**AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**

**241st MEETING OF THE HOUSE OF DELEGATES**

**JUNE 2020 SPECIAL MEETING**
**CONVENED ONLINE**
**June 7, 2020**

## CALL TO ORDER AND MISCELLANEOUS BUSINESS

Note: The 2020 Annual Meeting of the House of Delegates had been suspended by the Board of Trustees on April 3, 2020 due to the ongoing SARS-CoV-2 (COVID-19) pandemic. Following the suspension, on April 25 the Board of Trustees called for a special meeting to be convened virtually on June 7. That meeting is reflected in these Proceedings.

**CALL TO ORDER:** The House of Delegates convened a Special Meeting at 2 p.m. on Sunday, June 7, using a virtual platform provided by Lumi Global, based in the United Kingdom and having US headquarters in Minneapolis. The meeting adjourned later Sunday afternoon, lasting not quite three hours. Presiding over the Special Meeting was Bruce A. Scott, MD, Speaker.

**INVOCATION**: The following invocation was delivered by Rev Dr Russ Peterman, senior minister at University Christian Church in Fort Worth, Texas, who addressed the House remotely:

Good afternoon. I'm grateful for the opportunity and the privilege to offer the invocation this afternoon to invite God to be present and to bless your work together today. In that spirit, let us join together in prayer.

> God of many names and all faiths, you are the spirit of compassion, you are the infinite source of all wisdom and healing and peace. We come together before you scattered across the nation seeking your presence and your blessing in this gathering. We stand before you in this moment with grateful hearts for the sheer gift of life and breath in the body and gratitude for the love of family and friends and trusted colleagues.
>
> In this time when our nation and world is being torn apart by violence and division and disease, we seek your healing peace. Even in these difficult days, O God, we trust and believe that you are at work in us and through us, and pray that in this moment you will enable us to leverage all that is within us for good, for the healing of this world in body and mind and spirit. We are also grateful for the privilege of having been given meaningful work to do, both at the bedside as well as here today in the work that lies before us. Remind us, as has been said, that the meaning of medicine isn't science; the meaning of this work is service. It is work not just of the intellect, but, more importantly, a work of the heart and the soul. And so now more than ever, Divine Wisdom, open the door of your creative imagination, sharpen our intellect, inspire our hearts, strengthen our resolve to work for the good of all people in the service of making our world whole.
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> This we pray, O God, not knowing our need, but trusting solely in you. Amen.

**REPORTS OF THE COMMITTEE ON RULES AND CREDENTIALS**: The following reports were presented by Gary Thal, MD, Chair:

**CREDENTIALS**: The Committee on Rules and Credentials reported that when the Special Meeting commenced 612 out of 686 delegates (89.2%) had been accredited and were participating online. This constituted a quorum. Additional delegates continued to join the meeting as it progressed.

> Note: During the business portion of the meeting, the American Society of Nuclear Cardiology and the Society of Cardiovascular Computed Tomography were admitted to the House of Delegates, bringing the total number of eligible delegates to 689.

## RULES REPORT

**HOUSE ACTION: ADOPTED**

Your Committee on Rules and Credentials recommends:

1. Special Meeting of the House of Delegates (HOD)
   In accord with the official "Call for the Special Meeting" dated April 25, 2020, the AMA House of Delegates will convene via a virtual platform on June 7, 2020 at 2 pm CDT.

2. House of Delegates Security
   Maximum security shall be maintained at all times to prevent disruptions of the House, and only those individuals who have been properly credentialed shall be permitted to vote or comment.

3. Credentials
   The registration record of the Committee on Rules and Credentials shall constitute the official roll call at this Special Meeting of the House. Delegates have been issued a unique credential for use during the virtual meeting and should guard it carefully. If the credential is compromised, it should be reported immediately to HOD@ama-assn.org. Recredentialing can be accomplished by notifying the HOD office electronically no less than 2 hours prior to the call to order, in which case a new credential shall be issued and the previous credential made void. Only delegates may vote in elections and must use their unique credential in order to cast a ballot. For other business, either the delegate or alternate delegate may vote using the credential.

4. Business by the House of Delegates
   The order of business as published in the Handbook shall be the official order of business for this Special Meeting of the House of Delegates. This may be varied by the Speaker, subject to any objection sustained by the House. Under the bylaws, business is restricted to that for which this Special Meeting has been called. No further business shall be entertained.

5. Privilege of the Floor
   Delegates may request the privilege to comment using the chat function; if an alternate wishes to comment he/she must have the permission of the delegate. The Speaker may grant the privilege of the floor to such persons as may be presented by the President, or Chair of the Board of Trustees, or others who may expedite the business of the House, subject to objections sustained by the House.

6. Procedures of the House of Delegates
   As per the official "Call for the Special Meeting" and per the Bylaws governing the Special Meeting, discretion shall be given to the Speaker to conduct the business before the AMA House of Delegates.

7. Limitation on Debate
   Debate will be limited to the chat feature of the virtual platform or a two-minute limit on any oral presentation. A 10-minute limit shall be enforced on any single item of business, subject to waiver by the Speaker or a majority vote of the House.

8. Nominations and Elections
   The House will receive nominations for president-elect, speaker, vice speaker, trustees and council members during the Special Meeting. Individuals who wish to make additional nominations from the floor should do so using the chat function in order to ensure timely submission. Speeches will be limited to officer candidates in contested elections, with no seconding speeches permitted. The order of speeches was determined by lottery. After nominations are closed, any candidate in an uncontested race will be deemed elected by acclamation. As previously announced to the House of Delegates, any candidate to be nominated must have submitted their Conflict of Interest form not later than June 5, 2020 at 2 pm CDT. This includes candidates nominated for newly opened positions created by other elections.

9. Conflict of Interest
   Members of the House of Delegates who have a substantial financial interest in a commercial enterprise, which interest will be materially affected by a matter before the House of Delegates, must publicly disclose that interest.

10. Respectful Behavior
    Courteous and respectful dealings in all interactions with others, including delegates, AMA and Federation staff, and other parties, are expected of all attendees at House of Delegates meetings.

## CLOSING REPORT

**HOUSE ACTION: ADOPTED**

Your Committee on Rules and Credentials wishes to commend the Speaker, Doctor Scott, and the Vice Speaker, Doctor Egbert, for the outstanding manner in which they have presided over this Special Meeting of the House of Delegates, managing our deliberations under the most unusual circumstances. We wish also to commend the members of the House for their cooperation in expediting today's business.

**APPROVAL OF MINUTES**: The Proceedings of the 73rd Interim Meeting of the House of Delegates, held in San Diego, California, Nov. 13-16, 2019, were approved.

**ADDRESS OF THE PRESIDENT**: AMA President Patrice Harris, MD, MA, delivered the following address to the House of Delegates.

Mr. Speaker, officers, trustees, delegates, and physician colleagues: Gratitude.

I have made it a habit to practice gratitude as I have traveled on both my personal and professional journeys, through twists and turns, successes and setbacks, joy and pain. So let me start there.

It has been my honor and a privilege to have served as President of the American Medical Association, and I am grateful for the support of my many families.

So first a thanks to you, my AMA family. A great thanks to my psychiatry family, my Georgia and Atlanta families, my West Virginia family; to the sorors of Alpha Kappa Alpha Sorority, Inc., and my personal family, who have been steadfast in their support for me these many years. I also want to take a moment to recognize the service of our board chair, Dr. Jesse Ehrenfeld. It has been a pleasure to serve with him this past year.

A note of recognition and thanks to our departing trustees: Dr. William Kobler, Dr. William McDade, Ms. Sara Mae Smith, and Mr. Kevin Williams. And what a wonderful opportunity to have served with doctors Barbara McAneny and Sue Bailey, a terrific trio, or as I have come to call us, "We Three".

Barbara, thank you for your many years of unparalleled advocacy for physicians. Sue, thank you for all your years at the helm of the House of Delegates, and I wish you all the best as you become the 175th President of our beloved AMA.

And I can't let this moment go by without a note of gratitude for figures, both seen and hidden, who have advanced progress in science and medicine.

- Historical figures: Dr. Elizabeth Blackwell, Dr. Rebecca Lee Crumpler, Katherine Johnson.
- And modern–day trailblazers: Dr. Nancy Dickey and Dr. Lonnie Bristow.
- And Henrietta Lacks, who until recently was invisible, yet ubiquitous, and whose contribution to medicine and science is immeasurable.

Now, one of the many privileges afforded the President of our AMA is to travel the world, or, to quote the illustrious Dr. Seuss, to "go off to great places". And so along the way, and in those great places, I have met and been inspired by physicians and trainees whose work brings our AMA mission to life: a family physician in Alaska practicing in a remote part of the state; a young physician from Pennsylvania who is working to ensure equitable treatment for those who have a substance–use disorder; an African–American medical student in Illinois, the first in her family to even go to college, juggling supporting family back home while studying for exams.

I have also met nonphysicians who have shown me just how much our mission matters: a taxi driver and Iraq War veteran who told me he had great respect for physicians and that he knew that our journey was one of hard work and long years, and he just wanted to say thanks; a teacher in metro Atlanta who shared a story of a first grader in her class who wanted to grow up to be a doctor because she was inspired by my story; and a sorority sister whose mother told her, right now, during this pandemic, "I'm not going out until Patrice and the AMA says it's okay to go out."

And finally, a destination I could never have imagined. My journey has taken me to this wonderful place, the pinnacle of leadership in organized medicine. I am often asked what makes a great leader?

Great leaders are not those interested in the title or the corner office. We know who they are, but that's not who we are. Great leaders are about the work. Great leaders dream. They dare to inspire; they dare to challenge. Great leaders dare to have difficult conversation and dare to take risks. That is an apt description for what we do at the AMA, and those qualities have been particularly important at this moment, at this time.

Three months ago, all of our lives, and indeed our way of life, changed dramatically. In the United States, more than 1.7 million people have become infected with COVID–19, and more than 100,000 have died. And I want us to pause on that for a moment because those are people with families and loved ones who are grieving their loss, and they deserve a moment of pause.

Our country—indeed, our world—is being challenged as never before, challenged by a novel virus for which there is not yet a specific treatment or vaccine. Physicians are challenged by a lack of resources and PPE, challenged by a political climate that is highly polarized. We are all challenged by the rampant spread of misinformation and disinformation.

In November, I gave a speech about physicians matching the moment and continuing to earn public confidence in an era of mistrust. I spoke about how patients still trust us, their physicians, even though they've lost trust in other institutions, in other professions. I spoke about competency, truth–telling, compassion and purpose—the elements of trust—noting that in this era of distrust the AMA is just what the doctor ordered. Little did any of us realize at the time how dramatically we would be put to the test. But match the moment we have.

Physicians are working long hours in offices and hospitals, sleeping in their basements or hotels so they do not infect family members, working overtime to develop vaccines and treatments, countering the endless false narratives circulating across media channels, and reopening our medical practices so we can meet the postponed health needs of our patients.

On an organizational level, our AMA has pressured Congress and the administration to accelerate production of PPE, test kits and ventilators. We have lobbied for regulatory changes to facilitate remote patient visits and fought for financial support for independent and small practices. We have fought for freedom of speech so physicians can raise concerns about the lack of resources without fear of retribution or punishment. We have used our national platform to call on leaders to focus on science and evidence in all decision making. And it is those acts of competence, truth–telling, compassion, and purpose that will ultimately lead us through this pandemic.

Around this time last year, we were in Chicago, and after days of work on policy we celebrated my inauguration, and this is one of my favorite photos from that celebration. Pictured here are the men of my family, from the youngest, Che, who is an outstanding scholar/athlete, to the eldest, my uncle Ellis Ray Williams, a distinguished educator/principal, and World War II veteran. Our AMA gave them a warm welcome, so much so that at the end of the evening my cousin exclaimed, "I love the AMA!" But unfortunately, as we have seen outside of the walls of the Hyatt Regency, these same family members are not safe to jog or bird watch or drive, or even breathe.

I do have hope, however, but that hope is up to us. It is up to us, America's physicians and the AMA, to demonstrate how to understand more and to fear less, to be the voices our country can trust in this time of trial, and to lead on action to move us forward in this difficult, perilous time. In the words of King T'Challa, "More connects us than separates us" and "In times of crisis the wise build bridges, while the foolish build barriers."

One hundred seventy–four physicians have had the honor of the presidency of the American Medical Association, a position that gives voice to the concerns and work of our profession, and I am so grateful to be in that number. Today, though my tenure as president will end, my work will continue. I will continue work to ensure patients are prioritized

over politics and profits, and to fight any intrusion in the patient–physician relationship. I will work to ensure that as delivery systems are redefined, that the physician voice is heard loudly and clearly. I will work to ensure that mental health is integrated into overall health and that there is action to address the physical and psychological consequences of early traumatic experiences and inequities we see today. I will work to achieve equity and justice within the walls of our exam rooms, within the health–delivery ecosystem, within the halls of Congress, and our justice system. My promise to you is that I will be guided by the direction of Dr. Martin Luther King, Jr., in his final Sunday sermon: "to remain awake through a great revolution."

And so, as I speak to you for the last time as President of the American Medical Association, please know that this psychiatrist is in.

Thank you.

**DISTINGUISHED SERVICE AWARD**: Camran Nezhat, MD, and Vivian Pinn, MD, were nominated by the Board of Trustees and confirmed by the House of Delegates to receive the 2020 Distinguished Service Award at the 2020 Interim Meeting. Jesse Ehrenfeld, MD, MPH, Chair of the Board of Trustees, presented the following report:

The Board of Trustees is pleased to nominate Camran R. Nezhat, MD, and Vivian W. Pinn, MD, as recipients of the 2020 Distinguished Service Award.

Camran R. Nezhat, MD, Palo Alto, California

Dr. Camran R. Nezhat, a laparoscopic surgeon, reproductive endocrinology and infertility sub-specialist, has pioneered numerous methods in operative laparoscopy, such as the technique of video-assisted, "on the monitor" endoscopy, which revolutionized modern day surgery. His innovative approach to video-laparoscopic minimally invasive surgery has changed the treatment paradigm for conditions like endometriosis and uterine fibroids.

His work has opened the path for surgeons all around the world to help their patients.

Vivian W. Pinn, MD, Washington, DC

Dr. Vivian W. Pinn became the first director of the Office of Research on Women's Health (ORWH) in the Office of the Director at the National Institutes of Health (NIH) in 1991. In February of 1994, she was named associate director for Research on Women's Health at NIH, where she completed a national initiative to reexamine priorities for the women's health research agenda, as well as areas in need of research. Since retiring from NIH, Dr. Pinn has continued working as a senior scientist emerita at NIH's Fogarty International Center.

Dr. Pinn earned her MD from the University of Virginia School of Medicine in 1967 where she was the only woman and only minority in her class. She was the first African American woman appointed to chair a department of pathology in the U.S. while at Howard University College of Medicine. A past president of the National Medical Association, Dr. Pinn has been honored extensively by NMA for her leadership and commitment to women's health.

The Board believes Dr. Nezhat and Dr. Pinn are well qualified to receive awards for meritorious service in the art and science of medicine.

## REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES (S-20)

**Reference Committee F and Amendments to Constitution & Bylaws**
Ann R. Stroink, MD, Congress of Neurological Surgeons, Chair
Jerry P. Abraham, MD, California
David J. Bensema, MD, Kentucky
Michael D. Chafty, MD, Michigan
Lynda G. Kabbash, MD, American Academy of Allergy, Asthma & Immunology
Candace E. Keller, MD, American Society of Anesthesiologists
A. Lee Morgan, MD, Colorado

**Committee on Rules & Credentials**
Gary D. Thal, MD, American Society of Anesthesiologists, Chair
Mark Bair, MD, Utah
Shawn C. Jones, MD, Kentucky*
Nancy Church, MD, American Medical Women's Association
Nita Kulkarni, MD, American College of Obstetricians and Gynecologists
Haidn Foster, Regional Medical Student, Ohio

**Chief teller**
Gary D. Thal, MD, American Society of Anesthesiologists, Chair

* Alternate delegate

**INAUGURAL ADDRESS**: Susan Rudd Bailey, MD, was inaugurated as the 175th President of the American Medical Association during the Special Meeting. Following is her inaugural address.

Good afternoon, and thank you for that warm introduction. And special thanks to our speakers, Dr. Bruce Scott and Dr. Lisa Egbert, for their incredible efforts in making today's special meeting possible.

The inauguration of a new AMA President is typically a very formal, black-tie affair, with great celebration and fanfare. In my case, my family and close friends were all excited and ready to fly to Chicago to celebrate with me. I had a beautiful gown and Broadway entertainment and red velvet cake for dessert all picked out. My grandson was going to look so adorable in his tux, just like his daddy and his uncle did at his age, when I became President of the Tarrant County Medical Society. I was planning one final bow with my predecessors, doctors Patrice Harris and Barbara McAneny, capping our historic year with three consecutive women presidents.

But the Coronavirus had other plans, and seemingly overnight our world changed. So here I stand in a nearly empty studio talking to you through a video screen. That's okay. As physicians, we understand better than anyone how a health emergency can disrupt even the most carefully thought-out plans. No matter the circumstance, I'm grateful to address you for the first time as AMA President, and I am so honored to carry the mantle of leadership for this organization I've been proud to serve for 40 years.

On this journey to become AMA President, I've been asked who my heroes were growing up. We hear about heroes every day now it seems, but what is a hero? Who were my heroes?

I was never particularly into make believe superheroes as a kid. It was real people in my life whom I most admired and emulated, the people who inspired me and pushed me to a life beyond anything I could've imagined for myself. My heroes were my physicians. They were my first heroes and they're still my heroes.

I had significant allergies and asthma as a little girl, and my allergists were a guiding light in our family. In fact, the McGovern Allergy Clinic in my home town practically raised me, instilling in me a passion for medicine and teaching me the basics about working in a medical office: how to take a patient's history, perform allergy testing, and how to give a damn good shot.

I grew up in the shadow of the Texas Medical Center in Houston, and many of my friends' dads were physicians. At that time, in the 1960s, it was always the dads. Thankfully now it's moms, too.

Now, although I rarely saw those physicians, I idolized them. After my father had double cardiac bypass surgery in the early '70s, one thing that sped his recovery was taking daily walks by the home of his surgeon, Dr. Jimmy Howell, in the hope that one day the doctor would see him and be proud of him. One day he did see my dad, and he was indeed proud of him, and that kept Daddy walking the rest of his life. Oh, how Daddy and our hero, Dr. Howell, would be proud today.

What we've witnessed in this pandemic and what we know from history is that heroes are defined by their ability to adapt to a changing world, to follow a righteous cause, to overcome immense challenges, and to be changed by it forever. The author Joseph Campbell discusses this in his book, *Hero with a Thousand Faces*, which describes the mythological hero's journey in 12 stages, establishing the classic storyline in everything from the original Star Wars trilogy to *Harry Potter* to the *Wizard of Oz*. As Campbell describes it, a hero starts off in the ordinary, familiar world, but gets a call to adventure.

Think of a humble farm boy on Tatooine getting the call from Obi Wan Kenobi to help save Princess Leia. At first our hero is reluctant, even fearful, but a supernatural force or mentor comes along and brings out the most in them. A threshold is crossed, and the adventure begins. Dorothy skips down the yellow brick road. On her way, our hero encounters challenges, finds allies, and makes enemies. Eventually he or she arrives at the ultimate test. Harry Potter confronts Voldemort face to face. This is a dangerous place, a dark place, a place where survival is as important as the ultimate goal. There's a fight to the death.

Somehow, someway, the hero prevails, but the story is far from over. Going back to ordinary life is not easy, and there are many bumps in the road. But in the end, our hero emerges transformed. Luke is a Jedi Master. Dorothy returns to

Kansas. Harry lives out his life as a benevolent wizard. That's the hero's journey, and it's been told a million times in a million different ways.

A hero's journey is our journey, a physician's journey. You start off as a young student, maybe already in another career, but at some point you hear the call of medical school. Somebody gives you a hand, maybe a teacher or a coworker, and miraculously you've arrived as a first-year medical student. You feel like an imposter at first, and you wonder if you've made the biggest mistake of your life.

Through wit and resourcefulness, you figure out how to be successful. You don the white coat and you make lifelong friends, all the while confronting clinical challenges that you fear might break you.

At some point you confront the ultimate test. Maybe it's having a relationship suffer because your priorities have changed. Maybe it's not matching into the specialty or the program you thought you wanted. Maybe it's losing your first patient. You're in a dark place and it seems there is no way out. But you keep going. You find your way out of the darkness, and you emerge a better physician and a stronger person for having endured these trials. You realize that you are making a difference in people's lives. You're saving lives. You're not the same person you were before you went to medical school. You are a physician, and you're following the hero's journey.

But here's the thing: even heroes need allies on their sides. Luke needed R2D2, Harry Potter needed Hermione and Ron, Dorothy needed her ragtag crew. There isn't a single person I know who walks this journey alone.

My own allies are far too many to mention and thank in my limited time, but they include my husband, Doug, who's been my greatest supporter and partner on this journey. They include my sons, Michael and Stephen Wynn, and Michael's partner, Hannah Guel; my precious grandson, Jackson; my sister, Sally Rudd Ross; and her beautiful family. They include my wonderful partners, doctors Robert Rogers and Drew Beaty; my medical assistant, Joyce Hayes; and all of their families; and all my lifelong friends from Texas A&M University and the Disciples of Christ Church. And of course it includes my family in organized medicine: the Tarrant County Medical Society, where I got my start; the Texas Medical Association; and my allergy and pediatric specialty societies: the ACAAI, the QuadAI and the AAP. Special thanks to Dr. Melissa Garretson for your friendship, hard work and dedication to help me make this journey possible. It also includes my family at the AMA, and all of those colleagues, confidants and executives along the way who have mentored me and become dear friends. I haven't named you all by name, but please know that you're forever in my heart.

And like any hero's journey, ours in medicine is simple: let doctors be doctors.

After more than 30 years in a small private practice, I'm a passionate defender of the independent physician, and, like the AMA, I'm determined to remove all those obstacles that have come between us and our patients: insurer and government mandates, decreasing payments and increasing demands, burnout and physician suicide. And the coronavirus pandemic has made all of these problems more acute. We need the power of the AMA on this journey.

I believe involvement in organized medicine is a professional obligation. Taking good care of our patients requires much more from us than just the time we spend with them in an exam room. It requires advocacy at the highest levels to fight against the quagmire of regulation and for the support we need to sustain private practice during a pandemic that is threatening its very survival. It requires us to confront insurance companies and all their familiar tricks that seem to raise insurance premiums year after year without spending a dime more on patient care.

At times I fear our nation's dysfunctional health system is held together only by the oath that we take when we graduate medical school, the pledge to always put the needs and interests of our patients first.

