INTEGRATED PHYSICIAN PRACTICE SECTION
Governing Council Report A
Interim 2022 Meeting

Access full text of resolutions/reports in the HOD meeting handbook.

Recommendations Key

Instructions for the delegate and alternate delegate are designated as follows:

- *Strongly support* – the delegate/alternate delegate shall support the resolution as written and actively speak in favor of the resolution
- *Support* – the delegate/alternate delegate shall support the resolution as written
- *Listen* – the delegate/alternate delegate is not instructed to take any action, however, may if they believe it is in the best interest of the PPPS
- *Refer* – the delegate/alternate delegate shall move to refer (the item goes to a Council) or refer for decision (item goes to the Board)
- *Amend* – the delegate/alternate delegate shall move to amend the resolution in the manner prescribed in Report A
- *Oppose* – the delegate/alternate delegate shall oppose the resolution as written
- *Strongly oppose* – the delegate/alternate delegate shall oppose the resolution as written and actively speak in opposition of the resolution

Some items may contain specific instructions not included among those listed above. In such cases, instructions to the delegate/alternate delegate are described in detail alongside the item of business.

Item #	Ref Com	Title and Sponsor(s)	Proposed Policy	Governing Council Recommendation
1	CCB	Res. 009 – Medical Decision-Making Autonomy of the Attending Physician (Mississippi)	RESOLVED, That our American Medical Association advocate that no matter what may change in regard to a physician's employment or job status, that there is a sacred relationship between an attending physician and his/her patient that leads the patient's attending physician to hold the ultimate authority in the medical decision-making that affects that patient, and be it further RESOLVED, That our AMA advocate strongly that if there is a unique circumstance that puts the attending physician's care into question by a hospital administrator of any sort such as listed above but certainly not limited to that list– physician or not- in the event of a disagreement between an administrator and the attending physician regarding a decision one would call a mere judgment call, the onus would be on the administrator to prove to an ethics committee why the attending physician is wrong prior to anyone having the authority to overturn or overrule the order of the physician attending the patient directly (Directive to Take Action); and be it further RESOLVED, That our AMA reaffirm that the responsibility for the care of the individual patient lies with a prudent and responsible attending physician, and that his/her decisions should not easily be overturned unless there has been an	Delegate instructed to listen to testimony and act in the best interest of the IPPS. Rationale The IPPS Governing Council (GC) had concerns about attending physicians having the authority to override - in any circumstance - the authority of physicians in clinical leadership positions such as i.e.,CMO, CCO, etc..

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			egregious and dangerous judgment error made, and this would still call for an ethics committee consult in that instance (Reaffirm HOD Policy); and be it further RESOLVED, That our AMA aggressively pursue any encroachment of administrators upon the medical decision making of attending physicians that is not in the best interest of patients as strongly as possible, for there is no more sacred relationship than that of a doctor and his/her patient, and as listed above, first, we do no harm. (Directive to Take Action)	
2	B	Res 205 – Waiver of Due Process Clauses (Missouri)	RESOLVED, That our American Medical Association support legislation that bans the use of "Waiver of Due Process" provisions within employment contracts and declares such current provisions to be declared void. (New HOD Policy)	Delegate instructed to support.
3	C	CME 01 – The Impact of Private Equity on Medical Training	The Council on Medical Education therefore recommends that the following recommendations be adopted, and the remainder of this report be filed. That our AMA: 1. Affirm that an institution or medical education training program academic mission should not be compromised by a clinical training site's fiduciary responsibilities to an external corporate or for-profit entity. (New HOD Policy) 2. Encourage GME training institutions, programs, and relevant stakeholders to: a. demonstrate transparency on mergers and closures, especially as it relates to private equity acquisition of GME programs and institutions, and demonstrate institutional accountability to their trainees by making this information available to current and prospective trainees; b. uphold comprehensive policies which protect trainees, including those who are not funded by Medicare dollars, to ensure the obligatory transfer of funds after institution closure; c. empower designated institutional officials (DIOs) to be involved in institutional decision-making to advance such transparency	Delegate instructed to support.

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			and accountability in protection of their residents, fellows, and physician faculty; d. develop educational materials that can help trainees better understand the business of medicine, especially at the practice, institution, and corporate levels; e. develop policies highlighting the procedures and responsibilities of sponsoring institutions regarding the unanticipated catastrophic loss of faculty or clinical training sites and make these policies available to current and prospective GME learners. (Directive to Take Action) 3. Encourage necessary changes in Public Service Loan Forgiveness Program (PSLF) to allow medical students and physicians to enroll in the program even if they receive some or all of their training at a for-profit or governmental institution. (Directive to Take Action) 4. Support publicly funded independent research on the impact that private equity has on graduate medical education. (New HOD Policy) 5. Encourage physician associations, boards, and societies to draft policy or release their own issue statements on private equity to heighten awareness among the physician community. (Directive to Take Action) 6. Encourage physicians who are contemplating corporate investor partnerships to consider the ongoing education and welfare for trainee physicians who train under physicians in that practice, including the financial implications of existing funding that is used to support that training. (Directive to Take Action) 7. Amend Policy D-310.948 “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure” by addition to read as follows: Our AMA: (6) will continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by corporate and nonprofit entities and their effect on medical education. (Modify HOD Policy) 8. Reaffirm the following policies:	

