Your Reference Committee recommends the following consent calendar for acceptance:

**RECOMMENDED FOR ADOPTION**

1. OMSS GC Report B – Continuity of Medical Staff Leadership Following Termination of an Employment Agreement
2. OMSS GC Report C – Advocacy Education Towards a Sustainable Medical System
3. Resolution 5 – Revisiting Medical Staff and Hospital Engagement of Community Physicians

**RECOMMENDED FOR ADOPTION AS AMENDED**

4. Resolution 1 – Deceptive Hospital Badging 2.0
5. Resolution 6 – The Employee Retirement Income Security Act (ERISA) of 1974 Revisited

**RECOMMENDED FOR ADOPTION IN LIEU OF**

6. Resolution 3 – Acquisition and Consolidation by Private Equity/Hedge Funds Into the Practice of Medicine
   Resolution 4 – The Corporate Practice of Medicine, Revisited
7. Resolution 7 – Passage of the Facilitating Innovative Nuclear Diagnostics (FIND) Act

**RECOMMENDED FOR REFERRAL**

RECOMMENDED FOR ADOPTION

(1) OMSS GC REPORT B – CONTINUITY OF MEDICAL
STAFF LEADERSHIP FOLLOWING TERMINATION OF
AN EMPLOYMENT AGREEMENT

RECOMMENDATION:

The recommendations in OMSS GC Report B be
adopted and the remainder of the report be filed.

RECOMMENDATION

The OMSS Governing Council recommends that the following be adopted in lieu of
Resolution 1-A-23, and that the remainder of this report be filed:

1. That the Organized Medical Staff Section seek to update the AMA Physician’s Guide
to Medical Staff Organization Bylaws to further enumerate and describe the
protections afforded to employed physicians as medical staff members.

2. That the Organized Medical Staff Section seek to update the AMA Physician’s Guide
to Medical Staff Organization Bylaws to provide additional guidance and protections
for the medical staff in situations in which a medical staff leader’s employment contract
is terminated, not renewed, or altered.

Your Reference Committee heard universal support for OMSS GC Report B including
from the Online Forum. The Committee agreed that the issue was as yet unresolved and
could easily imagine a situation where the leadership status of a member of the medical
staff could suddenly change by virtue of a change in contracting, such as a hospital’s
administration opting to contract with a new specialty provider group and cancelling or
not renewing a previous contract. The Committee found the report raised a relevant
question that should be addressed in the AMA’s organized medical staff bylaws
materials.

(2) OMSS GC REPORT C – ADVOCACY EDUCATION
TOWARDS A SUSTAINABLE MEDICAL SYSTEM

RECOMMENDATION A:

The recommendation in OMSS GC Report C be adopted
and the remainder of the report be filed.

RECOMMENDATION B:

The recommendation in OMSS Report C be immediately
forwarded for consideration at the 2023 Interim Meeting
of the AMA House of Delegates.
RECOMMENDATION

The OMSS Governing Council recommends that the following be adopted in lieu of Resolution 7-A-23, and that the remainder of this report be filed:

1. That our American Medical Association explore innovative opportunities for engaging the public in advocacy on behalf of an improved healthcare environment.

Your Reference Committee heard universal support for OMSS GC Report C in the Online Forum and amongst itself. The Committee appreciates the wide and varied efforts of the American Medical Association to think carefully about how best to include advocacy for the practice of medicine and public health into the skills that physicians regularly demonstrate in their jobs. The Committee agreed that incorporating the public into these plans and strategies is likely to yield beneficial results.

(3) RESOLUTION 5 – REVISITING MEDICAL STAFF AND HOSPITAL ENGAGEMENT OF COMMUNITY PHYSICIANS

RECOMMENDATION:

Resolution 5 be adopted.

Resolved, That the Governing Council of our Organized Medical Staff Section revise, update and expand GC report B-I-13, “Medical Staff and Hospital Engagement of Community Physicians,” from both the perspective of engagement in medical staff affairs and clinical engagement of the community physician (Directive to Take Action).

Your Reference Committee heard general support for updating GC report B-I-13 from the Online Forum. In particular, the Committee heard suggestions that revisions to the original report, now 10 years old, could include an examination of how best to incorporate medical staff in hospital affairs, particularly as independent physicians may find themselves assigned to call either at odd hours or not at all or compensated differently for their time relatively to other physicians. Other testimony reflected a desire to see a revised report consider the role and growth of non-physician practitioners and suggestions for better recruitment of office-based physicians into staff committees and governing boards.

