Senior Physicians Section
Assembly Handbook

Annual Meeting 2017
Saturday, June 10 (11:30 am – 12 Noon)
Room: Columbus K/L
Annual Meeting 2017
Saturday, June 10 (11:30 am – 12 Noon)
Room: Columbus K/L
The Senior Physicians Section (SPS) Assembly is open to any senior physician 65 years of age and older as well as those interested in senior physician issues.

### Saturday, June 10

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<td>11:30 – 11:40 am</td>
<td><strong>Chair’s Report</strong>&lt;br&gt;Barbara S. Schneidman, MD, MPH&lt;br&gt;  o Introduction of Governing Council Members&lt;br&gt;  o Moment of silence to honor former SPS Governing Council Members&lt;br&gt;    o Richert “Rich” E. Quinn, Jr., MD&lt;br&gt;    o Virginia “Ginger” T. Latham, MD&lt;br&gt;  o SPS Governing Council Nominations Election Results&lt;br&gt;  o SPS Mission Statement</td>
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<td>11:40 am – 12:00 pm</td>
<td><strong>A-17 HOD Handbook Review / SPS Grid of Items for Discussion</strong>&lt;br&gt;Claire V. Wolfe, MD, Delegate &amp; John A. Knote, MD, Alternate Delegate&lt;br&gt;  o CEJA Report 2 - Competence, Self-Assessment and Self-Awareness - (Ref Comm: Amendments to C&amp;B)&lt;br&gt;  o Resolution 005: IL: Perioperative Do Not Resuscitate Orders - (Ref Comm: Amendments to C&amp;B)&lt;br&gt;  o Resolution 014: Jasser: The Need to Distinguish between 'Physician Assisted Suicide' and 'Aid in Dying' - (Ref Comm: Amendments to C&amp;B)&lt;br&gt;  o Resolution 316: Florida/Pennsylvania/Georgia/California/New York, Arizona/Texas/American College of Radiation Oncology/American Society of Interventional Pain Physicians: Action Steps Regarding Maintenance of Certification - (Ref Comm C)&lt;br&gt;  o Resolution 318: MI: Oppose Direct to Consumer Advertising of the ABMS MOC Product - (Ref Comm C)&lt;br&gt;  o Resolution 319: MI: Public Access to Initial Board Certification Status of Time-Limited ABMS Diplomates - (Ref Comm C)&lt;br&gt;  o CEJA Report 5 - Study Aid-in-Dying as End-of-Life Option (Res 015-A-16) - (Informational Report)&lt;br&gt;  Follow-up from I-16 Meeting&lt;br&gt;    o Late Resolution 816-I-16: SPS: Support for Seamless Physician Continuity of Care</td>
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<td>12:00 – 1:30 pm</td>
<td><strong>Immediately following the Assembly Meeting, the SPS will sponsor an educational program, “Mindfulness Interventions: A Workshop to Foster Resiliency”</strong>&lt;br&gt;Approved for 1.5 AMA PRA Category 1 Credits™&lt;br&gt;SPS Keynote Speaker:&lt;br&gt;Philip Cass, PhD, Consultant&lt;br&gt;TLP Group, Inc., Columbus Ohio&lt;br&gt;Introduced by: Claire V. Wolfe MD, AMA-SPS Governing Council&lt;br&gt;Moderator: Paul H. Wick, MD, Chair-Elect, AMA-SPS Governing Council (Flier for Program)</td>
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New items of business related to the Section’s mission may be introduced and Points of Personal Privilege, as time allows. Please come prepared to introduce new items of business related to the Section’s Mission that would be pertinent to the SPS for comment.
TAB A

(Chair’s Report)
SPS Governing Council

The AMA-SPS is governed by a seven-member Governing Council elected by the membership of the Senior Physicians Section. The Governing Council is responsible for directing the programs and activities of the group. AMA staff support is provided by Alice Reed, Senior Physician Section.

Senior Physicians Section (SPS) Governing Council 2016-2017

Barbara S. Schneidman, MD, MPH
Chair
Seattle, Wash.
Specialty: Psychiatry
Email

Barbara A. Hummel, MD
Immediate Past Chair
West Allis, Wisc.
Specialty: Family Medicine
Email

Claire V. Wolfe, MD
SPS Delegate
Dublin, Ohio
Specialty: Physical Medicine & Rehabilitation
Email

John A. Knote, MD
SPS Alternate Delegate
West Lafayette, Ind.
Specialty: Radiology
Email
Richard Allen, MD
Happy Valley, Ore.
Specialty: Obstetrics and Gynecology
Email

Paul H. Wick, MD
Tyler, Texas
Specialty: Psychiatry
Email
AMA-SPS Governing Council election results

Thank you to all who participated in the recent American Medical Association Senior Physicians Section (SPS) Governing Council elections and to those who applied to serve on the council.

Please join us in congratulating the new 2017–18 AMA-SPS Governing Council officers listed below. Their terms begin at the conclusion of the 2017 AMA Annual Meeting.

**Officer-at-large (both are two-year positions)**

- Barbara A. Hummel, MD (Muskego, Wis.)
- Louis Weinstein, MD (Charleston, S.C.)

They will join the current AMA-SPS Governing Council officers listed below.

- Barbara S. Schneidman, MD, MPH, chair (Seattle)
- Paul H. Wick, MD, chair-elect (Tyler, Texas)
- Claire V. Wolfe, MD, delegate (Dublin, Ohio)
• John A. Knote, MD, alternate delegate (West Lafayette, Ind.)
• Richard Allen, MD, officer-at-large (Happy Valley, Ore.)

The AMA-SPS Governing Council is responsible for directing the programs and activities of the section.

The AMA promotes the art and science of medicine and the betterment of public health.
Mission Statement – Senior Physicians Section

To engage physicians age 65 and above both active and retired to promote policies, products and services relevant to senior physicians.

Mission Statement – American Medical Association

To promote the art and science of medicine and the betterment of public health.
TAB B

(A-17 HOD Handbook Review)
The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

The profession of medicine promises that throughout their careers practitioners will have the knowledge, skills, and characteristics to practice safely and that the profession as a whole and its individual members will hold themselves accountable to identify and address lapses. Medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians’ technical knowledge and skills.

However, the ethical responsibility of competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients; competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

To fulfill the ethical responsibility of competence, individual physicians and physicians in training should:

(a) Exercise continuous self-awareness and self-observation;
(b) Recognize that different points of transition in professional life can make different demands on competence;
(c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations;
(d) Seek feedback from peers and others;
(e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient’s best interest.

Medicine as a profession should continue to refine mechanisms to meaningfully assess physician competence, including:

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<td>Amendm ents to C&amp;B</td>
<td>CEJA Report 2</td>
<td>Competence, Self-Assessment &amp; Self-Awareness</td>
<td>The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:</td>
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### Amendm ents to C&B Res. 005 Illinois Perioperative Do Not Resuscitate Orders

**RESOLVED,** That our American Medical Association adopt as policy the “required reconsideration” of patients’ existing advance directives in the perioperative period, in order to support the review of a patient’s advance directive prior to the performance of a procedure/surgery and the administration of anesthesia. (New HOD Policy)

**Fiscal Note:** Minimal – less than $1,000

**Procedures re honoring DNR vary hospital to hospital. Should be "required" discussion pre-op of directives to cover incidences that may occur during surgery.**

### Amendm ents to C&B Res. 007 Minority Affairs Section Healthcare as a Human Right

**RESOLVED,** That our American Medical Association recognize that a basic level of medical care is a fundamental human right (New HOD Policy); and be it further

**RESOLVED,** That our AMA support the United Nations’ Universal Declaration of Human Rights and its encompassing International Bill of Human Rights as guiding principles fundamental to the betterment of public health (New HOD Policy); and be it further

**RESOLVED** That our AMA advocate for the United States to remain a member state in the World Health Organization. (New HOD Policy)

**Fiscal Note:** Minimal – less than $1,000
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| Amendments to C&B | Res. 014 Introduced by M. Zuhdi Jasser, MD, Delegate | The Need to Distinguish between ‘Physician Assisted Suicide’ and ‘Aid in Dying’ | RESOLVED, That our American Medical Association, as a matter of organizational policy, when referring to what it currently defines as ‘Physician Assisted Suicide’ avoid any replacement with the phrase ‘Aid in Dying’ when describing what has long been understood by the AMA to specifically be ‘Physician Assisted Suicide’ (New HOD Policy); and be it further
RESOLVED, That our AMA develop definitions and a clear distinction between what is meant when the AMA uses the phrase ‘Physician Assisted Suicide’ and the phrase ‘Aid in Dying’ (Directive to Take Action); and be it further
RESOLVED, That these definitions and distinction be fully utilized by our AMA in organizational policy, discussions, and position statements regarding both ‘Physician Assisted Suicide’ and ‘Aid in Dying.’ (New HOD Policy)
Fiscal Note: Not yet determined
As CEJA is studying this (CEJA Informational Rept 5), this should be referred for the discussion. But is an FYI. |
| A | CMS Report 3 | Ensuring Continuity of Care Protections during Active Courses of Treatment (Resolution 108-A-16) | RECOMMENDATIONS:
The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-16, and that the remainder of the report be filed.
1. That our American Medical Association (AMA) reaffirm Policy H-285.911, which states that health insurance provider networks should be sufficient to provide meaningful access to all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy H-285.908, which supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when selecting and enrolling in a health insurance plan. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy H-285.952, which states that patients should have the opportunity for continued transitional care from physicians and hospitals whose contracts with health plans have terminated for reasons other than loss of or restrictions on their licenses and/or certifications, or fraud. (Reaffirm HOD Policy)
4. That our AMA modify Policy H-385.936 by addition and deletion to read as follows: Our AMA advocates for appropriate reimbursement payment for follow-up care of, and |
### Resolution/Report

**Title**

- **transitional care associated with complications and staged procedures from payers, including state and federal agencies.** (Modify HOD Policy)

5. That our AMA modify Policy H-285.924[4] by addition to read as follows:

   It is the policy of our AMA that health plans: ... (4) should continue to cover services provided by physicians who involuntarily leave a plan, for reasons other than loss of/restrictions on their medical license/certification or fraud (i.e., with cause), until the provider directory is updated online and a new printed directory is distributed. (Modify HOD Policy)

6. That our AMA support patients in an active course of treatment who switch to a new health plan having the opportunity to receive continued transitional care from their treating out-of-network physicians and hospitals at in-network cost-sharing levels. Transitional care should be provided at the physicians’ and hospitals’ discretion, after having agreed to payment terms with the health plan. (New HOD Policy)

7. That our AMA continue to provide assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure continuity of care protections for patients in an active course of treatment. (Directive to Take Action)

**Fiscal Note:** $5,000

- Of interest to our members regarding continuity of care protections.

