REPORT OF THE ORGANIZED MEDICAL STAFF SECTION
GOVERNING COUNCIL

GC Report A-I-20

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

Presented by: David Welsh, MD, Chair

Referred to: OMSS Reference Committee
(Nancy Mueller, MD, Chair)

OMSS Governing Council Report A identifies resolutions and reports relevant to medical staffs that have been submitted for consideration by the AMA House of Delegates (HOD) at the 2020 AMA Special Meeting. This report is submitted to the Assembly to facilitate the instruction of the OMSS Delegate and Alternate Delegate regarding the positions they should take in representing the Section in the HOD.

Visit the HOD meeting page to access full versions of all resolutions and reports: bit.ly/hod2020.

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

Ref Com	Title and Sponsor	Proposed Policy	Recommendation
.Con	CEJA Report 1 – Amendment to Opinion 1.2.2, "Disruptive Behavior and Discrimination by Patients"	In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that Policy D-65.991, "Discrimination against Physicians by Patients," be rescinded; that the title of Opinion 1.2.2, be amended to read "Disruptive Behavior and Discrimination by Patients"; that the body of Opinion 1.2.2 be amended by addition and deletion as follows; and the remainder of this report be filed: The relationship between patients and physicians is based on trust and should serve to promote patients' well-being while respecting ~~their~~ the dignity and rights of both patients and physicians. Disrespectful, ~~or~~ derogatory, or prejudiced, language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either ~~physicians~~ patients or physicians can undermine trust and compromise the integrity of the patient-physician relationship. It can make individuals who	1. That the OMSS Delegate be instructed to support the intent of CEJA Report 1-I-20.

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		themselves experience (or are members of populations that have experienced) prejudice reluctant to seek care as patients or to provide care as health care professionals, and create an environment that strains relationships among patients, physicians, and the health care team. Trust can be established and maintained only when there is mutual respect. Therefore, in their interactions with patients, physicians should: (a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those ~~they target~~ who are targeted. (b) Always treat patients with compassion and respect. (c) Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced ways insofar as possible. Physicians should identify, appreciate, and address potentially treatable clinical conditions or personal experiences that influence patient behavior. Regardless of cause, when a patient's behavior threatens the safety of health care personnel or other patients, steps should be taken to de-escalate or remove the threat. (d) Prioritize the goals of care when deciding whether to decline or accommodate a patient's ~~prejudiced~~ request for an alternative physician. Physicians should recognize that some requests for a concordant physician may be clinically useful or promote improved outcomes. (e) Within the limits of ethics guidance, trainees should not be expected to forgo valuable learning opportunities solely to accommodate prejudiced requests. (f) Make patients aware that they are able to seek care from other sources if they persist in opposing treatment from the physician assigned. If patients require immediate care, inform them that, unless they exercise their right to leave, care will be provided by appropriately qualified staff independent of their expressed preference. (g) Terminate the patient-physician relationship ~~who uses derogatory language or acts in a prejudiced manner~~ only when the patient will not modify disrespectful, derogatory or prejudiced behavior that is within the patient's control, in keeping with ethics guidance. Physicians, especially those in leadership roles, should encourage the institutions with which they are affiliated to: (h) Be mindful of the messages the institution conveys within and outside its walls by how it responds to prejudiced behavior by patients. (i) Educate staff, patients, and the community about the institution's expectations for behavior.	

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		(j) Promote a safe and respectful working environment and formally set clear expectations for how disrespectful, derogatory, or prejudiced behavior by patients will be managed. (k) Clearly and openly support physicians, trainees, and facility personnel who experience prejudiced behavior and discrimination by patients, including allowing physicians, trainees, and facility personnel to decline to care for those patients, without penalty, who have exhibited discriminatory behavior specifically toward them. (l) Collect data regarding incidents of discrimination by patients and their effects on physicians and facility personnel on an ongoing basis and seek to improve how incidents are addressed to better meet the needs of patients, physicians, other facility personnel, and the community. **Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.*	
.Con	CEJA Report 2 – Amendment to Opinion 8.1, "Routine Universal Immunization of Physicians"	In light of these considerations, the Council on Ethical and Judicial Affairs recommends that Opinion 8.7, "Routine Universal Immunization of Physicians," be amended by insertion and deletion as follows and that the remainder of this report be filed: As professionals committed to promoting the welfare of individual patients and the health of the public and to safeguarding their own and their colleagues' well-being, physicians have an ethical responsibility to encourage patients to accept immunization when the patient can do so safely, and to take appropriate measures in their own practice to prevent the spread of infectious disease in health care settings. Conscientious participation in routine infection control practices, such as hand washing and respiratory precautions is a basic expectation of the profession. In some situations, however, routine infection control is not sufficient to protect the interests of patients, the public, and fellow health care workers. In the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues, or threatens the availability of the health care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe, and effective vaccine, physicians ~~should:~~	2. That the OMSS Delegate be instructed to support the intent of CEJA Report 2-I-20.