The Committee also appreciates that this subject will be the focus of at least one educational session during the OMSS's 2023 Interim Business Meeting and believes that a future report would present an elegant method for ensuring that any discussion or conclusions offered during that session could be built upon and brought to fruition.
RECOMMENDED FOR ADOPTION AS AMENDED

(4) RESOLUTION 1 – DECEPTIVE HOSPITAL BADGING 2.0

RECOMMENDATION A:

The first resolve in Resolution 1 be amended by addition and deletion to read as follows:

Resolved, That our American Medical Association take on this three-fold task of putting forth a promote and prioritize public awareness campaign to teach the public of the difference and importance of having proper leveling of training and truthful clear identification and labeling of caregivers, so that they are aware of the level of training and expertise of those rendering their care and who oversee their care as that relates to quality and safety of health care (Directive to Take Action); and be it further

RECOMMENDATION B:

The second resolve in Resolution 1 be amended by addition and deletion to read as follows:

Resolved, That physicians be made aware of our AMA’s work with state and county medical societies to highlight to physicians the growing practice by hospitals to create of creating false equivalencies between physicians and non-physicians in the healthcare team members, in the hope that they can organize and push back on this practice and encourage action in local institutions to assure the quality and safety of patient care (Directive to Take Action).

RECOMMENDATION C:

Resolution 1 be adopted as amended.

RECOMMENDATION D:

Resolution 1 be immediately forwarded for consideration at the 2023 Interim Meeting of the AMA House of Delegates.

Resolved, That our American Medical Association take on this three-fold task of putting forth a public awareness campaign to teach the public of the difference and importance of having proper leveling of training and truthful labeling of caregivers, so that they are aware of the level of training and expertise of those rendering their care and who oversee their care (Directive to Take Action); and be it further
Resolved, That physicians be made aware of the growing practice by hospitals to create false equivalencies in the care team members, in the hope that they can organize and push back on this practice (Directive to Take Action).

Your Reference Committee heard strong support for Resolution 1 with many members reflecting not only the need for better protections and policies around identification, but several others reflecting that some of these changes had been made in their facilities or their home states with generally good results.

Some testimony pointed out that the AMA already has a robust body of policy surrounding proper identification, badging, and accreditation. Typically such a body of existing policy could lead to reaffirmation, however the Committee believed that because Resolution 1 has a focused call for action, namely an awareness campaign, rather than new HOD policy, the issue would be both novel enough to warrant consideration and germane to the Interim Meeting’s goals of addressing advocacy issues.

The Committee also considered that enactment of Resolution 1 would likely come with a fiscal cost, given its call for public awareness and a campaign to help achieve its goals that would account for some measure of investment by the AMA. Despite this potentially significant cost, the Committee believed that the results for such engagement would be beneficial not only for physicians but for patients and general public health as well, making the cost worthwhile.

(5) RESOLUTION 6 – THE EMPLOYMENT RETIREMENT INCOME SECURITY ACT (ERISA) OF 1974 REVISITED

RECOMMENDATION A:

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

Resolved, That our American Medical Association study the implication of the Supreme Court decision in Rutledge v. PCMA, and any other relevant legal decisions of the last several years, as well as the contemporary political temperament, in reference to potentially allowing more successful challenges to the actions of healthcare plans protected by the Employee Retirement Income Security Act of 1974 when the quality of care or healthcare outcomes are questioned, reporting back to the House of Delegates by I-24 (Directive to Take Action), and be it further

RECOMMENDATION B:

The second resolve in Resolution 6 be deleted.

Resolved, That our AMA review the contemporary political temperament and consider renewing efforts to amend The Employee Retirement Income Security Act of 1974 to allow
for more patient rights in actions to redress adverse healthcare decisions, including allowing states more rights to regulate employer-sponsored health plans currently shielded by ERISA (Directive to Take Action).

RECOMMENDATION C:

Resolution 6 be adopted as amended.

RECOMMENDATION D:

Resolution 6 be immediately forwarded for consideration at the 2023 Interim Meeting of the AMA House of Delegates.

Resolved, That our American Medical Association study the implication of the Supreme Court decision in Rutledge v. PCMA, and any other relevant legal decisions of the last several years, in reference to potentially allowing more successful challenges to the actions of healthcare plans protected by the Employee Retirement Income Security Act of 1974 when the quality of care or healthcare outcomes are questioned, reporting back to the House of Delegates by I-24 (Directive to Take Action); and be it further resolved, That our AMA review the contemporary political temperament and consider renewing efforts to amend The Employee Retirement Income Security Act of 1974 to allow for more patient rights in actions to redress adverse healthcare decisions, including allowing states more rights to regulate employer-sponsored health plans currently shielded by ERISA (Directive to Take Action).