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| A   | Res. 109 New York | Simplify Medicare Face to Face Requirement | RESOLVED, That our American Medical Association advocate to simplify the Medicare requirements for a “Face to Face” visit with a patient by a physician as a precondition for Medicare home health coverage, including advocating for alternatives for such “Face to Face” visit such as by telehealth. (New HOD Policy) | Fiscal Note: Minimal – less than $1,000
Of interest to our members & their senior patients. |
<p>| A   | Res. 116 California | Medicare Advantage Payment Policies | RESOLVED, That our American Medical Association urge the Centers for Medicare and Medicaid Services (CMS) to require Medicare Advantage plans to abide by all traditional Medicare Fee-for-Service payment and medical policies when reimbursing physicians on a fee-for-service basis to ensure uniformity in Medicare benefits and to reduce physician burdens. This policy is not intended to impact capitation rates that are agreed to between a Medicare |</p>
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<td>Advantage plan and a physician or physician organization. (New HOD Policy)</td>
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<td>Fiscal Note: Minimal – less than $1,000</td>
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<td>Of interest to our members &amp; their senior patients.</td>
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<td>Res. 121 Illinois</td>
<td>Advanced Care Planning Codes</td>
<td>RESOLVED, That our American Medical Association assess the degree of use of CPT Codes 99497 and 99498 since they were established (Directive to Take Action); and be it further</td>
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<td>RESOLVED, That our AMA study the barriers to discussion about advanced care planning by physicians and patients (Directive to Take Action); and be it further</td>
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<td>RESOLVED, That our AMA advocate for the expanded use of CPT Codes 99497 and 99498 when sufficient time and effort is spent in face-to-face contact with patients and families and when spread out over multiple clinical visits in order to satisfy the time requirements, due to the complexity of the subject matter. (New HOD Policy)</td>
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<td>Fiscal Note: Not yet determined</td>
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<td>Regarding reimbursement for discussion of end of life care.</td>
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<td>BoT 14</td>
<td>Medicare Part B Double Dipping</td>
<td>DISCUSSION</td>
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<td>Resolution 209 asks that our AMA prevent the federal government from deducting Medicare Part B from the salaries individuals may earn after they become eligible to draw on Social Security benefits. However, as explained above, a Medicare beneficiary’s share of the Part B premium is not financed through employee payroll taxes, it generally is deducted from the beneficiary’s Social Security check. Also, to the extent that a Medicare beneficiary continues to work, or returns to work, after becoming eligible for Medicare benefits, the Medicare payroll taxes that are deducted from the beneficiary’s (employee’s) paycheck go to fund the Medicare Part A trust fund, which is used to pay for Medicare Part A benefits.</td>
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<td>Resolution 209 states in the whereas clauses that “Medicare Part B is deducted from Social Security their checks,” and “once they return to work, Medicare Part B is also deducted from their paychecks, meaning the government is ‘double dipping’.”</td>
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<td>However, as discussed above, these paycheck deductions go to fund the Part A trust fund.</td>
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<td>fund, not the beneficiary’s share of the Part B premium. While it is true that some portion of a beneficiary’s federal income tax would be used to fund the federal government’s general revenue expenditures, which would include funding 75 percent of Medicare Part B premiums, federal income tax deductions do not appear to be the focus of this resolution. The Board, therefore, recommends that Resolution 209-A-16 not be adopted.</td>
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<td>RECOMMENDATION</td>
<td>The Board of Trustees recommends that Resolution 209-A-16 not be adopted and the remainder of the report be filed.</td>
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<td>Fiscal Note: Less than $500</td>
<td>Excellent report clarifying Part B coverage/payment and misconceptions in the original resolution. There is no &quot;double dipping&quot; for Part B.</td>
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<td>B 203 Missouri</td>
<td>AMA to Support Pharmaceutical Pricing Negotiation in US</td>
<td>RESOLVED, That our American Medical Association prioritize its support for the Centers for Medicare &amp; Medicaid Services (CMS) to negotiate pharmaceutical pricing for all applicable medications covered by CMS. (New HOD Policy)</td>
<td>Fiscal Note: Minimal – less than $1,000</td>
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<td>This should be on reaffirmation. Already AMA policy.</td>
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<td>B 205 Washington</td>
<td>Limiting Medicare Part D Enrollee Costs</td>
<td>RESOLVED, That our American Medical Association advocate for a Medicare Part D limiting charge for prescription medications (Directive to Take Action); and be it further</td>
<td>Fiscal Note: Modest – between $1,000 to $5,000</td>
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<td>RESOLVED, That our AMA advocate for a Medicare Part D annual out-of-pocket limit. (Directive to Take Action)</td>
<td>Believe elimination of the donut hole was scheduled for 2020 in ACA. Not sure where it is now in Congress but I do suspect this resolution and 207 below will be on the reaffirmation calendar as existing AMA policy.</td>
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<td>B</td>
<td>207</td>
<td>Sky Rocketing Drug Prices</td>
<td>RESOLVED, That our American Medical Association strongly advocate for policies, regulations and legislation that protect patients from sky rocketing exorbitant prices for previously affordable drugs (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for an “out of pocket” maximum dollar amount for total drug costs for our patients not to exceed $500 per month. (Directive to Take Action) Fiscal Note: Modest – between $1,000 To $5,000 Not just for Medicare folks.</td>
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<td>B</td>
<td>Res. 232</td>
<td>Create MACRA Opt-out Option</td>
<td>RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services to permit solo practitioners and small practices to opt-out of the Medicare Access and CHIP Reauthorization Act completely in order to protect their financial viability. (Directive to Take Action) Fiscal Note: Modest – between $1,000 - $5,000 Speaks to our members in small/solo practices but it most likely will be reaffirmation.</td>
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<td>C</td>
<td>Res. 305</td>
<td>Reduction of Caregiver Burnout</td>
<td>RESOLVED, That our American Medical Association encourage partner organizations to develop resources to better prepare caregivers in performing medical/nursing tasks (New HOD Policy); and be it further RESOLVED, That our AMA create an online educational module to promote physician understanding of caregiver burnout and develop strategies to support caregivers and their patients. (Directive to Take Action) Fiscal Note: Estimate cost between $15,000 - $25,000 to implement resolution. Probably pertinent to our membership but with a potentially high fiscal note. And not sure who &quot;partner organizations&quot; are.</td>
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<td>C</td>
<td>Res. 316</td>
<td>Action Steps Regarding Maintenance of Certification</td>
<td>RESOLVED, That our American Medical Association affirm that lifelong learning is a fundamental obligation of our profession (Directive to Take Action); and be it further RESOLVED, That our AMA recognize that lifelong learning for a medical physician is best</td>
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<td>California/New York/Arizona, Texas/American College of Radiation Oncology, American /Society of Interventional Pain Physicians)</td>
<td>achieved by ongoing participation in a program of high quality continuing medical education (CME) course appropriate to that physician’s medical practice as determined by the relevant specialty society (Directive to Take Action); and be it further RESOLVED, That our AMA develop model state legislation that would bar hospitals, health care insurers, and the state medical licensing board from using non-participation in the ABMS sponsored MOC process using lifelong, interval, high stakes testing as a exclusionary criteria for credentialing (Directive to Take Action); and be it further RESOLVED, That our AMA join with state medical associations and specialty societies in directly lobbying state medical licensing boards, hospital associations, and health care insurers to adopt policy supporting the use of satisfactory demonstration of lifelong learning with high quality CME as specified by a physician’s specialty society for credentialing and bar these entities from using the ABMS sponsored MOC process using lifelong interval high stakes testing for credentialing (Directive to Take Action); and be it further RESOLVED, That our AMA partner with state medical associations and specialty societies to undertake a study with the goal of establishing a program that will certify physicians as satisfying the requirements for continuation of their specialty certification by successful demonstration of lifelong learning utilizing high quality CME appropriate for that physician’s medical practice as determined by their specialty society with a target start date of 2020 or before, with report back biannually to the HOD and AMA members. (Directive to Take Action) Fiscal Note: Not yet determined This is probably VERY pertinent to our members. Apparently, some hospitals, some insurers and at least one state are using the MOC testing for credentialing, including those physicians who have been grandfathered by their specialty societies (which would include a lot of our members including me!). The resolution asks AMA to try &amp; stop the practice and instead advocate for the use of lifelong learning, using CME appropriate to the physician’s practice, in lieu of an expensive big MOC test.</td>
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<td>Michigan</td>
<td>Res. 318 Oppose Direct to Consumer Advertising of</td>
<td>RESOLVED, That our American Medical Association oppose direct-to-consumer marketing of the American Board of Medical Specialties Maintenance of Certification (MOC) product in the form of print media, social media, apps, and websites that specifically target patients and their</td>
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Fiscal Note: Not yet determined
### Resolution/Report: The ABMS MOC Product

**Title:**

Families including but not limited to the promotion of false or misleading claims linking MOC participation with improved patient health outcomes and experiences where limited evidence exists (Directive to Take Action); and be it further

RESOLVED, That our AMA amend existing AMA Policy D-275.954, “Maintenance of Certification and Osteopathic Continuous Certification” by addition as follows:

36. Direct the ABMS to ensure that any publicly accessible information pertaining to maintenance of certification (MOC) available on ABMS and ABMS Member Boards’ websites or via promotional materials includes only statistically validated, evidence based, data linking MOC to patient health outcomes. (Modify Current 7 HOD Policy)

**Fiscal Note:** Not yet determined

Since many senior physicians no longer participate in MOC, even with time limited certificates, this topic may be of interest.

