

**JOINT REPORTS OF THE COUNCIL ON CONSTITUTION AND BYLAWS AND
COUNCIL ON-LONG RANGE PLANNING AND DEVELOPMENT**

The following reports, 1–4, were presented by Charles J. Hickey, MD, Chair, Council on Constitution and Bylaws and H. Hugh Vincent, MD, Chair, Council on Long Range Planning and Development:

1. AMA POLICY DIRECTIVES WHICH ARE OBSOLETE, DUPLICATIVE OR ACCOMPLISHED

Reference committee hearing: see report of [Reference Committee F](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
AND REMAINDER OF REPORT FILED**

This year, consistent with AMA Policy G-600.110 that recommends that a policy be sunset when it is no longer relevant or necessary or has been accomplished, the Councils reviewed various directives from the AMA Policy Compendium. Many a directive called for a report, which was subsequently provided, but the original directive asking for the report was not rescinded after the report was issued. Other directives called for a specific action that AMA took and reported to the House of Delegates in the semiannual implementation charts (available online on the [HOD website](#) for the years 2007–2012); however, the directive calling for action remained in the AMA Policy Compendium. This report is distinct from the sunset reports submitted by each council.

These recommendations to sunset have the support of other AMA councils and sections whose input was sought. The Appendix contains the original text of all directives proposed for sunset, and a link to either the report(s) that the HOD requested and/or a rationale as to why the policy should be rescinded. All policies proposed for sunset will be retained in the AMA's historical archives.

RECOMMENDATIONS

The Councils recommend that the following directives be sunset, as they are obsolete, duplicative or accomplished and that the remainder of this report be filed:

Directives on Aging [[D-25.000](#)]

- [D-25.998 Building the Health Care Workforce for an Aging America](#)
- [D-25.999 2005 White House Conference on Aging: Review and Implementation of Recommendations](#)

Directives on Alcohol and Alcoholism [[D-30.000](#)]

- [D-30.996 Uniform Drinking Age Standards](#)

Directives on Allied Health Professions [[D-35.000](#)]

- [D-35.991 Licensure of Naturopaths](#)
- [D-35.993 Limited Licensure Health Care Provider Training and Certification Standards](#)

Directives on Armed Forces [[D-40.000](#)]

- [D-40.992 Acceptance of TRICARE Health Insurance](#)

Directives on Aviation Medicine [[D-45.000](#)]

- [D-45.996 Air Travel for Patients Using Supplemental Oxygen](#)
- [D-45.997 Commercial Aircraft Water Quality and Safety](#)
- Directives on Children and Youth [[D-60.000](#)]
- [D-60.978 Resources to Combat Teen and Young Adult Suicide in the United States](#)
- [D-60.981 The Diagnosis and Treatment of ADHD](#)
- [D-60.983 Teen and Young Adult Suicide in the United States](#)

Directives on Coding and Nomenclature [[D-70.000](#)]

- [D-70.968 National Standard for Code Combinations](#)

Directives on Contraception [[D-75.000](#)]

- [D-75.998 Access to Emergency Contraception](#)

Directives on Crime [[D-80.000](#)]

- [D-80.998 Criminal Background Checks for Elder Care Workers](#)

Directives on Drug Abuse [[D-95.000](#)]

- [D-95.988 Methamphetamine Epidemic in America](#)
- [D-95.991 Dextromethorphan Abuse](#)
- [D-95.992 Study of Abuse of Medications Containing Dextromethorphan](#)

Directives on Drugs [[D-100.000](#)]

- [D-100.984 Access to FDA Data Regarding the Safety and Efficacy of Medications](#)

Directives on Drugs: Cost [[D-110.000](#)]

- [D-110.989 Payment for Biologics and Pharmacologic Agents](#)
- [D-110.990 Study of Cost Sharing Arrangements in Prescription Benefits](#)

Directives on Drugs: Prescribing and Dispensing [[D-120.000](#)]

- [D-120.966 Pharmacists' Refusal to Fill Legally Valid Prescriptions](#)
- [D-120.981 Pharmaceutical Assistance Programs](#)
- [D-120.987 Prior Approval of Prescriptions](#)

Directives on Drugs: Substitution [[D-125.000](#)]

- [D-125.990 Generic Substitution of Narrow Therapeutic Index Drugs](#)

Directives on Emergency Medical Services [[D-130.000](#)]

- [D-130.973 Physician Identification in Emergencies](#)
- [D-130.977 Teaching of CPR as a Part of Comprehensive Health Education Programs](#)
- [D-130.978 Collaboration and Coordination During Disaster Relief](#)
- [D-130.979 Plan for the Implementation of a National Disaster Life Support \(NDLS\) Educational Program](#)
- [D-130.980 Changes in the Emergency Medical Treatment and Active Labor Act](#)

Directives on Environmental Health [[D-135.000](#)]

- [D-135.981 Public Health Lessons from the Massive Oil Spill in the Gulf of Mexico](#)
- [D-135.995 Studying the Health Effects of Aerial Herbicide Spraying Under "Plan Colombia"](#)

Directives on Ethics [[D-140.000](#)]

- [D-140.963 Security Breaches in Electronic Medical Records](#)
- [D-140.964 Employment Relations](#)
- [D-140.965 Physician Employment by a Physician Extender](#)
- [D-140.966 Medical Ethical Guidelines for Informed Consent in Investigational Trials](#)
- [D-140.969 "Secret Shopper" Patients](#)
- [D-140.971 Ethical and Legal Issues in Responding to Occupational HIV Exposure](#)
- [D-140.972 Possible Anti-Competitive and Ethical Implications of Integrated Hospital System Referral Expectations](#)
- [D-140.973 Trademarks, Patents, Copyrights, and Other Legal Restrictions on Medical Procedures](#)
- [D-140.974 Universal Out-of-Hospital DNR Systems](#)
- [D-140.975 Ethics of Physician Participation in Reality Television for Entertainment](#)
- [D-140.977 Selection of Health Care Decision-Making Surrogates](#)
- [D-140.986 Use of Anatomical Gifts in Medical Research and Education](#)
- [D-140.997 Professional Courtesy](#)
- [D-140.999 Preservation of Professional Courtesy](#)

Directives on Health Care Costs [[D-155.000](#)]

- [D-155.991 Accuracy of the Cost Estimates of Health Care Systems](#)
- [D-155.997 Containing Catastrophic Care Costs](#)

Directives on Health Care Delivery [[D-160.000](#)]

- [D-160.941 Rescind the Rule Signing of Verbal Orders within 48 Hours](#)
- [D-160.943 Ambulatory Surgical Centers](#)
- [D-160.982 Removing Patient Translation and Interpretation Costs From Physician Responsibility](#)
- [D-160.989 Physician-to-Physician Communication](#)

Directives on Health System Reform [[D-165.000](#)]

- [D-165.945 Study Effects of Individual Health Insurance Mandates](#)
- [D-165.947 Standardizing AMA Policy on the Tax Treatment of Health Insurance](#)
- [D-165.948 Standardizing AMA Policy on the Tax Treatment of Health Insurance](#)
- [D-165.960 Promoting a National Health Care Forum](#)
- [D-165.967 Health Reimbursement Arrangements](#)

Directives on Health Insurance [[D-180.000](#)]

- [D-180.982 Denial of Reimbursement Based on Volume of Procedures Performed](#)
- [D-180.983 Components of Health Insurance](#)

Directives on Health Insurance: Benefits and Coverage [[D-185.000](#)]

- [D-185.990 Health Insurance Coverage of Specialty Pharmaceuticals](#)
- [D-185.994 Mental Health Parity](#)

Directives on Health Insurance: Claim Forms and Claims Processing [[D-190.000](#)]

- [D-190.979 HIPAA and Foreign Outsourcing](#)

Directives on Health Workforce [[D-200.000](#)]

- [D-200.983 Barriers to Primary Care as a Medical Career Choice](#)
- [D-200.987 Physician Re-Entry](#)
- [D-200.988 Strategies for Increasing Diversity in the Health Care Workforce](#)
- [D-200.990 Physician Workforce and the Future of Emergency and Trauma Care](#)

Directives on Health Planning [[D-205.000](#)]

- [D-205.999 Profession of Medicine](#)

Directives on Home Health Services [[D-210.000](#)]

- [D-210.998 Mandated Medicare Transfer of Title of Home Oxygen Equipment](#)

Directives on Hospitals [[D-215.000](#)]

- [D-215.992 AMA Advocacy Report on the Advantages and Disadvantages of Certificate of Need Laws](#)
- [D-215.994 Possible Anti-Competitive and Ethical Implications of Integrated Hospital System Referral Expectations](#)
- [D-215.996 Specialty Hospitals and Impact on Health Care](#)

Directives on Hospitals: Accreditation Standards [[D-220.000](#)]

- [D-220.979 Access to JCAHO Standards](#)

Directives on Hospitals: Medical Staff [[D-225.000](#)]

