AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Report of the Organized Medical Staff Section Reference Committee

Chris Bush, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 5 – No Prior Authorization for Inexpensive Medications

RECOMMENDED FOR ADOPTION AS AMENDED

2. Resolution 6 – Addressing Anti-Physician Contractual Provisions
3. Resolution 7 – Comprehensive AMA Policy Publication Regarding Employed Physicians
4. Resolution 8 – Ensuring Patient Safety and Physician Oversight in the Integration of Hospital Inpatient Virtual Nursing

RECOMMENDED FOR REFERRAL

5. Resolution 1 – Increased Oversight of Private Equity's Involvement in the Healthcare System

RECOMMENDED FOR NOT ADOPTION

6. Resolution 2 – Standardizing Brain Death Policies
7. Resolution 3 – Mobile IV "Services"

RECOMMENDED FOR ADOPTION

(1) RESOLUTION 5 – NO PRIOR AUTHORIZATION FOR INEXPENSIVE MEDICATIONS

RECOMMENDATION A:

Resolution 5 be <u>adopted</u>.

RECOMMENDATION B:

Resolution 5 be <u>held back and forwarded for consideration at the 2025 Interim Meeting</u>.

RESOLVED, that our American Medical Association advocate that low-cost medications and procedures should not require prior authorization (Directive to Take Action).

Your Reference Committee heard strong support for Resolution 5 based largely on the grounds that while the AMA has substantial policy on appropriate use of prior authorization, particularly in relation to procedures or services, existing policy does not explicitly extend to medications. The Committee did consider that in advocating for a kind of threshold whereby prior authorization for some items are specifically prohibited, the AMA could be construed as conceding that prior authorization for others, in this case more expensive medications, is legitimate. The Committee heard convincing testimony refuting this interpretation, arguing that if prior authorization is justified as a method of cost containment, rather than a universal review of medical practice, then its legitimacy is limited only as a financial operation and allowing for exemptions for low-cost items is not the same as endorsing or conceding the need for prior authorization for others.

Your Reference Committee thus recommends that Resolution 5 be adopted. Given that the OMSS has been asked to be judicious about the number of items it forwards to the House of Delegates for Annual 2025 and given that Resolution 5 specifically speaks to advocacy, the Committee additionally recommends holding it back and automatically forwarding it for consideration at Interim 2025.

RECOMMENDED FOR ADOPTION AS AMENDED

(2) RESOLUTION 6 – ADDRESSING ANTI-PHYSICIAN CONTRACTUAL PROVISIONS

RECOMMENDATION A:

The first resolve in Resolution 6 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~advocate for~~ develop model state legislation to prohibit the inclusion of clauses indemnifying employers in physician contracts (Directive to Take Action); and be it further

RECOMMENDATION B:

The second resolve in Resolution 6 be deleted.

~~RESOLVED, that our AMA study the prevalence and impact of contractual provisions which require physicians to (i) pay for tail insurance or (ii) indemnify their employers, and return further recommendations for policy relating to these practices (Directive to Take Action); and be it further~~

RECOMMENDATION C:

Resolution 6 be adopted as amended.

RECOMMENDATION D:

Resolution 6 be immediately forwarded for consideration at the 2025 Annual Meeting of the AMA House of Delegates.

RESOLVED, that our American Medical Association advocate for legislation to prohibit the inclusion of clauses indemnifying employers in physician contracts (Directive to Take Action); and be it further

RESOLVED, that our AMA study the prevalence and impact of contractual provisions which require physicians to (i) pay for tail insurance or (ii) indemnify their employers, and return further recommendations for policy relating to these practices (Directive to Take Action); and be it further

RESOLVED, that our AMA actively work to increase the education and awareness of physicians on the advisability of rejecting employment contracts which require physicians to (i) pay for tail insurance, or (ii) indemnify their employers (Directive to Take Action).

Your Reference Committee heard support for Resolution 6 and agreed that the issue is timely and relevant. The Committee also appreciated that this resolution was developed in cooperation with the Medical Student Section and is hopeful that future collaborations like this will be forthcoming. The Committee would look forward to connecting with the Young Physicians Section and the Resident and Fellow Section to fulfil the needs of the third resolve clause.

