients, physicians, and caregivers. The question is how best to accomplish this?

This program will explore the true meaning of patient experience and engagement and identify gaps that must be addressed to deliver patient-centered, team-based care which embraces respect, trust, and compassion. Effective solutions to close these gaps will be discussed. In addition, the program will explore how creating a culture of excellence impacts teamwork, safety, clinical outcomes, and efficiency. The interconnection of executing this work and addressing one significant contributing factor to caregiver burnout will also be assessed. Finally, the program will analyze how creating a culture of excellence can, in addition to benefiting patients, physicians, and caregivers, produce a positive return on investment for the organization.

Upon completion of this activity the physician will be able to:

1. Summarize the true meaning of patient experience and engagement.
2. Identify the key drivers of creating a culture of excellence and solutions to develop this culture.
3. Explain the interconnection between creating a culture of excellence and delivering on every component of the value equation (clinical outcomes, safety, experience, and efficiency)
4. Discuss the interconnection between creating a culture of excellence and the positive impact on physician and caregiver burnout.

Faculty:
- William Maples, MD, Executive Director and Chief Experience Officer, The Institute for Healthcare Excellence

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The American Medical Association designates this live activity for a maximum of 1.25 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Preparing for MACRA/Washington update
Friday, November 11, 1:45-2:15 pm
Swan Ballroom 5

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), represents the biggest change in physician payment in more than 25 years. MACRA allows physicians to choose between adopting new payment models or retaining Medicare’s fee-for-service model. The proposed rule was issued on April 27, 2016, by the Centers for Medicare & Medicaid Services (CMS), with a final rule expected to be released in late October 2016.

This session will provide an overview of the final MACRA rule and its impact on physicians. The session will also explore the AMA’s ongoing dialogue with Administration officials and Congress to influence the implementation of the new rule and efforts to develop resources and tools that will enable physicians to succeed under the new payment systems.

Upon completion of this activity the physician will be able to:
1. Summarize the final rule.
2. Examine how the new payment systems will impact physicians.
3. Describe the AMA’s tools and resources available to help physicians succeed under the new payment systems.

Faculty:
- Richard Deem, Senior Vice President for Advocacy, AMA

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The American Medical Association designates this live activity for a maximum of 0.5 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Leading through effective communication

Saturday, November 12, 9:15-10:15 am
Swan Ballroom 5

Effective communication is an essential skill for physician leaders. From engaging peers to achieving consensus to securing buy-in for key initiatives, a physician leader must be able to clearly communicate his or her vision to a diverse group of stakeholders, each with its own motivations and communication style.

This program will explore the link between effective communication and realizing your goals as a physician leader. Using case studies, the program will also discuss various communication styles and illustrate how a physician leader can most effectively engage and lead diverse groups of stakeholders.

Upon completion of this activity the physician will be able to:
1. Explain why effective communication is an essential skill for physician leaders.
2. Identify various communication styles.
3. Describe how to engage and lead individuals with different communication styles.

Faculty:
- Peter Angood, MD, CEO, American Association for Physician Leadership

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The American Medical Association designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Engaging independent and employed physicians

Saturday, November 12, 10:30-11:30 am
Swan Ballroom 5

The demographics of the traditional organized medical staff are shifting. With recent trends in physician employment, employed physicians now constitute a majority of the medical staff in many hospitals. In addition, as healthcare services continue to move away from the hospital setting, a growing number of medical staff members provide either low or no volume of clinical services in the hospital. These demographic trends have given rise to “mixed medical staffs,” which require new approaches to ensure the engagement and alignment of all members -- irrespective of employment status or practice setting.

AMA policy holds that members of the medical staff must work collectively to improve patient care and outcomes, regardless of the employment status or practice setting of each individual member. This core principal is at risk when there is a lack of engagement of all members of the medical staff.

This session will examine the importance of physician engagement. Additionally, using real-world examples and case scenarios, this program will provide guidance on how medical staff organizations -- and, more broadly, hospitals and health systems -- can engage and align both employed and independent physicians to improve patient care and health outcomes.

Upon completion of this activity the physician will be able to:
1. Describe the composition of and challenges facing a “mixed” medical staff.
2. Discuss why engagement of both independent and employed physicians is vital to patient care and health outcomes.
3. Identify strategies by which medical staff leaders and hospital/health system administrators can engage both independent and employed physicians.

Faculty:
• Ronald Dunlap, MD, South Shore Cardiology PC
• Michael Glenn, MD, Chief Medical Officer, Virginia Mason Medical Center

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Mentorship in medicine

Saturday, November 12, 8-9 am
Swan Ballroom 5

Engaging in mentorship relationships is a fundamental aspect of physicians’ professional lives, helping them fulfill their obligations to lifelong learning and collegial sharing of knowledge. But successful mentorship, whether as mentor or mentee, does not happen on its own; rather it is the result of a deliberate thought process and constant nurturing of the relationship.

This program will explore the basic concepts of mentorship and identify keys to success for a fruitful mentor-mentee relationship. Drawing on their own experiences, a mentor and a mentee will share their successes and lessons learned in mentorship. Finally, participants will engage in group discussions around three specific types of mentoring: identifying and developing physician leaders, clinical mentorship, and general mentorship around professionalism and being a physician.

Upon completion of this activity the physician will be able to:

1. Explain the value to the medical profession of mentoring relationships.
2. Identify barriers to the establishment and maturation of mentoring relationships.
3. Describe specific strategies for mentoring peers, and for being a good mentee, in the following circumstances: identifying and developing future leaders, clinical mentorship, and mentorship around professionalism.

Faculty:
- Moderator: Rebecca Patchin, MD, Former Chair, AMA Board of Trustees
- Panelists: Maya Babu, MD, Member, AMA Board of Trustees, John Knote, MD, Member, AMA Senior Physician Section Governing Council, Sheila Rege, MD, Medical Director, Northwest Cancer Clinic

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The American Medical Association designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Education Program Presentations

Presentations and other materials for education programs will be posted to the Interim Meeting webpage (www.ama-assn.org/go/OMSSInterim), under the “Meeting Downloads” tab, as they become available, and where presenters have chosen to make those materials available.

Please note that presentations will not be distributed in hard copy at the meeting.
Since the last House of Delegates meeting, the AMA has been involved in the following cases that concern medical staff issues:

1. **Carron v. Rosenthal (RI S.Ct.)**

**Issue**

The issue in this case is whether the Federal Patient Safety and Quality Improvement Act of 2005 (PSQIA) and the analogous Rhode Island Patient Safety Act of 2008 shield hospital incident reports from discovery in litigation, if those incident reports have been prepared solely for the purpose of submission to a Patient Safety Organization (PSO).

