2019 AMA Organized Medical Staff Section Annual Meeting
Hyatt Regency Chicago
June 6-8, 2019

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Meeting times and locations are subject to change. Download the AMA meetings app to stay up to date, build your own schedule, and more!

Wednesday, June 5		
4 p.m.	Deadline to submit late resolutions (email to keith.voogd@ama-assn.org)	
Thursday, June 6		
11:30 a.m.-3 p.m.	OMSS credentialing *Please register and pick up your meeting badge in the Grand Ballroom Foyer before credentialing as an OMSS representative.*	Crystal Ballroom Foyer (West | Green)
11:15 a.m.-12 p.m.	Committee on Late Resolutions meeting	Field (West | Silver)
12-1:30 p.m.	Caucus meetings	
	Cowchip caucus	Plaza B (East | Green)
	Great Atlantic Seaboard caucus	Columbus C-D (East | Gold)
	Heartland caucus	Crystal Ballroom Foyer (West | Green)
	Western caucus	Grand Suite 5 (East | Gold)
2-5:30 p.m.	Business meeting and Reference Committee hearing	Crystal Ballroom B (West | Green)
5:30 p.m.-Late	Reference Committee executive session and report writing	Stetson B-C (West | Purple)
6-7 p.m.	Reception	Crystal Ballroom Foyer (West | Green)

Friday, June 7		
8-10:45 a.m.	OMSS credentialing *Please register and pick up your meeting badge in the Grand Ballroom Foyer before credentialing as an OMSS representative.*	Crystal Ballroom Foyer (West | Green)
8-9:15 a.m.	Caucus meetings	
	Cowchip caucus	Grand Suite 5 (East | Gold)
	Great Atlantic Seaboard caucus	Columbus C-D (East | Gold)
	Heartland caucus	Crystal Ballroom B (West | Green)
	Western caucus	Plaza B (East | Green)
9:30-10:30 a.m.	More than a pain in the neck: Correcting ergonomic stress in your practice setting	Crystal Ballroom B (West | Green)
10:00 a.m.	Deadline to submit amendments (see staff in Crystal Ballroom Foyer)	
10:45 a.m.- 12:15 p.m.	Business meeting	Crystal Ballroom B (West | Green)
12:30-1:15 p.m.	Lunch and open forum	Crystal Ballroom B (West | Green)
1:30-2:30 p.m.	All hands on deck: Medical staffs mobilizing communities	Crystal Ballroom B (West | Green)
2:45-3:45 p.m.	Debunked! Myths — and truths — about Joint Commission accreditation	Crystal Ballroom B (West | Green)
4-5 p.m.	State Chairs meeting	Columbus K-L (East | Gold)
Saturday, June 8		
Education sessions are open to all meeting attendees		
7:30-8:30 a.m.	All things being equal: Creating gender equity within the workplace *Hosted by the AMA Sections*	Crystal Ballroom B (West | Green)
8:40-9:40 a.m.	The physicians guide to advocacy *Hosted by the AMA Sections*	Crystal Ballroom B (West | Green)
9-10 a.m.	Back in the black: Personal finance for the young physician *Hosted by the Resident and Fellow Section*	Regency Ballroom D (West | Gold)
9-10 a.m.	Where do we go now? The medical student debt crisis *Hosted by the Medical Student Section*	Field (West | Silver)
9:45-10:45 a.m.	Differences in sex development (DSD): Clinical and ethical implications for providers, patients, and parents *Hosted by the LGBTQ Advisory Committee*	Crystal Ballroom B (West | Green)
10-10:45 a.m.	What does the science say about opioid management? *Hosted by the Medical Student Section*	Crystal Ballroom C (West | Green)
10:30- 11:30 a.m.	Health care think tank: Medical students leading change *Hosted by the Medical Student Section*	Field (West | Silver)
11:30 a.m.- 12:30 p.m.	Central American forced migration: Public health knowledge for care delivery and advocacy *Hosted by the Medical Student Section*	Crystal Ballroom C (West | Green)

12-1:30 p.m.	Down a road and back again: Making a late-life transition into a meaningful retirement *Hosted by the Senior Physicians Section*	Columbus K-L (East | Gold)
2-6 p.m.	House of Delegates meeting – Opening session	Grand Ballroom (East | Gold)
5:45-6:15 p.m.	Improving the health of all through academic medicine *Hosted by the International Medical Graduates Section*	Columbus G (East | Gold)
Sunday, June 9		
6:45-7:45 a.m.	OMSS caucus *All AMA members with an interest in organized medical staff issues are invited to attend. Invite your colleagues!*	San Francisco (West | Gold)
8-8:30 a.m.	House of Delegates meeting – Second opening session	Grand Ballroom (East | Gold)
8:30 a.m.- 12 p.m.	House of Delegates Reference Committee hearings	
	Reference Committee A (Medical Service)	Regency Ballroom A (West | Gold)
	Reference Committee B (Legislation)	Regency Ballroom B (West | Gold)
	Reference Committee C (Medical Education)	Regency Ballroom C (West | Gold)
	Reference Committee E (Science and Technology)	Regency Ballroom D (West | Gold)
	Reference Committee F (Governance and Finance)	Grand Ballroom (East | Gold)
1:30-5 p.m.	House of Delegates Reference Committee hearings	
	Reference Committee on Amendments to Constitution and Bylaws	Regency Ballroom C (West | Gold)
	Reference Committee D (Public Health)	Regency Ballroom D (West | Gold)
	Reference Committee G (Medical Practice)	Regency Ballroom A (West | Gold)
5-6 p.m.	OMSS caucus *All AMA members with an interest in organized medical staff issues are invited to attend. Invite your colleagues!*	San Francisco (West | Gold)

Updated 05/18/2019

Meeting logistics

Download the AMA meetings app
Hotel map
WiFi information Network: 2019ANNUAL (all caps) Password: 2019ANNUAL (all caps)

For the best user experience, please download a copy of this handbook to your personal device

Downloading the App

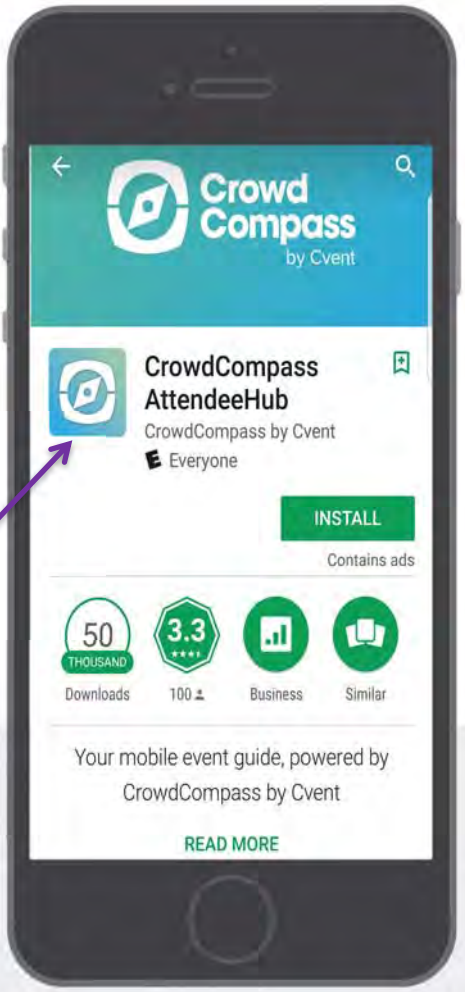
Get the app

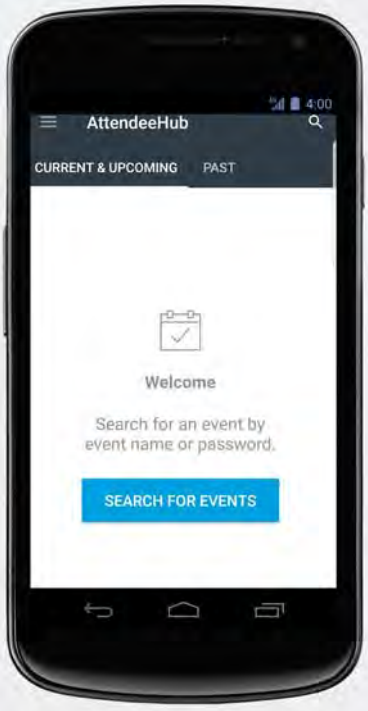
1. Go to the right store. Access the App Store on iOS devices and the Play Store on Android.

If you're using a Blackberry or Windows phone, skip these steps. **You'll need to use the web version of the app found here: https://event.crowdcompass.com/amaannual2019**

2. Install the app. Search for CrowdCompass AttendeeHub Once you've found the app, tap either **Download** or **Install**.

After installing, a new icon will appear on the home screen.





Find your event

1. Search the AttendeeHub. Once downloaded, open the AttendeeHub app and enter AMA 2019 Annual Meeting

2. Open your event. Tap the name of your event to open it.

AMA
AMERICAN MEDICAL ASSOCIATION

The "CrowdCompassAttendeeHub" Mobile App - FAQ

Where can I download the mobile app?

Go to the correct store for your device type. Access the App Store on iOS devices and the Play Store on Android.

Install the app. Search for CrowdCompassAttendeeHub. Once you have found the app, tap either Download or Install. After installing, a new icon will appear on your home screen.

AttendeeHub

If you're using a Blackberry or Windows phone, skip these steps. You'll need to use the web version of the app found here https://event.crowdcompass.com/amaannual2019

How do I find the Event?

Search the AttendeeHub. Once downloaded, open the AttendeeHub app and enter: AMA 2019 Annual Meeting

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

Once you log in to the mobile app, you will be able to access the same schedules, bookmarks, reminders, notes, and contacts on your phone, tablet, and desktop. Below is a list of some other great things you can do after logging in:

- Take notes
- Share photos
- Rate sessions
- Join the attendee list
- Check-in
- Share contacts
- Share over social media
- Take Surveys
- Message fellow attendees

Where can I get my log-in information?

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

1. **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.

2. **Enter your info:** You'll be prompted to enter your first and last name. Tap Next. Enter an email address, and then tap next again.

3. **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.

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

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

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

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

1. **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.

2. **Enter your info:** You'll be prompted to enter your first and last name. Tap Next.

3. **Click on Forgot Code:** If you've already logged in before, the app will already know your email address and will send a verification email to you again.

4. **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.

How do I create my own schedule?

1. **Open the Schedule.** After logging in, tap the Schedule icon.

2. **Browse the Calendar.** Switch days by using the date selector at the top of the screen. Scroll up and down to see all the sessions on a particular day.

3. **See something interesting?** Tap the plus sign to the right of its name to add it to your personal schedule.

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

1. **Access your schedule.** After logging in, tap the hamburger icon in the top right, then My Schedule.

2. Here you'll see a personalized calendar of the sessions you'll be attending. You can tap a session to see more details.

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

How do I allow notifications on my device?

Allowing Notifications on iOS:

1. **Access the Notifications menu.** From the home screen, tap Settings, then Notifications.

2. **Turn on Notifications for the app.** Find your event's app on the list and tap its name. Switch Allow Notifications on.

Allowing Notifications on Android:

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

1. **Access the Notification menu.** Swipe down on the home screen, then click the gear in the top right. Tap Sounds and notifications.

2. **Turn on Notifications for your event's App.** Scroll down and tap App notifications. Find your event's app on the list. Switch notifications from off to on.

How do I manage my privacy within the app?

Set Your Profile to Private…

1. **Access your profile settings.** If you'd rather have control over who can see your profile, you can set it to private.

2. After logging in, tap the hamburger icon in the top left, and then tap your name at the top of the screen.

3. **Check the box.** At the top of your Profile Settings, make sure that the box next to "Set Profile to Private" is checked.

…Or Hide Your Profile Entirely

1. **Access the Attendee List.** Rather focus on the conference? Log in, open the Event Directory, and tap the Attendees icon.

2. **Change your Attendee Options.** Click the Silhouette icon in the top right to open Attendee Options.

3. **Make sure the slider next to "Show Me On Attendee List" is switched off.** Fellow attendees will no longer be able to find you on the list at all.

How do I message other attendees within the app?

1. **Access the Attendee List.** After logging in, tap the Attendees icon.

2. **Send your message.** Find the person you want to message by either scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon to start texting.

3. **Find previous chats.** If you want to pick up a chat you previously started, tap the hamburger icon in the top right, then **My Messages**.

How do I block a person from chatting with me?

1. **Access the Attendee List.** Rather focus on the conference? Just as before, log in and tap the Attendees icon.

2. **Block the person.** Find the person you'd like to block about by scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon. But, don't type anything, instead tap Block in the top right.

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

1. **Access the Attendee List.** After logging in, tap the Attendees icon.

2. **Send a request.** Find the person you want to share your contact information by either scrolling through the list or using the search bar at the top of the screen.

3. Tap their name, then the plus icon to send a contact request. If they accept, the two of you will exchange info.

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

1. **Navigate to My Schedule.** Tap the hamburger icon in the top left, then My Schedule.

2. **Create Your Appointment.** In the top right corner of the My Schedule page you'll see a plus sign. Tap on it to access the Add Activity page.

3. **Give your appointment a name, a start and end time, and some invitees.** When you're finished, tap done. Invitations will be immediately sent to all relevant attendees.

How do I take notes within the app?

Write Your Thoughts...

1. **Find your Event Item.** After logging in, find the session, speaker, or attendee you'd like to create a note about by tapping on the appropriate icon in the Event Directory, then scrolling through the item list. Once you've found the item you're looking for, tap on it.

2. **Write your note.** Tap the pencil icon to bring up a blank page and your keyboard. Enter your thoughts, observations, and ideas. Tap done when you've finished.

…Then Export Them

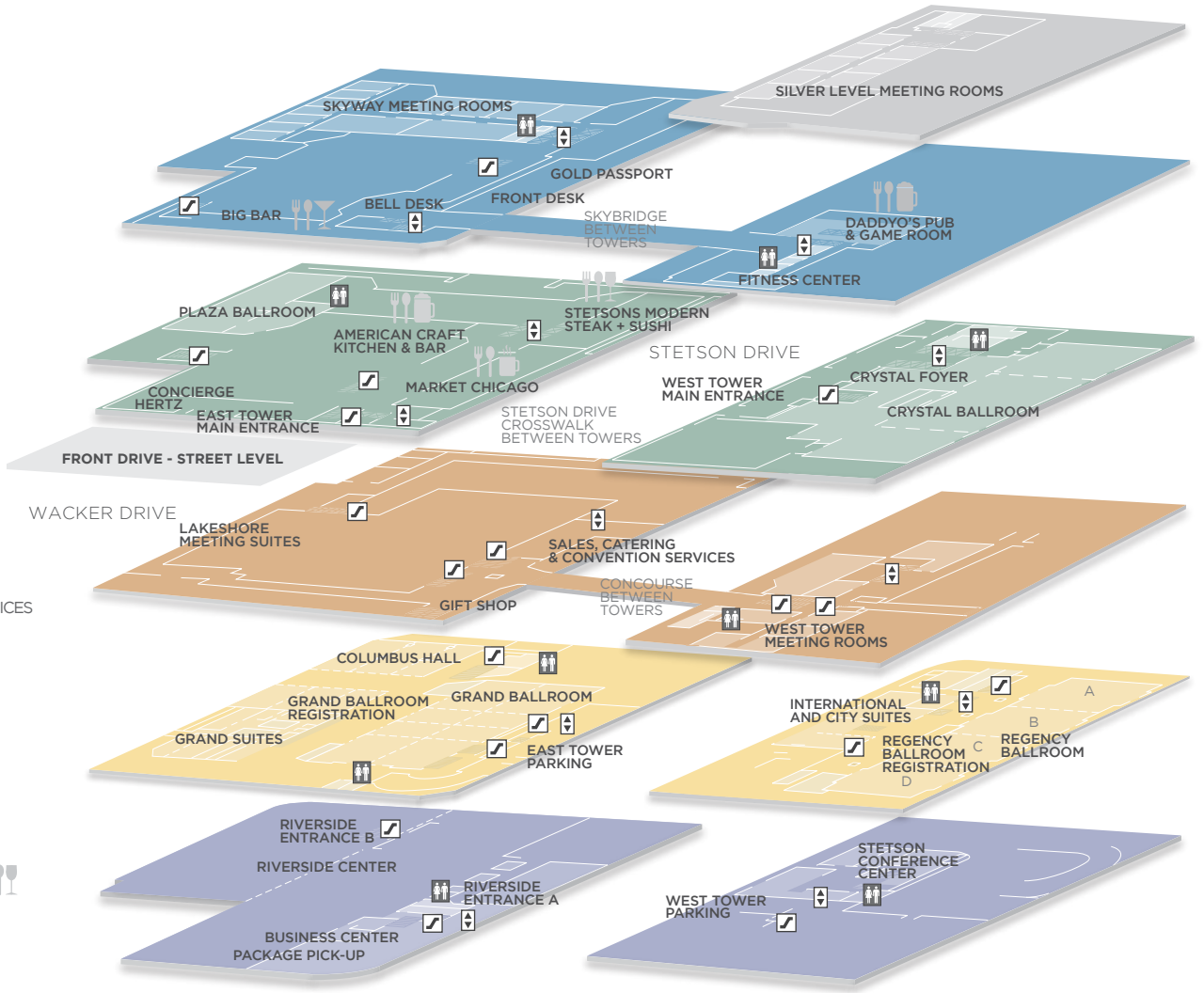
1. **Navigate to My Notes.** Tap the hamburger icon in the top right, then My Notes. Here you'll find all the notes you've taken organized by session.

2. **Choose where to send your notes.** Tap the share icon in the top right and CrowdCompass will automatically generate a draft of an email that contains all your notes. All you have to do is enter an email address, and then tap Send.

HYATT REGENCY CHICAGO
GUEST MAP

WELCOME TO HYATT REGENCY CHICAGO. Meeting rooms, ballrooms, restaurants and guest amenities are listed in alphabetical order and color coded by floor. For help, dial Guest Services at Extension 4460.

- ACAPULCO — West Tower, Gold Level
- ADDAMS — West Tower, Silver Level
- AMERICAN CRAFT KITCHEN & BAR — East Tower, Green Level
- ATLANTA — West Tower, Gold Level
- BELL DESK — East Tower, Blue Level
- BIG BAR — East Tower, Blue Level
- BUCKINGHAM — West Tower, Bronze level
- BURNHAM — West Tower, Silver Level
- BUSINESS CENTER — East Tower, Purple Level
- COLUMBIAN — West Tower, Bronze Level
- COLUMBUS HALL (ROOMS A-L) — East Tower, Gold Level
- COMISKEY — West Tower, Bronze Level
- CONCIERGE — East Tower, Green Level
- CRYSTAL BALLROOM — West Tower, Green Level
- DADDYO'S PUB & GAME ROOM — West Tower, Blue Level
- DUSABLE — West Tower, Silver Level
- EAST TOWER MAIN ENTRANCE — East Tower, Green Level
- EAST TOWER PARKING — East Tower, Gold Level
- FIELD — West Tower, Silver Level
- FITNESS CENTER — West Tower, Blue Level
- FRONT DESK — East Tower, Blue Level
- GIFT SHOP — East Tower, Bronze Level
- GOLD COAST — West Tower, Bronze Level
- GOLD PASSPORT — East Tower, Blue Level
- GRAND BALLROOM — East Tower, Gold Level
- GRAND BALLROOM REGISTRATION — East Tower, Gold Level
- GRAND SUITES — East Tower, Gold Level
- HAYMARKET — West Tower, Bronze level
- HERTZ — East Tower, Green Level
- HONG KONG — West Tower, Gold Level
- HORNER — West Tower, Silver Level
- LAKESHORE MEETING SUITES — East Tower, Bronze level
- MARKET CHICAGO — East Tower, Green Level
- McCORMICK — West Tower, Silver Level
- NEW ORLEANS — West Tower, Gold Level
- OGDEN — West Tower, Silver Level
- PACKAGE PICK-UP — East Tower, Purple Level
- PICASSO — West Tower, Bronze Level
- PLAZA BALLROOM — East Tower, Green Level
- REGENCY BALLROOM — West Tower, Gold Level
- RIVERSIDE CENTER — East Tower, Purple Level
- SALES, CATERING & CONVENTION SERVICES — East Tower, Bronze Level
- SAN FRANCISCO — West Tower, Gold Level
- SANDBURG — West Tower, Silver Level
- SKYWAY MEETING ROOMS — East Tower, Blue Level
- SOLDIER FIELD — West Tower, Bronze Level
- STETSON CONFERENCE CENTER — West Tower, Purple Level
- STETSONS MODERN STEAK + SUSHI — East Tower, Green Level
- TORONTO — West Tower, Gold Level
- WATER TOWER — West Tower, Bronze Level
- WEST TOWER PARKING — West Tower, Purple Level
- WRIGHT — West Tower, Silver Level
- WRIGLEY — West Tower, Bronze Level



ESCALATORS, ELEVATORS AND RESTROOMS are indicated on each floor. Elevators are conveniently located throughout the hotel for guests with disabilities or where no escalator is present.

CROSSING BETWEEN TOWERS: Cross between towers via the Blue Level Skybridge or the Concourse on the Bronze Level. You may also cross on the Green Level via the crosswalk on Stetson Drive.

- ELEVATORS
- ESCALATORS AND STAIRS
- RESTROOMS

Policy materials

Resolutions

Reports

For the best user experience, please download a copy of this handbook to your personal device

AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution: 1
(A-19)

Introduced by: Oklahoma State Medical Association OMSS

Subject: Patient Medical Marijuana Use in Hospitals

Referred to: OMSS Reference Committee
(James Guo, MD, Chair)

Whereas, By 2018, 33 states, the District of Columbia, Guam, and Puerto Rico, had passed legislation to legalize medical marijuana, including Oklahoma; and

Whereas, There are many legal implications due to the passage of state medical marijuana laws and the associated regulations passed by state departments of health; and

Whereas, Many community facilities continue to ban marijuana on their campuses in pursuit to the Federal Drug-Free Schools and Communities Act, the Drug-Free Workplace Act, and the Federal Controlled Substance Act; and

Whereas, Hospital medical staffs are struggling when patients with medical marijuana licenses report non-FDA approved marijuana products as home medication and bring these products into their facilities; and

Whereas, AMA Council on Science and Public Health Report 5-I-17, Clinical Implications and Policy Considerations of Cannabis Use, does not address patient non-FDA approved medical marijuana use in hospitals; therefore be it

RESOLVED, That our American Medical Association offer guidance to medical staffs regarding patient use of non-FDA approved medical marijuana and cannabinoids on hospital property, including product use and storage in patient rooms, nursing areas, and/or pharmacy, with report back at the 2019 Interim Meeting. (Directive to Take Action)

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

Received: 4/22/2019

RELEVANT AMA POLICY

D-95.969 Cannabis Legalization for Medicinal Use
Our AMA:

(1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use;
(2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process;
(3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential

for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process.";

(4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws;

(5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; and

(6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians.

AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution: 2
(A-19)

Introduced by: Massachusetts Medical Society OMSS

Subject: Military Physician Reintegration into Civilian Practice

Referred to: OMSS Reference Committee
(James Guo, MD, Chair)

Whereas, The strategic priorities of our AMA include promoting practice models that offer both quality care and high physician satisfaction in the practice of medicine; and

Whereas, Many physicians and surgeons serve the United States through active duty service; and

Whereas, Such service often requires extended time away from practicing medicine and/or performing surgical procedures in non-military settings; and

Whereas, When once again available for taking up civilian practice, a medical serviceman or servicewoman may need to be recredentialed at local facilities; and

Whereas, Particularly for surgeons, some procedures for which they are trained and had previously attained competency have not been performed during military service for an extended period of time given the demographics of their patient base; and

Whereas, Most credentialing requirements require documentation of current competency in requested privileges, which usually includes documentation of volume of given services performed within the previous calendar year, which may have been substantially reduced in the case of a returning serviceman or servicewoman; and

Whereas, There is a legitimate concern to assure competency, particularly for surgical procedures, of an applicant for privileges; and

Whereas, There is a competing concern to honor personal contributions to society and minimize difficulties in returning to non-military practice; therefore be it

RESOLVED, That our American Medical Association develop recommendations to inform local credentialing bodies of pathways to assure competency of returning military veteran physicians and surgeons while facilitating the process, and/or streamlining requirements, for them to return to civilian practice. (Directive to Take Action)

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

Received: 4/25/2019

RELEVANT AMA POLICY

H-180.963 Volume Discrimination Against Physicians
The AMA recommends that volume indicators should be applied only to those treatments where outcomes have been shown by valid statistical methods to be significantly influenced by frequency of performance; and affirms that volume indicators should not be used as the sole criteria for credentialing and reimbursement and that, when volume indicators are used, allowances should be made for physicians starting practice.

H-230.954 Privileging Physicians with Low Volume Hospital Activity
The following is AMA policy:

1. Due to the variation in hospitals across the country, each hospital and medical staff should create its own methodologies and standards for credentialing and privileging physicians with low activity at their hospitals. These methods and standards should be tailored to the individual hospital's needs, such as a monitoring system for low volume doctors in the absence of performance data, or creating a new, separate staff category for physicians and allied health professionals that would limit a practitioner's activities to referring and following patients, to insure continuity of care and patient safety;
2. When data are not used for physician evaluation, there should be stringent qualifications of those who provide peer recommendations/reviews. These physicians should be familiar with the competency and work of the physician and have an understanding of the specialty in question. Recommendations on medical staff membership and privileges should include the applicant's department chair and chief of staff;
3. Hospitals and medical staffs should use data and references, if available, from another hospital at which the applicant physician may be active as an additional method to verify his/her competency within the hospital environment;
4. Ongoing proctoring and evaluation are tools that should be used when recommending privileges for physicians who are classified as low volume only for certain procedures;
5. Ideally medical staffs should credential only when there is adequate clinical data to permit an objective assessment of an applicant's, or medical staff member's, clinical skill and ability; and
6. When an organized medical staff determines that there are not adequate data on an applicant physician, or if a physician seeking privileges has limited experience, consideration should be given to require mandatory consultation for admissions and other appropriate indications.

AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution: 3
(A-19)

Introduced by: Massachusetts Medical Society OMSS

Subject: EHR-Integrated PDMP Rapid Access

Referred to: OMSS Reference Committee
(James Guo, MD, Chair)

Whereas, Recent AMA strategic priorities included a five-year strategic plan of which one of three listed targets was “shaping delivery and payment models that demonstrate high quality care and value while enhancing physician satisfaction and practice sustainability;”[1] and

Whereas, The overview provided by the National Alliance for Model State Drug Laws (NAMSDL) clearly identifies the benefits of a Prescription Drug Monitoring Program (PDMP) as “a tool used by states to address prescription drug abuse, addiction and diversion, it may serve several purposes such as:

1. support access to legitimate medical use of controlled substances,
2. identify and deter or prevent drug abuse and diversion,
3. facilitate and encourage the identification, intervention with and treatment of persons addicted to prescription drugs,
4. inform public health initiatives through outlining of use and abuse trends, and
5. educate individuals about PDMPs and the use, abuse and diversion of and addiction to prescription drugs;”[2-3] and

Whereas, The AMA has the following policy: “Our AMA encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient’s controlled substances prescriptions” (H-95.947); and

Whereas, The AMA founded the Integrated Health Model Initiative (IHMI), a collaborative effort intended to lead solutions for improving, organizing, and exchanging health data; and

Whereas, The Electronic Health Record Association (EHRA) held a Capitol Hill briefing for Congressional staff and other stakeholders on June 6, 2018, to share data and insights from EHRA’s Opioid Crisis Task Force and among other issues, noted that “many providers do not have access to PDMP data directly within a patient’s chart, but must log in via a separate system. Many states do not support the cost of licensing PDMP integration within EHRs, and state variation again causes delays here. As a result, and given the time pressures and in the absence of any reason to doubt the patient’s stated medication history, many providers decide to forgo accessing their state’s PDMP...Because a key challenge is that many providers do not have access to PDMP data directly within the patient’s chart, but must log into a separate system, we encourage states to support the cost of licensing PDMP integration within EHR workflows;”[4-5] and

Whereas, Federal funding is available for PDMPs: The Harold Rogers Prescription Drug Monitoring Program (HRPDMP) is administered by the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, to provide three types of grants: planning, implementation, and enhancement. (Additional information can be found at

www.ojp.usdoj.gov/BJA/grant/prescripdrugs.html.) Also, the National All Schedules Prescription Electronic Reporting Act (NASPER), enacted in 2005, created a U.S. Department of Health and Human Services grant program for states to implement or enhance prescription drug monitoring programs. The intent of the law was to foster the establishment or enhancement of PDMPs that would meet consistent national criteria and have the capacity for the interstate exchange of information. (Information on NASPER can be found at www.samhsa.gov.) States can participate in both funding programs;[6] and

Whereas, Program applications that integrate PMP data, analytics, insights, and resources into EHRs and pharmacy management system workflows are already available in the marketplace, such as the one developed by the National Association of Boards of Pharmacy;[7-9] and

Whereas, Not all providers of EHRs belong to EHRA, nor do all provide direct access to a state's PDMP through the EHR, and there may be a charge associated with that if available; therefore be it

RESOLVED, That the American Medical Association advocate, at the state and national levels, to promote Prescription Drug Monitoring Program (PDMP) integration/access within Electronic Health Record workflows (of all developers/vendors) at no cost to the physician or other authorized health care provider. (Directive to Take Action)

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

Received: 4/25/2019

REFERENCES

(1) https://www.modernhealthcare.com/article/20120616/NEWS/306169923/ama-unveils-five-year-strategic-plan
(2) http://www.namsdl.org/library/1BB5FEBD-1C23-D4F9-749246AD85E4C586
(3) http://www.namsdl.org/prescription-monitoring-programs.cfm
(4) https://www.ehra.org/sites/ehra.org/files/EHR%20Association%20Congressional%20Briefing%20Summary%202018.pdf
(5) https://www.healthcareitnews.com/news/clinicians-need-better-opioid-data-within-their-workflows-says-ehra
(6) https://www.deadiversion.usdoj.gov/faq/rx_monitor.htm
(7) https://www.pmpinterconnect.com/integration-clinical-workflow/overview/
(8) https://nabp.pharmacy/initiatives/pmp-interconnect/
(9) https://nabp.pharmacy/initiatives/pmp-interconnect/faqs/

RELEVANT AMA POLICY

H-95.920 Advocacy for Seamless Interface Between Physicians Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs
Our AMA:
(1) will advocate for a federal study to evaluate the use of PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying whether PDMPs can distinguish team-based care from uncoordinated care, misuse, or "doctor shopping," as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care;

(2) urges EHR vendors and Health Information Exchanges (HIEs) to increase transparency of custom connections and costs for physicians to integrate their products in their practices;
(3) supports state-based pilot studies of best practices to integrate EHRs, HIEs, EPCS and PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such integration from occurring; and
(4) supports initiatives to improve the functionality of state PDMPs, including: (a) lessening the time delay between when a prescription is dispensed and when the prescription would be available to physicians through a PDMP; and (b) directing state-based PDMP's to support improved integrated EHR interfaces.

H-95.947 Prescription Drug Monitoring to Prevent Abuse of Controlled Substances
Our AMA:
(1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
(2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
(3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperative, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;
(4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions;
(5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians;
(6) will conduct a literature review of available data showing the outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;
(7) will advocate that U.S. Department of Veterans Affairs pharmacies report prescription information required by the state into the state PDMP;
(8) will advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state; and
(9) will seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs.

AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution: 4
(A-19)

Introduced by: Medical Society of the State of New York OMSS

Subject: Restrictive Covenants of Large Health Care Systems

Referred to: OMSS Reference Committee
(James Guo, MD, Chair)

Whereas, In 1960 the AMA made the following statement about Restrictive Covenants (RCs): "There is no ethical proscription against suggesting or entering into a reasonable agreement not to practice within a certain area for a certain time, if it is knowingly made, understood and consistent with local law;" and

Whereas, RCs are prohibited among lawyers in the U.S. with the American Bar Association in 1969 adopting a code of professional conduct that included a disciplinary rule prohibiting RCs between attorneys, using the logic that RCs interfere with the client's freedom to choose a lawyer; and

Whereas, The majority of RCs in the past were written to protect small physician practices and were of a reasonable geographic restriction; and

Whereas, With the trend of more physicians becoming contract employees entering into written agreements with their employers, contractual disputes will become a reality for an increasing number of physicians; and

Whereas, More and more hospitals are merging to form larger and larger health care systems with more and more control of patient lives over a wider and wider geographic region; and

Whereas, These health care systems are now writing in to their RCs restrictions on working for any of their other facilities within their own system as well as a competing health care system's facilities; and

Whereas, As physicians are terminated from these large health care systems they may effectively be banned from very large geographic areas, forcing them to relocate and incur much hardship; therefore be it

RESOLVED, That our American Medical Association, through its Organized Medical Staff Section, educate physicians entering into employment contracts with large health care system employers on the dangers of these aggressive restrictive covenants (Directive to Take Action); and be it further

RESOLVED, That our AMA, through its legal counsel, review and update the AMA's official position on restrictive covenants. (Directive to Take Action)

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

Received: 4/29/2019

RELEVANT AMA POLICY

Ethical Opinion 11.2.3.1 Restrictive Covenants
Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms.

Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care.

Physicians should not enter into covenants that:
(a) Unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and
(b) Do not make reasonable accommodation for patients' choice of physician.

Physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program.

AMA Principles of Medical Ethics: III,IV,VI,VII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

H-225.950 AMA Principles for Physician Employment
….
(3)(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
….

H-383.987 Restrictive Covenants in Physician Contracts
Our AMA will provide guidance, consultation, and model legislation concerning the application of restrictive covenants to physicians upon request of state medical associations and national medical specialty societies.

AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution: 5
(A-19)

Introduced by: Pennsylvania Medical Society OMSS

Subject: Abuse of Volume Based Metrics

Referred to: OMSS Reference Committee
(James Guo, MD, Chair)

Whereas, More hospitals are initiating volume-based metrics as a key element of physician privileging and credentialing; and

Whereas, Many hospitals hire physician staff that are directly salaried by the hospital; and

Whereas, Surgical, obstetric, and medical teams are being created with additional physician extenders to directly compete with affiliated but non-owned physician groups; and

Whereas, There have been accusations of specific hospitals giving preference to their employed physician staff to the detriment of non-owned physician practitioners; and

Whereas, AMA policies H-180.963, Volume Discrimination; H-230.971, Economic Credentialing; H-230.975, Economic Credentialing; and H-230.976, Economic Credentialing, only partially address the issue of unfair use of volume metrics to artificially de-credential or limit non-owned physician groups; therefore be it

RESOLVED, That our American Medical Association vigorously oppose policies that, based on volume metrics, do not allow equivalent access to hospital services, OR time, access to facilities, units of care, or restricted support staff between hospital employed physicians and other non-owned physicians who are judged otherwise competent by training and performance. (New HOD Policy)

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

Received: 4/29/2019

RELEVANT AMA POLICY

H-180.963 Volume Discrimination Against Physicians
The AMA recommends that volume indicators should be applied only to those treatments where outcomes have been shown by valid statistical methods to be significantly influenced by frequency of performance; and affirms that volume indicators should not be used as the sole criteria for credentialing and reimbursement and that, when volume indicators are used, allowances should be made for physicians starting practice.

H-230.971 Economic Credentialing
Our AMA will work with The Joint Commission to assure, through the survey process, that any criteria used in the credentialing process are directly related to the quality of patient care.

H-230.975 Economic Credentialing
The AMA (1) adopts the following definition of economic credentialing: economic credentialing is defined as the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges;
(2) strongly opposes the practice of economic credentialing;
(3) believes that physicians should continue to work with their hospital boards and administrators to develop appropriate educational uses of physician hospital utilization and related financial data and that any such data collected be reviewed by professional peers and shared with the individual physicians from whom it was collected;
(4) believes that physicians should attempt to assure provision in their hospital medical staff bylaws of an appropriate role for the medical staff in decisions to grant or maintain exclusive contracts or to close medical staff departments;
(5) will communicate its policy and concerns on economic credentialing on a continuing basis to the American Hospital Association, Federation of American Health Systems, and other appropriate organizations;
(6) encourages state medical societies to review their respective state statutes with regard to economic credentialing and, as appropriate, to seek modifications therein;
(7) will explore the development of draft model legislation that would acknowledge the role of the medical staff in the hospital medical staff credentialing process and assure various elements of medical staff self-governance; and
(8) will study and address the issues posed by the use of economic credentialing in other health care settings and delivery systems.

H-230.976 Economic Credentialing
The AMA opposes the use of economic criteria not related to quality to determine an individual physician's qualifications for the granting or renewal of medical staff membership or privileges.

AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution: 6
(A-19)

Introduced by: OMSS Governing Council

Subject: Gender Equity in Hospital Medical Staff Bylaws

Referred to: OMSS Reference Committee
(James Guo, MD, Chair)

Whereas, Our AMA has preexisting policy addressing gender equity in medicine in general; and

Whereas, There is no evidence of gender equity being addressed in hospital bylaws; and

Whereas, Our AMA has laid the groundwork in:

- Advancing gender equity in medicine (D-65.989);
- Gender discrimination in medicine (9.5.5);
- Gender disparities in physician income and advancement (D-200.981);
- Gender-Based questioning in residency interviews (H-310.976);
- Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin, and Religion During the Residency and Fellowship Application Process (H-310.919);
- Civil and Human Rights – Equal opportunity (H-65.968);
- Membership Discrimination (B-1.4); and
- Anti-Harassment Policy (H-140.837); and

Whereas, The American College of Physicians (ACP) has conducted research on gender and equity on physician compensation and career achievement;[1] and

Whereas, GLMA: Health Professionals Advancing LGBTQ Equality helped to create non-discrimination language for bylaws at Group Health Hospitals in Washington state as follows:

> "Nondiscrimination. All functions of the Health Management System (HMS) including appointment, reappointment, and the granting of clinical privileges, are conducted without discrimination as to race, religion, creed, color, sex, age, national origin, disability, marital status, veteran status, sexual orientation, gender identity and/or expression;" therefore be it

RESOLVED, That our American Medical Association affirm that hospital medical staff bylaws should promote, and not impede, gender equity in their implementation (New HOD Policy); and be it further

RESOLVED, That our AMA study existing hospital medical staff bylaws as to how they impact on issues of gender equity, directly or indirectly, and suggest any addition(s) to its model bylaws to assure this issue is properly addressed, and gender equity affirmed. (Directive to Take Action)

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

Received: 4/9/2019

REFERENCES

1. Butkus R, Serchen J, Moyer DV, Bornstein SS, Hingle ST. Achieving Gender Equity in Physician Compensation and Career Advancement: A Position Paper of the American College of Physicians. Ann Intern Med. 2018;168(10):721-723.

RELEVANT AMA POLICY

D-65.989 Advancing Gender Equity in Medicine

1. Our AMA will draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, including clarifying principles for state and specialty societies, academic medical centers and other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual Meeting.
2. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral objective criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.
3. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.
4. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.
5. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

9.5.5 Gender Discrimination in Medicine

Inequality of professional status in medicine among individuals based on gender can compromise patient care, undermine trust, and damage the working environment. Physician leaders in medical schools and medical institutions should advocate for increased leadership in medicine among individuals of underrepresented genders and equitable compensation for all physicians.

Collectively, physicians should actively advocate for and develop family-friendly policies that:

(a) Promote fairness in the workplace, including providing for:

(i) retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family;
(ii) on-site child care services for dependent children;
(iii) job security for physicians who are temporarily not in practice due to pregnancy or family obligations.

(b) Promote fairness in academic medical settings by:
(i) ensuring that tenure decisions make allowance for family obligations by giving faculty members longer to achieve standards for promotion and tenure;
(ii) establish more reasonable guidelines regarding the quantity and timing of published material needed for promotion or tenure that emphasize quality over quantity and encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research;
(iii) fairly distribute teaching, clinical, research, administrative responsibilities, and access to tenure tracks;
(iv) structuring the mentoring process through a fair and visible system.

(c) Take steps to mitigate gender bias in research and publication.

AMA Principles of Medical Ethics: II,VII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

D-200.981 Gender Disparities in Physician Income and Advancement
Our AMA:

1. encourages medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist;
2. supports physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations;
3. urges medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession;
4. will collect and publicize information on best practices in academic medicine and non academic medicine that foster gender parity in the profession; and
5. will provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit.

H-310.976 Gender-Based Questioning in Residency Interviews
The AMA (1) opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination; (2) supports inclusion in the AMA Fellowship and Residency Interactive Database Access (FREIDA) system information on residency Family and Medical Leave policies; and (3) supports monitoring the Accreditation Council for Graduate Medical Education as it proposes changes to the "Common Requirements" and the "Institutional Requirements" of the "Essentials of Accredited Residencies," to ensure that there is no gender-based bias.

H-310.919 Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process
Our AMA:
1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

H-65.968 Equal Opportunity
Our AMA: (1) declares it is opposed to any exploitation and discrimination in the workplace based on gender; (2) affirms the concept that equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender; (3) affirms the concept of equal rights for men and women; and (4) endorses the principle of equal opportunity of employment and practice in the medical field.

B-1.4 Discrimination.
Membership in the AMA or in any constituent association, national medical specialty society or professional interest medical association represented in the House of Delegates, shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities.

H-140.837Anti-Harassment Policy
Our AMA adopts the following policy:

Anti-Harassment Policy Applicable to AMA Entities
It is the policy of the American Medical Association that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings, or otherwise, including but not limited to dinners, receptions and social gatherings held in conjunction with HOD meetings, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an “AMA Entity”), as well as other AMA-sponsored events.