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		~~Accept~~ have a responsibility to accept immunization absent a recognized medical~~, religious, or philosophic reason to not be immunized~~ contraindication or when a specific vaccine would pose a significant risk to the physician's patients. ~~(b) Accept a decision of the medical staff leadership or health care institution, or other appropriate authority to adjust practice activities if not immunized (e.g., wear masks or refrain from direct patient care). It may be appropriate in some circumstances to inform patients about immunization status.~~ Physicians who are not or cannot be immunized have a responsibility to voluntarily take appropriate action to protect patients, fellow health care workers and others. They must adjust their practice activities in keeping with decisions of the medical staff, institutional policy, or public health policy, including refraining from direct patient contact when appropriate. Physician practices and health care institutions have a responsibility to proactively develop policies and procedures for responding to epidemic or pandemic disease with input from practicing physicians, institutional leadership, and appropriate specialists. Such policies and procedures should include robust infection control practices, provision and required use of appropriate protective equipment, and a process for making appropriate immunization readily available to staff. During outbreaks of vaccine-preventable disease for which there is a safe, effective vaccine, institutions' responsibility may extend to requiring immunization of staff. Physician practices and health care institutions have a further responsibility to limit patient and staff exposure to individuals who are not immunized, which may include requiring unimmunized individuals to refrain from direct patient contact. *[*]Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.*	
.Con	Res 007 – Access to Confidential Health Care Services for Physicians and Trainees (Miller)	RESOLVED, That our American Medical Association advocate that employers of physicians, other licensed independent professionals, advance practice practitioners, nurses, mental health therapists and addiction counselors, should encourage them to maintain self-care and to seek professional help from a mental health professional or addiction professional when they have concerns about psychiatric or substance-related symptoms that are not responding to self-care (Directive to Take Action); and be it further	3. That the OMSS Delegate be instructed to support the intent of Resolution 007-I-20.

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		_____ ____ RESOLVED, That our AMA advocate that employers of physicians, other licensed independent professionals, advance practice practitioners, nurses, mental health therapists and addiction counselors should do all they can to reduce stigma, reduce or eliminate discrimination, and remove barriers to treatment entry for those who need professional behavioral health care services (Directive to Take Action); and be it further _____ ____ RESOLVED, That our AMA advocate that employers in the health care sector including academic medical centers where residents and fellows are trained, as well as medical schools, who offer health benefits to their employees, fellows, residents and medical students, and where there is a defined set of in-network providers, should assure that physicians, other licensed independent professionals, advance practice practitioners, nurses, mental health therapists and addiction counselors are able to go out-of-network to see a mental health or addiction professional who does not work in the same health system as the employee (Directive to Take Action); and be it further _____ ____ RESOLVED, That our AMA advocate that fellows, residents and medical students be provided access to out-of-network providers when they are seeking to establish care with a primary care provider, so that they are able to use their health insurance benefits while not finding themselves under the care of a past, current or future faculty member, if the original provider network does not contain adequate options for primary care offered by clinicians not on the faculty of the medical school or academic medical center; (Directive to Take Action) and be it further _____ ____	

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		RESOLVED, That our AMA advocate that contracts should be established by medical schools, academic medical centers, and employers of practicing physicians such that the deductibles, copays, coinsurance, and out-of-pocket maximums for such practicing physicians, fellows, residents and medical students seeing out-of-network providers of mental health, addiction, and primary medical care should be the same as the deductibles, copays, coinsurance, and out-of-pocket maximums for seeing in-network providers. (Directive to Take Action)	
A	CMS Report 6 – Value-Based Management of Drug Formularies	1. That our American Medical Association (AMA) reaffirm Policy H-120.988, upholding the ability of patients to access treatments prescribed by their physicians. (Reaffirm HOD Policy) _____ 2. That our AMA reaffirm Policy H-285.965, which states that pharmacy and therapeutics (P&T) committee members should include independent physician representatives, and that mechanisms should be established for ongoing peer review of formulary policy as well as for appealing formulary exclusions. (Reaffirm HOD Policy) _____ 3. That our AMA advocate that pharmacy benefit managers (PBMs) and health plans use a transparent process in formulary development and administration, and include practicing network physicians from the appropriate medical specialty when making determinations regarding formulary inclusion or placement for a particular drug class. (New HOD Policy) _____ 4. That our AMA reaffirm Policy D-110.987, which supports improved transparency of PBM operations, including disclosing rebate and discount information as well as P&T committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy; and	4. That the OMSS Delegate be instructed to support the intent of CMS Report 6-I-20.