**AMA interest**

The AMA supports the protection of peer review information from litigation discovery.

**Case summary**

According to her complaint, Katherine Carron was admitted to Newport Hospital for induction of labor on the morning of June 22, 2013. Randall Rosenthal, MD, a hospital employee, was her obstetrician. Dr. Rosenthal prescribed Pitocin to induce the labor, but it did not work. Twelve hours after Mrs. Carron was admitted, Dr. Rosenthal artificially ruptured her amniotic membranes to further the process. She started bleeding, but the membrane rupture did not seem to work either. Dr. Rosenthal went home, leaving a nurse in charge to monitor Mrs. Carron. No obstetricians were left at the hospital after Dr. Rosenthal went home.

Mrs. Carron continued to bleed, but the nurse assured her that the bleeding was normal. Eventually, it became clear that the bleeding was excessive. After a few hours, Dr. Rosenthal was recalled to the hospital. He performed an emergency C-section, but by then the baby had incurred irreversible brain damage.
Two of the hospital nurses, including the nurse who had allegedly assured Mrs. Carron that her bleeding was normal, prepared incident reports on forms entitled “Medical Event Reporting System,” which described what had occurred. These reports were submitted to a federally and state certified PSO. The hospital did not retain copies.

The Carrons sued Dr. Rosenthal and the hospital for medical malpractice. As part of discovery, depositions were taken of the nurses. Although the nurses had trouble recalling what had happened, they did mention the incident reports.

The Carrons asked the hospital for production of the incident reports, but it objected, based on PSQIA and the Rhode Island Patient Safety Act. Following a motion to compel production of the incident reports, the trial judge ordered the hospital to show the incident reports to the nurses in order to refresh their recollections, and the nurses were then to be redeposited. The hospital would not be required to provide the reports directly to the Carrons.

The Rhode Island Supreme Court is hearing an interlocutory appeal from the order requiring that the reports be shown to the nurses.

Litigation Center involvement

The Litigation Center, along with the Rhode Island Medical Society and numerous other health care organizations, will file an *amicus* brief in the Rhode Island Supreme Court to urge reversal of the trial court order requiring production of the hospital incident reports.

2. **Charles v. Southern Baptist Hospital of Florida (Fla. S.Ct.)**

Issue

The issue in this case is whether the Patient Safety and Quality Improvement Act (PSQIA) privilege against non-disclosure preempts Florida state law, which would otherwise allow a plaintiff in a medical injury lawsuit to discover information voluntarily reported to a Patient Safety Organization (PSO).

AMA interest

The AMA supports federal legislation that will enhance protection of peer review information.

Case summary

Jean Charles, on behalf of her disabled sister and her sister’s children, sued Southern Baptist Hospital of South Florida and several medical personnel, including physicians, for malpractice. Florida law requires the hospital to prepare and maintain the documents in question, but it does not require the hospital to provide them to a state administrative agency unless specifically requested (and no such request has been made). The claimed privilege depends on a close reading of the PSQIA regulations. The plaintiffs read those regulations one way (not to create a privilege), and the hospital read them another (to create a privilege). The trial court agreed with the plaintiffs, denied the claim of privilege, and ordered the hospital to produce the documents. The hospital then asked the Florida District Court of Appeal to accept jurisdiction in order to decide the discoverability question on an interlocutory, expedited appeal.
Medical Staff Case Summary (I-16)

On October 28, 2015, the District Court of Appeal accepted jurisdiction and found PSQIA to be “clear and unambiguous such that the language must be given its plain and obvious meaning.” Under this plain and obvious language, the hospital reports were privileged under the PSQIA. Moreover, a provision of the Florida Constitution, which would have otherwise made the documents discoverable, was preempted and thus invalid in this case, as it was inconsistent with PSQIA. The District Court of Appeal therefore quashed the order requiring production of the hospital reports.

The case is now being appealed to the Florida Supreme Court. Oral argument is scheduled for October 5, 2016.

Litigation Center involvement

The Litigation Center, along with the Florida Medical Association and numerous other health care organizations, filed amicus briefs in the Florida District Court of Appeal and the Florida Supreme Court. The briefs supported the hospital and urged an expansive reading of the PSQIA privilege.

3. Meister v. Avera Marshall Regional Medical Center (Minn. Ct.App.)

Issue

The issues in this case were (a) whether a medical staff and its chief of staff have the legal capacity to enforce medical staff bylaws against the hospital, (b) whether medical staff bylaws can be legally enforced as a contract, and (c) whether a hospital can amend the medical staff bylaws unilaterally.

AMA interest

The AMA supports the self-governance of organized medical staffs. The AMA also supports the enforceability of medical staff bylaws.

Case summary

For several years, the administration of Avera Marshall Regional Medical Center (AMRMC) has been at odds with the medical staff, particularly those physicians on the medical staff who are not AMRMC employees. The medical staff felt the hospital administration was too controlling of the medical staff activities. Furthermore, the medical staff believed that AMRMC infringed upon the semi-independent status for the medical staff, as contemplated in the MS Bylaws. Some of the medical staff members suspected that AMRMC was trying to force the non-hospital employed physicians off the medical staff.

Ultimately, the organized medical staff of AMRMC and the chief of staff and chief of staff elect (in their official and personal capacities) sued AMRMC for a declaratory judgment. They asked that the MS Bylaws be deemed enforceable against the hospital and that the hospital be required to conform its behavior to them. The dispute centered on the following areas: (i) appointment and reappointment of medical staff members, (ii) medical staff and medical executive committee (MEC) operations, (iii) medical staff quality improvement committee composition, (iv) peer review procedures, and (v) unilateral amendment to the MS Bylaws. In each instance, according to the plaintiffs, the hospital administration infringed on the rights of medical staff self-governance and autonomy, as set forth in the MS Bylaws.
On July 6, 2012, the trial court found that the medical staff and, by extension, its officers have no legal existence separate from the hospital. It therefore dismissed the medical staff and its officers, acting in their official capacities, from the lawsuit. However, the chief of staff and chief of staff elect proceeded in their suit as individuals against the hospital.

On September 25, 2012, the trial court decided the remaining issues in the case, pursuant to cross-motions for summary judgment. It held that the MS Bylaws should not be deemed a contract between the medical staff and the hospital, and monetary damages would therefore be unavailable as a remedy for their breach. The trial court also held that, although not a contract, the MS Bylaws could be enforced by an injunction. Further, it held that the hospital could amend the MS Bylaws unilaterally, so long as the hospital gave the medical staff prior notice of its intended amendment.