Definition

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and

- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

Anti-Harassment Policy

1. Reporting a complaint of harassment
   Any persons who believe they have experienced or witnessed conduct in violation of Anti-Harassment Policy H-140.837 during any AMA House of Delegates meeting or associated functions should promptly notify the Speaker or Vice Speaker of the House or the AMA Office of General Counsel.

   Any persons who believe they have experienced or witnessed conduct in other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy H-140.837 should promptly notify the presiding officer(s) of such AMA-associated meeting or activity or either the Chair of the Board or the AMA Office of General Counsel.

Anyone who prefers to register a complaint to an external vendor may do so using an AMA compliance hotline (telephone and online) maintained on behalf of the AMA. The name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the AMA may investigate.

2. Investigations
   Investigations of harassment complaints will be conducted by AMA Human Resources. Each complaint of harassment or retaliation shall be promptly and thoroughly investigated. Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact between the accuser and the accused during the pendency of an investigation and (b) provide the accused an opportunity to respond to allegations. Based on its investigation, AMA Human Resources will make a determination as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.

3. Disciplinary Action
   If AMA Human Resources shall determine that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA-associated meeting or activity in which such violation occurred, as applicable, of such determination, (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with appropriate training.

   If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.

   If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.

   If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the matter to appropriate AMA management, and when appropriate, may suggest that the complainant contact legal authorities.

4. Confidentiality
   To the fullest extent possible, the AMA will keep complaints, investigations and resolutions confidential, consistent with usual business practice.
   [Editor's note. Individuals wishing to register a complaint with AMA's external vendor (Lighthouse Services, Inc.) may do so by calling 800-398-1496 or completing the online form at https://www.lighthouse-services.com/ama.]

REPORT OF THE ORGANIZED MEDICAL STAFF SECTION
GOVERNING COUNCIL

GC Report A-A-19

Subject: OMSS Handbook Review: House of Delegates Resolutions & Reports

Presented by: David Welsh, MD, Chair

Referred to: OMSS Reference Committee
(James Guo, MD, Chair)

OMSS Governing Council Report A identifies resolutions and reports relevant to medical staffs that have been submitted for consideration by the AMA House of Delegates (HOD) at the 2019 AMA Annual Meeting. This report is submitted to the Assembly to facilitate the instruction of the OMSS Delegate and Alternate Delegate regarding the positions they should take in representing the Section in the HOD.

The following recommendations regarding OMSS positions on HOD resolutions and reports are presented for the consideration of the Assembly:

Ref Com	Title and sponsor	Proposed policy	Recommendation
CCB	Res 010 - Covenants Not to Compete (New Mexico)	RESOLVED, That our American Medical Association consider as the basis for model legislation the New Mexico statute allowing a requirement that liquidated damages be paid when a physician partner who is a part owner in practice is lured away by a competing hospital system (Directive to Take Action); and be it further RESOLVED, That our AMA ask our Council on Ethical and Judicial Affairs to reconsider their blanket opposition to covenants not to compete in the case of a physician partner who is a part owner of a practice, in light of the protection that liquidated damages can confer to independent physician owned partnerships, and because a requirement to pay liquidated damages does not preclude a physician from continuing to practice in his or her community. (Directive to Take Action)	1. That the OMSS Delegate be instructed to support the intent of Resolution 111-A-19.

A	Res 111 - Practice Overhead Expense and the Site-of-Service Differential (Ohio)	RESOLVED, That our American Medical Association appeal to the US Congress for legislation to direct the Centers for Medicare and Medicaid Services (CMS) to eliminate any site-of-service differential payments to hospitals for the same service that can safely be performed in a doctor's office (Directive to Take Action); and be it further RESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS in regards to any savings to Part B Medicare, through elimination of the site-of-service differential payments to hospitals, (for the same service that can safely be performed in a doctor's office), be distributed to all physicians who participate in Part B Medicare, by means of improved payments for office-based Evaluation and Management Codes, so as to immediately redress underpayment to physicians in regards to overhead expense (Directive to Take Action); and be it further RESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS to make Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting. (Directive to Take Action)	2. That the OMSS Delegate be instructed to support the intent of Resolution 111-A-19.
A	Res 127 - Eliminating the CMS Observation Status (New Jersey)	RESOLVED, That our American Medical Association request, for the benefit of our patients' financial, physical and mental health, that the Centers for Medicare and Medicaid Services terminate the "48 hour observation period" and observation status in total. (Directive to Take Action)	3. That the OMSS Delegate be instructed to support the intent of Resolution 127-A-19.
B	Res 205 - Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to Employed Physician Salary (Illinois)	RESOLVED, That our American Medical Association adopt policy opposing any association between anonymous patient satisfaction scores (e.g. "loyalty scores") or the coworkers' observation reporting system, and employed physicians' salaries (New HOD Policy); and be it further RESOLVED, That our AMA adopt policy opposing any publication of anonymous patient satisfaction scores or coworkers' observation reporting system information directed at an individual physician (New HOD Policy); and be it further	4. That the OMSS Delegate be instructed to support the intent of Resolution 205-A-19.

		RESOLVED, That our AMA adopt policy opposing the use of any anonymous patient satisfaction scores or any individually and anonymously posted patient or co-worker comments in formulating or impacting employed physician salaries or in relation to any other physician compensation program. (New HOD Policy)	
B	Res 209 - Mandates by ACOs Regarding Specific EMR Use (Illinois)	RESOLVED, That our American Medical Association adopt policy stating that Accountable Care Organizations cannot mandate their membership to use a single specific Electronic Medical Record (EMR) (New HOD Policy); and be it further RESOLVED, That our AMA move to effect legislation that prevents Accountable Care Organizations from imposing EMR mandates. (Directive to Take Action)	The Governing Council does not at this time offer a recommendation on Resolution 209-A-19.
B	Res 226 - Physician Access to their Medical and Billing Records (New York)	RESOLVED, That our American Medical Association advocate that licensed physicians must always have access to all medical and billing records for their patients from and after date of service including after physician termination (Directive to Take Action); and be it further RESOLVED, That our AMA press for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to the medical and billing records such as treating these records as trade secrets or proprietary. (Directive to Take Action)	5. That the OMSS Delegate be instructed to support the intent of Resolution 226-A-19.
B	Res 237 - Opportunities in Blockchain for Healthcare (Medical Student Section)	RESOLVED, That our American Medical Association work with the Office of the National Health Information Technology to create official standards for the development and implementation of blockchain technologies in healthcare (Directive to Take Action); and be it further RESOLVED, That our AMA monitor the evolution of blockchain technologies in healthcare and engage in discussion with appropriate stakeholders regarding blockchain development. (Directive to Take Action)	6. That the OMSS Delegate be instructed to support the intent of Resolution 237-A-19.

C	Res 305 - Lack of Support for Maintenance of Certification (Illinois)	RESOLVED, That our American Medical Association urge all American Board of Medical Specialties (ABMS) Boards to phase out the use of mandated, periodic, pass/fail, point-in-time examinations, and Quality Improvement/Practice Improvement components of the Maintenance of Certification process, and replace them with more longitudinal and formative assessment strategies that provide feedback for continuous learning and improvement and support a physician's commitment to ongoing professional development (Directive to Take Action); and be it further RESOLVED, That our AMA encourage all ABMS Boards to adopt and immediately begin the process of implementing the following recommendation from the Continuing Board Certification Vision For the Future Commission Final Report: "Continuing certification must change to incorporate longitudinal and other innovative formative assessment strategies that support learning, identify knowledge and skills gaps, and help diplomates stay current. The ABMS Boards must offer an alternative to burdensome highly-secure, point-in-time examinations of knowledge." (Directive to Take Action)	7. That the OMSS Delegate be instructed to support the intent of Resolution 305-A-19.
C	Res 308 - Maintenance of Certification Moratorium (New York)	RESOLVED, That our American Medical Association call for an immediate end to the high stakes examination components as well as an end to the Quality Initiative (QI)/Practice Improvement (PI) components of Maintenance of Certification (MOC) (Directive to Take Action); and be it further RESOLVED, That our AMA call for retention of continuing medical education (CME) and professionalism components (how physicians carry out their responsibilities safely and ethically) of MOC only (Directive to Take Action); and be it further RESOLVED, That our AMA petition the American Board of Medical Specialties for the restoration of certification status for all diplomates who have lost certification status solely because they have not complied with MOC requirements. (Directive to Take Action)	8. That the OMSS Delegate be instructed to support the intent of Resolution 308-A-19.

C	Res 311 - Grandfathering Qualified Applicants Practicing in U.S. Institutions with Restricted Medical Licensure (International Medical Graduates Section)	RESOLVED, That the American Medical Association work with the Federation of State Medical Boards, the Organized Medical Staff Section and other stakeholders to advocate for state medical boards to support the licensure to practice medicine by physicians who have demonstrated they possess the educational background and technical skills and who are practicing in the U.S. Healthcare system. (Directive to Take Action)	9. That the OMSS Delegate be instructed to oppose the intent of Resolution 311-A-19.
D	Res 402 - Bullying in the Practice of Medicine (Young Physicians Section)	RESOLVED, That our American Medical Association help establish a clear definition of professional bullying, establish prevalence and impact of professional bullying, and establish guidelines for prevention of professional bullying with a report back at the 2020 Annual Meeting. (Directive to Take Action)	10. That the OMSS Delegate be instructed to support the intent of Resolution 402-A-19.
E	Res 525 - Support for Rooming-in of Neonatal Abstinence Syndrome Patients with their Parents (Medical Student Section)	RESOLVED, That our American Medical Association support keeping patients with neonatal abstinence syndrome with their parents or legal guardians in the hospital throughout their treatment, as the patient's health and safety permits, through the implementation of rooming-in programs (New HOD Policy); and be it further RESOLVED, That our AMA support the education of physicians about rooming-in patients with neonatal abstinence syndrome. (New HOD Policy)	11. That the OMSS Delegate be instructed to oppose the intent of Resolution 525-A-19.
F	BOT Report 10 - Conduct at AMA Meetings and Events	1. That Policy D-140.954, "Harassment Issues Within the AMA," be rescinded as having been fulfilled by the report. (Rescind HOD Policy) 2. That Policy H-140.837, "Anti-Harassment Policy," be renamed "Policy on Conduct at AMA Meetings and Events" and further amended by insertion and deletion as follows (Modify Current HOD Policy): ~~**Anti-Harassment Policy Applicable to AMA Entities**~~ **Policy on Conduct at AMA Meetings and Events** It is the **policy** of the American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit	12. That the OMSS Delegate be instructed to support the intent of BOT Report 10-A-19.

		respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants. ~~a~~Any type of harassment of any attendee of an AMA ~~staff, fellow delegates or others by members of the House of Delegates or~~ hosted meeting, event and other ~~attendees at or in connection with HOD meetings, or otherwise~~ activity, including but not limited to dinners, receptions and social gatherings held in conjunction with ~~HOD meetings,~~ an AMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA ~~delegates and staff are conducting AMA~~ business is conducted. This zero tolerance **policy** also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events. The purpose of the policy is to protect participants in AMA-sponsored events from harm. **Definition** Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise ~~protected group status~~, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits. Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or	

		aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting. **Sexual Harassment** Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this **policy**, sexual harassment includes: - making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and - creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct. Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact. Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential. **Operational Guidelines** The AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following: *1. Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)*	

		The Office of General Counsel will appoint a "Conduct Liaison" for all AMA House of Delegates meetings and all other AMA hosted meetings or activities (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports of alleged policy violations, conducting investigations, and initiating both immediate and longer-term consequences for such violations. The Conduct Liaison appointed for any meeting will have the appropriate training and experience to serve in this capacity, and may be a third party or an in-house AMA resource with assigned responsibility for this role. The Conduct Liaison will be (i) on-site at all House of Delegates meetings and other large, national AMA meetings and (ii) on call for smaller meetings and activities. Appointments of the Conduct Liaison for each meeting shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in investigation of alleged policy violations and in decisions on consequences for policy violations. The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA). The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms. *2. Reporting Violations of the Policy* Any persons who believe they have experienced or witnessed conduct in violation of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," during any AMA House of Delegates meeting or other activities associated with the AMA (such as meetings of AMA councils, sections, the	

		RVS Update Committee (RUC), CPT Editorial Panel or JAMA Editorial Boards) should promptly notify the (i) Conduct Liaison appointed for such meeting, and/or (ii) the AMA Office of General Counsel and/or (iii) the presiding officer(s) of such meeting or activity. Alternatively, violations may be reported using an AMA reporting hotline (telephone and online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will provide an option to report anonymously, in which case the name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the Conduct Liaison may investigate. These reporting mechanisms will be publicized to ensure awareness. *3. Investigations* All reported violations of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," pursuant to Section 2 above (irrespective of the reporting mechanism used) will be investigated by the Conduct Liaison. Each reported violation will be promptly and thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event to provide recommendations for action to the CCAM. Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator. Based on this investigation, the Conduct Liaison will determine whether a violation of the Policy on Conduct at AMA Meetings and Events has occurred. All reported violations of the Policy on Conduct at AMA Meetings and Events, and the outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the AMA's Office of General Counsel (i.e.	

		irrespective of whether the Conduct Liaison determines that a violation has occurred). *4. Disciplinary Action* If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison may take immediate action to protect the safety of event participants, which may include having the violator removed from the AMA meeting, event or activity, without warning or refund. Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall report any such violation to the CCAM, together with recommendations as to whether additional commensurate disciplinary and/or corrective actions (beyond those taken on-site at the meeting, event or activity, if any) are appropriate. The CCAM will review all incident reports, perform further investigation (if needed) and recommend to the Office of General Counsel any additional commensurate disciplinary and/or corrective action, which may include but is not limited to the following: - Prohibiting the violator from attending future AMA events or activities; - Removing the violator from leadership or other roles in AMA activities; - Prohibiting the violator from assuming a leadership or other role in future AMA activities; - Notifying the violator's employer and/or sponsoring organization of the actions taken by AMA; - Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action; - Referral to law enforcement. The CCAM may, but is not required to, confer with the presiding officer(s) of applicable events activities in making its recommendations as to disciplinary and/or corrective actions. Consequence for policy violations will	

		be commensurate with the nature of the violation(s). *5. Confidentiality* All proceedings of the CCAM should be kept as confidential as practicable. Reports, investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and Events will be kept confidential to the fullest extent possible, consistent with usual business practices. *6. Assent to Policy* As a condition of attending and participating in any meeting of the House of Delegates, or any council, section, or other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or activity, each attendee will be required to acknowledge and accept (i) AMA policies concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication and disciplinary processes for violations of such policies (including those implemented pursuant to these Operational Guidelines), and all attendees are expected to conduct themselves in accordance with these policies. Additionally, individuals elected or appointed to a leadership role in the AMA or its affiliates will be required to acknowledge and accept the Policy on Conduct at AMA Meetings and Events and these Operational Guidelines. ~~1. Reporting a complaint of harassment~~ ~~Any persons who believe they have experienced or witnessed conduct in violation of Anti-Harassment Policy H-140.837 during any AMA House of Delegates meeting or associated functions should promptly notify the Speaker or Vice Speaker of the House or the AMA Office of General Counsel.~~ ~~Any persons who believe they have experienced or witnessed conduct in other activities associated with the AMA (such as meetings of AMA~~	

		~~councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy H-140.837 should promptly notify the presiding officer(s) of such AMA-associated meeting or activity or either the Chair of the Board or the AMA Office of General Counsel.~~ ~~Anyone who prefers to register a complaint to an external vendor may do so using an AMA compliance hotline (telephone and online) maintained on behalf of the AMA. The name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the AMA may investigate.~~ ~~2. Investigations~~ ~~Investigations of harassment complaints will be conducted by AMA Human Resources. Each complaint of harassment or retaliation shall be promptly and thoroughly investigated. Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact between the accuser and the accused during the pendency of an investigation and (b) provide the accused an opportunity to respond to allegations. Based on its investigation, AMA Human Resources will make a determination as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.~~ ~~3. Disciplinary Action~~ ~~If AMA Human Resources shall determine that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA-associated meeting or activity in which such violation occurred, as applicable, of such determination, (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with appropriate training.~~ ~~If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or~~	

		~~corrective action in consultation with the Speaker and Vice Speaker of the House.~~ ~~If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.~~ ~~If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the matter to appropriate AMA management, and when appropriate, may suggest that the complainant contact legal authorities.~~ ~~4. Confidentiality~~ ~~To the fullest extent possible, the AMA will keep complaints, investigations and resolutions confidential, consistent with usual business practice.~~	
F	Res 604 - Engage and Collaborate with The Joint Commission (Illinois)	RESOLVED, That our American Medical Association study and report back on any potential impact, influence, or conflicts of interest related to unrestricted grants from pharmaceutical and medical device manufacturers on the development of Joint Commission accreditation standards (especially those that relate to medical prescribing, procedures, and clinical care by licensed physicians). (Directive to Take Action)	The Governing Council does not at this time offer a recommendation on Resolution 604-A-19.
F	Res 612 - Request to AMA for Training in Health Policy and Health Law (New Mexico)	RESOLVED, That our American Medical Association offer its members training in health policy and health law, and develop a fellowship in health policy and health law. (Directive to Take Action)	13. That the OMSS Delegate be instructed to support the intent of Resolution 612-A-19.
G	BOT Report 15 - Physician Burnout and Wellness Challenges; Physician and Physician Assistant Safety Net;	Physician Burnout and Wellness Challenges; Physician and Physician Assistant Safety Net; Identification and Reduction of Physician Demoralization 1. That our American Medical Association reaffirm the following policies: H-170.986, “Health Information and Education” H-405.957, “Programs on Managing Physician Stress and Burnout;”	14. That the OMSS Delegate be instructed to support the intent of BOT Report 15-A-19.

	Identification and Reduction of Physician Demoralization	H-405.961, “Physician Health Programs;” D-405.990, “Educating Physicians About Physician Health Programs;” H-95.955, “Physician Impairment;” and H-295.858, “Access to Confidential Health Services for Medical Students and Physicians.” (Reaffirm HOD Policy) 2. That our American Medical Association amend existing Policy H-405.961, “Physician Health Programs,” to add the following directive (Modify Current HOD Policy): 1. Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness. 2. Our AMA encourages state medical societies to collaborate with the state medical boards to a) develop strategies to destigmatize physician burnout, and b) encourage physicians to participate in the state’s physician health program without fear of loss of license or employment. 3. That our AMA amend existing Policy D-310.968, “Physician and Medical Student Burnout,” to add the following directives (Modify Current HOD Policy): 1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students. 2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets. 3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty. 4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education	

		and physician community. 5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements. 6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout. 7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify factors that may lead to physician demoralization. 8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being. 9. Our AMA will continue to (1) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (2) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.	
G	CMS Report 7 - Hospital Consolidation	1. That our American Medical Association (AMA) affirm that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority. (New HOD Policy) 2. That our AMA continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency. (New HOD Policy)	15. That the OMSS Delegate be instructed to support the intent of CMS Report 7-A-19.

		3. That our AMA encourage state medical associations to monitor hospital markets and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices. (New HOD Policy) 4. That our AMA reaffirm Policy H-215.969, which provides that, in the event of a hospital merger, acquisition, consolidation or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues: (a) medical staff representation on the board of directors; (b) clinical services to be offered by the institutions; (c) process for approving and amending medical staff bylaws; (d) selection of the medical staff officers, medical executive committee, and clinical department chairs; (e) credentialing and recredentialing of physicians and limited licensed providers; (f) quality improvement; (g) utilization and peer review activities; (h) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges; (i) conflict resolution mechanisms; (j) the role, if any, of medical directors and physicians in joint ventures; (k) control of medical staff funds; (l) successor-in-interest rights; and (m) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals. (Reaffirm HOD Policy) 5. That our AMA reaffirm Policy H-220.937, which states that geographic disparities or differences in patient populations may warrant multiple medical staffs within a single hospital corporation, and that each medical staff shall develop and adopt bylaws and rules and regulations to establish a framework for self-governance of medical activities and accountability to the governing body. (Reaffirm HOD Policy) 6. That our AMA reaffirm Policy H-225.950, which outlines AMA Principles for Physician Employment intended to assist physicians in addressing some of the unique challenges employment presents to the practice of medicine, including conflicts of interest, contracting, and hospital medical staff relations, and that discourage physicians from entering into agreements that restrict their right to practice medicine for a specified period of time or in a specified area upon termination of employment. (Reaffirm HOD Policy) and 7. That our AMA reaffirm Policy H-225.947, which encourages physicians	

		who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles that actively involve physicians in integrated leadership and preserve clinical autonomy. (Reaffirm HOD Policy)	
G	CMS Report 11 - Corporate Investors	1. That our American Medical Association (AMA) reaffirm Policy H-215.981, which opposes federal legislation preempting state laws prohibiting the corporate practice of medicine; states that the AMA will continue monitoring the corporate practice of medicine and its effect on the patient-physician relationship, financial conflicts of interest, and patient-centered care; and directs the AMA to provide guidance, consultation and model legislation regarding the corporate practice of medicine, at the request of state medical associations, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy H-225.950, which affirms that a physician's paramount responsibility is to his or her patients, and which outlines principles related to conflicts of interest and contracting. (Reaffirm HOD Policy) 3. That our AMA reaffirm Policy H-285.951, which states that physicians should have the right to enter into whatever contractual arrangements they deem desirable and necessary but should be aware of potential conflicts of interest due to the use of financial incentives in the management of medical care. (Reaffirm HOD Policy) 4. That our AMA reaffirm Policy H-160.960, which states that when a private medical practice is purchased by corporate entities, patients shall be informed of the ownership arrangement by the corporate entities and/or the physician. (Reaffirm HOD Policy)	16. That the OMSS Delegate be instructed to support the intent of CMS Report 11-A-19.

G	Res 705 - Physician Requirements for Comprehensive Stroke Center Designation (Thomas J. Madejski, MD, Delegate)	RESOLVED, That our American Medical Association advocate for changing the following two provisions from The Joint Commission Stroke Center Requirements: 1. Stroke procedurists should not be required to perform 15 mechanical thrombectomies per year to qualify for taking endovascular call at designated stroke hospitals; and 2. Stroke procedurists should be able to take call at more than one hospital at a time. (Directive to Take Action)	17. That the OMSS Delegate be instructed to support the intent of Resolution 705-A-19.
G	Res 706 - Hospital Falls and "Never Events" - A Need for More in Depth Study (Wisconsin)	RESOLVED, That our American Medical Association study the merits of recommending that "Patient death or serious injury associated with a fall while being cared for in a health care setting" be removed from the list of "Never Events" for which a hospital may face an adverse payment decision by third-party payors or an adverse accreditation decision by The Joint Commission (Directive to Take Action); and be it further RESOLVED, That our AMA study the merits of recommending that a pay-for-performance measure be added which would reward health care organizations for taking steps resulting in patients' improved ability to participate in self-care, improved functional status, and improved mobility for seniors who have been admitted to a facility for a condition resulting in a temporary need for bed rest. (Directive to Take Action)	The Governing Council does not at this time offer a recommendation on Resolution 706-A-19.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(A-19)

Introduced by: New Mexico

Subject: Covenants Not to Compete

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, Covenants not to compete have been used to force physicians to leave communities if they leave hospital employment; and

Whereas, Recruiting and promoting new partners, building their referral bases, and purchasing necessary equipment is a significantly expensive undertaking; and

Whereas, Practices endure significant financial harm when a hospital can lure a partner away, and a requirement to pay liquidated damages when that happens mitigates the financial harm without requiring the partner to leave the community; and

Whereas, New Mexico passed a statue that prohibits covenants not to compete for employed physicians but allows for liquidated damages to be paid when a partner who is a part owner in a practice is lured away by a competing hospital system; and

Whereas, The New Mexico statute is a model that could be used by the AMA Council on Legislation as an example for other states; and

Whereas, The AMA Council on Ethical and Judicial Affairs opposes covenants not to compete in all circumstances; therefore be it

RESOLVED, That our American Medical Association consider as the basis for model legislation the New Mexico statute allowing a requirement that liquidated damages be paid when a physician partner who is a part owner in practice is lured away by a competing hospital system (Directive to Take Action); and be it further

RESOLVED, That our AMA ask our Council on Ethical and Judicial Affairs to reconsider their blanket opposition to covenants not to compete in the case of a physician partner who is a part owner of a practice, in light of the protection that liquidated damages can confer to independent physician owned partnerships, and because a requirement to pay liquidated damages does not preclude a physician from continuing to practice in his or her community. (Directive to Take Action)

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

Received: 05/09/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(A-19)

Introduced by: Ohio

Subject: Practice Overhead Expense and the Site-of-Service Differential

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, In the 17-year period from 2001-2017, Medicare Part B payments to physicians increased only 6% while Medicare's index of inflation measuring the cost of running a medical practice increased 30%, (AMA Council on Medical Service (CMS) Report 4, I-18); and

Whereas, After adjustment for inflation in practice costs, physician pay has declined 19%, thus failing to match increases in office overhead costs (CMS Report 4, I-18); and

Whereas, In the 17-year period from 2001-2017, Medicare hospital payments increased roughly 50%, including average annual increases of 2.6% for inpatient services and 2.5% per year for outpatient services (CMS Report 4, I-18); and

Whereas, Hospitals have thus received payment increases more than 8-fold greater than payment adjustments to physicians in the period from 2001-2017; and

Whereas, Much of this disparate payment to hospitals is due to annual year- over-year increases in payments for services rendered in hospital outpatient facilities, where Medicare pays a so-called site-of-service differential amounting to, on average, approximately 360% of Medicare's payment for the same mix of services when they are performed in a physician's office; therefore be it

RESOLVED, That our American Medical Association appeal to the US Congress for legislation to direct the Centers for Medicare and Medicaid Services (CMS) to eliminate any site-of-service differential payments to hospitals for the same service that can safely be performed in a doctor's office (Directive to Take Action); and be it further

RESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS in regards to any savings to Part B Medicare, through elimination of the site-of-service differential payments to hospitals, (for the same service that can safely be performed in a doctor's office), be distributed to all physicians who participate in Part B Medicare, by means of improved payments for office-based Evaluation and Management Codes, so as to immediately redress underpayment to physicians in regards to overhead expense (Directive to Take Action); and be it further

RESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS to make Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting. (Directive to Take Action)

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

Received: 04/30/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 127
(A-19)

Introduced by: New Jersey

Subject: Eliminating the CMS Observation Status

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, “Observation Status” for a hospitalization does not count to meet Medicare’s “three day inpatient rule” for “skilled nursing facility care” financial coverage; and

Whereas, “Observation Status” to a hospital means our patients are financially responsible for a 20 percent co-pay for hospital costs, the full cost of medications and diagnostic testing; and

Whereas, Our patients should present for emergency care assessment as soon as symptoms and/or signs dictate, but the financial risks of “Observation Status” may dissuade patients from seeking hospital based care through the emergency department; and

Whereas, Medicare Part A patients do not get a thorough explanation, including situational examples, of Medicare coverage rules for “Observation Status” when pre-admitted or admitted to a hospital; and

Whereas, There is no insurance available for Part A “Observation Status” financial risk; therefore be it

RESOLVED, That our American Medical Association request, for the benefit of our patients’ financial, physical and mental health, that the Centers for Medicare and Medicaid Services terminate the “48 hour observation period” and observation status in total. (Directive to Take Action)

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

Received: 05/09/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(A-19)

Introduced by: Illinois

Subject: Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to Employed Physician Salary

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Patient or coworker observation experience surveys are increasingly used by healthcare centers in evaluating physician clinical care and are often tied to physician salaries; and

Whereas, These patient surveys focus on patient perspectives and brand management while not addressing any specific quality metrics of complicated clinical care; and

Whereas, Coworker observation metrics have not been validated as a reliable monitoring tool for patient care or clinical professional behavior; and

Whereas, Patient or coworker experience surveys depend upon active responses and thus may exhibit reporting bias due to complaints frequently unrelated to the providers' actual clinical care; and

Whereas, It has been demonstrated that higher patient satisfaction scores are associated with higher health care and prescription expenditures; and

Whereas, Patient satisfaction utilization can promote job dissatisfaction, attrition, and inappropriate clinical care (the very opposite of high-value clinical care); and

Whereas, Patient surveys or coworker observation metrics are not conducted nor evaluated in a peer-review environment; and

Whereas, These surveys and metrics are performed anonymously and thus cannot be adequately addressed by the clinician; and

Whereas, These metrics are usually utilized only to negatively impact an employed physician's salary in a punitive manner (with no potential for positive impact); and

Whereas, A clinician's overall work product cannot be distilled to a few numerical metrics; and

Whereas, Health care centers may publish the results of patient or coworker surveys regarding individual providers in an effort to be "transparent"; and

Whereas, It is apparent that patient satisfaction surveys or coworkers' observation reporting symptoms produce "scores" that are not related to any clinical quality metric, have questionable validity, and are often taken out of context; therefore be it

RESOLVED, That our American Medical Association adopt policy opposing any association between anonymous patient satisfaction scores (e.g. “loyalty scores”) or the coworkers’ observation reporting system, and employed physicians’ salaries (New HOD Policy); and be it further

RESOLVED, That our AMA adopt policy opposing any publication of anonymous patient satisfaction scores or coworkers’ observation reporting system information directed at an individual physician (New HOD Policy); and be it further

RESOLVED, That our AMA adopt policy opposing the use of any anonymous patient satisfaction scores or any individually and anonymously posted patient or co-worker comments in formulating or impacting employed physician salaries or in relation to any other physician compensation program. (New HOD Policy)

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

Received: 04/25/19

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(A-19)

Introduced by: Illinois

Subject: Mandates by ACOs Regarding Specific EMR Use

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, The private practice of medicine has protected the relationship between doctor and patient; and

Whereas, The patient chart and its data are protected under HIPAA; and

Whereas, The ownership of the chart rests with the doctor originating the chart; and

Whereas, The continued art and science of the practice of medicine depends on the protected relationship of the doctor and the patient, and the documentation of that relationship; and

Whereas, Electronic medical records have improved the documentation of the doctor-patient relationship; and

Whereas, The access to the patient chart is protected by HIPAA; and

Whereas, The private practice is affected by forces in the free marketplace; and

Whereas, The access and ownership of the patient chart has effect on its value in the marketplace; and

Whereas, The ownership of the chart has not been ruled on in most states; and

Whereas, The spread of Accountable Care Organizations (ACOs) may direct referrals within a geographic area and have restricted trade; and

Whereas, All electronic medical records are to move to interoperability as defined and mandated by the Centers for Medicare and Medicaid Services (CMS) for compliance with federal programs; and

Whereas, There are means of sharing data between organizations in accordance with HIPAA via alliances like CommonWell Health Alliance and Carequality Interoperability Framework that are in common usage for patient data and its interoperability; and

Whereas, The use of alliances such as CommonWell Health Alliance and Carequality Interoperability Framework have accelerated the ability of unrelated healthcare entities including inpatient and outpatient facilities to share data through interoperability; and

Whereas, ACOs have begun to mandate the use of single and specific EMR software vendors; therefore be it

RESOLVED, That our American Medical Association adopt policy stating that Accountable Care Organizations cannot mandate their membership to use a single specific Electronic Medical Record (EMR) (New HOD Policy); and be it further

RESOLVED, That our AMA move to effect legislation that prevents Accountable Care Organizations from imposing EMR mandates. (Directive to Take Action)

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

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(A-19)

Introduced by: New York

Subject: Physician Access to their Medical and Billing Records

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Contracts include language that medical and billing records are proprietary and the property of the employer and may limit access to the treating physician during employment or after separation; and

Whereas, Billing is frequently signed by physicians or billed under the physician's identifier; and

Whereas, Physician review is crucial to any compliance program; therefore be it

RESOLVED, That our American Medical Association advocate that licensed physicians must always have access to all medical and billing records for their patients from and after date of service including after physician termination (Directive to Take Action); and be it further

RESOLVED, That our AMA press for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to the medical and billing records such as treating these records as trade secrets or proprietary. (Directive to Take Action)

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

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237
(A-19)

Introduced by: Medical Student Section

Subject: Opportunities in Blockchain for Healthcare

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Blockchain is a distributed database that stores records of all transactions and digital events carried out by its participants, called the public ledger, hosted across all participants (nodes), rather than a central entity[1]; and

Whereas, Once something has been added to the blockchain, it is permanently stored across all nodes, and in this way, blockchain functions as a decentralized, immutable ledger capable of storing data without the need for a central responsible entity, mitigating risk from central failure[2-4]; and

Whereas, Blockchain may alleviate several pain points in the current state of information sharing in health information technology, for example, allowing multiple stakeholders to agree on the "true" state of data (immutable ledger), helping decrease administrative costs regarding authorization and claims adjudication, better defining data ownership, and reducing unauthorized data use through less burdensome computer code[9,10]; and

Whereas, The 21st Century Cares Act defines health information technology (HIT) interoperability as technology that "enables the secure change exchange of electronic health information with, and the use of electronic health information from, other health technology without special effort on part of the user" [6]; and

Whereas, Interoperability positively impacts health systems in a variety of ways; including by increasing operational efficiency, reducing clinical duplication/waste, and enhancing clinical care by providing access to longitudinal data at the point of care[7]; and

Whereas, There has been a concerted effort, including through the AMA-driven Integrated Health Model Initiative, to develop data structures that promote data sharing and standardize output of data from proprietary EHRs to facilitate interoperability[6-8]; and

Whereas, In considering the security advantages and risks of blockchain technology compared to contemporary approaches, each pillar of HIPAA (Administrative, Physical, Technical) must be assessed under more precise definitions of security: Confidentiality and Unforgeability[4]; and

Whereas, Several case studies have shown that blockchain can mitigate risks related to mobile data communication with EHRs through the use of smart contracts[12,13]; and

Whereas, The advent of secure data sharing between mobile platforms via blockchain platforms has potential to achieve incorporation of patient generated data routinely into daily clinical decision making due to access at the point of care[13]; and

Whereas, There is a paucity of data regarding testing blockchain applications in the clinical setting, and additional research will be required to definitively show the utility of this technology; and

Whereas, It is recognized that blockchain remains an early stage technology, but one with the potential through technical innovation to rapidly overcome existing drawbacks health information technology interoperability faces today; and

Whereas, To date, the AMA does not have explicit policy on blockchain technology; therefore be it

RESOLVED, That our American Medical Association work with the Office of the National Health Information Technology to create official standards for the development and implementation of blockchain technologies in healthcare (Directive to Take Action); and be it further

RESOLVED, That our AMA monitor the evolution of blockchain technologies in healthcare and engage in discussion with appropriate stakeholders regarding blockchain development. (Directive to Take Action)

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

Received: 05/09/19

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RELEVANT AMA POLICY

HIPAA Law And Regulations D-190.989
(1) Our AMA shall continue to aggressively pursue modification of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to remove burdensome regulations that could interfere with efficient patient care.
(2) If satisfactory modification to the HIPAA Privacy Rule is not obtained, our AMA shall aggressively pursue appropriate legislative and/or legal relief to prevent implementation of the HIPAA Privacy Rule.
(3) Our AMA shall continue to oppose the creation or use of any unique patient identification number, including the Social Security number, as it might permit unfettered access by governmental agencies or other entities to confidential patient information.

(4) Our AMA shall immediately begin working with the appropriate parties and trade groups to explore ways to help offset the costs of implementing the changes required by the Health Insurance Portability and Accountability Act so as to reduce the fiscal burden on physicians.
Citation: (Sub. Res. 207, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12

HIPAA Requirements for E-Commerce in Health Care D-478.998
Our AMA will: (1) intensify its on-going effort to inform practicing physicians about the consequences of implementation (including financial implications) of the Health Insurance Portability and Accountability Act (HIPAA) regulations for transmission of electronic information; and (2) study strategies on implementation of the HIPAA regulations, such as a limit on the frequency of modifications, which will lessen the financial impact on physicians, with a report back to the AMA House of Delegates when final regulations are promulgated.
Citation: (Res. 802, A-00; Reaffirmed: BOT Rep. 6, A-10

Health Information Technology H-478.994
Our AMA will support the principles that when financial assistance for Health IT originates from an inpatient facility: (1) it not unreasonably constrain the physician's choice of which ambulatory HIT system to purchase; and (2) it promote voluntary rather than mandatory sharing of Protected Health Information (HIPAA-PHI) with the facility consistent with the patient's wishes as well as applicable legal and ethical considerations.
Citation: (Res. 723, A-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 237, A-12

Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data H-315.973
1. It is AMA policy that any payer, clearinghouse, vendor, or other entity that collects and uses electronic medical records and claims data adhere to the following principles:
a. Electronic medical records and claims data transmitted for any given purpose to a third party must be the minimum necessary needed to accomplish the intended purpose.
b. All covered entities involved in the collection and use of electronic medical records and claims data must comply with the HIPAA Privacy and Security Rules.
c. The physician must be informed and provide permission for any analysis undertaken with his/her electronic medical records and claims data, including the data being studied and how the results will be used.
d. Any additional work required by the physician practice to collect data beyond the average data collection for the submission of transactions (e.g., claims, eligibility) must be compensated by the entity requesting the data.
e. Criteria developed for the analysis of physician claims or medical record data must be open for review and input by relevant outside entities.
f. Methods and criteria for analyzing the electronic medical records and claims data must be provided to the physician or an independent third party so re-analysis of the data can be performed.
g. An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived from an analysis of his/her electronic medical records and claims data.
h. Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care operations.
2. It is AMA policy that any physician, payer, clearinghouse, vendor, or other entity that warehouses electronic medical records and claims data adhere to the following principles:
a. The warehouse vendor must take the necessary steps to ensure the confidentiality, integrity, and availability of electronic medical records and claims data while protecting against threats to the security or integrity and unauthorized uses or disclosure of the information.
b. Electronic medical records data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.
c. Physician and patient permission must be obtained for any person or entity other than the physician or patient to access and use individually identifiable clinical data, when the physician is specifically identified.
d. Following the request from a physician to transfer his/her data to another data warehouse, the current vendor must transfer the electronic medical records and claims data and must delete/destroy the data from its data warehouse once the transfer has been completed and confirmed.
Citation: (CMS Rep. 6, I-06; Reaffirmed: BOT Rep. 17, A-13

National Health Information Technology D-478.995
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.
Citation: Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18

Health Information Technology Principles H-478.981
Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:
1. Enhance physicians ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.