Whether you took the Hippocratic Oath or, as in my case, recited the Prayer of Maimonides, these words demonstrate our loyalty to public service, to the pursuit of science and knowledge. These words bring purpose and meaning to our work, elevating it from a vocation to a profession.

We are now on a new quest that none of us expected, living and working in a world that may be changed forever; in a wounded, divided nation that needs our leadership. But we need not fear the dark times on our journey. We need only to lean on one another, to take care of each other, and to keep our eyes fixed on the horizon.

We will get through this pandemic. We will continue to fight for our patients and for the practice of medicine. This is our journey, and we will walk it together.

Thank you.

## REPORTS OF THE BOARD OF TRUSTEES

The following four reports were presented by Jesse M. Ehrenfeld, MD, MPH, Chair:

### 1. ANNUAL REPORT

*Reference committee hearing: see report of Reference Committee F and Amendments to Constitution and Bylaws.*

**HOUSE ACTION: FILED**

The Consolidated Financial Statements for the years ended December 31, 2019 and 2018 and the Independent Auditor's report have been included in a separate booklet, titled "2019 Annual Report." This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.

### 2. NEW SPECIALTY ORGANIZATIONS REPRESENTATION IN THE HOUSE OF DELEGATES

*Reference committee hearing: see report of Reference Committee F and Amendments to Constitution and Bylaws.*

**HOUSE ACTION: RECOMMENDATION ADOPTED**
**REMAINDER OF REPORT FILED**
*See Policy D-600.984*

The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the applications of the American Society of Nuclear Cardiology and the Society of Cardiovascular Computed Tomography for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

The applications were considered using criteria developed by the Council on Long Range Planning and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)

Organizations seeking admission were asked to provide appropriate membership information to the AMA. That information was analyzed to determine AMA membership, as required under criterion 3. A summary of this information is attached to this report as Exhibit B.

In addition, organizations must submit a letter of application in a designated format. This format lists the above-mentioned guidelines followed by each organization's explanation of how it meets each of the criteria.

Before a society is eligible for admission to the HOD, it must participate in the SSS for three years. Both organizations have actively participated in the SSS for more than three years.

Review of the materials and discussion during the SSS meeting at the 2019 Interim Meeting indicated that the American Society of Nuclear Cardiology and the Society of Cardiovascular Computed Tomography meet the criteria for representation in the HOD.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the American Society of Nuclear Cardiology and the Society of Cardiovascular Computed Tomography be granted representation in the AMA House of Delegates and that the remainder of the report be filed.

APPENDIX

Exhibit A - Guidelines for Representation in and Admission to the House of Delegates

National Medical Specialty Societies

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

Responsibilities of National Medical Specialty Organizations

1. To cooperate with the AMA in increasing its AMA membership.
2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.
3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.
4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting.
5. To provide information and data to the AMA when requested.

Exhibit B - Summary Membership Information

| Organization | AMA Membership of Organization's Total Eligible Membership |
|---|---|
| American Society of Nuclear Cardiology | 683 of 2,805 (24%) |
| Society of Cardiovascular Computed Tomography | 250 of 996 (25%) |

## 3. AMA 2021 DUES

*Reference committee hearing: see report of Reference Committee F and Amendments to Constitution and Bylaws.*

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS**
**REMAINDER OF REPORT FILED**
*See Policy G-635.130*

Our American Medical Association (AMA) last raised its dues in 1994. AMA continues to invest in improving the value of membership. As our AMA's membership benefits portfolio is modified and enhanced, management will continuously evaluate dues pricing to ensure optimization of the membership value proposition.

RECOMMENDATION

2021 Membership Year

1. The Board of Trustees recommends expanding the number of years over which young physician dues rates increase to the full $420 rate. The new recommended rates increase over four years, from $60 to $420 versus the current two-year period, which better aligns with career and financial situations. All other dues rates remain unchanged. The Board of Trustees recommends that the following be adopted and that the remainder of this report be filed:

| | |
|---|---|
| Regular Members | $ 420 |
| Physicians in Their Fourth Year of Practice | $ 315 |
| Physicians in Their Third year of Practice | $ 210 |
| Physicians in Their Second Year of Practice | $ 105 |
| Physicians in Their First Year of Practice | $ 60 |
| Physicians in Military Service | $ 280 |
| Semi-Retired Physicians | $ 210 |
| Fully Retired Physicians | $ 84 |
| Physicians in Residency Training | $ 45 |
| Medical Students | $ 20 |

2. The Board of Trustees recommends that our AMA disseminate and provide broad, prominent, and easy access to information on the financial hardship exemption.

## 4. COUNCIL ON LEGISLATION SUNSET REVIEW OF 2008 AND 2010 HOUSE POLICIES

*Reference committee hearing: see report of Reference Committee F and Amendments to Constitution and Bylaws.*

**HOUSE ACTION: RECOMMENDATION ADOPTED AS FOLLOWS**
**REMAINDER OF REPORT FILED**

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- In the spring of each year, the House policies that are subject to review under the policy sunset mechanism are identified.
- Using the areas of expertise of the AMA Councils as a guide, the staffs of the AMA Councils determine which policies should be reviewed by which Councils.
- For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy. A justification must be provided for the recommended action on each policy.
- The Speakers assign the policy sunset reports for consideration by the appropriate reference committees.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

In this report, the Board of Trustees presents the Council on Legislation's recommendations on the disposition of the House policies that were assigned to it. The Council on Legislation's recommendations on policies are presented in Appendix 1 to this report.

RECOMMENDATION

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX

| Policy Number | Title | Text | Recommendation |
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| D-120.957 | Electronic Prescribing Incentive Program | Our AMA will continue to work with CMS to ensure that the Electronic Prescribing Incentive Program policies and reporting procedures provide the greatest flexibility to physicians who electronically prescribe and elect to participate in the program.<br>Citation: Res. 223, I-08 | Rescind – The Electronic Prescribing Incentive Program ended in 2013. |
| D-120.959 | Elimination of Physician's "Appointment for Representative" Requirement in Medicare Prescription Drug Program Appeals | Our AMA urges the Centers for Medicare and Medicaid Services to immediately simplify the current Part D Prescription Drug Program Appeal Process by allowing physicians to submit an appeal without beneficiary approval.<br>Citation: Res. 212, A-08 | Retain – This policy remains relevant. |
| D-120.960 | Internet Prescriptions | Our AMA will continue to advocate for its model federal legislation on Internet prescribing as the best means to effectively regulate the sale of prescription drugs, including controlled substances, over the Internet.<br>Sub. Res. 506, A-08 | Rescind – This policy has been accomplished. AMA evaluated federal Internet prescribing legislation and advocated AMA policy to members of Congress; H.R. 6353, the Ryan Haight Online Pharmacy Consumer Protection Act of 2008, was enacted in October 2008 and provides for strong penalties for the inappropriate provision of prescription medication on the Internet. |
| ~~D-120.961~~ Convert to H policy | Personal Medication and Medical Supplies ~~Supply~~ in Times of Disaster | Our AMA urges continued dialogue with ~~the~~ appropriate federal agencies, ~~to convene a meeting of~~ medical societies, health care organizations, and other appropriate stakeholders to: (a) ~~develop a national plan to~~ ensure timely distribution of and access to medications for acute and chronic medical conditions in a disaster; (b) issue guidance to health professionals and the public on the appropriate stockpiling of medications for acute and chronic medical conditions in a disaster or other serious emergency; and (c) deliberate the design, feasibility, and utility of a universal mechanism~~, which~~ that provides the essential health and medical supplies and information that can assist emergency medical responders and other health care personnel with the provision of medical care and assistance in a disaster or other serious emergency.<br>Citation: BOT Rep. 15, A-08 | Modify and retain as an H policy<br>~~Rescind – This policy has been accomplished. Relevant stakeholders were encouraged to: (1) develop a national plan regarding access to medications for chronic medical conditions in a disaster; (2) issue guidance on the appropriate stockpiling of medications for chronic conditions in a disaster; and (3) design a universal mechanism that provides essential health information.~~ |
| D-130.991 | Hospital Emergency Use | Our AMA Board of Trustees, to the fullest extent appropriate, will authorize continued support of federal legislation containing the same provisions as appear in H.R. 904, Access to Emergency Medical Services Act of 1999, which would, among other things, ensure access to covered emergency medical services by group health | Retain – This policy remains relevant but language should be added to provide additional context on the purpose of the bill. |

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| | | plans and health insurance coverage without the need for any prior authorization determination and whether or not the physician furnishing such services is a participating physician.<br>Citation: (Sub. Res. 706, I-00; Reaffirmed: BOT Rep. 6, A-10) | |
| D-130.993 | Confidentiality of Physician Peer Review "…" | (1) Our AMA will ~~study~~continue to assess the threat to the physician peer review process created by health care related federal regulation or statute, i.e. the Emergency Medical Treatment and Active Labor Act (EMTALA); and (2) If our AMA determines that Federal regulations or laws (including EMTALA) undermine state protections for the confidentiality of the peer review process, our AMA will take urgent action to establish protections for covering all Federal programs and related regulations for physician peer review.<br>Citation: (Res. 219. I-00; Reaffirmed: BOT Rep. 6, A-10) | Retain in part, with a modification: change "Our AMA will study the threat to the physician peer review process..." to read instead "Our AMA will continue to assess the threat to the physician peer review process…." |
| D-130.994 | Limit Scope of EMTALA to Original Legislative Intent "…" | (1) The Board of Trustees within 30 days develop an action plan that implements AMA policy H-130.950 that seeks to return to the original congressional intent of Emergency Medical Treatment and Active Labor Act (EMTALA) and oppose the continued judicial and regulatory expansion of its scope. The action plan may include, but is not limited to: (a) Opposing regulations that expand the scope and reach of EMTALA, including the criminalization of hospitals and physicians;<br>(b) Working with the Administration to include adequate Federal funding to pay hospitals and physicians for providing medical screening examinations, for stabilization, and for any indicated transfers of uninsured patients;<br>(c) Establishing a work group that includes representatives of emergency medicine, other physician organizations, hospitals, health plans, business coalitions, and consumers groups to improve policies and regulations with regard to the application of EMTALA; and<br>(d) Seeking Congressional action or, if necessary, initiating litigation to compel revision of the onerous EMTALA regulations and their enforcement.<br><br>(2) Our AMA work with the American Hospital Association to: (a) rescind the regulations extending EMTALA to hospital outpatient departments; (b) modify the regulations requiring receiving hospitals to report to the Centers for Medicare & Medicaid Services (CMS) suspected inappropriate transfers; (c) have CMS incorporate appropriate standards, that prohibit the discharge or inappropriate transfer of unstable hospitalized patients, into the Medicare conditions of participation for hospitals in lieu of utilizing EMTALA for this purpose.<br><br>(3) Significant actions undertaken with regard to EMTALA will be reported to the AMA House of Delegates at the 2001 Annual Meeting.<br>Citation: (Sub. Res. 217, I-00; Reaffirmed: BOT Rep. 6, A-10) | Rescind – The report was submitted, and the general issues addressed in the directive are included in other policies/directives, such as The Future of Emergency and Trauma Care D-130.971; EMTALA -- Major Regulatory and Legislative Developments D-130.982; and Emergency Medical Treatment and Active Labor Act (EMTALA) H-130.950. |
| D-160.988 | Financial Impact of Immigration on American Health System | Our AMA will: (1) ask that when the US Department of Homeland Security officials have physical custody of undocumented foreign nationals, and they deliver those individuals to US hospitals and physicians for medical care, that the US Office of Customs and Border Protection, or other appropriate agency, be required to assume responsibility for the health care expenses | Retain – This policy remains relevant. |

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| | | incurred by those detainees, including detainees placed on "humanitarian parole" or otherwise released by Border Patrol or immigration officials and their agents; and (2) encourage that public policy solutions on illegal immigration to the United States take into consideration the financial impact of such solutions on hospitals, physicians serving on organized medical staffs, and on Medicare, and Medicaid.<br>Citation: Res. 235, A-06; Reaffirmation I-10 | |
| D-165.943 | Financial Assistance for Provision of Legally Mandated Health Care Services | Our AMA will request the continuation of funding for federally-mandated health care for non-residents.<br>Citation: (Res. 229, A-10) | Retain – This policy remains relevant. |
| D-165.962 | Health Savings Accounts for Older Americans | Our AMA will monitor pending regulations and take appropriate steps to ensure access to Health Savings Accounts by all Medicare eligible individuals.<br>Citation: (Sub. Res. 702, A-04; Reaffirmation A-10) | Retain – This policy is still relevant. |
| D-165.971 | Association Health Plans | Our AMA will work with federal legislators to ensure that any Association Health Plan program safeguard state and federal patient protection laws, including but not limited to those state regulations regarding fiscal soundness and prompt payment.<br>Citation: (Sub. Res. 125, A-03; Reaffirmation A-10; Reaffirmed in lieu of Res. 105, A-10) | Retain – This policy is still relevant. |
| D-175.991 | Action to Oppose The Office of Inspector General (OIG) "Draft Compliance Proposed Guidelines for Individual and Small Group Physician Practices" | Our AMA will: (1) condemn the OIG for its unwarranted punitive attitude and reject the final version of the "Office of the Inspector General's Compliance Program Guidance for Individual and Small Group Physician Practices" and discourage its members from voluntarily participating in the program the until such time that a program is developed which is not burdensome to medical practices and focuses on education rather than criminal punishment; (2) aggressively utilize all available means to have CMS and the OIG appropriately define true fraud and true abuse in fair legal terms and desist in the criminalization of the practice of medicine and focus on education rather than criminal punishment; and (3) pursue such relief through legislative and regulatory advocacy.<br>Citation: (Sub. Res. 204, I-00; Reaffirmed: BOT Rep. 6, A-10) | Rescind – Our AMA is actively engaging with the OIG on fraud and abuse policy reform as evident in our recent letters on the Stark/AKS proposed rules. |
| D-175.994 | Misapplication of Fraud and Abuse Laws | Our AMA: (1) will collaborate with state and component medical societies to develop an educational program for physicians on how to be in compliance with current fraud and abuse laws; and (2) continues implementation of our new web-based fraud and abuse tutorial system, and after careful review upon release of final Physician Office Compliance Guidelines issued by the Office of the Inspector General (OIG) of the Department of Health and Human Services, provide member physicians with information and advice consistent with those guidelines, and to advocate for physicians with the OIG regarding these guidelines, and to advocate for physicians with the OIG regarding these guidelines.<br>Citation: (Sub. Res. 244, A-00; Reaffirmed: BOT Rep. 6, A-10) | Rescind – Our AMA is actively engaging with the OIG on fraud and abuse policy reform and continues to provide updated information on our AMA's Medicare waste, fraud & abuse webpage. |
| D-185.998 | Litigation Regarding Patient Care Guidelines | Our AMA will: (1) continue to monitor Batas v. Prudential and provide such support as may be appropriate; and (2) aggressively seek other opportunities to challenge the misuse of M & R and similar patient care guidelines.<br>Citation: (BOT Rep. 4, I-00; Reaffirmed: BOT Rep. 6, A-10) | Rescind – Reference to the Batas case is no longer relevant and Policies H-373.995 (Government Interference in Patient Counseling) and H-410.980 (Principles for the Implementation of clinical |

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| | | | practice guidelines at the Local/State/Regional Level) address the use of clinical guidelines. |
| D-190.975 | Coordination of Benefits | Our AMA will work with payers and other appropriate parties to streamline the coordination of benefits attestation process by requiring employers to convey the attestation obtained during an open enrollment period to the payer and require the payer to accept the attestations from the employer as the only attestation required to release payment for dependent care.<br>Citation: (Res. 721, A-10) | Retain – This policy remains relevant. |
| D-275.962 | Threat to Medical Licensure | Our AMA will develop model legislation to ensure that medical licensure is independent of participation in any health insurance program.<br>Citation: (Res. 717, A-10; Reaffirmation I-10) | Rescind – Model legislation has been developed. "An Act to Prohibit Mandatory Physician Participation in Health Insurance Programs as a Condition of Physician Licensure." |
| D-285.966 | Benefit Management Companies Conflicts of Interest | Our AMA will study possible conflicts of interest and anti-competitive behavior when the owners of a benefit management company include providers or others who have a financial interest in the provision of medical services in the same market in which that benefit management company is contracted to help manage care, and where non-owner providers who are in competition with the owners of the benefit management company may be affected by the company's decisions.<br>Citation: (Res. 825, I-10) | Retain – this policy remains relevant. |
| D-315.980 | Encryption Standards for Storage and Transmission of Patient Data | Our AMA will work with the US Department of Health and Human Services to develop and disseminate to its membership, current information on privacy and security risk assessment tools, including tools addressing encryption, to help ensure physicians can meet the requirements of "safe harbor" provisions contained in regulations promulgated pursuant to the HITECH Act.<br>Citation: (Sub. Res. 828, I-10) | Rescind – The AMA maintains up-to-date information regarding HIPAA security and privacy as well as materials related to Meaningful Use (Promoting Interoperability). |
| D-385.981 | Increased Administrative Fees for Multivalent Vaccines | Our AMA: (1) advocate with the Centers for Medicare and Medicaid Services and ALL other payers to effect an increase in the administration fee for multivalent vaccines to reflect the true costs to the physician for the administration of such vaccines; and (2) work with the Centers for Medicare and Medicaid Services and appropriate specialty societies to develop pediatric specific immunization codes to accurately reflect the physician work in administering vaccines to the pediatric population.<br>Citation: (Res. 731, I-02; Reaffirmation I-10) | Rescind – The AMA has heard from a number of specialties and submitted comments to CMS about the crosswalk problems for immunization administration and has met with the Administration about this issue. In the 2020 MPFS, CMS left the door open so AMA will continue working with the Administration and urging them to fix this problem. AMA will also be commenting about this in our cover letter to the RUC recommendations, as well, so they will hopefully propose a change in the 2021 NPRM. AMA also has other policy on vaccines, including D-440.981. |
| D-390.959 | Supervision Requirements for Outpatient Therapeutic Services | Our AMA will work with key stakeholders to make general supervision, rather than direct supervision, the requirement for Medicare payment for most, but not all, outpatient therapeutic services. | Retain – the policy is still relevant. |

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| | | Citation: (BOT action in response to referred for decision Res. 218, A-10) | |
| D-390.960 | Assuring Patients' Continued Access to Physician Services | 1. Our AMA will immediately formulate legislation for an additional payment option in Medicare fee for service that allows patients and physicians to freely contract, without penalty to either party, for a fee that differs from the Medicare payment schedule and in a manner that does not forfeit benefits otherwise available to the patient. This legislative language shall be available to our AMA members no later than September 30, 2010.<br>2. Our AMA is committed to a well funded and priority legislative and grassroots campaign to ensure passage of legislation in the US Congress that will ensure Medicare patients can keep their benefits when they privately contract with any physician of their choice with the AMA's "Medicare Patient Empowerment Act" as the centerpiece legislation the AMA supports.<br>3. Our AMA will report back to the AMA House of Delegates on its progress in ensuring passage of the Medicare Patient Empowerment Act or similar legislation.<br>Citation: Sub. Res. 204, A-10; Appended: Res. 202, I-10 | Rescind – This directive has been implemented and superseded by more recent policy: D-390.957 (A Grassroots Campaign to Earn the Support of the American People for the Medicare Patient Empowerment Act); D-165.938 (Redefining AMA's Position on ACA and Healthcare Reform); D-380.997 (Private Contracting by Medicare Patients); and H-383.991 (Right to Privately Contract). See also Board Report 11-A-11 (Effective AMA Action to Preserve Medicare Benefits for Patients) |
| D-390.966 | Inappropriate Changes to Physician Medicare Participation Status by the Centers for Medicare & Medicaid Services | 1. Our AMA will work with the Centers for Medicare and Medicaid Services, when necessary, to:<br>a. return physicians to their self-designated Medicare non-participation status in those cases where CMS changed physicians from "non-participating" to "participating" status without the physicians? request or permission;<br>b. have the agency provide written documentation of the erroneous change in the physicians? Medicare participation status thereby allowing those affected physicians to prove that they had no part in the appearance of fraudulent activity resulting from the erroneous CMS action; and<br>c. have the agency provide written documentation of the erroneous change in the physicians' Medicare participation status thereby allowing those affected physicians to prove their innocence to their patients and to all of the Medigap providers whose erroneous explanation of medical benefits forms now imply wrongdoing by these non-participating physicians.<br>2. Our AMA will educate physicians, through appropriate means, of the option of electing the Medicare "non-participating status," together with simple instructions for effecting such a change of status.<br>Citation: (Res. 105, A-07; Appended: Res. 227, I-10) | Retain – This directive remains relevant. |
| D-390.970 | Recovery Audit Contractor Appeals | 1. Our AMA will: (a) educate state medical societies and AMA-member physicians about the available methods for administrative and judicial appeals of Recovery Audit Contractors overpayment recoveries; (b) define common appeal scenarios and methods of appeals, provide technical support on appeals, and seek to consolidate cases for appeal with assistance of state medical societies via the AMA Litigation Center; and (c) continue to oppose the Recovery Audit Contractors' pilot projects and reaffirm existing policy D-390.972.<br>2. Our AMA will inform state and specialty societies about available AMA resources to assist physicians with Recovery Audit Contractor audits and prominently feature on our AMA website information about methods, resources, and technologies related to appeals of Recovery Audit Contractor overpayment recoveries as a members only benefit. | Rescind – The AMA has recently updated our RAC web information, including the appeals information. In addition, the RAC recoveries have steeply declined in recent years, a trend that seemed to coincide with Medicare's Targeted Probe and Educate Initiative. |