The plaintiffs appealed to the Minnesota Court of Appeals, but the Court of Appeals held that the medical staff lacked the legal capacity to bring a lawsuit and the MS Bylaws were not a contract. The plaintiffs then appealed to the Minnesota Supreme Court.

On December 31, 2014, the Supreme Court, by a split decision, reversed and remanded. It held that the medical staff, under Minnesota statutory law, had the legal capacity to sue the hospital as an unincorporated association. Further, the MS Bylaws could be enforced as a contract. The majority decision did not address the question of whether the hospital could unilaterally amend the MS Bylaws (although the dissent argued that the hospital could do so).

On remand, the question was what changes, if any, the hospital could make in the MS Bylaws without the consent of the medical staff.

Acting under pressure from the hospital administration, the medical staff, as a legal entity, withdrew from the remanded lawsuit, notwithstanding the Minnesota Supreme Court holding that it has a legal right to pursue it. However, some individual members of the medical staff have continued to pursue the case.

The parties filed cross-motions for summary judgment in the remanded case. On October 16, 2015, the court granted part of each party’s motion. As to the principal remaining issue, which involved the ability of the hospital to amend the MS Bylaws unilaterally, the court held that MS Bylaws in Minnesota can only be enforced to the extent they comply with the hospital bylaws and with general corporate law (which provides that a corporation is to be run by its board of directors). Under this holding, therefore, the hospital would have a right to amend its medical staff bylaws unilaterally.

Three medical staff members appealed the order of October 16, 2015. On July 25, 2016, the Minnesota Court of Appeals affirmed in an unpublished opinion. It held that, under the wording of the specific medical staff bylaws at issue, as well as general principles of corporate law, the hospital could amend the medical staff bylaws unilaterally.

Litigation Center involvement

When the case was initially filed, the Litigation Center, along with MMA, asked the trial court for leave to file an amicus brief to support the medical staff, but the court denied that motion. The Litigation Center, along with MMA and four specialty medical societies, filed amicus briefs with the Court of Appeals and with the Minnesota Supreme Court in support of the medical staff. MMA and the Litigation Center are
also contributed to the legal fees of the medical staff and of the physicians who appealed the order of October 16, 2015.

4. **Novotony v. Sacred Heart Health Services (SD S.Ct.)**

**Issue**

The issue in this case is whether hospital peer review documents must be produced in discovery.

**AMA Interest**

The AMA believes that all documents submitted for purposes of peer review should be protected from legal discovery.

**Case summary**

Allen Sossan, f/k/a Alan Soosan, DO was born in Iran but grew up in Florida. There, he was convicted of felony burglary as well as felony bad check charges. He then adopted an alias, was admitted to medical school, and obtained a DO degree. Ultimately, he became an orthopedic surgeon.

Sossan moved to Nebraska, where he practiced orthopedic surgery. Shortly thereafter, issues arose as to his competence and ethical fitness. He lost his medical staff privileges at Faith Regional Hospital in Norfolk, Nebraska. However, Dr. Sossan applied for and obtained a South Dakota medical license.

Dr. Sossan then applied to join the medical staffs at Avera Sacred Heart Hospital (ASHH) and Lewis & Clark Specialty Hospital (LCSH), both of which are located in Yankton, South Dakota. Initially, both ASHH and LCSH denied privileges to Dr. Sossan. However, they then reversed their positions, and Dr. Sossan was granted privileges at both hospitals.

Soon after he was granted privileges, Dr. Sossan came under serious criticism from other physicians and from numerous patients. Among other misdeeds, he was guilty of “assaultive behavior” and performing unnecessary surgeries. Furthermore, he frequently performed the surgeries incompetently. Dr. Sossan has now apparently left the country, reportedly to his country of origin, Iran.

At least 31 medical malpractice suits have been filed against Dr. Sossan in the South Dakota state courts. Many of these cases include claims against ASHH, LCSH and/or the physicians on their peer review committees for improper credentialing. For administrative purposes, the cases were consolidated into a single suit. The plaintiffs in the consolidated cases sought production of the ASHH and LCSH peer review documents applicable to Dr. Sossan’s credentialing. The hospitals objected, based on the privilege mandated in the South Dakota Peer Review Confidentiality and Privilege Statute. The plaintiffs moved for an order to compel discovery.

On October 26, 2015, the trial court ruled in the consolidated proceedings that the peer review should be deemed subject to a “crime-fraud” exception. The court found that the plaintiffs had submitted sufficient evidence to make out a prima facie case of fraud and deceit. Consequently, the court ruled that various categories of the Sossan peer review documents were to be produced to the plaintiffs, although subject to redaction of deliberations of the peer review committee. The redacted material, in turn, would be discoverable if the plaintiffs could establish, by clear and convincing evidence, “that fraud,
deceit, illegality or other improper motive influenced the committee members in granting Dr. Sossan privileges.”

The rulings of October 26, 2015 are being appealed, on an interlocutory basis, to the South Dakota Supreme Court. The appellants are arguing that the trial court was wrong to create a crime-fraud exception to the peer review confidentiality statute.

Litigation Center involvement

The Litigation Center is helping to defray the cost of the trial court and Supreme Court amicus briefs of the South Dakota State Medical Association. The briefs point out the salutary purposes of the peer review statute and argue against the creation of a crime-fraud exception.

5. **Reginelli v. Boggs** (Pa. S.Ct.)

Issue

The issue in the case is whether the Pennsylvania Peer Review Protection Act, 63 P.S. §§ 425.1, *et seq.* (PRPA) privilege against legal discovery should apply when an independent contractor of a hospital reviewed the performance of a physician on the hospital’s medical staff.

AMA Interest

The AMA believes medical staff peer review documents should be privileged from discovery.

Case Summary

Eleanor Reginelli presented to the emergency department at Monongahela Valley Hospital (MVH), complaining of chest and back pains. The emergency room physician, Marcellus Boggs, MD, a member of the MVH medical staff, ordered and interpreted the results of an electrocardiogram and blood work. He diagnosed Reginelli with gastro-esophageal reflux disease and discharged her that day.

Five days later, Reginelli again experienced chest and back pains. An ambulance transported her to the emergency department at a different hospital, where she was told she was experiencing a heart attack. She subsequently suffered permanent heart damage.

Boggs was an employee of UPMC Emergency Medicine, Inc., d/b/a Emergency Resource Management, Inc. (ERMI). MVH had hired ERMI, an independent contractor, to staff its emergency department.