Our AMA will AMA utilize HIT principles to:
1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of Information Blocking.
Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.
Citation: BOT Rep. 19, A-18

Health Information Technology H-478.994
Our AMA will support the principles that when financial assistance for Health IT originates from an inpatient facility: (1) it not unreasonably constrain the physician's choice of which ambulatory HIT system to purchase; and (2) it promote voluntary rather than mandatory sharing of Protected Health Information (HIPAA-PHI) with the facility consistent with the patient's wishes as well as applicable legal and ethical considerations.
Citation: (Res. 723, A-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 237, A-12

EHR Interoperability D-478.972
Our AMA:
(1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System;
(2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;
(3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges;
(4) will continue efforts to promote interoperability of EHRs and clinical registries;
(5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;
(6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;
(7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;
(8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and
(9) will review and advocate for the implementation of appropriate recommendations from the “Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care,” a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services.
Citation: Sub. Res. 212, I-15; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: Res. 221, I-16; Reaffirmed in lieu of: Res. 243, A-17; Reaffirmed: CMS Rep. 10, A-17; Appended: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Appended: Res. 202, A-18; Appended: Res. 226, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(A-19)

Introduced by: Illinois

Subject: Lack of Support for Maintenance of Certification

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, The American Board of Medical Specialties (ABMS) has responded to a groundswell of criticism focused on the requirements for maintenance of certification (MOC) by creating an independent "Vision Commission" designed to "reimagine a system of continuing certification"; and

Whereas, The Vision Commission released its draft report December 11, 2018, with a public comment period that ended January 15, 2019; and

Whereas, The draft report was divided into "Findings" and "Recommendations," and some of the highlights include results of a survey conducted by the Vision Commission which showed that only 12% of 34,616 physicians surveyed valued the program; and

Whereas, Robust evidence does not exist correlating physicians' grades on secure, pass/fail MOC exams with patient outcomes; and

Whereas, Secure exam questions and assessments that rely exclusively on knowledge recall are not aligned with how diplomates practice and provide patient care; and

Whereas, The Vision Commission has documented significant harmful consequences of MOC, stating "The Commission heard compelling testimony from all stakeholders that loss of certification can lead to loss of employment or certain employment opportunities for diplomates or loss of reimbursement from insurance carriers"; and

Whereas, One of the promises in the Hippocratic Oath we take as physicians is "First, do no Harm" or "primum non nocere"; therefore be it

RESOLVED, That our American Medical Association urge all American Board of Medical Specialties (ABMS) Boards to phase out the use of mandated, periodic, pass/fail, point-in-time examinations, and Quality Improvement/Practice Improvement components of the Maintenance of Certification process, and replace them with more longitudinal and formative assessment strategies that provide feedback for continuous learning and improvement and support a physician's commitment to ongoing professional development (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage all ABMS Boards to adopt and immediately begin the process of implementing the following recommendation from the Continuing Board Certification Vision For the Future Commission Final Report: “Continuing certification must change to incorporate longitudinal and other innovative formative assessment strategies that support learning, identify knowledge and skills gaps, and help diplomates stay current. The ABMS Boards must offer an alternative to burdensome highly-secure, point-in-time examinations of knowledge.” (Directive to Take Action)

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

Received: 04/25/19

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(A-19)

Introduced by: New York

Subject: Maintenance of Certification Moratorium

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, Many physicians find elements of Continuous Certification/Maintenance of Certification (MOC) problematic; and

Whereas, Elements of MOC do not reflect the manner in which medicine is practiced; and

Whereas, Endless certification has become another element which contributes to physician stress and burnout; and

Whereas, MOC has harmed physicians--physically, emotionally, and economically; and

Whereas, Boards have reaped wealth at the expense of their diplomates; and

Whereas, Other professions require continuing education and professionalism, but none require secure examinations or "knowledge check-ins;" and

Whereas, The draft report of the Vision Initiative has found these issues and more; and

Whereas, The American College of Physicians, the National Board of Physicians and Surgeons, and the American Association of Plastic Surgeons and many state societies have all commented on the problematic state of MOC; therefore be it

RESOLVED, That our American Medical Association call for an immediate end to the high stakes examination components as well as an end to the Quality Initiative (QI)/Practice Improvement (PI) components of Maintenance of Certification (MOC) (Directive to Take Action); and be it further

RESOLVED, That our AMA call for retention of continuing medical education (CME) and professionalism components (how physicians carry out their responsibilities safely and ethically) of MOC only (Directive to Take Action); and be it further

RESOLVED, That our AMA petition the American Board of Medical Specialties for the restoration of certification status for all diplomates who have lost certification status solely because they have not complied with MOC requirements. (Directive to Take Action)

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

Received: 04/25/19

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(A-19)

Introduced by: International Medical Graduates Section

Subject: Grandfathering Qualified Applicants Practicing in U.S. Institutions with Restricted Medical Licensure

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, IMGs in the past were permitted to work in academic institutions, either for their specific skills or a need due to fill unmet patient care needs in certain physician specialties or geographical areas; and

Whereas, Physicians were allowed to work with an institutional or faculty temporary license granted by their local state medical board without having completed the USMLE examination, or without being American Board certified or eligible in their specialty; and

Whereas, These physicians completed medical school and specialty training abroad were often excellent candidates with strong curricula and their titles were recognized equivalent to the ones received in the U.S. by the receiving academic institution to allow them to work; and

Whereas, In recent years, these physicians faced the problem that many academic and non-academic institutions created rules to have only American Board certified physicians among their faculty/staff and were unwilling to grant institutional licenses any longer which creates a dramatic situation for these physicians who have practiced and trained U.S. medical students, residents and physicians in the U.S. for many years; and

Whereas, These IMGs admitted to work in the U.S. to fill a void and a need are now faced with losing their jobs without the ability to practice anywhere in the U.S.; and

Whereas, in the Commonwealth of Pennsylvania, an IMG or graduate of an unaccredited medical college may have their unmet qualifications waived by the Board if the applicant is determined to possess the educational background and technical skills and the waiver is considered to be beneficial to patients and the community; therefore be it

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards, the Organized Medical Staff Section and other stakeholders to advocate for state medical boards to support the licensure to practice medicine by physicians who have demonstrated they possess the educational background and technical skills and who are practicing in the U.S. health care system. (Directive to Take Action)

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

Received: 05/01/19

RELEVANT AMA POLICY

Medical Specialty Board Certification Standards H-275.926
Our AMA:
1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
5. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
Citation: Res. 318, A-07; Reaffirmation A-11; Modified: CME Rep. 2, I-15

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 Credit*", 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 be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier 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.
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.
27.Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.
Citation: CME Rep. 16, A-09; Reaffirmed: CME Rep. 11, A-12; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 919, I-13; Appended: Sub. Res. 920, I-14; Reaffirmed: CME Rep. 2, A-15; Appended: Res. 314, A-15; Modified: CME Rep. 2, I-15; Reaffirmation A-16; Reaffirmed: Res. 309, A-16; Modified: Res. 307, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 319, A-17; Reaffirmed in lieu of: Res. 322, A-17; Modified: Res. 953, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-19)

Introduced by: Young Physicians Section

Subject: Bullying in the Practice of Medicine

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, Bullying and disrespectful behavior within the practice of medicine in the U.S. and overseas has been well demonstrated in prior studies,[2,4,6,7,9,12,16] and that perpetrators of bullying within medicine can be other physician colleagues, superior ranking colleagues in training, ancillary staff, and patients[7,9,2]; and

Whereas, "Bullying or aggressive behavior has been defined by criteria such as: intention to cause harm or distress, imbalance of power between the bully (perpetrator, aggressor) and the victim (target), and repeatability over time,"[2] and the British Medical Association defines bullying as "persistent behaviour against an individual that is intimidating, degrading, offensive or malicious and undermines the confidence and self-esteem of the recipient[10]; and

Whereas, Disrespectful behavior "encompasses a broad array of conduct, from aggressive outbursts to subtle patterns of disruptive behavior so embedded in our culture that they seem normal,"[17] and disrespectful behavior can also be considered "any behavior that influences the willingness of staff or patients to speak up or interact with an individual because he or she expects the encounter will be unpleasant or uncomfortable"[8]; and

Whereas, A survey published in 2008 found in the United States "A total of 77% of the respondents reported that they had witnessed disruptive behavior in physicians at their hospitals"[13]; and

Whereas, A 2013 survey from Institute for Safe Medication Practices exposed "healthcare's continued tolerance of and indifference to disrespectful behavior. Despite more than a decade of emphasis on safety, little improvement has been made"[8]; and

Whereas, One U.S. longitudinal survey of medical students published in 2006 demonstrated that "most medical students in the U.S. reported having been harassed or belittled during their training,"[7]; and

Whereas, Fnais et al in a 2014 meta-analysis found that "59.4% of medical trainees had experienced at least one form of harassment or discrimination during their training, with verbal harassment being the most commonly cited form of harassment"[5]; and

Whereas, "Workplace bullying is associated with stress, depression, and intention to leave"[9] and increased "absenteeism, career damage, poorer job performance, and lower productivity resulting in poorer quality of healthcare services and patient care"[2]; and

Whereas, "Victims of bullying suffer from anxiety, loss of self-control, depression, lower self-confidence, occupational job stress, job dissatisfaction, dissatisfaction with life, burnout

syndrome, musculoskeletal complaints, increased risk of cardiovascular disease, suicide attempts, and drug abuse"[2] and disrespectful behaviors "have been linked to adverse events, medical errors, compromises in patient safety, and even patient mortality"[2,8]; and

Whereas, The Joint Commission in 2008 issued an alert "warning that offensive and hostile behavior among healthcare professionals not only makes for an unpleasant working environment but can also pose a considerable threat to patient safety"[12]; and

Whereas, Creswall et al describe how British medical schools are integrating curricula to teach students how to differentiate undermining and destructive bullying behavior from constructive and supportive firm supervision, and how take action against bullying[3] and positive teaching methods have been recommended within medical education,[12,16] and formal procedures to safely, accurately, and freely report bullying are needed in order to protect bullying victims and address the issue[2,9]; therefore be it

RESOLVED, That our American Medical Association help establish a clear definition of professional bullying, establish prevalence and impact of professional bullying, and establish guidelines for prevention of professional bullying with a report back at the 2020 Annual Meeting. (Directive to Take Action)

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

Received: 04/04/19

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RELEVANT AMA POLICY

Teacher-Learner Relationship In Medical Education H-295.955
The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.
CODE OF BEHAVIOR
The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.
A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.
In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.
Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.
On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.
While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.
Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.
Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.
Citation: (BOT Rep. ZZ, I-90; Reaffirmed by CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, I-99; Modified: BOT Rep. 11, A-07; Reaffirmed: CME Rep. 9, A-13

Violence and Abuse Prevention in the Health Care Workplace H-515.966
Our AMA encourages all health care facilities to: adopt policies to reduce and prevent all forms of workplace violence and abuse; develop a reporting tool that is easy for workers to find and complete; develop policies to assess and manage reported occurrences of workplace violence and abuse; make training courses on workplace violence prevention available to employees and consultants; and include physicians in safety and health committees.
Citation: Res. 424, I-98; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: BOT Rep. 2, I-12; Reaffirmed in lieu of Res. 423, A-13; Modified: CSAPH Rep. 07, A-16

Reduction of Online Bullying H-515.959
Our AMA urges social networking platforms to adopt Terms of Service that define and prohibit electronic aggression, which may include any type of harassment or bullying, including but not limited to that occurring through e-mail, chat room, instant messaging, website (including blogs) or text messaging.
Citation: Res. 401, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 525
(A-19)

Introduced by: Medical Student Section

Subject: Support for Rooming-in of Neonatal Abstinence Syndrome Patients with their Parents

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Neonatal abstinence syndrome (NAS) is defined as a postnatal withdrawal syndrome often occurring in infants exposed to opioids in-utero[1]; and

Whereas, The prevalence of opioid use disorder in pregnant women quadrupled from 1994 to 2014 to 6.5 per 1,000 births[2]; and

Whereas, The prevalence of NAS between 2000 to 2012 increased to 6.0 per 1,000 births, a five-fold increase, and in 2016 was found to be as high as 20 per 1,000 births in 23 hospitals[1]; and

Whereas, Current treatment focuses on both pharmacologic care (most commonly the prescription of morphine) and non-pharmacologic care (swaddling, frequent feeds, and skin-to-skin care), with most patients being admitted to a neonatal intensive care unit (NICU) [3]; and

Whereas, The American Academy of Pediatrics (AAP) recommends that patients with NAS be treated via non-pharmacologic care in less severe cases[4]; and

Whereas, The cost of treating patients with NAS was found to have surged from $61 million in 2003 to $316 million in 2012 with a mean length of stay (LOS) in the NICU of 16.57 days, occupying 4% of US NICU beds[5-6]; and

Whereas, Patients with NAS are hyperarousable with altered sleep/wake states and thus require a dark, quiet environment and minimal stimulation[7]; and

Whereas, The flashing lights and alarms in a NICU do not reflect the recommended environment for patients with NAS, and patients with NAS placed in NICUs have been found to experience more severe withdrawal, have longer LOS, and increased pharmacotherapy compared to those who were not[8-9]; and

Whereas, Rooming-in, where patients with NAS are admitted to in-patient rooms with their parents or legal guardians for the duration of their stay, is an alternative to NICU admission; and

Whereas, Mothers of patients with NAS are often treated at prenatal clinics for substance use disorder, where they also receive education about NAS, and continue to receive treatment while rooming-in with their child[10-11]; and

Whereas, Rooming-in was found to be associated with a reduction of 20-60% in patients requiring pharmacological treatment, shortened LOS from 17 days to an average of 12 days,

and lowered cost by 75% without a significant difference in readmission rates or adverse in-hospital events[1,9,11,12]; and

Whereas, Rooming-in has been noted to have the additional benefits of increasing parental involvement and breastfeeding[9,12]; and

Whereas, Bonding and attachment aided by the release of oxytocin during breastfeeding may protect the mother against addiction relapse and stress, and breastfeeding can prevent or reduce complications of NAS so infants demonstrate lower NAS scores, need less pharmacological treatment, and have a shorter LOS[13-15]; and

Whereas, Maximum parental presence (100%) was associated with a 9-day shorter LOS and 8 fewer days of infant opioid therapy as well as fewer days of infant opioid therapy and reduced mean NAS score after adjusting for breastfeeding[16]; and

Whereas, The AAP Committee on Fetus and Newborn found that rooming-in provides more security for healthy term newborns, increases supervised maternal-newborn interactions, and more opportunities for hospital staff to empower parents to care for their infants[17]; therefore be it

RESOLVED, That our American Medical Association support keeping patients with neonatal abstinence syndrome with their parents or legal guardians in the hospital throughout their treatment, as the patient's health and safety permits, through the implementation of rooming-in programs (New HOD Policy); and be it further

RESOLVED, That our AMA support the education of physicians about rooming-in patients with neonatal abstinence syndrome. (New HOD Policy)

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

Received: 05/09/19

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RELEVANT AMA POLICY

Treatment Versus Criminalization - Physician Role in Drug Addiction During Pregnancy H-420.970
It is the policy of the AMA (1) to reconfirm its position that drug addiction is a disease amenable to treatment rather than a criminal activity;
(2) to forewarn the U.S. government and the public at large that there are extremely serious implications of drug addiction during pregnancy and there is a pressing need for adequate maternal drug treatment and family supportive child protective services;
(3) to oppose legislation which criminalizes maternal drug addiction or requires physicians to function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment; and
(4) to provide concentrated lobbying efforts to encourage legislature funding for maternal drug addiction treatment rather than prosecution, and to encourage state and specialty medical societies to do the same.
Citation: (Res. 131, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CEJA Rep. 6, A-10

Perinatal Addiction - Issues in Care and Prevention H-420.962
Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care.
Citation: CSA Rep. G, A-92; Reaffirmation A-99; Reaffirmation A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Modified: Alt. Res. 507, A-16; Modified: Res. 906, I-17

Drug Abuse in the United States - the Next Generation H-95.976
Our AMA is committed to efforts that can help prevent this national problem from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:
(1) supports cooperation in activities of organizations such as the National Association for Perinatal Addiction Research and Education (NAPARE) in fostering education, research, prevention, and treatment of substance abuse;
(2) encourages the development of model substance abuse treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;
(3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;
(4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration with the Partnership for a Drug-Free America in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;
(5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Federal Office for Substance Abuse Prevention to continue to support research and demonstration projects around effective prevention and intervention strategies;
(6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco dependence as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;
(7) affirms the concept that substance abuse is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and
(8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction. Citation: (BOT Rep. Y, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-A-19

Subject:	Conduct at AMA Meetings and Events
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee F (Greg Tarasidis, MD, Chair)

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates adopted Policy D-140.954, "Harassment Issues Within the AMA," which provided:

> That our American Medical Association immediately engage outside consultants to evaluate current processes and, as needed, implement new processes for the evaluation and adjudication of sexual and non-sexual harassment claims involving staff, members, or both with report back regarding said processes and implementation at the 2019 Annual Meeting. (Directive to Take Action)

In furtherance of Policy D-140.954, the AMA immediately engaged two outside consultants, Amy L. Bess, Esq. of Vedder Price PC and Sherry Marts of S*Marts Consulting, to review, evaluate and provide recommendations as to the AMA Policy H-140.837, "Anti-Harassment Policy," including the investigative and disciplinary processes thereunder, as previously adopted by the House of Delegates (see Appendix A for the consultants' professional biographies). This report of the Board of Trustees summarizes the evaluation and joint recommendations provided by the consultants and recommends revisions to the procedures implementing the anti-harassment policy with respect to conduct during meetings of the House of Delegates, councils, sections, and all other AMA entities. The Board of Trustees believes that these recommendations will result in significant improvements to help ensure that AMA meetings are safe, welcoming and free of inappropriate conduct.

BACKGROUND

At the 2017 Annual Meeting, the AMA House of Delegates adopted Policy H-140.837, "Anti-Harassment Policy." The policy communicates the AMA's commitment to zero tolerance for harassing conduct at or in conjunction with AMA-sponsored meetings and events, and provides a clear definition of what constitutes harassing conduct (see Appendix B for full text). The policy was proffered by Board of Trustees Report 23-A-17, which provided that:

> Upon adoption of the Anti-Harassment Policy, the Board will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident. Additionally, the Board will consider and prepare for future consideration by the HOD, potential corrective action and/or discipline for conduct in violation of this policy, which may include, but shall not be limited to, referral of the matter to the applicable delegation, expulsion from AMA meetings, or expulsion from the HOD.

At the 2018 Annual Meeting, the Board of Trustees presented Board of Trustees Report 20-A-18, which recommended procedures to fully implement the anti-harassment policy with respect to conduct during meetings of the House of Delegates, councils, sections, and all other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards. Such recommended procedures included:

- Mechanisms by which any persons who believe they have experienced or witnessed conduct in the AMA House of Delegates or in other meetings and activities hosted by the AMA (e.g., meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards) in violation of Anti-Harassment Policy H-140.837 could promptly notify the presiding officer(s) of such AMA meeting or activity, the Chair of the Board and/or the AMA Office of General Counsel, or report such violation by means of a telephonic or online hotline (with the option to report anonymously).
- Prompt and thorough investigation of harassment complaints to be conducted by AMA Human Resources, with AMA Human Resources responsible for making determinations as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.
- The establishment of a three-member disciplinary committee comprised of the Chair of the Board of Trustees, the Immediate Past President of the AMA and the President-Elect of the AMA, to which violations of Anti-Harassment Policy H-140.837 would be referred for disciplinary and/or corrective action, including but not limited to expulsion from the relevant AMA meetings or activities and/or referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action.

At the 2018 Annual Meeting, following extensive testimony concerning the recommended procedures set forth in Board of Trustees Report 20-A-18, the AMA House of Delegates adopted *with amendment* the recommendations of the Board of Trustees as to disciplinary action. In particular, the House of Delegates modified the recommendations of the Board of Trustees whereby all violations of Anti-Harassment Policy H-140.837 would be referred immediately to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary action, rather than to the three-member disciplinary committee recommended by the Board of Trustees, as follows:

> If AMA Human Resources shall determine that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA -associated meeting or activity in which such violation occurred, as applicable, of such determination, (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with appropriate training.
>
> If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.
>
> If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.

At the 2018 Interim Meeting, CEJA presented Council on Ethical and Judicial Affairs Report 4-I-18, "CEJA Role in Implementing H-140.937, 'Anti-Harassment Policy,'" expressing concerns about the scope of responsibilities delegated to CEJA under Anti-Harassment Policy H-140.837(3),

Disciplinary Action, as modified and adopted by the House of Delegates at the 2018 Annual Meeting, and requesting that Policy H-140.837(3), Disciplinary Action, be reconsidered. The House of Delegates did not accept CEJA's recommendation, but did adopt Policy D-140.954, as noted above.

DISCUSSION

In furtherance of Policy D-140.954, two external consultants with substantial expertise in this area were immediately engaged. The purpose of engaging two separate consultants was to ensure that legal and operational points of view were both considered, and that any recommendations would reflect a common view of best practice, rather than a single evaluation. The consultants reviewed and evaluated Policy H-140.837, "Anti-Harassment Policy," and compared it to current best practices as well as policies and procedures currently in use by other membership societies. The consultants' review considered the policy in two parts – i) the anti-harassment policy itself, and ii) the procedures to implement the policy.

The consultants observed that the AMA's existing anti-harassment policy includes the critical elements of an effective policy (the first of the two parts mentioned above): a clear definition of unacceptable conduct; a clear statement of when, where, and to whom the policy applies; a statement that retaliation for reporting violations of the policy is itself a violation of the policy; and a statement that reports of violations will be kept confidential to the extent possible. Thus, the consultants were complimentary of this first portion of the policy, and recommended only modest changes (see "*Consultants' recommendations for revision of the policy,"* below). However, the consultants noted that the current policy also includes material that more properly belongs in a detailed "enforcement procedures" document, and that the implementation procedures described in the existing policy (the second of the two parts mentioned above) do not entirely reflect current best practices. The consultants therefore recommended more substantive revisions to these procedural aspects of the policy (see "*Consultant recommendations for changes to implementation and enforcement of the policy – Operational Guidelines,"* below.)

Below are the consultants' specific observations and joint recommendations.

Consultants' recommendations for revision of the policy

The consultants recommend that the name of the policy be changed to "Policy on Conduct at AMA Meetings and Events." The reasons for this recommendation are:

- It more accurately captures a comprehensive objective to promote respectful, professional, and collegial behavior at AMA meetings and events and to effectively address violations of the policy.
- It avoids confusion as to what the policy covers. Most people equate "anti-harassment" policies or trainings with anti-*sexual* harassment. Although this policy addresses sexual harassment, it is much broader in scope and includes a prohibition of harassment on the basis of characteristics other than sex or gender.

The consultants recommend that the current policy be retained, with the following additions:

- A statement that the purpose of the policy is to protect participants in AMA activities from harm
- A description of desired behavior in interactions, for example:
  - Exhibit professional, collegial behavior at all times

  - Exercise consideration and respect in your speech and actions, including while making formal presentations to attendees
  - Be mindful of one's surroundings and of fellow participants
  - Alert meeting Chair or meeting organizer of violations of the anti-harassment policy – even if they seem inconsequential
- A statement about potential consequences for violation of the policy. For example: If a participant engages in unacceptable behavior at an AMA meeting or event, AMA reserves the right to take any action deemed appropriate based on the outcome of the incident investigation(s). This action may include but is not limited to:
  - Removing the violator from the AMA event or activity, without warning or refund;
  - Prohibiting the violator from attending future AMA events or activities;
  - Removing the violator from leadership or other roles in AMA activities;
  - Prohibiting the violator from assuming a future leadership or other role in AMA activities;
  - Revoking the violator's membership in the AMA, following the CEJA processes for taking such an action;
  - Notifying the violator's employer of the actions taken by AMA; and/or
  - Notifying law enforcement.

The consultants recommend the implementation of processes and tactics to help ensure that attendees of AMA meetings and events are made aware of the policy and consequences for violations of the policy, and mechanisms by which attendees affirmatively acknowledge and assent to the policy.

The consultants recommend that the sections of the policy beginning with "1. Reporting a complaint of harassment" through "3. Disciplinary Action" be replaced with Operational Guidelines as described below.

Consultant recommendations for changes to implementation and enforcement of the policy – Operational Guidelines

The current policy includes detailed procedures for reporting, investigation, and enforcement of the policy. However, the procedures described in the policy do not entirely reflect current best practices in implementation and enforcement of such a policy. In addition, implementation of these procedures would be cumbersome and unlikely to bring about the desired outcome of making AMA meetings and events safer and more welcoming to all participants.

Current best practices for implementation and enforcement include:

1. Ensuring awareness, acknowledgement and acceptance of the policy by meeting/event participants
2. Simple and straightforward ways to report violations of the policy at the time of (or very close in time to) the incident in question.
3. Independence and neutrality in investigation of violations of the policy.
4. Avoidance of even the appearance of conflicts of interest in decisions on consequences for violations of the policy.
5. Assurance that all reports of violation and the outcomes of investigations will be reported to the organization's counsel.
6. Assurance that reports, investigations, and outcomes will be kept confidential to the fullest extent possible, consistent with usual business practices.

The consultants further recommend that the policy be amended to reflect the need for flexibility in procedures for receiving reports, investigating incidents, and making decisions on consequences. This flexibility is necessary because of the wide range of meetings and activities covered by the policy, including consideration of the purpose, size and duration of meetings and activities.

Specifically, the consultants recommend adoption of the following operational guidelines for reporting, investigation, and enforcement of the policy.

Violation Reporting Procedures

In order to encourage individuals who are targets of harassment to report incidents, it is important to have a simple, straightforward, and easily publicized reporting mechanism. Ideally, reports should be taken and investigated by a single individual who is unlikely to face conflicts of interest in this role.

The consultants recommend that the AMA bring in an independent consultant to act as the Conduct Liaison for larger meetings and events. This should be someone who is trained and experienced in handling incidents of harassment and bullying. The Conduct Liaison should be the primary point of contact for event participants to report violations of the policy, and responsible for any on-site investigations of those violations. The Conduct Liaison should provide recommendations for immediate action to the Event Chair or other senior designated AMA officer or representative involved in the AMA meeting in question, and should provide a formal report with recommendations for any further action to the Committee on Conduct at AMA Meetings and Events (CCAM, see below). All reported violations of the policy, and the outcomes of investigations by the Conduct Liaison, should be provided to the Office of General Counsel.

For smaller meetings, the role of the Conduct Liaison may be assumed by an individual designated by the AMA Office of General Counsel and trained in advance of assuming such role, who may or may not be physically on-site at the meeting. If not on-site, the Conduct Liaison should be on-call.

The consultants recommend retaining the requirement for a reporting hotline in addition to the Conduct Liaison, which will be an alternative source for meeting attendees to lodge complaints regarding conduct at meetings.

Investigation of Incidents

Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event in order to provide recommendations for action to the CCAM.

Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator.

Committee on Conduct at AMA Meetings and Events (CCAM)

The consultants recommend the establishment of a Committee on Conduct at AMA Meetings and Events (CCAM), to include 5-7 members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The consultants recommend that the CCAM should include one member of the

Women Physicians Section (WPS), and one member of the Council on Ethical and Judicial Affairs (CEJA). The remaining members may be appointed from AMA membership generally. Emphasis should be placed on maximizing the diversity of membership.

The consultants recommend that the CCAM receive reports on all violations of the policy arising from any AMA meeting or event. When an incident is significant enough that it requires action beyond those taken on-site at the event, the CCAM reviews the incident reports, performs further investigation if needed, and makes recommendations regarding further commensurate sanctions to the Office of General Counsel and to the appropriate AMA body (e.g., meeting or event organizers, appropriate AMA staff, and/or CEJA).

To prevent possible retaliatory action against CCAM members, all proceedings of the CCAM should be kept as confidential as practicable.

CONCLUSION

As noted above, consultants engaged by the AMA in furtherance of Policy D-140.954 have reviewed and evaluated the AMA's current Anti-Harassment Policy (Policy H-140.837) and confirmed that this existing policy includes many of the critical elements of an effective anti-harassment policy. However, while the current policy includes detailed procedures for reporting, investigation, and enforcement, several amendments to the policy are necessary to bring it fully in line with current best practices in implementation and enforcement. The consultants suggested that implementation of the existing procedures would be cumbersome and unlikely to bring about the desired outcome of making AMA meetings and events safer and more welcoming.

The consultants have recommended modifications to ensure that the policy itself, and the procedures for reporting, investigation and enforcement of the policy, reflect current best practices. In particular, the consultants' recommended modifications are intended to ensure 1) simple ways to report violations, 2) prompt investigation and resolution of alleged violations, 3) independence and neutrality in investigation of violations, and the avoidance of conflicts of interest, and 4) flexibility in procedures for receiving reports, investigating incidents, and making decisions on consequences of the policy (recognizing the nature, number and varying size of AMA meetings conducted each year).

The Board of Trustees has carefully considered the recommendations of the consultants, and believes that these recommendations are consistent with the goals and objectives of the AMA's current Anti-Harassment Policy and will result in significant improvements to help ensure that AMA meetings and events are safe and welcoming to all participants. The Board of Trustees also believes that these recommendations are responsive to comments and concerns expressed at the 2018 Interim Meeting. Therefore, the Board of Trustees is recommending corresponding modifications to Policy H-140.837, "Anti-Harassment Policy," as set forth below.

RECOMMENDATION

The Board of Trustees recommends the following, and that the remainder of this report be filed:

1. That Policy D-140.954, "Harassment Issues Within the AMA," be rescinded as having been fulfilled by the report. (Rescind HOD Policy)

2. That Policy H-140.837, "Anti-Harassment Policy," be renamed "Policy on Conduct at AMA Meetings and Events" and further amended by insertion and deletion as follows (Modify Current HOD Policy):

~~Anti-Harassment Policy Applicable to AMA Entities~~
Policy on Conduct at AMA Meetings and Events

It is the **policy** of the American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.

~~a~~Any type of harassment of any attendee of an AMA ~~staff, fellow delegates or others by members of the House of Delegates or~~ hosted meeting, event and other ~~attendees at or in connection with HOD meetings, or otherwise~~ activity, including but not limited to dinners, receptions and social gatherings held in conjunction with ~~HOD meetings,~~ an AMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA ~~delegates and staff are conducting AMA~~ business is conducted. This zero tolerance **policy** also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events. The purpose of the policy is to protect participants in AMA-sponsored events from harm.

Definition
Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise ~~protected group status~~, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.
Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this **policy**, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and

- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any

AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

Operational Guidelines

The AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following:

1. *Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)*

   The Office of General Counsel will appoint a "Conduct Liaison" for all AMA House of Delegates meetings and all other AMA hosted meetings or activities (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports of alleged policy violations, conducting investigations, and initiating both immediate and longer-term consequences for such violations. The Conduct Liaison appointed for any meeting will have the appropriate training and experience to serve in this capacity, and may be a third party or an in-house AMA resource with assigned responsibility for this role. The Conduct Liaison will be (i) on-site at all House of Delegates meetings and other large, national AMA meetings and (ii) on call for smaller meetings and activities. Appointments of the Conduct Liaison for each meeting shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in investigation of alleged policy violations and in decisions on consequences for policy violations.

   The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA). The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.

2. *Reporting Violations of the Policy*

   Any persons who believe they have experienced or witnessed conduct in violation of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," during any AMA House of Delegates meeting or other activities associated with the AMA (such as meetings

of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel or JAMA Editorial Boards) should promptly notify the (i) Conduct Liaison appointed for such meeting, and/or (ii) the AMA Office of General Counsel and/or (iii) the presiding officer(s) of such meeting or activity.

Alternatively, violations may be reported using an AMA reporting hotline (telephone and online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will provide an option to report anonymously, in which case the name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the Conduct Liaison may investigate.

These reporting mechanisms will be publicized to ensure awareness.

3. Investigations

All reported violations of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," pursuant to Section 2 above (irrespective of the reporting mechanism used) will be investigated by the Conduct Liaison. Each reported violation will be promptly and thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event to provide recommendations for action to the CCAM. Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator.

Based on this investigation, the Conduct Liaison will determine whether a violation of the Policy on Conduct at AMA Meetings and Events has occurred.

All reported violations of the Policy on Conduct at AMA Meetings and Events, and the outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the AMA's Office of General Counsel (i.e. irrespective of whether the Conduct Liaison determines that a violation has occurred).

4. Disciplinary Action

If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison may take immediate action to protect the safety of event participants, which may include having the violator removed from the AMA meeting, event or activity, without warning or refund.

Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall report any such violation to the CCAM, together with recommendations as to whether additional commensurate disciplinary and/or corrective actions (beyond those taken on-site at the meeting, event or activity, if any) are appropriate.

The CCAM will review all incident reports, perform further investigation (if needed) and recommend to the Office of General Counsel any additional commensurate disciplinary and/or corrective action, which may include but is not limited to the following:

- Prohibiting the violator from attending future AMA events or activities;
- Removing the violator from leadership or other roles in AMA activities;
- Prohibiting the violator from assuming a leadership or other role in future AMA activities;
- Notifying the violator's employer and/or sponsoring organization of the actions taken by AMA;
- Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action;
- Referral to law enforcement.

The CCAM may, but is not required to, confer with the presiding officer(s) of applicable events activities in making its recommendations as to disciplinary and/or corrective actions. Consequence for policy violations will be commensurate with the nature of the violation(s).

5. Confidentiality

All proceedings of the CCAM should be kept as confidential as practicable. Reports, investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and Events will be kept confidential to the fullest extent possible, consistent with usual business practices.

6. Assent to Policy

As a condition of attending and participating in any meeting of the House of Delegates, or any council, section, or other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or activity, each attendee will be required to acknowledge and accept (i) AMA policies concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication and disciplinary processes for violations of such policies (including those implemented pursuant to these Operational Guidelines), and all attendees are expected to conduct themselves in accordance with these policies.

Additionally, individuals elected or appointed to a leadership role in the AMA or its affiliates will be required to acknowledge and accept the Policy on Conduct at AMA Meetings and Events and these Operational Guidelines.

~~1. Reporting a complaint of harassment~~

~~Any persons who believe they have experienced or witnessed conduct in violation of Anti-Harassment Policy H-140.837 during any AMA House of Delegates meeting or associated functions should promptly notify the Speaker or Vice Speaker of the House or the AMA Office of General Counsel.~~

~~Any persons who believe they have experienced or witnessed conduct in other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy H-140.837 should promptly notify the presiding officer(s) of such AMA-associated meeting or activity or either the Chair of the Board or the AMA Office of General Counsel.~~

~~Anyone who prefers to register a complaint to an external vendor may do so using an AMA compliance hotline (telephone and online) maintained on behalf of the AMA. The name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the AMA may investigate.~~

~~2. Investigations~~

~~Investigations of harassment complaints will be conducted by AMA Human Resources. Each complaint of harassment or retaliation shall be promptly and thoroughly investigated. Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact between the accuser and the accused during the pendency of an investigation and (b) provide the accused an opportunity to respond to allegations. Based on its investigation, AMA Human Resources will make a determination as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.~~

~~3. Disciplinary Action~~

~~If AMA Human Resources shall determine that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA-associated meeting or activity in which such violation occurred, as applicable, of such determination, (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with appropriate training.~~

~~If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.~~

~~If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.~~

~~If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the matter to appropriate AMA management, and when appropriate, may suggest that the complainant contact legal authorities.~~

~~4. Confidentiality~~

~~To the fullest extent possible, the AMA will keep complaints, investigations and resolutions confidential, consistent with usual business practice.~~

Fiscal note: $75,000-$100,000 for Conduct Liaison fees and travel expenses, as well as potential meeting costs for the Committee on Conduct at AMA Meetings and Events.

APPENDIX A

Biographies

AMY L. BESS, J.D. has practiced in the area of employment defense for more than thirty years and currently serves as Chair of the global Labor and Employment practice group for Vedder Price and is a member of firm's Board of Directors.

Her employment litigation experience includes the representation of employers before U.S. state and federal courts and administrative agencies, defending against claims of race, sex, disability and age discrimination; sexual harassment; whistleblower retaliation; restrictive-covenant disputes; wrongful termination; and wage and hour violations. She regularly counsels clients in all of these areas, drafts and negotiates employment and severance agreements, conducts on-site workplace investigations, presents training seminars and speaks to employer groups on avoiding workplace problems. Ms. Bess is an author and frequent speaker on a variety of employment topics, most notably on the impact of the #MeToo movement and anti-harassment laws and best practices organizations should undertake to prevent and resolve harassment concerns. She is regularly quoted in the media on these and related topics.

Select Publications

"A Four-Part Series: Addressing Sexual Harassment in the #MeToo Era" ("Best Practices for Investigating Allegations", "The Rights of the Alleged Harasser", "The Superstar Harasser–Is Anyone Really Too Big to Lose?" and "The Same Old Workplace Training Won't Cut It") *Corporate Compliance Insights*, February 8, March 28, May 4 and June 21, 2018

"Oops, He (or She) Did It Again! Implementing a Best-In-Class Harassment-Free Workplace Program to Help Your Company Stay Out of the Headlines" *Employee Relations Law Journal*, Winter 2017

"Gender Identity Discrimination Claims on the Rise at State and Federal Levels" *The National Law Review*, March 3, 2016

Select Speaking Engagements

Conference Co-Chair/Moderator, "Employment Law Lessons Learned from Recent Scandals" PLI Employment Law Institute 2018, October 2018, New York, NY

"Vedder Talk: Lessons Learned from the #MeToo Movement" 2018 Vedder Works Employment Law Series, October 2018, Washington, D.C.

"Advising Clients on Sexual Harassment Law in the #MeToo Era" DC Bar, July 12, 2018

"Harassment in the Workplace, Part 2 - Community and Resources: Hearing Voices & Exploring Conversation Strategies" American Institute of Architects Conference on Architecture 2018, June 23, 2018, New York, NY

"Employee Relations in the #MeToo Era: Creating a Culture of Respect" 2018 Vedder Works Employment Law Series: April 24, Chicago, IL and June 1, Chicago–O'Hare, IL, June 14, New York, NY

"Sexual Harassment: Lessons Learned from Recent Scandals" PLI Sexual Harassment Webcast, November 2017

"Conducting and Documenting Investigations and Termination Actions" 2014 Vedder Price Employment Law Update: Rosemont, IL

SHERRY A. MARTS, PH.D., CEO of S*Marts Consulting LLC, is a former association CEO with a wide-ranging background in biomedical research, nonprofit management, public education, and research advocacy, Sherry provides expert consulting services to nonprofits and academic institutions on diversity and inclusion, harassment and bullying, and interpersonal communication. Her work includes a particular focus on harassment and bullying at professional society meetings and conferences. She provides training for society and association staff on how to implement and enforce meeting codes of conduct. She also leads workshops on active bystander intervention, harassment resistance, and ally skills. Her interest in the issue of harassment and bullying lies at the intersection of her professional life as a woman in science, and her previous experience as a women's self-defense instructor.

Sherry is the recipient of the 2018 MIT Media Lab Disobedience Award.

Select Publications

"Open Secrets and Missing Stairs: Sexual and Gender-Based Harassment at Scientific Meetings," available at http://bit.ly/osmspdf

"Include is a Verb: Moving from Talk to Action on Diversity and Inclusion," available at http://bit.ly/2peWwP0

"The Book of How: Answers to Life's Most Important Question."

Dr. Marts received her B.Sc. (Hons.) in Applied Biology from the University of Hertfordshire, and her Ph.D. in Physiology from Duke University.

APPENDIX B

AMA Policy H-140.837, "Anti-Harassment Policy"

1. Our AMA adopts the following policy:

Anti-Harassment Policy Applicable to AMA Entities
It is the policy of the American Medical Association that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings, or otherwise, including but not limited to dinners, receptions and social gatherings held in conjunction with HOD meetings, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events.

Definition
Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment
Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each

complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

2. Our AMA's Board of Trustees will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident; and consider and prepare for future consideration by the House of Delegates, potential corrective action and/or discipline for conduct in violation of this policy, with report back at the 2017 Interim Meeting.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(A-19)

Introduced by: Illinois

Subject: Engage and Collaborate with The Joint Commission

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, The Joint Commission's stated mission is "to continuously improve health care for the public in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value"; and

Whereas, The Joint Commission accredits a large number of hospitals in the United States; and

Whereas, Joint Commission standards established in 2000 prioritized pain management (including chronic non-cancer pain) guidelines over the root causes of pain [1]; and

Whereas, The manufacturer of OxyContin is believed to have provided funding for the Joint Commission's pain management educational programs during the time that these standards were developed; and

Whereas, As a result of these pain standards, the increased use of opioids may have been indirectly encouraged as a way to comply with the guidelines, even though there was little evidence or validation to support the long-term use of narcotics to treat chronic, non-cancer pain; and

Whereas, A very recent Cochrane Review [2] concluded that there is a "paucity of high-quality controlled evaluations of the effectiveness and the cost-effectiveness of external inspection systems"; and

Whereas, Another systematic review [3] came to a similar conclusion, stating that their "review did not find evidence to support accreditation and certification of hospitals being linked to measureable changes in quality of care"; therefore be it

RESOLVED, That our American Medical Association study and report back on any potential impact, influence, or conflicts of interest related to unrestricted grants from pharmaceutical and medical device manufacturers on the development of Joint Commission accreditation standards (especially those that relate to medical prescribing, procedures, and clinical care by licensed physicians). (Directive to Take Action)

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

Received: 04/25/19

References:

1. Phillips DM. JCAHO Pain Management Standards are Unveiled. JAMA. 2000; 284(4):428-429.
2. Flodgren G, Goncalves-Bradley DC, Pomey MP. External inspection of compliance with standards for improved healthcare outcomes. Cochrane Database Syst Rev. 2016, Dec 2; 12. CD008992; doi:10.1002/14651858.CD008992.pub3.
3. Brubakk K, Vist GE, Bukholm G, et al. A systematic review of hospital accreditation: the challenges of measuring complex intervention effects. BMC Health Services Research. 2015; 15:280-290.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 612
(A-19)

Introduced by: New Mexico

Subject: Request to AMA for Training in Health Policy and Health Law

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, Healthcare in the United States is being largely managed and reshaped by hospital administrators, consultants and politicians, with relatively little substantive input from physicians; and

Whereas, Physicians who care for patients understand better than anyone the ways in which our healthcare system is broken and needs to be improved; and

Whereas, Dysfunction of our healthcare system and lack of opportunities for physicians to have a meaningful voice in bringing about needed changes, are significant contributing factors to physician dissatisfaction, frustration and burnout; and

Whereas, Physicians are disadvantaged by the lack of easily available education in health policy and health law, essential skills for navigating barriers and effecting change; and

Whereas, Existing fellowships in health policy and health law offered by outside organizations tend to promote the values and priorities of those organizations; therefore be it

RESOLVED, That our American Medical Association offer its members training in health policy and health law, and develop a fellowship in health policy and health law. (Directive to Take Action)

Fiscal Note: Estimated cost of $200,000 to implement resolution.

Received: 05/09/19

REPORT 15 OF THE BOARD OF TRUSTEES (A-19)
Physician Burnout and Wellness Challenges
Physician and Physician Assistant Safety Net
Identification and Reduction of Physician Demoralization
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2017 Interim Meeting, three resolutions (601-I-17, "Physician Burnout and Wellness Challenges," 604-I-17, "Physician and Physician Assistant Safety Net," and 605-I-17, "Identification and Reduction of Physician Demoralization") with shared components of a central issue were referred for report back together at the 2018 Annual Meeting and presented in BOT Report 31-A-18. Based on testimony in Reference Committee G asking for further clarifications, BOT 31-A-18 was referred back for a report at the 2019 Annual Meeting.

The AMA is committed to addressing the issues of physician, resident, and medical student burnout, stress and suicide. This report addresses the overarching topic, each resolution as it relates to the issue, and the concerns raised at the 2018 Annual Meeting.

This report discusses the numerous efforts underway at the AMA to help identify and provide solutions to the issue and presents recommendations to amend existing HOD Policy related to the issues discussed throughout the report.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-A-19

Subject:	Physician Burnout and Wellness Challenges (Resolution 601-I-17); Physician and Physician Assistant Safety Net (Resolution 604-I-17); Identification and Reduction of Physician Demoralization (Resolution 605-I-17)
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee G (Rodney Trytko, MD, Chair)

INTRODUCTION

At the 2017 Interim Meeting, three resolutions (601-I-17, "Physician Burnout and Wellness Challenges," 604-I-17, "Physician and Physician Assistant Safety Net," and 605-I-17, "Identification and Reduction of Physician Demoralization") with shared components of a central issue were referred for report back together at the 2018 Annual Meeting and presented in BOT Report 31-A-18. Based on testimony in Reference Committee G asking for further clarifications, BOT 31-A-18 was referred back for a report at the 2019 Annual Meeting. This report addresses the overarching topic, each resolution as it relates to the issue, and the concerns raised at the 2018 Annual Meeting, and presents recommendations accordingly.