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| | | Citation: Sub. Res. 603, I-06; Appended and Reaffirmed: Sub. Res. 603, I-10 | |
| D-420.999 | To Amend The Family Leave Act | Our AMA will work to simplify the Family Medical Leave Act form, reducing the physician work required for completion.<br>Citation: (Sub. Res. 203, I-00; Modified: BOT Rep. 6, A-10) | Retain – this policy is still relevant. |
| D-450.980 | Physician Time Spent with Patients and with Hospital Documentation | Our AMA will:<br>(1) advocate for continued research into quality determinants--including time spent with patients--and lead the effort to develop and appropriately implement quality indicators, i.e., clinical performance measures;<br>(2) continue to work with accrediting bodies and government agencies to substantially reduce hospital paperwork; and<br>(3) continue to work with electronic health record (EHR) system developers to ensure that the perspectives of practicing physicians are adequately incorporated, to ensure the standardization and integration of clinical performance measures developed by physicians for physicians, and to ensure a seamless integration of the EHR into the day-to-day practice of medicine.<br>Citation: (BOT Action in response to referred for decision Res. 511, A-03; Reaffirmation I-10) | Retain – This policy is still relevant. |
| D-478.998 | HIPAA Requirements for E-Commerce in Health Care | 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.<br>Citation: (Res. 802, A-00; Reaffirmed: BOT Rep. 6, A-10) | Rescind – The AMA has worked on educational efforts around HIPAA and produced the required BOT Report (BOT Report 34-A-01, HIPAA Update; It was an informational report and was adopted). |
| D-478.999 | Guidelines for Patient-Physician Electronic Mail | The BOT revisit "Guidelines for Patient-Physician Electronic Mail" when the proposed HIPAA guidelines, encryption, and pertinent federal laws or regulations have been proposed or implemented.<br>Citation: (BOT Rep. 2, A-00; Reaffirmed: BOT Rep. 6, A-10) | Rescind - Regulations around electronic transmission of PHI, including encryption, have been around for many years now and there is guidance from OCR on use of email from 2008. AMA also has policy H-478.997 (Guidelines for Patient-Physician Electronic Mail and Text Messaging), which was reaffirmed at I-18, providing guidelines to physicians for use of email and text. |
| D-510.992 | Restoring Veteran Administration Physicians' Use of Prescription Drug Monitoring Programs | Our AMA will work to address the statutory restrictions which impede the ability of VA physicians and pharmacists in participating state-run Drug Monitoring Programs in order to better treat their veteran patients.<br>Citation: (Res. 705, A-10) | Rescind - The VA Prescription Data Accountability Act, signed into law in 2017, requires Veterans Health Administration (VHA) health professionals with the authority to dispense controlled substances to provide data to their state PDMPs. |

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| H-100.958 | Inappropriate Pharmacy Advertising | Our AMA supports legislation or regulation that prohibits pharmacies and pharmacy benefit managers from using patient-specific drug information to directly market to patients.<br>Citation: (Res. 215, I-10) | Retain – This policy remains relevant. |
| H-130.957 | Emergency Transfer Responsibilities | Our AMA supports seeking amendments to Section 1867 of the Social Security Act, pertaining to patient transfer, to:<br>(1) require that the Office of the Inspector General (IG) request and receive the review of the ~~Peer Review Organization (PRO)~~ Quality Improvement Organization (QIO) prior to imposing sanctions;<br>(2) make the ~~PRO~~QIO determination in alleged patient transfer violations binding upon the IG;<br>(3) expand the scope of ~~PRO~~QIO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks;<br>(4) restore the knowing standard of proof for physician violation;<br>(5) recognize appropriate referral of patients from emergency departments to physician offices;<br>(6) clarify ambiguous terms such as emergency medical transfer and stabilized transfer;<br>(7) clarify ambiguous provisions regarding the extent of services which must be provided in examining/treating a patient;<br>(8) clarify the appropriate role of the on-call specialist, including situations where the on-call specialist may be treating other patients; and<br>(9) clarify that a discharge from an emergency department is not a transfer within the meaning of the act.<br>Citation: (Sub. Res. 78, A-91; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10) | Retain in part, with a modification to reflect the change from Peer Review Organization to Quality Improvement Organization<br>(1) require that the Office of the Inspector General (IG) request and receive the review of the ~~Peer Review Organization (PRO)~~ Quality Improvement Organization (QIO) prior to imposing sanctions;<br><br>(2) make the ~~PRO~~ QIO determination in alleged patient transfer violations binding upon the IG<br><br>(3) expand the scope of ~~PRO~~ QIO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks. |
| H-130.959 | Repeal of COBRA Anti-Physician Provisions | It is the policy of the AMA (1) to seek legal or legislative opportunities to clarify that Section 1867 of the Social Security Act applies only to inappropriate transfers from hospital emergency departments and not to issues of malpractice; and (2) to continue to seek appropriate modifications of Section 1867 of the Social Security Act to preclude liability for discharges from the hospital, including emergency department and outpatient facility.<br>Citation: (Sub. Res. 145, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10) | Retain – This policy remains relevant. |
| H-165.834 | National Pain Care | Our AMA will, in consultation with all interested Federation organizations whose members treat pain disorders, become actively engaged in the implementation and enabling process of the Patient Protection and Affordable Care Act (HR 3590) as it relates to pain care in SEC. 4305 et seq. pertaining to "Institute Of Medicine Conference On Pain," "Pain Research" and "Program For Education And Training In Pain Care."<br>Citation: (Res. 226, A-10) | Rescind – This policy has been accomplished through the passage of the Affordable Care Act, and subsequent AMA advocacy activities over the past decade on pain management and treating substance use disorder. |
| H-165.836 | Government Health Care Czars' Accountability | Our AMA will pursue all regulatory or legislative action in proposed health system reform legislation and regulations to assure accountability, an appeal process and judicial review for decisions made by healthcare officials charged with the responsibility of decisions related to patients and providers of health care.<br>Citation: (Res. 209, A-10) | Rescind – This policy has been accomplished by passage of the Affordable Care Act. |
| H-180.988 | Federal Policy Favoring HMOs | Our AMA supports legislation amending the current federal law so that employers must offer multiple options for health care benefits to employees or to their union | Retain – This policy remains relevant. |

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| | | representatives, including the traditional fee-for-service coverage option, if a health care benefit is provided.<br>Citation: (Sub. Res. 43, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10) | |
| H-190.957 | Free Electronic Claims Billing | Our AMA: (1) supports the ability of physicians to submit claims directly to payors, either electronically or by mailing paper claims; and (2) opposes clearinghouses that inappropriately charge physicians for claim submission, alter codes, or otherwise inappropriately reduce reimbursements.<br>Citation: (Res. 702, A-10) | Retain in part, with the following modification:<br>Our AMA: (1) supports the ability of physicians to submit claims directly to payors, either electronically or by mailing paper claims; and (2) opposes clearinghouses that inappropriately charge physicians for claim submission, alter codes, or otherwise inappropriately reduce reimbursements.<br>Citation: (Res. 702, A-10) |
| H-190.963 | Identity Fraud | Our AMA policy is to discourage the use of Social Security numbers to identify insureds, patients, and physicians, except in those situations where the use of these numbers is required by law and/or regulation.<br>Citation: (Res. 805, A-01; Reaffirmed: Res. 804, A-02; Reaffirmation A-10) | Retain – This policy remains relevant. |
| H-220.929 | Use of Ongoing Professional Practice Evaluation Data | Our AMA advocates that Ongoing Professional Practice Evaluation (OPPE) data be considered as peer review information and therefore be afforded protections under relevant state and federal law, and not be used for economic credentialing purposes.<br>Citation: (Sub. Res. 821, I-10) | Retain – This policy remains relevant. |
| H-230.995 | Medical Liability Insurance Coverage as Mandatory Requirement for Hospital Staff Appointment | 1. Each hospital medical staff should determine for itself whether or not it will require professional liability insurance coverage as a condition for membership on the hospital medical staff.<br>2. Our AMA also believes that, if equity demands that voluntary staff members should have insurance coverage so that the burden of financial loss would not fall entirely upon the hospital, then salaried hospital physicians should likewise be covered by adequate insurance or protected financially through self-insurance mechanisms established by the hospital, so that the burden would not fall unfairly upon the members of the voluntary medical staff.<br>3. Our AMA will seek federal legislation that would amend the federal bankruptcy code such that medical liability premiums that are contractually paid by a hospital on behalf of physician employees shall be considered a priority claim in bankruptcy filings and paid immediately out of the proceeds of the bankrupt hospital's estate.<br>Citation: (BOT Rep. T, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 11, A-03; Reaffirmation A-04; Appended: Res. 230, I-10) | Retain – This policy remains relevant. |
| H-270.975 | Cost Effectiveness of Legislation Regulating Medicine | The AMA will seek legislation to require a cost effectiveness study, including evaluation of the effects on the delivery of high quality patient care services, before congressional passage of any future legislation regulating the medical profession.<br>Citation: (Res. 235, I-92; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10) | Retain – This policy remains relevant. |
| H-270.980 | Independent Health Policy Advisory Council | Our AMA believes that yet another national health advisory body would be redundant and that the AMA should not sponsor legislation at the national level that | Rescind – This policy is no longer relevant. |

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| | | would provide for an independent health policy advisory council.<br>Citation: (BOT Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10) | |
| H-270.982 | Truth in Advertising Standards for Managed Health Care Plans | It is the policy of the AMA to seek legislation which would provide that managed health care plans meet high standards of truth in advertising and legal safeguards to assure high quality medical care is not compromised by deceptive marketing activities, unsubstantiated claims, bogus quality assurance activities, disruptive referral requirements, and unreasonable precertification and concurrent review practices.<br>Citation: (Res. 220, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10) | Retain – This policy remains relevant. |
| H-270.997 | Legal Restrictions on Sexual Behavior Between Consenting Adults | Our AMA supports in principle repeal of laws which classify as criminal any form of noncommercial sexual conduct between consenting adults in private, saving only those portions of the law which protect minors, public decorum, or the mentally incompetent.<br>Citation: (BOT Rep. I, A-75; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: BOT Rep. 6, A-10) | Retain – This policy remains relevant. |
| H-275.963 | Mandatory Medicare Assignment or Determination of Fee Levels | Our AMA supports federal legislation that would prohibit states from enacting legislation to require that acceptance of Medicare assignment or the Medicare allowance of reimbursement be a condition of medical licensure, or used in determinations of unprofessional conduct, or made effectively mandatory in any other fashion.<br>Citation: (Sub Res. 75, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09; Reaffirmation I-10) | Retain – This policy remains relevant. |
| H-275.984 | Legislative Action | The AMA (1) vigorously opposes legislation which mandates that, as a condition of licensure, physicians who treat Medicare beneficiaries must agree to charge or collect from Medicare beneficiaries no more than the Medicare allowed amount; (2) strongly affirms the policy that medical licensure should be determined by educational qualifications, professional competence, ethics and other appropriate factors necessary to assure professional character and fitness to practice; and (3) opposes any law that compels either acceptance of Medicare assignment or acceptance of the Medicare allowed amount as payment in full as a condition of state licensure.<br>Citation: (Sub. Res. 117, I-85; Modified by CLRPD Rep. 2, I-95; Reaffirmed: BOT Rep. 12, A-05; Reaffirmation I-10) | Retain – This policy remains relevant. |
| H-275.995 | Physician Membership on State Boards of Medicine | Rather than developing a model Medical Practice Act, our AMA supports providing continued assistance in the drafting of Medical Practice Act provisions by working individually with each state medical association desiring such assistance.<br>Citation: (BOT Rep. Q, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10) | Retain – This policy remains relevant. |
| H-290.989 | Access to Care by Medicaid Patients | Our AMA (1) requests CMS to improve Medicaid patients' access to care by considering physicians' costs in its determinations regarding the cost effectiveness of Medicaid third party liability requirement; and (2) will work with CMS and/or Congress to allow state Medicaid agencies to waive the requirement that physicians pursue third party payments prior to seeking payment from Medicaid. | Retain – This policy remains relevant. |

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| | | Citation: (Res. 225, I-92; Appended: Res. 201, A-00; Modified: BOT Rep. 6, A-10) | |
| H-320.951 | AMA Opposition to "Procedure-Specific" Informed Consent | Our AMA opposes legislative measures that would impose procedure-specific requirements for informed consent or a waiting period for any legal medical procedure.<br>Citation: (Res. 226, A-99; Reaffirmed: Res. 703, A-00; Reaffirmed: BOT Rep. 6, A-10) | Retain – This policy remains relevant. |
| H-330.892 | Medicare Participation Status | It is AMA policy to eliminate any restrictions, including timing, on physicians' ability to determine their Medicare participation status.<br>Citation: (Res. 104, A-10) | Retain – This policy remains relevant. |
| H-330.910 | Congressional Oversight Hearings and Legislative Reform of CMS | Our AMA will: (1) seek immediate and periodic Congressional oversight hearings of the CMS on issues related to the administration of the Medicare and Medicaid programs and additionally will seek legislation to reform CMS; and (2) undertake and support activities that would hold state and federal agencies, their contractors, and employees dealing with health care issues to the same level of accountability as are physicians.<br>Citation: (Sub. Res. 207, A-00; Reaffirmed: BOT Rep. 6, A-10) | Retain – This policy remains relevant. |
| H-340.949 | Repeal/Modification of OBRA 1989 | It is the policy of the AMA to continue to seek repeal and/or modification of OBRA 1989 to (1) allow for transfer of women in labor when medically indicated, and (2) provide for regular PRO work-up prior to any referral to HHS Office of Inspector General.<br>Citation: (Res. 214, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10) | Rescind – This policy focuses on PROs, which were replaced by QIOs. AMA has policy superseding this one on QIOs, including Quality Improvement Organization Program Status H-340.901 and Quality Improvement Organization Status H-340.903. |
| H-345.991 | Psychologists' Admitting Privileges | The AMA encourages state medical associations to oppose legislation or regulations granting hospital admitting privileges to psychologists.<br>Citation: (Sub. Res. 205, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: BOT Rep. 23, A-09) | Retain – This policy remains relevant. |
| H-373.996 | Exclusion of Medical Debt That Has Been Fully Paid or Settled | Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner.<br>Citation: (Res. 226, I-10) | Retain – This policy remains relevant. |
| H-390.910 | Repeal of Portions of Catastrophic Coverage Act of 1988 | It is the policy of the AMA to continue to work to effect legislation to repeal those portions of any law or regulation that would require that CMS include information in every Explanation of Benefits form for unassigned claims on how Medicare assignment would have affected nonassigned claims.<br>Citation: (Sub. Res. 63, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10) | Retain – This policy remains relevant. |
| H-390.994 | Government Regulations | Our AMA vigorously opposes regulations and legislation which would: (1) interfere with and/or redefine the practice of medicine;<br>(2) substitute hourly wages or annual salaries for present reimbursement mechanisms for physicians' services to patients;<br>(3) base physician reimbursement on any system which does not give recognition to knowledge, skill, time and effort; or<br>(4) otherwise impinge significantly upon the practice of medicine. | Retain – This policy remains relevant. |

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| | | Citation: (Sub. Res. 28, I-82; Amended: CLRPD Rep. A, I-92; Reaffirmed by Sub. Res. 203, A-98; Reaffirmation A-00; Reaffirmation I-01; Reaffirmed: Res. 704, A-10) | |
| H-40.968 | Health Care Coverage for Children of Military Families | Our AMA supports legislation that would provide coverage for military children under TRICARE, consistent with coverage afforded to children under non-grandfathered private health plans.<br>Citation: (Res. 218, I-10) | Retain – This policy remains relevant. |
| H-40.981 | Liability Insurance Costs Caused by Military Service | Our AMA supports petitioning Congress, the President, and other relevant authorities to seek appropriate amendments to the ~~Soldiers and Sailors Relief Act~~ Servicemembers Civil Relief Act in order to provide adequate professional liability protections for physicians called to active military duty.<br>Citation: (Sub. Res. 133, I-90; Modified: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10) | Retain in part. This policy remains relevant but should be modified to reflect a change in the name of the statute cited in this policy. |
| H-40.996 | Appointment of Assistant Secretary of Defense for Health Affairs | Our AMA believes that the U.S. President should nominate a physician experienced in military medicine for appointment as Assistant Secretary of Defense for Health Affairs.<br>Citation: (Res. 123, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CLRPD Rep. 1, A-10) | Retain – This policy remains relevant. |
| H-40.998 | ~~Variable~~ Incentive Pay Programs for Physicians in Military Service | Our AMA, through letters to the President and appropriate members of the Congress and through such other means as are appropriate, strongly supports ~~timely re-enactment of the Variable I~~incentive ~~P~~pay ~~P~~programs for physicians in military service.<br>Citation: (Res. 91, A-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CLRPD Rep. 1, A-10) | Retain in part. The term "Variable Incentive Pay Program" is outdated and should be updated to apply to incentive pay programs more generally. |
| H-420.957 | Shackling of Pregnant Women in Labor | 1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:<br>- An immediate and serious threat of harm to herself, staff or others; or<br>- A substantial flight risk and cannot be reasonably contained by other means.<br>If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used."<br>2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist.<br>Citation: Res. 203, A-10 | Retain – policy remains relevant. |
| H-460.969 | Biomedical Research Protection | Our AMA: (1) encourages state medical associations to support legislation which would amend current criminal codes to specifically state that the unauthorized removal of research animals and/or damage to research projects/facilities is a crime, and the minimum penalty for this offense shall be a felony; and (2) supports passage of the intent of the Federal Animal Research Facilities Protection Act of 1989 (S 727) as originally proposed by Senator Heflin (D-Alabama).<br>Citation: (Res. 251, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: BOT Rep. 6, A-10) | Retain – This policy remains relevant. |

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| H-480.996 | Medical Device Amendments of the FDA | (1) The AMA reiterates its concerns regarding the implementation of the Medical Device Amendments to the Food and Drug Administration (FDA) and urges that regulations be promulgated or interpreted so as to: (a) not interfere with the physician-patient relationship; (b) not impose regulatory burdens that may discourage creativity and innovation in advancing device technology; (c) not change the character and mandate of existing Institutional Review Boards to unnecessarily burden members of the IRB's and clinical investigators; (d) not raise the cost of medical care and new medical technology without any concomitant benefit or additional safeguards being provided the patients; and (e) not interfere with patient records' confidentiality. (2) The AMA urges that existing mechanisms to assure ethical conduct be used to minimize burdensome reporting requirements and keep enforcement costs to a minimum for patients, health care providers, industry and the government.<br>Citation: (Res. 146, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10) | Retain – This policy remains relevant. |
| H-510.994 | Ethics Reform Act of 1989 (PL 101194) | It is the policy of the AMA to work with representatives of [the] Central Office, Department of Veterans Affairs, to develop provisions to exclude either by regulation or by legislation part-time Department of Veterans Affairs physicians (as well as attending and consulting physicians) from the provisions of the Ethics Reform Act of 1989.<br>Citation: (Res. 254, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10) | Retain – This policy remains relevant. |
| H-65.971 | Mental Illness and the Right to Vote | Our AMA will advocate for the repeal of laws that deny persons with mental illness the right to vote based on membership in a class based on illness.<br>Citation: (Res. 202, A-10) | Retain – This policy remains relevant. |

APPENDIX 2 - AMA Policies Superseding Policies Recommended for Rescission

Policy D-130.994, “Limit Scope of EMTALA to Original Legislative Intent”
(1) The Board of Trustees within 30 days develop an action plan that implements AMA policy H-130.950 that seeks to return to the original congressional intent of Emergency Medical Treatment and Active Labor Act (EMTALA) and oppose the continued judicial and regulatory expansion of its scope. The action plan may include, but is not limited to: (a) Opposing regulations that expand the scope and reach of EMTALA, including the criminalization of hospitals and physicians; (b) Working with the Administration to include adequate Federal funding to pay hospitals and physicians for providing medical screening examinations, for stabilization, and for any indicated transfers of uninsured patients; (c) Establishing a work group that includes representatives of emergency medicine, other physician organizations, hospitals, health plans, business coalitions, and consumers groups to improve policies and regulations with regard to the application of EMTALA; and (d) Seeking Congressional action or, if necessary, initiating litigation to compel revision of the onerous EMTALA regulations and their enforcement. (2) Our AMA work with the American Hospital Association to: (a) rescind the regulations extending EMTALA to hospital outpatient departments; (b) modify the regulations requiring receiving hospitals to report to the Centers for Medicare & Medicaid Services (CMS) suspected inappropriate transfers; (c) have CMS incorporate appropriate standards, that prohibit the discharge or inappropriate transfer of unstable hospitalized patients, into the Medicare conditions of participation for hospitals in lieu of utilizing EMTALA for this purpose. (3) Significant actions undertaken with regard to EMTALA will be reported to the AMA House of Delegates at the 2001 Annual Meeting.
Sub. Res. 217, I-00 Reaffirmed: BOT Rep. 6, A-10

Policy H-130.950, “Emergency Medical Treatment and Active Labor Act” (EMTALA)
Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act (EMTALA) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under EMTALA;
(2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act (EMTALA) rules and regulations;
(3) urgently seeks return to the original congressional intent of EMTALA to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and. (4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous EMTALA requirements.

Sub. Res. 214, A-97 Reaffirmation I-98 Reaffirmation A-99 Appended: Sub. Res. 235 and Reaffirmation A-00 Reaffirmation A-07 Reaffirmed: BOT Rep. 22, A-17

Policy D-130.982, "EMTALA -- Major Regulatory and Legislative Developments"
Our AMA: (1) continue to work diligently to clarify and streamline the EMTALA requirements to which physicians are subject; (2) continue to work diligently with the Department of Health and Human Services (HHS) to further limit the scope of EMTALA, address the underlying problems of emergency care, and provide appropriate compensation and adequate funding for physicians providing EMTALA-mandated services; (3) communicate to physicians its understanding that following inpatient admission of a patient initially evaluated in an emergency department and stabilized, care will not be governed by the EMTALA regulations; and (4) continue strongly advocating to the Federal government that, following inpatient admission of a patient evaluated in an emergency department, where a patient is not yet stable, EMTALA regulations shall not apply.
BOT Rep. 17, I-02 Reaffirmation A-07 Modified: BOT Rep. 22, A-17

Policy D-130.971, "The Future of Emergency and Trauma Care"
Our AMA will: (1) expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care; (2) with the advice of specific specialty societies, advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties; (3) continue to advocate for the following: a. Insurer payment to physicians who have delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status, b. Financial support for providing EMTALA-mandated care to uninsured patients, c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service, d. Federal and state liability protections for physicians providing EMTALA-mandated care; (4) disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation; (5) support demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care; (6) support the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by such extension; and (7) if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by extension of the FTCA, our AMA will conduct a legislative campaign, coordinated with national specialty societies, targeted toward extending FTCA protections to all EMTALA-mandated care, and the AMA will assign high priority to this effort.
BOT Rep. 14, I-06 Reaffirmation A-07 Reaffirmation A-08 BOT action in response to referred for decision Res. 204, A-11 Appended: Res. 221, I-11 Modified: CCB/CLRPD Rep. 2, A-14

Policy D-185.998, "Litigation Regarding Patient Care Guidelines"
Our AMA will: (1) continue to monitor Batas v. Prudential and provide such support as may be appropriate; and (2) aggressively seek other opportunities to challenge the misuse of M & R and similar patient care guidelines. BOT Rep. 4, I-00; Reaffirmed: BOT Rep. 6, A-10

Policy H-373.995, "Government Interference in Patient Counseling"
1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.
4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.
5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?