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		formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities. (Reaffirm HOD Policy) _____ 5. That our AMA reaffirm Policy H-110.986, which outlines principles guiding AMA's support for value-based pricing programs, initiatives and mechanisms for pharmaceuticals. (Reaffirm HOD Policy) _____ 6. That our AMA advocate that any refunds or rebates received by a health plan or PBM from a pharmaceutical manufacturer under an outcomes-based contract be shared with impacted patients. (New HOD Policy) _____ That our AMA oppose indication-based formularies in order to protect the ability of patients to access and afford the prescription drugs they need, and physicians to make the best prescribing decisions for their patients. (New HOD Policy)	
A	Res 106 – Bundling Physician Fees with Hospital Fees (New York)	RESOLVED, That our American Medical Association oppose bundling of physician payments with hospital payments, unless the physician has agreed to such an arrangement in advance. (New HOD Policy)	5. That the OMSS Delegate be instructed to support the intent of Resolution 106-I-20.
B	BOT Report 06 – Covenants Not to Compete	Our American Medical Association create a state restrictive covenant legislative template to assist state medical associations, national medical specialty societies and physician members as they navigate the intricacies of restrictive covenant policy at the state level. (Directive to Take Action)	6. That the OMSS Delegate be instructed to support the intent of Board of Trustees Report 06-I-20.
B	Res 205 – Telehealth Post SARS-COV-2 (Virginia)	RESOLVED, That our American Medical Association advocate to facilitate the widespread adoption of telehealth services in the practice of medicine for physicians or physician-led teams post SARS-COV-2 (Directive to Take Action); and be it further	7. That the OMSS Delegate be instructed to support the intent of Resolution 205-I-20.

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		_____ ____ RESOLVED, That our AMA encourage the Centers for Medicare and Medicaid Services, health insurance industry, and Federal/State government agencies to adopt uniform, clear regulations as well as equitable coverage and reimbursement mechanisms that promote physician-led telehealth services (New HOD Policy); and be it further _____ ____ RESOLVED, That our AMA advocate for equitable access to telehealth services especially for the most at risk and under resourced patient populations and communities. (Directive to Take Action)	
B	Res 207 – AMA Position on All Payer Database Creation (New York)	RESOLVED, That our American Medical Association advocate that any All Payer Database should also provide true payments that hospitals are making to their employed physicians, not just the amount of payment that the insurer is making on the physician's behalf to the hospital. (Directive to Take Action)	8. That the OMSS Delegate be instructed to support the intent of Resolution 207-I-20.
C	CME Report 01 – An Update on Continuing Board Certification	1. That our American Medical Association (AMA), through its Council on Medical Education, continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development of new, integrated standards for continuing certification programs by 2020 that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency. (New HOD Policy)	9. That the OMSS Delegate be instructed to support the intent of CME Report 01-I-20.
C	CME Report 03 – Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure	1. That our AMA rescind Policy H-310.943 (2), "Closing of Residency Programs," as having been fulfilled by this report. (Rescind HOD Policy) _____ ____ 2. That our AMA ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution. (Directive to Take Action)	10. That the OMSS Delegate be instructed to support the intent of CME Report 03-I-20.

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		_____ ____ 3. That our AMA encourage the Association of American Medical Colleges (AAMC) and National Resident Matching Program (NRMP) to develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure. (Directive to Take Action) _____ ____ 4. That our AMA encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger. (Directive to Take Action) _____ ____ 5. That our AMA encourage the Association of American Medical Colleges (AAMC) and the Accreditation Council for Graduate Medical Education (ACGME) to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity. (Directive to Take Action) _____ ____ 6. That our AMA encourage the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure. (Directive to Take Action)	