- [D-225.978 The Physician's Right to Exercise Independent Judgment in All Organized Medical Staff Affairs](#)
- [D-225.979 Guaranteeing Due Process for Employed Physicians](#)
- [D-225.983 Protection of Medical Staff Members' Personal Proprietary Financial Information](#)

Directives on Hospitals: Medical Staff – Credentialing and Privileges [[D-230.000](#)]

- [D-230.990 Inspector General to Rule on Exclusionary Credentialing](#)

Directives on Hospitals: Medical Staff – Organization [[D-235.000](#)]

- [D-235.992 JCAHO Standard MS 1.20 and Element of Performance 19](#)
- [D-235.993 Medical Staff Bylaws as a Contract](#)
- [D-235.995 Physicians' Guide to Medical Staff Organization Bylaws](#)

Directives on International Medical Graduates [[D-255.000](#)]

- [D-255.990 Nondiscrimination in Residency Selection](#)

Directives on Laboratories [[D-260.000](#)]

- [D-260.996 Improvements to Reporting of Clinical Laboratory Results](#)

Directives on Legal Medicine [[D-265.000](#)]

- [D-265.992 Threats Against Physicians Based on Americans with Disabilities Act](#)
- [D-265.994 Expert Witness Affirmation](#)

Directives on Legislation and Regulation [[D-270.000](#)]

- [D-270.991 Repeal of Contact Lens Law](#)

Directives on Licensure and Discipline [[D-275.000](#)]

- [D-275.968 Independent Regulation of Physician Licensing Exams](#)
- [D-275.978 Initial State Licensure](#)
- [D-275.980 Simplifying the State Medical Licensure Process](#)
- [D-275.982 Rational Role for USMLE Step Exams](#)

Directives on Managed Care [[D-285.000](#)]

- [D-285.971 Rental \(Silent\) Network PPOs](#)
- [D-285.985 Inappropriate Bundling of Medical Services by Third Party Payers](#)
- [D-285.994 Creation of Model State and Local Medical Society Private Sector Advocacy Programs](#)

Directives on Medical Education [[D-295.000](#)]

- [D-295.944 Current and Future Availability of Resources to Support the Clinical Education of Medical Students](#)
- [D-295.945 Initiative to Transform Medical Education: Strategies for Medical Education Reform](#)
- [D-295.947 A Balanced Medical Curriculum](#)
- [D-295.948 Report on the Status of Education in Substance Abuse and Addiction in America's Medical Schools and Residency Programs](#)
- [D-295.950 Equal Fees for Osteopathic and Allopathic Medical Students](#)
- [D-295.956 Medical Student Clinical Training and Education Conditions](#)
- [D-295.986 Evaluating the Impact of Hospital Mergers on Clinical Education for Medical Students and Resident Physicians](#)

Directives on Medical Education: Continuing [[D-300.000](#)]

- [D-300.982 Opposition to Increase CME Provider Fees](#)
- [D-300.985 Revisiting PhRMA Code](#)
- [D-300.986 Updated ACCME Standards for Commercial Support](#)
- [D-300.987 Updated ACCME Standards for Commercial Support](#)
- [D-300.990 CME Validation Criteria](#)
- [D-300.997 Use of Medical Education Numbers In Continuing Medical Education](#)

Directives on Medical Education: Financing and Support [[D-305.000](#)]

- [D-305.976 Federal Student Loan Program Interest Rates](#)

Directives on Medical Education: Graduate [[D-310.000](#)]

- [D-310.969 Fellowship Application Reform](#)
- [D-310.970 Improving Parental Leave Policies for Residents](#)
- [D-310.975 Fellowship Application Reform](#)

Directives on Medical Records and Patient Privacy [[D-315.000](#)]

- [D-315.985 Electronic Medical Record and Privacy Protections](#)
- [D-315.986 Guiding Principles, Collection and Warehousing of Electronic Medical Record Information](#)
- [D-315.997 Preservation of Medical Records](#)

Directives on [Medical Review](#)

- [D-320.990 Appropriate Use of Preauthorization](#)

Directives on Medicare [[D-330.000](#)]

- [D-330.953 Affordability of the Medicare Prescription Drug Programs](#)
- [D-330.955 Division of Medicare into a Program for Elderly and a Program for the Disabled](#)

Directives on Medicare: Carrier Review [[D-335.000](#)]

- [D-335.985 Carrier Advisory Committees](#)

Directives on Mental Health [[D-345.000](#)]

- [D-345.988 Suicide in Physicians and Physicians-in-Training](#)
- [D-345.989 Preventing Suicide in Physicians](#)
- [D-345.991 Access to Psychiatric Beds and Impact on Emergency Medicine](#)
- [D-345.992 Promoting Parity for the Treatment of Mental Illness and Substance Use Disorders](#)
- [D-345.996 Depression and Suicide on College Campuses](#)

Directives on [Minorities](#)

- [D-350.989 Health Insurance Differences Contribute to Health Care Disparities and Poorer Outcomes](#)

Directives on National Practitioner Data Bank [[D-355.000](#)]

- [D-355.999 National Practitioner Data Bank](#)

Directives on Organ Donation and Transplantation [[D-370.000](#)]

- [D-370.989 Organ Donation Procurement](#)

Directives on Peer Review [[D-375.000](#)]

- [D-375.989 Inappropriate Peer Review](#)
- [D-375.992 Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations](#)

Directives on Physician Negotiating [[D-383.000](#)]

- [D-383.986 Managed Care Environment](#)
- [D-383.987 State Managed Care Legislation](#)

Directives on Physician Payment [[D-385.000](#)]

- [D-385.961 Physician Tax Credits for Uncompensated Care](#)
- [D-385.970 Tiering System for Third-Party Payers](#)
- [D-385.971 Gain-Sharing](#)
- [D-385.972 National Provider Identification \(NPI\) Implementation](#)
- [D-385.998 Private Sector Advocacy Activities Update](#)

Directives on Physician Payment: Medicine [[D-390.000](#)]

- [D-390.965 Sustainable Growth Rate and Medicare](#)
- [D-390.968 Educate the Public on Potential Lack of Access to Health Care for Medicare Recipients](#)
- [D-390.973 Opting Out of Medicare Information Dissemination](#)

Directives on Physicians [[D-405.000](#)]

- [D-405.994 Pending Litigation Regarding Medical Errors](#)
- [D-405.995 Defining “Loss of Practice” in Catastrophic Events](#)

Directives on Practice Parameters [[D-410.000](#)]

- [D-410.994 Radiology Benefits Managers: Practicing Medicine Without the Patient](#)
- [D-410.997 Criminalization of Physician Departure from Guidelines and Standards](#)

Directives on Pregnancy and Childbirth [[D-420.000](#)]

- [D-420.996 SSRI Use During Pregnancy](#)

Directives on Professional Liability [[D-435.000](#)]

- [D-435.971 Combating Enhanced Lawsuit Funding](#)
- [D-435.972 Hospitals Suing Physicians to Recover the Cost of Professional Liability Settlements](#)
- [D-435.976 Protection From Liability Arising From Care Rendered to Patients During Officially Declared Disasters](#)
- [D-435.982 Frivolous Lawsuit Management](#)

Directives on Public Health [[D-440.000](#)]

- [D-440.952 Fighting the Obesity Epidemic](#)
- [D-440.953 Need for Action for Access to Immunization](#)
- [D-440.963 Promoting Four Principles of Hand Awareness](#)
- [D-440.960 Prohibiting the Sale of Tanning Parlor Ultraviolet Rays to Those Under 18 Years of Age](#)
- [D-440.970 Federal Financing of Poison Center Network](#)
- [D-440.977 Chronic Wasting Disease](#)

Directives on Quality of Care [[D-450.000](#)]

- [D-450.969 Improve the Recertification Process](#)
- [D-450.971 Evaluating the Physician Quality Reporting Initiative](#)
- [D-450.985 Health Insurance Company Report Cards](#)
- [D-450.998 Addressing the Disruptive Physician](#)

Directives on Radiation and Radiology [[D-455.000](#)]

- [D-455.995 Imaging Safety and Standardization](#)
- [D-455.996 Development of Standards for MRI Equipment and Interpretation to Improve Patient Safety](#)
- [D-455.997 Development of Standards for MRI Equipment and Interpretation to Improve Patient Safety](#)

Directives on Research [[D-460.000](#)]

- [D-460.981 Support for Federally-Funded Medical Research](#)

Directives on Technology – Computer [[D-478.000](#)]

- [D-478.983 Physicians and Electronic Social Networking](#)
- [D-478.985 Supporting the Establishment of Guidelines Regarding Online Professionalism](#)
- [D-478.987 Request that CMS Lower the Minimum Threshold for e-Prescribing Rebate from 50% to 25% for 2009](#)

Directives on Technology [[D-480.000](#)]

- [D-480.982 RFID Labeling in Humans](#)

Directives on Tobacco: Labeling and Warnings [[D-495.000](#)]

- [D-495.995 Active Support for “Screen Out”](#)

Directives on Tobacco: Marketing and Promotion [[D-500.000](#)]