### Michigan

**Res. 319**

**Title:** Public Access to Initial Board Certification Status of Time-Limited ABMS Diplomates

**Notes:**

Whereas, Initial American Board of Medical Specialties (ABMS) board certification is a credential of great accomplishment for many physicians; and

Whereas, Initial ABMS board certification is all that is required of time-unlimited or “grandfathered” physicians; and

Whereas, Existing AMA Policy H-275.924, “Maintenance of Certification,” protects the status of “grandfathered” physicians, stating “No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC;” and

Whereas, The names of grandfathered physicians are available when verifying certification status on ABMS credentialing websites, indicating the date of initial certification, regardless of their participation in Maintenance of Certification (MOC); and

Whereas, Similar protections for physicians holding time-limited certificates do not exist; and
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<td>Whereas, The ABMS and ABMS member boards erase the name of time-limited physicians when they choose not to participate in any of the four parts of MOC, regardless of how many times the physician has passed his or her board examinations; and</td>
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<td>Whereas, Under this punitive system that erases the name of time-limited physicians, the only way for the public to verify initial certification is via formal inquiry and a fee; and</td>
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<td>Whereas, This punitive system causes great harm to time-limited diplomates during professional physician credentialing, when initial certification is not readily available; and</td>
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<td>Whereas, This punitive system causes great harm to time-limited diplomates in terms of patient trust under the current direct-to-consumer advertising campaigns directing patients and families to “verify if your doctor is board certified,” when patients and families are not able to access initial board certification status of time-limited diplomates; therefore be it</td>
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<td>RESOLVED, That our American Medical Association amend the AMA Principles of Maintenance of Certification (MOC), AMA Policy H-275.924, “Maintenance of Certification,” by addition as follows:</td>
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<td>26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards’ websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards’ websites or physician certification databases even if the diplomate chooses not to participate in MOC. (Modify Current HOD Policy)</td>
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<td>Fiscal Note: Minimal – less than $1,000</td>
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<tr>
<td>C</td>
<td>Res. 322</td>
<td>Ending Maintenance of</td>
<td>RESOLVED, That our American Medical Association oppose the requirement of Maintenance of Certification (MOC) as currently constituted in privileging and credentialing providers by health</td>
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**THIS DIRECTLY IMPACTS OUR SENIOR MEMBERS. WE HAVE HAD TESTIMONY PREVIOUSLY THAT PHYSICIANS WHO ARE OLDER DO NOT WISH TO SPEND THE TIME AND MONEY REDOING CERTIFICATIONS THAT THEY HAVE DONE SEVERAL TIMES PREVIOUSLY.**
<table>
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<tr>
<th>Ref Comm</th>
<th>Resolution/Report</th>
<th>Title</th>
<th>Notes</th>
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<tr>
<td>New Hampshire</td>
<td>Certification Examinations</td>
<td>systems, hospitals, and payers (New HOD Policy); and be it further RESOLVED, That our AMA call on the American Board of Medical Specialties to pursue ongoing meaningful continuing medical education as a pathway to MOC without the requirement for re-examination (Directive to Take Action); and be it further RESOLVED, That our AMA reaffirm Policies H-275.924 and D-275.954, and report back at the 2017 Interim Meeting with an update on progress made to toward these policies. (Directive to Take Action) Fiscal Note: Minimal – less than $1,000 Most likely on reaffirmation calendar.</td>
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<tr>
<td>E Res. 521</td>
<td>Retail Prescription Bottle Label Privacy</td>
<td>RESOLVED, That our American Medical Association petition the American Pharmacist Association, the US Food and Drug Administration and other relevant agencies, to recommend that labels used for retail prescription bottles be affixed in a manner that allows easy removal or destruction to protect patient privacy. (Directive to Take Action) Fiscal Note: Modest – between $1,000 - $5,000</td>
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<tr>
<td>G Res. 708</td>
<td>Removing ‘Three Star Minimum’ Requirement for Skilled Nursing Facilities to Participate in Next Gen Accountable Care Organizations &amp; Bundled Payments for Care Improvement</td>
<td>RESOLVED, That our American Medical Association advocate to the Centers for Medicare &amp; Medicaid Services to remove the three star quality requirement for skilled nursing facilities to participate in Next Gen Accountable Care Organizations and the Bundled Payments for Care Improvement programs with waiver of three night hospital stays for patients. (Directive to Take Action) Fiscal Note: Modest – between $1,000- $5,000</td>
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<td>Ref Comm</td>
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<td>Programs and Care for Patients with Wavier of Three Night Hospital Stay Requirement</td>
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<tr>
<td>G</td>
<td>Res. 715 Michigan</td>
<td>Prescription Availability for Weekend Discharges</td>
<td>RESOLVED, That our American Medical Association work with pharmacy benefit managers (PBMs), health insurers, and pharmacists at a national level to address the problem of patients, discharged by a health care facility on a weekend or holiday, being denied access to vital medications because the patient’s health insurance carrier or applicable PBM does not have staff available on weekends or holidays to resolve coverage and/or formulary issues. (Directive to Take Action)</td>
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<td>Fiscal Note: Modest – between $1,000 - $5,000</td>
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<tr>
<td>Information Report</td>
<td>BOT Report 6</td>
<td>Redefining AMA’s Position on ACA and Healthcare Reform</td>
<td>CONCLUSION The 115th Congress promises the best opportunity to make important refinements to the ACA since the law’s implementation. Our AMA will continue to work to promote AMA supported refinements as part of current congressional activities surrounding health system reform, consistent with AMA objectives and other policies, and report back at the next meeting of the House of Delegates.</td>
</tr>
<tr>
<td>Information Report</td>
<td>CEJA Report 5</td>
<td>Study Aid-in-Dying as End-of-Life Option (Res. 015-A-16)</td>
<td>In light of the complex and deeply contested nature of the issues at stake, CEJA believes it is wisest to proceed cautiously and allow ample time for thoughtful reflection in developing its report.</td>
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<td>SPS will wait for final report before commenting. Will probably be discussed with Res. 014.</td>
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REPORT 2 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (2-A-17)
Competence, Self-Assessment and Self-Awareness
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society.

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient’s well-being.

To fulfill their ethical responsibility of competence, physicians at all stages in their professional lives should cultivate and exercise skills of self-awareness and active self-observation; take advantage of tools for self-assessment that are appropriate to their practice settings and patient populations; and be attentive to environmental and other factors that may compromise their ability to bring their best skills to the care of individual patients. As a profession, medicine should provide meaningful opportunity for physicians to hone their ability to be self-reflective.
REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 2-A-17

Subject: Competence, Self-Assessment and Self-Awareness

Presented by: Ronald J. Clearfield, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Michael Hoover, MD, Chair)

The expectation that physicians will provide competent care is central to medicine. This expectation shaped the founding mission of the American Medical Association (AMA) and runs throughout the AMA Code of Medical Ethics [1-4]. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society [5]. The profession promises that practitioners will have the knowledge, skills, and characteristics to practice safely and that the profession as a whole and its individual members will hold themselves accountable to identify and address lapses [6-9].

Yet despite the centrality of competence to professionalism, the Code has not hitherto examined what the commitment to competence means as an ethical responsibility for individual physicians in day-to-day practice. This report by the Council on Ethical and Judicial Affairs explores this topic to develop ethics guidance for physicians.

DEFINING COMPETENCE

A caveat is in order. Various bodies in medicine undertake point-in-time, cross-sectional assessments of physicians’ technical knowledge and skills. However, this report is not concerned with matters of technical proficiency assessed by medical schools and residency programs, specialty boards (for purposes of certification), or hospital and other health care organizations (e.g., for privileging and credentialing). Such matters lie outside the Council’s purview.

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole. For purposes of this analysis, competence is understood as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served” and as “developmental, impermanent, and context dependent” [10].

Moreover, the Council is keenly aware that technical proficiency evolves over time—what is expected of physicians just entering practice is not exactly the same as what is expected of mid-

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

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career physicians or physicians who are changing or re-entering practice or transitioning out of active practice to other roles. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues.

The concept that informs this report differs as well from the narrower legal definition of competence as the knowledge and skills an individual has to do a job. Rather, this report explores a broader notion of competence that encompasses deeper aspects of wisdom, judgment and practice that enable physicians to assure patients, the public, and the profession that they provide safe, high quality care moment to moment over the course of a professional lifetime.

SELF-ASSESSMENT & ITS LIMITATIONS

Health care institutions and the medical profession as a whole take responsibility to regulate physicians through credentialing and privileging, routinely testing knowledge (maintenance of certification, requirements for continuing education, etc.) and, when needed, taking disciplinary action against physicians who fail to meet expectations for competent, professional practice. However, the better part of the responsibility to maintain competence rests with physicians’ “individual capacity, as clinicians, to self-assess [their] strengths, deficiencies, and learning needs to maintain a level of competence commensurate with [their] clinical roles” [11].