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C	Res 307 – USMLE Step Examination Failures During the COVID-19 Pandemic (Littles)	RESOLVED, That our American Medical Association advocate to the National Board of Medical Examiners (NBME) that students at allopathic schools of medicine who failed the United States Medical Licensing Examination (USMLE) Step 1 Examination or the USMLE Step 2-CK Examination that was scheduled between March 1, 2020 and September 30, 2020 be allowed the opportunity to be re-examined one time at no additional examination fee charged to the student (Directive to Take Action); and be it further RESOLVED, That our AMA ask that the various state and territorial medical boards, through outreach to the NBME and Federation of State Medical Boards (FSMB), not require students who failed any USMLE Step 1 or USMLE Step 2 CK examination, between March 1 and September 30, 2020 to reveal this information to state medical licensure boards during the processes of obtaining or renewing state licensure (Directive to Take Action); and be it further RESOLVED, That our AMA advocate to the NBME and FSMB that such failures not count toward the total number of exam attempts by a potential licensee (Directive to Take Action); and be it further RESOLVED, That our AMA advocate to hospital accreditation organizations such as, but not limited to, The Joint Commission and American Hospital Association, that those who have failed any USMLE Step 1 or USMLE Step 2-CK examination between March 1 and September 30, 2020 not be required to disclose this information to hospital boards and other accrediting bodies that determine a physician's fitness to practice at or admit patients to hospitals in the United States. (Directive to Take Action)	11. That the OMSS Delegate be instructed to listen on Resolution 307-I-20.
D	BOT Report 09 – Bullying in the Practice of Medicine	1. That our American Medical Association (AMA) reaffirm the following policies: a. H-215.978, "Workplace Violence Prevention" b. H-295.955, "Teacher-Learner Relationship In Medical Education" c. H-515.966, "Violence and Abuse." (Reaffirm HOD Policy)	12. That the OMSS Delegate be instructed to support the intent of Board of Trustees Report 09-I-20.

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		_____ ____ 2. That our AMA define “workplace bullying” as repeated, emotionally or physically abusive, disrespectful, disruptive, inappropriate, insulting, intimidating, and/or threatening behavior targeted at a specific individual or a group of individuals that manifests from a real or perceived power imbalance and is often, but not always, intended to control, embarrass, undermine, threaten, or otherwise harm the target. (New HOD Policy) _____ ____ 3. That our AMA adopt the following guidelines for the establishment of workplace policies to prevent and address bullying in the practice of medicine: (New HOD Policy) Health care organizations, including academic medical centers, should establish policies to prevent and address bullying in their workplaces. An effective workplace policy should: o Describe the management’s commitment to providing a safe and healthy workplace. Show the staff that their leaders are concerned about bullying and unprofessional behavior and that they take it seriously. o Clearly define workplace violence, harassment, and bullying, specifically including intimidation, threats and other forms of aggressive behavior. o Specify to whom the policy applies (i.e., medical staff, students, administration, patients, contractors, etc.). o Define both expected and prohibited behaviors. o Outline steps for individuals to take when they feel they are a victim of workplace bullying. o Provide contact information for a confidential means for documenting and reporting incidents. o Prohibit retaliation and ensure privacy and confidentiality. o Document training requirements and establish clear expectations about the training objectives.	

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		In addition to formal policies, organizations should strategize to create a culture in which bullying does not occur. Fostering respect and appreciation among colleagues across disciplines and ranks can contribute to an atmosphere in which employees feel safe, secure and confident in their roles and professions. Tactics to help create this type of organizational culture include: o Surveying staff, and medical students in academic settings, anonymously and confidentially to assess their perceptions of the workplace culture and prevalence of bullying behavior, including their ideas about the impact of this behavior on themselves and patients. Use the results to inform the development of programs and resources, showing the respondents that their feedback is taken seriously. o Encouraging open discussions in which staff can talk freely about problems and/or encounters with behavior that may constitute bullying. o Establishing programs for staff and students, such as Employee Assistance Programs, that provide a place to confidentially address personal experiences of bullying. Establishing procedures and conducting interventions within the context of the organizational commitment to the health and well-being of all staff.	
D	Res 406 – Face Masking in Hospitals During Flu Season (Littles)	RESOLVED, That our American Medical Association encourage The Joint Commission and other hospital accreditation organizations recognized by major insurers to stipulate that all hospitals require hospital employees, physicians, patients, and visitors to wear a facial mask that completely covers the mouth and nose while within hospital walls (unless they are consuming food while “socially distanced,” or unless they are patients in their own rooms while “socially distanced”) (Directive to Take Action); and be it further _____ RESOLVED, That our AMA encourage publication of commentaries supportive of such regulations and standards in scientific journals and other publications (Directive to Take Action); and be it further _____ RESOLVED, That our AMA study the comparative disease-reduction effectiveness of various types of masks (N-95 masks versus “surgical” masks	13. That the OMSS Delegate be instructed to listen on Resolution 406-I-20.