- [D-500.997 Issuing a Postage Stamp to Commemorate the First Surgeon General’s Report on Smoking and Health \(1964\)](#)
- [D-500.998 Smoking and Health to Remain a Top Priority for the CDC After Reorganization](#)

Directives on Veterans Medical Care [[D-510.000](#)]

- [D-510.995 Health Care for Veterans and Their Families](#)

Directives on Violence and Abuse [[D-515.000](#)]

- [D-515.981 Surveying Violence in the Non Hospital Work Environment](#)
- [D-515.987 Prevention of Violence in Schools](#)
- [D-515.988 Warning Labels on Video Games](#)

Directives on Women [[D-525.000](#)]

- [D-525.995 Investigating the Continued Gender Disparities in Physician Salaries](#)

Directives on Governance: AMA House of Delegates [[D-600.000](#)]

- [D-600.959 Specialty Society Representation in the House of Delegates](#)

Directives on Governance: Federation of Medicine [[D-620.000](#)]

- [D-620.992 Association Services and Physician Organization](#)

APPENDIX – Text of directive and rationale for sunset

D-25.998 Building the Health Care Workforce for an Aging America

Our AMA will work with appropriate specialty societies to review the recommendations of the April 2008 Institute of Medicine Report, “Retooling for an Aging America: Building the Health Care Workforce,” and make recommendations (action required prior to the 2008 Interim Meeting) regarding steps to support and implement specific IOM recommendations.

Rationale: Obsolete. AMA was represented on the Coordinating Council of the National Workforce Alliance for Care of an Aging America formed by over 30 national organizations to implement the recommendations of the IOM Report on Building a Health Care Workforce for an Aging America. Also, the recommendations of the IOM report were incorporated into an AMA initiative on Care of the Aging and Long Term Care.

D-25.999 2005 White House Conference on Aging: Review and Implementation of Recommendations

Our AMA will work with appropriate specialty societies to review the resolutions of the 2005 White House Conference on Aging to identify those with relevance to health care and make recommendations to the Board of Trustees (action required prior to the 2006 Interim Meeting) or House of Delegates regarding their implementation.

Rationale: Accomplished. The Board considered a report related to D-25.999 and voted that in response our AMA would work with appropriate specialty medical societies and all other key stakeholders to increase the number of physicians caring for the elderly who can demonstrate proficiency in geriatric care principles and practices; work with all appropriate specialty medical societies and other key public and private stakeholders addressing the redesign of the Medicare system to support coordination and continuity of comprehensive patient care in the least restrictive environment and to ensure access to quality medical care (preventive, acute, chronic, rehabilitation, and end of life) for all seniors, particularly those with increased vulnerability due to frailty, disability, geographic location, poverty, and racial or ethnic disparities; and support the work to develop appropriate performance measures for geriatric care by the [Physician Consortium for Performance Improvement](#).

D-30.996 Uniform Drinking Age Standards

Our AMA will encourage Guam’s 28th legislature and the Governor of Guam to support 21 as the legal drinking age, support 0.04 percent blood-alcohol level as per se illegal for driving, and urge incorporation of that provision in drunk driving laws in all US states and territories in accordance with AMA Policies H-30.986 and H-30.989.

Rationale: Accomplished/duplicative. In 2010, Guam enacted legislation raising the legal drinking age to 21. The balance of the directive is duplicative of Policy [H-30.986](#), Alcohol and the Driver.

D-35.991 Licensure of Naturopaths

Our AMA will work through the Scope of Practice Partnership and interested Federation partners to oppose the licensure of naturopaths and report back to the House of Delegates at the 2006 Interim Meeting.

Rationale: [BOT Report 2-I-06](#) provided the requested report. The conclusion of the informational report stated that our AMA will continue to play an active role as a convener within the Federation with respect to scope of practice issues, continue to monitor the legislative and regulatory activity of naturopaths at the state level and assist the Federation as needed. A working group will be formed to discuss the issues surrounding licensure of naturopaths and their efforts to expand already existing state scopes of practice. In 2012, our AMA [opposed](#) Maryland’s Senate Bill 180, a naturopathic licensure bill.

D-35.993 Limited Licensure Health Care Provider Training and Certification Standards

Our AMA, along with the Scope of Practice Partnership and interested Federation partners, will study the qualifications, education, academic requirements, licensure, certification, independent governance, ethical standards, disciplinary processes, and peer review of the limited licensure health care providers and limited independent practitioners, as identified by the Scope of Practice Partnership, and report back at the 2006 Annual Meeting.

Rationale: [BOT Report 24-A-06](#) provided the requested report. The conclusion of the informational report stated that our AMA will continue to play an active role as a convener and consensus builder between state medical associations and

national medical specialty societies with respect to scope of practice issues. See AMA website for additional details regarding its Scope of Practice [campaign](#).

D-40.992 Acceptance of TRICARE Health Insurance

Our AMA will: (1) convene a meeting with representatives of TRICARE to discuss how to improve its contracting process and funding, in order to better the health care of veterans and their families; and (2) report back at the 2008 Interim Meeting on issues regarding TRICARE in light of the increased numbers of new veterans and their families.

Rationale: The AMA convened a meeting with senior TRICARE officials regarding how to improve the contracting process. [CMS Report 2-I-08](#) provided the requested information and additional recommendations are embodied in Policy [D-40.991](#), Acceptance of TRICARE Health Insurance.

D-45.996 Air Travel for Patients Using Supplemental Oxygen

Our AMA will formally submit comments encouraging the Department of Transportation's Proposed Rule that will require airlines to permit portable oxygen concentrators that have met all applicable safety and security testing on board airplanes for use by patients.

Rationale: Our AMA sent a letter to the Department of Transportation encouraging airlines to allow passengers to board planes with portable oxygen concentrators that have met safety guidelines. Oxygen-dependent passengers may now carry their own portable oxygen concentrators on board all U.S. domestic flights and international flights beginning or ending in the United States, so long as the concentrators are FAA-approved.

D-45.997 Commercial Aircraft Water Quality and Safety

Our AMA will: (1) recognize the efforts of the US Environmental Protection Agency (EPA) and participating commercial airlines to improve water sanitation on domestic passenger aircraft; and (2) support the current efforts by the EPA to amend the regulatory authority of the US Department of Transportation to include water system sanitation and sanitation testing as part of routine passenger aircraft maintenance as mandated under 14 CFR Part 121, 14 CFR Part 135, and other appropriate Federal Aviation Regulations, and to submit formal comments to the Proposed Rule for this amendment to the regulations.

Rationale: Our AMA sent the requested comments to the EPA.

D-60.978 Resources to Combat Teen and Young Adult Suicide in the United States

Our AMA will convene a time-limited work group to meet through conference call to identify and evaluate appropriate resources for physicians intended to prevent and reduce teen and young adult suicide, and that such resources be maintained on a publicly accessible Web page hosted by our AMA.

Rationale: Accomplished. Requested resources are [online](#) on the AMA website.

D-60.981 The Diagnosis and Treatment of ADHD

Our AMA Council on Science and Public Health will work with all appropriate specialty societies to prepare an update to the 1997 CSA report on the diagnosis and treatment of Attention Deficit Hyperactivity Disorder.

Rationale: [CSAPH Report 10-A-07](#) provided the requested report, which updated Policy [H-60.950](#), Diagnosis and Treatment of Attention Deficit/Hyperactivity Disorder in School-Age Children.

D-60.983 Teen and Young Adult Suicide in the United States

Our AMA will work with appropriate federal agencies, national organizations, and medical specialty societies to compile resources to reduce teen and young-adult suicide, including but not limited to continuing medical education classes, patient education programs, and other appropriate educational and interventional programs for health care providers, and report back at the 2006 Interim Meeting.

Rationale: [CSAPH Report 3-I-06](#) provided the requested report and established Policy [D-60-978](#) (see above). The requested resources are [online](#).

D-70.968 National Standard for Code Combinations

Our AMA will study and report back to the House of Delegates on the feasibility of developing a national standard for the utilization of codes, code combination, and modifiers that is consistent with all CPT codes, guidelines, and conventions, and that would be used by all commercial and governmental payers.

Rationale: [BOT Reports 13-A-05](#) and [7-I-05](#) provided the requested reports. The latter report noted that based on multiple interviews with a wide range of CPT stakeholders, a review of existing federal law and regulation, and other research, a privately conducted study concluded that the national standard referenced in the directive was not feasible. It would be exceedingly difficult to secure a legislative or regulatory mandate requiring all payers to comply with CPT guidelines and instructions, and essentially impossible to obtain such a mandate for AMA-developed code combination edits.

D-75.998 Access to Emergency Contraception

(1) Our AMA will study the issue of access to Emergency Contraception. (2) The study include the issue of after hours access and access in communities served by hospitals and pharmacies that restrict Emergency Contraception from their inventory. (3) Our Board of Trustees will report back to the House of Delegates at the I-00 meeting.

Rationale: Requested report was prepared in 2000. Other updated policies exist: [D-75.997](#), Access to Emergency Contraception and [H-120.947](#), Preserving Patients' Ability to Have Legally Valid Prescriptions Filled.