Reginelli and her husband sued Boggs, MVH, and ERMI for medical negligence. As part of discovery, the plaintiffs deposed Brenda Walther, MD, the medical director of the MVH emergency department and also an ERMI employee. Walther disclosed that she maintained a “performance file” on Boggs, which included her evaluations. She said that ERMI required her to perform and retain these evaluations and she considered her evaluations to be peer review protected. She also testified that, in addition to the ERMI peer review evaluations, MVH has a formal peer review committee, which meets on a monthly basis.
The plaintiffs asked MVH to produce the Walther performance file on Boggs. Based on a claimed peer review privilege, the defendants objected to its production. MVH produced the performance file to the judge for review in camera.

Following its review, the trial court observed that MCH had possession of the performance file (as it had produced the same in camera), but Walther was an agent of ERMI, an agency distinct from MVH. It commented: “it is untenable that [MVH] could claim a privilege for documents that it neither generated nor maintained.” The trial court ordered the performance file to be produced to the plaintiffs’ counsel, who was then to keep the file confidential. The defendants appealed.

On appeal, the Pennsylvania Superior Court adopted the trial court’s rationale for finding MVH had no right to claim privilege in documents generated and maintained by ERMI. It further held that neither ERMI nor Boggs was entitled to assert a peer review privilege. Because ERMI was an independent contractor of MVH, it was “not an entity enumerated in [the PRPA] as being protected by peer review privilege. Moreover, it held, by sharing the file with MVH Boggs and ERMI had “destroyed” any privilege they might otherwise have claimed.

The Superior Court affirmed the order of production, and the defendants appealed to the Pennsylvania Supreme Court, where briefing is underway.

**Litigation Center involvement**

The Litigation Center joined with the Pennsylvania Medical Society to file an *amicus* brief in the Pennsylvania Supreme Court. The brief, which supports the defendants, argues that the PRPA privilege against legal discovery should apply in this case.

6. **Tibbs v. Bunnell (S.Ct.)**

**Issue**

The issue in this case was whether the Patient Safety and Quality Improvement Act (PSQIA) privilege against non-disclosure preempts Kentucky state law, which would otherwise allow a plaintiff in a medical injury lawsuit to discover information voluntarily reported to a Patient Safety Organization (PSO).

**AMA interest**

The AMA supports federal legislation that will enhance protection of peer review information.

**Case summary**

A patient died while being treated for a medical condition at a University of Kentucky hospital, and the estate for the decedent subsequently sued various health care providers for malpractice. The hospital had prepared an incident report and submitted the report to a PSO for the purpose of compiling and analyzing the data to improve health care quality. During discovery, the estate asked for production of the incident report. The defendants objected to the production on the basis of the privilege in the PSQIA, and the trial court ruled the privilege inapplicable.
The defendants then filed an interlocutory appeal with the Kentucky Court of Appeals. They asserted that, even if Kentucky law would otherwise have allowed production of the PSO incident report, the PSQIA preempted the state law. The Court of Appeals held that the PSQIA did preempt Kentucky law. However, the court continued, the privilege would only apply to the extent the incident reports contained a “self-examining analysis.” The defendants appealed this case to the Kentucky Supreme Court, where they contended that the incident report was fully privileged, regardless of whether it contained a self-examining analysis and regardless of whether it included information beyond such analysis.

On August 21, 2014, by a split decision the Kentucky Supreme Court reversed the Court of Appeals. The Supreme Court held that incident reports may be privileged even if they do not contain a “self-examining analysis.” However, incident reports may be discoverable if they are prepared pursuant to state laws requiring their preparation in connection with the state’s regulation of health care facilities.

The hospital petitioned the Kentucky Supreme Court for rehearing. On December 18, 2014, by a vote of 3 to 3, the petition for rehearing was denied.

The hospital petitioned the United States Supreme Court for certiorari, but that petition was denied on June 27, 2016.

Litigation Center involvement

The Litigation Center, through the AMA and the Kentucky Medical Association, filed an amicus brief on the case in chief in the Kentucky Supreme Court, urging recognition and an expansive reading of the PSQIA privilege. The Litigation Center also submitted an amicus brief in support of the petition for rehearing, although the Kentucky Supreme Court refused to allow it. Further, the Litigation Center joined an amicus brief in the United States Supreme Court in support of the hospital’s certiorari petition.

7. **Tulare Hospital Medical Staff v. Tulare Local Healthcare District**  
   (Tulare Cnty. Cal. Super. Ct.)

**Issue**

The issue in this case is whether Tulare Regional Medical Center (Tulare Hospital), a publicly owned hospital in Tulare, California, could unilaterally dissolve its medical staff and form a new medical staff, with the same members as the previous one but with medical staff officers of the hospital’s choosing and without affording the medical staff an opportunity to approve or reject the new medical staff bylaws.

**AMA interest**

The AMA supports medical staff self-governance.

**Case summary**
Medical Staff Case Summary (I-16)

Tulare Hospital claims it was compelled to create a new medical staff governance structure because the medical staff leadership had acted antagonistically to the hospital’s interests. Both the Joint Commission and the Centers for Medicare and Medicaid Services had cited Tulare Hospital for deficiencies relating to its medical staff.

On January 26, 2016, Tulare Hospital, at a closed meeting of its board of trustees, abruptly terminated its relationship with the organized medical staff then in existence. In place of the former medical staff, the hospital created a new medical staff, under new medical staff bylaws. All members of the former medical staff were provisionally credentialed on the new medical staff. Except for a select few, members of the old medical staff had no opportunity to approve their new bylaws or vote on their new officers. Also, the old medical staff had funds, from which the hospital blocked access.

The medical staff maintains that any failures associated with the relationship between the medical staff and the hospital should be attributed primarily or fully to the ineptitude of the Tulare Hospital administration. Furthermore, the former medical staff was investigating the professional competence of three of the newly handpicked medical staff officers, and this may have motivated the hospital’s precipitous action.

On February 10, 2016, the former medical staff sued Tulare Hospital for its usurpation of the medical staff’s self-governing prerogative. The former medical staff moved for a temporary restraining order, but that motion was denied. The parties have now begun discovery.

Litigation Center involvement

The Litigation Center, along with the California Medical Association and the Tulare County Medical Society, are helping to defray the medical staff legal expenses.


Issue

The issue in the case is whether the Iowa Morbidity and Mortality Study Law, Iowa Code §§ 135.40, et seq. (MMMSL), created a privilege against legal discovery of a hospital’s incident reports and related documents.

AMA Interest

The AMA believes peer review documents should be privileged from discovery.