Resolution 601-I-17, "Physician Burnout and Wellness Challenges," was introduced by the International Medical Graduates Section and the American Association of Physicians of Indian Origin. Resolution 601-I-17 asks the American Medical Association (AMA) to advocate for health care organizations to develop a wellness plan to prevent and combat physician burnout and improve physician wellness, and for state and county medical societies to implement wellness programs to prevent and combat physician burnout and improve physician wellness.

Resolution 604-I-17, "Physician and Physician Assistant Safety Net," was introduced by the Oregon Delegation and asks the AMA to study a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Such safety net services would be provided by doctorate level mental health clinicians experienced in treating physicians. Resolution 604-I-17 also directs the AMA to advocate that funding for such safety net programs be sought from such entities as foundations, hospital systems, medical clinics, and donations from physicians and physician assistants.

Resolution 605-I-17, "Identification and Reduction of Physician Demoralization," was introduced by the Organized Medical Staff Section and asks that the AMA: (1) recognize that physician demoralization, defined as a consequence of externally imposed occupational stresses, including but not limited to electronic health record (EHR)-related and administrative burdens imposed by health systems or by regulatory agencies, is a problem among medical staffs; (2) advocate that hospitals be required by accrediting organizations to confidentially survey physicians to identify factors that may lead to physician demoralization; and (3) develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff wellness.

BACKGROUND

Today's physicians are experiencing burnout at increasing rates, expressing feelings of professional demoralization, and feeling professionally under-valued and overburdened by an ever-changing health care system.[1-3] Forty-four percent of practicing physicians report experiencing at least one symptom of burnout, compared to 54 percent in 2014 and 45 percent in 2011.[4] Practicing physicians are not alone in reported symptoms of burnout; resident and medical student burnout is also on the rise. It is recognized that with growing numbers of physicians, residents and medical students experiencing burnout, health care quality will decline and patient safety will suffer.[5] Physician suicide rates have been found to be historically higher than the general population.[6] Stress, depression and burnout can lead to suicidal ideation and sometimes suicide. Resources such as safety nets and hotlines are available for individuals experiencing suicidal ideation and are available from a number of national and reputable sources.

AMA POLICY

The AMA recognizes the importance of addressing and supporting physician satisfaction as well as the impact physician burnout may have on patient safety, health outcomes and overall costs of health care. This commitment to physician satisfaction and well-being is evidenced by AMA's ongoing development of targeted policies and tools to help physicians, residents and medical students, and its recognition of professional satisfaction and practice sustainability as one of its three strategic pillars.

The AMA supports programs to assist physicians in early identification and management of stress. The programs supported by the AMA concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, as well as when to seek professional assistance for stress-related difficulties (Policy H-405.957, "Programs on Managing Physician Stress and Burnout"). AMA policy and the Code of Ethics acknowledge that when physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided (Code of Ethics 9.3.1, "Physician Health & Wellness"). In recognizing the importance of access to health and wellness-focused resources, AMA policy encourages employers to provide, and employees to participate in, programs on health awareness, safety and the use of health care benefit packages (Policy H-170.986, "Health Information and Education"). The AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness (Policy H-405.961, "Physician Health Programs").

Educating physicians about physician health programs is greatly important to the AMA. The AMA will continue to work closely with the Federation of State Physician Health Programs (FSPHP) to educate its members about the availability of services provided by state physician health programs to ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory. The AMA, in collaboration with the FSPHP, develops state legislative guidelines to address the design and implementation of physician health programs, as well as messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training (Policy D-405.990, "Educating Physicians About Physician Health Programs"). The AMA will continue to collaborate with other relevant organizations on activities that address physician health and wellness.

The AMA recognizes physical or mental health conditions that interfere with a physician's ability to engage safely in professional activities can put patients at risk, compromise professional relationships and undermine trust in medicine. While protecting patients' well-being must always be the primary consideration, physicians who are impaired are deserving of thoughtful, compassionate care (Code of Ethics 9.3.2, "Physician Responsibilities to Impaired Colleagues"). AMA policy defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities. In the same policy, the AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians and to develop case finding mechanisms for all types of physicians (Policy H-95.955, "Physician Impairment").

Access to confidential health services for medical students and physicians is encouraged by the AMA to provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services. The AMA will continue to urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or re-licensure who are undergoing treatment for mental health or addiction issues to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety. The AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would: (a) be available to all medical students on an opt-out basis; (b) ensure anonymity, confidentiality, and protection from administrative action; (c) provide proactive intervention for identified at-risk students by mental health and addiction professionals; and (d) inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation. The AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and, (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior. The AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education (Policy H-295.858, "Access to Confidential Health Services for Medical Students and Physicians").

The AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem not only with practicing physicians, but among residents, fellows, and medical students. The AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment and prevention of burnout) through appropriate media outlets. In addition, the AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students. The AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community. Finally, the AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and

changes in accreditation requirements (Policy D-310.968, "Physician and Medical Student Burnout").

DISCUSSION

The AMA is committed to upholding the tenets of the Quadruple Aim: Better Patient Experience, Better Population Health, Lower Overall Costs of Health Care, and Improved Professional Satisfaction.[7] This is evidenced by AMA policy supporting the Triple Aim and requesting that it be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers (Policy H-405.955, "Support for the Quadruple Aim"). In order to achieve the fourth aim, the AMA acknowledges that interventions at both system and individual levels are necessary for enhancing physician satisfaction and reducing burnout.

The AMA partnered with the RAND Corporation in 2013 to identify and study the factors that influence physician professional satisfaction, as well as understand the implications of these factors for patient care, health systems, and health policy.[8] This seminal work informed subsequent initiatives and a long-term strategy for AMA's Professional Satisfaction and Practice Sustainability (PS2) unit. This dedicated AMA unit is focused on institutional and system-level solutions that aim to resolve root causes of burnout and demoralization, rather than solely focusing on improving individual resilience to alleviate symptoms experienced by dealing with a dysfunctional health system.

Through the PS2 unit, the AMA supports and carries out research efforts aimed at understanding and identifying solutions to the system-level issues that lead to physician demoralization and burnout. In 2017 and 2018 the AMA partnered with leading academic institutions to conduct follow-up research to its 2011 and 2014 national studies on physician burnout and satisfaction, seeking to learn if the rates of burnout have changed over the past 7 years.[9] The AMA has studied how physicians spend their time to quantify the administrative burdens during and after a physicians' workday.[10] The AMA has also completed significant research on the burdens of EHRs, including the time to complete tasks, the usability of products, and the process of EHR development.[11, 12] Furthermore, the AMA has researched the impacts of physician burnout, including the effects on a physician's innate sense of calling[13] and implications for the physician workforce.[14] All of this research has been published in leading peer-reviewed journals to build the evidence base for the factors that cause physician dissatisfaction and burnout and their impacts. This body of knowledge has been a powerful tool for advocating to legislators, regulators, and industry executives to make improvements to address the issues that cause physician dissatisfaction.

The AMA continues to convene members of the research community at the bi-annual American Conference on Physician Health and International Conference on Physician Health. To provide hands-on, real-world demonstration of practice-level solutions, the AMA hosts boot camps that help physicians learn how to plan and implement effective strategies to improve their practice to reduce the amount of time they spend on administrative and clerical work, ultimately improving physician satisfaction and reducing reports of burnout.

A number of key accomplishments and offerings have been realized through AMA's launch of the free, online STEPS Forward™ practice transformation platform. This online resource offers over 50 modules of content developed by subject matter experts and is specifically designed for physicians, practices, and health systems. The STEPS Forward platform has been openly shared with leadership of many state and specialty societies, as well as presented to their memberships in various forums. In addition, the AMA has partnered with health systems, large practices, state

medical societies, state hospital associations and graduate medical education programs to deploy and assess physician burnout utilizing the Mini-Z Burnout Assessment. The assessment offers organizations a validated instrument that provides an organizational score for burnout, along with two subscale measures for "Supportive Work Environment" and "Work Pace and EMR Frustration." In addition to the organizational dashboard, the assessment is able to provide a comprehensive data analysis complete with medical specialty and clinic level benchmarking. The trends and findings from the assessment are shared and targeted interventions are recommended to the surveying organization. The interventions and suggested solutions are curated from existing STEPS Forward content and through specific best practices identified through AMA collaborators.

The AMA is also developing the AMA Practice Transformation Initiative: Solutions to Increase Joy in Medicine. This initiative will support research to advance evidence-based solutions and engage health care leaders to improve joy in medicine through the use of validated assessment tools, a centralized, integrated data lab, grant-funded practice science research, and field-tested information dissemination and implementation support. It will build the evidence base for private and public investment in clinician well-being as a means of achieving the Quadruple Aim. The focus of the AMA Practice Transformation Initiative is distinct from and complementary to other national initiatives addressing clinician well-being. For example, the work of the National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience is focused on building awareness. This AMA initiative will move beyond awareness to filling the knowledge gaps that exist regarding effective systemic interventions to reduce burnout. In a similar manner, the 1999 Institute of Medicine (now renamed the National Academy of Medicine) report "To Err is Human" raised awareness of patient safety issues. It was then up to other organizations to build further evidence and disseminate effective interventions. In this vein, the AMA Practice Transformation Initiative will be positioned to lead the medical community in building momentum and disseminating evidence-based solutions to reduce burnout and improve satisfaction. This effort is currently in the pilot phase with broader expansion planned for mid- to late-2019.

Resolution 601-I-17 asks the AMA to advocate for health care organizations to develop a wellness plan to prevent and combat physician burnout and improve physician wellness, and for state and county medical societies to implement wellness programs to prevent and combat physician burnout and improve physician wellness. In addition to HOD policy that affirms the importance of physician health and education about wellness, the AMA has been actively and directly engaged with health care organizations, including state and county medical societies, to build awareness and support for addressing physician burnout. The Physicians Foundation funded an effort to develop a manual on how to create a Physician Wellness Program (PWP) for medical societies called LifeBridge. In addition to a toolkit, the manual includes research and background supporting the need for such a program. Having medical societies provide local, onsite counseling is the cornerstone of the program, in addition to including other aspects of physician wellness resources such as professional coaching, educational topics, resource centers, and ways to address health system barriers and advocate for employer change. With this resource, numerous state and county medical societies are developing and launching physician wellness programs with in-person support. Hundreds of physicians have accessed these resources to date.

The mission of the Federation of State Physician Health Programs (FSPHP) is to support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care. One of FSPHP's top priorities is the development of a Performance Enhancement and Effectiveness Review program called PEER™. The goal of PEER is to empower physician health programs (PHPs) to optimize effectiveness. At the same time, they are developing a Provider Accreditation program that will accredit specialized treatment centers and other providers in the care of physicians and other safety-sensitive professionals. These programs will ensure quality care

and ensure PHPs select providers that have proven compliance with objective standards. The AMA has provided grant funding toward this new effort and has provided a designee to serve on FSPHP's Accreditation Review Council (ARC) that will oversee the strategy and policies of the developing PEER program.

Concerns have been raised that physicians who access wellness programs may be stigmatized if they report feelings of demoralization or burnout. This could subject a physician to loss of employment or to state medical licensing board actions, including loss of license. It is imperative that strategies be developed by state medical associations to encourage physicians to participate in health programs without fear of loss of license or employment. Assuring that de-stigmatization of physician burnout is addressed at the local, state and national levels is an important first step in ensuring those who need support can receive it without fear of adverse consequences.

Resolution 604-I-17 asks the AMA to study a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Testimony heard in the reference committee hearing further clarified the request for a task force to research, collect, publish and administer a repository of information about programs and strategies that optimize physician wellness. The AMA, through its ongoing work in the Professional Satisfaction and Practice Sustainability (PS2) strategy unit, acknowledges the importance of addressing and supporting physician mental health and has developed and published numerous resources to help physicians manage stress and prevent and reduce burnout. Since its inception in 2011, the activities have been aided by a PS2 Advisory Committee composed of a diverse membership representing the AMA physician membership as well as the business of medicine. Meeting quarterly, the PS2 Advisory Committee provides strategic insight and direct feedback to the PS2 staff on activities ranging from practice transformation and burnout to digital health, payment and quality. The composition of the PS2 Advisory Committee ensures the committee provides content expertise in the subject matter areas on which the PS2 group focuses.

While an online search indicates there is no current, easily identifiable suicide prevention line exclusively for physicians or health care workers, there are many national, state and locally operated hotlines available that are open to all individuals regardless of profession. A list of many of these resources is available in the STEPS Forward module "Preventing Physician Distress and Suicide." The AMA is evaluating Employee Assistance Program (EAP) service providers to explore the option of piloting a service to AMA members as a membership benefit. Some EAP services provide participants with 24/7 telephone or video access to qualified and trained counselors, wellness services, and critical incident support. This evaluation is in early stages and a decision to pursue various options will be considered. In addition, the AMA will continue to update the list of available suicide prevention resources in its related STEPS Forward module.

The AMA is also developing a dynamic education module that will help physicians, physicians in training, and medical students learn about the risks of suicide for physicians, identify characteristics to look for in patients who may be at risk of harming themselves, and recognize the warning signs of potential suicide risk in colleagues. The module, to be offered with continuing medical education credit on the AMA's Education Center, will also provide tools and resources to guide learners in supporting patients and colleagues at risk for suicide.

In addition, the AMA regularly reviews and updates relevant modules of the STEPS Forward program and identifies validated student-focused, high-quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students. In addition to the "Preventing Physician Distress and Suicide" module, the STEPS Forward platform provides other relevant modules to address

physician well-being, specifically “Improving Physician Resiliency” and “Physician Wellness: Preventing Resident and Fellow Burnout.” In conjunction with STEPS Forward modules, the Mini-Z Burnout Assessments provide organizations the option to embed the PHQ-2 Depression Screening Tool. This allows organizations to gain a deeper understanding of those physicians experiencing more severe levels of depression and disinterest and correlate those responses to burnout. The survey also offers a free text section for physicians in need of services to self-identify and receive direct outreach and support. Additionally, the Mini-Z tool provides information on the National Suicide Prevention Lifeline for organizations to utilize in their physician wellness and burnout efforts.

Current efforts and strategic priorities demonstrate that the AMA recognizes the importance of assessment and attention to depression in physicians, residents and medical students, as well as the relationship that depression can have with suicidal ideation. Current AMA research and strategic initiatives are focused on enhancing workflows within the system and clinical setting with the intent to increase efficiency and reduce feelings of burnout among physicians. The AMA’s role in sharing burnout and depression screening data is to assist physician employers in understanding individual physician burnout and connecting physicians with employee assistance resources. Considering the AMA’s current efforts and ongoing commitment to providing resources on the topics of burnout, distress and suicide prevention, stress reduction, and wellness, convening an exclusive task force separate from the AMA staff already dedicated to this work would be duplicative. Making existing relevant AMA resources available to physicians seeking help can be accomplished and is part of current AMA practices. The AMA will continue to direct physicians to its current resources and those that are being developed by state and county medical associations to learn about strategies, programs and tools related to this topic, and will further explore options for providing more direct assistance for physicians in need.

Feedback from the reference committee at A-18 expressed concern about the earlier report’s lack of proposals for prevention and treatment programs to address physician burnout. By its current policies, through the work of AMA business units, and in the Code of Medical Ethics, the AMA recognizes the importance of programs that prevent and treat stress, depression and other conditions that can lead to burnout. We also realize that the AMA is not a direct provider of health care services; however, the AMA supports and will continue to encourage the development of and participation in programs to assist physicians in early identification and management of stress, burnout and demoralization.

Resolution 605-I-17 asks the AMA to (1) recognize that physician demoralization is a problem among medical staffs; (2) advocate that hospitals be required by accrediting organizations to confidentially survey physicians to identify factors that may lead to physician demoralization; and (3) develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff wellness. Testimony in the reference committee hearing recognized that “burnout” is a commonly used term favored by many physicians, and while there is some preference for the use of another term instead of “burnout,” there was no consensus on what that term should be. The AMA recognizes that burnout is characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness. These feelings can result from a multitude of driving factors, such as administrative burden, excessive EHR documentation and systemic cultural deficiencies. The term “burnout” is often used to encompass the multiple driving factors of physician dissatisfaction as well as the resultant feelings and behaviors associated with being overworked, excessively scrutinized and overburdened with unnecessary tasks. As the term “burnout” is used broadly, this allows for many variations in the interpretation of its meaning. The AMA does not define the term “burnout” as an individual “resilience deficiency” or character flaw.

The AMA supports and voices a position that burnout is derived from system and environmental issues, not from the individual physician. In other words, physician burnout is a symptom of system dysfunction. This position is evidenced by AMA resources and services targeted at system-level approaches to intervention.

The AMA has numerous efforts underway to address the system-driven sources of physician demoralization and burnout, such as the increasing volume of administrative requirements like quality reporting and prior authorization, the lack of transparency and interoperability with EHRs, and the complex and ever-changing payment environment. The AMA, as part of its prior authorization reform initiatives, convened a workgroup of 17 state and specialty medical societies, national provider associations and patient representatives to develop a set of Prior Authorization Principles. The AMA has used these principles to spur conversations with health plans about "right-sizing" prior authorization programs. One outcome of these discussions was the January 2018 release of the Consensus Statement on Improving the Prior Authorization Process by the AMA, American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association. The consensus document reflects an agreement between national associations representing both providers and health plans on the need to reform prior authorization programs in multiple ways, including advancing automation to improve transparency and efficiency. The AMA, in addition to providing an evidence-base demonstrating the need for prior authorization reform, offers multiple resources to help physicians understand prior authorization laws and improve processes within the practice.

It is well-documented that the use of EHRs is a source of dissatisfaction for physicians. The AMA's research includes multiple time-motion studies to determine how much and in what ways physicians spend time completing tasks in their EHRs. This research demonstrates evidence highlighting the need for system-level changes in the demands placed on the EHR as a tool for reporting and patient care. The AMA has also published eight EHR usability priorities, which outline and support the need for better usability, interoperability, and access to data for both physicians and patients. If followed, these priorities will enable the development of higher-functioning, more efficient EHRs, contributing to a reduction in the burden that EHR use places on patient care. Multiple collaborations are in place to help foster better EHR design and innovative HIT solutions to help make the EHR user experience better and more efficient. The AMA has established partnerships with the SMART Initiative, AmericanEHR Partners and Medstar Health's National Center for Human Factors in Healthcare to help foster innovative HIT design and transparent testing solutions which will ensure EHRs are designed and implemented with physicians and patients in mind. In addition, the AMA actively participates in The Sequoia Project, Carequality, and the CARIN Alliance, all aimed at enhancing interoperability in health care. The AMA is also working to address specific cost drivers, such as connecting to clinical data registries and prohibitive fees that amount to data blocking. The AMA's Physician Innovation Network is connecting physicians and health care technology entrepreneurs to ensure that the physician voice is integrated into health care technology solutions coming to market. Finally, the AMA is working with other high-profile stakeholders, including five EHR vendors, to develop a Voluntary EHR Certification framework which will help catalyze an industry wide shift to higher-quality EHR systems that enable better, more efficient use.

Another source of discontent for physicians are the myriad changes in payment models and quality reporting requirements facing practices. The AMA recently published a follow-up study to its 2014-2015 RAND research on the effects of payment models on physician practices in the U.S. The findings of the 2017-2018 study help the AMA, other industry stakeholders, and policymakers understand that the challenges experienced in practice due system complexity continue, and much

improvement is still needed. To help physicians and practices navigate these challenges, particularly those spurred by the MACRA Quality Payment Program, the AMA offers a variety of educational resources and practical tools, including step-by-step tutorials on QPP reporting, a MIPS Action Plan, and several others. Additional resources are in development to help physicians navigate the changing payment system that is increasingly putting an emphasis on cost and quality measurement.

Physicians who work irregular or long hours, or physicians in certain specialties, may experience a lack of work-life balance, which can further exacerbate burnout and professional dissatisfaction.[15] Forty percent of physicians report not feeling that their work schedule leaves enough time for personal and/or family life.[9] Furthermore, female physicians are more likely to be dissatisfied with work-life balance.[15] To help physicians improve work-life balance, the AMA Women Physicians Section is working together with the American Academy of Pediatrics to explore the workforce issues and help physicians find practice options that work best for them and their families. For example, a physician may consider reducing work hours to accommodate their schedule. The AMA provides a self-assessment tool that helps physicians explore work/practice options and address career goals. The AMA hosts a series of educational resources that offer strategies on how to increase practice efficiency, understand physician burnout and how to address it, as well as develop a culture that supports physician well-being. Examples of education include online CME modules: "Creating the Organizational Foundation for Joy in Medicine™: Organizational changes lead to physician satisfaction," "Creating Strong Team Culture: Evaluate and improve team culture in your practice," "Physician Wellness: Preventing Resident and Fellow Burnout," "Preventing Physician Burnout: Improve patient satisfaction, quality outcomes and provider recruitment and retention," and "Improving Physician Resiliency: Foster self-care and protect against burnout."

In addition, the AMA will continue to advocate for organizations to confidentially survey physicians to understand local levels of burnout and opportunities for strategic improvement. It should be noted that the AMA's Mini-Z Burnout Assessment is deployed confidentially and takes protective safeguards very seriously to ensure accurate and safe reporting of results. To date, numerous health systems, physician practices, and residency programs have completed AMA's burnout measurement program. This program will continue to be marketed and scaled to expand the use of measuring physician dissatisfaction and burnout. Through leveraging ongoing AMA media channels, hosting educational webinars, live speaking engagements, and the Transforming Clinical Practices Initiative (TCPI) grant through the Centers for Medicare and Medicaid Services (CMS), the AMA is striving to scale awareness and intervention to advance physician satisfaction and help address the burnout epidemic.

CONCLUSION

The AMA is committed to addressing the issue of burnout and enhancing joy in practice for physicians, residents and medical students. The AMA will continue its focus on research, advocacy and activation to address the issues presented in each of the resolutions discussed herein. The AMA will continue to work diligently to address the issues through its existing work, partnerships, resource development and policies. We present the following recommendation to not only emphasize the work already being done, but also to further address the issues brought forth in these three resolutions.

RECOMMENDATIONS

The AMA Board of Trustees recommends that the following recommendations be adopted in lieu of Resolutions 601-I-17, 604-I-17 and 605-I-17, and that the remainder of the report be filed:

1. That our American Medical Association reaffirm the following policies:
    1. H-170.986, "Health Information and Education"
    2. H-405.957, "Programs on Managing Physician Stress and Burnout;"
    3. H-405.961, "Physician Health Programs;"
    4. D-405.990, "Educating Physicians About Physician Health Programs;"
    5. H-95.955, "Physician Impairment;" and
    6. H-295.858, "Access to Confidential Health Services for Medical Students and Physicians." (Reaffirm HOD Policy)

2. That our American Medical Association amend existing Policy H-405.961, "Physician Health Programs," to add the following directive (Modify Current HOD Policy):

    1. Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.
    2. Our AMA encourages state medical societies to collaborate with the state medical boards to a) develop strategies to destigmatize physician burnout, and b) encourage physicians to participate in the state's physician health program without fear of loss of license or employment.

3. That our AMA amend existing Policy D-310.968, "Physician and Medical Student Burnout," to add the following directives (Modify Current HOD Policy):

    1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.

    2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.

    3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.

    4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.

    5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

    6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify factors that may lead to physician demoralization.

8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.

9. Our AMA will continue to (1) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (2) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.

Fiscal note: Minimal – Less than $500

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REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
Hospital Consolidation
(Resolution 235-A-18)
(Reference Committee G)

EXECUTIVE SUMMARY

Most hospital markets are highly concentrated, largely due to consolidation. This report describes horizontal and vertical hospital consolidation and potential consequences for physicians and patients in highly concentrated hospital markets (e.g., increased prices, reduced choice, and fewer physician practice options).

Because hospital markets are predominantly local, states play a significant role in regulating them. States have their own antitrust laws, and state attorneys general and other regulators have access to the local market-level data needed to oversee and challenge proposed mergers in their states. In addition to challenging hospital mergers outright, state strategies to address consolidation include all-payer rate setting for hospitals (Maryland, Pennsylvania and Vermont) and the Massachusetts Health Policy Commission, which are discussed in this report.

The Council reviewed an abundance of relevant American Medical Association (AMA) policy and recommends affirming that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority.

Because antitrust efforts may not be effective in hospital markets that are already highly concentrated, the Council also recommends that the AMA continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-19

Subject:	Hospital Consolidation (Resolution 235-A-18)
Presented by:	James G. Hinsdale, MD, Chair
Referred to:	Reference Committee G (Rodney Trytko, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 235-A-18, "Hospital Consolidation," which was introduced by the Washington Delegation. The Board of Trustees assigned this item to the Council on Medical Service for a report back at the 2019 Annual Meeting. Resolution 235-A-18 asked that our American Medical Association (AMA) actively oppose future hospital mergers and acquisitions in highly concentrated hospital markets, and study the benefits and risks of hospital rate setting commissions in states where highly concentrated hospital markets currently exist.

This report discusses horizontal and vertical hospital consolidation; outlines findings from a recent AMA analysis of hospital market concentration levels; highlights the role of states; describes alternative solutions that promote competition and choice in hospital markets; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

Consolidation in health care markets includes both horizontal and vertical mergers of physicians, hospitals, insurers, pharmaceutical companies, pharmaceutical benefit managers, and other entities. As stated in Council Report 5-A-17, "Hospital Consolidation," the AMA believes that health care entity mergers—including among hospitals—should be examined individually, taking into account the case-specific variables of market power and patient needs. The AMA strongly supports health care market competition as well as vigorous state and federal oversight of health care entity consolidation. Antitrust advocacy for physicians is a longstanding AMA priority, and close monitoring of health care markets is a key aspect of AMA antitrust activity.

Horizontal Hospital Consolidation

Although the AMA's most visible health care consolidation efforts have focused on health insurance markets, the AMA has also analyzed hospital market concentration using 2013 and 2016 data from the American Hospital Association. In a 2018 analysis, the AMA looked at 1,946 hospitals in 363 metropolitan statistical area (MSA)-level markets in 2013 and 2,028 hospitals in 387 MSAs in 2016 and found that, in most markets, hospitals (or systems) have large market shares.[1] In terms of hospital market shares, the AMA found that in 95 percent of MSAs, at least one hospital or hospital system had a market share of 30 percent or greater in both 2013 and 2016. In 2016, 72 percent of MSAs were found to have a single hospital or system with a market share of at least 50 percent, and 40 percent of MSAs had a single hospital or system with a market share of

70 percent or more.[2] The AMA analysis also found that, in 2016, 92 percent of MSA-level markets were highly concentrated, and 75 percent of hospitals were members of hospital systems.[3]

Hospital markets are concentrated largely due to consolidation. There were 1,412 hospital mergers between 1998 and 2015—with 561 reported between 2010 and 2015—and an additional 102 and 115 mergers documented in 2016 and 2017, respectively.[4,5] Eleven of the transactions in 2017 were mega-deals involving sellers with net revenues of $1 billion or more.[6]

There are potential benefits and harms resulting from horizontal hospital consolidation, with savings due to economies of scale and enhanced operational efficiencies cited as potential benefits. Hospitals acquiring market power through mergers may also increase prices for hospital care above competitive levels. Although not all hospital mergers impact competition, research has found that mergers in concentrated markets lead to price increases, and that the increases are significant when close competitors consolidate.[7,8] Studies have found little evidence of quality improvements post-merger, and lower quality in more concentrated hospital markets.[9,10] The evidence is more consistent for markets where prices are administered (e.g., Medicare). In markets where prices are market determined, consolidation can also lead to lower quality, but the evidence is more mixed.[11] Highly concentrated hospital markets may also lessen the practice options available to physicians in communities dominated by large hospital systems.

Vertical Hospital Consolidation

A hospital acquiring a physician practice is an example of vertical hospital consolidation. The AMA closely monitors trends in hospital acquisition of physician practices—which was the focus of Council on Medical Service Report 2-A-15, "Expanding AMA's Position on Healthcare Reform Options,"—via biennial Physician Practice Benchmark Surveys (Benchmark Surveys), which are nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week. In 2018, the share of physicians who worked in practices that were at least partially owned by a hospital was 26.7 percent, up from 25.4 percent in 2016, 25.6 percent in 2014 and 23.4 percent in 2012.[12] The share of physicians who were direct hospital employees in 2018 was 8.0 percent, up from 7.4 percent in 2016, 7.2 percent in 2014 and 5.6 percent in 2012.[13]

Vertical hospital consolidation has been found to increase prices and, in markets where prices are administered (e.g., Medicare), to increase total spending.[14,15] Recent steps taken by the Centers for Medicare & Medicaid Services (CMS) to level the site-of-service playing field between physician offices and off-campus hospital provider-based departments may have diminished a crucial incentive for hospitals to purchase physician practices in the future. For many years, higher payments to hospital outpatient departments likely incentivized the sale of physician practices and ambulatory surgical centers (ASCs) to hospitals because acquired facilities meeting certain criteria (e.g., located within 35 miles of the hospital) were routinely converted to hospital outpatient departments and allowed to charge higher rates for services performed at these off-campus facilities. However, a provision in the Bipartisan Budget Act of 2015 (BBA) disallowed provider-based billing by hospitals for newly acquired physician practices and ASCs. Beginning in 2017, off-campus entities acquired after enactment of the BBA—in November 2015—were no longer permitted to bill for services under Medicare's Outpatient Prospective Payment System (OPPS), and instead required to bill under the applicable payment system (Physician Fee Schedule). Since 2017, CMS has paid for services at non-excepted off-campus provider-based hospital departments using a Physician Fee Schedule relativity adjuster that is based on a percentage of the OPPS payment rate. CMS has since extended site-neutral payments to include clinic visits provided at off-campus provider-based hospital departments acquired prior to November 2015 that were

previously excepted from the BBA provision.[16] The AMA will continue to monitor the impact of these changes on hospital markets.

PROMOTING COMPETITION AND CHOICE

The AMA is aware of the potential effects of hospital consolidation on physicians and patients, including concerns about the loss of physician autonomy in clinical decision-making and preserving physician leadership in large systems, and also increased hospital prices in concentrated markets. The AMA also recognizes that employment preferences vary greatly among physicians, and that employment by large hospital systems or hospital-owned practices remains an attractive practice option for some physicians. A 2013 AMA-RAND study on professional satisfaction found that physicians in physician-owned practices were more satisfied than physicians in other ownership models (e.g., hospital or corporate ownership), but that work controls and opportunities to participate in strategic decisions mediate the effect of practice ownership on overall professional satisfaction.[17]

The AMA has long been a strong advocate for competitive health care markets and antitrust relief for physicians, and maintains that health care markets should be sufficiently competitive to allow physicians to have adequate choices and practice options. AMA efforts to obtain antitrust relief for physicians, maximize their practice options, and protect patient-physician relationships include legislative advocacy; advocacy at the Federal Trade Commission (FTC) and the US Department of Justice (DOJ); and the creation of practical physician resources.

State and federal antitrust enforcement for hospital consolidation has been somewhat limited and has had mixed results over the years, with some successes and also periods of intense merger activity.[18] Many mergers have proceeded unchallenged. Experts have also asserted that in hospital markets that are already highly concentrated, antitrust provides no remedy.[19] Accordingly, in addition to antitrust activities, the AMA has pursued alternative solutions that promote competition and choice, including: eliminating state certificate of need (CON) laws; repealing the ban on physician-owned hospitals; reducing the administrative burden to enable physicians to compete with hospitals; and achieving meaningful price transparency.

Eliminating State CON Laws: The AMA supports the elimination of state CON laws, which are barriers to market entry that harm competition, and supports state medical associations in their advocacy efforts to repeal them. CON laws require state boards to review all entities seeking to enter a health care market to provide care, including existing facilities seeking to offer new services or services in new locations. Thirty-five states and the District of Columbia currently administer CON programs.[20] As stated in Policy H-205.999, the AMA believes that there is little evidence to suggest that CON programs are effective in restraining health care costs or in limiting capital investment. In the absence of such evidence, AMA policy also opposes CON laws and the extension of CON regulations to private physician offices.

Repealing the Ban on Physician-Owned Hospitals: The AMA strongly advocates that Congress repeal limits to the whole hospital exception of the Stark physician self-referral law, which essentially bans physician ownership of hospitals and places restrictions on expansions of already existing physician-owned hospitals. Repealing the ban would allow new entrants into hospital markets, thereby increasing competition. Because physician-owned hospitals have been shown to provide the highest quality of care to patients, limiting their viability reduces access to high-quality care. The AMA firmly believes that physician-owned hospitals should be allowed to compete equally with other hospitals, and that the federal ban restricts competition and choice.

Reducing Administrative Burdens: Physicians are increasingly burdened by administrative tasks that are extremely costly to practices and reduce time with patients, yet increase the work necessary to provide medical services. Examples of these burdens include abiding by state and federal rules and regulations, meeting quality reporting requirements, managing electronic health records, and navigating a plethora of payer protocols and utilization management programs. Utilization management has become so burdensome that in 2018 the average physician reported completing 31 prior authorizations per week, a process that required 14.9 hours of work or the equivalent of two business days.[21] Taken together, these burdens make it difficult for physician practices—particularly smaller practices—to compete, which may lead physicians to consolidate with larger groups or hospitals.[22] The AMA conducts widespread prior authorization advocacy and outreach, including promoting Prior Authorization and Utilization Management Reform Principles, the Consensus Statement on Improving the Prior Authorization Process, model state legislation, the Prior Authorization Physician Survey, and the AMA Prior Authorization toolkit.

Price Transparency: The lack of complete, accurate and timely information about the cost of health care services prevents health care markets from operating efficiently. Patients are increasingly becoming active consumers of health care services rather than passive recipients of care in a market where price is often unknown until after the service is delivered. The AMA supports price transparency and recognizes that achieving meaningful price transparency may help lower health care costs and empower patients to choose low-cost, high-quality care. The AMA supports measures that expand the availability of health care pricing information, enabling patients and their physicians to make value-based decisions when patients have a choice of provider or facility.

ROLE OF STATES

While it is recognized that most hospital markets are highly concentrated and do not work as well as they could, it is also recognized that hospital markets are local and that states play a significant role in regulating them. States have their own antitrust laws, and state attorneys general and other regulators have better access to the local market-level data needed to oversee and challenge proposed mergers in their states. States can take on mergers themselves or join federal antitrust efforts. Some states have approved mergers but established conditions that must be met, such as requiring merged hospitals to maintain charity care programs or capping price increases for a certain number of years. As discussed previously, states can also reduce barriers to new competitors in hospital markets by eliminating CON laws.

All-Payer Rate Setting for Hospitals (Maryland, Pennsylvania and Vermont)

The approach to fostering competition cited in referred Resolution 235-A-18 is all-payer rate setting for hospitals, under which all payers (e.g., Medicare, Medicaid, private insurers and employer self-insured plans) pay hospitals the same price for services. Although-payer rate setting was popular in the 1970s, Maryland is the only state where it remains. Building on its all-payer rate setting approach, Maryland began implementing an all-payer global budgeting model for hospitals in 2014, while Pennsylvania began a similar model for rural hospitals in 2017. Vermont has developed an all-payer model for accountable care organizations (ACOs) that enables Medicare, Medicaid and private insurers to pay ACOs differently than through fee-for-service. These more recent all-payer payment models are still in the early stages of implementation and continue to undergo refinements and ongoing evaluation. Hospitals under this model are exempt from Medicare's inpatient and outpatient prospective payment systems and instead are paid based on fixed annual budget amounts for inpatient and outpatient hospital services that are established in advance.

A federally-funded evaluation of the first three years of Maryland's all-payer model found that it reduced total expenditures and hospital expenditures for Medicare patients but did not impact total expenditures or hospital expenditures for privately insured patients.[23] The evaluation further found that hospitals have adapted to global budgets without being adversely impacted financially. Other studies have looked at hospitals in eight urban counties in Maryland and the state's earlier rural pilot program, and research is ongoing. Accordingly, the Council believes that it may be premature to draw meaningful conclusions about the potential impact of hospital rate-setting in states with highly concentrated hospital markets.

All-payer rate setting for hospitals is intended to increase price competition and lessen the bargaining power of dominant hospitals, and it moves hospitals away from fee-for-service. However, appropriate payment rates can be challenging to establish and the model can be costly for states to administer.[24] Strong state leadership as well as an established information technology infrastructure are needed for all-payer global budgeting to be successful.[25]

Massachusetts Health Policy Commission

The Massachusetts Health Policy Commission (HPC) is an independent state agency that monitors health care spending growth and makes policy recommendations regarding health care payment and delivery reforms. Among other responsibilities, the HPC—established in 2012—is charged with monitoring changes in the health care market. Massachusetts regulations stipulate that health care provider organizations with more than $25 million in revenue must notify the HPC before consummating transactions for the purpose of enabling the state watchdog to conduct a "cost and market impact review."[26] The HPC has conducted several such reviews of proposed hospital mergers over the years and made them available to stakeholders as well as the public, thereby increasing transparency surrounding these transactions. Notably, mergers may be allowed to move forward despite criticisms from the HPC.

AMA RESOURCES

Recognizing that physicians are increasingly becoming employed by hospitals and health systems, the AMA has developed several practical tools for physicians, including the Annotated Model Co-Management Service Line Agreement, Annotated Model Physician-Hospital Employment Agreement and the Annotated Model Physician-Group Practice Employment Agreement which assist in the negotiation of employment contracts. For physicians considering a practice setting change or looking for an alignment strategy with an integrated health system, the AMA developed Joining or Aligning with a Physician-led Integrated Health System. The AMA has also made available a set of resources called "Unwinding Existing Arrangements" that guides employed physicians on how to "unwind" from their organization, factoring in operational, financial, and strategic considerations.

AMA principles for physician employment (Policy H-225.950) have been codified to address some of the more complex issues related to employer-employee relationships, and the AMA Physician's Guide to Medical Staff Bylaws is a useful reference manual for drafting and amending hospital medical staff bylaws. The AMA has also developed a series of model state bills, available from the AMA's Advocacy Resource Center, that are intended to address concerns expressed by employed physicians. Through these resources, the AMA is well-positioned to help employed physicians and those considering employment by hospitals or other corporations to preserve physician autonomy and independent decision-making and protect patient-physician relationships. The inviolability of the patient-physician relationship is a recurrent theme throughout the AMA Code of Medical Ethics, which also addresses mergers of secular and religiously affiliated health care institutions

(Code of Medical Ethics Opinion11.2.6). AMA staff are available to provide guidance and consultation on a range of issues related to employment and consolidation.

Working Toward Integrated Leadership Structures

Importantly, the AMA has always supported the ability of physicians to choose their mode of practice. The AMA promotes physician leadership in integrated structures and develops policy and resources intended to help safeguard physicians employed by large systems. The AMA has collaborated with hospitals, independent physician associations, large integrated health care systems' leaders and payers to cultivate successful physician leadership that improves the value of care for patients. Working with these stakeholders to bring clinical skills and business insights together at the leadership level, the AMA is fostering a more cohesive and integrative decision-making process within hospitals and health care systems. To help hospitals and health care systems institute that kind of decision-making process, the American Hospital Association (AHA) and the AMA released "Integrated Leadership for Hospitals and Health Systems: Principles for Success" in June 2015. The "Principles" provide a guiding framework for physicians and hospitals that choose to create an integrated leadership structure but are unsure how to best achieve the engagement and alignment necessary to collaboratively prioritize patient care and resource management.

RELEVANT AMA POLICY

Policy H-215.968 supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care. Antitrust relief for physicians that enables physicians to negotiate adequate payment remains a top priority of the AMA under Policies H-380.987, D-383.989, D-383.990 and H-383.992. Under Policy H-160.915, antitrust laws should be flexible to allow physicians to engage in clinically integrated delivery models without being employed by a hospital or ACO. Policy D-385.962 directs the AMA to support antitrust relief for physician-led accountable care organizations. Policy H-225.950 outlines AMA Principles for Physician Employment intended to assist physicians in addressing some of the unique challenges employment presents to the practice of medicine, including conflicts of interest, contracting, and hospital medical staff relations.

The AMA has substantial policy intended to protect medical staffs, including Policy H-220.937, which states that geographic disparities or differences in patient populations may warrant multiple medical staffs within a single hospital corporation, and that each medical staff shall develop and adopt bylaws and rules and regulations to establish a framework for self-governance of medical activities and accountability to the governing body. Policy H-215.969 provides that, in the event of a hospital merger, acquisition, consolidation or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues: (a) medical staff representation on the board of directors; (b) clinical services to be offered by the institutions; (c) process for approving and amending medical staff bylaws; (d) selection of the medical staff officers, medical executive committee, and clinical department chairs; (e) credentialing and recredentialing of physicians and limited licensed providers; (f) quality improvement; (g) utilization and peer review activities; (h) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges; (i) conflict resolution mechanisms; (j) the role, if any, of medical directors and physicians in joint ventures; (k) control of medical staff funds; (l) successor-in-interest rights; and (m) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals. Policy H-215.969 also states that the AMA will work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services. Under Policy H-235.991, medical staff bylaws should include

successor-in-interest provisions to protect medical staffs from a hospital ignoring existing bylaws and establishing new bylaws to apply post-merger, acquisition, affiliation or consolidation.