E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
G. Is there a process for appeal to accommodate individual patients' circumstances?
6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.
Res. 201, A-11Reaffirmation: I-12Appended: Res. 717, A-13Reaffirmed in lieu of Res. 5, I-13Appended: Res. 234, A-15Reaffirmation: A-19

Policy H-410.980, “Principles for the Implementation of clinical practice guidelines at the Local/State/Regional Level”
Our AMA has adopted the following principles regarding the implementation of clinical practice guidelines at the local/state/regional level: (1) Relevant physician organizations and interested physicians shall have an opportunity for input/comment on all issues related to the local/state/regional implementation of clinical practice guidelines, including: issue identification; issue refinement, identification of relevant clinical practice guidelines, evaluation of clinical practice guidelines, selection and modification of clinical practice guidelines, implementation of clinical practice guidelines, evaluation of impact of implementation of clinical practice guidelines, periodic review of clinical practice guideline recommendations, and justifications for departure from clinical practice guidelines..
(2) Effective mechanisms shall be established to ensure opportunity for appropriate input by relevant physician organizations and interested physicians on all issues related to the local/state/regional implementation of clinical practice guidelines, including: effective physician notice prior to implementation, with adequate opportunity for comment; and an adequate phase-in period prior to implementation for educational purposes.
(3) clinical practice guidelines that are selected for implementation at the local/state/regional level shall be limited to practice parameters that conform to established principles, including relevant AMA policy on practice parameters.
(4) Prioritization of issues for local/state/regional implementation of clinical practice guidelines shall be based on various factors, including: availability of relevant and high quality practice parameter(s), significant variation in practice and/or outcomes, prevalence of disease/illness, quality considerations, resource consumption/cost issues, and professional liability considerations.
(5) clinical practice guidelines shall be used in a manner that is consistent with AMA policy and with their sponsors' explanations of the appropriate uses of their clinical practice guidelines, including their disclaimers to prevent inappropriate use.
(6) clinical practice guidelines shall be adapted at the local/state/regional level, as appropriate, to account for local/state/regional factors, including demographic variations, patient case mix, availability of resources, and relevant scientific and clinical information.
(7) clinical practice guidelines implemented at the local/state/regional level shall acknowledge the ability of physicians to depart from the recommendations in clinical practice guidelines, when appropriate, in the care of individual patients.
(8) The AMA and other relevant physician organizations should develop principles to assist physicians in appropriate documentation of their adherence to, or appropriate departure from, clinical practice guidelines implemented at the local/state/regional level.
(9) clinical practice guidelines, with adequate explanation of their intended purpose(s) and uses other than patient care, shall be widely disseminated to physicians who will be impacted by the clinical practice guidelines.
(10) Information on the impact of clinical practice guidelines at the local/state/regional level shall be collected and reported by appropriate medical organizations.
CMS Rep. D, A-93Reaffirmed: CMS Rep. 10, A-03Reaffirmed: CMS Rep. 4, A-13

Policy D-385.981, “Increased Administrative Fees for Multivalent Vaccines”
Our AMA: (1) advocate with the Centers for Medicare and Medicaid Services and ALL other payers to effect an increase in the administration fee for multivalent vaccines to reflect the true costs to the physician for the administration of such vaccines; and (2) work with the Centers for Medicare and Medicaid Services and appropriate specialty societies to develop pediatric specific immunization codes to accurately reflect the physician work in administering vaccines to the pediatric population.
Res. 731, I-02 Reaffirmation I-10

Policy D-440.981, “Appropriate Reimbursements and Carve-outs for Vaccines”
Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers; (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; (4) seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on vaccine recommendations, the Advisory Committee on Immunization Practices; and (5) advocate that a physicians office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care.
BOT Rep. 20, A-03 Reaffirmation A-07 Res. 128, A-09 Reaffirmation I-10 Reaffirmed: Res. 807, I-11 Appended: Res. 217, A-19

Policy D-390.960, “Assuring Patients’ Continued Access to Physician Services”
1. Our AMA will immediately formulate legislation for an additional payment option in Medicare fee for service that allows patients and physicians to freely contract, without penalty to either party, for a fee that differs from the Medicare payment schedule and in a manner that does not forfeit benefits otherwise available to the patient. This legislative language shall be available to our AMA members no later than September 30, 2010.
2. Our AMA is committed to a well funded and priority legislative and grassroots campaign to ensure passage of legislation in the US Congress that will ensure Medicare patients can keep their benefits when they privately contract with any physician of their choice with the AMA's “Medicare Patient Empowerment Act” as the centerpiece legislation the AMA supports.
3. Our AMA will report back to the AMA House of Delegates on its progress in ensuring passage of the Medicare Patient Empowerment Act or similar legislation.
Citation: Sub. Res. 204, A-10; Appended: Res. 202, I-10

Policy D-390.957, “A Grassroots Campaign to Earn the Support of the American People for the Medicare Patient Empowerment Act”
Our AMA will now initiate and sustain our well-funded grassroots campaign to secure the support of the American People for passage of the Medicare Patient Empowerment Act in Congress as directed by the 2010 Interim Meeting of the House of Delegates through AMA Policy D-390.960.
Res. 203, I-11

Policy D-165.938, “Redefining AMA’s Position on ACA and Healthcare Reform”
1. Our AMA will develop a policy statement clearly stating this organization's policies on the following aspects of the Affordable Care Act (ACA) and healthcare reform:
A. Opposition to all P4P or VBP that fail to comply with the AMA's Principles and Guidelines;
B. Repeal and appropriate replacement of the SGR;
C. Repeal and replace the Independent Payment Advisory Board (IPAB) with a payment mechanism that complies with AMA principles and guidelines;
D. Support for Medical Savings Accounts, Flexible Spending Accounts, and the Medicare Patient Empowerment Act (“private contracting”);
E. Support steps that will likely produce reduced health care costs, lower health insurance premiums, provide for a sustainable expansion of healthcare coverage, and protect Medicare for future generations;
F. Repeal the non-physician provider non-discrimination provisions of the ACA.
2. Our AMA will immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals.
3. There will be a report back at each meeting of the AMA HOD.
Res. 231, A-13Reaffirmed in lieu of Res. 215, A-15Reaffirmation: A-17

Policy D-380.997, “Private Contracting by Medicare Patients”
1. It is the policy of the AMA: (a) that any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services; (b) to pursue appropriate legislative and legal means to permanently preserve that patient's basic right to privately contract with physicians for wanted or needed health care services; (c) to continue to expeditiously pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the physician/patient relationship; and (d) to seek immediately suitable cases to reverse the limitations on patient and physician rights to contract privately that have been imposed by CMS or the private health insurance industry.
2. Our AMA strongly urge CMS to clarify the technical and statutory ambiguities of the private contracting language contained in Section 4507 of the Balanced Budget Act of 1997.
3. Our AMA reaffirms its position in favor of a pluralistic health care delivery system to include fee-for-service medicine, and will lobby for the elimination of any restrictions and physician penalties for provision of fee-for-service medicine by a physician to a consenting patient, including patients covered under Medicare.
CMS Rep. 6, A-99Reaffirmation A-04Reaffirmation A-08Reaffirmation I-13Modified: CMS Rep. 1, A-15Reaffirmed: Res. 217, I-16

Policy H-383.991, “Right to Privately Contract”
Our AMA includes in its top advocacy priorities: (1) the enactment of federal legislation that ensures and protects the fundamental right of patients to privately contract with physicians, without penalties for doing so and regardless of payer within the framework of free market principles with the goal of accomplishing this by 2010; (2) the restoration of fairness to the current health care marketplace through changes in statutes and regulations so that physicians are able to negotiate (individually and as defined groups) fair contracts with private sector and public sector health plans.
Res. 203, A-09Reaffirmed: BOT Rep. 09, A-19
Also see: BOT Report 11-A-11 - Effective AMA Action to Preserve Medicare Benefits for Patients.

Policy D-478.999, “Guidelines for Patient-Physician Electronic Mail”
The BOT revisit “Guidelines for Patient-Physician Electronic Mail” when the proposed HIPAA guidelines, encryption, and pertinent federal laws or regulations have been proposed or implemented.
BOT Rep. 2, A-00 Reaffirmed: BOT Rep. 6, A-10

Policy H-478.997, “Guidelines for Patient-Physician Electronic Mail and Text Messaging”
New communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. Furthermore, before using electronic mail or other electronic communication tools, physicians should consider Health Information Portability and Accountability Act (HIPAA) and other privacy requirements, as well as related AMA policy on privacy and confidentiality, including Policies H-315.978 and H-315.989. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient's care. These guidelines do not address communication between physicians and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.
(1) For those physicians who choose to utilize e-mail for selected patient and medical practice communications, the following guidelines be adopted.
Communication Guidelines:
(a) Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
(b) Inform patient about privacy issues.
(c) Patients should know who besides addressee processes messages during addressee's usual business hours and during addressee's vacation or illness.
(d) Whenever possible and appropriate, physicians should retain electronic and/or paper copies of e-mail communications with patients.
(e) Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.
(f) Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
(g) Request that patients put their name and patient identification number in the body of the message.
(h) Configure automatic reply to acknowledge receipt of messages.
(i) Send a new message to inform patient of completion of request.
(j) Request that patients use autoreply feature to acknowledge reading clinicians message.
(k) Develop archival and retrieval mechanisms.
(l) Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
(m) Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
(n) Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
(o) Explain to patients that their messages should be concise.
(p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
(q) Remind patients when they do not adhere to the guidelines.
(r) For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.
Medicolegal and Administrative Guidelines:
(a) Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:
(b)Terms in communication guidelines (stated above).
(c) Provide instructions for when and how to convert to phone calls and office visits.
(d) Describe security mechanisms in place.
(e) Hold harmless the health care institution for information loss due to technical failures.
(f) Waive encryption requirement, if any, at patient's insistence.
(g) Describe security mechanisms in place including:
(h) Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.
(i) Never forwarding patient-identifiable information to a third party without the patient's express permission.
(j) Never using patient's e-mail address in a marketing scheme.
(k) Not sharing professional e-mail accounts with family members.
(l) Not using unencrypted wireless communications with patient-identifiable information.
(m) Double-checking all “To” fields prior to sending messages.
(n) Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
(o) Commit policy decisions to writing and electronic form.
(2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.
(3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate.
(4) The policies and procedures for e-mail be applied to text and electronic messaging using a secure communication platform, where appropriate.
BOT Rep. 2, A-00 Modified: CMS Rep. 4, A-01 Modified: BOT Rep. 24, A-02 Reaffirmed: CMS Rep. 4, A-12 Modified: BOT Rep. 11, A-17 Reaffirmation: I-18

Policy H-340.949, "Repeal/Modification of OBRA 1989"
It is the policy of the AMA to continue to seek repeal and/or modification of OBRA 1989 to (1) allow for transfer of women in labor when medically indicated, and (2) provide for regular PRO work-up prior to any referral to HHS Office of Inspector General.
Res. 214, A-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: BOT Rep. 6, A-10

Policy H-340.901, "Quality Improvement Organization Program Status"
1. Our AMA strongly urges CMS to require that Medicare Quality Improvement Organizations (QIOs) adhere to the following principles: (a) physicians should be provided with the fundamental principles of fairness and due process throughout QIO proceedings; (b) all appeal mechanisms available to physicians should be exhausted before QIOs disclose their decisions to beneficiaries; (c) the language used in QIO correspondence with beneficiaries should be properly worded to ensure that the patient/physician relationship is not jeopardized; and (d) QIOs should be required to receive affirmative physician consent before patients are notified of QIO review determinations.
2. Our AMA will advocate to: (a) change the Centers for Medicare and Medicaid Services (CMS) quality improvement organization (QIO) process to mandate an opportunity for practitioners and/or providers to request an additional review when the QIO initial determination peer review and the QIO reconsideration peer review are in conflict; (b) require CMS authorized QIOs to disclose to practitioners and/or providers when the QIO peer reviewer is not a peer match and is reviewing a case outside of their area of expertise; and (c) require CMS authorized QIOs to disclose in their annual report, the number of peer reviews performed by reviewers without the same expertise as the physician being reviewed.
CMS Rep. 7, I-96 Reaffirmed: CMS Rep. 16, I-98 Reaffirmation A-01 Reaffirmed: CMS Rep. 7, I-01 Modified: CMS Rep. 7, A-11 Appended: Res. 224, I-18

Policy H-340.903, "Quality Improvement Organization Status"
The AMA urges CMS to carefully review the potential for conflict of interest when the same organization that contracts as a Medicare Quality Improvement Organization fulfills similar quality improvement contracts in the private sector.
CMS Rep. 9, I-95 Reaffirmed and Modified with change in title: CMS Rep. 7, A-05 Reaffirmed: CMS Rep. 1, A-15

## REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following report was presented by Kathryn L. Moseley, MD, Chair.

### 1. CEJA's SUNSET REVIEW OF 2010 HOUSE POLICIES—UPDATED

*Reference committee hearing: see report of Reference Committee F and Amendments to Constitution and Bylaws.*

**HOUSE ACTION: RECOMMENDATION ADOPTED**
**REMAINDER OF REPORT FILED**

At its 1984 Interim Meeting, the House of Delegates (HOD) established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) policy database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of HOD deliberations.

At its 2012 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- Each year the House policies that are subject to review under the policy sunset mechanism are identified.
- Policies are assigned to appropriate Councils for review.
- For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) sunset the policy; (c) retain part of the policy; d) reconcile the policy with more recent and like policy. A justification must be provided for the recommended action to retain a policy.
- A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. A reaffirmation or amendment to policy by the House of Delegates resets the sunset clock, making the reaffirmed or amended policy viable for another 10 years.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

2010 POLICIES

In this report, the Council on Ethical and Judicial Affairs (CEJA) presents its recommendations regarding the disposition of 2010 House policies that were assigned to or originated from CEJA.

DUPLICATIVE POLICIES

On the model of the Council on Long Range Planning & Development (CLRPD)/CEJA Joint Report I-01 and of subsequent reports of CEJA's sunset review of House policies, this report recommends the rescission of House policies issued since June 2010. As noted previously, the intent of this process is the elimination of duplicative ethics policies from PolicyFinder. The process does not diminish the substance of AMA policy in any sense. Indeed, CEJA Opinions are a category of AMA policy.

MECHANISM TO ELIMINATE DUPLICATIVE ETHICS POLICIES

The Council continues to present reports to the HOD. If adopted, the recommendations of these reports continue to be recorded in PolicyFinder as House policy. When a CEJA Opinion responding to a resolution from the House of Delegates is issued, the corresponding House policy is rescinded.

The Appendix provides recommended actions and their rationale on House policies from 2010, as well as on duplicate policies.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX - Recommended Actions

| **Policy No.** | **Title** | **Recommended Action & Rationale** |
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| D-140.991 | Continuing Efforts to Exclude Physicians from State Executions Protocols | Reaffirm. |
| D-235.989 | Strengthening Medicare Requirements on Self-Governance<br>Our AMA will take all appropriate steps to (1) seek federal regulatory and/or statutory changes to strengthen a medical staff's right to **self-governance** to ensure that the medical staff as a whole is responsible for the patient care, patient safety, and the quality of care delivered in the hospital;<br>(2) seek federal statutory and/or regulatory changes as necessary to ensure that the **Medicare** program has the ability to, and does in fact, enforce **Medicare** conditions of participation relating to the organized medical staff. (2008) | Rescind.<br>Duplicative and outdated. Policy is largely incorporated into other newer provisions at this time. |
| D-235.994 | Medical Staff Autonomy and Self-Governance | Reaffirm. |
| D-255.995 | Discrimination Against IMGs in Classified Advertising | Reaffirm |
| D-35.999 | Non Physicians' Expanded Scope of Practice (Laboratory Testing and Test Interpretation) | Reaffirm. |
| H-140.854 | Responsible Biomedical and Bioethics Journalism | Reaffirm. |
| H-215.985 | Child Care in Hospitals | Reaffirm. |
| H-215.999 | Denial of Hospital Service Resultant from Labor Discord<br>Our AMA encourages hospitals to take all reasonable measures to resolve labor disputes expeditiously so that citizens of the community are not deprived of essential medical service. (1975) | Rescind.<br>Policy is duplicative of E-1.2.10 Political Action by Physicians. E-1.2.10 also discusses the rationale of this guidance. |
| H-235.965 | Physician Involvement in Hospital or Health Care Corporate Compliance Committees Concerning Fraud and Abuse | Reaffirm. |
| H-265.993 | Peer Review of Medical Expert Witness Testimony<br>AMA policy is that: (1) the giving of medico-legal testimony by a physician expert witness be considered the practice of medicine, and (2) all medico-legal expert witness testimony given by a physician should be subject to peer review. (1997) | Reaffirm. |
| H-265.995 | Guidelines for Expert Witness<br>The AMA supports (1) continued study of the various state and specialty society expert witness guidelines that are available, and (2) again disseminating its model state legislation establishing expert witness guidelines and working with the American Bar Association to achieve passage of the guidelines embodied therein. (1991) | Reaffirm. |
| H-275.951 | Mandatory Acceptance of Patient's Group Plan<br>It is the policy of the AMA that the sole purpose of medical licensure is to assure the competence of physicians to practice medicine. | Rescind.<br>Policy is outdated; “group plan” is no longer relevant terminology. |
| H-280.968 | Do Not Hospitalize Orders | Reaffirm. |

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| H-295.996 | Psychological Testing Without Informed Consent | Reaffirm. |
| H-295.998 | Due Process<br>(1) Our AMA reaffirms its 1974 approval of the policy adopted by the Liaison Committee on Medical Education, which states: "A medical school should develop and publicize to its faculty and students a clear definition of its procedures for the evaluation, advancement, and graduation of students. Principles of fairness and 'due process' must apply when considering actions of the faculty or administration which will adversely affect the student to deprive him of his valuable rights."<br>(2) In addition, to clarify and protect the rights of medical students, the AMA recommends that: (a) Each school develop and publish in its catalog, student handbook or similar publication the institutional policies and procedures both for evaluation of academic performance (promotion, graduation, dismissal, probation, remedial work, and the like) and for nonacademic disciplinary decisions. (b) These policies and procedures should define the responsible bodies and their function and membership, provide for timely progressive verbal and written notification to the student that his/her academic/nonacademic performance is in question, and provide an opportunity for the student to learn why it has been questioned. (c) These policies and procedures should also ensure that when a student has been notified of recommendations by the responsible committee for nonadvancement or dismissal, he/she has adequate notice and the opportunity to appear before the decision-making body to respond to the data submitted and introduce his/her own data. (d) The student should be allowed to be accompanied by a student or faculty advisor. (e) The policies and procedures should include an appeal mechanism within the medical school. (f) The student should be allowed to continue in the academic program during the proceedings unless extraordinary circumstances exist, such as physical threat to others.(1979) | *Reaffirm.*<br><br>*NOTE: LCME language has been updated. H-295.998 should be edited as follows:*<br><br>*Due Process*<br>*(1) Our AMA reaffirms its 1974 approval of the policy adopted by the Liaison Committee on Medical Education, which states: ~~"A medical school should develop and publicize to its faculty and students a clear definition of its procedures for the evaluation, advancement, and graduation of students. Principles of fairness and 'due process' must apply when considering actions of the faculty or administration which will adversely affect the student to deprive him of his valuable rights."~~*<br>*"The faculty of a medical school establish criteria for student selection and develop and implement effective policies and procedures regarding, and make decisions about, medical student application, selection, admission, assessment, promotion, graduation, and any disciplinary action. The medical school makes available to all interested parties its criteria, standards, policies, and procedures regarding these matters."* |
| H-30.970 | The Use of AMA Funds for the Purchase of Alcohol | Reaffirm |
| H-315.970 | Personal Health Records | Reaffirm |
| H-315.971 | Patient Information in the Electronic Medical Record<br>AMA Guidelines for Patient Access to Physicians' Electronic Medical Record Systems: | Rescind.<br>This policy is no longer relevant as it predates HIPAA. Further, confidentiality in this context is extensively discussed in more recent AMA policy. |
| H-320.979 | Potential Breaches of Confidentiality Resulting from Third Party Payers' Requests for Patient Information | Rescind.<br>This policy is no longer relevant as it predates HIPAA. Further, confidentiality is extensively discussed in more recent AMA policy. |
| H-320.994 | Confidentiality | Rescind.<br>This policy is no longer relevant as it predates HIPAA. Further, confidentiality is extensively discussed in more recent AMA policy. |
| H-350.971 | AMA Initiatives Regarding Minorities | Reaffirm. |
| H-350.975 | Improving Healthcare of Hispanic Populations in the United States | Reaffirm. |
| H-375.960 | Protection Against External Peer Review Abuses | Reaffirm. |

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| H-375.961 | Protection of Performance Evaluations of Residents and Fellows During Litigation<br>Our AMA opposes the utilization of resident and fellow performance evaluations: (1) for any purpose other than providing educational feedback; and (2) in connection with litigation. (BOT 29-A-10) | Reaffirm. |
| H-40.984 | Physician Reservists | Reaffirm |
| H-405.981 | Professional Autonomy | Reaffirm. |
| H-405.985 | Truthful Specialty Information<br>Our AMA: (1) reaffirms its policy that: (a) individual character, training, competence, experience and judgment be the criteria for granting privileges in hospitals; (b) physicians representing several specialties can and should be permitted to perform the same procedures if they meet these criteria; (c) a physician who acquires new skills as a result of additional education or training should be given individual evaluation and the same consideration as a new physician applying for privileges; and (2) believes that advertising by physicians should comply with ethical opinion 5.02 of the Council of Ethical and Judicial Affairs. (1989) | Reaffirm.<br>NOTE: Ethical opinion cited has been updated and should be 9.6.1, as noted below:<br>(2) believes that advertising by physicians should comply with ethical opinion ~~5.02~~ 9.6.1 of the Council of Ethical and Judicial Affairs. |
| H-405.994 | Exemption of Physicians from Jury Service | Reaffirm |
| H-405.998 | Opposition to the Concept of Withholding Medical Services | Rescind.<br>This policy is duplicative of E-1.2.10 Political Action by Physicians |
| H-406.996 | Use and Release of Physician-Specific Health Care Data | Reaffirm. |
| H-460.945 | Physicians and Other Health Care Personnel as Targets of Threats, Harassment, and Violence<br>Our AMA will: (1) develop educational materials to assist physicians in identifying the legal options available to protect them from targeted harassment, threats, and stalking; (2) support increased national, state, and local protection for physicians and other personnel providing health care services or engaged in biomedical research; and (3) develop model state legislation that defines "stalking" as a crime, and that includes adequate provisions relating to physicians and other health care personnel. (1993) | Rescind.<br>The intent of this policy has been accomplished through criminal stalking laws which have been expanded to cover cyberstalking, a nonexistent threat at the time this policy was written.<br>This resource also outlines both state and federal criminal and civil stalking laws, as well as military, & tribal policies. |
| H-460.966 | Scientific Fraud and Misrepresentation | Reaffirm. |
| H-475.982 | Surgical Safety Checklists | Reaffirm. |
| H-478.999 | An International Code of Ethics for Internet Health Sites | Reaffirm. |
| H-5.992 | Fetal Tissue Transplantation Research<br>Our AMA (1) supports continued research employing fetal tissue obtained from induced abortion, including investigation of therapeutic transplantation; and (2) demands that adequate safeguards be taken to isolate decisions regarding abortion from subsequent use of fetal tissue, including the anonymity of the donor, free and non-coerced donation of tissue, and the absence of financial inducement. (1989) | Rescind.<br>This policy has been superseded by E- 7.3.5 Research Using Human Fetal Tissue and E-6.2.1 Guidelines for Organ Transplantation from Deceased Donors |
| H-5.994 | Use of Fetal Tissue for Legitimate Scientific Research<br>The AMA supports (1) the concept of the use of fetal tissue for legitimate scientific research, including transplantation; and (2) continued federal funding for such research. (1988) | Rescind.<br>This policy has been superseded by E- 7.3.5 Research Using Human Fetal Tissue and E-6.2.1 Guidelines for Organ Transplantation from Deceased Donors |
| H-5.995 | Abortion | Reaffirm. |

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| H-65.970 | Punitive Mutilation | Reaffirm. |

## REPORT OF THE COUNCIL ON MEDICAL EDUCATION

The following report was presented by Jacqueline A. Bello, MD, Chair.