Case summary

Dennis Willard was injured in a motorcycle accident and was taken to a hospital in Davenport, Iowa for treatment. Because of the seriousness of his injuries, he was transferred to the University of Iowa Hospital, which is an agency of the State of Iowa. Willard was under heavy sedation at the time of the transfer. He believed the University of Iowa Hospital handled him negligently during the transfer process and he suffered further injuries as a result.
Willard sued the State of Iowa for the injuries he allegedly suffered during the transfer. During discovery, he sought production of various documents pertaining to his care, including the hospital’s incident report. The hospital objected to the discovery, claiming, *inter alia*, the requested documents were privileged under MMSL.

The trial court heard testimony from the hospital regarding the nature of the contested documents, and it ordered their *in camera* review. Following such review, the trial court concluded that the hospital’s witness “simply was unable to provide any information that the [incident report] and related materials ... were created for use in the course of any [peer review] study.” The trial court then ordered the State to produce the documents.

The State appealed to the Iowa Supreme Court and secured a stay of discovery of the contested documents. Briefing is underway.

**Litigation Center involvement**

The Litigation Center, along with the Iowa Medical Society, will file an *amicus* brief in the Iowa Supreme Court. The brief, which will support the University of Iowa Hospital, will argue that the MMSL privilege against legal discovery should apply in this case.

Further information about these cases and about the Litigation Center can be found at: [http://www.ama-assn.org/go/litigationcenter](http://www.ama-assn.org/go/litigationcenter).
OMSS Representative
Duties and Responsibilities

1. Exhibit leadership related to the needs of their patients and medical staffs (employed and volunteer physicians) at the local level.

2. Effectively represent their medical staff’s on their felt needs and issues of concern and facilitates bringing these matters and/or related resolutions to the state OMSS/association and the national AMA-OMSS.

3. Communicate medical staff needs concisely at the local, state, and national level (AMA-OMSS).

4. Enlist others to participate in AMA and AMA-OMSS initiatives that benefit physicians and patients.

5. Take full advantage of positive changes brought about by AMA advocacy, then share this information with peers and colleagues to keep them informed about AMA activities and the positive effect of AMA membership.

6. Utilize AMA resources to educate physicians on the “AMA Principles for Strengthening the Physician-Hospital Relationships.

7. Utilize available resources to include the AMA to educate physicians on the role and importance of medical staff leadership.

8. Educate physicians on the significance of the role of physician leaders in enhancing the quality and safety of patient care.

9. At a minimum provide updates on the activities of the AMA-OMSS to their medical staffs/organizations following the Annual and Interim Meetings of the AMA-OMSS.

Note: The AMA-OMSS has available PowerPoint presentations on the AMA-OMSS and the activities of the AMA-OMSS to assist representatives.

As required, communicate supplemental updates on AMA-OMSS activities to their medical staff/organization.
10. As requested by the AMA-OMSS, collect physician comments and provide a summary response to their State Chair and/or the AMA-OMSS (when there is no state chair) concerning Field Reviews of Joint Commission standards.

11. Mentor other physicians to include young physicians and residents/fellows on medical staff leadership and to serve as OMSS representatives.

12. Facilitate and participate in periodic meetings of state, county, and local OMSS representatives and promote physician participation in the state and national OMSS.

13. Seek hospital and/or medical staff financial support for OMSS representative attendance at local and national meetings of the OMSS.
American Medical Association Organized Medical Staff Section
Internal Operating Procedures

I. Mission and Vision Statement

A. Mission Statement. AMA Bylaw 7.01 defines the mission of the AMA Sections as follows:

1. Involvement. To provide a direct means for membership segments represented in the Sections to participate in the activities, including policy-making, of the AMA.

2. Outreach. To enhance AMA outreach, communication, and interchange with the membership segments represented in the Sections.

3. Communication. To maintain effective communications and working relationships between the AMA and organizational entities that are relevant to the activities of each Section.

4. Membership. To promote AMA membership growth.

5. Representation. To enhance the ability of membership segments represented in the Sections to provide their perspective to the AMA and the House of Delegates.

6. Education. To facilitate the development of information and educational activities on topics of interest to the membership segments represented in the Sections.

B. Mission specific to the OMSS. The AMA Organized Medical Staff Section (OMSS) provides a direct and ongoing relationship between the AMA and medical staff organizations. The Section debates issues and develops policy that influences the complex and rapidly changing environment within which our nation's hospitals and other delivery systems operate. Specifically, the OMSS:

1. Develops and nurtures medical staff leadership within the policy-making structure of the AMA, as well as state and county medical associations.

2. Provides a forum to discuss timely and often controversial issues, solve problems, and avoid polarization of medical staffs.

3. Identifies the implications of future trends, and the role of medical staffs individually and collectively.

4. Serves as a clearinghouse for issues pertinent to medical staffs.

5. Works to strengthen the self-governing medical staff.

6. Provides medical staff leaders with a contact point to receive timely information, as well as AMA source materials and services.
II. Membership

A. AMA Bylaw 7.41 limits membership in the Section to physicians, including residents and fellows, selected by physician members of the medical staffs of hospitals and other delivery systems.

III. Officers/Governing Council

A. Officer Designations. In addition to the Chair and Vice Chair identified in AMA Bylaw 7.04 there shall be a Secretary.

B. Governing Council. There shall be seven voting members of the Governing Council, consisting of the officers, delegate, alternate delegate and two members at-large elected at the Business Meeting of the Section as provided in AMA Bylaw 7.03. In addition, the Immediate Past Chair shall serve, ex officio, as a voting member of the Governing Council for one year only, to provide continuity in the leadership of the Section.

C. Eligibility. AMA Bylaw 7.40 defines eligibility and cessation of eligibility for those elected to the OMSS Governing Council.

D. Duties and Privileges. The Governing Council shall direct the programs and activities of the OMSS including the creation of OMSS committees, subject to the approval of such programs and activities, when required, by the Board of Trustees or House of Delegates of the AMA. Time commitments will include 5 days each for the Annual and Interim Meetings with the exception of the Delegate and Alternate Delegate whose commitment will be 7 days for the Annual Meeting and 6 days for the Interim Meeting and 4 weekend days associated with 2 Governing Council Meetings plus conference calls and other meetings on request.

1. Chair. The Chair shall:
   a. Preside at all meetings of the Section and meetings of the Governing Council.
   b. Represent the Section on all matters of policy.

2. Vice Chair. The Vice Chair shall:
   a. Assist the Chair and preside at meetings in the absence of the Chair or at the Chair's request.
   b. Act as liaison for the OMSS Outreach Program.

3. Secretary. The Secretary shall:
   a. Prepare summary minutes of Governing Council meetings in coordination with Department of Organized Medical Staff Services.
b. Work with staff of the Department of Organized Medical Staff Services in the production of communication materials.

c. Serves as Chair of the Credentials Committee

4. Delegate. The Delegate shall:

a. Present testimony on OMSS resolutions in the AMA House of Delegates.

b. Act as advocate for the OMSS in the AMA House of Delegates.

c. Monitor issues not directly commented on by the OMSS Assembly.