The Committee recommends removing the second resolve clause because it believes the first and third are stronger without it. If the AMA is to advocate for prohibition of anti-physician clauses in contracts, doing so while also asking to study the impact of those clauses weakens the organization's resolve in the first case. The Committee believes the AMA can stand on its convictions and that a study, which could potentially raise the fiscal note of the resolution and put it at risk before the House of Delegates, is unnecessary.

Your Reference Committee thus recommends that Resolution 6 be adopted as amended and immediately forwarded for consideration by the House of Delegates at the 2025 Annual Meeting.

(3) RESOLUTION 7 – COMPREHENSIVE AMA PUBLICATION REGARDING EMPLOYED PHYSICIANS

RECOMMENDATION A:

The second resolve in Resolution 7 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, that our AMA ~~include this review in~~ <u>create</u> a comprehensive policy publication, which will be an essential tool for employed physicians with guiding principles, rights, and responsibilities regarding, but not limited to, the following:

- Employment contracting
- Different compensation models
- Professional accountability to, and as a member of, the medical staff
- Primacy of the doctor-patient relationship within the context of employment;

(Directive to Take Action); and be it further

RECOMMENDATION B:

The third resolve in Resolution 7 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, that our AMA ~~will widely distribute this policy publication~~ <u>have a comprehensive policy publication regarding employed physicians available</u> to all physicians,

in any employment model, and to all healthcare collaborators with the AMA who directly employ and/or have contracting arrangements with physicians (Directive to Take Action).

RECOMMENDATION C:

Resolution 7 be <u>adopted as amended</u>.

RECOMMENDATION D:

Resolution 7 be <u>immediately forwarded for consideration at the 2025 Annual Meeting of the AMA House of Delegates.</u>

RESOLVED, that our American Medical Association comprehensively review the current landscape of the employment of physicians for report back to the House of Delegates at Annual 2026, including but not limited to:

1. The changing context and expectations of different practice models
2. Factors which have led to physicians increasingly choosing an employment practice model over independent practice
3. The employed physician relationship with healthcare organizations, including those controlled by private equity
4. The evolution of collective bargaining by, and unionization of, physicians;

(Directive to Take Action); and be it further

RESOLVED, that our AMA include this review in a comprehensive policy publication, which will be an essential tool for employed physicians with guiding principles, rights, and responsibilities regarding, but not limited to, the following:

1. Employment contracting
2. Different compensation models
3. Professional accountability to, and as a member of, the medical staff
4. Primacy of the doctor-patient relationship within the context of employment;

(Directive to Take Action); and be it further

RESOLVED, that our AMA will widely distribute this policy publication to all physicians, in any employment model, and to all healthcare collaborators with the AMA who directly employ and/or have contracting arrangements with physicians (Directive to Take Action).

Your Reference Committee heard testimony in support of Resolution 7 with several members stating that having such a document as recommended by the resolution at the start of their career would have been helpful. The Committee found itself in complete agreement that the development and sharing of such a resource would undoubtedly be beneficial. The Committee's recommendations are largely editorial and done to ensure that each resolve clause stands independently. The only significant change the Committee identified was to pare back the final resolve slights so that the AMA would be tasked merely with creating a publication and making it available, not proactively disseminating it. This change was done solely to keep the fiscal note for the resolution lower with an understanding that a dissemination campaign would potentially be cost-prohibitive. Your Reference Committee thus recommends that Resolution 7 be adopted

as amended and immediately forwarded to the House of Delegates at the 2025 Annual Meeting.

(4) RESOLUTION 8 – ENSURING PATIENT SAFETY AND PHYSICIAN OVERSIGHT IN THE INTEGRATION OF HOSPITAL INPATIENT VIRTUAL NURSING

RECOMMENDATION A:

The first resolve in Resolution 8 be amended by addition and deletion to read as follows:

RESOLVED, that our ~~American Medical Association~~ AMA recognizes that organized medical staffs, as leaders in hospital medicine who have a duty to protect patient safety within their institutions, should work collaboratively to ~~integrate inpatient virtual nursing in a way that supports~~ ensure physician-led, high-quality, patient-centered care in the integration of inpatient virtual nursing (New HOD Policy).~~; and be it further~~

RECOMMENDATION B:

The second resolve in Resolution 8 be deleted.