Your Reference Committee heard slightly mixed testimony in response to Resolution 6. Generally, testimony supported the resolution in concept, particularly agreeing that private payers have slowly encroached on coverage decisions in a significantly cumulative way since the 1970s when ERISA was codified into law. A general agreement, both from online testimony and from Committee members, was that allowing payers to effectively make approvals or denials of care is unacceptable.

ERISA, for better or worse, is one of the central legs of United States health insurance law with wide-reaching implications for any kind of alteration. Additionally, interpretation of holdings from the United States Supreme Court, as well as any other court, is outside the expertise of most AMA members and contains nuance that may not be otherwise appreciated.

The Committee also wondered about the practicality of putting such a foundational law into the AMA’s sights. With the bulk of AMA advocacy resources being dedicated to advancement of the priorities under the AMA Recovery Plan, the Committee wondered if incorporating new interpretations of standing law could reasonably be folded into that plan or considered alongside it. The Committee worried additionally that despite highlighting a recent legal development, the resolution could be considered for reaffirmation just by its nature.
Despite these issues, however, the Committee appreciated that Resolution 6’s primary ask was, to the Committee’s mind, a careful investigation of possibilities, rather than a direct call to new action. The Committee considered that in order to determine a course of action that could theoretically be predicated on a US Supreme Court holding that could be understood to crack open existing foundational law, that action would be best served by a thorough understanding of what has changed and what has not. In that sense, the Committee believed that combining the two resolve clauses, which independently asked for a study of the implication of the Supreme Court holding and review of the current political climate, presumably with an eye toward identifying potential courses of action arising from the Court’s holding, into one clause that would incorporate a more holistic view of the state of play would not only improve the resolution’s prospects for avoiding reaffirmation but also set the AMA on a workable pathway toward determining a reasonable outcome.
RECOMMENDED FOR ADOPTION IN LIEU OF

(6) RESOLUTION 3 – ACQUISITION AND CONSOLIDATION
BY PRIVATE EQUITY/HEDGE FUNDS INTO THE
PRACTICE OF MEDICINE

RESOLUTION 4 – THE CORPORATE PRACTICE OF MEDICINE, REVISTED

RECOMMENDATION A:

Resolution 4 be adopted in lieu of Resolution 3.

Resolved, That our American Medical Association revisit the concept of restrictions on the corporate practice of medicine, including private equities, review existing state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report to our House of Delegates by Annual 2024 that will inform advocacy to protect the autonomy of physician-directed care and access of the public to quality healthcare, while containing healthcare costs (Directive to Take Action).

RECOMMENDATION B:

Resolution 4 be immediately forwarded for consideration at the 2023 Interim Meeting of the AMA House of Delegates.

Resolution 3 – Acquisition and Consolidation by Private Equity/Hedge Funds Into the Practice of Medicine
Resolved, That our American Medical Association open a deep investigation into the current status of such consolidations, with an eye on informing physicians, whether employed or of private practice, of the ramifications of this pattern (Directive to Take Action); and be it further

Resolved, That the ongoing monitoring of this practice keep apace of the impacts on the practice of medicine, at all levels including on a national level (Directive to Take Action); and be it further

Resolved, That consideration be given to proposing regulations and/or other restrictions as deemed appropriate to combat this new intrusion and disempowerment of physicians (Directive to Take Action).

Resolution 4 – The Corporate Practice of Medicine, Revisited
Resolved, That our American Medical Association revisit the concept of restrictions on the corporate practice of medicine, including private equities, review existing state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report to our House of Delegates by Annual 2024 that will inform advocacy to protect the
autonomy of physician-directed care and access of the public to quality healthcare, while
containing healthcare costs (Directive to Take Action).

Your Reference Committee heard testimony supporting both Resolution 3 and
Resolution 4 with several members recommending combining the two resolutions. The
Committee universally agreed that both resolutions had merit and that the issue was
worth taking up, even knowing that there already exists robust policy on the subject of
corporate practice of medicine and the encroachment of private equity into the
healthcare sector.

The Committee considered that the likely most advantageous pathway for addressing
the need for a more thorough understanding of the penetration of private equity or other
forms of corporate ownership into healthcare practice would be to advance Resolution 4
in lieu of Resolution 3. As written, Resolution 4 provides instructions for a report,
components the report should consider, and a deadline for reporting back. The
Committee also believes that Resolution 4’s resolve clause would gather more support
than Resolution 3’s clauses under the House of Delegate’s requirement that Interim
Meeting resolutions be advocacy-related.