5. Alternate Delegate. The Alternate Delegate shall:

a. Present testimony on OMSS resolutions in the AMA House of Delegates.

b. Act as advocate for the OMSS in the AMA House of Delegates.

c. Monitor issues not directly commented on by the OMSS Assembly.

6. Members at-Large. The Members at-Large shall:

a. Complete special OMSS projects assigned by the Chair or Governing Council.

7. Immediate Past Chair. The Immediate Past Chair shall:

a. Provide continuity in the leadership of the Section.

b. Serve as an ex-officio member of the Governing Council.

E. Terms. Governing Council members, including the delegate and alternate delegate, shall serve a term of 2 years, beginning at the conclusion of the Annual Meeting at which they were elected and ending at the conclusion of the second Annual Meeting after their election. These provisions shall not be applicable to the Immediate Past Chair, whose term is one year.

F. Tenure. Governing Council members shall serve for no more than 2 consecutive terms in the same position on the Governing Council, except that the delegate and alternate delegate shall serve no more than three consecutive terms. A member elected to serve an unexpired term shall not be regarded as having served a term. These provisions shall not be applicable to the Immediate Past Chair, whose total tenure is limited to one year.

G. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next Business Meeting of the Section.
IV. Elections

Members of the OMSS Governing Council shall be elected as follows:

A. Time of the Election. Elections shall be conducted at annual OMSS Business Meetings.

B. Vacancies. A deadline of 60 days prior to the OMSS Business meeting shall be established for the notification of a vacant position to be filled on the Governing Council. If a vacancy occurs on the Governing Council during the 60 days prior to the Business meeting, or during the Business meeting, the vacancy shall remain open until the next Business meeting when a formal election to fill the balance of the vacant position's term of office shall be held.

C. Nominations. A deadline of 30 days shall be established for the receipt in the Department of Organized Medical Staff Services of the nomination application from individuals declaring their candidacy for a position on the Governing Council. Any nomination form not received 30 days prior to the meeting will not be included in the advance OMSS Handbook. All candidates for office shall be urged to provide adequate information regarding their background, experience and qualifications for office by completing the application form adequately and meeting the deadline for including the application form in the advance OMSS Handbook. Nominations from the floor shall be allowed to assure to the fullest the democratic nature of the selection process.

D. Eligibility. Each candidate for a position on the Governing Council shall offer his/her name for only one position in any given election.

E. Campaign Materials. Candidates shall submit a sample of their election campaign materials to the OMSS staff before distribution.

F. Method of Election.

1. Nominations for election shall occur at the Business Meeting on Friday morning. If elections are uncontested, the Chair shall solicit nominations from the floor. If there are no nominations from the floor, candidates shall be elected by acclamation. The total minutes allocated to each candidate for nomination, seconding and addressing the Assembly shall be 4 minutes. Candidates for office shall be encouraged to address the Assembly during that 4-minute period.

2. Contested elections shall occur at polling places outside the Business meeting room on Saturday morning. Election results shall be announced as soon as they are available. If no candidate receives a majority of votes, the run-off election will occur between the two candidates receiving the most votes. Tellers will distribute ballots to the Assembly. Run-off election results will be announced as soon as they are available.

3. The Tellers Committee shall oversee the election process, assuring that credentials are verified and ballots are appropriately distributed, collected and tallied. The chair of the Tellers Committee will verify and transmit the election results to the Chair of the Governing Council.
V. OMSS Assembly Meeting

A. AMA Bylaw 7.06 provides for a Business Meeting of each Section on a day prior to each Annual and Interim Meeting of the House of Delegates.

B. AMA Bylaw 7.061 specifies the purpose of the Business Meeting as follows:

1. Hear such reports as may be appropriate.

2. Consider other business and vote upon such matters as may properly come before the meeting.

3. Adopt resolutions for submission by the Section to the House of Delegates.

4. Hold elections.

C. Meeting Procedure. AMA Bylaw 7.062 sets forth the general Meeting Procedure for the Sections. Additional procedures specific to the OMSS are:

1. OMSS representatives shall be seated with the representatives from their respective states at OMSS meetings. Some states hold regional caucus meetings in conjunction with the Assembly meeting. As part of their leadership responsibilities, state OMSS section chairs and caucus chairs shall be requested to:

   a. Assist in educating their representatives regarding the purposes of the reference committee hearings and OMSS business session.

   b. Appoint representatives from their state to each reference committee hearing and testify on the issues.

   c. Advise representatives that repetitious testimony during the business session should be limited;

   d. Review OMSS rules and procedures which will be used to conduct the business of the Assembly during their caucus meetings;

   e. Invite neighboring states that do not have a section to meet with their caucus;

   f. During caucus meetings review the reference committee's reasons for recommendations;

   g. Advise all representatives that they have an obligation to remain through the entire meeting; and

   h. Remain for the HOD Reference Committee hearings on Sunday and Monday, since an important purpose of the OMSS is to have the HOD adopt policies that are responsive to the needs of organized medical staffs, their representatives and the patients they serve.
D. Representatives and Alternate Representatives

1. Representatives to the Business Meeting. AMA Bylaw 7.43 states: The physician members of the medical staff of each hospital and delivery system meeting the requirements established by the Governing Council may select one or more representatives to the Business Meeting. The representatives must be physician members of the medical staff or residents/fellows affiliated with the hospital or delivery system. Selected physicians who are not AMA members may participate in the Business Meeting as provisional representatives without the right to vote. Provisional representatives may attend a maximum of 2 Business Meetings. Selected representatives to the Business Meeting shall be properly certified by the President or Secretary of the medical staff. AMA Bylaws 7.431 and 7.432 speak to ex officio participation in OMSS Business Meetings.

   a. Per AMA Bylaw 7.41, selected physicians who are not AMA members may participate in the Section’s Business Meeting as provisional members without the right to vote. Provisional members may attend a maximum of 2 Business Meetings.

2. Delivery System. A delivery system is defined as any formalized medical staff organization whose purpose is to deliver health care, including group practices with 3 or more physicians.

E. Registration/Credentialing Process.

1. Before being seated at any Assembly meeting, all OMSS representatives and alternate representatives must be duly certified as the representative for his/her organized medical staff in order to be credentialed to vote at the meeting.

2. A credentialed representative may transfer his/her credentials to an alternate representative from the same hospital or other delivery system by notifying the Credentials Committee that the individual meets the criteria for serving as an OMSS representative. Upon approval of the Credentials Committee, the credentialed representative shall transfer the official badge with the credentialing ribbon and label to the alternate representative.

