JOINT COUNCIL REPORT

The following report was presented by Kevin D. Reilly, Sr., MD, Chair, Council on Constitution and Bylaws; and Edmund Cabbabe, MD, MPH, Chair, Council on Long Range Planning and Development:

1. JOINT COUNCIL SUNSET REVIEW OF 2013 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates (House) 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 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 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 (per Policy G-600.111(4), The consolidation process permits editorial amendments for the sake of clarity, so long as the proposed changes are transparent to the House and do not change the meaning); (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 to handle the sunset reports.

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to the House or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.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

RECOMMENDATION

The Councils on Constitution and Bylaws and Long Range Planning and Development recommend 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 Number	Title	Text	Recommendation
D-405.991	Clarification of the Title "Doctor" in the Hospital Environment	1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials. 2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969) that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree. 3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.	Retain. Still Relevant. [The Councils acknowledge there is some overlap with other AMA policies D-405.974, Clarification of Healthcare Physician Identification: Consumer Truth & Transparency, H-405.989, Physicians and Surgeons, and H-405.951, Definition and Use of the Term Physician, and H-405.969, Definition of a Physician, and plans to issue a consolidation report at I-23.]
D-450.965	Patients' Responsibilities for Health Care Outcomes	Our AMA will: (1) continue to support the development of resources for patients and physicians to promote adherence through its partnerships with the National Council on Patient Information and Education and National Consumer League National Medication Adherence Campaign; (2) publicize existing resources for	Sunset. Superseded by more recent policies that exist, including H-373.993, Medication Adherence, H-

		physicians to help patients adhere to treatment through its website; and (3) examine issues of patient adherence as part of its strategic initiative on Improving Health Outcomes and, if appropriate, will develop with others targeted education and resources to support patient adherence.	450.942, Patient Adherence to Treatment Plans, H-115.967, Addressing Drug Overdose and Patient Compliance with Targeted Pharmaceutical Packaging Efforts, H-275.976, Boundaries of Practice for Health Professionals, H-120.967, Dispensing of Drug Information, and Code of Medical Ethics Opinion 1.1.4, Patient Responsibilities. Improving Health Outcomes is one of AMA's major focus areas. Other resources include The AMA's STEPS Forward™ practice management tools which include modules on patient adherence, BOT Report 3-I-12, Physician Education to Support Patient Adherence to Treatment, and BOT Report 11-A-14, Medication Non-Adherence and Error.
D-75.994	Tubal Ligation and Vasectomy Consents	1. Our AMA will work closely with the American College of Obstetricians and Gynecologists, the American Urological Association, and any other interested organizations, to advocate to Congress for the legislative or regulatory elimination of the required 30 day interval between informed consent and a permanent sterilization procedure. 2. Our AMA will work with the Centers for Medicare & Medicaid Services to eliminate the time restrictions on informed consent for permanent sterilization procedures.	Sunset. Superseded by more current policy H-290.977, Medicaid Sterilization Services Without Time Constraints. Also, BOT 17-A-14, Tubal Ligation and Vasectomy Consents provides a historical context to the issue.
G-600.045	Online Member Forums in the	Online member forums should be incorporated into every House of Delegates policymaking meeting, using the following parameters: a. Each reference	Retain. Still relevant. Policy D-600.956, Increasing the