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		versus simple cloth facial coverings), toward potentially refining or making more specific any future mandates for facial coverings for persons while in-hospital as a visitor, patient or health care worker. (Directive to Take Action)	
E	CSAPH Report 1 – Drug Shortages: 2020 Update	That Policy H-100.956, "National Drug Shortages" be amended by addition and deletion to read as follows: 1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients. 2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion. 3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage. 4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant. 5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back ~~at least annually~~ to the House of Delegates when warranted on progress made in addressing drug shortages.	14. That the OMSS Delegate be instructed to support the intent of CSAPH Report 1-I-20.

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		6. Our AMA urges continued analysis of ~~the development of a comprehensive independent report on~~ the root causes of drug shortages that includes consideration of~~. Such an analysis should consider~~ federal actions, ~~the number of~~ evaluation of manufacturer,~~s~~ Group Purchasing Organization (GPO), and distributor practices, ~~as well as~~ contracting practices by market participants on competition, access to drugs, ~~and~~ pricing, and ~~. In particular, further transparent In particular, a further~~ analysis of economic drivers ~~is warranted~~. ~~is warranted~~. ~~The federal Centers for Medicare & Medicaid Services (CMS) should review and evaluate its 2003 Medicare reimbursement formula of average sales price plus 6% for unintended consequences including serving as a root cause of drug shortages.~~ 7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons. 8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history. 9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs. 10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages. 11. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, and provide more detailed information regarding the causes and anticipated duration of drug shortages.	

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		12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages. 13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages. 14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing. 15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling. 16. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes. 17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan. (Modify Current HOD Policy)	
F	CLRPD Report 02 – Organized Medical Staff Section Five-Year Review	The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Organized Medical Staff Section through 2025 with the next review no later than the 2025 Annual Meeting and that the remainder of this report be filed. (Directive to Take Action)	15. That the OMSS Delegate be instructed to support the intent of CLRPD Report 02-I-20.

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F	CLRPD Report 03 – Establishment of a Private Practice Physicians Section	The Council on Long Range Planning and Development recommends that the following recommendations be adopted and the remainder of the report be filed: 1. That our American Medical Association transition the Private Practice Physicians Congress to the Private Practice Physicians Section as a delineated section. (Directive to Take Action) _____ 2. That our AMA develop bylaw language to recognize the Private Practice Physicians Section. (Directive to Take Action)	16. That the OMSS Delegate be instructed to support the intent of CLRPD Report 03-I-20.
G	CMS Report 4 – Economic Discrimination in the Hospital Practice Setting	1. That our American Medical Association (AMA) actively oppose policies that limit a physician's access to hospital services based on the number and type of referrals made, the number of procedures performed, the use of any and all hospital services or employment affiliation. (New HOD Policy) _____ 2. That our AMA recognize that physician onboarding, credentialing and peer review should not be tied in a discriminatory manner to hospital employment status. (New HOD Policy) _____ 3. That our AMA reaffirm Policy H-230.982, which states that clinical privileges shall include access to those hospital resources essential to the full exercise of such privileges, and that privileges can be abridged only upon recommendation of the medical staff, for reasons related to professional competence, adherence to appropriate standards of medical care, health status, or other parameters agreed upon by the medical staff. (Reaffirm HOD Policy) _____ 4. That our AMA reaffirm Policy H-230.953, which encourages the Joint Commission to support alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum	17. That the OMSS Delegate be instructed to support the intent of CMS Report 4-I-20.