Policy H-225.947, which was established via Council on Medical Service Report 5-A-15, "Hospital Incentives for Admission, Testing and Procedures," encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles including that: (a) physician clinical autonomy is preserved; (b) physicians are included and actively involved in integrated leadership opportunities; (c) physicians are encouraged and guaranteed the ability to organize under a formal self-governance and management structure; (d) physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care; (e) a mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care; and (f) a clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures. Policy H-225.947 also encourages continued research on the effects of integrated health care delivery models that employ physicians on patients and the medical profession. Policy H-285.931 adopts principles for physician involvement in integrated delivery systems and health plans. Policy D-225.977 directs the AMA to continue to assess the needs of employed physicians and promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures.

AMA policy does not prohibit the application of restrictive covenants in the physician employment context generally, although Policy H-225.950, "Principles for Physician Employment," discourages physicians from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment. AMA Code of Medical Ethics Opinion 11.2.3.1 states that covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care. Accordingly, physicians should not enter into covenants that: (a) unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and (b) do not make reasonable accommodation for patients' choice of physician. This opinion also states that physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program. Under Policy H-140.984, the AMA opposes an across-the-board ban on self-referrals, because of benefits to patients including increased access and competition.

DISCUSSION

The Council shares the concerns among physicians regarding potential negative consequences for physicians and patients in highly concentrated hospital markets (e.g., increased prices, reduced choice, and fewer physician practice options). In addition to reviewing the literature, the Council received input from AMA antitrust experts during the development of this report, and notes that AMA staff are readily available to assist and advise AMA members and state medical associations with questions or concerns about physician-hospital relations or hospital consolidation. Nonetheless, the AMA does not have the resources to actively oppose all future hospital mergers in highly concentrated markets, as requested by Resolution 235-A-18. Attempting to address hospital mergers in the same manner that the AMA has addressed major health insurance mergers would place an undue burden on the organization's resources and may alienate many valued AMA members who work for hospitals and hospital systems.

Having prepared two reports on hospital consolidation in a two-year time period, the Council has a clear understanding of ongoing AMA efforts to monitor and respond to health care consolidation,

including engaging with the FTC and the DOJ as well as state attorneys general and insurance commissioners. The Council further appreciates the abundance of AMA policy embracing competition and choice, and concludes that hospital consolidation is sufficiently addressed (and not prohibited) by existing policy. Accordingly, the Council developed a new policy recommendation that brings together existing AMA policy to affirm that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority.

The Council also recognizes that most hospital markets are highly concentrated, and that hospital markets are predominantly local. The Council's review of the literature found that antitrust efforts may not be effective in hospital markets that are already highly concentrated, and that alternative solutions are warranted. Accordingly, the Council recommends that the AMA continue to support actions that promote competition and choice, including: (a) eliminating state CON laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency.

Because hospital markets are local, the Council further recommends encouraging state medical associations to monitor hospital markets and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.

Having discussed the potential impact of hospital consolidation on medical staffs, and the need to protect affected medical staffs post-merger, the Council recommends reaffirmation of four policies intended to help guide medical staffs and physicians experiencing consolidation: Policy H-215.969, which provides that, in the event of a hospital merger, acquisition, consolidation or affiliation, a joint committee with merging medical staffs should be established to resolve critical issues; Policy H-220.937, which states that geographic disparities or differences in patient populations may warrant multiple medical staffs within a single hospital corporation; Policy H-225.950, which outlines AMA Principles for Physician Employment; and Policy H-225.947, which encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles that actively involve physicians in integrated leadership and preserve clinical autonomy.

The Council is intrigued by state efforts to promote competition, including Maryland's all-payer rate setting model and Massachusetts' HPC. The AMA will continue to monitor these and other models but, at this time, does not make recommendations regarding their widespread adoption.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 235-A-18, and the remainder of the report be filed:

1. That our American Medical Association (AMA) affirm that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority. (New HOD Policy)

2. That our AMA continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency. (New HOD Policy)

3. That our AMA encourage state medical associations to monitor hospital markets and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices. (New HOD Policy)

4. That our AMA reaffirm Policy H-215.969, which provides that, in the event of a hospital merger, acquisition, consolidation or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues: (a) medical staff representation on the board of directors; (b) clinical services to be offered by the institutions; (c) process for approving and amending medical staff bylaws; (d) selection of the medical staff officers, medical executive committee, and clinical department chairs; (e) credentialing and recredentialing of physicians and limited licensed providers; (f) quality improvement; (g) utilization and peer review activities; (h) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges; (i) conflict resolution mechanisms; (j) the role, if any, of medical directors and physicians in joint ventures; (k) control of medical staff funds; (l) successor-in-interest rights; and (m) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-220.937, which states that geographic disparities or differences in patient populations may warrant multiple medical staffs within a single hospital corporation, and that each medical staff shall develop and adopt bylaws and rules and regulations to establish a framework for self-governance of medical activities and accountability to the governing body. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-225.950, which outlines AMA Principles for Physician Employment intended to assist physicians in addressing some of the unique challenges employment presents to the practice of medicine, including conflicts of interest, contracting, and hospital medical staff relations, and that discourage physicians from entering into agreements that restrict their right to practice medicine for a specified period of time or in a specified area upon termination of employment. (Reaffirm HOD Policy) and

7. That our AMA reaffirm Policy H-225.947, which encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles that actively involve physicians in integrated leadership and preserve clinical autonomy. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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REPORT 11 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
Corporate Investors
(Reference Committee G)

EXECUTIVE SUMMARY

While the extent of corporate investment in physician practices is not precisely known, growing numbers of physicians are employed by corporations including hospitals, health systems and insurers. Increasingly, private equity firms have also acquired majority and/or controlling interests in entities that manage physician practices. However, there is little peer-reviewed evidence regarding the impact of these arrangements on physicians, patients or health care prices, and physician experiences and opinions vary.

There are risks and benefits of partnering with any corporate investor, including a private equity firm. Risks include loss of control over the physician practice and its future and future revenues; loss of some autonomy in decision-making; an emphasis on profit or meeting financial goals; potential conflicts of interest; and potential uncertainties for non-owner early and mid-career physicians. Benefits include financially lucrative deals for physicians looking to exit ownership of their practices; access to capital for practice expenses or expansions, which may relieve physicians' financial pressures; potentially fewer administrative and regulatory burdens on physicians; and centralized resources for certain functions such as IT, marketing or human resources. Concerns regarding these partnerships have primarily centered on the potential for subsequent increases in prices, service volume, and internal referrals, as well as the use of unsupervised non-physician providers.

Longstanding AMA policy states that physicians are free to choose their mode of practice and enter into contractual arrangements as they see fit. This report recommends a series of guidelines that should be considered by physicians who are contemplating corporate investor partnerships; supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices; and encourages further study by affected national medical specialty societies.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 11-A-19

Subject: Corporate Investors

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates adopted Policy D-383.979, "Corporate Investors." This policy states that our American Medical Association (AMA) will study, with report back at the 2019 Annual Meeting, the effects on the health care marketplace of corporate investors (e.g., public companies, venture capital/private equity firms, insurance companies and health systems) acquiring a majority and/or controlling interest in entities that manage physician practices, such as the degree of corporate investor penetration and investment in the health care marketplace; the impact on physician practice and independence; patient access; resultant trends in the use of non-physician extenders; long term financial viability of practices; effects of ownership turnovers and bankruptcies on patients and practice patterns; effectiveness of methodologies employed by unpurchased private independent, small group and large group practices to compete for insurance contracts in consolidated marketplaces; and the relative impact corporate investor transactions have on the paths and durations of junior, mid-career and senior physicians.

This report describes physician practice consolidation with corporate investors, including private equity investment in physician practices; discusses the corporate practice of medicine; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

Consolidation among health care entities, including consolidation involving physician practices, is closely monitored by the AMA. An array of factors—including changes in payment and delivery models, physician payment challenges, high costs of new technology and equipment, and increased administrative and regulatory burdens—have driven some physicians to be employed by, merge with or join hospitals, health systems and insurers. Increasingly, private equity partnerships/firms, which pool funds to invest in companies with the goal of running them more efficiently and selling them at a profit, have also acquired majority and/or controlling interests in entities that manage physician practices.

While the extent of corporate investment in health care is not precisely known, increasing numbers of physicians are employed by corporations, including hospitals, health systems and health insurers.[1] Data from the 2018 Health Care Services Acquisition Report demonstrates corporate investor interest in physician practices. The report documented that 2017 saw the highest annual number of transactions (166 deals) involving physician medical groups since 1998 (264 deals). Of the 10 largest physician medical group transactions completed between 2013 and 2017, two were acquisitions of large physician groups by UnitedHealth's Optum unit, and another two involved private equity firms. Many of the largest transactions involved public companies.[2]

The long-term trend away from physicians being practice owners and toward physicians being employees has been documented via the AMA's Physician Practice Benchmark Surveys, which yield nationally representative samples of non-federal physicians providing at least 20 hours of patient care. These surveys, conducted biennially, have found that physician ownership dropped by seven percentage points (from 53.2 percent to 45.9 percent) between 2012 and 2018.[3] Notably, the year 2018 was the first time that the percentage of physician owners was less than the percentage of physician employees (47.4 percent).[4]

Private Equity Investment in Physician Practices

Private equity firms, which acquire equity in businesses with funds from private investors, vary in terms of size, structure, business model and investment thesis. Venture capital is typically used to invest in emerging or early stage businesses such as start-ups. Buyout or leveraged buyout firms typically invest in mature or later-stage businesses, often taking a controlling interest.

Private equity investment in dermatology, radiology, anesthesiology, urology, gastroenterology, cardiology, orthopedic, radiology and ophthalmology practices, among other specialties, has garnered substantial publicity and attention from the physician community. Growth in the demand for health care services, coupled with an aging population and the development of innovative treatments, have made the health care sector attractive to private equity investors. Globally, total disclosed value of deals in the sector exceeded $63 billion in 2018, the most since 2006, with much of this activity concentrated in North America and the US in particular.[5] Providers and related services, including physician practice management, accounted for the most deals in 2018, with increased activity observed in anesthesia, radiology and behavioral health.[6] A reported 84 private equity deals involving providers (including but not limited to physician practices) were consummated in 2018, totaling $23 billion.[7] Private equity firms have also invested in hospitals, ambulatory surgical centers, retail health, health information technology (IT), home care and hospice, among many other services.[8]

Hospitals, health systems, academic medical centers, large multispecialty groups, and corporate buyers frequently compete with private equity firms for the same physician practice targets. Corporate buyers may also partner with private equity investors or form consortia of buyers to acquire highly sought-after practices. Increased competition for physician groups in some specialties has led price valuations of these practices to rise.

Because many private equity transactions are not disclosed (nondisclosure agreements are commonly used during negotiations),[9] the degree of investment in physician practices, while believed to be relatively small overall, cannot be precisely determined. Incomplete data on corporate transactions involving physician practices is in fact a significant impediment to determining the impact of corporate investors on physicians, patients, and the health care marketplace. That said, there is evidence that physician practices are being acquired, not only by private equity firms but also by hospitals, health systems, academic medical centers, insurers, and large physician groups. Transactions involving private equity investors are occurring with some regularity. Consequently, affected physician specialties are attempting to understand these practice shifts as well as the risks and benefits of this practice model.

Dermatology is one such specialty, having experienced a surge in private equity deals involving dermatology-related practices in the last three to five years. Fifteen percent of recent private equity/physician practice transactions have been "dermatology-related," although dermatologists make up only one percent of US physicians.[10] As noted in a recent commentary in *JAMA Dermatology*:

> Consolidation of practices fueled by private equity investments has begun to transform dermatology … Existing dermatologists are encouraged to stay after the sale through equity stakes or deferred payouts, but in some cases, the investors may accept departures because the buyout recipients can sometimes be replaced by younger dermatologists or physician assistants who are paid at a lower level.[11]

Private equity firms have also shown interest in ophthalmology practices, as described in *Review of Ophthalmology*:

> The basic premise is that a private equity firm offers to form a partnership with an ophthalmology practice that it believes has the potential to grow. It provides funding to the practice owners, including an upfront payment in cash and/or stock, in exchange for a percentage of future profits. Ultimately, the goal is to increase the value of the practice by investing in its growth—often partly by consolidating it with other practices—so that in a few years it can be resold to another private equity firm for a significant profit.[12]

Noted researcher Lawrence Casalino, MD, et al. described the phenomenon as follows:

> These investors anticipate average annual returns of 20 percent or more. To achieve such returns, private equity firms focus on acquiring "platform practices" that are large, well managed, and reputable in their community. The firms sell these practices after augmenting their value by recruiting additional physicians, acquiring smaller practices to merge with the larger practice, increasing revenue (for example, by bringing pathology services into a dermatology practice), and decreasing costs (for example, by substituting physician assistants for physicians). Growth makes it possible to spread fixed costs, exploit synergies across merged practices, expand ancillary revenues, and increase negotiating leverage with health insurers.[13]

A recent *JAMA Viewpoint* concluded:

> Even though consolidation may create economies of scale and layoffs and other cost-cutting measures may reduce operating costs, increased market power over price negotiations with insurers and boosting volume for ancillary revenue streams may increase spending. Empirical analysis is needed to understand the net consequences and to compare spending among private equity-owned, hospital-owned, and independent practices.[14]

Risks and Benefits of Partnering with Corporate Investors

There is little peer-reviewed evidence regarding the impact of corporate investors on physicians, physician autonomy, patients or health care prices. Anecdotal information suggests an increase in the use of non-physician extenders by some private equity firms and other challenges facing physicians working for practices affiliated with private equity firms. The experiences of practices entering employment arrangements with hospitals, health systems, academic medical centers and insurers may differ from private equity investors because these entities function in the health care marketplace and frequently have existing physician leadership in place. Additionally, in contrast to private-equity backed practices, hospitals, health systems and academic medical centers may use some of their revenues to provide uncompensated care and/or contribute to medical education and training.[15]

There are risks and benefits of partnering with any corporate investor, including a private equity firm. Risks include loss of control over the physician practice and its future and future revenues;

loss of some autonomy in decision-making; an emphasis on profit or meeting financial goals; potential conflicts of interest; and potential uncertainties for non-owner early and mid-career physicians. Benefits include financially lucrative deals for physicians looking to exit ownership of their practices; access to capital for practice expenses or expansions, which may relieve physicians' financial pressures; potentially fewer administrative and regulatory burdens on physicians; and centralized resources for certain functions such as IT, marketing or human resources. Concerns regarding these partnerships have primarily centered on the potential for subsequent increases in prices, service volume, and internal referrals, as well as the use of unsupervised non-physician providers.[16] Importantly, corporate investors are obviously not all the same and may differ significantly in terms of their business models and culture. Some are centralized and physician-led, while others are centralized but not physician-led; the degree of physician autonomy in decision making also varies.

AMA ACTIVITY

In monitoring mergers and acquisitions, the AMA's position is that each health care entity consolidation must be examined individually, taking into account case-specific variables related to market power and patient needs. AMA policy strongly supports and encourages competition in all health care markets to provide patients with more choices while improving care and lowering the costs of that care. Markets should be sufficiently competitive to allow physicians to have adequate practice options. The AMA also recognizes that employment preferences vary greatly among physicians, and that employment by large systems can be an attractive practice option for some physicians. A 2013 AMA-RAND study on professional satisfaction found that physicians in physician-owned practices were more satisfied than physicians in other ownership models (e.g., hospital or corporate ownership), but that work controls and opportunities to participate in strategic decisions mediate the effect of practice ownership on overall professional satisfaction.[17]

The AMA promotes physician leadership in integrated structures and has developed policies and resources intended to help safeguard physicians employed by large systems. The AMA has also developed several resources intended to help physicians understand employment contracts. These include the Annotated Model Co-Management Service Line Agreement, Annotated Model Physician-Group Practice Employment Agreement, and the Annotated Model Physician-Hospital Employment Agreement as well as a Making the Rounds podcast on contracts. For physicians considering a practice setting change or looking for an alignment strategy with an integrated health system, the AMA developed the guide Joining or Aligning with a Physician-led Integrated Health System. The AMA has also made available a set of resources called "Unwinding Existing Arrangements" that guides employed physicians on how to "unwind" from their organization, factoring in operational, financial, and strategic considerations.

At the time that this report was written, the AMA was planning to release, mid-year in 2019, resources related to venture capital and private equity investments that highlight the main issues physicians may encounter when engaging with such firms, including modifications to compensation, investment in infrastructure, how to evaluate contractual agreements, and hands-on management. A related checklist was also planned that will offer specific considerations such as terms-of-sale for the practice, standardization techniques and economies of scale, and unwinding terms.

Corporate Practice of Medicine

The term "corporate practice of medicine" encompasses complex legal issues that may mean different things to different people and vary widely by state. The corporate practice of medicine

can, for example, prohibit a lay corporation from practicing medicine or employing physicians, or prohibit non-physicians or lay organizations from having an ownership interest in a physician practice. The doctrine is based on concerns that: (1) allowing corporations to practice medicine or employ physicians will result in the commercialization of the practice of medicine; (2) a corporation's obligation to its shareholders may not align with a physician's obligations to his or her patients; and (3) employment of a physician by a corporation may interfere with the physician's independent medical judgement.[18]

As delivery systems and physician employment arrangements have evolved over the years, so too has the corporate practice of medicine doctrine. The health care environment is shifting toward increased integration of care, with growth in both the number of employed physicians and acquisitions of physician practices. These trends have led to formalized employment relationships between physicians and non-physician entities, arrangements that in certain states may run afoul of corporate practice of medicine policies. Council on Medical Service Report 6-I-13 addressed the corporate practice of medicine.

RELEVANT AMA POLICY

Policy H-215.981 opposes federal legislation preempting state laws prohibiting the corporate practice of medicine; states that the AMA will continue monitoring the corporate practice of medicine and its effect on the patient-physician relationship, financial conflicts of interest, and patient-centered care; and directs the AMA to provide guidance, consultation and model legislation regarding the corporate practice of medicine, at the request of state medical associations, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations. Under Policy D-225.977, the AMA continues to assess the needs of employed physicians, ensuring physician clinical autonomy and self-governance. Policy H-285.951 states that physicians should have the right to enter into whatever contractual arrangements they deem desirable and necessary but should be aware of potential conflicts of interest due to the use of financial incentives in the management of care. Policy H-215.968 supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective care. Antitrust relief is a top AMA priority under Policy H-380.987.

AMA Principles for Physician Employment are outlined in Policy H-225.950. Policy H-225.997 addresses physician-hospital relationships, and Policy H-225.942 outlines physician and medical staff rights and responsibilities. Policy H-225.947 encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles, including that: (a) physician clinical autonomy is preserved; (b) physicians are included and actively involved in integrated leadership opportunities; (c) physicians are encouraged and guaranteed the ability to organize under a formal self-governance and management structure; (d) physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care; (e) a mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care; and (f) a clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures. Policy H-160.960 states that when a private medical practice is purchased by corporate entities, patients shall be informed of the ownership arrangement by the corporate entities and/or the physician. Truth in advertising is addressed by Policies H-410.951 and H-405.969.

AMA policy does not prohibit the application of restrictive covenants in the physician employment context generally, although Policy H-225.950, "Principles for Physician Employment," discourage

physicians from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment. AMA Code of Medical Ethics Opinion 11.2.3.1 states that covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care. Accordingly, physicians should not enter into covenants that: (a) unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and (b) do not make reasonable accommodation for patients' choice of physician. This opinion also states that physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program.

Policy H-140.984 opposes an across-the-board ban on self-referrals because of benefits to patients including increased access to competition, and includes standards to ensure ethical and acceptable financial arrangements. This policy states that the opportunity to invest in the medical or health care facility established by a health care services financial arrangement should be open to all individuals who are financially able and interested in an investment.

DISCUSSION

The Council's study of corporate investors acquiring majority and/or controlling interest in entities that manage physician practices was hindered by the lack of empirical evidence regarding the impact of these practice models on physicians, patients, medical practice, and the costs and quality of care. Although anecdotal information is available from affected specialties, there is not sufficient data to draw meaningful or actionable conclusions. Nonetheless, the Council underscores the paramount importance to this discussion of safeguarding patient-centered care, clinical governance and physician autonomy in all physician practice arrangements, including those involving corporate investors.

The Council also believes it is worth noting that physician opinions vary regarding corporate investor involvement in physician practices. Although there has been a great deal of angst among many physicians regarding private equity investments in practices, other physicians and physician groups have readily partnered with these firms. Long-standing policy states that physicians are free to choose their mode of practice and enter into contractual arrangements as they see fit, and it is essential that the AMA maintain a leadership role that is uniting and supportive of all physicians and care delivery models.

The Council recommends, therefore, reaffirmation of four existing AMA policies—on the corporate practice of medicine, financial incentives, physician employment, and corporate ownership of private medical practices—that are relevant to corporate investor relationships with physician practices. Because physicians appear to be looking for guidance and solutions, the Council also recommends a series of guidelines that it believes should be considered by physicians who are contemplating corporate investor partnerships.

As previously noted, nondisclosure agreements are commonly used in private equity and corporate investor transactions, and the Council believes that more information is needed regarding the degree of corporate investment in physician practices and what this means for health care prices. The lack of complete and accurate information may prevent health care markets from operating efficiently and preclude patients from making informed decisions regarding low-cost, high-value care. Accordingly, the Council recommends supporting improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.

The Council recognizes that further study is needed on the impact of corporate investors, and recommends encouraging national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and physicians.

Finally, the Council recommends rescinding Policy D-383.979, which led to the development of this report.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-215.981, which opposes federal legislation preempting state laws prohibiting the corporate practice of medicine; states that the AMA will continue monitoring the corporate practice of medicine and its effect on the patient-physician relationship, financial conflicts of interest, and patient-centered care; and directs the AMA to provide guidance, consultation and model legislation regarding the corporate practice of medicine, at the request of state medical associations, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-225.950, which affirms that a physician's paramount responsibility is to his or her patients, and which outlines principles related to conflicts of interest and contracting. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-285.951, which states that physicians should have the right to enter into whatever contractual arrangements they deem desirable and necessary but should be aware of potential conflicts of interest due to the use of financial incentives in the management of medical care. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-160.960, which states that when a private medical practice is purchased by corporate entities, patients shall be informed of the ownership arrangement by the corporate entities and/or the physician. (Reaffirm HOD Policy)

5. That our AMA encourage physicians who are contemplating corporate investor partnerships to consider the following guidelines:

    a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
    b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
    c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
    d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
    e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
    f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.

g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships. (New HOD Policy)

6. That our AMA support improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices. (New HOD Policy)

7. That our AMA encourage national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty. (New HOD Policy)

8. That our AMA rescind Policy D-383.979, which requested this report. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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APPENDIX

Corporate Practice of Medicine H-215.981
1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine. 2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations. 3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.

AMA Principles for Physician Employment H-225.950
1. Addressing Conflicts of Interest
a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address. b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority. d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients. (i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and (ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions. e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.
Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.
2. Advocacy for Patients and the Profession
a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated. b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.
3. Contracting
a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession. b) Physicians should never be coerced into employment with hospitals, health care systems,

medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts. c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based. d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician. (e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures. (f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff. (g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment. (h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

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

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs. b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes. c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of

their employment agreements, nor be retaliated against by their employers, for asserting these interests. d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.
Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.
5. Peer Review and Performance Evaluations
a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings. b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status. c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians. d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment. e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc. (f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met: i. The agreement is for the provision of services on an exclusive basis; and ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.
Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.
6. Payment Agreements
a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement. b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Financial Incentives Utilized in the Management of Medical Care H-285.951
Our AMA believes that the use of financial incentives in the management of medical care should be guided by the following principles: (1) Patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated. (2) Physicians should have the right to enter into whatever contractual arrangements with health care systems, plans, groups or hospital departments they deem desirable and necessary, but they should be aware of the potential for some types of systems, plans, group and hospital departments to create conflicts of interest, due to the use of financial incentives in the management of medical care. (3) Financial incentives should enhance the provision of high quality, cost-effective medical care. (4) Financial incentives should not result in the withholding of appropriate medical services or in the denial of patient access to such services. (5) Any financial incentives that may induce a limitation of the medical services offered to patients, as well as treatment or referral options, should be fully disclosed by health plans to enrollees and prospective enrollees, and by health care groups, systems or closed hospital departments to patients and prospective patients. (6) Physicians should disclose any financial incentives that may induce a limitation of the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options. Physicians may satisfy their disclosure obligations by assuring that the health plans with which they contract provide such disclosure to enrollees and prospective enrollees. Physicians may also satisfy their disclosure obligations by assuring that the health care group, system or hospital department with which they are affiliated provide such disclosure to patients seeking treatment. (7) Financial incentives should not be based on the performance of physicians over short periods of time, nor should they be linked with individual treatment decisions over periods of time insufficient to identify patterns of care. (8) Financial incentives generally should be based on the performance of groups of physicians rather than individual physicians. However, within a physician group, individual physician financial incentives may be related to quality of care, productivity, utilization of services, and overall performance of the physician group. (9) The appropriateness and structure of a specific financial incentive should take into account a variety of factors such as the use and level of "stop-loss" insurance, and the adequacy of the base payments (not at-risk payments) to physicians and physician groups. The purpose of assessing the appropriateness of financial incentives is to avoid placing a physician or physician group at excessive risk which may induce the rationing of care. (10) Physicians should consult with legal counsel prior to agreeing to any health plan contract or agreeing to join a group, delivery system or hospital department that uses financial incentives in a manner that could inappropriately influence their clinical judgment. (11) Physicians agreeing to health plan contracts that contain financial incentives should seek the inclusion of provisions allowing for an independent annual audit to assure that the distribution of incentive payments is in keeping with the terms of the contract. (12) Physicians should consider obtaining their own accountants when financial incentives are included in health plan contracts, to assure proper auditing and distribution of incentive payments. (13) Physicians, other health care professionals, third party payers and health care delivery settings through their payment policies, should continue to encourage use of the most cost-effective care setting in which medical services can be provided safely with no detriment to quality.

Corporate Ownership of Established Private Medical Practices H-160.960
When a private medical practice is purchased by corporate entities, patients going to that practice shall be informed of this ownership arrangement by the corporate entities and/or by the physician.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(A-19)

Introduced by: Thomas J. Madejski, MD, Delegate

Subject: Physician Requirements for Comprehensive Stroke Center Designation

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

Whereas, The government is moving to credential hospitals as different level stroke centers and would then direct ambulances to divert patients to these hospitals; and

Whereas, Much of the focus for such diversion would be a hospital's ability to provide mechanical thrombectomy service; and

Whereas, Mechanical thrombectomy is a relatively straightforward endovascular procedure that is infrequently performed as part of successful stroke management--for example a hospital that sees 1000 patients per year as a "rule out stroke" might actually only have 500 stroke patients, and only 20 patients who qualify for mechanical thrombectomy, of which only 10 will potentially do well after the thrombectomy; and

Whereas, Some of the planned requirements for these stroke center designations, such as from The Joint Commission, are arbitrary, and unduly burdensome, and not based on sound scientific evidence such as:

(a) Doctors who perform fewer than 15 thrombectomies per year would no longer be eligible to cover call

(b) Doctors covering endovascular services could only cover one hospital at a given time; and

Whereas, There are no studies available that establish a distinct threshold for a volume – outcome relationship in regards to mechanical thrombectomy; and

Whereas, These stringent requirements will unnecessarily disqualify most endovascular procedurists -- endovascular neurosurgeons, endovascular neurologists, and endovascular neuro-radiologists -- from continuing to work, as they will not be able to perform 15 thrombectomies per year; and

Whereas, The Society for Interventional Radiology sponsored an independent analysis of the Centers for Medicare and Medicaid Services' thrombectomy data from 2016 that showed that 85% of physicians who billed this code, billed it 10 times or fewer, and of the 15% of physicians who performed the procedure more than 10 times that year, the median number was 15; that is to say, most physicians who were performing the procedure, would not meet the stringent volume requirement; and

Whereas, There is no reason that a doctor could not cover more than one hospital at a time for a procedure that is straightforward, brief, and will likely be performed at even a busy hospital no more than once per week; and

Whereas, These unusually stringent requirements will actually prevent most hospitals from achieving appropriate stroke center designations, and will thus lead to having all neurological volume diverted away from their ER's, leading paradoxically to potential stroke patients being diverted long distances for care when such care was readily available nearby; therefore be it

RESOLVED, That our American Medical Association advocate for changing the following two provisions from The Joint Commission Stroke Center Requirements:

1) Stroke procedurists should not be required to perform 15 mechanical thrombectomies per year to qualify for taking endovascular call at designated stroke hospitals; and

2) Stroke procedurists should be able to take call at more than one hospital at a time. (Directive to Take Action)

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

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(A-19)

Introduced by: Wisconsin

Subject: Hospital Falls and "Never Events" - A Need for More in Depth Study

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

Whereas, Concerns regarding gaps in medical quality and patient safety led The Joint Commission in 1996 to identify serious patient safety events (such as patient death, permanent harm to a patient, or temporary harm to a patient requiring immediate intervention to sustain the patient's life) as "Sentinel Events" that warrant immediate investigation and remediation to prevent their recurrence; and

Whereas, The National Quality Forum (NQF) expanded such analysis of serious patient safety events to develop its list of "Never Events," events that could occur during the process of offering medical care that should be expected to never happen, such as wrong-sited surgery; and

Whereas, Payors of health care services, including the Center for Medicare and Medicaid Services (CMS) and major commercial payors, have determined that insurance claims for entire episodes of care should be denied if, in the course of that care episode, a "never event" occurred; and

Whereas, The 2016 list of "Never Events" (referred to formally as "Serious Reportable Events") compiled by the NQF, includes "Patient death or serious injury associated with a fall while being cared for in a health care setting;" and

Whereas, Out of sincere concern for the safety of patients, and out of concern regarding adverse publicity should a "never event" occur, and out of concern that reimbursement could be significantly impacted adversely were a "never event" to occur, hospitals are diligent about educating their staff about "never events" on the NQF list and how to avoid them; and

Whereas, Our current system of "keeping score" of falls has created a disincentive for mobilizing patients and consequently increases patients' risk for falls due to deconditioning effects of bed rest;[1] and

Whereas, Nursing staff in hospitals are understandably afraid for what may happen to patients or to themselves as licensed health professionals and as employees were there to be a patient fall resulting in serious injury or patient death, and have become hypervigilant, to assure that patients do not experience falls in the healthcare setting;[2,3] and

Whereas, "Driving in fear" has been shown to be counterproductive to the generation of improved overall results in patient safety and health care outcomes; and

Whereas, A result of nursing staff fear has been demonstrated to be an increase in efforts of nursing staff to keep patients in bed and to not get up and move about, lest a fall occur,

including the use of bed and chair alarms, which further restrict mobility, to notify staff should a patient get up;[3-7] and

Whereas, Restricting mobility has been shown to directly cause loss of muscle mass and strength[8] and increase fall risk in older adult patients[9], and is associated with Hospital-Acquired Disability[10] and are counterproductive to patients restoring their functional abilities after an illness or injury leads to a hospitalization; and

Whereas, Limiting older adult patient mobility during a hospital stay results in post-hospital syndrome[11] and trauma of hospitalization[12], increasing risk for adverse health events such as falls post discharge,[13] new nursing home placement,[14] mortality,[14] decrease quality of life and readmission within 30 days;[15] and

Whereas, The Wisconsin State Journal, the daily newspaper in the state's second largest city, published a three-part Special Report in March 2019, supported by a journalism fellowship from the Gerontological Society of America, Journalists Network on Generations and the John A. Hartford Foundation, reporting that Wisconsin leads the nations in falls, in fatal falls, and falls in health care institutions, and highlighting research in the nursing professional literature that accreditation standards intended to prevent falls can have counterproductive effects; and

Whereas, It has been demonstrated through research by the University of Wisconsin's Barbara King, RN, PhD, and others that patients' functional abilities during a hospitalization and in the weeks or months after hospital discharge are diminished quantitatively and over longer spans of time when patients have been kept in bed longer rather than assisted to get up and reestablish mobility sooner;[16-19] and

Whereas, It has been demonstrated through an impact assessment of CMS "never events" that the CMS policy on falls has actually had no salutary effect on the rates of injurious falls;[20] therefore be it

RESOLVED, That our American Medical Association study the merits of recommending that "Patient death or serious injury associated with a fall while being cared for in a health care setting" be removed from the list of "Never Events" for which a hospital may face an adverse payment decision by third-party payors or an adverse accreditation decision by The Joint Commission (Directive to Take Action); and be it further

RESOLVED, That our AMA study the merits of recommending that a pay-for-performance measure be added which would reward health care organizations for taking steps resulting in patients' improved ability to participate in self-care, improved functional status, and improved mobility for seniors who have been admitted to a facility for a condition resulting in a temporary need for bed rest. (Directive to Take Action)

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

Received: 05/01/19

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REPORT OF THE ORGANIZED MEDICAL STAFF SECTION
GOVERNING COUNCIL

GC Report AA-A-19

Subject: OMSS Position on Board of Trustees Report 13-A-19: Employed Physician Bill of Rights and Basic Practice Professional Standards

Presented by: David Welsh, MD, Chair

Referred to: OMSS Reference Committee
(James Guo, MD, Chair)

EXECUTIVE SUMMARY OF BOARD OF TRUSTEES REPORT 13

At the 2018 Annual Meeting, the House of Delegates (HOD) referred Resolution 701, "Employed Physician Bill of Rights." Resolution 701-A-18 was introduced by the Illinois Delegation and asked our AMA to adopt an extensive Employed Physician's Bill of Rights. The HOD also referred Resolution 702-A-18, "Basic Practice Professional Standards of Physician Employment," which was introduced by the Indiana Delegation and asked our AMA to adopt a series of best practices for physician employment contracts. [Governing Council note: At A-18, the OMSS considered a resolution identical to Resolution 702-A-18, but decided to support Resolution 702 in lieu of submitting a duplicate resolution to the House of Delegates.]

Testimony on Resolutions 701 and 702-A-18 suggested that much of the content of the resolutions is already addressed by AMA policy, and that in some cases the proposed policy positions might be inconsistent with existing AMA policy. This report compares these resolutions to the existing body of AMA policy on physician employment and related matters and provides recommendations accordingly.

The Board's analysis found that most of the concepts set forth in Resolutions 701 and 702-A-18 are already addressed in AMA policy, and the Board recommends reaffirmation of these policies. In some cases, the proposed policies are inconsistent with existing policy. Finally, the Board's analysis identified two themes in Resolutions 701 and 702-A-18 not addressed by existing policy—academic freedom for employed physicians and appropriate levels of administrative and clinical support—and recommends adoption of new policy in these areas.

RECOMMENDATION OF BOT REPORT 13

The Board of Trustees recommends the following be adopted in lieu of Resolution 701-A-18 and Resolution 702-A-18, and the remainder of the report be filed:

1. That our AMA reaffirm the following policies:

    - H-225.950, AMA Principles for Physician Employment,
    - H-225.997, Physician-Hospital Relationships,
    - H-225.942, Physician and Medical Staff Member Bill of Rights,

- H-225.955, Protection of Medical Staff Members' Personal Proprietary Financial Information,
- H-300.982, Maintaining Competence of Health Professionals, and
- H-383.998, Resident Physicians, Unions and Organized Labor. (Reaffirm HOD Policy)

2. That our AMA amend policy H-225.955, Protection of Medical Staff Members' Personal Proprietary Financial Information:

   "(1)(a) Physicians should be required to disclose personal financial information to the hospital/health system only if they are serving or being considered to serve as a member of the governing body, as a corporate officer, or as an employee/contractor of the hospital/health system; and such information should be used only so that other individuals understand what conflicts may exist when issues are discussed and when recusal from voting or discussion on an issue may be appropriate."

3. That our AMA amend policy H-225.950, AMA Principles for Physician Employment:

   "(1)(b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization." (Amend HOD Policy)

4. That our AMA advocate that employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients. (New HOD Policy)

GOVERNING COUNCIL RECOMMENDATION

The Governing Council recommends that the OMSS Delegate be instructed to support the intent of the recommendations of BOT Report 13-A-19.

REPORT 13 OF THE BOARD OF TRUSTEES (A-19)
Employed Physician Bill of Rights and Basic Practice Professional Standards
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting, the House of Delegates (HOD) referred Resolution 701, "Employed Physician Bill of Rights." Resolution 701-A-18 was introduced by the Illinois Delegation and asked our AMA to adopt an extensive Employed Physician's Bill of Rights. The HOD also referred Resolution 702-A-18, "Basic Practice Professional Standards of Physician Employment," which was introduced by the Indiana Delegation and asked our AMA to adopt a series of best practices for physician employment contracts.

Testimony on Resolutions 701 and 702-A-18 suggested that much of the content of the resolutions is already addressed by AMA policy, and that in some cases the proposed policy positions might be inconsistent with existing AMA policy. This report compares these resolutions to the existing body of AMA policy on physician employment and related matters and provides recommendations accordingly.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-A-19

Subject:	Employed Physician Bill of Rights and Basic Practice Professional Standards (Resolution 701-A-18 and Resolution 702-A-18)
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee G (Rodney Trytko, MD, Chair)

INTRODUCTION

At the 2018 Annual Meeting, the House of Delegates (HOD) referred Resolution 701, Employed Physician Bill of Rights. Resolution 701 was introduced by the Illinois Delegation and asked our AMA to adopt an extensive Employed Physician's Bill of Rights. The HOD also referred Resolution 702, Basic Practice Professional Standards of Physician Employment, which was introduced by the Indiana Delegation and asked our AMA to adopt a series of best practices for physician employment contracts. These resolutions are reproduced in full in the appendix.

Testimony on Resolutions 701 and 702-A-18 suggested that much of the content of the resolutions is already addressed by AMA policy, and that in some cases the proposed policy positions might be inconsistent with existing AMA policy. This report compares these resolutions to the existing body of AMA policy on physician employment and related matters and provides recommendations accordingly.

BACKGROUND

AMA policy on physician employment matters dates back more than two decades and covers an extensive range of issues. In 2012, recognizing the growing number of physicians becoming employed, the AMA consolidated and expanded this guidance in the form of the AMA Principles for Physician Employment (Policy H-225.950), which have since been updated a handful of times. As noted in the original preamble, the Principles "are intended to help physicians, those who employ physicians, and their respective advisors identify and address some of the unique challenges to professionalism and the practice of medicine arising in the face of physician employment." In addition to this body of policy, the AMA has developed a variety of resources to help physicians navigate physician-employer relations, most notably its model employment agreements.

RESOLUTION 701-A-18, EMPLOYED PHYSICIAN BILL OF RIGHTS

The first resolve of Resolution 701-A-18 asks the AMA to adopt an "Employed Physician Bill of Rights," the provisions of which are delineated in resolves 2-11. We discuss below the asks of each resolve with respect to the AMA Principles for Physician Employment and other AMA policy.

Resolve 2 asks "That this bill of rights include the principle that compensation should be based on the totality of physician activities for the organization, including but not limited to educational

endeavors and preparation, committee participation, student/resident activities and administrative responsibilities."

Resolve 2 is addressed by Policy H-225.997, "Physician-Hospital Relationships," which is also more nuanced than the proposed policy position:

> "(4) Hospital-associated medical specialists, as well as all members of the medical staff, are expected to contribute a reasonable amount of their time, without compensation, to participation in hospital staff committee activities for the purpose of improving patient care; providing continuing education for the benefit of the medical staff; and assisting in the training of physicians and allied health personnel. Physicians who provide teaching or other services in excess of those ordinarily expected of members of the attending staff are entitled to reasonable compensation therefore."

Resolve 3 asks "That this bill of rights include the principle that physicians have academic freedom, without censorship in clinical research or academic pursuits."

While existing policy recognizes several areas in which employed physicians should have "freedom," it does not explicitly address academic freedom. We therefore propose an amendment to Policy H-225.950, "AMA Principles for Physician Employment," as follows:

> "(1)(b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. <u>Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.</u>"

Resolve 4 asks "That this bill of rights include the principle that physicians should not be solely responsible for data entry, coding and management of the use of electronic medical record systems."

Current AMA policy does not explicitly address administrative burden on employed physicians. While physicians must ultimately take responsibility for the care of their patients, which includes documentation and other uses of the electronic medical record, they should not be burdened with such tasks to the detriment of patient care. We therefore recommend adoption of new AMA policy as follows:

> Employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients.

Resolve 5 asks "That this bill of rights include the principle that clinical activity should be evaluated only through the peer review process and judged only by clinicians, not corporate executives."

Resolve 5 is addressed by Policy H-225.950, "AMA Principles for Physician Employment," and H-225.942, "Physician and Medical Staff Member Bill of Rights:"

H-225.905: "(5)(c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians—not lay administrators—should be ultimately responsible for all peer review of medical services provided by employed physicians."

H-225.942: "(IV)(d) "individual medical staff members have "the right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty."

Resolve 6 asks "That this bill of rights include the principle that physician activities performed outside of defined employed-time boundaries are the sole prerogative of the individual physician and not the employer organization unless it directly conflicts with or increases risk to the organization."

AMA Policy H-225.950, "AMA Principles for Physician Employment," recognizes two important points related to Resolve 6: First, that employed physicians do in fact owe a duty of loyalty to their employers, which may reasonably limit their rights to engage in activities that conflict with the financial or other interests of the employer–for example, moonlighting at a competing hospital:

"(1)(a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest...which employed physicians should strive to recognize and address."