	House of Delegates	committee should participate in the online member forum process; b. Each online member forum should cover as many items of business as possible, including, at minimum, those items that appear in the initial compilation of the Delegate Handbook; c. Comments submitted to an online member forum should be used to prepare a summary report that reflects the comments received up to that point; d. Full, free and complete testimony should be allowed in the onsite hearings; and e. The Speakers should experiment with alternative procedures to enhance and improve the overall online member forum process.	Effectiveness of Online Reference Committee, commits our AMA to a two-year study of preliminary reference committee documents based on the written online testimony, with those documents being used to inform the discussion at the in-person reference committee.
G-615.001	Establishment and Function of Sections	1. Our AMA adopts the following criteria in consideration of requests for establishing new sections or changing the status of member component groups: A. Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group. B. Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative. C. Appropriateness - The structure of the group will be consistent with its objectives and activities. D. Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members. It is important to note this threshold will not be used to determine representation as each new group will be allocated only one delegate and one alternate delegate. E. Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body. F. Accessibility - Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the HOD. 2. Our AMA will consider requests for establishing new sections by letter of application to the	Retain. Still relevant and necessary to specify the criteria used to evaluate new sections or changing the status of a member component group. A five-year review cycle of delineated sections provides an excellent opportunity for the House to receive updates on section activities to ensure that these sections continue to meet HOD goals. CLRPD Report 1-I-10, Establishment and Function of Sections provides a historical context.

		CLRPD, which will make recommendations to the BOT and HOD for further action or by submission of a resolution.	
G-625.020	AMA Strategic Planning	1. Our AMA annual strategic planning cycle shall include the following dimensions: (a) Information: Our AMA strategic planning process shall be based on information about the environment in which medicine and our AMA must function. Drawing from a variety of sources including public and physician survey data, other types of research findings and data, and the work of our AMA councils, sections, and special groups, the Council on Long Range Planning and Development (CLRPD) shall provide strategic support to our AMA Board by identifying, analyzing, and interpreting environmental trends. The Board of Trustees and the CLRPD shall work collaboratively to distribute information on the environment and our AMA's vision, objectives, and strategies to all the participants in the strategic planning process. (b) Participation: Our AMA strategic planning process should provide for broad participation by the House of Delegates, Councils, Sections, Special Groups, staff, and other appropriate internal and external sources. The Board of Trustees shall provide opportunities for these entities to provide input into the development of our AMA's strategic plan. 2. Our AMA strategic planning process should generate: (a) A multi-year plan that identifies the most critical strategic issues for the organization; (b) The critical success factors for each issue; and (c) Annual work plans with measurable performance objectives, tasks and timelines, assignments for implementation, and expected outcomes. 3. The Board must ensure that adequate resources - staff, funding, and material - are available for developing our AMA strategic plan. 4. The goals of our AMA strategic plan should become an overarching part of all Board and Council meetings. All ongoing initiatives and new undertakings must be regularly measured against the plan, and emerging issues that impact the plan should be identified. 5. The AMA strategic plan will be presented to the HOD in a more visible, proactive, and interactive way. 6. Our AMA Board of Trustees will continue to (a) consider input from the House, CLRPD, and broad physician community when developing the Strategic Plan and making resource allocation decisions; (b) exercise its fiduciary responsibilities with respect to allocating resources appropriately and consistent with the AMA's vision, goals and priorities; and (c) monitor the activity and results	Retain as editorially amended in #7 for accuracy. Still Relevant and Necessary.

		related to commitments established in the planning process. 7. Our AMA will continue to communicate activities, achievements, and opportunity for physician involvement through the Federation, Physician ~~Action~~ Grassroots Network, AMA publications (paper, email, and web-based), and other channels as appropriate.	
H-255.967	Mock Residency Interview Program	Our AMA will promote the AMA-International Medical Graduates Section's Mock Residency Interview Program to any AMA member who is in the process of applying for a medical residency position and as one of the benefits of AMA membership.	Retain. Still Relevant and Necessary
H-40.993	Support of the Civilian-Military Contingency Hospital System	The AMA supports the CMCHS and urges U.S. civilian hospitals, when requested, to provide all possible support to the Department of Defense CMCHS in this important effort which will enable the U.S. to prepare for the treatment of casualties from any future conventional military conflict.	Retain. Still Relevant.
H-475.992	Definitions of "Cosmetic" and "Reconstructive" Surgery	(1) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer.	Retain. Still Relevant.
H-475.983	Definition of Surgery	Our AMA adopts the following definition of 'surgery' from American College of Surgeons Statement ST-11: Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and	Retain. Still Relevant.

		intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel. Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards.	
H-475.988	Laser Surgery	The AMA supports the position that revision, destruction, incision or other structural alteration of human tissue using laser is surgery.	Rescind (duplicative of Policy H-475.983 being recommended for retention).
H-475.984	Office-Based Surgery Regulation	Our AMA supports the following Core Principles on Office-Based Surgery: Core Principle #1: Guidelines or regulations for office-based surgery should be developed by states according to levels of anesthesia defined by the American Society of Anesthesiologists (ASA) excluding local anesthesia or minimal sedation. (American Society of Anesthesiologists. Continuum of depth of sedation. Available at: https://www.asahq.org/standards-and-guidelines/guidelines-for-office-based-anesthesia, https://www.asahq.org/standards-and-guidelines/continuum-of-depth-of-sedation-definition-of-general-anesthesia-and-levels-of-sedationanalgesia ~~http://www.asahq.org/for-members/standards-guidelines-and-statement.aspx. Accessed July 2, 2013)~~. Core Principle #2: Physicians should select patients for office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia by criteria including the ASA Physical Status Classification System and so document. (American Society of Anesthesiologists. ASA physical status classification system. Available at: https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system ~~http://www.asahq.org/for-members/clinical-informaion/asa-physical-status-classification-system.aspx. Accessed July 2, 2013~~). Core Principle #3: Physicians who perform office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have their facilities accredited by The Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), American Osteopathic Association (AOA), or by a state recognized entity, such as the Institute for Medical Quality (IMQ), or be state licensed and/or Medicare certified. Core Principle #4: Physicians	Retain as editorially amended for accuracy. Still relevant.

		performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospital, or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital. Core Principle #5: States should follow the guidelines outlined by the Federation of State Medical Boards (FSMB) regarding informed consent. (Report of the Special Committee on Outpatient [Office-Based] Surgery. ~~(Med. Licensure Discipline. 2002; 88:160-174).~~ Core Principle #6: For office surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, states should consider legally privileged adverse incident reporting requirements as recommended by the FSMB and accompanied by periodic peer review and a program of Continuous Quality Improvement. (Report of the Special Committee on Outpatient (Office-Based) Surgery. ~~Journal Medical Licensure and Discipline. 2002; 88:160-174)~~. Core Principle #7: Physicians performing office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia must obtain and maintain board certification by one of the boards recognized by the American Board of Medical Specialties, American Osteopathic Association, or a board with equivalent standards approved by the state medical board within five years of completing an approved residency training program. The procedure must be one that is generally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care. Core Principle #8: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia may show competency by maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center, for the procedures they perform in the office setting. Alternatively, the governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards. Core Principle #9: For office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, at least one physician who is credentialed or currently recognized as having successfully completed a course in advanced resuscitative techniques (e.g., ATLS, ACLS, or PALS), must be present or immediately available with age- and size-appropriate resuscitative equipment until the patient has met the criteria for discharge from the facility. In addition, other medical personnel with direct patient contact should at a minimum be	

		trained in Basic Life Support (BLS). Core Principle #10: Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have appropriate education and training.	
D-478.977	Exam Room Computing and Patient Physician Interactions	Our AMA will make physicians aware of tips and resources for effectively using computers and electronic health records (EHRs) in patient-physician interactions through AMA publication vehicles, and encourages physicians to incorporate questions regarding use of computers and EHRs in patient-satisfaction surveys to provide feedback on how their own patients experience the use of computers in the examination room.	Sunset. The actions requested have been accomplished. The AMA's STEPS Forward™ practice management tools, found at the AMA Ed Hub™, provide physicians with in-depth CME on acquisition and efficient use of an EHR. Modules include "Electronic Health Record (EHR) Software Selection and Purchase" and "Electronic Health Record Optimization: Strategies for Thriving," which include techniques physicians and office staff can use to "maximize the benefits and minimize the burdens of the EHR." The AMA Ed Hub also includes a substantial selection of EHR case studies. An additional resource is AMA's Taming the EHR Playbook. Policy, H-480.971, commits our AMA to continued work in this area.