Self-assessment has thus become “integral to many appraisal systems and has been espoused as an important aspect of personal professional behavior by several regulatory bodies and those developing learning outcomes for students” [12]. Undergraduate and graduate medical education programs regularly use self-assessment along with third-party evaluations to ensure that trainees are acquiring the knowledge and skills necessary for competent practice [5, 10, 13-16].

Yet how accurately physicians assess their own performance is open to question. Research to date suggests that there is poor correlation between how physicians rate themselves and how others rate them [5, 12, 13]. Various studies among health professionals have concluded that clinicians and trainees tend to assess their peers’ performance more accurately than they do their own; several have found that poor performers (e.g., those in the bottom quartile) tend to over-estimate their abilities while high performers (e.g., those in the top quartile), tend to under-estimate themselves [5, 12, 17].

The available findings suggest that self-assessment involves an interplay of factors that can be complicated by lack of insight or of metacognitive skill, that is, ability to be self-observant in the moment. Similarly, personal characteristics (e.g., gender, ethnicity, or cultural background) and the impact of external factors (e.g., the purpose of self-assessment or whether it is designed to assess practical skills or theoretical knowledge) can all affect self-assessment [12, 18]. The published literature also indicates that interventions intended to enhance self-assessment may seek different goals—improving the accuracy of self-assessors’ perceptions of their learning needs, promoting appropriate change in learning activities, or improving clinical practice or patient outcomes [12].

Self-assessment alone is not a reliable enough tool to ensure that physicians acquire and maintain the competence they need to provide safe, high quality care. Feedback from third parties is essential—or as one researcher has observed, “The road to self-knowledge may run through other people” [19]. However, physicians are often wary of assessment. They have indicated that while they want feedback, they are not sure how to use information that is not congruent with their self-appraisals [20]. Physicians can be hesitant to seek feedback for fear of looking incompetent or exposing possible deficiencies or out of concern that soliciting feedback could adversely affect
their relationships with those whom they approach [20]. They may also question the accuracy and
credibility of the assessment process and the data it generates [21].

To be effective, feedback must be valued by both those being assessed and those offering
assessment [14]. When there is tension between the stated goals of assessment and the implicit
culture of the health care organization or institution, assessment programs can too readily devolve
into an activity undertaken primarily to satisfy administrators that rarely improves patient care [20].
Feedback mechanisms should be appropriate to the skills being assessed—multi-source reviews
(“360° reviews”), for example, are generally better suited to providing feedback on communication
and interpersonal skills than on technical knowledge or skills—and easy for evaluators to
understand and use [14]. High quality feedback will come from multiple sources; be specific and
focus on key elements of the ability being assessed; address behaviors rather than personality or
personal characteristics; and “provide both positive comments to reinforce good behavior and
constructive comments with action items to address deficiencies” [22].

EXPERTISE & EXPERT JUDGMENT

On this broad understanding of competence, physicians’ thought processes are as important as their
knowledge base or technical skills. Thus, understanding competence requires understanding
something of the nature of expertise and processes of expert reasoning, themselves topics of
ongoing exploration [23, 24, 25, 26]. Prevailing theory distinguishes “fast” from “slow” thinking;
that is, reflexive, intuitive processes that require minimal cognitive resources versus deliberate,
analytical processes that require more conscious effort [25]. Some scholars take expertise to
involve “fast” processes, and specifically decision making that involves automatic, nonanalytic
resources acquired through experience [23]. Others argue that expertise consists in using “slow,”
effortful, analytic processes to address problems [23]. A more integrative view argues that
expertise resides in being able to transition between intuitive and analytical processes as
circumstances require. On this account, experts use automatic resources to free up cognitive
capacity so that they maintain awareness of the environment (“situational awareness”) and can
determine when to shift to effortful processes [23].

Expert judgment is the ability “to respond effectively in the moment to the limits of [one’s]
automatic resources and to transition appropriately to a greater reliance on effortful processes when
needed” [23], a practice described as “slowing down.” Knowing when to slow down and be
reflective has been demonstrated to improve diagnostic accuracy and other outcomes [25]. To
respond to the unexpected events that often arise in a clinical situation, the physician must
“vigilantly monitor relevant environmental cues” and use these as signals to slow down, to
transition into a more effortful state [24]. This can happen, for example, when a surgeon confronts
an unexpected tumor or anatomical anomaly during a procedure. “Slowing down when you should”
serves as a critical marker for intraoperative surgical judgment [23].

INFLUENCES ON CLINICAL REASONING

Clinical reasoning is a complex endeavor. Physicians’ capabilities develop through education,
training, and experiences that provide tools with which to shape their clinical reasoning. Every
physician arrives at a diagnosis and treatment plan for an individual in ways that may align with or
differ from the analytical and investigative processes of their colleagues in innumerable ways.
When something goes wrong in the clinic, it can be difficult to discern why. Nonetheless, all
physicians are open to certain common pitfalls in reasoning, including relying unduly on heuristics
and habits of perception, and succumbing to overconfidence.
Heuristics

Physicians often use various heuristics—i.e., cognitive short cuts—to aid decision making. While heuristics can be useful tools to help physicians identify and categorize relevant information, these time-saving devices can also derail decision making. For example, a physician may mistakenly assume that “something that seems similar to other things in a certain category is itself a member of that category” (the representative heuristic) [27], and fail to diagnose a serious health problem. Imagine a case in which a patient presents with symptoms of a possible heart attack or a stroke that the physician proceeds to discount as stress or intoxication once the physician learns that the patient is going through a divorce or smells alcohol on the patient’s breath. Or a physician may miscalculate the likelihood of a disease or injury occurring by placing too much weight “on examples of things that come to mind easily, . . . because they are easily remembered or recently encountered” (the availability heuristic) [27]. For example, amidst heavy media coverage of an outbreak of highly infectious disease thousands of miles away in a remote part of the world, a physician seeing a patient with symptoms of what is actually a more commonplace illness may misdiagnose (or over diagnose) the exotic condition because that is what is top of mind.

Clinical reasoning can be derailed by other common cognitive missteps as well. These can include misperceiving a coincidental relationship as a causal relationship (illusory bias), or the tendency to remember information transferred at the beginning (or end) of an exchange but not information transferred in the middle (primary or recency bias) [25, 27, 29].

Habits of Perception

Like every other person, physicians can also find themselves prone to explicit (conscious) or implicit (unconscious) habits of perception or biases. Physicians may allow unquestioned assumptions based on a patient’s race or ethnicity, gender, socioeconomic status, or health behavior, among other features, to shape how they perceive the patient and how they engage with, evaluate and treat the individual. Basing one’s interactions with a patient on pre-existing expectations or stereotypes depletes the patient, undermines the patient’s relationship with the physician and the health care system, and can result in significant health disparities across entire communities [30]. This is of particular concern for patients who are members of minority and historically disadvantaged populations [30]. Physicians may fall victim to the tendency to seek out information that confirms established expectations or dismiss contradicting information that does not fit into predetermined beliefs (confirmatory bias) [27]. These often inadvertent thought processes can result in a physician pursuing an incorrect line of questioning or testing that then leads to a misdiagnosis or the wrong treatment.

No matter how well a patient may seem to fit a stereotype, it is imperative that the physician look beyond categories and assumptions to investigate openly the health issues experienced by the patient. Although all human beings exhibit both conscious and unconscious habits of perception, physicians must remain vigilant in not allowing preconceived or unexamined assumptions to influence their medical practice.

Overconfidence

Finally, another obstacle to strong clinical reasoning that physicians may encounter is overconfidence. Despite their extensive training, physicians, like all people, are poor at identifying the gaps in their knowledge [27, 29]. Physicians may consider their skills to be excellent, when, in fact, their peers have identified areas for improvement [29]. Overconfidence in one’s abilities can
lead to suboptimal care for a patient, be it through mismanaging resources, failing to consider the advice of others, or not acknowledging one’s limits [27, 29].

To avoid falling into such traps, physicians must recognize that many factors can and will influence their clinical decisions [27]. They need to be aware of the information they do and do not have and they need to acknowledge that many factors can and will influence their judgment. They should keep in mind the likelihood of diseases and conditions and take the time to distinguish information that is truly essential to sound clinical judgment from the wealth of possibly relevant information available about a patient. They should consider reasons their decisions may be wrong and seek alternatives, as well as seek to disprove rather than confirm their hypotheses [27]. And they should be sensitive to the ways in which assumptions may color their reasoning and not allow expectations to govern their interactions with patients.

Shortcomings can be an opportunity for growth in medicine, as in any other field. By becoming aware of areas in which their skills are not at their strongest and seeking additional education or consulting with colleagues, physicians can enhance their practice and best serve their patients.

FROM SELF-ASSESSMENT TO SELF-AWARENESS

Recognizing that many factors affect clinical reasoning and that self-assessment as traditionally conceived has significant shortcomings, several scholars have argued that a different understanding of self-assessment is needed, along with a different conceptualization of its role in a self-regulating profession [31]. Self-assessment, it is suggested, is a mechanism for identifying both one’s weaknesses and one’s strengths. One should be aware of one’s weaknesses in order to self-limit practice in areas in which one has limited competence, to help set appropriate learning goals, and to identify areas that “should be accepted as forever outside one’s scope of competent practice” [31]. Knowing one’s strengths, meanwhile, allows a physician both to “act with appropriate confidence” and to “set appropriately challenging learning goals” that push the boundaries of the physician’s knowledge [31].

If self-assessment is to fulfill these functions, physicians need to reflect on past performance to evaluate not only their general abilities but also specific completed performances. At the same time, they must use self-assessment predictively to assess how likely they are to be able to manage new challenges and new situations. More important, physicians should understand self-assessment as an ongoing process of monitoring tasks during performance [32]. The ability to monitor oneself in the moment is critical to physicians’ ethical responsibility to practice safely, at the top of their expertise but not beyond it.