~~RESOLVED, that our AMA undertake a comprehensive study of hospital inpatient virtual nursing, including an assessment of its benefits and risks for patient safety and an analysis of guidelines for credentialing, privileging, and documentation standards and any policy gaps related to oversight by the Centers for Medicare & Medicaid Services and The Joint Commission (Directive to Take Action); and be it further~~

RECOMMENDATION C:

The third resolve in Resolution 8 be deleted.

~~RESOLVED, that our AMA engage relevant stakeholders—including nursing organizations, hospital systems, accrediting bodies, and federal agencies—to promote policies that ensure hospital inpatient virtual nursing models are implemented with clear roles, physician collaboration, and protections for patient safety and quality of care (Directive to Take Action).~~

RECOMMENDATION D:

A new resolve in Resolution 8 be inserted before the first resolve to read as follows:

RESOLVED, that our American Medical Association undertake a comprehensive study of hospital inpatient virtual nursing, including an assessment of its benefits and risks for patient safety and an analysis of guidelines for credentialing, privileging, and documentation standards and any policy gaps related to oversight by the Centers for Medicare & Medicaid Services and The Joint Commission (Directive to Take Action); and be it further

RECOMMENDATION E:

Resolution 4 be adopted as amended.

RECOMMENDATION F:

Resolution 8 be immediately forwarded for consideration at the 2025 Annual Meeting of the AMA House of Delegates.

RESOLVED, that our American Medical Association recognizes that organized medical staffs, as leaders in hospital medicine who have a duty to protect patient safety within their institutions, should work collaboratively to integrate inpatient virtual nursing in a way that supports physician-led, high-quality, patient-centered care (New HOD Policy); and be it further

RESOLVED, that that our AMA undertake a comprehensive study of hospital inpatient virtual nursing, including an assessment of its benefits and risks for patient safety and an analysis of guidelines for credentialing, privileging, and documentation standards and any policy gaps related to oversight by the Centers for Medicare & Medicaid Services and The Joint Commission (Directive to Take Action); and be it further

RESOLVED, that our AMA engage relevant stakeholders—including nursing organizations, hospital systems, accrediting bodies, and federal agencies—to promote policies that ensure hospital inpatient virtual nursing models are implemented with clear roles, physician collaboration, and protections for patient safety and quality of care (Directive to Take Action).

Your Reference Committee heard collective support for Resolution 8 and found itself in agreement with the testimony heard, though it did question the need for a study. As with other resolutions, the Committee found that calling for a study that would examine the implications of virtual nursing after asserting the responsibilities of the medical staff work collaboratively with virtual nursing weakened the resolution's own argument. The Committee believes switching the order of the two resolve clauses, such that the call for a study is first and is supported by the assertion of medical staff responsibilities, makes more sense. The Committee considered also that the third resolve was likely unnecessary and could add to the potentially significant cost of a study, possibly putting the outcome of Resolution 8 in doubt. The Committee believed reordering the resolve

clauses with minor edits to put the emphasis on physician-led leadership while working collaboratively and removing the final resolve would strengthen the resolution while keeping a mindful eye on cost.

Your Reference Committee thus recommends that Resolution 8 be adopted as amended and immediately forwarded to the House of Delegates at the 2025 Annual Meeting.

RECOMMENDED FOR REFERRAL

(5) RESOLUTION 1 – INCREASED OVERSIGHT OF PRIVATE EQUITY'S INVOLVEMENT IN THE HEALTHCARE SYSTEM

RECOMMENDATION:

Resolution 1 be referred .