At the same time, the policy states that "employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees."

We believe that these two statements taken together appropriately addresses the matter of "physician activities performed outside of defined employed-time boundaries" and recommend no amendments to existing policy. Physicians are encouraged to carefully negotiate their contract to ensure their desired level of independence outside the context of employed time is protected.

Resolve 7 asks "That this bill of rights include the principle that conflict-of-interest disclosures should be limited to physician activities that directly affect the organization and should only be disclosed to entities that directly reimburse the physician during their employed time period."

Resolve 7 is addressed by two provisions of Policy H-225.955, "Protection of Medical Staff Members' Personal Proprietary Financial Information," to which we recommend a clarifying edit:

"(1)(a) Physicians should be required to disclose personal financial information to the hospital/health system only if they are serving or being considered to serve as a member of the governing body, as a corporate officer, or as an employee/contractor of the hospital/health system; and such information should be used only so that other individuals understand what conflicts may exist when issues are discussed and when recusal from voting or discussion on an issue may be appropriate."

"(2) Medical staff members' personal financial information shall remain confidential except for disclosure to those with a bona fide need for access to such information. The security and storage of such information, including electronic and paper-based, should be at the same level as that afforded to other data and files in the hospital, such as patient and peer review

> information that enjoy confidentiality and privacy protections, including restricted access, password protection and other protective mechanisms."

Resolve 8 asks "That this bill of rights include the principle that restrictive covenants should be limited only to physicians with partnership stakes in the organization and should not apply to salary-based physicians."

Resolve 8 is addressed by Ethical Opinion 11.2.3.1, "Restrictive Covenants," and Policy H-225.950, "AMA Principles for Physician Employment," both of which discourage physicians from entering into employment contracts that contain restrictive covenants, regardless of status as a partner or salaried employee:

> Code of Medical Ethics 11.2.3.1: "Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms. Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care. Physicians should not enter into covenants that: (a) Unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and (b) Do not make reasonable accommodation for patients' choice of physician."
>
> H-225.950: "(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment."

Resolve 9 asks "That this bill of rights include the principle that resources should be appropriately allocated by the organization for continuing medical education as defined by state licensure guidelines."

Resolve 9 is inconsistent with Policy H-300.982, "Maintaining Competence of Health Professionals," which places on the physician the burden of the cost of completing continuing medical education:

> "(1) Health professionals are individually responsible for maintaining their competence and for participating in continuing education; all health professionals should be engaged in self-selected programs of continuing education. In the absence of other financial support, individual health professionals should be responsible for the cost of their own continuing education."

We note also that compensation or reimbursement for CME is a fairly common benefit of employment which physicians should consider carefully as they negotiate employment contracts. Refer to the AMA annotated model physician employment agreements for guidance.[1]

Resolve 10 asks "That this bill of rights include the principle that employed physicians have the right to the collective bargaining process as outlined in the National Labor Relations Act of 1935 (The Wagner Act)."

Given that collective bargaining is largely toothless without the specter of a strike, resolve 10 is arguably inconsistent with Ethical Opinion 1.2.10, "Political Action by Physicians," and Policy H-383.998, "Resident Physicians, Unions and Organized Labor," which discourage physicians

[1] These and other resources on employment contracts are available at ama-assn.org/residents-students/career-planning-resource/understanding-employment-contracts.

from withholding essential medical services from patients or otherwise disrupting patient care as a bargaining tactic:

> Code of Medical Ethics 1.2.10: "Physicians who participate in advocacy activities should: (a) Ensure that the health of patients is not jeopardized and that patient care is not compromised; (b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice; (c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians' primary and overriding commitment to patients; (d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate."

> H-383.998: "Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients."

Resolve 11 asks "That this bill of rights include the principle that all physicians be empowered to first be the patient's advocate and be allowed to adhere to the spirit of the Hippocratic Oath allowing patient privacy, confidentiality and continuity of a patient's health care and dignity."

Resolve 11 is addressed by Policy H-225.950, "AMA Principles for Physician Employment:"

> H-225.950: "(2)(a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated."

> H-225.950: "(1)(b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests."

Additionally, as noted in the AMA's history of its Code of Medical Ethics, the Code "is rooted in an understanding of the goals of medicine as a profession, which dates back to the 5th century BCE and the Greek physician Hippocrates, to relieve suffering and promote well-being in a relationship of fidelity with the patient."

RESOLUTION 702-A-18, BASIC PRACTICE PROFESSIONAL STANDARDS OF PHYSICIAN EMPLOYMENT

Resolution 702-A-18 identifies a set of "best practices" related broadly to physician employment and asks our AMA to support specific contract provisions that might improve the physician experience in the employed settings:

That our American Medical Association support best practice for physician employment that will promote improved work-life balance and maximum employment adaptability and professional treatment to maintain physicians in productive medical practice and minimize physician burnout. To achieve these goals, best practice efforts in physician employment contracts would include, among other options:

1. Establishing the degree of physician medical staff support as well as specifying how different medical staff costs will be covered.

2. Establishing a specific degree of clerical and administrative support. This would include access to an EMR (electronic health record) scribe, as well as specifying how different clerical or administrative support costs will be shared/covered.

3. Providing information regarding current EMR systems and their national ranking, including user ratings and plans to improve these systems.

4. Providing work flexibility with pay and benefit implications for reduced work hours, reduced call coverage, job sharing, child care support, use of locum tenens coverage, leave of absence for personal reasons or extended duty in the military, medical service organizations or other "greater societal good" organizations.

5. Establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county/region.

While none of these aims is objectionable on its face, the creation of such a list would seem to be inconsistent with an overarching theme of AMA employment-related policy: that physicians must be free to and should exercise self-determination in employment contracting. Specifically, Policy H-225.950, "AMA Principles for Physician Employment," avers that "Physicians should be free to enter into *mutually satisfactory* contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession" (emphasis added). Furthermore, "physicians should never be coerced into employment" and "employment agreements between physicians and their employers should be negotiated in good faith," with "both parties [being] urged to obtain the advice of legal counsel experienced in physician employment matters…."

Individual physicians must determine for themselves what they seek in employment arrangements and how they weigh these various desires. For example, some physicians may choose to forego work flexibility or smaller workload in exchange for greater compensation; others may choose to forego additional compensation to work for an organization that provides a higher level of administrative support. So long as they balance these desires in a manner that does not compromise the ethical principles of the medical profession, physicians should be free to negotiate their contracts as they see fit. Physicians are encouraged to use AMA resources in this regard, such as the AMA's model physician employment agreements. These valuable resources include a thorough description of basic contract terms typically found in an employment agreement, an in-depth explanation of the significance of such provisions and language that benefits the physician employee, and important examples of language that may be problematic to the physician employee.

Finally, we note that some sections of Resolution 702-A-18—in particular, items 1-3—raise an issue discussed earlier in this report: appropriate levels of support for employed physicians. While physicians should be free to negotiate for their desired level of staffing, AMA should ensure that physicians are provided at least the level of staffing needed to ensure that they can deliver safe,

high-quality care to their patients. We therefore recommend adoption of new AMA policy as follows (and as presented in the discussion on Resolve 4 of Resolution 701-A-18):

> Employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients.

CONCLUSION

The concepts set forth in Resolution 701-A-18, "Employed Physician Bill of Rights," and Resolution 702-A-18, "Basic Professional Standards of Physician Employment," are for the most part addressed by a variety of existing AMA policies. We recommend reaffirmation of these policies. In a few instances, the concepts set forth in Resolutions 701 and 702-A-18 are inconsistent with current policy, in which case we recommend no change in policy. Finally, we have identified two themes not addressed by existing policy—academic freedom for employed physicians and appropriate levels of administrative and clinical support—and we recommend adoption of new policy in these areas.

RECOMMENDATIONS

The Board of Trustees recommends the following be adopted in lieu of Resolution 701-A-18 and Resolution 702-A-18, and the remainder of the report be filed:

1. That our AMA reaffirm the following policies:

   - H-225.950, AMA Principles for Physician Employment,
   - H-225.997, Physician-Hospital Relationships,
   - H-225.942, Physician and Medical Staff Member Bill of Rights,
   - H-225.955, Protection of Medical Staff Members' Personal Proprietary Financial Information,
   - H-300.982, Maintaining Competence of Health Professionals, and
   - H-383.998, Resident Physicians, Unions and Organized Labor. (Reaffirm HOD Policy)

2. That our AMA amend policy H-225.955, Protection of Medical Staff Members' Personal Proprietary Financial Information:

   > "(1)(a) Physicians should be required to disclose personal financial information to the hospital/health system only if they are serving or being considered to serve as a member of the governing body, as a corporate officer, or as an employee/contractor of the hospital/health system; and such information should be used <u>only</u> so that other individuals understand what conflicts may exist when issues are discussed and when recusal from voting or discussion on an issue may be appropriate." (Modify Current HOD Policy)

3. That our AMA amend policy H-225.950, AMA Principles for Physician Employment:

   > "(1)(b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. <u>Employed physicians also should enjoy academic freedom to pursue clinical</u>

research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization." (Modify Current HOD Policy)

4. That our AMA advocate that employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients. (New HOD Policy)

Fiscal Note: Less than $500.

Appendix

Resolution 701-A-18, “Employed Physician’s Bill of Rights”

RESOLVED, That our American Medical Association adopt an “Employed Physician’s Bill of Rights”; and be it further

RESOLVED, That this bill of rights include the principle that compensation should be based on the totality of physician activities for the organization, including but not limited to educational endeavors and preparation, committee participation, student/resident activities and administrative responsibilities; and be it further

RESOLVED, That this bill of rights include the principle that physicians have academic freedom, without censorship in clinical research or academic pursuits; and be it further

RESOLVED, That this bill of rights include the principle that physicians should not be solely responsible for data entry, coding and management of the use of electronic medical record systems; and be it further

RESOLVED, That this bill of rights include the principle that clinical activity should be evaluated only through the peer review process and judged only by clinicians, not corporate executives; and be it further

RESOLVED, That this bill of rights include the principle that physician activities performed outside of defined employed-time boundaries are the sole prerogative of the individual physician and not the employer organization unless it directly conflicts with or increases risk to the organization; and be it further

RESOLVED, That this bill of rights include the principle that conflict-of-interest disclosures should be limited to physician activities that directly affect the organization and should only be disclosed to entities that directly reimburse the physician during their employed time period; and be it further

RESOLVED, That this bill of rights include the principle that restrictive covenants should be limited only to physicians with partnership stakes in the organization and should not apply to salary-based physicians; and be it further

RESOLVED, That this bill of rights include the principle that resources should be appropriately allocated by the organization for continuing medical education as defined by state licensure guidelines; and be it further

RESOLVED, That this bill of rights include the principle that employed physicians have the right to the collective bargaining process as outlined in the National Labor Relations Act of 1935 (The Wagner Act); and be it further

RESOLVED, That this bill of rights include the principle that all physicians be empowered to first be the patient’s advocate and be allowed to adhere to the spirit of the Hippocratic Oath allowing patient privacy, confidentiality and continuity of a patient’s health care and dignity.

Resolution 702-A-18, “Basic Practice Professional Standards of Physician Employment”

RESOLVED, That our American Medical Association support best practice for physician employment that will promote improved work-life balance and maximal employment adaptability and professional treatment to maintain physicians in productive medical practice and minimize physician burnout. To achieve these goals, best practice efforts in physician employment contracts would include, among other options:

1. Establishing the degree of physician medical staff support as well as specifying how different medical staff costs will be covered.

2. Establishing a specific degree of clerical and administrative support. This would include access to an EMR (electronic medical record) scribe, as well as specifying how different clerical or administrative support costs will be shared/covered.

3. Providing information regarding current EMR systems and their national ranking, including user ratings and plans to improve these systems.

4. Providing work flexibility with pay and benefit implications for reduced work hours, reduced call coverage, job sharing, child care support, use of locum tenens coverage, leave of absence for personal reasons or extended duty in the military, medical service organizations or other “greater societal good” organizations.

5. Establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county/region.

REPORT OF THE ORGANIZED MEDICAL STAFF SECTION
GOVERNING COUNCIL

GC Report BB-A-19

Subject: OMSS Position on Board of Trustees Report 32-A-19: Impact of High Capital Costs of Hospital EHRs on the Medical Staff

Presented by: David Welsh, MD, Chair

Referred to: OMSS Reference Committee
(James Guo, MD, Chair)

EXECUTIVE SUMMARY OF BOARD OF TRUSTEES REPORT 32

At the 2018 Annual Meeting Policy D-225.974, "Impact of the High Capital Cost of Hospital EHRs on the Medical Staff," was adopted by the House of Delegates (HOD). [AMA Policy D-225.974 was the result of an OMSS-sponsored resolution at the 2018 Annual Meeting.] The policy asks the American Medical Association (AMA) to study the long-term economic impact for physicians and hospitals of EHR system procurement, including but not limited to its impact on downsizing of medical staffs and its effect on physician recruitment and retention. This report provides the requested study of documented economic and financial impacts of procuring electronic health record systems.

Implementing or upgrading an Electronic Health Record (EHR) in a medical practice, while beneficial in many ways, comes with a variety of costs. These costs include financial, productivity, workforce/personnel, and clinician and patient satisfaction. Long-term, these costs can all have effects on a health system's medical staff/workforce. These impacts, and the long-term economic and financial costs, are not widely studied or discussed.

RECOMMENDATION OF BOT REPORT 32

The Board of Trustees recommends that Policy D-225.974, "Impact of the High Capital Cost of Hospital EHRs on the Medical Staff," be rescinded as having been fulfilled by this report and that the remainder of this report be filed. (Rescind HOD Policy)

GOVERNING COUNCIL RECOMMENDATION

The Governing Council recommends that the OMSS Delegate be instructed to support the intent of the recommendations of BOT Report 32-A-19.

REPORT 32 OF THE BOARD OF TRUSTEES (A-19)
Impact of High Capital Costs of Hospital EHRs on the Medical Staff
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting Policy D-225.974, "Impact of the High Capital Cost of Hospital EHRs on the Medical Staff," was adopted by the House of Delegates (HOD). The policy asks the American Medical Association (AMA) to study the long-term economic impact for physicians and hospitals of EHR system procurement, including but not limited to its impact on downsizing of medical staffs and its effect on physician recruitment and retention. This report provides the requested study of documented economic and financial impacts of procuring electronic health record systems.

Implementing or upgrading an Electronic Health Record (EHR) in a medical practice, while beneficial in many ways, comes with a variety of costs. These costs include financial, productivity, workforce/personnel, and clinician and patient satisfaction. Long-term, these costs can all have effects on a health system's medical staff/workforce. These impacts, and the long-term economic and financial costs, are not widely studied or discussed.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 32-A-19

Subject:	Impact of High Capital Costs of Hospital EHRs on the Medical Staff
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee G (Rodney Trytko, MD, Chair)

INTRODUCTION

At the 2018 Annual Meeting Policy D-225.974, "Impact of the High Capital Cost of Hospital EHRs on the Medical Staff," was adopted by the House of Delegates (HOD). The policy asks the American Medical Association (AMA) to study the long-term economic impact for physicians and hospitals of EHR system procurement, including but not limited to its impact on downsizing of medical staffs and its effect on physician recruitment and retention.

This report provides the requested study of documented economic and financial impacts of procuring electronic health record systems.

BACKGROUND

Electronic health records (EHRs) are an integral part of the vast majority of health care delivery in the United States. In 2017, 99 percent of large, 97 percent of medium, and 93 percent of small rural non-federal hospitals had a certified EHR product in operation.[1] In 2015, the most recent year for which data could be found, 84 percent of non-federal acute care hospitals had at least a basic EHR in operation, and 87 percent of office-based physicians were using an EHR.[2] The benefits of EHR use are well-documented, however, so are the growing concerns with the amount of time and types of tasks required in using an EHR in practice.[3, 4] There is also evidence showing the often-burdensome financial investment that implementing and maintaining an EHR system requires. Although there are several studies quantifying the financial investment, the reported costs of EHR implementation vary greatly across studies,[5, 6] owing most likely to differences in geographic locations, practice size and type, and EHR type. One study estimated EHR implementation in a five-physician practice would cost $233,297, or $46,659 per physician, in the first year.[7] In 2017 some hospitals and health systems reported EHR implementations costing from $25 million up to $10 billion.[8] The differences in practice size and type, EHR type, health information technology (HIT) budgets, specialty, and rural/urban location, make it difficult to accurately quantify costs that are representative across health care practices in the U.S. In addition, the Centers for Medicare & Medicaid Services (CMS) has not updated the practice expense component of the resource-based relative value scale (RBRVS) physician fee schedule in nearly a decade, compounding the lack of valid comparisons and the potential underpayment to physicians for expenses required to maintain a current EHR system. Notwithstanding the challenges in quantifying costs, it is important to consider and understand the long-term impacts of the financial commitment required to implement or upgrade an EHR, including the effects on the physician and clinician workforce.

The financial costs of implementing an EHR system comprise many factors, including software licensing, projected maintenance, fees, and costs for initial and ongoing training and labor. Some hospitals include the salaries of existing HIT staff in their cost estimates. Others may include the costs of hardware such as new computers, tablets or other devices. These costs can add up to millions, and even billions of dollars for the largest purchasers.[9] Additional costs arise when expenses exceed budgets and when organizations invest in upgrading or optimizing their original EHR system. Other costs, sometimes attributable to EHR implementation, can occur in the form of workforce attrition that happens when organizations cut staff to reduce costs or physicians reduce work hours or leave practice due to frustrations with administrative burden created by EHRs. Despite these challenges, EHRs will continue to be a principal component of health care delivery in the U.S. However, for the technology to be a viable and sustainable solution for practices of all sizes and types, it will be important to know the potential long-term effects the high implementation, optimization, and maintenance costs will have on the ability to sustain existing medical staff and recruit new staff to meet the growing demand of patients' needs.

AMA POLICY

The AMA has extensive policy supporting the use of EHRs and encouraging stakeholders to implement policies, technology improvements, and utilization standards to minimize the financial burden and maximize efficiency and safety in the use of EHRs.

The AMA is committed to working with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure, so that the financial burden on physicians is not disproportionate when they implement health care technologies in their offices. The AMA also continues to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining EHRs (Policy D-478.996, "Information Technology Standards and Costs"). The AMA is working with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production (Policy D-478.973, "Principles for Hospital Sponsored Electronic Health Records").

The AMA supports the drive for innovation in the use of EHRs to develop best practices concerning key EHR features that can improve the quality, safety, and efficiency of health care (Policy D-478.976, "Innovation to Improve Usability and Decrease Costs of EHR Systems for Physicians"). In addition, the AMA advocates for legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community-based settings of care delivery. The AMA works with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost-effective use and sharing of electronic health records across all settings of care delivery (Policy D-478.995, "National Health Information Technology").

It is AMA policy that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules, which if represented appropriately would help offset these costs for many practices (Policy H-478.981, "Health Information Technology Principles"). Furthermore, the AMA advocates for inclusion of payment supplements in the current and proposed payment systems specifically to cover the costs of maintaining (including upgrades of) EHRs and continuously evaluates and monitors the cost to physicians and their practices of maintaining and upgrading EHRs (Policy D-478.975, "Maintenance Payments for Electronic Health Records").

DISCUSSION

Costs of implementing or upgrading an EHR system

The costs associated with implementing and/or optimizing an EHR system have been shown to vary significantly across practices and organizations. This is based on a variety of factors, including but not limited to, practice type and size, infrastructure needs, staffing resources, and maintenance fees. Due to the variability of factors, precise costs are difficult to confirm across practice settings.

Several studies and reports have endeavored to document and estimate the immediate and ongoing costs of EHR implementation. One study estimated EHR implementation for a solo physician in practice to cost $163,765, inclusive of labor and hardware costs. In the same study, it was estimated EHR implementation in a five-physician practice would cost $233,297, or $46,659 per physician, in the first year.[7] In 2017 some hospitals and health systems reported EHR implementations costing from $25 million up to $10 billion.[8]

In conjunction with evaluating the costs of implementation, several studies have also described the cost-benefit analysis of EHRs in various practice settings. A 2003 study of EHR implementation in a primary care practice estimated the net benefit from using an electronic medical record for a five-year period was $86,400 per provider. Benefits resulted primarily from savings in drug expenditures, improved utilization of radiology tests, better capture of charges, and decreased billing errors. Using a five-way sensitivity analysis that accounted for variables such as proportion of capitated patients, patient panel size, and software and hardware costs, this study showed results ranging from a $2,300 net cost to a $330,900 net benefit to the organization. However, among fee-for-service patients, a large portion of the savings from improved utilization may accrue to the payer instead of the provider organization.[10] This study was completed using data from an internally developed EMR at Partners HealthCare, an integrated network formed by Brigham and Women's Hospital and Massachusetts General Hospital.

Another study found that implementation of EHRs in solo or small practices incurred initial costs of approximately $44,000 per FTE provider per year, including software, hardware and lost revenue from reduced productivity. Ongoing costs were estimated at $8,500 per FTE provider per year, including software and hardware maintenance or replacement, and support staff. This study also found the average practice paid for its initial and cumulative ongoing EHR costs within two and a half years, and began to see more than $23,000 in net benefits per FTE provider per year. Also of note, participants in this evaluation reported that providers worked longer hours for about four months after implementation, as they became more familiar with the system.[11]

A 2013 projection of return on investment (ROI) five years after an EHR pilot predicted each physician would lose nearly $44,000 and only 27% of practices surveyed would achieve a positive ROI. An additional 14% would experience a net gain if they received the federal meaningful use incentive. This analysis revealed the largest difference between practices with a positive return on investment and those with a negative return would be the extent to which they used their EHRs to increase revenue, primarily by seeing more patients per day or by improved billing that resulted in fewer rejected claims and more accurate coding.[12]

A 2014 ROI analysis found that primary care practices recovered their EHR investments within an average period of 10 months. An observed increase in the number of active patients, the increase in the active-patients-to-clinician-FTE ratio, and the increase in the clinic net revenue are positively

associated with the EHR implementation, likely contributing substantially to the 10-month average break-even point.[13]

In addition to initial implementation costs, upgrades and optimizations require significant resources, but can help the organization realize cost and time efficiencies. In 2017, 38 percent of health care CIOs indicated "EMR optimization" as their organization's top item planned for capital investment through 2020.[14] A 2018 case study at a Colorado hospital employed an optimization strategy that saved them between $300,000 and $500,000 per year, in addition to a 53 percent increase in cash collections since go-live, a 15 percent decrease in days in accounts receivable, assistance from time-saving tools that automatically track changes to payer rules, authorization management services that free up staff to take on high-value work, and reduced operating costs with transparent pricing that includes upgrades and interfaces.[15]

Furthermore, to encourage organizations to adopt HIT technology and specifically EHR systems, the federal government provided incentives to those providers who met "meaningful use" standards through the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. As of October 2018, CMS reported payments of $38.4 billion to almost 550,000 Medicare and Medicaid providers, or approximately $65,000 per provider. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) sunset the meaningful use program for physicians participating in Medicare. Physicians and hospitals participating in CMS programs now fall under Promoting Interoperability (PI) program requirements.[16] The Quality Payment Program, which replaced the Medicare meaningful use program, sunset the HITECH Act meaningful use incentives. However, PI participants in Medicaid are still eligible for incentive payments through 2021. It should be noted, however, that practices that did not implement an EHR system or were not eligible for the meaningful use program did not receive incentive payments.

Staff/workforce reductions resulting from EHR investment

Many healthcare organizations have reported reductions in workforce over recent years. The reasons for staff reductions vary from lowered reimbursements, realignment towards value-based care, optimizing operational efficiency, and EHR-related costs. Organizations citing workforce reductions related to excessive EHR costs have widely reported layoffs in the areas of general operations, administration, revenue cycle and information technology, not in the positions of direct patient care, such as physicians, advanced practice providers and nursing.[17] In a recent statement from Tenet Healthcare, leadership reported the intent to offshore more than 1,000 jobs, likely in the area of corporate functions. Tenet leadership also expressly stated direct patient care employees, such as physicians and nurses, would not be affected by the change.[18]

Reports of workforce reduction or job outsourcing specifically due to investments in EHR technology exist, but are few. For example, in 2015 Lahey Health in Massachusetts lost $21 million due to both lost business and expenses related to EHR implementation. The shortfall prompted Lahey to lay off 130 people, which their CEO attributed partly to unplanned training expenses connected to the EHR implementation.[19] Also in 2015, Southcoast Hospital reduced its workforce by one percent after expenses related to their EHR implementation exceeded what they budgeted.[20]

At the end of 2015, Brigham and Women's Hospital reported lower financial gains than they had originally anticipated with their EHR implementation after falling $53 million short of the $121 million expectation. These losses led to the subsequent elimination of 80 open positions and 20 staff members. Hospital president Betsy Nabel, MD, credited this in part to reduced reimbursements from payers, high labor expenses among a largely unionized workforce, and high

capital costs, including those related to new facilities and their Epic implementation.[21] The hospital budgeted $47 million for its implementation, but faced $27 million in unexpected costs.[22] In 2017, even while finances were improving, Brigham and Women's was still facing a shortfall, forcing them to commit to a $50 million reduction in operating expenses, including offering a buyout to more than 1,000 senior employees, including nursing staff.[23]

In 2017, MD Anderson Cancer Center cut between 800 and 900 administrative positions after experiencing significant losses after EHR implementation. MD Anderson also reported decreased patient revenues resulting from EHR implementation but did not provide details on how the EHR affected patient revenue.[24] However, they reported operating margins were net positive at fiscal year-end 2017.[25] Wake Forest Baptist Medical Center and Moses Cone Memorial Hospital in North Carolina have both experienced downgraded bond ratings and significant operating losses after implementing EHR systems. They have both also cut staff to make up for these losses.[26]

EHR implementation was undoubtedly a major factor in the financial circumstances that prompted workforce reductions for these organizations. No one factor can be considered the sole catalyst, however, as other significant costs, such as investments in new facilities, acquisition of other practices, losses on investments, changing reimbursement rates, and increased operational costs contributed to the budget holes that forced these hospitals to take cost-saving measures.[27] It is also important to consider that hospitals and health systems reduce workforce for many reasons, including forces entirely separate from EHR implementation, such as changing patient population, specialty mix, or community needs.

Considerable costs, unbudgeted expenses, unforeseen training needs, and lost productivity due to learning curves and unexpected downtime, are all known risks of implementing any new or upgraded EHR.[28] Despite these accounts of losses and financial distress, some organizations implement EHRs without issue and the long-term gains outweigh the short term financial losses. It is also of note that the cases described above all involve the same EHR vendor product, therefore generalizing these adverse experiences to all EHRs is not advised.

In addition to staff/workforce reductions driven by budgetary reasons, EHR implementation is transforming the personnel needs and roles for healthcare organizations. A 2016 publication from the North Carolina Medical Journal highlights the need for new jobs to assist before, during, and after EHR implementation, such as technical software support staff, medical scribe specialists, health care quality improvement specialists, and health care data scientists.[29] The most common areas of staff reduction due to EHR implementation are in the areas of medical records, transcription, and billing by replacing paper-related processes.[29, 30]

An indirect cost of EHR implementation can be seen in the effects EHRs have on physicians in practice, including increasing administrative burden, reducing face-to-face time with patients, and even prompting reduction in work hours or leaving medicine altogether.[31] Nearly 40 percent of doctors list EHR design as one of the two things they find least satisfying about their jobs. Fifty-six percent say the requirement has reduced efficiency and 66 percent report EHR use has reduced the amount of time they spend with patients.[32] In a 2017 survey, nearly one in five physicians indicated they planned to reduce work hours within the following year. Dissatisfaction with the EHR was an independent predictor of a physician's intent to leave practice or reduce clinical hours.[31]

Effects of EHR investment on the financial state of hospitals

Implementing an EHR system is a significant undertaking for any practice or health care organization. Adequate implementation can be costly and time consuming, resulting in many organizations assuming a financial loss for a duration of time, a factor to be included in the capital planning and budgetary process. Many eligible providers received incentive payments for the adoption and use of EHRs,[16] and the majority of eligible hospitals have demonstrated meaningful use of certified HIT through participation in the EHR incentive program.[1]

Common drivers and challenges contribute to the financial impact of EHR implementation. During the implementation process, an increase in overall operational expenses occurs due to training of personnel and the need for additional staff, consultants, and upfront product purchases. During this time, the organization simultaneously experiences a reduction in productivity resulting in decreased patient revenue. In addition to these two factors, some organizations discover they underestimated the full costs of EHR implementation. For example, primary budgeting may only account for the cost reported by the vendor, and the organization does not consider the expenses of staff, training, infrastructure costs, and ongoing maintenance, resulting in significant unexpected costs.

Other areas of additional or unexpected costs include compliance with regulatory requirements, credit challenges, and vendor deficiencies. With the introduction of meaningful use requirements and government incentives, additional costs are often incurred to comply with regulatory requirements.[33] Some hospitals have reported credit challenges in having adequate financial reserves to support the initial capital investment required for implementing an EHR platform.[34] Other organizations have cited additional costs due to vendor shortcomings. For example, Mountainview Medical Center in White Sulphur Springs, Montana filed a lawsuit against NextGen for failing to install a compliant system on time.[34]

As technology advances and regulatory requirements for data collection evolve, EHR implementation and optimization projects are becoming more comprehensive. As a result, many organizations have reported initial financial losses. However, recovery of net operating income and a return to prior productivity levels occur within a short period of time. In 2015 and 2016, Partners HealthCare, the site of the 2003 study previously discussed,[10] implemented a new EHR system. Partners HealthCare reported a decline of $74.1 million in operating income for the last quarter of 2015 compared to the same quarter the prior year, due in part to the organization's EHR implementation. By the second quarter of 2016, leadership reported gains in operating income, despite simultaneously experiencing costs of $18 million in EHR-related upgrades and expenses.[35]

In the first quarter of 2016, Allegheny Health Network reported an operating loss of $17.8 million due to EHR implementation expenses, $8.1 million more than the same period in the prior year. In planning, the health system projected $9.4 million in net losses for the first quarter of the year, yet reported $20.6 million. Leadership stated that in addition to decreased patient volumes, much of the costs were attributed to a one-time investment in the EHR system.[35]

While there is evidence that practices have incurred financial losses during EHR implementation and optimization,[35] an extensive literature search does not identify an instance of any practice or organization closing or changing their physician recruitment and retention practices specifically due to exorbitant HIT/EHR costs. In addition, there is no requirement for medical staffs to report to a state or national database why a medical staff member decides to resign, nor is there a requirement to report the number of medical staff members and their membership status (e.g., active, courtesy, consulting, emeritus making it further difficult to quantify such effects.

Long-term economic impacts

There are very few studies available about the long-term economic impacts or effects of EHR implementation. One 2015 study attempted to examine financial and clinical work day productivity outcomes associated with the use of an EHR over nine years. The difference in net clinical revenue per provider per year did not change significantly after EHR implementation. Charge capture, the proportion of higher- and lower-level visit codes for new and established patients, and patient visits per provider remained stable, and a total savings of $188,951 in transcription costs occurred over a 4-year time period post-EHR implementation.[36] Another 2014 study evaluated the long-term financial impact of EHR implementation in ambulatory practice. Practice productivity was tracked over two years post-EHR implementation and demonstrated that the implementation was associated with increased revenue, even after accounting for observed reduction in the number of patient visits.[37] The AMA inquired with leadership at the American Hospital Association to determine if they had additional research, content, or resources on the subject of EHR cost impacts on hospitals and medical staffs, and they indicated they do not currently have any materials or resources available.

CONCLUSION

It is evident from the literature that the costs, break-even point, and ROI all vary dramatically depending on practice type, size, patient panel, specialty, and location. Given these disparate representations, and the limited amount of recent, rigorous long-term study, it is difficult to establish a universal ROI-focused narrative that makes a case that EHRs are either a wise or poor long-term investment for hospitals or health systems, or any practice type. While there is anecdotal evidence of physicians retiring early due to the implementation costs of EHR's there is little to no data available to assert that investments in EHR technology will lead to subsequent reductions in medical staff. Although EHR investments have contributed to temporary financial losses for some organizations, there are no reports of hospitals or health systems forced to make sweeping reductions in medical staff or completely closing explicitly due to investments in EHR technology. One could speculate that organizations cutting or outsourcing non-direct patient care staff may not be in a financial position to add more physicians to the staff, however there is no data to support this. Although the impacts of staffing cuts inevitably affect care teams and patients, there is little to no evidence that physicians have been included in the groups of workers laid off by organizations that have made cuts.

A common theme throughout the available literature on cost-benefit analysis is that realizing the benefits and achieving a positive ROI depend heavily on the engagement with and optimization of the EHR as a tool for efficiency and process change. Simply installing the system without proper training and feature customization will slow productivity and create new problems. Partial implementation of an EHR, i.e., the continued use of paper for some record keeping, will inhibit the benefits of implementing an EHR and reduce the total return on investment. Organizational policies that promote EHR-enabled changes, such as EHR-supported clinic workflow, along with more thorough research and planning for the implementation process, could facilitate the realization of positive ROI and reduce the potential need for workforce reduction.

RECOMMENDATION

The Board of Trustees recommends that Policy D-225.974, "Impact of the High Capital Cost of Hospital EHRs on the Medical Staff," be rescinded as having been fulfilled by this report and that the remainder of this report be filed. (Rescind HOD Policy)

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REPORT OF THE ORGANIZED MEDICAL STAFF SECTION
GOVERNING COUNCIL

GC Report CC-A-19

Subject: OMSS Position on Council on Medical Education Report 6-A-19: Study of Medical Student, Resident, and Physician Suicide

Presented by: David Welsh, MD, Chair

Referred to: OMSS Reference Committee
(James Guo, MD, Chair)

EXECUTIVE SUMMARY OF CME REPORT 6

AMA Policy D-345.984 (1), "Study of Medical Student, Resident, and Physician Suicide," asks that the American Medical Association (AMA) determine the most efficient and accurate mechanism to study the actual incidence of medical student, resident, and physician suicide. Resolution 959-I-18, "Physician and Medical Student Mental Health and Suicide," asks that the AMA create a new Physician and Medical Student Suicide Prevention Committee with the goal of addressing suicides and behavioral health issues in physicians and medical students. This report considers appropriate deliverables to fulfill these directives and to further establish the AMA's leadership role in this area.

Burnout in physicians, residents, and medical students has been widely reported in recent years in both the lay and scholarly press, and incidence of depression and suicide is greater in medical students, residents, and physicians than in the general population. The AMA has studied the mental and physical toll that medical education exacts on medical students as they seek to balance their personal lives with the need to master a growing body of knowledge and develop the skills required to practice medicine. AMA policy addresses the long-standing and deeply ingrained stigma against physicians, residents, and students who seek care for either physical or behavioral health issues, partly due to concerns of career and licensure implications. Organizations such as the National Academy of Medicine, Federation of State Medical Boards, and Accreditation Council for Graduate Medical Education (ACGME) have begun to recognize the scope of this critical issue and are moving to address the problem. The AMA has also taken steps to decrease physician and medical trainee stress and improve professional satisfaction through resources such as the AMA's STEPS Forward™ practice improvement strategies and the Ed Hub™.

In addition to providing education resources for physicians, the AMA works with organizations to help them understand the incidence of burnout in their workplaces. Using data from the validated Mini-Z assessment tool enables the AMA to work with the organizations to identify solutions, which helps improve environmental, organizational, or cultural factors that, if not addressed, could lead to heightened stress or suicide risk for some.

The AMA is planning to partner with a leading academic medical institution to conduct a pilot study using data to be obtained from the National Death Index (NDI) to identify manner of death for a subset of the AMA Masterfile population. This research, planned for broad dissemination through publication in a peer-reviewed journal, will help the AMA identify opportunities to better

help physicians, residents, and medical students reduce factors that contribute to suicidal ideation and ultimately could help reduce the number of lives lost to suicide each year. This analysis could also include comparison to the general U.S. population, comparison to rates of physician burnout, longitudinal evaluation for various cohorts, as well other variables allowed by the data. The manner of death data could also enable additional study into physician mortality trends, such as patterns of other disease states or geographic variations.

It will also be important for the AMA to monitor progress that has been made by the Association of American Medical Colleges and the ACGME to collect data on medical student, resident, and fellow suicides to identify patterns that could predict such events.

RECOMMENDATION OF CME REPORT 6

The routine occurrence of burnout, depression, and suicide in physicians, residents/fellows, and medical students warrants continued study. Several recommendations have been offered to collect data on the actual incidence of physician and physician-in-training suicide. The Council on Medical Education therefore recommends the following recommendations be adopted in lieu of Resolution 959-I-18 and the remainder of this report be filed.

1. That our American Medical Association (AMA) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies. (Directive to Take Action)
2. That our AMA monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events. (Directive to Take Action)
3. That our AMA supports the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free behavioral health services. (Directive to Take Action)
4. That our AMA collaborate with other stakeholders to study the incidence of suicide among physicians, residents, and medical students. (Directive to Take Action)
5. That Policy D-345.984, “Study of Medical Student, Resident, and Physician Suicide,” be rescinded, as having been fulfilled by this report and through requests for action by the Liaison Committee on Medical Education and ACGME. (Rescind HOD Policy)

GOVERNING COUNCIL RECOMMENDATION

The Governing Council recommends that the OMSS Delegate be instructed to support the intent of the recommendations of CME Report 6-A-19.

REPORT 6 OF THE COUNCIL ON MEDICAL EDUCATION (A-19)
Study of Medical Student, Resident, and Physician Suicide (Resolution 959-I-18)
(Reference Committee C)

EXECUTIVE SUMMARY

AMA Policy D-345.984 (1), "Study of Medical Student, Resident, and Physician Suicide," asks that the American Medical Association (AMA) determine the most efficient and accurate mechanism to study the actual incidence of medical student, resident, and physician suicide. Resolution 959-I-18, "Physician and Medical Student Mental Health and Suicide," asks that the AMA create a new Physician and Medical Student Suicide Prevention Committee with the goal of addressing suicides and behavioral health issues in physicians and medical students. This report considers appropriate deliverables to fulfill these directives and to further establish the AMA's leadership role in this area.

Burnout in physicians, residents, and medical students has been widely reported in recent years in both the lay and scholarly press, and incidence of depression and suicide is greater in medical students, residents, and physicians than in the general population. The AMA has studied the mental and physical toll that medical education exacts on medical students as they seek to balance their personal lives with the need to master a growing body of knowledge and develop the skills required to practice medicine. AMA policy addresses the long-standing and deeply ingrained stigma against physicians, residents, and students who seek care for either physical or behavioral health issues, partly due to concerns of career and licensure implications. Organizations such as the National Academy of Medicine, Federation of State Medical Boards, and Accreditation Council for Graduate Medical Education (ACGME) have begun to recognize the scope of this critical issue and are moving to address the problem. The AMA has also taken steps to decrease physician and medical trainee stress and improve professional satisfaction through resources such as the AMA's STEPS Forward™ practice improvement strategies and the Ed Hub™.

In addition to providing education resources for physicians, the AMA works with organizations to help them understand the incidence of burnout in their workplaces. Using data from the validated Mini-Z assessment tool enables the AMA to work with the organizations to identify solutions, which helps improve environmental, organizational, or cultural factors that, if not addressed, could lead to heightened stress or suicide risk for some.

The AMA is planning to partner with a leading academic medical institution to conduct a pilot study using data to be obtained from the National Death Index (NDI) to identify manner of death for a subset of the AMA Masterfile population. This research, planned for broad dissemination through publication in a peer-reviewed journal, will help the AMA identify opportunities to better help physicians, residents, and medical students reduce factors that contribute to suicidal ideation and ultimately could help reduce the number of lives lost to suicide each year. This analysis could also include comparison to the general U.S. population, comparison to rates of physician burnout, longitudinal evaluation for various cohorts, as well other variables allowed by the data. The manner of death data could also enable additional study into physician mortality trends, such as patterns of other disease states or geographic variations.

It will also be important for the AMA to monitor progress that has been made by the Association of American Medical Colleges and the ACGME to collect data on medical student, resident, and fellow suicides to identify patterns that could predict such events.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-A-19

Subject: Study of Medical Student, Resident, and Physician Suicide (Resolution 959-I-18)

Presented by: Carol Berkowitz, MD, Chair

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

AMA Policy D-345.984 (1), "Study of Medical Student, Resident, and Physician Suicide," asks:

> That our American Medical Association (AMA) determine the most efficient and accurate mechanism to study the actual incidence of medical student, resident, and physician suicide, and report back at the 2018 Interim Meeting of the House of Delegates (HOD) with recommendations for action.

Recognizing the importance and timeliness of this topic, the Council on Medical Education agreed that appropriate resources should be dedicated to identifying mechanisms for study, noting that meaningful and constructive review of this issue, and of the work done to date by other organizations, required additional time. Accordingly, this report was moved to the 2019 Annual Meeting.

This report also addresses Resolution 959-I-18, "Physician and Medical Student Mental Health and Suicide," introduced by the Indiana Delegation and referred by the AMA HOD; it asks:

> That our AMA create a new Physician and Medical Student Suicide Prevention Committee with the goal of addressing suicides and mental health disease in physicians and medical students. This committee will be charged with:
> 1) Developing novel policies to decrease physician and medical trainee stress and improve professional satisfaction.
> 2) Vociferous, repeated, and widespread messaging to physicians and medical students encouraging those with mood disorders to seek help.
> 3) Working with state medical licensing boards and hospitals to help remove any stigma of mental health disease and to alleviate physician and medical student fears about the consequences of mental illness and their medical license and hospital privileges.
> 4) Establishing a 24-hour mental health hotline staffed by mental health professionals whereby a troubled physician or medical student can seek anonymous advice. Communication via the 24-hour help line should remain anonymous. This service can be directly provided by the AMA or could be arranged through a third party, although volunteer physician counselors may be an option for this 24-hour phone service.