D-80.998 Criminal Background Checks for Elder Care Workers

Our AMA will work with federal regulators to ensure the proper implementation of existing federal programs and databases that provide for criminal background checks for elder care workers.

Rationale: Our AMA has been actively involved with the Administration on fraud and abuse issues, and has conveyed concern regarding long term care workers to senior HHS and CMS officials.

D-95.988 Methamphetamine Epidemic in America

Our AMA will work with appropriate organizations to study the problem of methamphetamine use and addiction, and develop recommendations to address this emerging health problem.

Rationale: Our AMA gathered information about methamphetamine use in the US and spoke with representatives from federal drug abuse agencies who advised that an extensive campaign was unwarranted.

D-95.991 Dextromethorphan Abuse

Our AMA will issue a statement of concern regarding the sale of bulk Dextromethorphan (DXM) via the Internet to the general population; and will support legislation outlawing the sale of bulk DXM to the general population, especially via the Internet.

Rationale: [CSA Report 1-I-04](#) provided the requested information, and established Policy [D-95.990](#), Dextromethorphan Abuse.

D-95.992 Study of Abuse of Medications Containing Dextromethorphan

Our AMA will: (1) study, in consultation with the Food and Drug Administration (FDA), the Drug Enforcement Administration (DEA), the over-the-counter pharmaceutical industry, and other appropriate organizations, the status of abuse of medications containing dextromethorphan among adolescents in the United States, with a report back at the 2004 Interim Meeting including recommendations regarding dissemination of the findings to physicians and the general public; and (2) strongly request that the FDA, the DEA, and other appropriate government authorities use every means possible to halt bulk sales of dextromethorphan over the Internet.

Rationale: [CSA Report 1-I-04](#) provided the requested information, and established Policy [D-95.990](#), Dextromethorphan Abuse.

D-100.984 Access to FDA Data Regarding the Safety and Efficacy of Medications

Our AMA will ask the Council on Scientific Affairs to (1) study the issue of enhancing access to Food and Drug Administration data regarding the safety and efficacy of medications, and (2) develop recommendations designed to improve access to clinically relevant research collected by the FDA.

Rationale: [CSA Report 6-A-05](#) provided the requested information, and established [D-100.982](#), Enhanced Physician Access to Food and Drug Administration Data.

D-110.989 Payment for Biologics and Pharmacologic Agents

Our AMA will: (1) study the inability of practicing physicians to obtain payment (including drugs and their managerial acquisition costs) for biologics and pharmacologic agents at the rates intended by Congress; and (2) make recommendations directly to the Centers for Medicare and Medicaid Services to correct inadequate payment for biologics and pharmacologic agents and their managerial acquisition costs.

Rationale: [CMS Report 3-I-08](#) provided the requested information, reaffirmed and amended Policy [D-330.960](#), Cuts in Medicare Outpatient Infusion.

D-110.990 Study of Cost Sharing Arrangements in Prescription Benefits

Our AMA will study the relative advantages and disadvantages of two models of patient cost sharing in prescription benefits, namely fixed dollar co-payments and percentage-based coinsurance, and recommend a plan of action that will advocate for better containment of price inflation and greater freedom for patients to obtain the best prescriptions for their disorders, with a report back to the AMA House of Delegates at the 2007 Interim Meeting.

Rationale: [CMS Report 1-I-07](#) provided the requested information, and established Policy [H-110.990](#), Cost Sharing Arrangements for Prescription Drugs.

D-120.966 Pharmacists' Refusal to Fill Legally Valid Prescriptions

Our AMA will (1) prepare a report summarizing the available information regarding delays or difficulties patients have experienced due to pharmacists' refusal to fill legally valid prescriptions; and (2) develop specific recommendations to ensure that patients' prescriptions are filled in a timely and appropriate manner.

Rationale: [BOT Report 2-A-08](#) provided the requested information, and established Policy [H-120.947](#), Preserving Patients' Ability to Have Legally Valid Prescriptions Filled.

D-120.981 Pharmaceutical Assistance Programs

Our AMA will study the feasibility of recommending a uniform application process and form which could be used by all pharmaceutical manufacturers offering pharmaceutical assistance programs, and the AMA Board of Trustees will report back to the House at the 2004 Annual Meeting with the results of this study.

Rationale: [BOT Report 13-A-04](#) provided the requested information, and affirmed Policy [H-120.975](#), Certifying Indigent Patients for Pharmaceutical Manufacturers' Free Drug Programs.

D-120.987 Prior Approval of Prescriptions

Our AMA shall develop policy against inappropriate prior approval mechanisms for pharmaceuticals and report back at the 2003 Annual Meeting.

Rationale: [CMS Report 6-A-03](#) provided the requested information, established Policy [D-125.995](#), Health Plan Coverage of Prescription Drugs, reaffirmed Policies [H-120.988](#) and [H-285.965](#); and amended Policy [H-125.991](#). Also, see Policy [D-125.992](#), Opposition to Prescription Prior Approval.

D-125.990 Generic Substitution of Narrow Therapeutic Index Drugs

Our AMA will inform the Centers for Medicare and Medicaid Services, America's Health Insurance Plans, the Pharmaceutical Care Management Association, the National Association of Boards of Pharmacy, the National Association of Chain Drug Stores, the National Community Pharmacists Association, and the American Pharmacists Association about AMA Policies H-125.984 and H-115.974, and will urge these payer and pharmacy organizations to support these AMA policies.

Rationale: As requested, our AMA sent letters to Karen Ignagni, AHIA; John A. Gans, PharmD, APA; Carmen Catizone, MS, NABP; Steven Anderson, IOM, NACDS; Bruce Roberts, RPh, NCPA; Mark Merritt, PCMA informing them of AMA policies on generic drugs and prescription labeling. Also, see Policies [H-125.984](#), Generic Drugs and [H-115.974](#), Prescription Labeling.

D-130.973 Physician Identification in Emergencies

Our AMA will: (1) advocate for a uniform state physician ID for identification when responding to disasters; (2) work with appropriate agencies to identify mechanisms that would allow physicians to render care during disasters in states where they are not currently licensed and report back to the House at the 2006 Interim Meeting; (3) study and report to the House of Delegates on the issue of possible protection from accusations of civil or criminal liability arising from care rendered to patients during officially declared local, state, or national disasters.

Rationale: [BOT 15-I-06](#) provided the requested information, and established Policy [H-130.943](#), Physician Identification in Emergencies.

D-130.977 Teaching of CPR as a Part of Comprehensive Health Education Programs

Our AMA will encourage the Centers for Disease Control and Prevention to incorporate CPR training for appropriate age levels in their guidelines on comprehensive health education.

Rationale: Our AMA sent letters to the American Red Cross, National Safety Council and National Center for Chronic Disease Prevention and Health Promotion informing them of AMA's position, and strongly recommending that CPR classes be incorporated as a voluntary part of secondary school programs. Our AMA also encouraged CDC to incorporate CPR training for appropriate age levels in their guidelines on comprehensive health education. Additional AMA policies speak to the importance of CPR training: [H-130.983](#), Teaching of Cardiopulmonary Resuscitation to All High School Students, [H-245.988](#), Cardiopulmonary Resuscitation Training for Expectant and New Parents, and [H.60.957](#), First Aid Training for Child Day Care Workers

D-130.978 Collaboration and Coordination During Disaster Relief

Our AMA Board of Trustees will develop a plan to work with other organizations and help coordinate domestic and international donations of physician resources to populations in acute and chronic need and present the plan at the 2005 Interim Meeting.

Rationale: The BOT issued several reports addressing the subject matter of this directive. Also, see current policies [H-130.942](#), Development of a Federal Public Health Disaster Intervention Team, and [H-130.941](#), Legal Issues Surrounding the Deployment and Utilization of Licensed Physicians in Response to Declared Disasters.

D-130.979 Plan for the Implementation of a National Disaster Life Support (NDLS) Educational Program

Our AMA will: (1) actively pursue the creation of a National Training Network for the National Disaster Life Support (NDLS) program, based at the state level and coordinated through a newly-developed AMA-based NDLS National Program Office; and (2) support the NDLS Program Office at a level that permits the following enhancements to the NDLS program: revision of the NDLS course sequence, including creation of online Core Disaster Life Support and Basic Disaster Life Support courses, creation of a voluntary electronic registry of NDLS-trained individuals, and outreach to other members of the National Disaster Life Support Education Consortium, to encompass individuals from many specialties and disciplines within the Federation.

Rationale: Obsolete. The action requested was accomplished, but the AMA NDLS Program Office was closed effective June 30, 2012. The [National Disaster Life Support Foundation, Inc.](#) (NDLSF™) assumed responsibility for the NDLS Program and the associated National Disaster Life Support Education Consortium™ (NDLSEC™) on July 1, 2012.