### 1. COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2010 HOUSE OF DELEGATES' POLICIES

*Reference committee hearing: see report of Reference Committee F and Amendments to Constitution and Bylaws.*

**HOUSE ACTION: RECOMMENDATION ADOPTED AS FOLLOWS**
**REMAINDER OF REPORT FILED**

AMA Policy G-600.110, "Sunset Mechanism for AMA Policy," is intended to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations. The current policy reads as follows:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii) Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification; (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

The Council on Medical Education's recommendations on the disposition of the House policies that were assigned to it are included in the Appendix to this report.

RECOMMENDATION

The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX - Recommended Actions on 2010 and Other Related House of Delegates Policies

| Policy Number, Title, Policy | Recommended Action |
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| *H-200.950, "Retraining Refugee Physicians"* | |
| Our AMA supports federal programs, and funding for such programs, that assist refugee physicians who wish to enter the US physician workforce, especially in specialties experiencing shortages and in underserved geographical areas in the US and its territories.<br>(BOT Rep. 20, A-10) | Retain; still relevant. |
| *H-200.959, "Support for the Funding of the National Health Service Corps"* | |
| The AMA supports the continuation of funding to the National Health Service Corps at least at the level originally appropriated in 1995.<br>(Res. 241, A-95; Reaffirmed: CME Rep. 2, I-00; Reaffirmed: CME Rep. 2, A-10) | Sunset; superseded by D-200.980, "Effectiveness of Strategies to Promote Physician Practice in Underserved Areas," which reads, in part: "1. Our AMA, in collaboration with relevant medical specialty societies, will continue to advocate for the following: (a) Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations…."<br><br>Also superseded by H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage," which reads, in part:<br>"F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.<br>"G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program." |
| *H-200.984, "National Health Service Corps Reauthorization"* | |
| It is the policy of the AMA: (1) to support legislative efforts to revitalize and reauthorize the NHSC; and (2) to undertake efforts to assure that such legislation include increased funding for recruitment and retention efforts and adequate funding for both the loan repayment and scholarship programs.<br>(Res. 120, A-90; Reaffirmed: Sunset Report and CME Rep. 2, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmation I-15) | Sunset; superseded by D-200.980, "Effectiveness of Strategies to Promote Physician Practice in Underserved Areas," which reads, in part: "1. Our AMA, in collaboration with relevant medical specialty societies, will continue to advocate for the following: (a) Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations…."<br><br>Also superseded by H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage," which reads, in part:<br>"F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.<br>"G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program." |
| *H-200.989, "National Health Service Corps"* | |
| The AMA believes that since a sufficient need for physician manpower is expected to continue to exist in certain areas of the U.S., continuation of assistance from the NHSC is justified. As long as this need continues, the AMA does not think it would be appropriate to deprive residents of certain | Sunset; no longer relevant. |

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| areas of the U.S. of necessary medical services by diverting NHSC physicians to other countries.<br>(CMS Rep. F, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, I-00; Reaffirmed: CME Rep. 2, A-10) | |

*H-200.987, "Supply and Distribution of Health Professionals"*

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| (1) Licensure, certification and accreditation should not be used for the purpose of regulating the supply of health professionals.<br>(2) Health professions' curricula should emphasize the needs of underserved populations, including the poor, minorities, the chronically ill and disabled, and the geographically isolated. Decisions regarding the financing of health professions education should be based in part on the data and analyses of the national consortium on the supply and distribution of health professionals.<br>(BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmation A-01; Modified: CME Rep. 2, I-03; Reaffirmation I-10) | Retain Clause 1, as it is still relevant; delete Clause 2.<br><br>The first sentence of Clause 2 is superseded by H-295.874, "Educating Medical Students in the Social Determinants of Health and Cultural Competence." This policy should be revised to include mention of underserved populations, as follows:<br><br>"Our AMA: (1) Supports efforts designed to integrate training in social determinants of health, ~~and~~ cultural competence, and meeting the needs of underserved populations across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models."<br><br>The second sentence of Clause 2 is no longer relevant: For example, a "national consortium on the supply and distribution of health professionals" does not currently exist. |

*H-215.987, "Elimination of Hospital Medical Library"*

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| It is the policy of the AMA through appropriate councils, to review current trends in scientific journal publishing and pricing and lend its support to efforts which will maintain Health Sciences Libraries at a level which ensures adequate learning resources for the present and future.<br>(Sub. Res. 24, A-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10) | Retain; still relevant, with edits as shown below.<br><br>"~~It is the policy of~~ T~~t~~he AMA should work, through appropriate councils, to review current trends in scientific journal publishing and pricing and lend its support to efforts ~~which will~~ to maintain Health Sciences Libraries at a level ~~which~~ that ensures adequate learning resources for the present and future." |

*H-220.996, "Private Patients and the Responsibility of the Attending Physician in a Teaching Hospital Setting"*

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| Our AMA opposes mandatory delegation of diagnosis and treatment of private patients primarily to housestaff physicians in teaching hospitals and recommends that (1) refusal to delegate care of private patients to housestaff not be grounds for reduction or termination of privileges; (2) the patient's own private physician be responsible for his care; and (3) JCAHO assure that accreditation standards maintain | Sunset. The Academic Physicians Section or another AMA section will be asked to review the policy and consider an updated version, if needed. |

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| the right of free choice by patients to have care provided by his own physician.<br>(Sub. Res. 131, A-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10) | |

*H-255.969, "Create Local Observership Programs"*

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| Our AMA encourages physician preceptors, medical associations, and medical organizations to establish local observership programs by utilizing the IMG Observership Guidelines and Evaluation Tools.<br>(Res. 307, A-10) | Retain; still relevant. |

*H-255.975, "J-1 Exchange Visitor Program (J-1 Visa)"*

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| 1. Policy of the AMA states: the purpose of the physician J-1 Visa Exchange Program is to ameliorate physician specialty shortages in other countries; and the AMA will work to correct the problems of inconsistency, lack of accountability, and non-compliance in the administration of the physician J-1 Visa Exchange Program.<br><br>2. Our AMA supports a model employment contract specific to J-1 Visa Waiver physicians.<br>(CME Rep. 2, A-97; Modified and Reaffirmed: CME Rep. 2, A-07; Appended: Res. 304, A-10) | Retain; still relevant. |

*H-255.978, "Unfair Discrimination Against International Medical Graduates"*

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| It is the policy of the AMA to take appropriate action, legal or legislative, against implementation of Section 4752(d) of the OBRA of 1990 that requires international medical graduates, in order to obtain a Medicaid UPlN number, to have held a license in one or more states continuously since 1958, or pass the Foreign Medical Graduate Examination in Medical Sciences (FMGEMS), or pass the Educational Commission for Foreign Medical Graduates (ECFMG) Examination, or be certified by ECFMG.<br>(Res. 123, I-90; Reaffirmation A-00; Reaffirmed: CME Rep. 2, A-10) | Retain; still relevant. |

*D-255.997, "Alternate Licensure Protocols for IMGs"*

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| Our AMA will actively support the Florida Medical Association in pursuing legislation that would require the Florida Department of Health to prevent and negate separate criteria for International Medical Graduates to become licensed as Florida physicians.<br>(Res. 311, A-00; Reaffirmed: CME Rep. 2, A-10) | Sunset; no longer relevant. This policy resulted from a resolution related to approximately 400 Cuban refugee physicians seeking to practice medicine in the U.S. (in Florida, in particular). As noted in a 2000 *New York Times* article, "To accommodate them, the Florida Legislature, at the urging of the Cuban-American Caucus, has established a separate test for this group, in the hopes of making it easier to pass. It has placed less emphasis on pure science and more on treatment and diagnosis, for example, and made special courses available to help these immigrants prepare for the test."<br><br>Also, superseded by H-200.950, "Retraining Refugee Physicians": "Our AMA supports federal programs, and funding for such programs, that assist refugee physicians who wish to enter the US physician workforce, especially in specialties experiencing shortages and in underserved geographical areas in the US and its territories." |

*H-275.921, "Licensure for Physicians Not Engaged in Direct Patient Care"*

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| Our AMA: (1) opposes laws, regulations, and policies that would limit the ability of a physician to obtain or renew an unrestricted state or territorial medical license based solely on | Retain; still relevant. |

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| the fact that the physician is engaged exclusively in medical practice which does not include direct patient care; (2) advocates that the Federation of State Medical Boards support provision of unrestricted state or territorial medical licenses to physicians engaged in medical practice that does not include direct patient care; (3) urges constituent state and territorial medical societies to advocate with their respective medical boards to establish policy that will facilitate provision of unrestricted state or territorial medical licenses to physicians in medical practice that does not include direct patient care; and (4) opposes activities by medical licensure boards to create separate categories of medical licensure solely on the basis of the predominant professional activity of the practicing physician.<br>(Res. 923, I-10) | |

*H-275.958, "Discouraging the Use of Licensing Exams for Internal Promotion in Medical Schools"*

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| It is the policy of the AMA to use its representatives on key national medical education committees to encourage the discontinuation of the use of the USMLE Step 1 Exam as a requirement for the promotion of medical students to the clinical phase.<br>(Res. 289, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10) | Retain; still relevant, with edits as shown below, as AMA representatives to external medical education committees have a fiduciary responsibility to that organization, not to the AMA.<br><br>"It is the policy of the AMA to ~~use its representatives on key national medical education committees to~~ encourage the discontinuation of the use of the USMLE Step 1 Exam as a requirement for the promotion of medical students to the clinical phase." |

*H-280.998, "Resident Medical Training in Nursing Homes for Geriatric Patients"*

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| Our AMA endorses the concept of affiliation between nursing home facilities for geriatric patients and resident training programs for the development of clinical experience in such facilities where feasible.<br>(Sub. Res. 12, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10) | Sunset; still relevant, but append to D-295.969, "Geriatric and Palliative Care Training For Physicians," to read as follows:<br><br>"Our AMA: ~~will~~ 1) encourages geriatrics and palliative care training for physicians caring for elderly and terminally ill patients in long-term care facilities; and 2) endorses the concept of affiliation between nursing home facilities for geriatric patients and residency/fellowship programs, where feasible, for the development of physicians' clinical experience in such facilities." |

*H-295.873, "Eliminating Benefits Waiting Periods for Residents and Fellows"*

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| Our AMA:<br>(1) supports the elimination of benefits waiting periods imposed by employers of resident and fellow physicians-in-training;<br>(2) will strongly encourage the Accreditation Council for Graduate Medical Education (ACGME) to require programs to make insurance for health care, dental care, vision care, life, and disability available to their resident and fellow physicians on the trainees' first date of employment and to aggressively enforce this requirement; and<br>(3) will work with the ACGME and with the Liaison Committee on Medical Education (LCME) to develop policies that provide continuous hospital, health, and disability insurance coverage during a traditional transition from medical school into graduate medical education.<br>(4) encourages the Accreditation Council for Graduate Medical Education to request that sponsoring institutions offer to residents and fellows a range of comparable medical insurance plans no less favorable than those offered to other institution employees. | Retain; still relevant. |

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| (BOT Action in response to referred for decision Res. 318, A-06; Appended: CME Rep. 5, A-10) | |

*H-295.886, "Progress in Medical Education: Evaluation of Medical Students' and Resident Physicians' Professional Behavior"*

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| AMA policy is that the educational programs for medical students and resident physicians must include an evaluation of professional behavior, carried out at regular intervals and employing methods shown to be valuable in adding to the information that can be obtained from observational reports. An ideal system would utilize multiple evaluation formats and would build upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident physicians aimed at improving their performance and for summative decisions about progression in training.<br>(CME Rep. 3, I-00; Reaffirmed: CME Rep. 2, A-10) | Sunset; still relevant, but append to D-295.983, "Fostering Professionalism During Medical School and Residency Training," to read as follows:<br><br>"(1) Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements: (a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics.<br>(b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism.<br>(c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees' acquisition of professionalism.<br>(d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism.<br><br>"(2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism, to include an evaluation of professional behavior, carried out at regular intervals and employing methods shown to be valuable in adding to the information that can be obtained from observational reports. An ideal system would utilize multiple evaluation formats and would build upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident physicians aimed at improving their performance and for summative decisions about progression in training." |

*H-295.957, "Use of Animals in Medical Education"*

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| Our AMA has adopted the following guidelines on the use of animals in medical school curricula and continuing medical education courses: (1) Where appropriate, medical school faculty should consider using non-animal models in education activities; when animals are used in the curriculum, education goals should be clearly stipulated.<br><br>(2) Each medical school should disseminate a policy statement to students before matriculation regarding their participation in educational experiences involving animals.<br><br>(3) All educational experiences involving animals should have the approval of the institutional Animal Care and Use Committee.<br><br>(4) Involved faculty should discuss with students the learning objectives of any educational experience that utilizes animals, and faculty should remain available throughout the laboratory exercise for advice and guidance on the conduct of the | Retain; still relevant. Although now encompassed in research regulations and laws for animal care, it is appropriate for the AMA to maintain this ethical stance. |

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| educational experience.<br><br>(5) All educational experiences involving animals should be carried out in a humane manner without inflicting pain on the animal. This includes the appropriate use of anesthetic and analgesic drugs.<br><br>(6) At the conclusion of study, animals should be euthanized in the manner described by the American Veterinary Medical Association.<br>(CSA Rep. A, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10) | |

*H-295.959, "Departments of Family Practice in all LCME Approved Medical Schools"*

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| Our AMA urges the LCME to strongly encourage every medical school without a Department of Family Practice to develop one.<br>(Res. 59, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10) | Retain; still relevant, with edits as shown below to policy and title. Although, as noted in a 2016 article in STAT, "only 10 medical schools in the nation … don't have a department of family medicine, according to the American Academy of Family Physicians," this list includes several prominent institutions, such as Harvard, Yale, Johns Hopkins, and Columbia.<br><br>Note: The LCME does not encourage or mandate specific department structure, so it has been removed from the revision. In addition, the language of the policy's title has been revised for precision.<br><br>"Departments of Family ~~Practice~~ Medicine in all LCME-~~Approved~~Accredited Medical Schools"<br><br>"Our AMA urges ~~the LCME to strongly encourage~~ every medical school without a Department of Family ~~Practice~~ Medicine to develop one." |

*H-295.960, "Broadly Based Clinical Experience and Clinical Proficiency Standards"*

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| It is the policy of the AMA: (1) to direct its representatives on the LCME to continue to monitor the educational content of the final year of educational programs accredited by the LCME so that the standards, and their application to accredited programs, will provide a broad clinical experience; and (2) to reaffirm existing policy that the first year of graduate medical education should provide the resident physician with a broad clinical experience.<br>(CME Rep. H, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10) | Sunset; still relevant, but superseded by other policies, as noted below. In addition, there are no AMA representatives to the LCME, and the LCME does not monitor programs' educational content.<br><br>Clause 1 is superseded by H-295.895 (2), "Progress in Medical Education: Structuring the Fourth Year of Medical School," which reads:<br><br>"(2) The third and fourth years as a continuum should provide students with a broad clinical education that prepares them for entry into residency training."<br><br>Clause 2 is superseded by H-295.995 (19), "Recommendations for Future Directions for Medical Education," which reads:<br><br>"(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training." |

*H-295.966, "Medical School Honor Codes"*

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| Our AMA urges the LCME to facilitate the development of honor codes by medical schools.<br>(CME Rep. D, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10) | Sunset. The LCME doesn't "facilitate" this, and schools are required by LCME standards to define expectations for professional conduct. In addition, the LCME requires the creation of professionalism policies related to appropriate behavior on the part of students and faculty, which covers the same ground as an honor code. |

*H-295.968, "Training Physicians for the 21st Century"*

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| Our AMA approves the concept of undertaking focused studies of medical education, with the participation of other appropriate organizations, at such time as adequate funding can be obtained.<br>(CME Rep. D, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10) | Sunset; superseded by the AMA's work through the Accelerating Change in Medical Education initiative. |

*H-295.977, "Socioeconomic Education for Medical Students"*

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| 1. The AMA favors (a) continued monitoring of U.S. medical school curricula and (b) providing encouragement and assistance to medical school administrators to include or maintain material on health care economics in medical school curricula.<br><br>2. Our AMA will advocate that the medical school curriculum include an optional course on coding and billing structure, RBRVS, RUC, CPT and ICD-9.<br>(CME Rep. B, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05; Appended: Res. 318, A-10) | Sunset; still relevant but superseded by the following policies (with proposed edits as shown).<br><br>For clause 1:<br>D-295.321, "Health Care Economics Education"<br>"Our AMA, along with the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, and other entities, will work to encourage education in health care economics during the continuum of a physician's professional life, ~~starting in~~ including undergraduate medical education, graduate medical education and continuing medical education."<br><br>For clause 2:<br>H-310.953, "Practice Options and Skills Curriculum ~~for Residents~~ in Medical Education"<br><br>"The AMA will assist medical societies, medical schools, and residency programs in the development of model curricula ~~for resident physicians and those entering practice~~ regarding practice options and management skills, including information on CPT and ICD coding, as well as RBRVS and RUC." |

*D-295.984, "Progress in Medical Education: Evaluation of Medical Students' and Resident Physicians' Professional Behavior"*

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| Our AMA will: (1) encourage research and collect information on methods for evaluating the objectives related to professional behavior, and share this information with the medical education community; and (2) offer to work with other organizations, such as the Association of American Medical Colleges, the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, the Federation of State Medical Boards, and the American Board of Medical Specialties, to develop methods and strategies for the evaluation of professional behavior.<br>(CME Rep. 3, I-00; Reaffirmed: CME Rep. 2, A-10) | Sunset; this is encompassed in the work of the AMA's Accelerating Change in Medical Education initiative. |

*H-300.953, "Content-Specific CME Mandated for Licensure"*

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| (1) The AMA, state medical societies, specialty societies, and other medical organizations should reaffirm that the medical profession alone has the responsibility for setting standards and determining curricula in continuing medical education. (2) State medical societies should establish avenues of communication with groups concerned with medical issues, so that these groups know that they have a place to go for discussion of issues and responding to problems. (3) State medical societies should periodically invite the various medical groups from within the state to discuss issues and priorities. (4) State medical societies in states which already have a content-specific CME requirement should consider appropriate ways of rescinding or amending the mandate.<br>(CME Rep. 6, A-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 12, A-10) | Retain; still relevant. |

*H-300.976, "Unification of Education Credits"*

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| It is the policy of the AMA to develop, in cooperation with national specialty organizations and state medical associations, uniform nationwide standards for continuing medical education credits recognized by all medical associations and specialty societies.<br>(Res. 102, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10) | Retain; still relevant. |

*H-300.980, "Focused Continuing Education Programs for Enhanced Clinical Competence"*

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| 1. The AMA encourages state and, where appropriate, local medical societies to respond to the needs of physicians who have been identified as requiring focused continuing medical education.<br><br>2. The AMA encourages state and county medical societies to cooperate with organizations and agencies concerned with physician competence, such as state licensing boards, and to assist in providing opportunities for physicians to participate in focused continuing education programs.<br><br>3. The AMA supports the collection and dissemination of information on focused continuing medical education programs that have been developed or are in the process of development.<br><br>4. Our AMA recommends that organizations with responsibilities for patient care and patient safety request physicians to engage in content-specific educational activities only when there is a reasonable expectation that the CME intervention will be appropriate for the physician and effective in improving patient care or increasing patient safety in the context of the physicians' practice.<br>(CME Rep. C, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08; Appended: CME Rep. 12, A-10) | Retain; still relevant. |

*H-300.994, "Support of Voluntary Continuing Medical Education"*

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| Our AMA supports individual physician responsibility for self-education.<br>(Res. 138, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 12, A-10) | Retain; still relevant. |

*H-300.996, "Reaffirmation of Support for Continuing Medical Education"*

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| Our AMA supports investing funds in effective self-instructional educational programs that are within the budget and are potentially self-supportive.<br>(Sub. Res. 122, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10) | Retain; still relevant. |

*H-300.997, "'Medical Education' Travel"*

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| Our AMA (1) deplores excessive charges for continuing medical education programs which exploit physicians or distort the real purposes of education programs; (2) encourages state society accrediting agencies to consider the impact of the cost of the accreditation process on program charges; and (3) supports making a concentrated effort to acquaint physicians with programs that will help them meet their particular educational needs at a reasonable cost. | Retain; still relevant. |

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| (Sub. Res. 84, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10) | |

*H-300.998, "Continuing Medical Education"*

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| Our AMA continues to encourage physicians to voluntarily participate in continuing medical education.<br>(Sub. Res. 13, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10) | Sunset; still relevant, but superseded by H-300.994, "Support of Voluntary Continuing Medical Education," which reads, "Our AMA supports individual physician responsibility for self-education." |

*H-305.934, "Medical School Tuition and Opposition to Tax Increases"*

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| 1. Our American Medical Association opposes the imposition of mid-year and retroactive tuition increases at both public and private medical schools.<br><br>2. Our AMA opposes tuition taxes and any other attendance-based taxes by any government entity.<br>(CME Rep. 2, I-02; Reaffirmed: CME Rep. 3, I-03; Appended: Res. 905, I-10) | Sunset; still relevant, but append to D-305.983, "Strategies to Combat Mid-year and Retroactive Tuition Increases," to read as follows:<br><br>"Our AMA will: (1) assist state medical societies in advocacy efforts in opposition to mid-year and retroactive tuition increases, tuition taxes, and any other attendance-based taxes by any government entity at both public and private medical schools; (2) make available, upon request, the judicial precedent that would support a successful legal challenge to mid-year tuition increases; and (3) continue to encourage individual medical schools and universities, federal and state agencies, and others to expand options and opportunities for financial aid to medical students." |