(7) RESOLUTION 7 – PASSAGE OF THE FACILITATING
INNOVATIVE NUCLEAR DIAGNOSTICS (FIND) ACT

RECOMMENDATION A:

That Alternate Resolution 7 be adopted in lieu of
Resolution 7:

FACILITATING APPROPRIATE REIMBURSEMENT OF DIAGNOSTIC
RADIOPHARMACEUTICALS

Resolved, That our American Medical Association advocate
with Congress and with the Centers for Medicare and
Medicaid Services to change the categorization of
diagnostic radiopharmaceuticals by the Hospital Outpatient
Prospective Payment System from “supplies” to correctly
classify them as “drugs,” as would be consistent with the
Medicare Modernization Act of 2003, and which will allow
diagnostic radiopharmaceuticals, similar to other drugs, to
similarly be paid separately for costs above the packaging
threshold of $140 per day (Directive to Take Action).

RECOMMENDATION B:

Alternate Resolution 7 be immediately forwarded for
consideration at the 2023 Interim Meeting of the AMA
House of Delegates.
Resolved, That our American Medical Association support adequate reimbursement of vital diagnostic radiopharmaceuticals through advocating for swift passage of the Facilitating Innovative Nuclear Diagnostics (FIND) Act (Directive to Take Action).

Your Reference Committee heard generally supportive perspectives on Resolution 7, though several members qualified their comments by pointing out that the subject matter was either not squarely in their area of expertise or that they did not feel educated enough on the subject to render a solid position statement. One concern that was raised through online testimony and during the Reference Committee hearing itself was that Resolution 7 as written may run afoul of the AMA’s practice of not adopting or addressing resolutions that call for direct action on specific state or federal legislation, as is the case here.

The Committee instead believes that adopting an alternate resolution that speaks to support for the changes that the Facilitating Innovative Nuclear Diagnostic Act would enact could function as a reasonable solution in this case. Additionally, framing support for the outcome rather than the specific legislation will also ensure that support stays perennial, rather than discontinue at the end of the current Congress.
RECOMMENDED FOR REFERRAL

(8) RESOLUTION 2 – INCLUSION OF PATIENT SAFETY AND ENVIRONMENTAL STEWARDSHIP IN CSAPH REPORT “IMPROVING RESEARCH STANDARDS, APPROVAL PROCESSES POST-MARKET AND SURVEILLANCE STANDARDS FOR MEDICAL DEVICES”

RECOMMENDATION:

Resolution 2 be referred.

Resolved, That our American Medical Association develop policy that specifically addresses concerns about the design, use, and maintenance of reusable medical devices in the context of the growth of antibiotic-resistant microbes, as it threatens patient safety (Directive to Take Action); and be it further

Resolved, That our AMA develop policy that specifically addresses single use/disposable medical devices with regards to 1) adverse environmental consequences (material use and medical waste), and 2) the balance of fiscal expense vs. patient safety concerns (Directive to Take Action); and be it further

Resolved, our AMA advocate for an augmented recommendation on medical devices that addresses patient safety as it intersects with fiscal and environmental considerations to the U.S. Food and Drug Administration’s Center for Devices and Radiological Health and advocate for its incorporation into the Center’s policies regarding approval and continuance of medical devices. (Directive to Take Action).

Your Reference Committee heard testimony supporting Resolution 2 with several echoing the sentiment that their own practices had far too many occurrences of waste related to surgical items. The Committee agreed that the amount of waste continues to be both a logistical and financial problem for many healthcare facilities and practices, as well as present an environmental problem for the world at large.

While the Committee found itself in support of the concept of Resolution 2, it struggled with the tension between all three resolve clauses. The Committee found the first resolve clause focused on the safety implications of reusable equipment, while the second focused on single-use equipment. The Committee considered that developing policy to address each of these independently may create policy that is internally inconsistent; one way to deal with medical devices is to not reuse them, which presumably leads to better safety precautions but increases the volume of disposable items, which the second resolve specifically asks for a policy to address. Likewise, reducing the use of disposable items will naturally lead to greater use of re-usable ones.

The Committee considered that these two “asks” in the resolution are locked together and that furthermore, as they both call for the development of policy, there was a reasonably likelihood that the resolution would not be accepted as an item that addressed advocacy, which is required for items before the House of Delegates in an Interim Meeting. Because the focus is on policy development and because the
Committee believed the tension between the resolve clauses needed more consideration, it therefore believes the best course of action is to refer Resolution 2 to the Organized Medical Staff Section Governing Council for a report, due back to the Section at Annual 2024.
Doctor Chair, this concludes the report of the Organized Medical Staff Section Reference Committee. I would like to thank Drs. Chris Bush, Christopher Gribbin, Jay Gregory, and Marilyn Laughead as well as all those who testified before the Committee.

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Alan Klitzke, MD                           Chris Bush, MD
Chair, OMSS Reference Committee

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Christopher Gribbin, MD                    Jay Gregory, MD

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Marilyn K. Laughead, MD