Expert practitioners rely on pattern recognition and other automatic resources to be able to think and act intuitively. As noted above, an important component of expert judgment is transitioning effectively from automatic modes of thinking to more effortful modes as the situation requires. Self-awareness, in the form of attentive self-observation (metacognitive monitoring), alerts physicians when they need to direct additional cognitive resources to the immediate task. For example, among surgeons, knowing when to “slow down” during a procedure is critical to competent professional performance, whether that means actually stopping the procedure, withdrawing attention from the surrounding environment to focus more intently on the task at hand, or removing distractions from the operating environment [24].

Physicians should also be sensitive to the ways that interruptions and distractions, which are common in health care settings, can affect competence in the moment [33, 34], by disrupting memory processes, particularly the “prospective memory”—i.e., “a memory performance in which
a person must recall an intention or plan in the future without an agent telling them to do so”—
important for resuming interrupted tasks [34, 35]. Systems-level interventions have been shown to
help reduce the number or type of interruptions and distractions and mitigate their impact on
medical errors [36].

A key aspect of competence is demonstrating situation-specific awareness in the moment of being
at the boundaries of one’s knowledge and responding accordingly [32]. Slowing down, looking
things up, consulting a colleague, or deferring from taking on a case can all be appropriate
responses when physicians’ self-awareness tells them they are at the limits of their abilities. The
capacity for ongoing, attentive self-observation, for “mindful” practice, is an essential marker of
competence broadly understood:

Safe practice in a health professional’s day-to-day performance requires an awareness of when
one lacks the specific knowledge or skill to make a good decision regarding a particular patient
. . . . This decision making in context is importantly different from being able to accurately rate
one’s own strengths and weaknesses in an acontextual manner. . . . Safe practice requires that
self-assessment be conceptualized as repeatedly enacted, situationally relevant assessments of
self-efficacy and ongoing “reflection-in-practice,” addressing emergent problems and
continuously monitoring one’s ability to effectively solve the current problem [31].

Self-aware physicians discern when they are no longer comfortable handling a particular type of
case and know when they need to obtain more information or need additional resources to
supplement their own skills [31]. Self-aware physicians are also alert to how external stressors—
the death of a loved one or other family crisis, or the reorganization of their practice, for example—
may be affecting their ability to provide care appropriately at a given time. They recognize when
they should ask themselves whether they should postpone care, arrange to have a colleague provide
care, or otherwise find ways to protect the patient’s well-being.

MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME

For physicians, the ideal is not simply to be “good” practitioners, but to excel throughout their
professional careers. This ideal holds not just over the course of a sustained clinical practice, but
equally when physicians re-enter practice after a hiatus, transition from active patient care to roles
as educators or administrators, or take on other functions in health care. Self-assessment and self-
awareness are central to achieving that goal.

A variety of strategies are available to physicians to support effective self-assessment and help
physicians cultivate the kind of self-awareness that enables them to “know when to slow down” in
day-to-day practice. One such strategy might be to create a portfolio of materials for reflection in
the form of written descriptions, audio or video recording, or photos of encounters with patients
that can provide evidence of learning, achievement and accomplishment [16] or of opportunities to
improve practice. A strength of portfolios as a tool for assessing one’s practice is that, unlike
standardized examinations, they are drawn from one’s actual work and require self-reflection [15].

As noted above, to be effective, self-assessment must be joined with input from others. Well-
designed multi-source feedback can be useful in this regard, particularly for providing information
about interpersonal behaviors [14]. Research has shown that a four-domain tool with a simple
response that elicits feedback about how well one maintains trust and professional relationships
with patients, one’s communication and teamwork skills, and accessibility offers a valid, reliable
tool that can have practical value in helping to correct poor behavior and, just as important,
consolidate good behavior [14]. Informal arrangements among colleagues to provide thoughtful feedback will not have the rigor of a validated tool but can accomplish similar ends.

Reflective practice, that is, the habit of using critical reflection to learn from experience, is essential to developing and maintaining competence across a physician’s practice lifetime [37]. It enables physicians to “integrate personal beliefs, attitudes, and values in the context of professional culture,” and to bridge new and existing knowledge. Studies suggest that reflective thinking can be assessed, and that it can be developed, but also that the habit can be lost over time with increasing years in practice [37].

“Mindful practice,” that is, being fully present in everyday experience and aware of one’s own mental processes (including those that cloud decision making) [38], sustains the attitudes and skills that are central to self-awareness. Medical training, with its fatigue, dogmatism, and emphasis on behavior over consciousness, erects barriers to mindful practice, while an individual’s unexamined negative emotions, failure of imagination, and literal-mindedness can do likewise. Mindfulness can be self-taught, but for most it is most effectively learned in relationship with a mentor or guide. Nonetheless, despite challenges, there are myriad ways physicians can cultivate mindfulness. Meditation, which may come first to mind, is one, but so is keeping a journal, reviewing videos of encounters with patients, or seeking insight from critical incident reports [38].

“Exemplary physicians,” one scholar notes, “seem to have a capacity for self-critical reflection that pervades all aspects of practice, including being present with the patient, solving problems, eliciting and transmitting information, making evidence-based decisions, performing technical skills, and defining their own values” [38].

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

The profession of medicine promises that throughout their careers practitioners will have the knowledge, skills, and characteristics to practice safely and that the profession as a whole and its individual members will hold themselves accountable to identify and address lapses. Medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians’ technical knowledge and skills.

However, the ethical responsibility of competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

To fulfill the ethical responsibility of competence, individual physicians and physicians in training should:

(a) Exercise continuous self-awareness and self-observation;
(b) Recognize that different points of transition in professional life can make different
   demands on competence;

(c) Take advantage of well-designed tools for self-assessment appropriate to their practice
   settings and patient populations;

(d) Seek feedback from peers and others;

(e) Be attentive to environmental and other factors that may compromise their ability to bring
   appropriate skills to the care of individual patients and act in the patient’s best interest.

   Medicine as a profession should continue to refine mechanisms to meaningfully assess
   physician competence, including:

(f) Developing appropriate ways to assess knowledge and skills across the professional
   lifecycle;

(g) Providing meaningful opportunity for physicians and physicians in training to hone their
   ability to be self-reflective and attentive in the moment;

(h) Supporting efforts to develop more and better techniques to address gaps in knowledge,
   skills, and self-awareness.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500.
REFERENCES

Whereas, The automatic suspension of a patient’s do-not-resuscitate order is commonly practiced in operating rooms across the United States and the automatic suspension of a do-not-resuscitate order in the perioperative period undermines patients’ rights and the ethical principle of autonomy; and

Whereas, The Patient Self-Determination Act of 1990 requires health care institutions to provide patients with information regarding advance directives and patients’ rights to accept or refuse medical treatment; and

Whereas, The American Society of Anesthesiologists, the American College of Surgeons, and the Association of Operating Room Nurses support “required reconsideration” of patients’ existing advance directives in the perioperative period to support the review of patients’ advance directives prior to the performance of a procedure/surgery and the administration of anesthesia; and

Whereas, The Joint Commission requires that policies are present to uphold the respect of patients who refuse resuscitation; therefore be it

RESOLVED, That our American Medical Association adopt as policy the “required reconsideration” of patients’ existing advance directives in the perioperative period, in order to support the review of a patient’s advance directive prior to the performance of a procedure/surgery and the administration of anesthesia. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 05/01/17
Whereas, Existing AMA Policy H-270.965, "Physician-Assisted Suicide," is clear that “our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician’s role as healer” and H-140.952, “Physician Assisted Suicide,” which states that “Physician Assisted Suicide is fundamentally inconsistent with the physician’s professional role; and

Whereas, A review of all AMA policy yields no results for the phrase ‘aid in dying,’ especially in any way meant to be synonymous with ‘physician assisted suicide’; and

Whereas, The replacement of the use of the known phrase ‘physician assisted suicide’ with the new phrase ‘aid in dying’ will have and is having the effect of concealing the reality of the fact that both these phrases are being used interchangeably to refer to the same specific defined procedure long established and defined already to be ‘physician assisted suicide’; and

Whereas, ‘Physician assisted suicide’ is clearly defined to be a situation where a physician is asked to and agrees to prescribe a lethal dose of medication to a patient known to be terminally ill so that the patient can self-administer that lethal dose and bring about the immediate end of their own life; and

Whereas, There is no more clear and appropriate phrase to define this procedure than “Physician Assisted Suicide”; and

Whereas, AMA policy is often operationally meted out in the public sector and daily through the terms it endorses and advertises making its selection of terms and phrases like ‘physician assisted suicide’ or ‘aid in dying’ very important with regards to how we maintain transparency and clarity with regards to AMA policy positions; and

Whereas, Any attempt to re-brand what is clearly “physician assistance in the act of suicide” to what is felt to be a softer, less ‘inflammatory’, ‘aid in dying’, can be well-intended but can also have many unintended consequences; and

Whereas, Physicians may either agree or disagree on the ethics and propriety of assisted suicide, the change in terminology creates an insidious misrepresentation if not confusion about the reality of the ‘physician assisted suicide’ process and act which does not hold true to the transparency of the AMA’s current policy position; therefore be it
RESOLVED, That our American Medical Association, as a matter of organizational policy, when referring to what it currently defines as ‘Physician Assisted Suicide’ avoid any replacement with the phrase ‘Aid in Dying’ when describing what has long been understood by the AMA to specifically be ‘Physician Assisted Suicide’ (New HOD Policy); and be it further

RESOLVED, That our AMA develop definitions and a clear distinction between what is meant when the AMA uses the phrase ‘Physician Assisted Suicide’ and the phrase ‘Aid in Dying’ (Directive to Take Action); and be it further

RESOLVED, That these definitions and distinction be fully utilized by our AMA in organizational policy, discussions, and position statements regarding both ‘Physician Assisted Suicide’ and ‘Aid in Dying.’ (New HOD Policy)

Fiscal Note: Not yet determined

Received: 05/11/17

RELEVANT AMA POLICY

Physician Assisted Suicide H-140.952
It is the policy of the AMA that: (1) Physician assisted suicide is fundamentally inconsistent with the physician's professional role. (2) It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide. (3) Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease. (4) Requests for physician assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated. (5) Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations.