D-130.980 Changes in the Emergency Medical Treatment and Active Labor Act

Our AMA will study the impact that the new EMTALA regulations will have on patient care particularly at academic medical centers and at facilities in less populous regions, and report back to the AMA House of Delegates at the 2005 Annual Meeting.

Rationale: [CME Report 3-A-05](#) provided the requested information, and established Policy [D-130.976](#), Implications of the November 2003 Emergency Medical Treatment and Labor Act (EMTALA) Final Rule.

D-135.981 Public Health Lessons from the Massive Oil Spill in the Gulf of Mexico

Our AMA: (1) will work with the Department of Health and Human Services and other appropriate federal agencies to promptly convene an expert panel, comprised of all appropriate public and private sector health agencies and organizations, to address the

immediate and long-term human and environmental health impacts of the massive oil spill in the Gulf of Mexico; (2) will utilize its electronic and print communication vehicles to educate physicians, other health professionals, and the public about public health risks associated with exposure to crude oil, crude oil byproducts, and dispersants associated with the massive spill in the Gulf of Mexico, and encourages patients to talk to their physicians about their concerns; (3) urges Congressional support for the design and implementation of longitudinal/prospective studies to assess the human and environmental health impact of the massive oil spill in the Gulf of Mexico; such studies should be used to inform future oil spill disaster mitigation, preparedness, response, and recovery efforts; and (4) will report back on efforts to protect human and environmental health from the massive oil spill in the Gulf of Mexico at the 2010 Interim Meeting.

Rationale: [CSAPH Report 3-I-10](#) provided the requested information, and established Policy [D-135.980](#), Gulf Oil Spill Health Risks: Update on AMA Involvement. Our AMA hosted a Gulf Oil Spill webinar in 2010 that reviewed the long term mental and behavioral health effects of the Gulf Oil Spill. The December 2010 Journal of Disaster Medicine Public Health Preparedness included an AMA commentary on the issue.

D-135.995 Studying the Health Effects of Aerial Herbicide Spraying Under “Plan Colombia”

Our AMA will request the World Medical Association and the World Health Organization to study the health effects of aerial herbicide spraying in the South American country of Colombia and its neighboring countries.

Rationale: Our AMA sent letters to the Pan American Health Organization and the Environmental Protection Agency seeking information on the spraying program in Colombia. The EPA responded with several reports and scientific studies about the spraying program, and in particular, the concern with “spray drift”. A Memorandum of Justification and other documents were also received from the US Department of State. From the volume of documentation collected, it is apparent that this issue has been extensively studied and documented by the US Government.

D-140.963 Security Breaches in Electronic Medical Records

Our AMA will study what the physician’s role is in informing a patient if he/she has reason to believe that the patient’s protected health information has been inappropriately disclosed.

Rationale: [CEJA Report 3-A-09](#) provided the requested information, and established Policy [E-5.10](#), A Physicians Role Following a Breach of Electronic Health Information.

D-140.964 Employment Relations

Our AMA Council on Ethical and Judicial Affairs will submit a report on the ethical implications of permitting physicians to be employees of non-physician health care providers whom the physician is charged with supervising.

Rationale: [CEJA Report 4-A-09](#) provided the requested information, and established Policy [E-3.05](#), Physician Employment by a Nonphysician Supervisee.

D-140.965 Physician Employment by a Physician Extender

Our AMA will define the ethical boundaries applicable to physicians supervising or collaborating with physician extenders while concurrently employed by the physician extender.

Rationale: [CEJA Report 4-A-09](#) provided the requested information, and established Policy [E-3.05](#), Physician Employment by a Nonphysician Supervisee.

D-140.966 Medical Ethical Guidelines for Informed Consent in Investigational Trials

Our AMA Council on Ethical and Judicial Affairs will review the physician investigator’s obligation to inform patients of potential conflicts of interest in recommending patients for, or the conduct of, a proposed research study.

Rationale: [CEJA Report 4-I-08](#) provided the requested information.

D-140.969 “Secret Shopper” Patients

Our AMA Council on Ethical and Judicial Affairs will study and report back regarding the ethics of such practices as using “secret shopper” patients or other similar practices to evaluate the care that is delivered.

Rationale: [CEJA Reports 3-A-08](#) and [4-A-09](#) provided the requested information.

D-140.971 Ethical and Legal Issues in Responding to Occupational HIV Exposure

Our AMA Council on Ethical and Judicial Affairs will further examine the ethical issues pertaining to HIV testing.

Rationale: [CEJA Report 4-I-07](#) provided the requested information, and amended Policy [E-2.23](#), HIV Testing.

D-140.972 Possible Anti-Competitive and Ethical Implications of Integrated Hospital System Referral Expectations

Our AMA Council on Ethical and Judicial Affairs will consider revising E-8.132 to address all health care delivery settings.

Rationale: [CEJA Report 3-A-07](#) provided the requested information, and amended Policy [E-8.132](#), Referral of Patients: Disclosure of Limitations.

D-140.973 Trademarks, Patents, Copyrights, and Other Legal Restrictions on Medical Procedures

Our AMA Council on Ethical and Judicial Affairs will study and evaluate: (1) whether there is an ethical difference between the use of patents for medical procedures and techniques and the use of such legal devices as trademarks, copyrights, confidentiality agreements and practice agreements for the specific effect of limiting access to new medical procedures and techniques; and (2) whether to affirm Opinion E-9.095 in its present form or to amend Opinion E-9.095 to provide that the use of any legal devices,

including patents, trademarks, copyrights, confidentiality agreements and practice agreements, for the purpose of restricting and limiting access to medical procedures and techniques shall be considered unethical.

Rationale: [CEJA Reports 4-A-07](#) and [3-I-07](#) provided the requested information, and amended Policy [E-9.905](#), The Use of Patents and Other Means to Limit Availability of Medical Procedures.

D-140.974 Universal Out-of-Hospital DNR Systems

Council on Ethical and Judicial Affairs' proposed replacement of Opinion E-2.22, "Do Not Resuscitate Orders," will be filed at the 2005 Interim Meeting.

Rationale: Accomplished; see Policy [E-2.22](#), Do-Not-Resuscitate Orders.

D-140.975 Ethics of Physician Participation in Reality Television for Entertainment

Our AMA Council on Ethical and Judicial Affairs will evaluate existing opinions on advertising and informed consent and render new opinions as appropriate to guide the participation of professionals in the emerging commercial medical practice of reality television for entertainment.

Rationale: [CEJA Report 2-I-05](#) provided the requested information, and amended Policy [E-5.045](#), Filming Patients in Health Care Settings.

D-140.977 Selection of Health Care Decision-Making Surrogates

The Council on Ethical and Judicial Affairs' proposed amendments to Opinion E-8.081, "Surrogate Decision Making," will be filed at I-04.

Rationale: Accomplished; see Policy [E-8.081](#), Surrogate Decision Making.

D-140.986 Use of Anatomical Gifts in Medical Research and Education

Our AMA will study current legal safeguards for proper ethical procurement and use of human tissue for research and education.

Rationale: See Policy [E-2.08](#), Commercial Use of Human Tissue.

D-140.997 Professional Courtesy

Our AMA will disseminate the AMA's and CMS's current positions regarding professional courtesy to the physicians in this country.

Rationale: See Policies [E-6.13](#), Professional Courtesy and [H-140.938](#), Professional Courtesy.

D-140.999 Preservation of Professional Courtesy

Our AMA will petition CMS, the U.S. Attorney General and the U.S. Congress to reverse the unreasonable and intrusive policy of considering professional courtesy among physicians fraud.

Rationale: See Policies [E-6.13](#), Professional Courtesy and [H-140.938](#), Professional Courtesy.

D-155.991 Accuracy of the Cost Estimates of Health Care Systems

Our AMA will undertake a careful examination of the reported cost estimates of the health care systems of comparable developed countries, clarify the services and attendant expenses which are included in such estimates, publicize any estimates which ignore costs shifted to other parts of national budgets, use this information in our efforts to ensure that the true cost of all of the services provided by the United States health care system are appropriately figured into any system redesign, and report back to the House of Delegates at the 2009 Interim Meeting.

Rationale: [CMS Report 4-I-09](#) provided the requested information. The informational report, in its conclusion, noted the Council's belief that international comparisons of health system expenditures offer only limited value in terms of helping countries identify strengths, weaknesses, or potential efficiency improvements, and points out that individual countries face unique realities shaped by history and culture that make it unlikely that large scale "successes" in one country could translate into similar successes.

D-155.997 Containing Catastrophic Care Costs

Our AMA will gather together all relevant information concerning the most expensive 5% of the medical patients in order to be able to devise ways to handle these cases less expensively by: using best-management practices, exploring whether "centers of excellence" provide catastrophic care more efficiently, exploring whether consultation from regional or national experts at an earlier time in these high cost cases might provide benefit, earlier consideration of end-of-life issues, and better education about "palliative" medicine.

Rationale: [CMS Report 5-A-05](#) established Policy [D-155.995](#), Containing Catastrophic Care Costs; and [Joint CMS/CSAPH Report A-06](#) established Policy [H-170.963](#), Reward-Based Incentive Programs for Healthy Lifestyles.