BACKGROUND

Burnout in physicians, residents, and medical students has been widely reported in recent years in both the lay and scholarly press, and incidence of depression and suicide is greater in medical students, residents, and physicians than the general population.[1-7] A recent study conducted by the

AMA, Stanford University School of Medicine, and Mayo Clinic shows rates of physician burnout in 2017 declined to 44 percent from 54 percent in 2014.[8] While burnout may have declined to levels present in 2011, the proportion of physicians screening positive for depression has modestly increased to nearly 42 percent.[8] Medical school and residency are stressful periods of physician training, each with their own dynamic. Many medical students experience substantial distress, which contributes to a decline in mental health and well-being. The American Medical Student Association reports that medical students are three times more likely to commit suicide than the rest of the general population in their age range in other educational settings.[4] Residents and practicing physicians also experience depression and burnout, and because they often lack a regular source of care, face barriers to the prompt diagnosis and treatment of behavioral disorders.[9] Stress, depression, and burnout are risk factors for suicidal ideation and suicide deaths.[9]

Resources such as hotlines exist for individuals experiencing suicidal ideation and are available from a number of reputable local, state, and national sources. In a recent Medscape report, based on a survey of more than 15,000 physicians in 29 specialties, 14 percent of respondents indicated that they had felt suicidal, and one percent had attempted suicide.[10] More than half of physicians who had thoughts of suicide told someone (therapist, family member, friend/colleague), but only two percent who had thoughts of suicide used a suicide hotline.[10]

Institutions and physician associations have begun to recognize the scope of this critical issue and are moving to address the problem.[11-12] The National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience is exploring recommendations in this regard, working with more than 150 health care organizations to raise visibility about clinician burnout and developing a commentary that calls on health systems to consider hiring chief wellness officers.[13]

QUANTIFYING THE RATES OF PHYSICIAN SUICIDE

As early as the late 19th century,[14-18] and throughout the 20th and 21st centuries, reports quantifying the rates of physician suicide have been presented in health care journals and industry publications, and more recently in mainstream media. Studies of physician suicide rates compared to the general U.S. population have resulted in conflicting conclusions—some indicating physicians are more prone to suicide, and others demonstrating no significant difference. Medical student and resident/fellow deaths have been studied in more recent years. Inclusion of a literature review in this report is important to demonstrate the various modes of study and sources of data over time, and the implications of study methods for future efforts to quantify physician, resident/fellow, and medical student suicide rates.

In the late 1800s and into the 20th century, the primary source of data on physician deaths used by researchers was the AMA's Deceased Physicians file, which provided information on hundreds of thousands of deceased physicians from the early 19th century to the mid-1960s.[19-21] The cause of death listed in the records was obtained by various means, including *JAMA* obituaries, which cited death certificates and autopsy reports.[22-23] For example, one study published in 1926 concluded from AMA's data that the suicide rate of white male physicians in the U.S. was 45.4 out of 100,000.[24] Another study, using AMA's records from 1967 to 1972, showed the rates of suicide in American female physicians was 40.7 per 100,000, higher than male physician suicides during the same time range.[25] A study of death certificates in California from 1959 to 1961 found that physicians and health care workers were twice as prone to commit suicide when compared to the general population.[20] A 1977 *JAMA* article claimed that physicians took their own lives at a rate equivalent to one medical school class each year, but cited no specific number or source for this information.[26]

In the later part of the 20th century, researchers began using the National Occupational Mortality Surveillance (NOMS) database to identify causes of death for physicians, which was deemed a more accurate and reliable source than the AMA information.[27-28] The data in NOMS is sourced from state vital records (death certificates) and lists the proportionate mortality ratio for the total population.[29] The Social Security Death Index, another source of mortality information used by researchers, records the deaths of anyone in the U.S. who was issued a social security number. The Centers for Disease Control and Prevention (CDC) has several databases featuring varying degrees and descriptions of mortality and manner of death information. The CDC in 2016 published a study of suicides in 17 states using cause of death information from the National Violent Death Reporting System. This limited study concluded that the suicide rate for health care practitioners was 17.4 per 100,000 population.[30] This study was later found to have included erroneous data, however, and the authors are reanalyzing the findings.

Most of these studies call out limitations in the availability, reliability, and consistency of the data used to identify causes of death and occupation. A test of accuracy of the *JAMA* obituaries was conducted on a small sample, and it was determined that only half of the causes of death listed were accurate when compared with records from the state's department of health computerized records.[19] *JAMA*'s editor, in a quoted communication, alluded to the incompleteness of the obituary data and acknowledged that this was in part because some suicides may be listed on a death certificate or autopsy report as something other than suicide, such as respiratory failure.[31] *JAMA* also would not include the cause of death if requested by the family of the deceased physician, further limiting the completeness of the records.[28] Even death certificates, the primary vital record used by secondary sources, are not 100 percent consistent, accurate, or complete. Studies have found errors in manner of death certification in approximately 33 percent to 41 percent of cases.[32-34] Other studies have demonstrated variance in how different medical examiners interpret facts surrounding a decedent's death and how they ultimately report manner of death.[35-36]

SOURCES FOR COLLECTING DATA TO STUDY SUICIDE STATISTICS IN THE UNITED STATES

The databases and reports shown in Table 1 were identified as sources for collecting data to study suicide statistics in the United States.

Table 1. Sources for Data on Suicide Statistics in the United States

Source	Type of Data
Centers for Disease Control and Prevention	Fatal Injury Reports Leading Cause of Death Reports Mortality Reports National Vital Statistics System National Violent Death Reporting System National Occupational Mortality Surveillance Wide-ranging Online Data for Epidemiologic Research National Death Index
American Medical Association	JAMA Obituaries Deceased Physicians Masterfile (1906-present) Directory of Deceased American Physicians Vols. 1 & 2 (1804-1929)
World Health Organization	Compiled from member state local databases

Department of Defense	Department of Defense Suicide Event Annual Reports
Department of Veterans Affairs	National Suicide Data Report
Bureau of Justice Statistics	Suicide and Homicide in State Prisons and Local Jails
Social Security Administration	Social Security Death Index
Other	State and Local Vital Records; Legacy Obit

Although generally reliable, some inconsistency also exists in the recording of a deceased person's primary occupation, somewhat limiting the ability of researchers to accurately determine rates of suicide among specific populations, such as physicians, residents, or medical students. Occupation has long been a captured data point on death certificates, but it has not always been codified, utilized, and monitored the way it is today.[37] More recently, occupation and industry information have become more reliable.[38] Occupation information can now be recorded in most electronic health records (EHRs), helping to capture accurate information on the death certificates, but it is not required, and evidence shows it may not be consistently used.[39-41]

Studies have shown that suicide is likely under-reported due to a lack of systematic approaches to reporting and assessing the statistics.[42] Experts have also observed that cultural attitudes toward suicide determine how suicide is defined and how "intention to die" is legally interpreted.[43] These effects, as well as differing procedures for obtaining evidence about the death, cause coroners to vary in their definitions and reporting processes. Some believe this variation makes official statistics valueless and too unreliable to compare the suicide rates of countries, districts, or of demographic and other groups; to discern trends; or to investigate the social relations of suicide. However, other researchers disagree and have concluded that, despite inconsistency, the statistics still have utility.[44]

RELEVANT WORK OF OTHER ORGANIZATIONS

Accreditation Council for Graduate Medical Education

In 2017 the Accreditation Council for Graduate Medical Education (ACGME) studied the number and causes of resident deaths by matching their deceased resident data with cause of death information obtained from the National Death Index (NDI), a comprehensive database managed by the CDC. From this research they identified suicide as the leading cause of death for male trainees, the second leading cause for female trainees, and the second leading cause of death overall.[45] The cause of death data sourced from the NDI produced a 94 percent match to records in the ACGME's database, suggesting that these data represent an accurate and reliable source that could be used for future study.

National Academy of Medicine

The National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience recently launched the Clinician Well-Being Knowledge Hub. The Hub is intended to provide resources to help organizations learn more about clinician burnout and solutions.[13] The repository contains peer-reviewed research, toolkits, and other resources for health system administrators and clinicians.

American Foundation for Suicide Prevention

The American Foundation for Suicide Prevention (AFSP) has developed an Interactive Screening Program (ISP), which is in place for use by institutions of higher education, including undergraduate and medical schools, and which has been customized for use by workforces in multiple industries.[46] This initiative identifies individuals who may be at risk for suicide by offering them the opportunity to participate in an anonymous online screening.

UC San Diego Health Education Assessment and Referral Program

The UC San Diego Health Education Assessment and Referral (HEAR) Program, in collaboration with the AFSP, also provides a program of ongoing education and outreach, which encourages medical students, residents, and faculty, as well as pharmacists, nurses, and other clinical staff, to engage in an online, anonymous, interactive screening program.[47] The AFSP program model has been adopted by many schools of medicine and is used by clinicians of all disciplines.

Other Organizations

The AMA, American Osteopathic Association, and state and specialty medical associations are also positioned to help alleviate physician stress and burnout. CME Report 1-I-16, "Access to Confidential Health Services for Medical Students and Physicians,"[48] provides an overview of potential solutions by several key stakeholders including accrediting agencies, medical schools, residency/fellowship programs, employers, hospitals, and professional associations, including the AMA.

RELEVANT WORK OF THE AMA

The AMA has studied the mental and physical toll that medical education exacts on medical students and resident/fellow physicians as they seek to balance their personal lives with the need to master a growing body of knowledge and develop the skills required to practice medicine. Specific AMA policy mandates and recommendations related to this topic are shown in the Appendix. AMA policy also addresses the long-standing and deeply ingrained stigma against physicians and students who seek care for either physical or behavioral health issues, partly due to concerns of career and licensure implications.

Work of Professional Satisfaction and Practice Sustainability (PS2) and STEPS Forward™

The AMA is already taking steps to decrease physician and medical student/trainee stress and improve professional satisfaction through resources such as the STEPS Forward™ practice improvement module, "Preventing Physician Distress and Suicide," which offers targeted education for practicing physicians seeking information about how to help their physician colleagues who may need support. The AMA is also developing an education module that will help physicians, residents, and medical students learn about the risks of physician suicide, identify characteristics to look for in patients who may be at risk of harming themselves, and recognize the warning signs of potential suicide risk in colleagues. The module, to be offered with continuing medical education credit on the AMA's Ed Hub™, will also provide tools and resources to guide learners in supporting at-risk patients and colleagues.

In addition to education resources for physicians, the AMA works with organizations to help them understand the incidence of burnout in their workplaces. Using the validated Mini-Z assessment tool, organizations are assigned a burnout score, along with targeted data on culture and workplace

efficiency factors that can lead to stress and burnout for physicians. These data enable the AMA to work with the organizations to identify solutions, helping improve environmental, organizational, or cultural factors that, if not addressed, could lead to heightened stress or suicide risk for some.

Accelerating Change in Medical Education

Schools in the AMA's Accelerating Change in Medical Education Consortium formed a student wellness interest group to share ideas across schools about best practices to ensure wellness and counter burnout. The results of a wellness survey conducted among medical school consortium members showed that 81 percent of respondents employ an individual tasked with focusing on student wellness to at least some extent; these roles range from program coordinators to graduate assistants to deans who also serve as wellness directors. Most schools had dedicated wellness committees, with budgets up to $7,000 annually.

DISCUSSION

Overall, the available literature suggests that obtaining both accurate manner of death and specific occupation information is the most reliable means of quantifying rates of suicide among physicians. However, most researchers still face challenges with this approach. Primary barriers include:

- Cost and limitations of obtaining and using the data from reliable sources;
- Irregular/restricted access to mortality information, including date, cause, and manner of death;
- Inconsistency in medical examiner interpretation of cause/manner of death;
- Lack of standard physician and medical examiner/coroner training on completion of the death certificate;
- Possible underutilization of standard code-sets to report manner of death;
- Social or cultural stigma associated with reporting a death as a suicide;
- Underutilization of "occupation" field in electronic heath records; and
- Inaccurate or inconsistent assignment of occupation upon death.

Physician-focused Programs and Resources

Resolution 959-I-18 asks the AMA to create a committee tasked with establishing a 24-hour mental health hotline for physicians and medical students to access when in need. Establishing and maintaining a mental health hotline is resource intensive, requiring investments in staffing, infrastructure, management, training, costs of licensing, and accreditation to operate. Operating the Crisis Call Center, a backup center for the National Suicide Prevention Lifeline, costs approximately $1.1 million per year.[49] A smaller, Louisiana based non-profit operation, which also fields calls directed from the national lifeline, operates on $350,000 per year.[49] Most of the funding for local services comes from county and city sources, as well as in-kind and private donations. Accredited programs may receive a small stipend from the Substance Abuse and Mental Health Services Association. Due to limited available funds, many programs rely on volunteers more than paid staff.[50-51] In addition to substantial costs, establishing a new, physician-focused mental health line may introduce potential liabilities for the AMA. Considering the extensive resources involved, the potential for liability, and demonstrated low rates of usage,[10] it is not recommended that the AMA pursue an independent mental health hotline at this time. However, the AMA has evaluated Employee Assistance Program (EAP) service providers to explore the option of piloting a service to AMA members as a membership benefit. Some EAP services provide participants with 24/7 telephone or video access to qualified and trained counselors, wellness services, and critical

incident support. This evaluation is in its early stages, and a decision to pursue various options will be considered.

Removing the Stigma Associated With Behavioral Health Treatment

Resolution 959-I-18 also asks the AMA to create a committee to work with state medical licensing boards and hospitals to help remove any stigma of behavioral health and to alleviate physician and medical student fears about the consequences of behavioral health treatment on their medical license and hospital privileges. In addition to multiple policies expressing the AMA's commitment to resolving this issue, CME Report 6-A-18, "Mental Health Disclosures on Physician Licensing Applications," adopted at the 2018 Annual HOD Meeting, addressed concerns that have been raised about the presence and phrasing of questions on licensing applications related to current or past impairment. These questions may be discouraging physicians from seeking appropriate treatment because of fear of stigmatization, public disclosure, and the effect on one's job due to licensing or credentialing concerns.[52] Many medical and osteopathic licensing boards recognize that the manner in which they evaluate the fitness of potential licensees has the potential to create a barrier that prevents licensees from seeking help. Some state boards, such as the Oregon and Washington State Medical Boards, have taken steps to address these barriers. In addition, the Federation of State Medical Boards has established a Workgroup on Physician Wellness and Burnout. The workgroup is addressing symptoms that arise from the practice of medicine for which physicians may be reluctant to seek treatment due to concern about the presence and phrasing of questions on licensing applications about behavioral health, substance abuse, and leave from practice. The workgroup is also seeking to draw an important distinction between physician "illness" and "impairment" as well as determine whether it is necessary for the medical boards to include probing questions about a physician applicant's behavioral health on licensing applications in the interests of patient safety.

Current and Planned AMA Efforts

<u>Updating the AMA Physician Masterfile for Research</u>

The AMA's Deceased Physician database, which includes records of deceased physicians dating back to 1804, includes 242,541 physicians (as of January 2019). Currently only 107 records have a manner of death listed. This information is not made available on a consistent basis by the sources the Masterfile team relies on for mortality information. To capture the manner of death information needed to pursue relevant research, the Masterfile needs to be supplemented with third-party information that is made available at the individual level. To advance research in quantifying rates of physician suicide, as well as to identify patterns, risk factors, and methods by which to prevent suicides, the AMA is exploring options to enhance its Physician Masterfile data by collecting and maintaining manner of death information for physicians listed as deceased.

The AMA is partnering with a leading academic medical institution to conduct a pilot study using data from the National Death Index (NDI) to identify manner of death for a subset of the AMA Masterfile population. The goals of this initial research are to study and quantify incidence of suicide among physicians, residents, and medical students, and to evaluate the quality and reliability of the NDI data to determine if they represent a viable and cost-effective source for further, long-term study. Results from this research are anticipated by the end of 2019. In addition to staffing, establishment of processes, and ongoing data security requirements, there are financial costs for the procurement of these data from the NDI. Obtaining the data for the planned 2019 study will cost between $65,000 and $80,000. Obtaining NDI data for all individuals whose date of death occurred from 1979 through 2017 (the years for which NDI data is available) would require

approximately $600,000. Based on the average number of records updated as deceased in the Masterfile each year, requesting future NDI data every year for long-term study would cost approximately $30,000 per year.

This research, planned for broad dissemination through publication in a peer-reviewed journal, will assist the AMA in identifying opportunities to better help physicians, residents, and medical students reduce factors that contribute to suicidal ideation and ultimately could help reduce the number of lives lost each year. This analysis could also include comparison to the general US population, comparison to rates of physician burnout, and longitudinal evaluation for various cohorts, as well other variables allowed by the data. The manner of death data could also enable additional study into physician mortality trends, such as patterns of other disease states or geographic variations.

Other data sources were explored during the preparation of this report, including the National Occupational Mortality Surveillance, Social Security Administration Death Index, National Violent Death Reporting System, National Association for Public Health Statistics and Information Systems, and the CDC Wide-ranging OnLine Data for Epidemiologic Research. While these sources are valuable for observing aggregate data, none allows access to the individual-level information needed to match records in the Masterfile or conduct research rigorous enough to accurately quantify the incidence of suicide among physicians.

Ongoing Data Collection

Collecting manner of death information on an ongoing basis will be important should the AMA choose to continue long-term study of physician suicide. In addition to the NDI data previously outlined, the AMA is continuously exploring sources and potential new mechanisms through which the Masterfile team can obtain the manner of death information for ongoing updates.

At its 2018 Interim Meeting, the AMA adopted policy that urges the Liaison Council on Medical Education (LCME) and the ACGME to collect data on medical student and resident/fellow suicides to enable these organizations and the AMA to better identify patterns that could predict, and ultimately prevent, further suicides. In response, the LCME voted at its February 2019 meeting not to participate in the data-gathering requested through the AMA policy, in that the LCME felt that such data gathering and analysis was beyond its purview. A current LCME standard requires medical schools to include programs that promote student well-being. The AMA will continue to monitor progress made by the AAMC and ACGME on this and related objectives.

Creating a Physician and Medical Student Suicide Prevention Committee

Resolution 959-I-18 asks the AMA to create a committee with the goal of addressing suicides and behavioral health in physicians and medical students. As noted above, the AMA has already carried out extensive and sustained work in developing policy, communications, and resources to decrease physician and medical trainee stress, improve professional satisfaction, and decrease the stigma associated with mental illness that physicians may face when applying for licensure and hospital privileges. As also noted above, the AMA has explored the establishment of a 24-hour mental health hotline for physicians and medical students and is currently exploring EAP service providers that provide 24/7 access to counselors, wellness services, and critical incident support. For these reasons, the formation of a new committee would duplicate existing AMA efforts, and the Council on Medical Education believes that such a body is not necessary at this time.

SUMMARY AND RECOMMENDATIONS

The routine occurrence of burnout, depression, and suicide in physicians, residents/fellows, and medical students warrants continued study. Several recommendations have been offered to collect data on the actual incidence of physician and physician-in-training suicide. The Council on Medical Education therefore recommends the following recommendations be adopted in lieu of Resolution 959-I-18 and the remainder of this report be filed.

1. That our American Medical Association (AMA) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies. (Directive to Take Action)

2. That our AMA monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events. (Directive to Take Action)

3. That our AMA supports the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free behavioral health services. (Directive to Take Action)

4. That our AMA collaborate with other stakeholders to study the incidence of suicide among physicians, residents, and medical students. (Directive to Take Action)

5. That Policy D-345.984, “Study of Medical Student, Resident, and Physician Suicide,” be rescinded, as having been fulfilled by this report and through requests for action by the Liaison Committee on Medical Education and ACGME. (Rescind HOD Policy)

Fiscal Note: $81,500.

APPENDIX: RELEVANT AMA POLICIES

9.3.1, "Physician Health & Wellness"

When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.

To fulfill this responsibility individually, physicians should:

(a) Maintain their own health and wellness by:

(i) following healthy lifestyle habits;

(ii) ensuring that they have a personal physician whose objectivity is not compromised.

(b) Take appropriate action when their health or wellness is compromised, including:

(i) engaging in honest assessment of their ability to continue practicing safely;

(ii) taking measures to mitigate the problem;

(iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;

(iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.

Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

(Issued: 2016)

D-345.984, "Study of Medical Student, Resident, and Physician Suicide "

Our AMA will: (1) determine the most efficient and accurate mechanism to study the actual incidence of medical student, resident, and physician suicide, and report back at the 2018 Interim Meeting of the House of Delegates with recommendations for action; and (2) request that the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education collect data on medical student, resident and fellow suicides to identify patterns that could predict such events.

(Res. 019, A-18 Appended: Res. 951, I-18)

H-295.858, "Access to Confidential Health Services for Medical Students and Physicians"

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to: A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means; B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees; C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient

safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
    A. be available to all medical students on an opt-out basis;
    B. ensure anonymity, confidentiality, and protection from administrative action;
    C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
    D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

(CME Rep. 01, I-16 Appended: Res. 301, A-17 Appended: Res. 303, A-17 Modified: CME Rep. 01, A-18 Appended: Res. 312, A-18)

H-295.927, "Medical Student Health and Well-Being"

The AMA encourages the Association of American Medical Colleges, Liaison Committee on Medical Education, medical schools, and teaching hospitals to address issues related to the health and well-being of medical students, with particular attention to issues such as HIV infection that may have long-term implications for health, disability and medical practice, and consider the feasibility of financial assistance for students with disabilities.

(BOT Rep. 1, I-934 Modified with Title Change: CSA Rep. 4, A-03 Reaffirmed: CME Rep. 2, A-13)

H-295.993, "Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs"

Our AMA: (1) recognizes the need for appropriate mechanisms to include medical students and resident physicians in the monitoring and advocacy services of state physician health programs and wellness and other programs to prevent impairment and burnout; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available student assistance programs and other related services.
(Sub. Res. 84, I-82 Reaffirmed: CLRPD Rep. A, I-92 Reaffirmed and appended: CME Rep. 4, I-98 Reaffirmed: CME Rep. 2, A-08 Modified: CME Rep. 01, A-18)

H-310.907, "AMA Duty Hours Policy"

Our AMA adopts the following Principles of Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training:
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
(CME Rep. 5, A-14 Modified: CME Rep. 06, I-18)

D-310.968, "Physician and Medical Student Burnout"

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

(CME Rep. 8, A-07 Modified: Res. 919, I-11)

H-405.957, "Programs on Managing Physician Stress and Burnout"

1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.

2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.

(Res. 15, A-15 Appended: Res. 608, A-16)

H-405.961, "Physician Health Programs"
Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.
(CSAPH Rep. 2, A-11 Reaffirmed in lieu of Res. 412, A-12 Reaffirmed: BOT action in response to referred for decision Res. 403, A-12)

D-405.990, "Educating Physicians About Physician Health Programs"
1) Our AMA will work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory; 2) Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness; 3) Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs; and 4) Our AMA will work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training.
(Res. 402, A-09 Modified: CSAPH Rep. 2, A-11 Reaffirmed in lieu of Res. 412, A-12 Appended: BOT action in response to referred for decision Res. 403, A-12)

H-345.973, "Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians"
Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place.
(Res. 915, I-15 Revised: CME Rep. 01, I-16)

H-275.970, Licensure Confidentiality
1. The AMA (a) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (b) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (c) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (d) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (e) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is suffering from any condition that currently impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger.

2. Our AMA will encourage those state medical boards that wish to retain questions about the health of applicants on medical licensing applications to use the language recommended by the Federation of State Medical Boards that reads, "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)."
CME Rep. B, A-88 Reaffirmed: BOT Rep. 1, I-93 CME Rep. 10 - I-94 Reaffirmed: CME Rep. 2, A-04 Reaffirmed: CME Rep. 2, A-14 Appended: CME Rep. 06, A-18

D-295.319, Discriminatory Questions on Applications for Medical Licensure
Our American Medical Association will work with the Federation of State Medical Boards and other appropriate stakeholders to develop model language for medical licensure applications which is non discriminatory and which does not create barriers to appropriate diagnosis and treatment of psychiatric disorders, consistent with the responsibility of state medical boards to protect the public health.
(Res. 925, I-09)

D-275.974, Depression and Physician Licensure
Our AMA will (1) recommend that physicians who have major depression and seek treatment not have their medical licenses and credentials routinely challenged but instead have decisions about their licensure and credentialing and recredentialing be based on professional performance; and (2) make this resolution known to the various state medical licensing boards and to hospitals and health plans involved in physician credentialing and recredentialing.
(Res. 319, A-05 Reaffirmed: BOT action in response to referred for decision Res. 403, A-12)

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REPORT OF THE ORGANIZED MEDICAL STAFF SECTION
GOVERNING COUNCIL

GC Report DD-A-19

Subject: OMSS Position on Council on Medical Service Report 8-A-19: Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor

Presented by: David Welsh, MD, Chair

Referred to: OMSS Reference Committee
(James Guo, MD, Chair)

EXECUTIVE SUMMARY OF CMS REPORT 8

AMA Policy D-345.984 (1), "Study of Medical Student, Resident, and Physician Suicide," asks that the American Medical Association (AMA) determine the most efficient and accurate mechanism to study the actual incidence of medical student, resident, and physician suicide. Resolution 959-I-18, "Physician and Medical Student Mental Health and Suicide," asks that the AMA create a new Physician and Medical Student Suicide Prevention Committee with the goal of addressing suicides and behavioral health issues in physicians and medical students. This report considers appropriate deliverables to fulfill these directives and to further establish the AMA's leadership role in this area.

Burnout in physicians, residents, and medical students has been widely reported in recent years in both the lay and scholarly press, and incidence of depression and suicide is greater in medical students, residents, and physicians than in the general population. The AMA has studied the mental and physical toll that medical education exacts on medical students as they seek to balance their personal lives with the need to master a growing body of knowledge and develop the skills required to practice medicine. AMA policy addresses the long-standing and deeply ingrained stigma against physicians, residents, and students who seek care for either physical or behavioral health issues, partly due to concerns of career and licensure implications. Organizations such as the National Academy of Medicine, Federation of State Medical Boards, and Accreditation Council for Graduate Medical Education (ACGME) have begun to recognize the scope of this critical issue and are moving to address the problem. The AMA has also taken steps to decrease physician and medical trainee stress and improve professional satisfaction through resources such as the AMA's STEPS Forward™ practice improvement strategies and the Ed Hub™.

In addition to providing education resources for physicians, the AMA works with organizations to help them understand the incidence of burnout in their workplaces. Using data from the validated Mini-Z assessment tool enables the AMA to work with the organizations to identify solutions, which helps improve environmental, organizational, or cultural factors that, if not addressed, could lead to heightened stress or suicide risk for some.

The AMA is planning to partner with a leading academic medical institution to conduct a pilot study using data to be obtained from the National Death Index (NDI) to identify manner of death for a subset of the AMA Masterfile population. This research, planned for broad dissemination through publication in a peer-reviewed journal, will help the AMA identify opportunities to better

help physicians, residents, and medical students reduce factors that contribute to suicidal ideation and ultimately could help reduce the number of lives lost to suicide each year. This analysis could also include comparison to the general U.S. population, comparison to rates of physician burnout, longitudinal evaluation for various cohorts, as well other variables allowed by the data. The manner of death data could also enable additional study into physician mortality trends, such as patterns of other disease states or geographic variations.

It will also be important for the AMA to monitor progress that has been made by the Association of American Medical Colleges and the ACGME to collect data on medical student, resident, and fellow suicides to identify patterns that could predict such events.

RECOMMENDATION OF CMS REPORT 8

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 252-A-18, and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-125.986 supporting efforts to ensure that reimbursement policies established by pharmaceutical benefit managers (PBMs) are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy H-110.992 stating that the AMA will monitor the relationships between PBMs and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy H-100.956 calling for collaboration with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs (Reaffirm HOD Policy)
4. That our AMA renew efforts urging the federal government to support greater public transparency and accountability efforts involving the contracting mechanisms and funding structures subject to the Group Purchasing Organization and PBMs anti-kickback safe harbor, including the potential impact on drug pricing and drug shortages. (New HOD Policy)
5. That our AMA support efforts to update and modernize the fraud and abuse laws and regulations to address changes in the health care delivery and payment systems including the potential impact on drug pricing and drug shortages. (New HOD Policy)

GOVERNING COUNCIL RECOMMENDATION

The Governing Council recommends that the OMSS Delegate be instructed to support the intent of the recommendations of CMS Report 8-A-19.

REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting, the House of Delegates referred Resolution 252, which was introduced by the Organized Medical Staff Section and assigned for study to the Council on Medical Service with assistance from the Council on Legislation. Resolution 252-A-18 asked: that our American Medical Association (AMA): (1) collaborate with medical specialty partners, patient advocacy groups, and other stakeholders to seek repeal of the 1987 Safe Harbor exemption to the Medicare Anti-Kickback Statute for Group Purchasing Organizations (GPOs) and Pharmacy Benefit Managers (PBMs); (2) educate its members on how safe harbor exemption for GPOs and PBMs affects drug prices and drug shortages; and (3) reaffirm Policy H-100.956, which states in part that "Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs."

Although the Council agrees with the sentiment that the GPO safe harbor is flawed, the Council finds little empirical evidence exists to definitively assess the impact of the GPO safe harbor. Most research studies are funded by interested parties, and a limited economic model with no funding ties to GPOs, PBMs, or proponents of repeal, found that while removal of the safe harbor decreased providers' nominal purchasing price, their total purchasing costs are the same as when the safe harbor was present. Thus, repeal would not affect any party's profits or costs. In a broader economic model, a study found that total purchasing cost of the providers is not affected by the presence of the GPO administration fees, although providers may experience higher unit prices. Accordingly, the Council recommends reaffirming Policy H-100.956 calling for collaboration with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.

Additionally, the Council is concerned that, if the GPO safe harbor is repealed, GPOs and PBMs could simply shift fees into other forms, such as rebates or other fees, rather than lose their revenue stream. Moreover, the Council believes that repeal of the GPO safe harbor could create widespread disruption of the supply chain and administrative challenges for not only hospitals (including physician-owned hospitals), but also clinics, ambulatory surgery centers, and other provider arrangements. As such, physician-owned practice settings may be adversely impacted if the viability of the GPO business model is compromised. Whatever the defects in their funding structure, the Council finds that GPOs serve a function in enabling cost savings and efficiencies in procurement to facilitate patient care. Accordingly, the Council recommends renewing efforts urging the federal government to support greater public transparency and accountability efforts involving the contracting mechanisms and funding structures subject to the GPO and PBM anti-kickback safe harbor, including the potential impact on drug pricing and drug shortages. The Council also recommends supporting efforts to update and modernize the fraud and abuse laws and regulations to address changes in the health care delivery and payment systems including the potential impact on drug pricing and drug shortages.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-A-19

Subject:	Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor (Resolution 252-A-18)
Presented by:	James G. Hinsdale, MD, Chair
Referred to:	Reference Committee G (Rodney Trytko, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 252, which was introduced by the Organized Medical Staff Section and assigned for study to the Council on Medical Service with assistance from the Council on Legislation. Resolution 252-A-18 asked:

> That our American Medical Association (AMA): (1) collaborate with medical specialty partners, patient advocacy groups, and other stakeholders to seek repeal of the 1987 Safe Harbor exemption to the Medicare Anti-Kickback Statute for Group Purchasing Organizations (GPOs) and Pharmacy Benefit Managers (PBMs); (2) educate its members on how safe harbor exemption for GPOs and PBMs affects drug prices and drug shortages; and (3) reaffirm Policy H-100.956, which states in part that "Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs."

This report provides background on GPOs, how they function, and the relevant federal anti-kickback statute; details how the GPO safe harbor is used by PBMs; outlines possible antitrust and anticompetitive concerns with the GPO safe harbor; specifies the possible legal and patient access implications of repeal of the safe harbor; and offers recommendations to refine the GPO safe harbor operations.

BACKGROUND

At the 2016 Annual Meeting, Resolution 201-A-16, "Repeal of Anti-Kickback Safe Harbor for Group Purchasing Organizations," sponsored by the Medical Student Section, asked the AMA to support the repeal of the Anti-Kickback safe harbor for GPOs. Resolution 201-A-16 was referred for decision by the House of Delegates. The Council on Legislation discussed and provided input for the Management Report for Board Action, which recommended not adopting Resolution 201-A-16. The Board voted that Resolution 201-A-16 not be adopted.

At the 2018 Annual Meeting, concern was raised during the reference committee hearing regarding Resolution 252-A-18 that its proposed solution of repealing the GPO safe harbor could be both ineffective and counterproductive in addressing the identified problems of drug shortages and pricing. With respect to GPO pricing incentives, testimony also stated that GPO contracts are voluntary in nature. GPO customers may have the ability to purchase products and services off-contract if they find a preferable or better-priced option. Testimony further indicated that GPO customers include not only hospitals, but also clinics, ambulatory surgery centers, and other

provider arrangements. As such, physician-owned hospitals and other physician practice settings may be adversely impacted if the viability of the GPO business model is compromised.

HOW A GPO FUNCTIONS

GPOs are organizations that act as purchasing intermediaries that negotiate contracts between their customers—health care providers—and vendors of medical products. A GPO is generally made up of provider-members, and such members may receive profits from the GPO. A provider joins a GPO to "incur a lower purchasing cost . . . by buying through the GPO [rather] than by contracting for the same item directly with a manufacturer. GPOs assert that they are able to lower their provider-members' price per unit by employing market intelligence and product expertise that no single member could afford, and by contracting for the group's combined purchase quantity. GPOs are able to lower a provider's contracting cost by spreading its own, presumably higher, fixed contracting cost over its many members."[1] For example, AMA members can receive practice discounts through Henry Schein Medical for medical, surgical, pharmaceutical, and equipment purchases.[2] Henry Schein is partnered with GroupSource, a GPO serving the non-acute physician market, to offer physicians a wide range of products.[3]

GPOs earn revenue from several sources:

- Administrative fees paid by the manufacturer of products;
- Membership fees from provider-members;
- Administrative fees charged to distributors authorized to distribute products under a GPO's contract;
- Miscellaneous service fees that are charged directly to provider-members; and
- Other sources of revenue like outside investments.

GPOs offer a variety of services that may be paid by the administration fees or through direct charging to provider members. The U.S. Government Accountability Office identifies the funding methods that GPOs reported using for the services they provided:[4]

Table 3: The Six Largest Group Purchasing Organizations' (GPO) Reported Funding Methods for Services Provided in 2008

Service[a]	Number of GPOs offering service	Number of GPOs funding only through administrative fees	Number of GPOs funding only through charges to customers	Number of GPOs using both funding methods
Custom contracting	6	2	2	2
Clinical evaluation and standardization	6	4	0	2
Technology assessments	6	5	1	0
Supply-chain analysis	5	1	1	3
Electronic commerce	5	2	0	3
Materials management consulting	5	1	1	3
Benchmarking data	5	1	1	3
Continuing medical education	5	4	0	1
Market research	4	2	2	0
Materials management outsourcing	3	0	3	0
Patient safety services	3	2	1	0
Marketing products or services	3	2	1	0
Insurance services	2	1	1	0
Revenue management	2	0	2	0
Warehousing	1	1	0	0
Equipment repair	1	1	0	0
Other[b]	3	2	0	1

STATUTORY AND REGULATORY BACKGROUND ON THE FEDERAL ANTI-KICKBACK STATUTE

The federal anti-kickback statute provides *criminal* penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration to induce business reimbursed under the Medicare or state health care programs.[5] The offense is classified as a felony, and is punishable by fines of up to $100,000, imprisonment for up to 10 years, and subjects the offending party to false claims act liability. The Secretary of the US Department of Health and Human Services (HHS) delegated authority over the anti-kickback statute to the HHS Office of Inspector General (OIG).

This provision is extremely broad. The types of remuneration covered specifically include kickbacks, bribes, and rebates made directly or indirectly, overtly or covertly, or in cash or in kind. In addition, prohibited conduct includes not only remuneration intended to induce referrals of patients, but also intended to induce the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid for by Medicare or state health care programs.

Because of the broad reach of the statute, concern was expressed that some relatively innocuous commercial arrangements were covered by the statute and, therefore, potentially subject to criminal prosecution. In response, Congress provides statutory exceptions from illegal remuneration where the anti-kickback statute does not apply. In addition, Congress specifically required the development and promulgation of regulations, the so-called safe harbor provisions, that would specify various payment and business practices that would not be treated as criminal offenses under the anti-kickback statute, even though they may potentially be capable of inducing referrals of business under federal health care programs.[6] In authorizing HHS to protect certain arrangements and payment practices under the anti-kickback statute, Congress intended that the safe harbor regulations be updated periodically to reflect changing business practices and technologies in the health care industry.

Accordingly, the legal framework governing the anti-kickback statute includes both statutory exceptions *and* regulatory safe harbors. The federal government considers the statutory exceptions and regulatory safe harbors as co-terminus, meaning that they cover the same conduct and the regulatory safe harbor is implementing the statutory safe harbor. Industry and the provider community have argued that they are distinct, separate protections. For example, a provider could receive protection under the statutory exception for discounts even if the arrangement would not fit within the counterpart regulatory safe harbor. Whether the protections are co-terminus or distinct is an open legal question that depends on the legal precedent of case law in each federal circuit (if a circuit has considered this specific issue).

This report will focus on three specific statutory exceptions and regulatory safe harbors that may cover the various funding mechanisms of GPOs: (1) GPO safe harbor; (2) discount safe harbor; and (3) personal services and management contracts safe harbor.

GPO Statutory Exception and Regulatory Safe Harbor

With GPOs, Congress enacted section 9321 of the Omnibus Budget Reconciliation Act of 1986, which excludes from the definition of "remuneration" certain fees paid by vendors to GPOs from prosecution under the anti-kickback statute.[7] According to the legislative history, Congress believed that GPOs could "help reduce health care costs for the government and the private sector alike by enabling a group of purchasers to obtain substantial volume discounts on the prices they are charged."[8]

In 1991, OIG issued a final rule implementing a GPO safe harbor to apply to payments from vendors to entities authorized to act as a GPO for individuals or entities who are furnishing Medicare or Medicaid services. The proposed safe harbor required a written agreement between the GPO and the individual or entity that specifies the amounts vendors will pay the GPO.

To qualify for protection under the GPO safe harbor, a GPO must have a written agreement with each individual or entity for which items or services are furnished. That agreement must either provide that participating vendors from which the individual or entity will purchase goods or services will pay a fee to the GPO of three percent or less of the purchase price of the goods or services provided by that vendor or, in the event the fee paid to the GPO is not fixed at three percent or less of the purchase price of the goods or services, specify the amount (or if not known, the maximum amount) the GPO will be paid by each vendor (where such amount may be a fixed sum or a fixed percentage of the value of purchases made from the vendor by the members of the group under the contract between the vendor and the GPO).

Where the entity that receives the goods or services from the vendor is a health care provider of services, the GPO must disclose in writing to the entity at least annually, and to the Secretary upon request, the amount received from each vendor with respect to purchases made by or on behalf of the entity. As explained in the preamble to the final regulations, the safe harbor is not intended to protect fees to arrange for referrals or recommendations within a single entity.[9] Therefore, the safe harbor provides that "Group Purchasing Organization" means an entity authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services for which payment may be made in whole or in part under Medicare, Medicaid, or other federal health care programs, and who are neither wholly owned by the GPO nor subsidiaries of a parent corporation that wholly owns the GPO (either directly or through another wholly owned entity).

Thus, if a GPO meets the above requirements, it fits within the GPO safe harbor and its administrative fees will not be subject to criminal prosecution under the anti-kickback statute. Of course, these administrative fees may cover a variety of services.

Discount Statutory Exception and Regulatory Safe Harbor

The discount statutory exception applies to arrangements where there is a discount or other reduction in price that was obtained by a provider or other entity when such discounts are properly disclosed and reflected in the costs for which reimbursement could be claimed.[10] Congress included the discount exception to "ensure that the practice of discounting in the normal course of business transactions would not be deemed illegal."[11]

The regulatory discount safe harbor exempts from the definition of remuneration discounts on items or services for which the federal government may pay and certain disclosure requirements are met.[12] A discount means a reduction in the amount a buyer is charged for an item or service based on an arms-length transaction. In addition, rebates are also covered under the discount safe harbor to mean an amount that is described in writing at the time of the purchase but is not paid at the time of sale. The safe harbor also specifically excludes from the definition of a discount cash or cash-equivalents (except for rebates in the form of a check); certain swapping arrangements (e.g., induce purchasing one good for another good); exempted remuneration from other safe harbors (e.g., warranties); and other remuneration, in cash or in kind not explicitly described by the safe harbor.

The regulatory safe harbor disclosure requirements vary based on the type of entity—buyer, seller, offeror—in the discount arrangement. Moreover, a buyer's disclosure requirements depend on

whether the entity is (1) acting under a risk contract; (2) reports costs on a cost report; or (3) submits a claim or a request for payment is submitted for the discounted item or service and payment may be made, in whole or in part, under Medicare, Medicaid, or other federal health care programs.[13]

Thus, a GPO's up-front discount is covered by the statutory exception and the regulatory safe harbor if properly disclosed, and it will not be subject to criminal prosecution under the anti-kickback statute.