*H-305.969, "Financial Information Requirements for Independent Medical Students"*

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| Our AMA urges the HHS to abolish its requirement that independent students submit parental financial information when applying for financial assistance, consistent with the current policy of the Department of Education.<br>(Sub. Res. 250, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10) | Sunset; see the following information from the Student Financial Aid Guidelines for Health Professions Programs, related to the Primary Care Loan (PCL) Program (December 2011:<br><br>"[T]he Affordable Care Act changed the parental financial information requirement for independent students who want PCLs [Primary Care Loans]. As of March 23, 2010, the requirement for independent students to provide parental financial information to determine financial need is eliminated. However, at its discretion, a school may still want to require parental financial information for independent students seeking a PCL. For this program, an independent student is defined as a student who is at least 24 years of age and can prove that he or she has been independent for a minimum of 3 years."<br>[Section 5201(b) of the Affordable Care Act] |

*D-305.994, "Postgraduate Medical Education Reimbursement"*

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| Our AMA: (1) will study the formula for funding graduate medical education that is used by Medicare, and make recommendations to ensure that all sites where resident physicians are trained are included in the funding formula; and (2) policies related to the mechanisms for the funding of graduate medical education be reviewed and, if appropriate, be consolidated.<br>(Sub. Res. 301, A-00; Reaffirmed: CME Rep. 2, A-10) | Sunset. The AMA has frequently studied the Medicare formula for funding graduate medical education and continues to do so. The phrase "make recommendations to ensure that all sites where resident physicians are trained are included in the funding formula" is superseded by D-305.967 (6), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," which reads:<br><br>"6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.)." |

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| | Finally, clause 2, which asks that "policies related to the mechanisms for the funding of graduate medical education be reviewed and, if appropriate, be consolidated," is accomplished periodically through this report as well as other AMA Council and Board of Trustees' reports that consider medical education funding. |

*D-305.995, "Physician Workforce Planning and Physician Retraining"*

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| (1) Our AMA will raise the awareness of groups using the model of adjusting entry-level residency positions to control the physician workforce of the substantial effect of retraining and changes in choice of specialty training on the number of filled entry-level positions.<br><br>(2) Our AMA will collect data on access to health care by specialty and geographic location to assist in ongoing workforce planning initiatives.<br><br>(3) A new model for workforce planning be developed to address the needs of the public for access to health care and the subsequent impact on the needs of teaching institutions to maintain the quality of their educational programs in considering the number of entry-level residency positions.<br>(CME Rep. 2, A-00; Reaffirmed: CME Rep. 2, A-10) | Sunset; superseded by D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education." Relevant segments include:<br><br>"18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes."<br><br>"20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education."<br><br>Also superseded by D-305.958, "Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy." Relevant segments include the following:<br><br>"4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages."<br><br>"5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians." |

*H-305.999, "Financial Aid to Medical Students"*

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| Our AMA urges physicians to contribute to the AMA Foundation for support of medical education and provision of scholarships to medical students.<br>(Res. 6, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CME Rep. 2, A-10) | Retain; still relevant. |

*H-310.914, "Appropriate Use of 360 Degree Evaluations"*

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| Our AMA will: (1) encourage the Accreditation Council on Graduate Medical Education (ACGME) to study mechanisms used by residency programs to evaluate resident performance in the ACGME six general competencies, including 360-degree evaluation tools; and (2) encourage the ACGME to develop standards for the use of 360-degree evaluations, including a determination of their validity in resident assessment, and methods to ensure that the content of individual evaluations remains confidential and legally protected.<br>(Res. 316, A-10) | Sunset; reflected in ACGME Common Program Requirements, as follows:<br><br>V.A.1.c) The program must provide an objective performance evaluation<br>based on the Competencies and the specialty-specific Milestones, and must:<br>V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members)…. |

*H-310.915, "Securing Funding for Graduate Medical Education"*

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| Our AMA will: (1) actively advocate for strong physician representation and significant participation in any proposed health-care workforce advisory committees, demonstration projects, or workforce assessments, since PL 111-148 calls for a "Health Workforce Commission"; (2) continue to advocate for adequate and sustained federal funding of pediatric residency programs independent of Medicare payments; and (3) encourage sponsors of graduate medical education (GME) training programs to use any refunded Federal Insurance Contributions Act (FICA) dollars they receive to enhance their GME training programs.<br>CME Rep. 15, A-10 | Sunset. Clause 1 is no longer relevant, as the proposed national health workforce commission of PL 111-148 (the Patient Protection and Affordable Care Act of 2010) was never funded. Clause 2 is superseded by D-305.973 (1.e), "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," which directs our AMA to work with "the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to… (e) stabilize funding for pediatric residency training in children's hospitals." Clause 3 is no longer relevant, as the refunded FICA monies have been distributed by the IRS. (In 2010, the IRS announced that medical residents may be eligible for a refund for the FICA (Social Security and Medicare) taxes withheld prior to April 1, 2005, and established a process by which refunds were requested by institutions on behalf of former residents.) |

*D-310.958, "Fellowship Application Reform"*

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| 1. Our AMA will: (a) continue to collaborate with the Council of Medical Specialty Societies and other appropriate organizations toward the goal of establishing standardized application and selection processes for specialty and subspecialty fellowship training; and (b) continue to encourage all subspecialties to use the same application cycle and such application cycle should commence only in the final year of residency for programs of less that 5 years, or in the final 2 years of residency for programs of 5 years or longer.<br><br>2. Our AMA will work with relevant stakeholders to study the impact of delayed fellowship start dates after July 1 to evaluate the benefits and drawbacks for all interested parties.<br>(CME Rep. 5, A-09; Appended: Res. 303, A-18) | Retain, still relevant, with minor edit as shown below.<br><br>1. Our AMA will: (a) continue to collaborate with the Council of Medical Specialty Societies and other appropriate organizations toward the goal of establishing standardized application and selection processes for specialty and subspecialty fellowship training; and (b) continue to encourage all subspecialties to use the same application cycle and such application cycle should commence only in the final year of residency for programs of less ~~that~~ than 5 years, or in the final 2 years of residency for programs of 5 years or longer.<br><br>2. Our AMA will work with relevant stakeholders to study the impact of delayed fellowship start dates after July 1 to evaluate the benefits and drawbacks for all interested parties. |

*D-310.965, "Credentialing Materials: Timely Submission by Residency and Fellowship Programs"*

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| 1. Our AMA: (a) encourages residency programs and fellowship programs to properly complete and promptly submit verification of resident education/training on credentialing and re-credentialing forms to the requesting agency within thirty days of the request; and (b) encourages the Accreditation Council for Graduate Medical Education to add to the accreditation standards for residency and fellowship programs and to the Institutional Program Requirements the requirement of the proper completion and prompt submission of verification of resident education/training on credentialing and re-credentialing forms to the requesting agency within thirty days of the request.<br><br>2. Our AMA will work with the Federation of State Medical Boards, American Osteopathic Association and the Accreditation Council for Graduate Medical Education to develop a model form that residency programs can use to document resident performance, dates of participation, and any disciplinary measures imposed, to be maintained in the resident's training file and used when future requests are submitted for evaluation of resident performance.<br>(Res. 311, A-08; Appended: Sub. Res. 308, A-10) | Sunset. Clause 1 is now part of the ACGME Common Program Requirements:<br><br>The program director must:<br>II.A.4.a).(14) document verification of program completion for all graduating residents within 30 days;<br><br>II.A.4.a).(15) provide verification of an individual resident's completion upon the resident's request, within 30 days;<br><br>Clause 2 has been accomplished, through development of the Verification of Postgraduate Medical Education form, available via the Federation of State Medical Boards website. |

*H-310.968, "Opposition to Centralized Postgraduate Medical Education"*

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| Our AMA (1) continues to support a pluralistic system of postgraduate medical education for house officer training; and (2) opposes the mandatory centralization of postgraduate medical training under the auspices of the nation's medical schools.<br>(Res. 69, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10) | Sunset. Clause 1 is superseded by D-305.967 (6), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," which reads:<br><br>"6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.)."<br><br>Clause 2 is no longer relevant, as (unlike in the late 1990s, when the initial resolution was drafted) there are no plans for "mandatory centralization" of GME in medical schools. |

*H-310.970, "Mandatory Helicopter Flight for Emergency Medical Residents in Training"*

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| Our AMA urges residency training programs that require helicopter transport as a mandatory part of their residency to notify applicants of that policy prior to and during the interview process.<br>(Res. 239, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10) | Retain; still relevant. |

*H-310.972, "Residency Review Committee Representation and Requirements"*

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| Our AMA (1) supports obtaining community practitioners representation on the Residency Review Committees (RRC); and (2) urges RRC members to be mindful of the concerns of community hospital residency programs in addressing residency program requirements and to become more representative of community hospital residency programs.<br>(Res. 219, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10) | Retain, with edits as shown.<br><br>Our AMA (1) supports obtaining community practitioners representation on ~~the Residency~~ ACGME Review Committees (~~R~~RCs); and (2) urges ~~R~~RC members to be mindful of the concerns of community hospital residency programs in addressing residency program requirements and to become more representative of community hospital residency programs. |

*D-310.994, "Intern and Resident Work Standards"*

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| Our AMA: (1) will support the various standards of Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committees as a template for reasonable resident work conditions, pending further data; and (2) will stress the consideration of patterns and trends of program violations of ACGME requirements, and affirm the recommendations of Council on Medical Education Report 3, A-00, that recommended various alternatives to enforce compliance with requirements, including the shortening of the cycle for review of programs that receive unfavorable Institutional Reviews.<br>(Sub. Res. 306, I-00; Appended: CME Rep. 2, A-10) | Sunset; no longer relevant, and superseded by H-310.907, "Resident/Fellow Clinical and Educational Work Hours." |

*D-310.995, "Enforcement of ACGME Requirements"*

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| (1) The ACGME be asked to distribute the alternatives suggested in this report to each of the Residency Review Committees (RRC) and the Institutional Review Committee for their consideration and comment as mechanisms to enforce compliance with requirements.<br><br>(2) Our AMA representatives be requested to ask the ACGME and the RRCs to discuss mechanisms included in this report to enhance the enforcement of Institutional and Program Requirements without increasing the risk of the withdrawal of accreditation.<br><br>(3) Our AMA representatives be requested to ask the | Sunset; no longer relevant, and generally accomplished, in all likelihood. |

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| ACGME and the RRCs to determine any additional information regarding program evaluations that can be added to the ACGME web site and that they encourage the ACGME to simplify that web site to facilitate the retrieval of information.<br><br>(4) Our AMA, through the Medical Student Section and the Resident and Fellow Section, will provide medical students and residents a guide to interpreting the ACGME Web site as it relates to the various levels of accreditation and the length of the survey cycle.<br>(CME Rep. 3, A-00; Reaffirmed: CME Rep. 2, A-10) | |

*D-383.996, "Impact of the NLRB Ruling in the Boston Medical Center Case"*

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| Our AMA: (1) representatives to the ACGME be encouraged to ask the ACGME to review the Institutional Requirements and make recommendations for revisions to address issues related to the potential for resident physicians to be members of labor organizations. This is particularly important as it relates to the section on Resident Support, Benefits, and Conditions of Employment; and (2) through the Division of Graduate Medical Education, the Resident and Fellow Section, and the Private Sector Advocacy Group develop a system to inform resident physicians, housestaff organizations, and employers regarding best practices in labor organizations and negotiations.<br>(CME Rep. 7, A-00; Reaffirmed: CME Rep. 2, A-10) | Retain.<br>~~Sunset; the topic is still relevant, but this policy is superseded by other more relevant policies, including H-383.999 (2, 3), "Physician Negotiation," which notes:~~<br><br>~~"2. Our AMA continue to support the development of independent house staff organizations for employed, resident and fellow physicians and support the development and operation of local negotiating units as an option for all employed, resident and fellow physicians authorized to organize labor organizations under the National Labor Relations Act.~~<br><br>~~"3. Our AMA continues to advance its private sector advocacy programs and explore, develop, advocate, and implement other innovative strategies, including but not limited to initiating litigation, to stop egregious health plan practices and to help physicians level the playing field with health care payers."~~<br><br>~~In addition, D-383.977, "Investigation into Residents, Fellows and Physician Unions," states that "Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment."~~ |

*H-405.984, "Physician and Public Attitudes on Medicine as a Career"*

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| Our AMA (1) supports continuation of its many efforts to address issues, such as professional liability and excessive regulation and interference by third parties, which contribute to the professional dissatisfaction expressed by some physicians;<br><br>(2) supports continuation of its efforts to communicate to students, from elementary through college level, the rewards of a career in medicine, emphasizing the positive aspects of a career in medicine;<br><br>(3) supports utilizing the Association's communications resources to make the 40 percent of the physician population who are dissatisfied with medicine as a career aware of the impact they are having on the career decisions of potential medical students and the implications that this has for the future of medicine; and<br><br>(4) encourages the majority of physicians who feel positive about their career, and who understand that the profession is both challenging and rewarding, to aggressively convey, on a personal basis, their thoughts on the attributes of medicine as a career to students, the media, and other interested parties. | Sunset; the policy, which was originally adopted in 1989, has been superseded by and incorporated into AMA's multi-departmental work to promote the value of a career in medicine and enhance the joy of medical practice by addressing administrative and regulatory burdens that can lead to physician burnout. |

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| (CLRPD Rep. D, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10) | |

*H-405.987, "Identification of Board Certified Physicians"*

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| Our AMA urges physicians to identify themselves by stating the full name of their certifying board.<br>(Res. 99, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10) | Retain; still relevant. This is reflected in the AMA's "Truth in Advertising" campaign, which notes the following (see page 13):<br><br>"A medical doctor or doctor of osteopathic medicine may not hold oneself out to the public in any manner as being certified by a public or private board including but not limited to a multidisciplinary board or 'board certified,' unless all of the following criteria are satisfied: (a) The advertisement states the full name of the certifying board…." |

*H-435.946, "Liability Coverage for Medical Students Completing Extramural Electives"*

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| Our AMA: (1) supports the continuance of the AAMC online Extramural Electives Compendium (EEC) database as a resource for information on medical school electives, including liability insurance fees; and (2) will work with the AAMC to encourage medical schools to provide sufficient medical liability insurance for their own students completing electives at US Medical Doctor and Doctor of Osteopathy granting medical schools.<br>(CME Rep. 9, A-10) | Retain; still relevant. |

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

The following report was presented by W. Alan Harmon, MD, Chair.

### 1. COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2010 AMA HOUSE POLICIES

*Reference committee hearing: see report of Reference Committee F and Amendments to Constitution and Bylaws.*

**HOUSE ACTION: RECOMMENDATION ADOPTED AS FOLLOWS**
**REMAINDER OF REPORT FILED**

In 1984, the House of Delegates established a sunset mechanism for House policies (Policy G 600.110). Under this mechanism, a policy established by the House ceases to be viable after ten years unless action is taken by the House to re-establish it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House deliberations.

Modified by the House on several occasions, the policy sunset process currently includes the following key steps:

- Each year, the House policies that are subject to review under the policy sunset mechanism are identified, and such policies are assigned to the appropriate AMA Councils for review.
- Each AMA Council that has been asked to review policies develops and submits a separate report to the House that presents recommendations on how the policies assigned to it should be handled.
- For each policy under review, the reviewing Council recommends one of the following alternatives: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy.
- For each recommendation, the Council provides a succinct but cogent justification for the recommendation.
- The Speakers assign the policy sunset reports for consideration by the appropriate reference committee.

RECOMMENDATION

The Council on Medical Service recommends that the policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of the report be filed.

APPENDIX - Recommended Actions on 2010 Socioeconomic Policies

| Policy # | Policy Title | Recommended Action and Rationale |
|---|---|---|
| D-140.962 | Hospice Services Under Medicare | Rescind. In 2010, the AMA distributed a briefing packet on hospice care and palliative medicine to key stakeholders within the Federation. The AMA also urged CMS to undertake the requested study in consultation with relevant national medical specialty societies. Additionally, Policies, H-85.951, H-85.955 and H-85.966 supersede the 2010 policy. |
| D-155.996 | Health Care Expenditures | Retain. Still relevant. |
| D-165.984 | Status Report On Expanding Coverage For The Uninsured | Rescind. Superseded by Policies H-165.824, H-165.828, H-165.920, H-165.851 and H-165.865. |
| D-165.986 | Out of Pocket Expenses in an Individually Selected and Owned Health Insurance System | Rescind. Superseded by Policy H-385.926. |
| D-165.993 | Federal Tax Legislation | Rescind. Superseded by Policy H-165.920. |

| Policy # | Policy Title | Recommended Action and Rationale |
|---|---|---|
| D-190.996 | ERISA and Health Plan Related Legislation | Retain. Still relevant. |
| D-225.995 | Hospital Merger Study | Retain. Still relevant. |
| D-330.943 | Physician Input in MAC Contracting Process | Retain. Still relevant. |
| D-330-974 | Support for Maintaining the Medicare Carrier Advisory Committee and Carrier Medical Director | Retain. Still relevant. |
| D-330.989 | Medicare Coverage for Low Molecular Weight Heparin | Retain. Still relevant. |
| D-335.996 | Status Report on Medicare Review Activities | Retain. Still relevant. |
| D-355.998 | National Practitioner Data Bank | Retain. Still relevant. |
| D-385.993 | Medicare Global Surgical Guidelines | Retain. Still relevant. |
| D-478.990 | Clinical Information Technology Assistance | Retain. Still relevant. |
| D-480.984 | Physician Information on Third Party Payer Performance | Rescind. The AMA dissolved the Private Sector Advocacy unit in mid-2013, and the activities referred to in this policy were performed by that unit. Moreover, the National Health Insurer Report Card, which evaluated major national health plans on metrics including time to payment, correct payment rate, appeals, etc. was last published by the AMA in 2013. There is no longer a business unit at the AMA that performs this type of work due to changing organizational priorities. |
| D-510.993 | Availability of Veterans Affairs Pharmacy Benefit | Retain. Still relevant. |
| D-70.987 | Appropriate Use of Component Codes in Current Procedural Terminology (CPT) | Retain. Still relevant. |
| D-70.991 | Insurers Excessive Documentation Requirements and Claims Submission | Retain. Still relevant. |
| D-70.993 | Reimbursement for Telephonic and Electronic Communications | Retain. Still relevant. |
| H-125.991 | Drug Formularies and Therapeutic Interchange | Retain. Still relevant. |
| H-130.960 | Payment for Emergency Visits | Rescind. The AMA is no longer engaged in efforts on this issue. |
| H-130.961 | Refusal of Appropriate Patient Transfers | Retain-in-part. Change "~~Principles of Appropriate Interhospital Patient Transfer~~" to "Appropriate Interfacility Patient Transfer" to reflect the title of the guidelines. |
| H-130.964 | Federal Patient Transfer Laws | Retain-in-part. Rescind (1) as no longer timely since EMTALA was promulgated in 2009 and last amended in 2013. Policy should be amended to read:<br><br>H-130.964 Federal Patient Transfer Laws<br>~~(1) It is the policy of the AMA to do whatever is appropriate to modify the new regulations of Federal Patient Transfer so that (a) an appropriate reporting mechanism is developed for those physicians who were on-call and did not respond in a reasonable period of time to stabilize patients in an emergency setting and (b) it is not necessary to include the name and address of said physician in a transfer record to another facility. (2)~~ The AMA urges physicians and component medical associations to collect and submit to the AMA reports on physician willingness to serve on Emergency Department on-call panels. (Res. 275, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10) |

| Policy # | Policy Title | Recommended Action and Rationale |
|---|---|---|
| H-130.965 | Refusal of Appropriate Patient Transfers | Retain. Still relevant. |
| H-130.966 | Federal Hospital Patient Transfer Amendments | Retain. Still relevant. |
| H-130.968 | Confusion Between Inappropriate Patient Transfer and Appropriate Patient Transfer | Retain. Still relevant. |
| H-130.972 | Unfair CMS/OIG Review and Sanction Process for Hospital Emergency Room Care and Patient Transfers | Retain-in-part. Change references to "emergency room" in the title and body to "emergency department" to reflect modern terminology. Policy should be amended to read:<br><br>H-130.972 Unfair CMS/OIG Review and Sanction Process for Hospital Emergency Department ~~Room~~ Care and Patient Transfers<br>Our AMA supports modification of inadequate procedures utilized by CMS and the OIG in decertifying hospitals for "noncompliance" with the Medicare Conditions of Participation, particularly as they are being applied to hospital emergency department ~~room~~ Care room care issues. (Res. 88, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10) |
| H-130.973 | Federal Emergency Transfer/"Anti-Dumping" Law | Retain. Still relevant. |
| H-130.982 | Transfer of Emergency Patients | Retain-in-part. Change "~~Guidelines for Transfer of Patients~~" to "Policy Statement entitled 'Appropriate Interfacility Patient Transfer'" to reflect the title of the guidelines. |
| H-140.983 | Hospital Medical Staff and Joint Ventures Oversight Committees | Retain. Still relevant. |
| H-160.916 | Payment for Care Provided by US Physicians to Foreign Medical Evacuees | Retain. Still relevant. |
| H-165.837 | Protecting the Patient-Physician Relationship | Retain. Still relevant. |
| H-180.949 | Health Insurance Safeguards | Retain. Still relevant. |
| H-180.995 | Government Subsidies to HMOs | Rescind. Superseded by Policy H-165.985. |
| H-185.947 | Insurance Underwriting Reform | Rescind. Superseded by Policies H-165.838 and H-165.856. |
| H-185.965 | Insurance Coverage of Periodic Health Care Services | Retain. Still relevant. |
| H-185.979 | Allocation of Health Services | Retain. Still relevant. |
| H-185.984 | Toll-Free 24-Hour Insurance Information | Retain with minor editorial change. Still relevant. Correct editorial errors so that the policy be modified to read:<br><br>(3) Our AMA seeks legislation to require that, where a plan does not provide toll-free, 24-hour access to verify patient coverage eligibility, the patient's identification card from the plan will ~~with~~ be deemed valid. |
| H-185.986 | Nondiscrimination in Health Care Benefits | Retain. Still relevant. |
| H-185.987 | Prayer Fees Reimbursed As Medical Expenses | Retain. Still relevant. |
| H-185.988 | High Cost Health Benefits Management | Retain. Still relevant. |
| H-185.996 | Utilization in Appropriate Settings | Rescind. Superseded by Policies H-285.951 and H-285.998. |
| H-205.997 | AMA Statement on Voluntary Health Planning | Retain. Still relevant. |
| H-205.999 | Cost Effectiveness of State Certificate of Need Programs | Retain. Still relevant. |