D-160.941 Rescind the Rule Signing of Verbal Orders within 48 Hours

Our AMA will report back to the House of Delegates on the progress made in rescinding the 48 hour rule.

Rationale: [BOT Report 8-I-09](#) provided the requested update. The informational report noted that our AMA has advocated to CMS both through formal and informal communications for repeal of the 48-hour verbal authentication rule, developed model state legislation, and shared AMA concerns with the American Hospital Association and the Federation of American Hospitals. Also see Policy [D-160.987](#), Hour Signature Rule.

D-160.943 Ambulatory Surgical Centers

Our AMA will: (1) review economic data regarding the comparative effectiveness of ambulatory surgical centers (ASCs); and (2) advocate for federal and state legislative solutions that would remove barriers, including Certification Of Need (CON) laws, that impair the ability of physicians to build, own and practice in ASCs.

Rationale: Review of the economic data found a small literature and mixed evidence regarding the comparative effectiveness of ASCs. Our AMA communicated with all state and specialty societies its willingness to advocate through its Advocacy Resource Center for federal and state legislative solutions that would remove barriers, including Certification of Need (CON) laws that impair the ability of physicians to build, own and practice in ASCs. Also, see [D-215.995](#), Specialty Hospitals and Impact on Health Care.

D-160.982 Removing Patient Translation and Interpretation Costs From Physician Responsibility

Our AMA will provide an update to its membership on the progress it has made on eliminating the requirement that physicians pay for translation and interpretation services for patients, an analysis of the implications of current regulatory activity on this issue, and plans for addressing this problem.

Rationale: Our AMA submitted comments to the Department of Justice (DOJ) expressing concern over its proposal to expand the scope of its public accommodation requirement to provide auxiliary aids and services to the disabled companions of patients, and met with the Government Accountability Office (GAO) to discuss the challenges that providers face in meeting Medicare and Medicaid Limited English Proficiency requirements. Our AMA continues to aggressively advocate for eliminating the requirement that physicians pay for translation and interpretation services for patients. In August 2008, the AMA submitted comments to the Department of Justice (DOJ) in response to the Notice of Proposed Rulemaking (NPRM) on “Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities,” requesting the agency add an exception for “undue burden” as it relates to expanding the scope of the public accommodation requirement to provide auxiliary aids and services to the disabled companions of patients. Also see Policy [D-385.978](#), Language Interpreters.

D-160.989 Physician-to-Physician Communication

Our AMA will: (1) study and report back to the House of Delegates with recommendations for action on how to improve communication between physicians and among health systems as patients transition from one health care setting to another, and that these recommendations may include: (a) Definition of the basic package of information to be included with a transfer; (b) Lists of tests completed, but results pending, including how these results may be accessed; (c) Lists of tests and procedures planned, but not completed, including who, when and where such tests and procedures shall be done; (d) Name, specialty and telephone number of each physician caring for the patient; (e) Preparation of a discharge summary at the time of transfer, explaining the outcomes of the presenting complaints; (f) Outpatient consultation forms detailing the reasons a specialty consultation has been requested; (g) Means of transmitting information, including written and electronic formats; and (h) Identification of who may be notified should communication fail; and (2) work with other interested organizations to improve physician-to-physician communications.

Rationale: [BOT Report 6-A-05](#) provided the requested information, and established Policy [D-450.984](#), Physician-to-Physician Communication.

D-165.945 Study Effects of Individual Health Insurance Mandates

Our AMA will conduct a study of the effects of the Massachusetts individual health insurance mandate on individuals, taxpayers and physicians for report back to the House of Delegates by the 2009 Annual Meeting. The report shall include details on the number of uninsured remaining, public financing required, effect on private health insurance, primary care physician availability, physician reimbursement, and physician public reporting and compliance requirements.

Rationale: [CMS Report 7-A-09](#) provided the requested information.

D-165.947 Standardizing AMA Policy on the Tax Treatment of Health Insurance

Our AMA will study and report back at the 2008 Interim Meeting the effect of changing the tax system from the deductibility of healthcare “expenses” to the deductibility of “insurance premiums” on self-insured employers.

Rationale: [CMS Report 8-I-08](#) provided the requested analysis.

D-165.948 Standardizing AMA Policy on the Tax Treatment of Health Insurance

Our AMA will study the tax treatment of health savings account contributions, earnings and withdrawals, both currently and upon enactment of legislation to replace the existing employee income tax exclusion for employer-sponsored health insurance with tax credits for individuals and families, as referenced in AMA Policy H-165.852[2].

Rationale: [CMS Report 7-I-08](#) provided the requested study.

D-165.960 Promoting a National Health Care Forum

Our AMA will: (1) continue to place a high priority on advocacy and coalition-building activities to expand health insurance coverage to the uninsured; (2) include a session on health system reform as part of its 2005 National Advocacy Conference in Washington, DC, and invite representatives of the Centers for Medicare and Medicaid Services, insurance industry, business community, legal community, hospitals, and nursing homes, as well as consumers and others determined by our Board of Trustees that have a significant interest in access and financing of health care to participate in the session; and (3) publicize the

results of the 2005 National Advocacy Conference session on health system reform to the participants and other interested parties.

Rationale: Activities specified have been accomplished. Also, see more recent policy that addresses Recommendation #1: [D-165.953](#), Crisis Commission on the State of Health Care in America.

D-165.967 Health Reimbursement Arrangements

Our AMA will: strongly encourage employers to consider offering Health Reimbursement Arrangements to their employees; and report to the House on the implementation of Health Savings Accounts.

Rationale: Our AMA sent letters to The Leapfrog Group, The National Business Group on Health, and the National Business Coalition on Health urging them to encourage their members to consider offering Health Reimbursement Arrangements (and Health Savings Accounts) to their members. Also, [CMS Report 6-A-04](#) provided the requested information, and established Policy [D-165.963](#), Health Savings Accounts.

D-180.982 Denial of Reimbursement Based on Volume of Procedures Performed

Our AMA will study the issue of low hospital volume and restrictions on patients.

Rationale: [CMS Report 6-A-11](#) provided the requested information. The informational report noted that [BOT Report 3-A-09](#) previously established Policy [H-230.954](#), Privileging Physicians with Low Volume Hospital Activity, and that the national medical specialty societies were in the best position to study specific procedures and to determine the level of volume that correlates with high quality outcomes.

D-180.983 Components of Health Insurance

Our AMA will study and clearly spell out to what extent a prepaid health service component and a risk-based component contribute to the costs of health insurance, and report back to the House of Delegates.

Rationale: [CMS Report 2-A-09](#) provided the requested information. The conclusion of the informational report noted that the prepaid component of health insurance contributes approximately a quarter of the cost of health insurance, with the risk-based component largely accounting for the remaining three-quarters of health insurance costs. It also stressed the challenges of measuring the components of health insurance, particularly separating the effect of the level of prepaid coverage from the effects of other factors such as health plan cost-sharing features and state health insurance market regulations.

D-185.990 Health Insurance Coverage of Specialty Pharmaceuticals

Our AMA will continue to monitor health plan treatment of specialty pharmaceuticals to ensure patient access to needed pharmaceuticals, and report back to the House of Delegates at the 2006 Interim Meeting.

Rationale: [CMS Report 4-I-06](#) provided the requested information. The informational report notes the council's concerns that the need to manage the costs of specialty pharmaceuticals may overshadow the importance of ensuring that patients have appropriate access to effective therapies. Also, AMA continues to collaborate with health insurance plans and individual Medicare Part D plans to develop a set of "best practices" that could be used to ensure appropriate patient access to specialty drugs. Also, see Policy [H-110.997](#), Cost of Prescription Drugs.

D-185.994 Mental Health Parity

Our AMA, along with the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry, will circulate a letter for state medical societies and specialty societies to sign urging the United States Senate and House of Representatives to bring federal mental health insurance coverage parity legislation to a vote during the 108th Congress.

Rationale: Our AMA strongly supported mental health parity legislation during the 110th Congress and worked with multiple stakeholder groups toward the enactment of legislation that would provide parity for mental health treatment and addiction and substance abuse treatment. Legislation was passed and signed into law as part of the Emergency Economic Stabilization Act of 2008. Also, see [H-185.974](#), Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs.

D-190.979 HIPAA and Foreign Outsourcing

Our AMA will: (1) encourage physicians to be careful that business associate agreements with overseas business associates adequately safeguard the privacy and security protections for patients set forth in the Health Insurance Portability and Accountability Act and encourages physicians to perform adequate and appropriate due diligence prior to entering into relationships with overseas business associates and (2) investigate ways to protect physicians from HIPAA violations when they have contracted for services in good faith and report back to the House of Delegates at the 2006 Annual Meeting.

Rationale: [BOT 15-I-06](#) provided the requested information, and established Policy [H-315.972](#), HIPAA Business Associate Contracting, Domestic and Foreign, and Foreign Outsourcing.