Personal Services and Management Contracts Regulatory Safe Harbor

This safe harbor protects certain payments made by a principal to an agent as compensation for the agents' services. Protection applies only if certain standards are met that "limit the opportunity to provide financial incentives in exchange for referrals."[14] These standards include that aggregate compensation is set in advance, consistent with fair market value in an arms-length transaction, and not determined in a manner that takes into account the volume or value of any referrals or business generated between the parties.[15]

Thus, if a GPO offers additional services that go beyond the administration fees (i.e., direct charges to the provider-members), the GPO may be able to structure such fees under the personal services safe harbor and receive protection from criminal prosecution under the anti-kickback statute.

APPLICATION TO PHARMACY BENEFIT MANAGERS

Overall, the application of the anti-kickback safe harbors and exceptions to PBMs is difficult because PBMs and their current activities were not prevalent or existent when the safe harbors were created.

GPO Statutory Exception and Regulatory Safe Harbor

The OIG's only formal pronouncement on PBMs and the GPO regulatory Safe Harbor is found in sub-regulatory guidance: Compliance Program Guidance for Pharmaceutical Manufacturers issued in 2003.[16] "Any rebates or other payments by drug manufacturers to PBMs that are based on the PBM's customers' purchases potentially implicate the anti-kickback statute." Protection is available by structuring such arrangements to fit in the GPO safe harbor. That safe harbor requires, among other things, that the payments be authorized in advance by the PBM's customer and that all amounts actually paid to the PBM on account of the customer's purchases be disclosed in writing at least annually to the customer and to HHS upon request. In addition, Medicare Part D sponsors and other entities that provide PBM services are required to report various data elements to CMS. The statute specifies that this data is confidential and generally must not be disclosed by the government or by a plan receiving the information.[17]

The OIG potentially extended the GPO regulatory Safe Harbor, which is meant to cover administrative fees, to include "any rebates or other payments." Thus, PBMs can argue that fees and rebates have protection under the GPO Safe Harbor. However, PBMs would attempt to fit non-administrative fees within different safe harbors first and then potentially rely on GPO Safe Harbor as a backstop.[18]

Discount Statutory Exception and Regulatory Safe Harbor

On February 6, 2019, HHS issued a proposed rule to amend the safe harbor regulations concerning discounts.[19] HHS is proposing to disallow these traditional discount/rebate arrangements for plan sponsors under Part D and Medicaid Managed Care Organizations and attempt to instead pass any price concession directly to the beneficiary at the point-of-sale of the drug. To do this, they are proposing changes to the anti-kickback safe harbor regulation concerning discounts. Under the proposal, CMS would eliminate the current safe harbor protections for discounts paid by manufacturers directly to plan sponsors and PBMs. HHS also proposes the creation of two new safe harbor protections: protection for reductions in price at the point-of-sale and protection for fixed fees paid to PBMs for services rendered to manufacturers.[20]

In its formal response to the proposed rule, the AMA commented that OIG either needs to eliminate the application of the GPO regulatory safe harbor to PBMs or clarify its application only to administrative fees and define what services are covered. The AMA's comments went on to state that PBMs may be able to avail themselves to existing regulatory safe harbors including the GPO safe harbor, the personal services and management contracts safe harbor, managed care safe harbor, and the proposed certain PBM services safe harbor. The AMA requested that the Department clarify what PBM fees and services apply to both the proposed and existing safe harbors. Otherwise, the AMA is concerned that the lack of clarity may provide further opportunity for exploitation.

Moreover, on May 16, 2018, Secretary Azar noted: "We would welcome the PBM industry coming forth with broader proposals for moving away from today's system, including a plan for implementation with the pharmaceutical industry. But we also have the administrative power to end this system ourselves—to eliminate rebates and forbid remuneration from pharmaceutical companies, align interests, and end the corrupt bargain that keeps driving list prices skyward." In his comments before the Senate Health, Education, Labor & Pensions Committee, Secretary Azar went further, noting: "Rebates are allowed under an exception to the Anti-Kickback Statute, and that's an exception that we believe by regulation we could modify."

In the legal community, there is debate as to whether a PBM truly meets the definition of a "buyer" under the regulatory discount safe harbor considering PBMs do not take physical possession of the drugs. That said, most discount arrangements between PBMs and drug manufacturers (or other entities) are structured to fit within the discount safe harbor.

Personal Services and Management Contracts Regulatory Safe Harbor

As with GPOs, if a PBM offers additional services that go beyond the administration fees (e.g., data analytics, disease management), the PBM may be able to structure such fees under the personal services safe harbor and receive protection from criminal prosecution under the anti-kickback statute.

Summary Table

	GPO	**PBM**	**Anti-Kickback Statute exception/safe harbor**
Administrative Fees	~3%	~4.5-5%[21]	Protected by the GPO safe harbor
Type of Discount	Up front discount at time of purchase	After the purchase rebate	Protected by the Discount safe harbor
Other fees	Data analytics, market research, clinical evaluation, etc.	Data analytics, disease management	If applicable, protected by the Personal Services safe harbor

ANTITRUST AND COMPETITION CONCERNS

In response to antitrust concerns in the health care area, the Department of Justice (DOJ) and the Federal Trade Commission (FTC) from 1993-1996 issued policy statements involving mergers and various joint activities in the health care arena.[22] Statement 7 discusses DOJ/FTC enforcement policy involving health care providers' joint purchasing agreements, which includes GPOs. Generally, DOJ/FTC believe that most joint purchasing arrangements among hospitals or other health care providers do not raise antitrust concerns because the participants frequently can obtain volume discounts, reduce transaction costs, and have access to other services like consulting advice that may not be available to each participant on their own. Absent extraordinary circumstances, the agencies will not challenge any joint purchasing arrangement if it is in the "Antitrust Safety Zone."

Two conditions must be present to enter the zone:

(1) The purchases by the health care provider account for less than 35 percent of the total sales of the purchased product or services in the relevant market.
(2) The cost of the products and services purchased jointly accounts for less than 20 percent of the total revenue from all products or services sold by each competing participant in the joint purchasing arrangements.

The agencies also listed certain safeguards that joint purchasing arrangements can adopt to minimize concerns including not requiring the use of arrangements for all services; having an independent employee or agent negotiate on behalf of the joint purchasing arrangement, and ensuring communications between the purchasing group and participants are kept confidential.

Since this guidance was issued, GPO market consolidation has increased and led to an oligopoly market structure for national GPOs. The five largest GPOs by purchasing volume have approximately 85-90 percent of the market[23] and in 2017 the top four GPOs reported a total purchasing volume of $189 billion.[24]

Competition concerns are also raised when it comes to contracts between GPOs and vendors including sole-source contracting, minimum purchasing requirements that may cause overspending, length of the contract (5+ years in some instances), and bundling.

- Sole-source contracts: In a GAO report, all five major GPOs reported that they do negotiate sole-source contracts when it is advantageous to their customers, though some GPOs reported negotiating a higher proportion of sole source contracts than others. One GPO said that about 18 percent of its customers' spending through the GPO is through sole-source contracts. Three GPOs reported sole-source contracting for branded drugs and

commodities, and four GPOs reported sole-source contracting for generic drugs, including generic injectable drugs.

- Contracts that bundle related products: GPOs report negotiating contracts that offer discounts based on the purchase of bundled products, but restricting bundling to products that are used together or are otherwise related in order to create efficiencies and help standardize products for their customers.
- Long-term contracts: GPOs report awarding longer terms for certain types of products, such as IV systems and laboratory products.

Alternatively, all GPO contracts are voluntary and the product of market negotiations. Hospitals and other health care providers are generally not required to only contract with one GPO and may belong to multiple GPOs. Vendors are not required to contract with GPOs and health care providers are not required to use the contracts negotiated by GPOs with their vendors. While GPOs may negotiate sole-source contracts, providers are generally not required to purchase through their GPO contracts but can instead purchase supplies "off contract" by negotiating their own prices directly with suppliers.[25] In economic models, on-contract prices are not necessarily the lowest available. In fact, off-contract prices are sometimes lower. However, off-contract prices could be lower than on-contract prices because of the presence of the GPO. Without the GPO, the off-contract price could potentially be higher.[26]

In addition to the above concerns related to GPO contracts, PBM contracting mechanism may also have an impact on competition. Complaints about the PBM contracting process include employers wanting an alternative to a rebate-driven approach to managing costs, PBMs lacking transparency about how they generate revenue, contracts being complicated and including clauses that benefit the PBM at the expense of the employer or patient, and rebates contributing to misaligned incentives that put PBM interests before patients or employers (no fiduciary obligation).[27]

Contributing Factors to Drug Shortages

Drug shortages remain an ongoing public health concern in the United States. Although the rate of new shortages has decreased, long-term active and ongoing shortages have not been resolved and critical shortages continue to impact patient care and pharmacy operations. Several commonly used products required for patient care are in shortage including sterile infusion solutions (e.g., saline, amino acids, dextrose), as well as diazepam, lidocaine, hydromorphone, and morphine.

Proponents supporting the repeal of the GPO Safe Harbor state the root cause of drug shortages is the existence of the GPO Safe Harbor.[28] However, the drug shortage issue is multi-factorial and complex. Ongoing supply challenges of certain medications, typically injectable products that are off-patent and have few suppliers, persist. Causes of these shortages continue to remain largely unchanged:

- Quality problems – drug shortages are mostly triggered by quality problems during manufacturing processes which causes manufacturers to slow or halt production to address these problems.
- Limited inventory – widespread use of just-in-time inventory practices can increase the vulnerability of the supply chain to shortages.
- Regulatory approval – new manufacturers may not be able to quickly enter the market to produce a drug in shortage because the U.S. Food & Drug Administration's (FDA) approval is required. Existing manufacturers also need FDA approval of changes to manufacturing conditions or processes.

- Production complexity – costly, specialized equipment is required to manufacture drugs and maintaining sterility throughout the production process is challenging and may require facilities dedicated solely to those drugs.
- Constrained manufacturing capacity – in the generic sterile injectable market, the industry is concentrated and has limited manufacturing capacity. The pressures to produce many drugs on only a few manufacturing lines can leave manufacturers with little flexibility when one manufacturer ceases production of a particular drug.

With respect to GPOs, a 2014 GAO report in examining causes of drug shortages was inconclusive and, importantly, did not mention the GPO safe harbor as a causal factor of drug shortages.[29] Accordingly, while the presence of the GPO safe harbor may be a factor in drug shortages, drug shortages are multi-factorial, no consensus exists as to what percentage, if any, the safe harbor contributes to drug shortages, and no empirical evidence exists that the safe harbor is the root cause of drug shortages.

Contributing Factors to Drug Pricing

Proponents supporting the repeal of the GPO Safe Harbor also state that the safe harbor causes unprecedented drug price spikes.[30] While impacted by supply chain dynamics, other contributing factors to pharmaceutical pricing include the type of pharmaceutical (generic, brand, biologic), level of negotiation authority of the purchasing entity, and market exclusivity and manipulations. At the front-end, pharmaceutical manufacturers set a drug's list price, which does not include discounts or rebates. The list price is set to cover costs of production, research and development, and profits. Patients who are uninsured and in high-deductible health plans have greater exposure to the list price; for other patients who are insured, it more represents a starting price in the distribution chain from wholesalers to pharmacies to patients, ultimately impacting patient cost-sharing levels. While concerns have been raised that the rebate process between pharmaceutical companies and PBMs results in list prices above what they would be absent rebates, other key factors foundationally impact a drug's list price.

When addressing the pricing of brand-name drugs, such factors include the number of individuals expected to use the drug, development costs, and competition in the marketplace. Brand-name drugs have 20 years of patent protection from the date of filing, and also enjoy a period of market exclusivity, depending on the type of drug. Orphan drugs – drugs to treat rare diseases or conditions affecting less than 200,000 individuals in the U.S., or affecting more than 200,000 individuals but for which there is not a reasonable expectation that the sales of the drug would recover the costs – have seven years of market exclusivity. Drugs deemed to be innovative products that include an entirely new active ingredient – a new chemical – have five years of market exclusivity. Six months of exclusivity are added to existing exclusivity periods once studies on the effects of a drug upon children are submitted for FDA review and meet the statutory requirements.[31]

Currently, biologic manufacturers have 12 years of market exclusivity for innovator products. Innovator biologics also have additional patent protection that generally exceeds the market exclusivity period by a few years. Overall prices for biologics are higher resulting from the high risk and expense of manufacturing these products, the special handling and administration required, and an overall lack of competition in the marketplace. Biosimilars can offer some cost savings in comparison with their originator equivalents, but thus far not at the level seen between traditional brand-name and generic drugs.

Brand-name drug manufacturers have also used various techniques to delay competition in the marketplace or lengthen patent protection. In reverse-payment patent litigation settlements, also known as "pay-for-delay" settlements, a brand-name drug manufacturer pays a potential generic competitor to abandon its patent challenge and delay offering a generic drug product for a number of years. Brand-name manufacturers can also attempt to effectively extend the term of patent protection for a single product by creating a patent portfolio, composed of patents with staggered terms for modified forms of the same drug, new delivery systems for that drug, or other variations of the original product, a practice known as "evergreening." Examples of evergreening include reformulating a drug as extended release or changing the mix of chemical isomers. In situations where a newer version of an existing brand-name drug enters the marketplace, brand-name manufacturers can also choose to take the older drug off the market or restrict access to the older drug, including by limiting its distribution through select specialty pharmacies.

Several factors can impact the prices of generic drugs, including drug shortages, supply disruptions, limits in manufacturing capacity, and generic drug industry mergers and acquisitions. In addition, generic drug companies may transition to manufacture drugs recently off patent to gain early market share, while others have chosen to manufacture generic drugs that have been on the market for some time and no longer have ample competition.

Patient out-of-pocket costs for the same prescription drug can vary based on the health plan in which they are enrolled. Certain government programs, including Medicaid, the Veterans Affairs and Department of Defense, secure discounts and/or rebates on the price of prescription drugs. In most other coverage situations, patient cost-sharing levels result from insurer/PBM-pharmaceutical company negotiations, and depend on whether drugs are on their health plan formulary, and if so, at what cost-sharing tier.

Our AMA policies on drug shortages and pricing advocate pursing a collaborative approach focused on finding the root causes of problems. Blaming GPOs for the complicated drug shortage problem risks compromising this solution-oriented strategy, especially without a current policy consensus on this point. With respect to GPO pricing incentives, it is important to keep in mind that GPO contracts are voluntary in nature. GPO customers retain the ability to purchase products and services off-contract if they find a preferable or better-priced option.

DISCUSSION

Throughout the evolution of this report, the Council on Medical Service welcomed input from the Council on Legislation and thanks the Council on Legislation for its thoughtful comments throughout the drafting process. The Council on Medical Service is confident that the collaboration between the Councils was essential to the formulation of a measured report on a highly complex subject and the nuances therein.

The GAO has expressly declined to call for eliminating the safe harbor as the appropriate solution, noting that "a repeal of the safe harbor provision would require a clearer understanding of the impact of the GPO funding structure." GAO emphasized, and the Council agrees, that eliminating the safe harbor could have unintended consequences, at least in the short term:

> Some experts believe there is an incentive for GPOs to negotiate higher prices for products and services because GPO compensation increases as prices increase. However, other experts, as well as GPOs, stated that there is sufficient competition between them to mitigate any potential conflicts of interest. Almost 30 years after its passage, there is little empirical evidence to definitively assess the impact of the vendor-

fee-based funding structure protected under the safe harbor. While repealing the safe harbor could eliminate misaligned incentives, most agree there would be a disruption while hospitals and vendors transitioned to new arrangements. Over the longer term, if the current trend of hospital consolidation continues, the concerns about these disruptions may be diminished to the extent that large hospital systems may be in a better position to pay GPOs directly for their services or negotiate contracts with vendors on their own. Furthermore, given that some hospitals are already paying a subsidiary of one GPO directly for access to vendor contracts, alternative approaches are possible.[32]

GPO Studies

As mentioned by the GAO, the Council finds little empirical evidence exists to definitively assess the impact of the GPO safe harbor. Most research studies are funded by interested parties like the Healthcare Supply Chain Association. A limited economic model with no funding ties to GPOs, PBMs, or proponents of repeal, found that while removal of the safe harbor decreased providers' nominal purchasing price, their total purchasing costs are the same as when the safe harbor was present. Thus, repeal would not affect any party's profits or costs.[33] In a broader economic model, a study found that total purchasing cost of the providers is not affected by the presence of the GPO administration fees, although providers may experience higher unit prices.[34]

Legal Impact of Fitting GPOs or PBMs Within Personal Services Safe Harbor

If the GPO safe harbor were repealed, the Council believes that GPOs and PBMs simply could shift fees into other forms, such as rebates or other fees, rather than lose their revenue stream. For example, the current administrative fee could fit within the personal services and management contracts safe harbor or fit within enough factors of the safe harbor that OIG would use its enforcement discretion and not pursue criminal charges against the GPO or PBM.[35] This safe harbor covers a wide variety of conduct. The Council notes that the personal services category covers many types of services provided in the health care industry including professional physician services provided under an independent contractor arrangement, a physician group providing medical services to a hospital, and medical director agreements. The management contracts category covers all non-professional services billing and collection, accounting, marketing, purchasing, staffing, recruiting, quality assurance, and facilities and personnel management.

In this case, the GPO Safe Harbor three percent or 4.5 - 5 percent administration fee could be repackaged under the personal services and management contracts safe harbor as a management contract. To fit within that safe harbor, a GPO or PBM would need to meet the following requirements:

1. Agreement in writing and signed;
2. Covers all of the services provided;
3. Not less than one year;
4. Aggregate compensation paid to the agent (GPO) over the term of the agreement is set in advance, is fair market value, and does not take into the volume or value of any referrals of federal health care program beneficiaries;
5. Arrangement does not violate any state or federal law;
6. Contracted services do not exceed what is reasonably necessary to accomplish the commercially reasonable business objective; and
7. If services are on a part-time basis (e.g., part-time housekeeping), lay out schedule of internals, precise length, and exact charge for such intervals.

Repackaging the administrative fee into the personal services and management contracts safe harbor may not squarely meet all of the safe harbor's requirements because a percentage may not be an aggregate compensation set in advance. OIG is silent on fixed percentages laid out in advance under this exception. OIG, in Advisory Opinions, does allow performance or other percent bonuses as compensation even if it does not fit squarely within the safe harbor. In those instances, OIG uses its enforcement discretion to decline to pursue (e.g., lack of intent). There is also a low risk that the compensation (three percent) was payment for patient referrals because the percentage does not directly vary with the number of patients treated. With determining fair market value, OIG would likely find the three percent GPO fee or the 4.5 percent PBM fee to be fair market value given the percentage of the market that uses these percentages in practice.

Moreover, specifically regarding PBMs, the Council notes that CMS Report 5-A-19, which is before the House of Delegates at this meeting, recommends supporting the active regulation of PBMs under state departments of insurance, supporting efforts to ensure that PBMs are subject to federal laws that prevent discrimination against patients, and supporting improved transparency in PBM operations including a list of disclosures.

Impact on Patient Care

The Council strongly believes that repeal of the GPO safe harbor may also have, at least in the short-term, widespread disruption of the supply chain and administrative challenges for not only hospitals (including physician-owned hospitals), but also clinics, ambulatory surgery centers, and other provider arrangements. As such, physician-owned practice settings may be adversely impacted if the viability of the GPO business model is compromised. Whatever the flaws in their funding structure, the Council finds that GPOs serve a function in enabling cost savings and efficiencies in procurement to facilitate patient care.

Accordingly, the Council believes that adopting a policy to oppose the GPO safe harbor may not only hurt the AMA's credibility but also will not accomplish the objectives set forth by proponents of repeal because limited economic studies show no impact on repeal, entities involve may continue to operate the same practices under a different safe harbor, and repeal would potentially cause a disruption of care and the supply chain.

Instead, the Council believes that the AMA should promote greater transparency and accountability efforts regarding the actions covered by the GPO and PBM anti-kickback safe harbor. In 2014, GAO recommended that CMS should determine whether hospitals are appropriately reporting administrative fee revenues on their Medicare cost reports and take steps to address any underreporting that may be found. In response, CMS issued a Technical Direction Letter to the Medicare Administrative Contractors (MACs) in 2015 adding steps to the desk review program. Specifically, CMS directed MACs to verify that GPO revenues have been offset where appropriate in order to mitigate any risk to the Medicare program. However, nothing has been publicly released based off of these desk reviews. Moreover, HHS has the capability to request records from GPOs the amount received from each vendor with respect to purchases made by or on behalf of the GPOs customers. Yet, the Council is unaware of any requests or public reports based off any requests since the GAO report. Given the push for greater price and cost transparency and the lack of recent data related to GPOs and PBMs, the Council recommends that the federal government renew efforts to support greater public transparency and accountability efforts involving the contracting mechanisms and funding structures subject to the GPO and PBM anti-kickback safe harbor.

Additionally, the Council believes that the AMA should focus efforts on modernizing the fraud and abuse laws to address the changing realities of the health care delivery and payment system. The

Anti-Kickback Statute was passed in 1972, Stark (physician self-referral law) in 1989. Significant changes in health care payment and delivery have occurred since the enactment of these laws. For example, PBMs did not exist, or were at least not as pervasive, when these laws were created. Numerous initiatives are attempting to align payment and coordinate care to improve the quality and value of care delivered. The delivery of care is going through a digital transformation with innovative technology. However, the fraud and abuse laws have not commensurably changed.

The fraud and abuse laws were enacted during a time when fee-for-service, which pays for services on a piecemeal basis, was blamed for rising costs. The policy reasoning behind the fraud and abuse laws is to act as a deterrent against overutilization, inappropriate patient steering, and compromised medical judgment with heavy civil and criminal penalties, such as treble damages, exclusion from participation in federal health care programs, and potential jail time.

The health care system has evolved since the creation of these laws, and the Council believes that they need to be updated to reflect changing business practices and technologies in the health care industry.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 252-A-18, and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-125.986 supporting efforts to ensure that reimbursement policies established by pharmaceutical benefit managers (PBMs) are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-110.992 stating that the AMA will monitor the relationships between PBMs and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-100.956 calling for collaboration with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs (Reaffirm HOD Policy)

4. That our AMA renew efforts urging the federal government to support greater public transparency and accountability efforts involving the contracting mechanisms and funding structures subject to the Group Purchasing Organization and PBMs anti-kickback safe harbor, including the potential impact on drug pricing and drug shortages. (New HOD Policy)

5. That our AMA support efforts to update and modernize the fraud and abuse laws and regulations to address changes in the health care delivery and payment systems including the potential impact on drug pricing and drug shortages. (New HOD Policy)

Fiscal Note: Less than $500

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[3] Henry Schein Medical, *AMA Medical Supply Buying Program*, https://www.henryschein.com/us-en/medical/about-henry-schein-medical/partnerships-associations/ama.aspx.
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[6] Medicare and Medicaid Patient and Program Protection Act of 1987, 101 Stat. 680, 697, P.L. 100-93 § 14 (Aug. 18, 1987).
[7] Omnibus Budget Reconciliation Act of 1986, 100 Stat. 1874, 2016, P.L. 99-509, § 9321 (Oct. 21, 1986). While many articles and documents state that the statutory exception was created in 1987 by the Medicare and Medicaid Patient and Program Protection Act of 1987, the statutory exception was created in 1986.
[8] H.R. Rep. No. 99-727, at 73 (1986), *reprinted in* 1986 U.S.C.C.A.N. 3607, 3663.
[9] 56 Fed. Reg. 35952, 35982 (July 29, 1991).
[10] Social Security Act § 1128B(b)(3)(A).
[11] H.R. Report No. 95-393(II), at 53, reprinted in 1977 U.S.C.C.A.N. 3039, 3056. ("In fact, the committee would encourage providers to seek discounts as a good business practice which results in savings to Medicare and Medicaid program costs.").
[12] 42 CFR § 1001.952(h).
[13] Medicare rules generally require providers to offset purchase discounts, allowances, and refunds against expenses on their Medicare cost reports. In 2005, OIG reviewed 21 GPO members, and found that they did not fully account for net revenue distributions on their Medicare cost reports. There was considerable variation among the GPOs, with members of one GPO offsetting 92 percent of the distributions, members of another offsetting only 54 percent. In total, 22 percent of net revenue distributions were not offset. OIG, Health Care Fraud and Abuse Control Program Annual Report for FY 2005, (Aug. 2006), https://oig.hhs.gov/publications/docs/hcfac/hcfacreport2005.pdf.
[14] 56 Fed. Reg. 35952, 35953 (July 29, 1991).
[15] 42 CFR § 1001.952(d).
[16] HHS OIG, *Compliance Program Guidance for Pharmaceutical Manufacturers* (Apr. 2003), https://oig.hhs.gov/fraud/docs/complianceguidance/042803pharmacymfgnonfr.pdf.
[17] SSA § 1150A (42 U.S.C. § 1320b-23). In relevant part, the regulations requires each entity that provides PBM services to provide to the Part D sponsor and for each part D sponsor to provide to CMS the aggregate amount and type of rebates, discounts, or price concessions (excluding bona fide service fees as defined in §423.501) that the PBM negotiates that are attributable to patient utilization under the plan and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions that were dispensed. 42 C.F.R. § 423.514(d).
[18] Based off of AMA staff interviews with trade associations and private practice attorneys who represent both sides of an arrangement.
[19] 84 Fed. Reg. 2340 (Feb. 6, 2019)
[20] *Id.*
[21] Based off of AMA staff interviews with trade associations and private practice attorneys who represent both sides of an arrangement.
[22] U.S. Department of Justice and the Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care*, (Aug. 1996), pp. 53-60, https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf.
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[29] GAO, *Drug Shortages: Public Health Threat Continues, Despite Efforts to Help Ensure Product Availability* (Feb. 2014), *available at* https://www.gao.gov/assets/670/660785.pdf.
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[31] FDA, *Frequently Asked Questions on Patents and Exclusivity*, May 2, 2018, *available at* https://www.fda.gov/drugs/developmentapprovalprocess/ucm079031.htm.
[32] Government Accountability Office, *Group Purchasing Organizations: Funding Structure has Potential Implications for Medicare Costs* (GA)-15-13) (Nov. 2014).
[33] Q. Hu & L. Schwarz, *Controversial Role of GPOs in Healthcare-Product Supply Chains*, Production and Operations Management (2010). This study used a Hotelling model which assumes a continuum of identical providers and two manufacturers.
[34] Q. Hu & L. Schwarz, *The Impact of Group Purchasing Organizations on Healthcare-Product Supply Chains*, Purdue University (2011).
[35] E.g., Bloomberg BNA, *Health Care Program Compliance, Personal Services and Management Agreements*, chap. 1415 (2012) ("If business realities preclude meeting all of the requirements, then meeting as many of the requirements as possible will increase the chances that the arrangement will be viewed as non-abusive, as long as there is no underlying purpose to induce or reward referrals of business reimbursed under federal health care programs.").

Education materials

Education sessions

More Than a Pain in the Neck: Correcting Ergonomic Stress in Your Practice Setting
Friday, June 7, 9:30 – 10:30 a.m., Crystal Ballroom B

- David Welsh, MD, MBA

All Hands on Deck: Medical Staffs Mobilizing Communities
Friday, June 7, 1:30 – 2:30 p.m., Crystal Ballroom B

- Cesar De Leon, MD, MHA
- Richard Levenstein, JD
- Robert Stucker, JD

Debunked! Myths—and truths—about Joint Commission Accreditation
Friday, June 7, 2:45 – 3:45 p.m., Crystal Ballroom B

- Edward Pollak, MD
- Jay Gregory, MD

Speaker biographies

Speaker slides

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For the best user experience, please download a copy of this handbook to your personal device

More Than a Pain in the Neck: Correcting Ergonomic Stress in Your Practice Setting

2019 AMA Annual Meeting

9:30 – 10:30 a.m. | Friday, June 7 | Crystal Ballroom B | Hyatt Regency Chicago

Program Description

Every day, physicians deal with ergonomic stressors that threaten patient safety and their own health. These stressors can result from both poor physician habits and suboptimal workplace/equipment design and configuration. Join the Organized Medical Staff Section to learn how ergonomic stressors impact physicians and patients, and how you can make improvements in your practice setting.

To claim your credit, visit the AMA Ed Hub™—your center for personalized learning from sources you trust.
https://edhub.ama-assn.org/pages/a-19

Deadline for claiming CME credits is **July 31, 2019**. For questions, contact us at (800) 337-1599 or HODmeetingsupport@ama-assn.org

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All Hands on Deck: Medical Staffs Mobilizing Communities

2019 AMA Annual Meeting

1:30 – 2:30 p.m. | Friday, June 7 | Crystal Ballroom B | Hyatt Regency Chicago

Program Description

The organized medical staff is responsible for advocating for the interests of patients and, more broadly, the community. But is there also a role for the community to advocate for itself, and where does the medical staff fit into any such efforts? Join the Organized Medical Staff Section to learn how your medical staff can successfully mobilize the community to ensure that hospital policies promote safe, high quality patient care.

To claim your credit, visit the AMA Ed Hub™—your center for personalized learning from sources you trust. https://edhub.ama-assn.org/pages/a-19

Deadline for claiming CME credits is **July 31, 2019**. For questions, contact us at (800) 337-1599 or HODmeetingsupport@ama-assn.org

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AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Debunked! Myths—and truths—about Joint Commission Accreditation

2019 AMA Annual Meeting

2:45 – 3:45 p.m. | Friday, June 7 | Crystal Ballroom B | Hyatt Regency Chicago

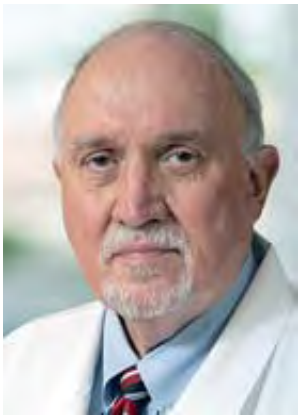
Program Description

In order to effectively advocate for their patients, physicians must have a good understanding of the regulatory environment in which they practice. Join the Organized Medical Staff Section and Edward Pollak, MD, medical director and patient safety officer at The Joint Commission, for a discussion of some of the most pressing issues in hospital accreditation.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

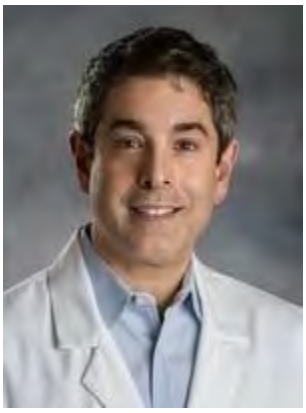
Speaker biographies

Cesar De Leon, DO, MHA, is President of the Collier County Medical Society. A board-certified family practice physician, Dr. De Leon is Chair of the family practice department at NCH Healthcare in Naples, Fla., and Associate Professor of Medicine at University of Central Florida. He received his Doctor of Osteopathy degree with the President's Award and Recognition at Western University of the Health Science College of Osteopathic Medicine, and he holds a master's degree in health care administration from Colorado State University.



Jay Gregory, MD, is a board-certified general surgeon in Muskogee, Okla., where he is also Director of Medical Affairs at Saint Francis Hospital Muskogee. Since 2016, he has served as a member of The Joint Commission Board of Commissioners. Dr. Gregory has served in many other roles in organized medicine throughout his career, including as President of the Oklahoma State Medical Association, President of the American Society of General Surgeons, and Chair of the AMA Organized Medical Staff Section. Dr. Gregory received his medical degree from University of Oklahoma.

Richard Levenstein, JD, is a shareholder at Nason, Yeager, Gerson, Harris & Fumero, P.A. in Palm Beach Gardens, Fla. His practice has a heavy concentration in representing individual physicians, professional medical practices, and the physician leadership of organized medical staffs, and he has successfully challenged the policies of major hospitals, and has won several substantial victories that have shaped the law to protect physicians and medical staffs. Mr. Levenstein is also an Adjunct Professor of Healthcare Law at Tulane University Law School and a lecturer at Tulane University Medical School, where he teaches medical students about the intersection of medicine and law.

	**Ed Pollak, MD**, a practicing anesthesiologist and Fellow of the American Society of Anesthesiologists, is medical director and patient safety officer for the Division of Healthcare Improvement at The Joint Commission. In this role, he is responsible for promoting The Joint Commission's performance improvement and patient safety initiatives. Dr. Pollak provides oversight and physician leadership to the Division of Healthcare Improvement, and leads the response to reported patient safety incidents at accredited and certified health care organizations. A surveyor of record, Dr. Pollak is a member of the Accreditation Council. He also serves on working groups which look at areas of focus for The Joint Commission's patient safety efforts and ongoing issues related to interpretation of current standards. He directs the patient safety fellowship and leads physician patient safety education throughout the organization. Dr. Pollak recently led a webinar on workplace violence, is a member of the Sentinel Event Alert writing group, and frequently speaks on physician engagement, safety culture, and burnout.
	**Robert Stucker, JD**, is Chairman Emeritus of the law firm Vedder Price. He has served on the board of directors of several corporate and charitable organizations, including at the Naples Community Hospital and as a member of the Executive Committee of the Northwestern Memorial Foundation. A resident of Naples, Fla., Mr. Stucker received his law degree from the University of Chicago.
	**David Welsh, MD, MBA**, is Chair of the AMA Organized Medical Staff Section (OMSS) and a board-certified general surgeon in private practice in Batesville, Ind. In addition to his role in the OMSS, Dr. Welsh is a member of the AMA Council on Science & Public Health and a member of the executive committee of the American College of Surgeons Board of Governors. Dr. Welsh received his medical degree from Indiana University School of Medicine and a master's degree in business administration from Ball State University.

About the OMSS

Our people Committees State Chairs Governing Council
OMSS Representative duties and responsibilities
OMSS Internal Operating Procedures
Contact information AMA Department of Organized Medical Staff Services 330 N Wabash Ave, Suite 39300 Chicago, IL 60611 Phone: (312) 464-4539 Fax: (312) 464-2450 Email: omss@ama-assn.org Website: ama-assn.org/go/omss

For the best user experience, please download a copy of this handbook to your personal device

OMSS Committees

A listing of OMSS Committee members will be available at the meeting.

OMSS State Chairs

If you notice an error, or would like to fill a vacancy, please email: omss@ama-assn.org.

Alabama - Vacant	Nebraska - Vacant
Alaska - Vacant	Nevada - Vacant
Arizona - Vacant	New Hampshire - Vacant
Arkansas - Vacant	New Jersey - Nancy Mueller, MD
California - John Luster, MD	New Mexico - Albert Kwan, MD
Colorado - Vacant	New York - Stephen Coccaro, MD
Connecticut - Vacant	North Carolina - Vacant
Delaware - Nancy Fan, MD	North Dakota - Vacant
Florida - Robert Lastomirsky, MD, PhD	Ohio - Marvin Rorick, III, MD
Georgia - Vacant	Oklahoma - Jay Gregory, MD
Hawaii - Vacant	Oregon - Vacant
Idaho - Vacant	Pennsylvania - Martin Trichtinger, MD
Illinois - Vacant	Puerto Rico - Vacant
Indiana - Frederick Ridge, Jr., MD	Rhode Island - Ricardo Correa Marquez, Sr., MD
Iowa - Vacant	South Carolina - Vacant
Kansas - Arthur Snow, Jr., MD	South Dakota - Vacant
Kentucky - Nancy Swikert, MD	Tennessee - Vacant
Louisiana - Dolleen Licciardi, MD	Texas - James Guo, MD
Maine - Vacant	Utah - Louis Moench, MD
Maryland - Vacant	Vermont - Robert Tortolani, MD
Massachusetts - Frank Carbone, Jr., MD	Virginia - Lawrence Monahan, MD
Michigan - Robert Jackson, MD	Washington - Douglas Myers, MD
Minnesota - Vacant	West Virginia - Hoyt Burdick, MD
Missouri - Peggy Barjenbruch, MD	Wisconsin – Keshni Ramnanan, MD
Mississippi - Eric Lindstrom, MD	Wyoming - Vacant
Montana - Vacant	

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

OMSS Governing Council

David Welsh, MD, Chair
djwelsh_1980@yahoo.com

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

John Spurlock, MD, Vice Chair
jonthebold@aol.com

Dr. Spurlock is a gynecologist in solo practice in Bethlehem, Penn., and the OMSS representative for St. Luke's Hospital.

Nancy Church, MD, Secretary
nancyrgchurch@gmail.com

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

Matthew Gold, MD, Delegate
mdgold@massmed.org

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

Raj Lal, MD, Alternate Delegate
r_lal@ix.netcom.com

Dr. Lal is a cardiovascular thoracic surgeon in Oakbrook, Il., and the OMSS representative for Loyola-Gottlieb Memorial Hospital.

John Flores, MD, Member at-Large
johnjala66@verizon.net

Dr. Flores is an internist with Little Elm Medical Clinic in Little Elm, Texas, and the OMSS representative for UT Southwestern Clinically Affiliated Physicians.

Lawrence Monahan, MD, Member at-Large
lkmonahan@jimed.roacoxmail.com

Dr. Monahan is an internist with Jefferson Internal Medicine in Roanoke, Va., and the OMSS representative for LewisGale Medical Center.

AMA Organized Medical Staff Section
Representative Information

Updated September 2017

Qualifications & Selection

OMSS representatives must be physician members of the AMA.

Representatives are selected by their medical staffs, using whatever process the medical staff deems appropriate. Each medical staff may select up to two representatives; additionally, the president or chief of staff may serve as a third representative if he or she is a physician member of the AMA.

The medical staff's choice of representative(s) must be certified in writing by the medical staff president or secretary.

Duties & Responsibilities

1. Serve as a liaison between members of your medical staff and the OMSS:
   a. Represent the concerns of your medical staff at OMSS Annual/Interim meetings and other events, schedule permitting, and otherwise contribute to the AMA's understanding of the challenges facing medical staffs and their members.
   b. Distribute information about OMSS meetings, events, and resources to members of your medical staff and other hospital/health system leaders, ideally providing semi-annual reports to your medical staff executive committee or full medical staff.
   c. Maintain contact with OMSS leadership and staff.

2. Advocate for and educate/mentor other physicians, including residents/fellows and young physicians, on the significance of medical staff governance and on the role of physicians in improving patient outcomes and enhancing physician experience.

3. Serve as a local expert on medical staff-related matters, answering questions from your medical staff and other stakeholders. Refer questions/concerns to OMSS as necessary.

4. Participate in OMSS meetings and events, schedule permitting. Where feasible, seek hospital and/or medical staff financial support for OMSS representative attendance at OMSS meetings and events.

5. Assist in OMSS member recruitment efforts at the local level.

American Medical Association Organized Medical Staff Section
Internal Operating Procedures

I. Mission and Vision Statement

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

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

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

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

4. **Membership.** To promote AMA membership growth.

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

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

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

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

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

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

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

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

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

II. Membership

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

III. Officers/Governing Council

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

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

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

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

1. Chair. The Chair shall:

    a. Preside at all meetings of the Section and meetings of the Governing Council.

    b. Represent the Section on all matters of policy.

2. Vice Chair. The Vice Chair shall:

    a. Assist the Chair and preside at meetings in the absence of the Chair or at the Chair's request.

    b. Act as liaison for the OMSS Outreach Program.

3. Secretary. The Secretary shall:

    a. Prepare summary minutes of Governing Council meetings in coordination with Department of Organized Medical Staff Services.

b. Work with staff of the Department of Organized Medical Staff Services in the production of communication materials.

c. Serves as Chair of the Credentials Committee

4. Delegate. The Delegate shall:

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

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

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

5. Alternate Delegate. The Alternate Delegate shall:

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

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

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

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

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

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

a. Provide continuity in the leadership of the Section.

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

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

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

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

IV. Elections

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

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

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

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

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

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

F. Method of Election.

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

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

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

V. OMSS Assembly Meeting

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

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

1. Hear such reports as may be appropriate.

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

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

4. Hold elections.

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

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

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

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

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

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

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

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

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

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

D. Representatives and Alternate Representatives

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

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

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

E. Registration/Credentialing Process.

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

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

F. Rules of Order.

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

a. The Chair shall preside over the Business Meeting.

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

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

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

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

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

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

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

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

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

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

H. Resolutions.

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

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

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

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

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

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

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

8. Late resolutions accepted as official business of the Assembly shall be distributed to the Assembly and introduced by the Chair of the Committee on Late Resolutions.

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

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

I. Reports.

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

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

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

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

VI. OMSS Committees

A. Credentials Committee.

1. The Credentials Committee is chaired by the Secretary of the Governing Council with assistance from other Governing Council members or state chairs when needed. The number to serve on the Credentials Committee will be determined by the Chair of the Governing Council based on meeting attendance.

2. The Committee is responsible for consideration of all matters relating to the registration and credentialing of all representatives.

B. Committee on Late Resolutions.

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

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

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

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

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

C. Reference Committee(s).

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

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

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

4. All reference committee members shall review and sign the final report. The OMSS Chair and Vice Chair shall review, with the reference committee chairs, the final reference committee reports for parliamentary procedure and clarity.

5. The entire report of the reference committee shall be presented on a Consent Calendar, with the items of business grouped together according to the committee's recommended courses of action. When the reference committee moves adoption of the consent calendar, the Chair shall ask if any member of the Assembly wishes to extract any item from it to be considered separately. Upon request of any representative, the item shall be withdrawn from the calendar and shall be considered as a separate item after the remainder of the consent calendar is acted upon.

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

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

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

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

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

D. Tellers Committee.

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

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

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

VII. Miscellaneous

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

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

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

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

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

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

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

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