| Policy # | Policy Title | Recommended Action and Rationale |
|---|---|---|
| H-210.979 | Physician Responsibility for Nursing Agencies | Retain. Still relevant. |
| H-210.998 | Home Health Service Abuse | Retain. Still relevant. |
| H-220.958 | The Joint Commission Professional and Technical Advisory Committees | Rescind. These professional and technical advisory committees no longer exist. |
| H-220.960 | The Joint Commission Hospital Accreditation Program Standards | Retain-in-part. Remove "that physician directors of hospital departments be board certified or possess equivalent qualifications; and that board certification is an excellent benchmark for the delineation of clinical privileges," as it conflicts with Policy H-230.986. Policy should be amended to read:<br><br>H-220.960 The Joint Commission Hospital Accreditation Program Standards Our AMA requests its trustees who serve as Commissioners to The Joint Commission to support retention of important medical staff structural standards in its hospital accreditation programs, including, but not limited to, standards requiring that medical staff operate as a self-governing entity - as defined in medical staff bylaws~~; that physician directors of hospital departments be board certified or possess equivalent qualifications; and that board certification is an excellent benchmark for the delineation of clinical privileges~~; and that any changes to the hospital accreditation program standards occur only after a full, thorough and deliberative process, including a full field review of all proposed changes to the hospital accreditation program standards.<br>(Res. 153, I-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10) |
| H-225.961 | Medical Staff Development Plans | Retain-in-part. The AMA has accomplished its communications and recommendations regarding the medical staff development plan principles. Policy should be amended to read:<br><br>H-225.961 Medical Staff Development Plans<br>~~1.~~ All hospitals/health systems incorporate the following principles for the development of medical staff development plans: …<br>~~2. The AMA communicates the medical staff development plan principles to the President and Chair of the Board of the American Hospital Association and recommend that state and local medical associations establish a dialogue regarding medical staff development plans with their state hospital association.~~<br>(BOT Rep. 14, A-98; Modified: BOT Rep. 11, A-07; Reaffirmation A-10) |
| H-225.975 | Compensation for the Medical Staff for Committee Work | Retain. Still relevant. |
| H-225.977 | Liability Coverage for Physician Members of Hospital Committees | Retain. Still relevant. |
| H-225.979 | Hospital Medical Staff Relationships - Dispute Resolution | Retain. Still relevant. |
| H-225.983 | Physician Representation on Hospital Governing Boards | Retain. Still relevant. |
| H-230.960 | Privileging for Ultrasound Imaging | Retain. Still relevant. |
| H-230.978 | Physician Assignment | Retain. Still relevant. |
| H-230.979 | Medical Staff Credentialing Verification | Retain. Still relevant. |
| H-230.998 | Hospital Privileges | Retain. Still relevant. |

| Policy # | Policy Title | Recommended Action and Rationale |
|---|---|---|
| H-235.966 | CMS Regulation to Eliminate the Critical Role of the Hospital Medical Staff | Retain.<br>~~Rescind. The proposal to eliminate 42 CFR 482.22 was made approximately ten years ago and has not re-surfaced. Should another attempt to eliminate the critical role of the medical staff ever be made, the AMA would be strongly in opposition, and Policy H-235.966 would not be needed to take that opposing role in the future.~~ |
| H-235.990 | Organized Self-Governing Medical Staff | Retain. Still relevant. |
| H-235.991 | Medical Staff Bylaws | Retain. Still relevant. |
| H-240.969 | Medicare Social Admissions | Rescind. Superseded by Policies D-160.931 and D-160.932. |
| H-240.970 | Reimbursement to Rural Hospitals for Patients Returning from Tertiary Care Centers | Retain. Still relevant. |
| H-240.971 | Elimination of Payment Differentials Between Urban and Rural Medical Care | Retain. Still relevant. |
| H-240.999 | Relationship of Hospital Costs and Hospital Charges | Retain. Still relevant. |
| H-275.994 | Physician Participation in Third Party Payer Programs | Retain. Still relevant. |
| H-280.949 | Caring for Group Home Residents | Retain. Still relevant. |
| H-280.967 | Nurse Practitioner Reimbursement in Nursing Facilities | Retain. Still relevant. |
| H-280.984 | Residential Facility Regulations | Retain. Still relevant. |
| H-285.962 | Anti-Psychiatry Practices of Certain Health Maintenance Organizations and Managed Care Organizations | Retain. Still relevant. |
| H-315.991 | Mandatory Computerization of Patient Records | Retain. Still relevant. |
| H-320.970 | Private Insurer's Medical Review Policy | Retain. Still relevant. |
| H-320.971 | Third Party Payers and Patient Care Standards | Retain. Still relevant. |
| H-320.972 | Problems with Review Entities | Retain. Still relevant. |
| H-320.976 | Medical Necessity of Diagnostic Tests | Retain. Still relevant. |
| H-330.909 | Medicare Coverage for Low Molecular Weight Heparin | Retain. Still relevant. |
| H-330.971 | Medicare Policy on Inpatient Rehabilitation | Retain. Still relevant. |
| H-330.981 | Hospital Responsibility for Diagnostic Reports | Retain. Still relevant. |
| H-340.902 | The New Role of PROs in Quality Improvement | Retain. Still relevant. |
| H-340.940 | Quality Improvement Organization Program Status | Retain. Still relevant. |
| H-345.987 | CPT Codes for Medical Management of Mental Illness for Outpatients | Retain. Still relevant. |
| H-375.979 | Litigation Over Hospital Peer Review Decisions | Retain. Still relevant. |
| H-375.982 | Peer Review Defined as the Practice of Medicine | Retain. Still relevant. |
| H-375.999 | Federal Hospital Utilization Review | Retain. Still relevant. |

| Policy # | Policy Title | Recommended Action and Rationale |
|---|---|---|
| H-380.996 | Voluntary Restraints of Physicians' Fee Increases | Retain. Still relevant. |
| H-380.997 | Limitation of Physicians' Fees | Retain. Still relevant. |
| H-383.996 | Restriction of Physicians from Performing Procedures by Managed Care Organizations | Retain. Still relevant. |
| H-385.933 | Actuarially Sound Capitation | Retain. Still relevant. |
| H-385.934 | Reimbursement for Office-Based or Outpatient Ultrasound Imaging | Retain. Still relevant. |
| H-385.990 | Payment for Physicians' Services | Retain. Still relevant. |
| H-385.996 | Support of the Concept of Cost Containment and Cost Effectiveness by Encouraging Patient Care in the Least Expensive Setting | Retain. Still relevant. |
| H-390.847 | Deactivation of Medicare Billing Privileges - Lack of Appeal Rights and Harsh Adverse Effects on Physicians | Retain. Still relevant. |
| H-390.855 | Replacement of Sustainable Growth Rate System | Rescind. No longer relevant. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed and replaced the Sustainable Growth Rate (SGR). |
| H-390.857 | Secondary Insurance Claims with Medicare Electronic Remittance Advice | Retain. Still relevant. |
| H-390.858 | Medicare Coverage for Cardiovascular Stress Testing | Retain. Still relevant. |
| H-390.877 | Home Health Care Services | Retain. Still relevant. |
| H-390.923 | Purchased Diagnostic Tests | Retain. Still relevant. |
| H-390.925 | Medicare Billing | Retain. Still relevant. |
| H-390.927 | Rehabilitation Physician Visits | Retain with minor editorial change. Still relevant. To clarify that a visit per day is appropriate, based on medical necessity, but should not be required, when not medically necessary, the policy should be modified to read:<br><br>Our AMA: (1) believes that a visit per day by the attending rehabilitation physician is appropriate, as medically necessary, for patients in certified acute inpatient rehabilitation units or facilities; and (2) supports communicating this position to CMS. (Sub. Res. 141, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CMS Rep. 6, A-10) |
| H-390.996 | Medicare Reimbursement Policy | Retain. Still relevant. |
| H-390.998 | Medicare Reimbursement Policy | Retain. Still relevant. |
| H-390.999 | Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediaries | Retain. Still relevant. |
| H-415.987 | Improper Discounts by Third Party Payers | Retain. Still relevant. |
| H-425.979 | Coverage of Therapeutic Shoes as a Preventive Measure | Retain. Still relevant. |
| H-475.990 | Physicians Credentialing | Retain. Still relevant. |
| H-510.995 | Budgetary and Management Needs of the Veterans Health Administration | Retain. Still relevant. |
| H-55.975 | Health Plan Coverage Policies for Anti-Nausea Regimens | Retain. Still relevant. |

| Policy # | Policy Title | Recommended Action and Rationale |
|---|---|---|
| H-70.923 | Conscious Sedation Reimbursement | Rescind. No longer relevant as the CPT/RUC successfully worked with specialty organizations to produce conscious sedation procedure codes eligible for reimbursement, in accordance with CPT coding guidelines and provider-appropriate CMS fee schedules. |
| H-70.927 | Prevention of Misuse of Current Procedural Terminology (CPT) | Retain. Still relevant. |
| H-70.931 | Medicare Coverage for Cardiovascular Stress Testing | Retain. Still relevant. |
| H-70.952 | Medicare Guidelines for Evaluation and Management Codes | Retain-in-part. Sections 5, 7 and 8 are no longer relevant following CPT 2021. The new Evaluation and Management descriptors and guidelines eliminate the single specialty examination component. Policy should be amended to delete Sections 5, 7 and 8, and renumbered accordingly. |
| H-70.954 | Improper Use of AMA-CPT by Carriers/Software Programs | Retain. Still relevant. |
| H-70.961 | Evaluation and Management Codes | Retain-in-part. The second clause is no longer relevant following CPT 2021. The new Evaluation and Management descriptors and guidelines eliminate the single specialty examination component. Policy should be amended to read:<br><br>H-70.961 Evaluation and Management Codes Our AMA will work with the CMS to continue to refine evaluation and management coding~~; and will work with CMS to publish the specialty specific physical exam criteria in a timely fashion~~. (Res. 804, A-96; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10) |
| H-70.976 | Limitation of Use of Time Component of Current Procedural Terminology (CPT-4) Coding | Retain. Still relevant. |
| H-70.983 | AMA Input to Diagnosis and Procedure Coding | Retain. Still relevant. |
| H-70.985 | Preservation of Evaluation/Management CPT Codes | Retain. Still relevant. |
| H-70.987 | Diagnostic Coding Requirements | Rescind. ICD-9 is no longer the standard. |
| H-70.989 | ICD-9-CM Coding | Rescind. ICD-9 is no longer the standard. |
| H-70.990 | ICD-9-CM Coding and Civil Money Penalties | Rescind. ICD-9 is no longer the standard. |
| H-70.992 | CPT Coding | Retain. Still relevant. |

## REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

The following report was presented by Michael M. Miller, MD, Chair.

### 1. CSAPH SUNSET REVIEW OF 2010 HOUSE OF DELEGATES POLICIES

*Reference committee hearing: see report of Reference Committee F and Amendments to Constitution and Bylaws.*

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS**
**REMAINDER OF REPORT FILED**

At its 1984 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) established a sunset mechanism for House policies (Policy G-600.110, "Sunset Mechanism for AMA Policy"). Under this mechanism, a policy established by the HOD ceases to be viable after 10 years unless action is taken by the HOD to retain it.

The objective of the sunset mechanism is to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of HOD deliberations.

At its 2012 Annual Meeting, the HOD modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following:

> (1) As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years. (2) In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset. (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii)Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification. (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports. (3) Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished. (4) The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices. (5) The most recent policy shall be deemed to supersede contradictory past AMA policies. (6) Sunset policies will be retained in the AMA historical archives.

In this report, the Council on Science and Public Health (CSAPH) presents its recommendations on the disposition of the HOD policies from 2010 that were assigned to it. The CSAPH's recommendations on policies are presented in the Appendix to this report.

RECOMMENDATION

The Council on Science and Public Health recommends that the House of Delegates policies listed in the Appendix to this report be acted upon in the manner indicated and the remainder of the report be filed.

APPENDIX - Recommended Actions on 2010 House Policies and Directives

| Number | Title | Recommended Action and Rationale |
|---|---|---|
| D-100.976 | Restriction of Non-Veterinary Antimicrobials in Commercial Livestock to Reduce Antibiotic Resistance | Retain. Still relevant. |
| D-100.997 | Use of Antimicrobials in Consumer Products | Retain in part to read as follows and change to an H-policy:<br>Our AMA will: (1) ~~encourage the Food and Drug Administration (FDA) to expedite their regulation of the use in consumer products of antimicrobials for which acquired resistance has been demonstrated;~~ ~~(2)~~ continue to monitor the impact ~~progress~~ of the ~~current~~ FDA evaluation and final guidance related to ~~of~~ the safety and effectiveness of antimicrobials for consumer use in over-the-counter (OTC) hand and body washes; and (~~3~~2) encourage continued research on the use of common antimicrobials as ingredients in consumer products and its impact on the major public health problem of antimicrobial resistance. |
| D-130.967 | Helicopter Emergency Medical Services (HEMS) Medical Provider and Patient Safety | Retain in part to read as follows and change to an H-policy:<br>Our AMA: (1) ~~will educate its members about~~ supports the Federal Aviation Administration's (FAA) Helicopter Air Ambulance Operations guidelines ~~Medical Service Operations and Safety Alert for Operators SAFO 06001~~ and its role as a critical component of Helicopter Emergency Medical Services in assuring the safety of patients and medical providers; and (2) advocates that its members contract with or implement a Helicopter Emergency Medical Service that is compliant with risk reduction systems/programs established in standards set forth ~~in~~ by the FAA ~~Federal Aviation Administration's Helicopter Medical Service Operations and Safety Alert for Operators~~. |
| D-140.961 | The Decade of Pain Control and Research | Rescind. The AMA has more recent policy that disagrees with some of the underpinnings of this initiative. Policy D-450.956 Pain as the Fifth Vital Sign advocates for removal of pain as a vital sign from Joint Commission standards. More recent policies support pain control and research based on current scientific evidence. |
| D-245.994 | Infant Mortality | Retain. Still relevant. |
| D-365.999 | Prophylaxis for Medical Students Exposed to Bloodborne Pathogens | Rescind. Accomplished. Bloodborne pathogens and trainees also addressed in CME/CSAPH report 1-A-19 updated policy. |
| D-370.996 | Xenotransplantation: Scientific Implications | Rescind. The Secretary's Advisory Committee on Xenotransplantation (SACX) was disbanded in 2006. Also addressed in H-370.972. |
| D-370.997 | The Physician's Role in Organ Donation | Retain. Still relevant. |
| D-40.999 | Medical Care for Persian Gulf War Veterans | Retain. Still relevant. |
| D-430.999 | Preventing Assault and Rape Of Inmates By Custodial Staff | Retain and change to an H policy |
| D-460.976 | Genomic and Molecular-based Personalized Health Care | Retain. Still relevant. |

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| D-95.980 | Opioid Treatment and Prescription Drug Monitoring Programs | Retain. Still relevant. |
| H-10.998 | Impact-Resistant Lens | Retain. Still relevant. |
| H-100.959 | Mandatory Electrophysiologic Testing for Patients Taking Vigabatrin (Sabril) | Rescind. Accomplished. On July 21, 2016, the REMS for vigabatrin were modified to be less prescriptive for prescribers. |
| H-100.963 | Essential Medicines for the Developing World | Retain. Still relevant. |
| H-100.968 | Improving the Quality of Geriatric Pharmacotherapy | Retain. Still relevant. |
| H-100.981 | United States Pharmacopoeial Convention Meetings | Retain. Still relevant. |
| H-100.986 | Ethical Concerns and Development of New Medications | Retain. Still relevant. |
| H-100.995 | Support of American Drug Industry | Retain. Still relevant. |
| H-100.997 | Drugs of Choice | Retain. Still relevant. |
| H-115.980 | Distinctive Labeling of Vials and Ampules, Prefilled Syringes, Ophthalmic Solutions and Related Liquid Medications | Retain. Still relevant. |
| H-115.996 | Generic Labeling for Drugs Crossing International Borders | Retain. Still relevant. |
| H-120.958 | Supporting Safe Medical Products as a Priority Public Health Initiative | Retain in part to read as follows:<br>Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names;<br>(2) continue participation ~~i~~on the ~~National Patient Safety Foundation's efforts to advance the science of safety in the medication use process and likewise work with the~~ National Coordinating Council for Medication Error Reporting and Prevention;<br>(3) support the FDA's Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events;<br>(4) vigorously work to support and encourage efforts to create and expeditiously implement a national ~~machine-readable~~ coding system for prescription medicine packaging in an effort to improve patient safety; and<br>(5) ~~participate in and report on the work of the Healthy People 2010 initiative in the area of safe medical products especially as it relates to existing AMA policy; and~~<br>(6) seek opportunities to work collaboratively with other stakeholders ~~within the Medicine-Public Health initiative (H-440.991) and with the Food and Drug Administration (FDA), National Institutes of Health (NIH), United States Pharmacopoeia (USP) and Centers for Disease Control and Prevention (CDC) the Agency for Health Care Policy and Research (AHCPR) and the Centers for Medicare & Medicaid Services (CMS)~~ to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety. |
| H-120.997 | Child-Protective Containers for Medications | Retain. Still relevant. |

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| H-130.949 | Organized Medicine's Role in the National Response to Terrorism | Retain. Still relevant. |
| H-130.971 | Emerging Toxic Challenge | Retain with a change in title:<br>~~Emerging Toxic Challenge~~ Poison Information Programs |
| H-130.998 | Special Amateur Radio Bands for Medical Emergencies | Retain. Still relevant. |
| H-135.935 | OSHA Standards for Lead | Retain. 50 ug/$m^3$ is still the permissible exposure limit. |
| H-135.968 | Support for the Improvement of the Health Environment in Developing Countries | Retain. Still relevant. |
| H-135.969 | Environmental Health Programs | Retain. Still relevant. |
| H-135.971 | Low-Level Radioactive Waste Disposal Facility | Retain. Still relevant. |
| H-135.972 | Environmental Preservation | Retain. Still relevant. |
| H-135.976 | Electromagnetic Pulse (EMP) and its Effects | Retain. Still relevant. |
| H-135.993 | Transportation and Storage of Hazardous Materials | Retain. Still relevant. |
| H-135.996 | Pollution Control and Environmental Health | Retain. Still relevant. |
| H-15.970 | Trucks and Highway Safety | Retain in part to read as follows:<br>The AMA (1) reaffirms its recommendation in Report I (I-82) to establish a reduction in highway injuries and deaths as a national goal; special attention should be given to this goal by the governmental, business, engineering, legal, and medical sectors;<br>(2) urges vehicle manufacturers to improve the safety of trucks and truck cabs;<br>(3) ~~encourages adoption of~~ supports the strict standards on drug and alcohol use set in the Omnibus Transportation Employee Testing Act, requiring DOT agencies to implement drug and alcohol testing of safety-sensitive transportation employees ~~similar to those for locomotive engineers, for truck drivers~~; and<br>(4) encourages regulators and truck fleet supervisors to give greater attention to drivers' performances and crash records, and to remove drivers with poor records from the highway. |
| H-15.972 | Licensing People to Drive | Retain in part to read as follows:<br>~~It is the policy of t~~The AMA encourages (1) ~~to encourage~~ research into the many components ~~and activities~~ of ~~the~~ driving ~~task~~ and into the development of more accurate testing devices;<br>(2) ~~that~~ physicians to continue to warn patients about the possibility of untoward side effects from medications, particularly those that might impair driving;<br>(3) ~~that the~~ physicians to ~~attempt to~~ give competent advice about the wisdom of the patient's driving, while keeping in mind the obligation to protect the community and obey the law; and<br>(4) ~~that the~~ physicians, if uncertain about the patient's ability to drive, consider recommending that the state licensing agency arrange a driving test.<br>Citation: (BOT Rep. L, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10) |

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| H-15.982 | Mandatory Seat Belt Utilization Laws | Retain. Still relevant. |
| H-15.995 | Medical Advisory Boards in Driver Licensing | Retain. Still relevant. |
| H-150.936 | Support for Uniform, Evidence-Based Nutritional Rating System | Retain. Still relevant. |
| H-150.938 | Healthy Food Options for Shift Workers | Retain. Still relevant. |
| H-150.939 | Accurate Reporting of Fats on Nutritional Labels | Retain. Still relevant. |
| H-150.940 | Update on the Food and Drug Administration's Efforts to Improve Food Safety | Retain. Still relevant. |
| H-170.993 | Health Education | Retain. Still relevant. |
| H-170.996 | Establishing Active Liaison with Schools and Colleges | Retain. Still relevant. |
| H-20.918 | Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission | Retain. Still relevant. |
| H-20.920 | HIV Testing | Retain in part to read as follows:<br>…(4) HIV Testing Procedures<br>a) Appropriate medical organizations should establish rigorous proficiency testing and quality control procedures for HIV testing laboratories on a frequent and regular basis;<br>b) Physicians and laboratories should review their procedures to assure that HIV testing conforms to standards that will produce the highest level of accuracy;<br>c~~) Appropriate medical organizations should establish a standard that a second blood sample be taken and tested on all persons found to be seropositive or indeterminate for HIV antibodies on the first blood sample. This practice is also advised for any unexpected negative result;~~<br>~~d)~~ Appropriate medical organizations should establish a policy that results from a single unconfirmed positive ELISA test never be reported to the patient as a valid indication of HIV infection;<br>d~~e~~) Appropriate medical organizations should establish a policy that laboratories specify the HIV tests performed and the criteria used for positive, negative, and indeterminate test results ~~Western blots or other confirmatory procedures~~;<br>e~~f~~) Our AMA recommends that training for HIV blood test counselors encourage patients with an indeterminate Western blot to be advised that three-to-six-month follow-up specimens may need to be submitted to resolve their immune status. Because of the uncertain status of their contagiousness, it is prudent to counsel such patients as though they were seropositive until such time as the findings can be resolved.<br>(5) Routine HIV Testing<br>a) Routine HIV testing should include appropriate~~ly modified~~ informed consent and ~~modified~~ pre-test and post-test counseling procedures;<br>~~b) Hospitals, clinics and physicians may adopt routine HIV testing based on their local circumstances. Such a program~~ |