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			• H-310.904 "Graduate Medical Education and the Corporate Practice of Medicine" • H-310.943 "Closing of Residency Programs" • H-310.929 "Principles for Graduate Medical Education" • H-215.981 "Corporate Practice of Medicine" (Reaffirm HOD policy) Rescind AMA Policy D-310.947 as having been accomplished by this report. (Rescind HOD policy)	
4	C	Res. 308 - Paid Family/Medical Leave in Medicine (American College of Radiology, American Academy of Pediatrics, Maryland, Radiological Society of North America, Society of Interventional Radiology, American Society for Radiation Oncology, American Institute of Ultrasound in Oncology, Association of University Radiologists, American College of Nuclear Medicine, American Society of Neuroradiology, Society of Nuclear Medicine and Molecular Imaging, Connecticut, Maine, Massachusetts, New	RESOLVED, That our American Medical Association policy H-405.960 "Policies for Parental Family and Medical Necessity Leave" be amended by addition and deletion to read as follows: AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians: 1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement. 2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption. 3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave	Delegate instructed to listen to testimony and act in the best interest of the IPPS. Rationale The GC had concerns that in small groups and private practice, the requirement to offer a 12-week paid leave could have devastating financial impacts on lean practices.

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		Hampshire, Rhode Island, Vermont)	for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status. 4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental, family, and medical necessity leave policies a ~~six~~ twelve-week minimum leave allowance, with the understanding that no ~~parent~~ individual should be required to take a minimum leave. 5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed. ~~5~~6. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave. ~~6~~7. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons. ~~7~~8. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick	

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			leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling. ~~8~~9. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity. ~~9~~10. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs. ~~10~~11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status. ~~11~~12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility. ~~12~~13. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.	

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			~~13~~14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year. ~~14~~15. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship. (Modify Current HOD Policy)	
5	F	BOT 09 – Employed Physicians	1. That our AMA adopt the following definition of "employed physician": An employed physician is any non-resident, non-fellow physician who maintains a contractual relationship to provide medical services with an entity from which the physician receives a W-2 to report their income, and in which the physician does not have a controlling interest, either individually or as part of a collective. (New HOD Policy) 2. That our AMA re-examine the definition and representation of employed physicians within the organization and report back at the 2024 Annual Meeting. (Directive to Take Action)	Delegate instructed to strike first resolve, amend second resolve as listed here. Alternately, Delegate instructed to seek referral if amendments are not possible. Rationale The GC felt the proposed definition of "employed physicians needs more work, with the possible deletion of "receives a W-2," etc.
6	J	CMS 02 – Corporate Practice of Medicine	The Council on Medical Service recommends that the following be adopted in lieu of Resolution 721-A-22, and the remainder of the report be filed: 1. That our American Medical Association (AMA) acknowledge that the corporate practice of medicine has the potential to erode the patient-physician relationship. (New HOD Policy)	Delegate instructed to engage via HOD Online Forum to clarify proposed item "j." Rationale The GC had concerns

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			2. That our AMA acknowledge that the corporate practice of medicine may create a conflict of interest between profit and best practices in residency and fellowship training. (New HOD Policy) 3. That our AMA amend Policy H-160.891 by addition of two new clauses, as follows: j. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including the use of mandated patient care algorithms or supervision of non-physician practitioners. k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate and graduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as educational and disciplinary issues related to these programs. (Modify Current HOD Policy)	about the 3.j. which gives any individual physician ultimate decision authority. That approach is contrary to the dynamic of team-based care. The GC is also concerned about giving individual physicians authority to override a patient care algorithm which many physician-led integrated systems work hard to develop for the benefit of quality of care.
7	J	Res. 803 – Patient Centered Medical Home – Administrative Burdens (New York)	RESOLVED, That our American Medical Association seek regulations which would reduce the increasing strain that Patient Centered Medical Home (PCMH) metrics are placing on physicians and patient care. (Directive to Take Action)	Delegate instructed to support.
8	J	Res. 804 – Centers for Medicare & Medicaid Innovation Projects (New York)	RESOLVED, That our American Medical Association advocate against mandatory participation in Centers for Medicare and Medicaid Innovation (CMMI) demonstration projects, and advocate for CMMI instead to focus on the development of voluntary pilot projects (Directive to Take Action); and be it further	Delegate instructed to strongly oppose second resolve. Rationale The GC supports the original intent of CMMI

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			RESOLVED, That our AMA advocate to ensure that any CMMI project that requires physician and/or patient participation be required to be approved by Congress. (Directive to Take Action)	to be unencumbered from Congressional oversight.
9	K	Res. 933 - Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV (Medical Student Section)	RESOLVED, That our American Medical Association amend Policy H-20.895 "Pre-Exposure Prophylaxis (PrEP) for HIV" by addition to read as follows: Pre-Exposure Prophylaxis (PrEP) for HIV, H-20.895 1. Our AMA will educate physicians, physicians-in-training, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines. 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances. 3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant. 4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use. <u>5. Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling, regardless of a patient's current reported sexual behaviors.</u> (Modify Current HOD Policy)	Delegate instructed to support.