F. Rules of Order.

1. The Assembly meeting shall be conducted pursuant to the established rules of procedure presented by the OMSS Chair and adopted by the Assembly. These rules stem from AMA Bylaws, Procedures of the OMSS Representative Assembly approved by the Board of Trustees, decreed by its presiding officer and generally pursuant to the current edition of the Standard Code of Parliamentary Procedures (Sturgis). These include the following procedures:
a. The Chair shall preside over the Business Meeting.

b. Representative must wear his/her official badge with a credentialing ribbon at all times.

c. A representative of the Assembly wishing to obtain the floor shall approach the nearest microphone, wait to be recognized, address the Chair, and give his/her name and affiliation before speaking on the issue.

d. No one representative or recognized official observer shall speak more than once on any issue or separate motion until all who wish to speak have been heard, nor more than twice, without permission of the Chair or upon approval by a majority of the Assembly.

e. Debate shall be limited based on the recommendation of the Chair and the approval of the Assembly.

f. Any major amendments shall be submitted to the OMSS headquarters office before they are placed on the floor for discussion and action.

g. Reference committee reports, the order of business for consideration of reference committee reports, and OMSS amendment forms shall be available on Saturday morning at a specific time designated by the Chair.

h. Individual OMSS representatives and/or state delegations that wish to introduce amendments during the business session shall print or clearly write their amendment(s) on the OMSS amendment form. The completed amendment form shall be submitted to the OMSS staff office as soon as possible, but at least one hour before the Assembly convenes. Amendments shall be accepted after this time; however, state delegations and OMSS Representatives shall be encouraged to submit their amendments by the designated time.

i. To facilitate the OMSS Business Meeting, substantive amendments to reference committee reports shall be typed and projected. Amendments, which are not substantive, shall be written on the OMSS amendment form and presented to the Chair before they are placed on the floor for discussion and action.

j. Voting shall be by voice, that is the “ayes” and “nays,” except where the Chair or a delegate calls for a division of the Assembly, in which case a standing vote will be taken.

G. **Quorum.** Fifty percent (50%) of the credentialed, registered representatives at any business meeting of the OMSS shall constitute a quorum for the conduct of business at that meeting.
H. Resolutions.

1. Resolutions may be submitted by individual representatives or state OMSS sections.

2. Resolutions must be submitted to the AMA Department of Organized Medical Staff Services no later than 40 days prior to commencement of the Business Meeting to be considered as regular business. State OMSS Sections that adjourn during or one week preceding this 40-day period, shall be allowed 7 days after the close of their meeting, but no less than 10 days prior to the OMSS meeting, to submit resolutions to the OMSS Chicago office.

3. Late resolutions (received after the 40-day and 7-day deadlines and before 4:00 p.m. on the day before the Business Meeting convenes) shall be submitted to the Committee on Late Resolutions. The Committee is not a reference committee. It shall not hold open hearings but shall provide sponsors of late resolutions an opportunity to explain the reasons for their submission. Sponsors shall be notified of the time and location of the meeting. The Committee on Late Resolutions shall then make its recommendations to the Assembly on their acceptance and the Assembly shall vote on the acceptance of each recommendation. A two-thirds affirmative vote shall be required for acceptance as official business of the Assembly.

4. An emergency resolution may be introduced by an individual representative or state sections after 4:00 p.m. on the day before the Assembly convenes and until the Assembly adjourns. The Chair and Vice Chair shall report to the Assembly as to whether the matter involved is or is not of an emergency nature. If the Chair and Vice Chair rule that the matter is of an emergency nature, it shall be presented to the Assembly and shall require a ¾ affirmative vote by the Assembly for acceptance as emergency business. The author shall have the right to appeal the chair’s ruling, but a ¾ affirmative vote of the Assembly shall be required to overrule the chair. If time permits, the emergency resolution shall be assigned to a reference committee, otherwise it shall be presented directly to the Assembly. If the emergency resolution fails to receive a ¾ affirmative vote, the Chair shall defer its introduction until the next meeting of the Assembly.

5. Authors of resolutions shall be responsible for making certain that their resolutions are received by the Department of Organized Medical Staff Services.

6. Resolutions must be submitted in official format, either via e-mail or computer disk. Authors are encouraged to call the Department to confirm receipt of their resolution. Late resolutions, submitted after Tuesday the week of the Assembly meeting, shall be e-mailed to the Department of Organized Medical Staff Services at omss@ama-assn.org to assure receipt by AMA staff.

7. Resolutions that meet the deadline date shall be included in the OMSS Handbook, and shall be considered as items of business for the Assembly. Sponsors/authors of resolutions may make changes to their own resolutions, or withdraw them without a vote. When a resolution is withdrawn the report of the reference committee shall note the event.
8. Late resolutions accepted as official business of the Assembly shall be distributed to the Assembly and introduced by the Chair of the Committee on Late Resolutions.

9. Resolutions that appear to reaffirm AMA policy shall be reviewed by the Committee on Late Resolutions. Information supporting reaffirmation shall be provided to both the Committee and the author. If the Committee determines that the resolution reaffirms policy, it shall be placed on the Reaffirmation Consent Calendar. Resolutions reaffirming policy shall be cited in the Report of the Committee on Late Resolutions. An OMSS representative shall have the ability to extract a resolution from the Reaffirmation Calendar.

10. When a resolution presents a legal problem, AMA staff shall contact the author/sponsor and discuss the problem with the resolution as prepared. If the author/sponsor is able to remedy the situation, then the resolution shall be distributed in a routine manner. If the legal problem cannot be resolved, the Chair shall designate it a "deferred" resolution. It shall not be distributed in the OMSS Handbook. Rather, it will be referred to the Committee on Late Resolutions for consideration.

I. Reports.

The Governing Council shall issue reports in response to referred resolutions or directives stemming from adopted resolutions.

1. The Governing Council also shall have the ability to initiate reports on topics, which it believes should be brought to the Assembly's attention.

2. The Governing Council also shall have the ability to issue reports on “green” paper to discuss the disposition of OMSS resolutions that have been referred by the House of Delegates to the Board of Trustees or appropriate Council. The “green” reports shall be an item of business to allow the Assembly to fully participate in the policy-making process and to inform representatives of the outcome of their resolution.

3. Reports shall be referred to reference committees and shall be subject to discussion at the reference committee hearing. After hearing testimony, the reference committee shall make recommendations to adopt, amend, not adopt, file, or refer back to the Council for further consideration. Reports of an informational nature with no specific proposal for action may be filed.