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| | | ~~is not a substitute for universal precautions. Local considerations may include (i) the likelihood that knowledge of a patient's serostatus will improve patient care and reduce HIV transmission risk; (ii) the prevalence of HIV in patients undergoing invasive procedures; (iii) the costs, liabilities and benefits; and (iv) alternative methods of patient care and staff protection available to the patient;~~<br>b~~e~~) State medical associations should ~~review and seek modification of~~ work to create state laws that ~~restrict the ability of~~ encourage hospitals and other medical facilities to initiate routine HIV testing programs;<br>~~(d) Encourages a review of the evidence for routine HIV testing by the US Preventive Services Task Force;~~ and<br>d~~e~~) Supports coverage of and appropriate reimbursement for routine HIV testing by all public and private payers.<br>(6) ~~Voluntary~~ Opt-out HIV Testing<br>a) Voluntary HIV testing should be provided with informed consent for individuals who may have come into contact with the blood, semen, or vaginal secretions of an infected person in a manner that has been shown to transmit HIV infection. Such testing should be encouraged for patients for whom the physician's knowledge of the patient's serostatus would improve treatment. ~~Voluntary~~ Opt-out HIV testing should be regularly provided for the following types of individuals who give an informed consent: (i) patients at sexually transmissible disease clinics; (ii) patients at drug abuse clinics; (iii) individuals who are from areas with a high incidence of AIDS or who engage in high-risk behavior and are seeking family planning services; and (iv) patients who are from areas with a high incidence of AIDS or who engage in high-risk behavior requiring surgical or other invasive procedures;<br>b) The prevalence of HIV infection in the community should be considered in determining the likelihood of infection. If ~~voluntary~~ opt-out HIV testing is not sufficiently accepted, the hospital and medical staff may consider requiring HIV testing.<br>(7) Mandatory HIV Testing<br>a) Our AMA opposes mandatory HIV testing of the general population;<br>b) Mandatory testing for HIV infection is recommended for (i) ~~all entrants into federal and state prisons; (ii)~~ military personnel; (ii) ~~(iii)~~ donors of blood and blood fractions; breast milk; organs and other tissues intended for transplantation; and semen or ova for artificial conception;<br>c) All entrants into federal and state prisons should be offered HIV screening, but it should only be mandatory when risk factors are present;<br>d) Our AMA will review its policy on mandatory testing periodically to incorporate information from studies of the unintended consequences or unexpected benefits of HIV testing in special settings and circumstances.<br>(8) HIV Test Counseling<br>a) Pre-test and post-test voluntary counseling should be considered an integral and essential component of HIV testing. Full pre-test and post-test counseling procedures |

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| | | must be utilized for patients when HIV is the focus of the medical attention, when an individual presents to a physician with concerns about possible exposure to HIV, or when a history of high-risk behavior is present;<br>b) Post-test information and interpretation must be given for negative HIV test results. All negative results should be provided in a confidential manner accompanied by information in the form of a simple verbal or written report on the meaning of the results and the offer, directly or by referral, of appropriate counseling and potentially pre-exposure prophylaxis treatment;<br>c) Post-test counseling is required when HIV test results are positive. All positive results should be provided in a confidential face-to-face session by a professional properly trained in HIV post-test counseling and with sufficient time to address the patient's concerns about medical, social, and other consequences of HIV infection.<br>(9) HIV Testing of Health Care Workers<br>a) Our AMA supports routine voluntary HIV testing of physicians, health care workers, and students in appropriate situations;<br>b) Employers of health care workers should provide, at the employer's expense, serologic testing for HIV infection to all health care workers who have documented occupational exposure to HIV;<br>c) Our AMA opposes HIV testing as a condition of hospital medical staff privileges;<br>d) Physicians and other health care workers who perform exposure-prone patient care procedures should know their immune or infection status with respect to HIV ~~that pose a significant risk of transmission of HIV infection should voluntarily determine their serostatus at intervals appropriate to risk and/or act as if their serostatus were positive. The periodicity will vary according to locale and circumstances of the individual and the judgment should be made at the local level. Health care workers who test negative for HIV should voluntarily redetermine their HIV serostatus at an appropriate period of time after any significant occupational or personal exposure to HIV. Follow-up tests should occur after a time interval exceeding the length of the "antibody window~~.<br>(10) Counseling and Testing of Pregnant Women for HIV<br>Our AMA supports the position that there should be universal HIV testing of all pregnant women, with patient notification of the right of refusal, as a routine component of perinatal care, and that such testing should be accompanied by basic counseling and awareness of appropriate treatment, if necessary. Patient notification should be consistent with the principles of informed consent.<br>(11) HIV Home Test Kits<br>a) O~~ur AMA opposes Food and Drug Administration approval of HIV home test kits. However, o~~ur AMA does not oppose ~~approval of~~ HIV home collection test kits that are linked with proper laboratory testing and counseling services, provided their use does not impede public health |

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| | | efforts to control HIV disease;<br>b) Standardized data should be collected by HIV home collection test kit manufacturers and reported to public health agencies;<br>~~c) A national study of HIV home collection test kit users should be performed to evaluate their experience with telephone counseling;~~<br>~~d) A national interagency task force should be established, consisting of members from government agencies and the medical and public health communities, to monitor the marketing and use of HIV home collection test kits.~~<br>(12) College Students<br>Our AMA encourages undergraduate campuses to conduct confidential, free HIV testing with qualified staff and counselors. |
| H-215.972 | Use of Wireless Radio-Frequency Devices in Hospitals | Retain. Still relevant. |
| H-215.983 | Distribution of Drug Samples in the in-Hospital Setting | Retain. Still relevant. |
| H-220.962 | Selection of Medical Staff Officers and Clinical Department Chairs | Retain. Still relevant. |
| H-220.998 | Education and Control of Therapeutic and Diagnostic Drug Usage | Retain. Still relevant. |
| H-245.988 | Cardiopulmonary Resuscitation Training for Expectant and New Parents | Retain. Still relevant. |
| H-245.989 | Adequate Funding of the WIC Program | Retain. Still relevant. |
| H-245.990 | Infant Walkers | Retain. Still relevant. |
| H-245.992 | Perinatal and Infant Mortality Reviews | Retain. Still relevant. |
| H-245.999 | Centralized Community and Regionalized Perinatal Intensive Care | Retain. Still relevant. |
| H-25.992 | Senior Suicide | Retain. Still relevant. |
| H-25.993 | Senior Care | Retain. Still relevant. |
| H-260.963 | Standardization of Testosterone Assays | Retain. Still relevant. |
| H-260.982 | Regulation of Clinical Laboratories | Retain. Still relevant. |
| H-260.983 | Repeal of Assignment of Physician-Office Laboratory Services | Retain. Still relevant. |
| H-260.984 | Quality of Cytotechnology | Retain. Still relevant. |
| H-275.964 | Impaired Physicians Practice Act | Rescind. Addressed in Educating Physicians About Physician Health Programs and Advocating for Standards D-405.990. |
| H-280.961 | Use of Restraints for Patients in Nursing Homes | Retain. Still relevant. |
| H-30.972 | Alcohol Abuse and the War on Drugs | Retain in part to read as follows with change in title:<br>Harmful Alcohol Use ~~Abuse~~ and Concomitant Substance Misuse ~~the War on Drugs~~<br>Our AMA (1) supports documenting the strong correlation between harmful alcohol ~~ab~~use and other substance ~~ab~~misuse; (2) reaffirms the concept that alcohol is an addictive drug and its abuse is one of the nation's leading drug problems; and (3) encourages state medical societies |

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| | | to work actively with drug task forces and study committees in their respective states to assure that their scope of study includes recognition of the strong correlation between harmful alcohol ~~ab~~use and other substance ~~ab~~misuse and recommendations to decrease the immense number of health, safety, and social problems associated with harmful alcohol ~~ab~~use. |
| H-30.998 | Recommendations for AMA Involvement in Alcoholism Activities | Retain in part to read as follows with change in title: Recommendations for AMA Involvement in ~~Alcoholism~~ Activities Related to Alcohol Use Disorder<br>To further emphasize the seriousness of alcohol use disorder ~~alcoholism~~ and the importance of the physician's role in prevention and treatment of this disease, our AMA: (1) encourages relevant medical specialty societies to inform their membership about opportunities for treatment and early intervention, especially among women with alcohol use disorder ~~alcoholics~~ and children of those with alcohol use disorder ~~alcoholics;~~ (2) encourages the broadcasting industry and appropriate advertising agencies to formulate a sustained public service campaign on the medical and social hazards of excessive alcohol use; (3) reaffirms that effective and comprehensive treatment for ~~alcoholic~~ persons with alcohol use disorder requires the involvement of a physician; and (4) urges that quality of treatment not be sacrificed to cost considerations. |
| H-345.998 | Reaffirmation of Position Regarding Diagnosis and Treatment of Mental Disorder | Retain. Still relevant. |
| H-35.990 | Non-Physician Measurement of Body Functions | Retain. Still relevant. |
| H-350.966 | Health Initiatives on Asian-Americans and Pacific Islanders | Retain. Still relevant. |
| H-365.987 | Revising "Guides to the Evaluation of Permanent Impairment" | Retain. The 6th Edition of the Guidelines was released in 2008, after not being updated for 18 years. It is safe to assume there will be a need for future updated versions. |
| H-365.988 | Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies | Retain. Still relevant. |
| H-365.998 | Confidentiality of Occupational Medical Records | Retain. Still relevant. |
| H-370.972 | Xenotransplantation: Scientific Implications | Retain. Still relevant. |
| H-370.973 | Methadone Maintenance and Transplantation | Retain. Still relevant. |
| H-370.985 | Insurance Coverage for Immunosuppression in Transplant Patients | Retain. Still relevant. |
| H-410.954 | Support an Independent Clinical Practice Guideline Development Process | Retain. Still relevant. |
| H-410.964 | Education Programs for Performance Improvement Activities in Physician Offices | Retain. Still relevant. |
| H-410.974 | Development of Practice Parameters by Non-Physician Organizations | Retain. Still relevant. |

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| H-410.995 | Participation in the Development of Practice Guidelines by Individuals Experienced in the Care of Minority and Indigent Patients | Retain. Still relevant. |
| H-420.956 | Stillbirth Awareness | Retain. Still relevant. |
| H-420.968 | Universal Hepatitis B Virus (HBV) Antigen Screening for Pregnant Women | Retain. Still relevant. |
| H-420.970 | Treatment Versus Criminalization - Physician Role in Drug Addiction During Pregnancy | Retain. Still relevant. |
| H-420.973 | Adoption | Retain. Still relevant. |
| H-420.995 | Medical Care for Indigent and Culturally Displaced Obstetrical Patients and Their Newborns | Retain. Still relevant. |
| H-420.998 | Obstetrical Delivery in the Home or Outpatient Facility | Retain. Still relevant. |
| H-425.980 | Screening and Early Detection of Prostate Cancer | Because of the possibility of age change for testing and the next review for this policy in 10 years, the recommendation is to remove the portion referring to specific ages and for the policy to remain broadly relevant. Therefore, retain in part to read as follows:<br>Screening and Early Detection of Prostate Cancer H-425.980<br>Our AMA believes that:<br>(1) All men who would be candidates for and interested in active treatment for prostate cancer should be provided with information regarding their risk of prostate cancer and the potential benefits and harms of prostate cancer screening, sufficient to support well-informed decision making.<br>(2) Prostate cancer screening, if elected by the informed patient, should include both prostate-specific antigen testing and digital rectal examination.<br>~~(3) Men most likely to benefit from tests for early detection of prostate cancer should have a life expectancy of at least 10 years and include: (a) Men 40 years of age or older of African American descent; (b) Men 40 years of age or older with an affected first-degree relative; and (c) Men 50 years of age or older.~~ |
| H-425.989 | Encouraging Health Activism by Physicians | Retain. Still relevant. |
| H-425.998 | Pharmacist in Hypertension Screening | Retain. Still relevant. |
| H-440.907 | Hand Washing | Retain. Still relevant. |
| H-440.952 | Routine Immunization Against Measles in Children | Retain. Still relevant. |
| H-440.955 | Federal Funding to Eliminate Tuberculosis as a Public Health Problem | Retain. Still relevant. |
| H-440.956 | Measles Vaccine | Retain. Still relevant. |
| H-440.960 | The IOM Report (The Future of Public Health) and Public Health | Retain in part to read as follows with change in title:<br>~~The IOM Report (The Future of Public Health)~~ Organized Medicine and Public Health Collaboration H-440.960<br>Our AMA (1) encourages medical societies to establish liaison committees through which physicians in private |

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| | | practice and officials in public health can explore issues and mutual concerns involving public health activities and private practice;<br>(2) seeks increased dialogue, interchange, and cooperation among national organizations representing public health professionals and those representing physicians in private practice or academic medicine;<br>(3) actively supports promoting and contributing to increased attention to public health issues in its programs in medical science and education;<br>(4) continues to support the providing of medical care to poor and indigent persons through the private sector and the financing of this care through an improved Medicaid program;<br>(5) encourages public health agencies~~, as the IOM report suggests,~~ to focus on assessment of problems, assurance of healthy living conditions, policy development, and other related activities ~~such as those mentioned in the "Model Standards"~~;<br>(6) ~~encourages physicians and others interested in public health programs to apply the messages and injunctions of the IOM report as these fit their own situations and communities;~~ and<br>~~(7)~~ encourages physicians in private practice and those in public health to work cooperatively, striving to ensure better health for each person and an improved community as enjoined in the Principles of Medical Ethics. |
| H-440.964 | Elimination of Tuberculosis | Retain. Still relevant. |
| H-440.979 | Control of Sexually Transmitted Infections | Retain. Still relevant. |
| H-440.988 | Pneumococcal, Influenza and Hepatitis-B Vaccines | Rescind. The AMA has more recent policy addressing each of these vaccines and vaccine financing. |
| H-440.992 | National Immunization Program | Retain. Still relevant. |
| H-440.993 | Smallpox Vaccination Policy | Retain. Still relevant. |
| H-440.995 | Complete and Prompt Reporting of Measles (Rubeola) | Retain. Still relevant. |
| H-440.996 | Sexually Transmitted Disease Control | Retain in part to read as follows with change in title:<br>Sexually Transmitted Infection ~~Disease~~ Control H-440.996<br>Our AMA (1) supports continued action to assert appropriate leadership in a concerted program to control sexually transmitted infection ~~disease~~;<br>(2) urges physicians to take all appropriate measures to reverse the rise in sexually transmitted infection ~~disease~~ and bring it under control;<br>(3) encourages constituent and component societies to support and initiate efforts to gain public support for increased appropriations for public health departments to fund research in development of practical methods for prevention and detection of sexually transmitted infection ~~disease~~, with particular emphasis on control of gonorrhea; and<br>(4) in those states where state consent laws have not been modified, encourages the constituent associations to support enactment of statutes that permit physicians and their co-workers to treat and search for sexually |

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| | | transmitted infection ~~disease~~ in minors legally without the necessity of obtaining parental consent. |
| H-445.994 | Corporate Visitation Program | Retain. Still relevant. |
| H-450.949 | Update on Patient Safety | Retain. Still relevant. |
| H-450.970 | Quality Management Principles | Retain. Still relevant. |
| H-450.979 | Impact of Quality of Care Analysis | Retain. Still relevant. |
| H-455.983 | Radiographic Contrast Media | Retain in part to read as follows. Still relevant.<br>(1) Third party payers should provide full reimbursement for the use of the contrast media which is deemed medically necessary by the physician.<br>(2) Avoidance of waste in the use of contrast media should be encouraged.<br>(3) The development and implementation by hospitals of procedures and policies to help ensure that ~~nonionic~~ contrast media are used when medically appropriate should be supported. |
| H-455.984 | Health Effects of Radon Exposure | Retain. Still relevant. |
| H-455.996 | Nuclear Regulatory Commission Licensure Requirements for Physicians | Retain. Still relevant. |
| H-455.997 | Human Use of Byproduct Material | Rescind. No longer relevant. |
| H-460.916 | Protection of Human Subjects in Research | Retain. Still relevant. |
| H-460.921 | Support for Institutional Review Boards | Retain. Still relevant. |
| H-460.926 | Funding of Biomedical, Translational, and Clinical Research | Retain. Still relevant. |
| H-460.933 | Clinical Research and the AMA | Retain. Still relevant. |
| H-460.956 | The Need for Increased Research and Development in Nuclear Fusion to Reduce Environmental Pollution | Retain. Still relevant. |
| H-460.959 | Health Services Research Training | Retain. Still relevant. |
| H-460.962 | National Human Genome Research Institute | Retain. Still relevant. |
| H-460.964 | Use of Animals in Research | Retain. Still relevant. |
| H-460.986 | Financial Protection for Clinical Research | Rescind. Addressed in H-460.926, H-460.943, and H-460.998. |
| H-460.996 | Basic Research | Retain. Still relevant. |
| H-480.952 | Prevent Mistaken Medical Tubing Connections | Retain. Still relevant. |
| H-480.960 | Preventing Needlestick Injuries in Health Care Settings | Retain. Still relevant. |
| H-480.973 | Unconventional Medical Care in the United States | Retain in part to read as follows:<br>Our AMA: (1) encourages the National Center for Complementary and Integrative Health (NCCIH) ~~Office of Alternative Medicine~~ of the National Institutes of Health (NIH) to determine by objective scientific evaluation the efficacy and safety of practices and procedures of unconventional medicine; and encourages its members to become better informed regarding the practices and techniques of such practices; and (2) utilizes the ~~National Institutes of Health's National Center for Complementary and Alternative Medicine's~~ classification system of alternative medicine set forth by the NCCIH at the NIH, "Major Domains of Complementary and Alternative |

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| | | Medicine," in order to promote future discussion and research about the efficacy, safety, and use of alternative medicine. |
| H-480.986 | Registry of Implantable Devices | Retain. Still relevant. |
| H-490.908 | Tobacco-Free School Environment | Retain. Still relevant. |
| H-50.985 | Nationwide Reporting of Elevated Blood Lead Levels | Retain. Still relevant. |
| H-50.996 | Blood for Medical Use | Retain. Still relevant. |
| H-515.988 | Repeal of Religious Exemptions in Child Abuse and Medical Practice Statutes | Retain. Still relevant. |
| H-520.992 | Chemical and Biologic Weapons | Retain. Still relevant. |
| H-55.986 | Home Chemotherapy and Antibiotic Infusions | Retain. Still relevant. |
| H-55.998 | Staging of Cancer | Retain. Still relevant |
| H-55.999 | Symptomatic and Supportive Care for Patients with Cancer | Retain. Still relevant. |
| H-60.952 | AMA Support for the United Nations Convention on The Rights of the Child | Retain. Still relevant. |
| H-60.998 | Ipecac as Household Poison Emetic | Rescind. New evidence shows syrup of ipecac is no longer recommended for treating poisoning and that it can be misused. |
| H-75.986 | Drug Interactions Between Oral Contraceptives and Antibiotics | Retain. Still relevant. |
| H-80.994 | Use of all Appropriate Medical Forensic Techniques in the Criminal Justice System | Retain. Still relevant. |
| H-85.981 | Improving the Accuracy of Death Certificates | Retain. Still relevant. |
| H-90.998 | Excluding Handicapped from Contact Sports | Retain. Still relevant. |
| H-90.999 | Access to Public Buildings for Handicapped Persons | Retain. Still relevant. |
| H-95.957 | Methadone Maintenance in Private Practice | Retain. Still relevant. |
| H-95.967 | Drug Abuse | Retain in part with a change in title to read as follows:<br>Harmful Substance ~~Drug Abuse~~ Use<br>Our AMA encourages every physician to make a commitment to join his/her community in attempting to reduce harmful substance ~~drug ab~~use and that said commitment encourage involvement in at least one of the following roles:<br>(1) donation of time to talk to local civic groups, schools, religious institutions, and other appropriate groups about harmful substance ~~drug ab~~use;<br>(2) join or organize local groups dedicated to ~~drug abuse~~ the prevention of harmful substance use;<br>(3) talk to youth groups about brain damage and other deleterious effects of harmful substance ~~drug ab~~use; and<br>(4) educate and support legislators, office holders and local leaders ~~toward~~ about ways to end~~ing~~ harmful substance ~~drug ab~~use ~~crisis~~ and providing adequate treatment to patients with substance use disorder. |

| Number | Title | Recommended Action and Rationale |
|---|---|---|
| H-95.973 | Increased Funding for Drug Treatment | Retain in part to read as follows:<br>Increased Funding for Substance Use Disorder ~~Drug~~ Treatment<br>Our AMA (1) urges Congress to substantially increase its funding for substance use disorder ~~drug~~ treatment programs; (2) urges Congress to increase funding for the expansion and creation of new staff training programs; and (3) urges state medical societies to press for greater commitment of funds by state and local government to expand the quantity and improve the quality of the substance use disorder ~~drug~~ treatment system. |
| H-95.977 | Medical Direction of Methadone Treatment | Retain. Still relevant. |
| H-95.991 | Referral of Patients to Chemical Dependency Programs | Retain in part to read as follows:<br>Referral of Patients to Substance Use Disorder Treatment Programs ~~Chemical Dependency~~<br>Our AMA urges its members to acquaint themselves with the various substance use disorder treatment ~~chemical dependency~~ programs available for the medical treatment of alcohol and drug use and, where appropriate, to refer their patients to them promptly. |

## ELECTIONS

| | Initial Election | Runoff |
|---|---|---|
| President-elect | | |
| Gerald E. Harmon | * | |
| Speaker | | |
| Bruce A. Scott | * | |
| Vice Speaker | | |
| Lisa Bohman Egbert | * | |
| Board of Trustees | | |
| David H. Aizuss | 431† | |
| Willarda V. Edwards | 485† | |
| Vidya Kora | 236 | |
| Ilse Levin | 377† | |
| Asa C. Lockhart | 279 | |
| Thomas J. Madejski | 352† | |
| Mike Miller | 212 | |
| David T. Tayloe, Jr. | 188 | |
| Council on Constitution and Bylaws | | |
| Pino Colone | * | |
| Council on Medical Education | | |
| Cynthia Jumper | * | |
| Council on Medical Education, resident seat | | |
| David Savage | * | |
| Council on Medical Service | | |
| Joseph P. Costabile | 162 | |
| Heidi M. Dunniway | 168 | 223 |
| Erick A. Eiting | 297 | 412† |
| Jerry Halverson | 104 | |
| Lynn Jeffers | 545† | |
| Council on Medical Service, new vacancy | | |
| Steven Chen | 215 | 386† |
| Joseph P. Costabile | 132 | |
| Heidi M. Dunniway | 143 | 244 |
| Jerry Halverson | 74 | |
| Peter Hollman | 66 | |
| Council on Medical Service, resident seat | | |
| Megan Srinivas | * | |
| Council on Science & Public Health | | |
| Alexander Ding | * | |
| David Welsh | * | |

* Uncontested election; deemed elected unanimously by acclamation under rules adopted for the Special Meeting.
† Elected in balloting during the Special Meeting.