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		volume requirements needed to maintain credentials and privileges. (Reaffirm HOD Policy) _____ 5. That our AMA reaffirm Policy H-230.975, which strongly opposes economic credentialing and believes that physicians should attempt to assure provisions in hospital medical staff bylaws of an appropriate role of the medical staff in decisions to grant or maintain exclusive contracts. (Reaffirm HOD Policy) _____ That our AMA reaffirm Policy H-230.976, which opposes use of economic criteria not related to quality to determine a physician's qualification for the granting or renewal of medical staff membership or privileges. (Reaffirm HOD Policy)	
G	Res 702 – Eliminating Claims Data for Measuring Physician and Hospital Quality (Oklahoma)	RESOLVED, That our American Medical Association collaborate with the Centers for Medicare & Medicaid Services (CMS) and other appropriate stakeholders to ensure physician and hospital quality measures are based on the delivery of care in accordance with established best practices (Directive to Take Action); and be it further _____ RESOLVED, That our AMA collaborate with CMS and other stakeholders to eliminate the use of claims data for measuring physician and hospital quality. (Directive to Take Action)	18. That the OMSS Delegate be instructed to support the first Resolve of Resolution 702-I-20, and listen on the second Resolve of Resolution 702-I-20
G	Res 704 – Government Imposed Volume Requirements for Credentialing (New York)	RESOLVED, That our American Medical Association create guidelines and standards for evaluation of government-imposed volume requirements for credentialing that would include at least the following considerations: (a) the evidence for that volume requirement (b) how many current practitioners meet that volume requirement (c) how difficult it would be to meet that volume requirement	19. That the OMSS Delegate be instructed to amend the Resolve of Resolution 704-I-20 to include the following language: "That our AMA consult with specialty societies and other stakeholders to evaluate and consider alternate requirements for credentialing."

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		(d) the consequences to that practitioner of not meeting that volume requirement (e) the consequences to the hospital and the community of losing the services of the practitioners who can't meet that volume requirement (f) whether volumes of similar procedures could also reasonably be used to satisfy such a requirement. (Directive to Take Action)	
G	Res 710 – A Resolution to Amend the AMA's Physician and Medical Staff Bill of Rights (Virginia)	RESOLVED, That our American Medical Association amend Policy H-225.942, "Physician and Medical Staff Member Bill of Rights" by addition to read as follows: **Physician and Medical Staff Member Bill of Rights H-225.942** Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities: Preamble The organized medical staff, hospital governing body and administration are all integral to the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated. The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients. Medical staff self-governance is vital in protecting the ability of physicians to act in their patient's best interest. Only within the confines of the principles	20. That the OMSS Delegate be instructed to seek referral for Resolution 710-I-20.

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		and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care. The AMA recognizes the responsibility to provide for the delivery of high quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body, and relies on accountability and inter-dependence with government and public health agencies that regulate and administer to these organizations. The AMA supports the right to advocate without fear of retaliation by the health care organization's administrative or governing body including the right to refuse work in unsafe situations without retaliation. The AMA believes physicians should be continuously provided with the resources necessary to continuously improve patient care and outcomes and further be permitted to advocate for planning and delivery of such resources not only with the health agency but with supervising and regulating government agencies. From this fundamental understanding flow the following Medical Staff Rights and Responsibilities: **I. Our AMA recognizes the following fundamental responsibilities of the medical staff:** a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organizations governing body. b. The responsibility to provide leadership and work collaboratively with the health care organizations administration and governing body to continuously improve patient care and outcomes. c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members. d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria	

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		unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation. e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct. f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review. **II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staffs ability to fulfill its responsibilities:** a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members. b. The right to advocate for its members and their patients without fear of retaliation by the health care organizations administration or governing body. c. The right to be provided with the resources necessary to continuously improve patient care and outcomes. d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments. e. The right to be represented and heard, with or without vote, at all meetings of the health care organizations governing body. f. The right to engage the health care organizations administration and governing body on professional matters involving their own interests. **III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:** a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.	

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		b. The responsibility to provide patient care that meets the professional standards established by the medical staff. c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff. d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization. e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff. f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement. **IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each members ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:** a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws. b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers. c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organizations administration or governing body. d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty. e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments. f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities. (Modify Current HOD Policy)	

The following recommendations regarding OMSS positions on items that traditionally would be discussed in "Green Report" are presented for the consideration of the assembly:

Ref Com	Title	Proposed Policy	Recommendation
G	BOT 17 – Hospital Website Voluntary Physician Inclusion	1. That our AMA (1) work with relevant stakeholders to encourage decision-makers at all appropriate levels that all credentialed physicians be included in healthcare organizations' website listings and search functions in a fair, equal, and unbiased fashion; and (2) support efforts to ensure that physicians, through their medical staffs, are able to provide input on what information is published. (Directive to Take Action) _____ 2. That our AMA work with relevant stakeholders to encourage healthcare organizations to notify credentialed physicians when a website is about to be changed if there is reason to believe that such a change could affect how physicians are listed or if they are listed at all. (Directive to Take Action) _____ 3. That our AMA, through its Organized Medical Staff Section, produce and promote educational materials, trainings, and any other relevant components to help physicians advocate for their own inclusion on facilities' websites and search functions. (Directive to Take Action)	21. That the OMSS Delegate be instructed to support the intent of Board of Trustees Report 17-I-20.