VI. OMSS Committees

A. Credentials Committee.

1. The Credentials Committee is chaired by the Secretary of the Governing Council with assistance from other Governing Council members or state chairs when needed. The number to serve on the Credentials Committee will be determined by the Chair of the Governing Council based on meeting attendance.
2. The Committee is responsible for consideration of all matters relating to the registration and credentialing of all representatives.

B. Committee on Late Resolutions.

1. The Committee on Late Resolutions is composed of 5 representatives selected by the Chair to meet with authors of late resolutions prior to the opening of the Assembly.

2. This Committee does not hold open hearings, but provides the sponsors of all late resolutions an opportunity to explain the reasons for submitting them.

3. The Committee considers the emergency nature of each late resolution. If the resolution is not of an emergency nature, it is recommended that the resolution be resubmitted to the next regular business meeting of the OMSS.

4. The Committee then submits its recommendations to the Assembly. The Assembly votes on the acceptance of each resolution. A two-thirds affirmative vote is required for acceptance of any item as official business of the Assembly.

5. The Committee also reviews resolutions that may be a reaffirmation of AMA policy. The Committee provides a reaffirmation calendar to the Assembly. A representative can extract a resolution from a reaffirmation calendar for referral to a reference committee. The Committee shall cite the current policy which the new resolution reaffirms in their report to the Assembly.

C. Reference Committee(s).

1. Reference committees shall consist of 5 representatives, who are selected by the Chair in consultation with the Governing Council. The committees shall conduct open hearing on all items of business before the Assembly. Based on testimony and their deliberations, the reference committee shall develop a report and make recommendations on the disposition of all referred items of business.

2. Reference committee reports shall comprise the bulk of the Business Meeting. They shall be constructed swiftly and succinctly after completion of the hearings in order that they may be processed and made available to the representatives as far in advance of formal presentation as possible.

3. Reference committees shall have wide latitude in their efforts to facilitate the will of the participants on the matters before them. They shall be able to amend resolutions and consolidate similar resolutions by constructing substitutes. They also shall be able to recommend the usual parliamentary procedure for disposition of the business before them, such as adopt, not adopt, amend and refer. Resolutions and reports, which are grouped together, shall be carefully reviewed to verify that they are similar.

4. All reference committee members shall review and sign the final report. The OMSS Chair and Vice Chair shall review, with the reference committee chairs, the final reference committee reports for parliamentary procedure and clarity.
5. The entire report of the reference committee shall be presented on a Consent Calendar, with the items of business grouped together according to the committee’s recommended courses of action. When the reference committee moves adoption of the consent calendar, the Chair shall ask if any member of the Assembly wishes to extract any item from it to be considered separately. Upon request of any representative, the item shall be withdrawn from the calendar and shall be considered as a separate item after the remainder of the consent calendar is acted upon.

6. The Chair shall open for discussion the matter that is the immediate subject of the reference committee report. The effect is to permit full consideration of the business at hand, unrestricted to any specific motion for its disposal. The reference committee report shall not contain a direct motion, and any appropriate motion shall be made from the floor. If the reference committee recommendation is to refer to the Governing Council, opportunity will be given prior to the discussion for referral for an alternative motion. In the absence of such a motion, the Chair shall state the question in accordance with the recommendation of the reference committee.

7. Reference committee hearings shall be open to all AMA members, OMSS representatives, guests and interested persons. The reference committee chair shall be privileged to call upon anyone attending the hearing if, in the chair’s opinion, the individual has information helpful to the committee. A reference committee hearing is the proper forum for discussion of controversial items of business. In general, representatives who do not take advantage of the hearing process to present their views on an issue shall be discouraged from doing so on the floor of the Assembly.

8. Equitable hearings shall be the responsibility of the reference committee chair, and the committee may establish its own rules on the presentation of testimony with respect to limitations of time, repetitive statements and the like. The chair shall also have the jurisdiction over such matters as photography, television filming and the introduction of recording devices. If, in the Chair’s estimation, these actions would be or become undesirable in order to conduct an orderly hearing, the Chair can prohibit them.

9. The reference committee chair shall not query those in attendance or take an informal vote on matters before the reference committee. Committee members shall be free to ask questions of those at the microphone in order for clarification or understanding of a statement. They also shall have the ability to answer questions if a member seeks clarification on an issue, but never shall engage in a debate with speakers or express opinions during the hearing. It shall be the charge of the committee to listen carefully and evaluate all opinions presented so that the recommendations in the reference committee report reflect thoughtful consideration.

10. After an open hearing, the reference committee members shall meet separately in executive session to deliberate and prepare a report. The committee shall have the ability to call into the executive session anyone who it wishes to hear from or question.
D. **Tellers Committee.**

1. The Tellers Committee is composed of 15 representatives, one of whom serves as chair. At the request of the Governing Council Chair, members of this committee are responsible for taking a count of votes in a designated section of the Assembly during the Business Meeting.

2. The Committee is selected by the Governing Council Chair.

3. The Committee is also responsible for distributing, collecting, and counting ballots during the elections.

VII. **Miscellaneous**

A. **Conflict of Interest.** OMSS Representatives or other individuals providing testimony at a reference committee hearing or speaking on the floor at the Business Meeting who have a personal interest or a substantial financial interest in a commercial enterprise which interest will be materially affected by a matter before the Assembly, including any pending litigation, must publicly disclose that interest before speaking.

B. **Testimony at House of Delegates Reference Committee Hearings.** Any member of the AMA has a right to testify before a HOD reference committee and share his/her views on any item of business. However, since the AMA Bylaws provide only for a Delegate and Alternate Delegate to represent the OMSS in the HOD and to minimize confusion at the HOD reference committee hearings, an OMSS Representative shall not introduce himself/herself as an OMSS representative unless the OMSS Delegate or Alternate Delegate has asked the representative to present testimony on behalf of the OMSS.

C. All material/information to be distributed to the Assembly must be cleared through the OMSS office.

D. Material relating to business of the OMSS shall be distributed during the Business Meeting. The Chair shall advise representatives and participants of this material.

E. Smoking shall be prohibited at all official business meetings of the OMSS including the Business Meeting, reference committees and workshops.

F. A credentialed representative may transfer his/her credentials to an alternate representative from the same entity by notifying the Credentials Committee that the individual meets the criteria for serving as an OMSS representative. Upon approval of the Credentials Committee, the credentialed representative shall transfer the official badge with the credentialing ribbon and label to the alternate representative.

G. The disposition of all new business or issues that are introduced by an OMSS educational speaker or at the open forum may be introduced as an emergency resolution by an OMSS representative.

H. A parliamentarian may be selected by the Chair prior to each meeting.