Physician-Assisted Suicide H-270.965
Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer.
Whereas, The AMA has established Policy D-275.954 which asks the American Board of Medical Specialties (ABMS) to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring, and reporting maintenance of certification (MOC) and certifying examinations, and this policy also calls on the AMA to continue to monitor the evolution of MOC, continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC and prepare a yearly report to the AMA HOD regarding the MOC process; and

Whereas, Hospitals, health care insurers, and at least one state board for medical licensure are using participation in ABMS sponsored MOC programs featuring interval, high stakes examinations as a condition for credentialing including for physicians previously “grandfathered in” with “permanent specialty boards”; and

Whereas, The ABMS response to the AMA request for improvements in the MOC process to work toward the elimination of lifelong interval, high stakes testing in favor of lifelong learning featuring high quality continuing medical education course work as determined by the physician’s specialty society in review of that physicians established medical practice was inadequate and unsatisfactory; therefore be it

RESOLVED, That our American Medical Association affirm that lifelong learning is a fundamental obligation of our profession (Directive to Take Action); and be it further

RESOLVED, That our AMA recognize that lifelong learning for a medical physician is best achieved by ongoing participation in a program of high quality continuing medical education (CME) course appropriate to that physician’s medical practice as determined by the relevant specialty society (Directive to Take Action); and be it further

RESOLVED, That our AMA develop model state legislation that would bar hospitals, health care insurers, and the state medical licensing board from using non-participation in the ABMS sponsored MOC process using lifelong, interval, high stakes testing as a exclusionary criteria for credentialing (Directive to Take Action); and be it further
RESOLVED, That our AMA join with state medical associations and specialty societies in
directly lobbying state medical licensing boards, hospital associations, and health care insurers
to adopt policy supporting the use of satisfactory demonstration of lifelong learning with high
quality CME as specified by a physician’s specialty society for credentialing and bar these
entities from using the ABMS sponsored MOC process using lifelong interval high stakes testing
for credentialing (Directive to Take Action); and be it further

RESOLVED, That our AMA partner with state medical associations and specialty societies to
undertake a study with the goal of establishing a program that will certify physicians as
satisfying the requirements for continuation of their specialty certification by successful
demonstration of lifelong learning utilizing high quality CME appropriate for that physician’s
medical practice as determined by their specialty society with a target start date of 2020 or
before, with report back biannually to the HOD and AMA members. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/03/17

The topic of this resolution is currently under study by the Council on Medical Education.

RELEVANT AMA POLICY

Maintenance of Certification and Osteopathic Continuous Certification D-275.954
Our AMA will:
1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic
   Continuous Certification (OCC), continue its active engagement in discussions regarding their
   implementation, encourage specialty boards to investigate and/or establish alternative
   approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC
   and OCC process.
2. Continue to review, through its Council on Medical Education, published literature and
   emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and
   its member boards on implementation of MOC, and encourage the ABMS to report its research
   findings on the issues surrounding certification and MOC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure
   the ability of physicians to access and apply knowledge to care for patients, and to continue to
   examine the evidence supporting the value of specialty board certification and MOC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component
   of MOC, including the exploration of alternative formats, in ways that effectively evaluate
   acquisition of new knowledge while reducing or eliminating the burden of a high-stakes
   examination.
6. Work with interested parties to ensure that MOC uses more than one pathway to assess
   accurately the competence of practicing physicians, to monitor for exam relevance and to
   ensure that MOC does not lead to unintended economic hardship such as hospital de-
   credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not
   been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently
   written, from MOC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency
   related to the costs of preparing, administering, scoring and reporting MOC and certifying
   examinations.
10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.
28. Examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways.
29. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.

30. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.

31. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

32. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.

33. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

34. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.

35. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.

Whereas, There are no studies linking physician’s participation in the American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC) product with a positive effect on the quality or cost of care; and

Whereas, Advertising medical products and processes directly to patients bypasses the critical filter of physicians who can help patients decipher complicated medical concepts; and

Whereas, There is no regulatory proof required for these direct-to-consumer advertising campaigns, making it difficult to refute these claims in the marketplace of ideas; and

Whereas, Existing AMA Policy H-105.988 opposes direct-to-consumer advertising of prescription drugs and implantable devices for the ethical concerns of misleading information and corporate interference with the doctor-patient relationship; and

Whereas, The American Board of Medical Specialties has launched a direct-to-consumer campaign at certificationmatters.org; and

Whereas, Subspecialty boards such as the American Board of Pediatrics are following suit with mycertifiedpediatrician.org; and

Whereas, These advertising campaigns contain misleading information linking quality care to the board certification product; and

Whereas, These advertising campaigns direct patients and families to search misleading databases that eliminate the names of physicians who have passed multiple board exams over decades, but choose not to participate in MOC; and

Whereas, These campaigns do not mention alternate certification boards where a physician may be certified; and

Whereas, These direct-to-consumer campaigns with misleading and incomplete information have potential to harm the physician-patient trust and relationship; therefore be it

RESOLVED, That our American Medical Association oppose direct-to-consumer marketing of the American Board of Medical Specialties Maintenance of Certification (MOC) product in the form of print media, social media, apps, and websites that specifically target patients and their families including but not limited to the promotion of false or misleading claims linking MOC participation with improved patient health outcomes and experiences where limited evidence exists (Directive to Take Action); and be it further
RESOLVED, That our AMA amend existing AMA Policy D-275.954, “Maintenance of Certification and Osteopathic Continuous Certification” by addition as follows:

36. Direct the ABMS to ensure that any publicly accessible information pertaining to maintenance of certification (MOC) available on ABMS and ABMS Member Boards’ websites or via promotional materials includes only statistically validated, evidence based, data linking MOC to patient health outcomes. (Modify Current HOD Policy)

Fiscal Note: Not yet determined

Received: 05/11/17

RELEVANT AMA POLICY

Maintenance of Certification H-275.924
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 CreditTM, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards developing MOC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. MOC activities and measurement should be relevant to clinical practice.

19. The MOC process should not be cost prohibitive or present barriers to patient care.

20. Any assessment should be used to guide physicians’ self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.


Maintenance of Certification and Osteopathic Continuous Certification D-275.954

Our AMA will:

1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.

2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.

3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.

4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.

5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.

6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.

7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.

8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.

9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.

10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.

11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.

12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.
28. Examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways.
29. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.
30. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
31. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
32. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
33. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
34. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
35. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.

Whereas, Initial American Board of Medical Specialties (ABMS) board certification is a credential of great accomplishment for many physicians; and

Whereas, Initial ABMS board certification is all that is required of time-unlimited or “grandfathered” physicians; and

Whereas, Existing AMA Policy H-275.924, “Maintenance of Certification,” protects the status of “grandfathered” physicians, stating “No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC;” and

Whereas, The names of grandfathered physicians are available when verifying certification status on ABMS credentialing websites, indicating the date of initial certification, regardless of their participation in Maintenance of Certification (MOC); and

Whereas, Similar protections for physicians holding time-limited certificates do not exist; and

Whereas, The ABMS and ABMS member boards erase the name of time-limited physicians when they choose not to participate in any of the four parts of MOC, regardless of how many times the physician has passed his or her board examinations; and

Whereas, Under this punitive system that erases the name of time-limited physicians, the only way for the public to verify initial certification is via formal inquiry and a fee; and

Whereas, This punitive system causes great harm to time-limited diplomates during professional physician credentialing, when initial certification is not readily available; and

Whereas, This punitive system causes great harm to time-limited diplomates in terms of patient trust under the current direct-to-consumer advertising campaigns directing patients and families to “verify if your doctor is board certified,” when patients and families are not able to access initial board certification status of time-limited diplomates; therefore be it
RESOLVED, That our American Medical Association amend the AMA Principles of Maintenance of Certification (MOC), AMA Policy H-275.924, "Maintenance of Certification," by addition as follows:

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards’ websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards’ websites or physician certification databases even if the diplomate chooses not to participate in MOC. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 05/11/17

RELEVANT AMA POLICY

Maintenance of Certification H-275.924
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 CreditTM, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise...
the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME. 

11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. MOC should be used as a tool for continuous improvement.

15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards developing MOC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. MOC activities and measurement should be relevant to clinical practice.

19. The MOC process should not be cost prohibitive or present barriers to patient care.

20. Any assessment should be used to guide physicians’ self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

Resolution 15-A-16, “Study Aid-in-Dying as End-of-Life Option,” presented by the Oregon Delegation and referred by the House of Delegates (HOD), asked:

That our American Medical Association (AMA) and its Council on Judicial and Ethical Affairs (CEJA), study the issue of medical aid-in-dying with consideration of (1) data collected from the states that currently authorize aid-in-dying, and (2) input from some of the physicians who have provided medical aid-in-dying to qualified patients, and report back to the HOD at the 2017 Annual Meeting with recommendation regarding the AMA taking a neutral stance on physician “aid-in-dying.”

Testimony spoke to the fact that many states have proposed or adopted legislation to legalize the practice, introducing a potential conflict for our members in those states. Additional testimony recognized the need for our AMA to respond to this highly relevant and expanding issue that may impact medical practice, looking to the Council on Ethical and Judicial Affairs for guidance.