RESOLVED, that our American Medical Association support efforts that all healthcare adhere to evidence-based quality of care and outcomes assessments, regardless of administrative structure of the healthcare providing organization, including but not limited to those controlled by agents of private equity, and will advocate for revision of law or regulation to assure that principle is upheld (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the model of physician-led healthcare teams, requiring active physician engagement even when non-physician practitioners are involved, in healthcare providing organizations, including but not limited to those controlled by agents of private equity, and will advocate for revision of law or regulation to assure that principle is upheld (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that a majority of voting members of hospital key committees and the leadership of said committees be reserved for physicians whose income is less than 50 percent derived from the hospital or parent organization or via groups under contract to them (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for nationwide expansion of oversight and monitoring of private equity firms' involvement in healthcare delivery, both direct and indirect, in order to minimize healthcare facilities' reduction of services and/or closure and to enhance public transparency of their operations (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that there should be mechanisms in place to prevent any untoward influences, such as peer review abuse or uninvited intrusion into medical staff meetings, from private equity or other corporate entities on medical staffs and medical staff committees (Directive to Take Action).

Your Reference Committee heard testimony agreeing in concept with Resolution 1, however questioning some of the resolve clauses. One testimony raised concern that inviting further governmental regulation or legislation on the practice of medicine could potentially backfire and may run contrary to the AMA's historical stance of doing its best to keep lawmakers away from decisions made between physicians and their patients.

The Committee also considered additional testimony around the third resolve clause pertaining to maintaining a majority of voting members of hospital committees among physicians whose income is less than 50 percent derived from the hospital. Testimony from physicians practicing in rural areas pointed out that such a provision would likely be impossible for them to meet given the makeup of the medical staff and the number who

derive income sourced from outside industries unrelated to private equity or corporate ownership of medical practices.

The Committee wondered to what extent current reports from AMA Councils and the Board introduced at A-25 (or anticipated at I-25) would cover some of the provisions offered in Resolution 1. The Council on Medical Education Report 03 speaks specifically to the corporate practice of ownership and the Committee noted that other reports on private equity are forthcoming. The Committee also felt the resolution could benefit from input from the Employed Physician Caucus, as its members would presumably be the first to feel many of these effects and would have a perspective on them.

Your Reference Committee thus recommends that Resolution 1 be referred to the OMSS Governing Council for further consideration and consultation with the Employed Physician Caucus, the Council on Medical Education, and any other relevant bodies within the AMA and make a recommendation back to the Section.

RECOMMENDED FOR NOT ADOPTION

(6) RESOLUTION 2 – STANDARDIZING BRAIN DEATH POLICIES

RECOMMENDATION:

Resolution 2 be <u>not adopted</u>.

RESOLVED, that our American Medical Association lead an effort in collaboration with appropriate stakeholders including medical, legal, and patient representations to identify 'accepted medical standards,' as required by the Uniform Determination of Death Act (UDDA) to determine brain death/death by neurologic criteria (BD/DNC), that can be followed throughout the United States (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate to the Centers for Medicare and Medicaid Services (CMS) and other relevant federal agencies to designate the most recent brain death/death by neurologic criteria (BD/DNC) consensus practice guidelines published in 2023 by the American Academy of Neurology, American Academy of Pediatrics, Child Neurology Society, and Society of Critical Care Medicine and its successor consensus guidelines as the accepted medical standard for the determination of death by neurologic criteria and thereby establish a national standard (Directive to Take Action); and be it further

RESOLVED, that our AMA acknowledges the most recent brain death/death by neurologic criteria (BD/DNC) consensus practice guidelines published in 2023 by the American Academy of Neurology, American Academy of Pediatrics, Child Neurology Society, and Society of Critical Care Medicine and its successor consensus guidelines as the accepted medical standard for the determination of death by neurologic criteria (New HOD Policy).

Your Reference Committee heard testimony universally supportive of Resolution 2. The Committee shared the perspective that a cleaner understanding of brain death policy could aid physicians in their treatment and care of patients. After discussion, however, the Committee ultimately concluded that it would likely be extremely difficult to achieve Resolution 2's goals because enforcing a nationwide policy would run counter to each state's legal ability to make its own determinations about care. The Committee questioned whether the AMA should push against those legal standards which could set a precedent for other standards further down the road.

The Committee also questioned whether a nationwide determination of this kind would be appropriate coming from the AMA, believing that such determinations should be made by specialty societies who are closer to their unique field of medicine. The Committee considered that the American Academy of Neurology, the American Academy of Pediatrics, the Child Neurology Society, and the Society of Critical Care Medicine have already considered the question of whether a national standard for brain death should be created and opted rather to create guidelines instead of standards. The Committee interpreted this choice as an acknowledgement that nationwide standards were in some way untenable for the experts in the field. Your Reference Committee thus recommends that Resolution 2 be not adopted.