D-200.983 Barriers to Primary Care as a Medical Career Choice

Our AMA will (1) explore the barriers to primary care medicine as a career choice and the impact of these barriers on the profession of medicine as a whole and on access to health care in the United States; and (2) report back at the 2008 Interim Meeting its findings and plan of action.

Rationale: [CME Report 3-I-08](#) provided the requested information, and established Policy [D-200.979](#), Barriers to Primary Care as a Medical School Choice.

D-200.987 Physician Re-Entry

Our AMA, in collaboration with appropriate state and specialty societies, the Accreditation Council on Graduate Medical Education, the American Board of Medical Specialties, and the Federation of State Medical Boards, will study the issue of physician re-entry into practice after a leave of absence from practice or a limitation of certain aspects of practice, including a consideration of issues related to retraining, certification, and credentialing. The study on physician re-entry into practice will also assess the overall impact of re-entry issues on the physician workforce.

Rationale: [CME Report 6-A-08](#) provided the requested information, and established Policy [D-300.984](#), Physician Reentry.

D-200.988 Strategies for Increasing Diversity in the Health Care Workforce

Our AMA commends the Institute of Medicine on its report, “In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce,” and will develop recommendations for specific strategies to increase workforce diversity with a report back to the House of Delegates at the 2007 Annual Meeting.

Rationale: [CME Report 1-I-06](#) provided the requested information, and established Policies [D-200.982](#), Diversity in the Physician Workforce and Access to Care, and [D-200.985](#), Strategies for Enhancing Diversity in the Physician Workforce. Also, see Policy [D-295.963](#), Continued Support for Diversity in Medical Education.

D-200.990 Physician Workforce and the Future of Emergency and Trauma Care

Our AMA will (1) convene a work group with the specialties affected by the impending shortage of specialists for emergency and trauma care and those organizations closely involved in physician workforce issues to develop solutions to the problem of the undersupply of specialist physicians and the future of emergency and trauma care; and (2) utilize the recommendations of this working group to develop comprehensive, long-term legislative and regulatory proposals that will address the problem of the undersupply of specialist physicians caring for children and adults and the future of emergency and trauma care for these patients.

Rationale: Our AMA met with the American Colleges of Surgeons and other groups in 2006 and began a process to review and make recommendations about workforce needs in emergency trauma care. [BOT Report 3-I-07](#) provided additional information. Also, see Policy [D-130.971](#), The Future of Emergency and Trauma Care.

D-205.999 Profession of Medicine

Our AMA will initiate efforts to educate the presidential candidates selected by the major political parties about the importance of promoting health care initiatives, consistent with the Association’s policies and principles, that enable patients and physicians to direct health care for the future.

Rationale: In 2007, the AMA pursued dialogues with all of the declared presidential candidates. Also, see Policy [D-165.950](#), Educating the American People About Health System Reform.

D-210.998 Mandated Medicare Transfer of Title of Home Oxygen Equipment

Our AMA will formally submit comments to Congress and the Centers for Medicare and Medicaid Services expressing opposition to the home oxygen system title transfer provision of the Deficit Reduction Act.

Rationale: Our AMA submitted the requested comments. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) repealed the transfer of ownership to beneficiaries but continued a 36-month rental cap.

D-215.992 AMA Advocacy Report on the Advantages and Disadvantages of Certificate of Need Laws

1. Our AMA Board of Trustees will prepare a report addressing the benefits and risks to our members, our patients and to the business and employer communities of elimination of Certificate of Need (CON) laws and regulations that restrict the development of physician-owned ambulatory surgery centers, procedural and imaging centers and laboratories and ancillary services. 2. Our AMA report advancing the practicing physician’s perspective on CON elimination will include an analysis of the major components of our adversaries’ positions. 3. Our AMA Board will report back at the 2007 Annual Meeting.

Rationale: [BOT Report 6-I-07](#) provided the requested information.

D-215.994 Possible Anti-Competitive and Ethical Implications of Integrated Hospital System Referral Expectations

Our AMA will study the possible anti-competitive and ethical implications of an expectation that referrals among health care providers remain within an integrated hospital system physician group, regardless of whether such an expectation is directly stated or indirectly implied or rewarded. This study should focus on situations in which there is a choice in referrals among equally competent, competing physicians, and such choice is not precluded by insurance coverage restrictions. Recommendations for new policy, legislation or regulations should be included.

Rationale: [BOT Report 38-A-06](#) provided the requested information, and established Policy [D-285.974](#), Possible Anti-Competitive and Ethical Implications of Integrated Hospital System Referral Expectations.

D-215.996 Specialty Hospitals and Impact on Health Care

Our AMA will comprehensively study the issue of specialty hospitals to determine: (1) their wide-ranging impact on the provision of health care; (2) competitive pressures and tactics used by hospitals and others to stop the building of specialty hospitals; (3) known and potential benefits associated with specialty hospitals including quality of care improvements; patient satisfaction and cost effectiveness; (4) the financial impact on community hospitals and “safety net” institutions, access to emergency and trauma care services, and the quality of physician training programs; (5) the appropriateness of physician referral patterns; and (6) any other issues relating to specialty hospitals that may impact quality of care.

Rationale: [BOT Report 15-I-04](#) provided the requested information, and established Policy [D-215.995](#), Specialty Hospitals and Impact on Health Care. [BOT Report 22-A-05](#) provided additional information.

D-220.979 Access to JCAHO Standards

Our AMA will: (1) commend the Joint Commission on Accreditation of Healthcare Organizations for its web site posting of FAQs (Frequently Asked Questions), clarifying the intent and application of several select standards; and (2) investigate the feasibility of disseminating the JCAHO standards as an AMA member benefit.

Rationale: Our AMA sent the requested letter.

D-225.978 The Physician's Right to Exercise Independent Judgment in All Organized Medical Staff Affairs

Our AMA Model Physician-Hospital Employment Agreement will be modified to incorporate a provision supporting the unfettered right of a physician to exercise his/her personal and professional judgment in voting, speaking and advocating on any matter regarding: [i] patient care interests; [ii] the profession; [iii] health care in the community; [iv] medical staff matters; [v] the independent exercise of medical judgment as appropriate interests to be incorporated into physician employment and independent contractor agreements; the right [vi] not to be deemed in breach of his/her employment or independent contractor agreement for asserting the foregoing enumerated rights; and [vii] not to be retaliated against by his/her employer in any way, including, but not limited to, termination of his/her employment or independent contractor agreement, commencement of any disciplinary action, or any other adverse action against him/her based on the exercise of the foregoing rights.

Rationale: The AMA [Annotated Model Physician-Hospital Employment Agreement](#) and the [AMA Physician's Guide to Medical Staff Organization Bylaws](#) were updated as requested.

D-225.979 Guaranteeing Due Process for Employed Physicians

Our American Medical Association will (1) study the unique employment arrangements of physicians employed or contracted by health care organizations; (2) seek legal advice for producing model language for inclusion in employment contracts and medical staff bylaws that would provide the greatest possible protection for physicians against denial of due process by health care organizations; and (3) design, produce, and make available to all members, an educational package that helps physicians negotiate contracts and formulate staff bylaws that provide the greatest possible protection from denial of due process following termination of employment or premature termination of contracts by health care organizations.

Rationale: [CME Report 3-I-10](#) provided the requested information and resources are available online. See [Annotated Model Physician-Hospital Employment Agreement](#) and the [AMA Physician's Guide to Medical Staff Organization Bylaws](#).

D-225.983 Protection of Medical Staff Members' Personal Proprietary Financial Information

Our AMA will develop policy on what kind of personal proprietary information a hospital has a right to ask as part of a "conflict of interest" program and how such data should be protected and the Council on Ethical and Judicial Affairs will consider expanding Opinion E-5.07 to include the confidentiality of medical staff members' personal proprietary financial information.

Rationale: [BOT Reports 20-A-08](#) and [6-A-09](#) provided the requested information, and established Policy [H-225.955](#), Protection of Medical Staff Members' Personal Proprietary Financial Information. [CEJA Report 7-A-08](#) also was issued in response to this policy.

D-230.990 Inspector General to Rule on Exclusionary Credentialing

Our AMA will (1) press the US Department of Health and Human Services, Office of the Inspector General to rule on whether exclusive credentialing as practiced by some hospitals/health care institutions constitutes violation of fraud and abuse laws and regulations; and (2) communicate physicians' ire over the inordinate delay by the Office of the Inspector General in addressing the exclusive credentialing issue.

Rationale: Accomplished. Also, see Policy [D-230.991](#), Inspector General to Rule on Exclusivity Restrictions for Medical Staff Membership.

D-235.992 JCAHO Standard MS 1.20 and Element of Performance 19

Our AMA Commissioners to JCAHO will petition JCAHO to move up the timetable for implementation of MS.1.20, EP 19.

Rationale: Our AMA sent the requested letter.