The question of whether physicians may actively aid death is of extraordinary importance to patients, families, and the medical profession and demands thorough and thoughtful reflection. CEJA has begun reviewing the extensive literature regarding physician aid in dying, along with numerous communications received to date that reflect diverse views. In addition, CEJA invited interested members of the House to participate in an open house session on June 10th to provide further input to help inform its deliberations.

In light of the complex and deeply contested nature of the issues at stake, CEJA believes it is wisest to proceed cautiously and allow ample time for thoughtful reflection in developing its report.
Resolution: 816
(l-16)

Introduced by: Senior Physicians Section

Subject: Support for Seamless Physician Continuity of Patient Care

Referred to: Reference Committee J
(Candace E. Keller, MD, Chair)

Whereas, With an aging population and shortage of physicians facing America, the AMA Senior Physicians Section (AMA-SPS) will work to engage senior physicians (age 65 and older), both active and retired, to ensure high-quality care and safety for patients by collaboration with other stakeholders in the changing health care system; and

Whereas, Senior physicians (and others) come out of training programs where continuity was considered one of the critical foundations of a quality medical practice; and

Whereas, There has been extreme growth of the present day practice of separating inpatient care from office care as far as the role of the physician is concerned; and

Whereas, Systems are not yet commonplace that assure seamless care between the inpatient and office care settings; and

Whereas, Those physicians and others who choose to provide care in both the inpatient and office settings are being precluded by health insurance system policies; therefore be it

RESOLVED, That our American Medical Association clearly support the concept of seamless continuity of care between hospital inpatient and outpatient care (New HOD Policy); and be it further

RESOLVED, That our AMA study whether there are instances of health insurers or HMO's precluding physicians via contracts from providing care to their patients in the in-patient setting for which the physician has clinical privileges. (Directive to Take Action)

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

Received: 10/13/16
Late Resolution 816 (from the I-16 Meeting)

The GC agreed to pull Resolution 816 at I-16 off the reaffirmation calendar. Substitute language was provided for the second resolve, see below.

Substitute Resolve language provided

Resolved, That our AMA investigate the practice of risk management companies and similar companies that require through Medicare Advantage and subcontracts or by other means that physicians delegate care of their contracted patients to the management company’s panel for approval of referrals, hospital and nursing home care, and put the physician at financial risk if they fail to follow such mandates.

Board and Management Reports for Action

• MGMT Report 2 – Support for Seamless Physician Continuity of Patient Care (Res. 816-I-16)

Management Report 2 was referred for decision, at the April Board Meeting. The following recommendations were approved by the Board.

RECOMMENDATIONS, OPTIONS, OR KEY POINTS FOR DISCUSSION

In lieu of Resolution 816-I-16, it is recommended that the American Medical Association (AMA):


2. Encourage physicians who encounter contractual difficulties with Medicare Advantage (MA) plans to contact their Centers for Medicare & Medicaid Services (CMS) Regional office.

(Note below from Claire Wolfe, MD, SPS Delegate)

The physician from Florida who submitted this resolution decided to opt out of the specific managed care plan that required him to turn over IP care to the hospitalists. He noted the “usual” practice these days: turning over IP care to hospitalists. If there are different hospitalists in charge on every shift and on each day, the “continuity” becomes the electronic chart note. There is no coordination among the many specialists who see each patient and there is no cohesive information given to the families in these cases.

The AMA already has policy that we pulled out of the Policy Compendium that stresses the importance of the patient-physician relationship and the coordination of care. It sounds good- it IS good- but it has no force of making any change in what’s happening.
However, the larger issue of continuity could be suited for the Senior Section to take a stand on. Most physicians who have cared for their patients while hospitalized feel the present state of care lends itself to poorer quality of care for the patient and often confusion and ill will toward medical providers on the part of families and the general public.

There could be several steps taken by organized medicine that might make the situation better as suggested by the physician who originally submitted this resolution.

1.) Incentivize the PCP to care for their hospitalized patients by increasing the reimbursements for doing that care (the AMA through the RUC has input in this area).

2.) The AMA should help medical schools and training programs stress continuity and support systems of education and training that would support continuity.

3.) The issue of hours during training has changed the work ethic and could be modified to return to the same patient care work ethic that we senior physicians were trained under.

(The alternative to this third thought is that the current generation of physicians starts with a different work/family ethic and does not wish to provide the time to practice medicine the long hours required for both in-office and hospital practice in which case neither item 1.) or 2.) would be particularly successful.)
TAB C

(SPS Educational Program)
The American Medical Association Senior Physicians Section (SPS) invites you to our assembly and educational program held in conjunction with the 2017 AMA Annual Meeting. We hope you can join us and enjoy the fellowship of your senior physician colleagues.

Noon–1:30 p.m.

**Mindfulness interventions: A workshop to foster resiliency**
Approved for 1.5 AMA PRA Category 1 Credits™

**Introduced by:** Claire V. Wolfe, MD, AMA-SPS Governing Council  
**Speaker:** Philip Cass, PhD, consultant, TLP Group Inc., Columbus, Ohio  
**Moderator:** Paul H. Wick, MD, chair-elect, AMA-SPS Governing Council

**Program description**
Mindfulness—the process of bringing one’s attention to internal and external experiences occurring in the present moment—can be developed through the practice of meditation. Recent research has indicated a correlation between mindfulness and improved well-being, suggesting mindfulness can even help alleviate many mental and physical conditions. This session will explore how incorporating mindfulness interventions into your daily life can be effective in developing a healthy state of active and open attention to the present.

**Objectives**
- Review the latest understanding of the effects that mindfulness meditation has on the brain.  
- Assess the implications mindfulness meditation has for physicians in their practice of medicine.  
- Evaluate how to incorporate mindfulness techniques in daily life.  
- Practice three easy-to-implement mindfulness techniques.

**Assembly meeting**
The AMA–SPS extends an open invitation to all physicians 65 years of age and above to attend our business meeting right before the mindfulness workshop. The AMA-SPS will discuss AMA House of Delegates’ business items and future AMA-SPS activities.

**A light lunch will be offered at 11:30 a.m. – first come, first served!**
Visit ama-assn.org/senior-physicians-section to learn more.
SPS Resources
Tasty desserts with an international flair and live entertainment!

Hosted by the AMA International Medical Graduates (IMG) Section

9:30 p.m.
Saturday, June 10

Crystal Ballroom
Hyatt Regency Chicago

Email img@ama-assn.org
with questions.
2017 AMA International Medical Graduates Section Annual Meeting

June 9–12
Hyatt Regency Chicago
Chicago

Join us at the American Medical Association International Medical Graduates (IMG) Section Annual Meeting. This meeting commemorates the 20th year of the AMA-IMG Section. We encourage you to invite a colleague or friend to attend and share in the AMA-IMG Section’s valuable information sessions.

Meeting highlights include:

**AMA-IMG and AMA Minority Affairs sections candidates forum**
3 p.m., Friday, June 9—Columbus G
Meet the candidates who are running for an AMA Board of Trustees position. The candidate’s forum is cosponsored by the Minority Affairs Section.

**Cosponsored educational sessions by the AMA Academic Physicians and AMA-IMG sections**
9–11:45 a.m., Saturday, June 10—Columbus C/D
Come learn about the “Apps for Academic Physicians: The Hows and Whys” and “Funding for Accountability, Sustainability and Transparency in Medical Education: A Proposed Model for Meeting Physician Workforce Needs.”

**AMA-IMG Section reception and congress**
5:30–7:30 p.m., Saturday, June 10—Columbus G
Join us as we celebrate the 20th anniversary of the AMA-IMG Section and hear a Washington Update by AMA’s Government Affairs staff. Additional discussions will include organizational reports and resolutions being considered at the 2017 AMA Annual Meeting. Don’t miss the opportunity to share your comments on those resolutions being considered for the meeting.

**11th annual “Desserts From Around the World” reception**
9:30–11 p.m., Saturday, June 10—Crystal Ballroom
Each year this event gets bigger and tastier! Join us and try new and exciting ethnic desserts. You are also welcome to be a sponsor for this event. For more information, contact img@ama-assn.org.

**Reference Committee hearings**
8:30 a.m.—5 p.m., Sunday, June 11
Participate and hear reference committee deliberations on AMA House of Delegates reports and resolutions.

**AMA-IMG and AMA Minority Affairs sections delegates caucus**
8:30 a.m.—9:30 a.m., Monday, June 12—Skyway 273
Meet your respective section delegates and discuss the strategies for deliberations on various reference committee reports and resolutions.

**Busharat Ahmad, MD, Leadership Development Program**
10:30–11:30 a.m., Monday, June 12—Roosevelt 3 A/B
Learn how to improve your leadership skills to become an effective leader in your organization.

Make plans to attend today! To register, visit ama-assn.org/sections-meeting-registration.

Email img@ama-assn.org or call the AMA-IMG Section at (312) 464-5397 if you have questions.
Hosted by the American Medical Association Women Physicians Section

Responding to the impact of the opioid epidemic on women

(1.5 AMA PRA Category 1 Credits™)

8:30–10 a.m.
Saturday, June 10
Hyatt Regency Chicago
Columbus I–J

Deaths from prescription painkiller overdoses among women have increased more than 400 percent since 1999, compared to 265 percent among men. Susceptibility to substance abuse among women may be influenced by biological differences and social factors that could have implications for prevention and treatment. Learning how to recognize these differences will prepare you to identify at-risk patients and implement interventions to address opioid use disorder in women across various age, race and socioeconomic spectrums.

Attendees will learn to differentiate between variables that increase the risk of addiction to prescription opioids in women; describe trends related to opioid prescribing, opioid use disorder and unintentional overdose among adolescent girls and women; identify ways to effectively manage pain and reduce opioid-related harm; and recognize maternal-obstetric complications associated with opiate dependency in pregnancy.