(7) RESOLUTION 3 – MOBILE IV "SERVICES"

RECOMMENDATION:

Resolution 3 be <u>not adopted</u>.

RESOLVED, that our American Medical Association study the business model of mobile IV services with an eye on safety, costs, risks, dangers, and oversight and report back on its findings at the 2026 Annual Meeting (Directive to Take Action).

Your Reference Committee heard testimony supportive of Resolution 3. There was near universal consensus that mobile intravenous services have a role in modern healthcare delivery, particularly for services such as home infusion therapy, insertion of PICC lines, or broader hospital at home practices. The Committee shared the concerns raised by some testimony that the services described in Resolution 3 could easily operate without good intent or without proper consideration of the needs of patient safety and continuity of care. The Committee questioned the need for a study of the business practices of these services, however, believing the business practices of these services is likely secondary to ensuring their operations are not actively harmful or dangerous. This led the Committee to consider what AMA policy already exists relating to mobile intravenous services.

The Committee considered that the two AMA policies cited by Resolution 3, D-480.972 "Guidelines for Mobile Medical Applications and Devices" and H-480.943 "Integration of Mobile Health Applications and Devices into Practice" cover some of the concerns about mobile services raised by the resolution. In particular, these two policies speak to the support the AMA maintains for mobile devices and services as legitimate forms of treatment, but the need to establish appropriate guidelines and standards for their use. The Committee considered, however, that mobile services like the IV services Resolution 3 speaks to are not the same as devices or applications. In fact, the Committee believes that the questions raised by Resolution 3 are more closely related to scope of practice standards and that mobile intravenous services should be understood as being closer to retail operations than mobile applications.

With that perspective, the Committee looked to Policy H-160.921 "Retail Clinics," which sets principles for any individual, company, or other entity that establishes and/operates retail clinics. The policy states that such clinics must:

- Have a well-defined and limited scope of clinical services consistent with state scope of practice laws;
- Use standardized medical protocols derived from evidence-based practice guidelines to ensure safety and quality of care;
- Establish arrangements by which their healthcare practitioners have direct access to and supervision by a licensed physician;
- Establish protocols for ensuring continuity of care with local physicians;
- Establish a referral system with physician practices for appropriate treatment if a patient's condition is beyond the scope of services of the clinic;

- Clearly inform patients of the qualifications of the healthcare practitioners providing care including the limitations of illnesses that can be diagnosed and treated;
- Establish appropriate sanitation and hygienic guidelines to ensure patient safety;
- Encourage the use of electronic health records as a means of communicating patient information and facilitating continuity of care; and
- Encourage patients to establish care with primary care physician to ensure continuity of care.

Additionally, the policy directs the AMA to monitor the effects of these clinics and continue to report back on them to the House of Delegates.

In considering each of these established AMA policies, the Committee believes that Resolution 3's goals have likely been met and further study is unlikely to glean new perspectives. The Committee considered amending the resolution to change existing AMA policy to add mobile services into the established policies above, however stopped short of making this recommendation as it did not want to do so without consulting more directly with the author. The Committee noted it would eagerly welcome the opportunity to work directly with the author to explore a more direct approach to achieving the resolution's goals, possibly with an eye to resubmitting the resolution at a future meeting.

Your Reference Committee believes that reaffirming AMA policies D-480.972, H-480.943, and H-160.921 in lieu of Resolution 3 is the most appropriate action, unfortunately Sections lack the ability to reaffirm AMA policy. Your Reference Committee thus recommends that Resolution 3 be not adopted, however it welcomes a revisiting of these policies and exploration of methods for strengthening them.

Doctor Chair, this concludes the report of the Organized Medical Staff Section Reference Committee. We would like to thank Drs. Maryann Bombaugh, Thomas Madejski, Nancy Mueller, and Heather Smith as well as all those who testified before the Committee.

Chris Bush, MD
Co-Chair, OMSS Reference Committee

Maryann Bombaugh, MD

Thomas Madejski, MD

Nancy Mueller, MD

Heather Smith, MD