Agenda

Moderator
Claudia Reardon, MD
Associate professor, University of Wisconsin School of Medicine and Public Health

Understanding the unique risks and epidemiology of opioid use disorders among women
Melinda Campopiano, MD
Chief medical officer, Substance Abuse and Mental Health Services Administration

Your role in effectively managing pain through opioids
Mishka Terplan, MD, MPH, FACOG, FASAM
Professor, Virginia Commonwealth University

Maternal-obstetric complications associated with opiate dependency in pregnancy
Mary Anne McCaffree, MD
Professor, College of Medicine University of Oklahoma

Overview of legislation and other policy related to opioid use disorder
Patrice A. Harris, MD, MA
Chair, AMA Board of Trustees

The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The American Medical Association designates this educational activity for a maximum of 1.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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Plan to attend!

2017 AMA Women Physicians Section Annual Meeting

Saturday, June 10
Hyatt Regency Chicago

The American Medical Association Women Physicians Section (AMA-WPS) Annual Meeting offers a unique opportunity to network with physicians from across the country and meet leaders from state societies, specialty societies and the AMA. Please plan to attend.

8:30–10 a.m.
Responding to the impact of the opioid epidemic on women
Approved for 1.5 AMA PRA Category 1 Credits™*
Columbus I/J room
Moderator: Claudia Reardon, MD, Associate Professor, University of Wisconsin School of Medicine
Speakers:
- Melinda Campopiano, MD, Chief Medical Officer, Substance Abuse and Mental Health Services Administration
- Mishka Terplan, MD, MPH, FACOG, FASAM, Professor, Virginia Commonwealth University
- Mary Anne McCaffree, MD, Professor of Pediatrics, University of Oklahoma College of Medicine
- Patrice Harris, MD, Chair, AMA Board of Trustees

Program description:
Attendees will learn to: differentiate between variables that increase the risk of addiction to prescription opioids in women; describe trends related to opioid prescribing, opioid use disorder, and unintentional overdose among adolescent girls and women; and identify ways to effectively manage pain and reduce opioid-related harm.

5:30–7:30 p.m.
Business meeting and reception
Columbus E/F room

The meeting will feature dynamic presentations and a review of the AMA House of Delegates Handbook.

Monday, June 12
Columbus H room
11:30 a.m.–1 p.m.
AMA-WPS Associates lunch and business meeting
Participants will discuss current and emerging issues impacting the professional lives of women physicians and women’s health issues. The discussion will also include details on Women in Medicine Month, taking place in September.

*The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The American Medical Association designates this live activity for a maximum of 1.5 AMA PRA Category Credits™. Physicians should claim only the credit commensurate with the extent of their participation in this activity.
Transgender health and social justice
Room: Plaza B
5:30–7 p.m. | Friday, June 9
Reception and caucus
Magda Houlberg, MD
Howard Brown Health of Chicago

Health equity and the intersectionality of minority and LGBTQ health
Room: Randolph 3
10 a.m.–noon | Saturday, June 10

Session 1 (10–11 a.m.)
Moderator
Carl G. Streed Jr., MD
AMA Advisory Committee on LGBTQ Issues

Panelists
Abbas Hyderi, MD, MPH
University of Illinois at Chicago College of Medicine
David Ernesto Munar
Howard Brown Health
Mona Noriega, MBA, MPA
Chicago Commission on Human Relations

Session 2 (11 a.m.–noon)
Moderator
Frank A. Clark, MD
Governing Council, AMA-MAS

Panelists
Maxx Boykin
AIDS Foundation of Chicago
Kim Hunt
Pride Action Tank
Julie Morita, MD, MPH
Chicago Department of Public Health
2017 AMA Minority Affairs Section Annual Meeting

**Addressing intentional violence through a public health lens**
Room: Columbus K/L
4:30–6 p.m. | Friday, June 9
Reception and business meeting

*Selwyn Rogers, MD, MPH*
University of Chicago Medicine Trauma Center

**Health equity and the intersectionality of minority and LGBTQ health**
Room: Randolph 3
10 a.m.–noon | Saturday, June 10

**Session 1 (10–11 a.m.)**
Moderator
*Carl G. Streed Jr., MD*
AMA Advisory Committee on LGBTQ Issues

Panelists
*Abbas Hyderi, MD, MPH*
University of Illinois at Chicago College of Medicine

*David Ernesto Munar*
Howard Brown Health

*Mona Noriega, MBA, MPA*
Chicago Commission on Human Relations

**Session 2 (11 a.m.–noon)**
Moderator
*Frank A. Clark, MD*
Governing Council, AMA-MAS

Panelists
*Maxx Boykin*
AIDS Foundation of Chicago

*Kim Hunt*
Pride Action Tank

*Julie Morita, MD, MPH*
Chicago Department of Public Health

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Co-sponsors
AMA Minority Affairs Section
AMA Advisory Committee on LGBTQ Issues
AMA Medical Student Section Minority Issues Committee
Our AMA Senior Physicians Section keeps you in touch with the career you love

The American Medical Association Senior Physicians Section (SPS), with nearly 53,000 members, is the largest senior physician group in the United States. AMA members 65 years of age and above can remain involved in their profession through the section activities.

Professional involvement opportunities for AMA members

**AMA-SPS Governing Council** ▶ Directs the programs and activities of the section. Monitor the call for leadership positions and applications at ama-assn.org/go/sps.

**Policy development** ▶ The AMA-SPS holds two meetings a year that are open to all senior physicians. Attend in person or participate in the AMA-SPS online member forum and virtual AMA-SPS assembly process.

**Educational programs** ▶ Topics relevant to senior physicians, such as physician health and retirement planning, are addressed through informative programs.

**Jack B. McConnell, MD, Award for Excellence in Volunteerism** ▶ Honors an outstanding senior physician who provides volunteer treatment to those without access to health care.

Learn more about involvement opportunities at ama-assn.org/go/sps.

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**AMA Physicians’ Grassroots Network** ▶ Receive legislative alerts at Go Grassroots, the AMA’s Legislative Action Center website

Discover these and other resources at ama-assn.org.

Learn about the three AMA strategic focus areas at ama-assn.org/go/strategicfocus.
activating your membership.

Call: (800) 262-3211
Fax: (800) 262-3221

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American Medical Association
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Chicago, IL 60611-5885

Online:
amassn.org

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Provide email address for delivery of your member benefits

First name
Middle initial
Last name

Former last name (if applicable)

Preferred professional mailing address (Home Office or Both)

City
State ZIP

Office phone
Fax

Medical school Graduation year

Date of birth (to aid in tracking/identification)

Military branch of service (if applicable)

Medical Education (ME) Number

Method of payment (see rate chart on left)

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❑ Please charge my: ☐ Visa ☐ MasterCard ☐ American Express

Let us remember for you—choose automatic renewal. Select option 1 or 2 below.

(See below for terms and conditions of Automatic renewal. Automatic renewal does not apply to medical students.)

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2. Installment payments with automatic renewal
3. Single payment without automatic renewal

I authorize AMA to charge my credit card for annual AMA membership dues. The information I provided is accurate and I have authority to authorize charges to the designated account for the purpose of paying the amounts due.

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Expiration date ___________ ___________

Signature ____________________________________________________________________________

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Membership is contingent upon the American Medical Association’s (AMA) acceptance of the membership application. The endorsement, deposit or negotiation of an applicant’s check, or processing of a charge to applicant’s credit card, does not guarantee admission into or acceptance of membership by the AMA.

Checks received will routinely be deposited without a determination of the propriety of the payment or the applicability of the amount. Applicants who are not admitted to membership will receive a refund from the AMA for the amount submitted.

AMA dues are not deductible as a charitable contribution for federal income tax purposes, but may be partially deducted as a business expense. AMA estimates that 55% of your membership dues are allocable to lobbying activities of the AMA, and therefore are not deductible for income tax purposes.

Dues-paying members are eligible to receive a print copy of the Journal of the American Medical Association. For the 2017 membership year, the allocated cost of $31 for JAMA is included in, and not deductible from AMA membership dues. All members receive free online access to The JAMA Network, which brings together JAMA and the 11 specialty journals. In addition, all members are eligible to receive AMA Morning Rounds.

Conditions of AMA membership and application:
As part of a physician organization committed to strengthening the ethics of medicine, every member pledges to uphold the Principles of Medical Ethics as interpreted in the AMA Code of Medical Ethics, and to comply with the Bylaws of the American Medical Association and the Rules of the AMA Council on Ethical and Judicial Affairs.

• The AMA Principles and the AMA Code of Medical Ethics can be found at ama-assn.org/go/codeofmedicalethics
• The AMA’s Bylaws can be found at ama-assn.org/go/ccb
• The AMA’s Rules of the Council on Ethical and Judicial Affairs can be found at ama-assn.org/go/ceja

Applicants and members are required to disclose to the AMA Office of General Counsel any violations of the Principles of Medical Ethics or unprofessional conduct including actions taken or pending regarding professional licensure, medical staff privileges, or felony or fraud convictions. Additionally, the Health Care Quality Improvement Act requires professional societies (such as the AMA) to report certain professional review actions to the National Practitioner Data Bank.

Terms and conditions for automatic renewal authorization: Monthly installment payments with automatic renewal. Installment payments begin the month the membership transaction is made and continue until paid in full by December 31. You will receive a reminder notice each year on or around November 1. You will see the dues rates below at the time of renewal. The AMA will provide prior written notice of any change in the annual membership dues rate.

• Resident/fellow: $45
• First year in practice: $210
• Second year in practice: $315
• Regular practice: $420

Cancellation of your automatic renewal authorization must be submitted in one of the following ways:

Email: msc@ama-assn.org
Fax: (800) 262-3221
Mail: AMA Member Relations
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

February 3, 2018