D-235.993 Medical Staff Bylaws as a Contract

Our AMA: (1) Advocacy Resource Center will work with state and specialty societies to draft and support legislation to establish medical staff bylaws as a contract; (2) Advocacy Resource Center will work with state and specialty societies to draft and support legislation to require that due process protections for termination of staff privileges be included in all medical staff bylaws; (3) will work to have JCAHO require due process protections in medical staff bylaws as part of the JCAHO accreditation process; and (4) will take into consideration the analysis presented in Board of Trustees Report 9 (I-04) in the proposed model legislation referred to above.

Rationale: In 2005, the Council on Legislation revised its model legislation concerning medical staff bylaws as a contract, incorporating the recommendations of Board Report 9-I-04 (which established policy D-235.993). The Advocacy Resource Center staff disseminated the revised model to the federation of medicine.

D-235.995 Physicians' Guide to Medical Staff Organization Bylaws

Our AMA's Office of the General Counsel will develop a third edition of the Physicians' Guide to Medical Staff Organization Bylaws immediately, it will be made immediately available in an electronic format for AMA members as soon as possible, and it will be updated every two years, or more frequently as needed.

Rationale: Obsolete. The action requested was accomplished. Several further updates have since occurred to the [Physician's Guide to Medical Staff Organization Bylaws](#).

D-255.990 Nondiscrimination in Residency Selection

Policy H-255.983 will be communicated to the Accreditation Council for Graduate Medical Education and to all residency program directors.

Rationale: Accomplished. Policy [H-255.983, Graduates of Non-United States Medical Schools](#) remains current.

D-260.996 Improvements to Reporting of Clinical Laboratory Results

Our AMA will work with the appropriate specialty societies and laboratories in the United States for continued improvements in the reporting of clinical laboratory results with a report back to the House of Delegates at the 2006 Interim Meeting.

Rationale: [BOT Report 16-I-06](#) provided the requested information, and established Policy [D-260.995, Improvements to Reporting of Clinical Laboratory Results](#).

D-265.992 Threats Against Physicians Based on Americans with Disabilities Act

Our AMA will investigate the problem of physicians being harassed with the threat of a lawsuit based upon a non-meritorious claim using the Americans with Disabilities Act as the basis for the claim and, if found to be a problem, create a corrective action plan to deal with this abuse.

Rationale: [BOT Report 6-I-05](#) provided the requested information, and established Policy [D-90.994, Threats Against Physicians Based on Americans With Disabilities Act](#).

D-265.994 Expert Witness Affirmation

Our AMA will (1) develop an expert witness affirmation with the collaborative and active involvement of national specialty societies (particularly those that already have expert witness affirmations) and state medical societies and work with specialty societies and state medical societies to identify mechanisms for reporting unethical testimony and develop common standards for responding to reports of unethical testimony; and (2) present this expert witness affirmation to the House of Delegates at the 2004 Interim Meeting for consideration and adoption.

Rationale: [BOT Report 8-I-04](#) provided the requested information, and amended several policies: [H-265.992, Expert Witness Testimony](#) and [H-265.994, Expert Witness Testimony](#). Also, see Policy [D-435.970, Expert Witness Certification](#).

D-270.991 Repeal of Contact Lens Law

Our AMA will call for amendment of the Federal Fairness to Contact Lens Consumer Act (PL 108-164) to remove the passive verification subsection, which requires a physician who has issued a prescription for a contact lens to respond to a dispensing entity within eight hours.

Rationale: The Board of Trustees approved model federal legislation that would eliminate the passive verification provisions in the "Fairness to Contact Lens Consumer Act".

D-275.968 Independent Regulation of Physician Licensing Exams

Our AMA will study potential mechanisms of independent oversight regulation of the creation, implementation and regulation of physician licensing exams, with report back at the 2008 Annual Meeting.

Rationale: [CME Report 10-A-08](#) provided the requested information, and established Policy [D-295.939, Independent Regulation of Physician Licensing Exams](#)

D-275.978 Initial State Licensure

Our AMA will work with the Federation of State Medical Boards, state medical societies, state medical boards, and state legislatures, to eliminate the additional graduate medical education requirements imposed on IMGs for an unrestricted license, in the earnest hope of implementing AMA Policy H-275.985.

Rationale: Our AMA sent a letter to the Federation of State Medical Boards with a copy to the state licensing boards. The policy also was sent to each medical school, residency program director and directors of medical education at US teaching hospitals. Policy [H-275.985, Graduate Medical Education Requirement for Medical Licensure](#), referenced in the directive, remains current.

D-275.980 Simplifying the State Medical Licensure Process

Our AMA Board of Trustees will assign appropriate individuals from within the AMA to work with the Federation of State Medical Boards and keep the AMA membership apprised of the FSMB's actions on developing a standardized medical licensure application, and the individuals assigned by the AMA Board of Trustees regarding the FSMB's work on standardized medical licensure application will report back to the AMA on a yearly basis beginning at the 2005 Annual Meeting, until decided by the Board of Trustees that this is no longer necessary.

Rationale: [CME Report 1-A-05](#) provided the requested information. The informational report notes that our AMA is monitoring the work of the Federation of State Medical Boards and state licensing boards as they develop a common

licensure application. Also, see policies [D-275.992](#), Unified Medical License Application, and [H-275.962](#), Proposed Single Examination for Licensure.

D-275.982 Rational Role for USMLE Step Exams

Our AMA will work with the National Board of Medical Examiners and the Federation of State Medical Boards to implement the recommendations in Policy H-275.953.

Rationale: Our AMA continues to work with the National Board of Medical Examiners and the Federation of State Medical Boards. Also, see Policy [H-275.953](#), The Grading Policy for Medical Licensure Examinations.

D-285.971 Rental (Silent) Network PPOs

Our AMA will: (1) study the issue of rental (silent) network PPO “repricers,” and report back to the House of Delegates at the 2007 Interim Meeting; (2) educate physicians regarding the onerous practice of network “repricing” or silent rental networks; and (3) distribute our model state legislation for state regulation of the secondary discount market or rental (silent) networks.

Rationale: [BOT Report 9-I-07](#) provided the requested information. The information report notes that our AMA advocates regulation of silent PPOs and seeks to provide physicians with the information and tools they need to identify and effectively counter unauthorized rental network PPO practices. Our AMA also developed and distributed model state legislation on rental network PPO’s, and has sought the support of The National Conference of Insurance Legislators. Resources are available [online](#).

D-285.985 Inappropriate Bundling of Medical Services by Third Party Payers

Our AMA will urge physicians who are experiencing problems with health plans to complete the Health Plan Complaint Form available on the AMA Private Sector Advocacy Web site at <http://www.ama-assn.org/ama/pub/category/2387.html>.

Rationale: Accomplished. Physicians are regularly encouraged to complete the [Health Plan Complaint Form](#). Also, see [Policy D-70.983](#), Inappropriate Bundling of Medical Services by Third Party Payers.

D-285.994 Creation of Model State and Local Medical Society Private Sector Advocacy Programs

(1) Our AMA will develop as part of the Private Sector Advocacy Program, a model that could be used by state and local medical societies to deal with physician and patient issues with health plans. (2) The development and implementation of this program be a high priority item.

Rationale: Accomplished; see our AMA’s [Private Sector Advocacy website](#) for resources.

D-295.944 Current and Future Availability of Resources to Support the Clinical Education of Medical Students

1. Our AMA, in collaboration with the Association of American Medical Colleges; the American Osteopathic Association; the American Association of Colleges of Osteopathic Medicine; and other relevant stakeholder groups, such as the Educational Commission for Foreign Medical Graduates will: (a) collect data on the strategies being used by existing and developing medical schools to meet their current and anticipated resource needs for clinical education; (b) identify the current and anticipated gaps in resources for clinical education; and (c) develop a strategic plan to address the identified gaps, including (i) creating an advocacy agenda and (ii) identifying model programs and best practices and disseminating the results. 2. Our AMA will continue to monitor the expansion medical schools and the increase in the number of medical students taking their clinical education in the US. 3. Our AMA will report to the House of Delegates at the 2008 Interim Meeting the results of its data gathering related to medical education expansion and its advocacy activities in support of adequate resources for medical student clinical education.

Rationale: [CME Report 2-I-08](#) provided the requested information, and established Policy [D-295.931](#), Update on the Availability of Clinical Training Sites for Medical Student Education.

D-295.945 Initiative to Transform Medical Education: Strategies for Medical Education Reform

1. Our AMA will work to gain consensus for the agenda for transforming medical education with appropriate coordinated stakeholder collaboration and action. 2. Our AMA will work with collaborators to select priority areas for change in medical education, collect data on best practices in these areas, and develop plans for model programs that address identified gaps in physician preparation and continuing professional development and training. 3. Existing AMA policies and directives for action will be reviewed and, if necessary, new policies and directives will be created to facilitate the implementation of needed changes in medical education. 4. A report on progress in implementation and evaluation of identified changes in medical education will be prepared for the 2008 Annual Meeting of the House of Delegates.

Rationale: [CME Report 9-A-08](#) provided an update and implementation plan. [D-295.945](#), Initiative to Transform Medical Education: Strategies for Medical Education Reform, which also originated from CME 3-A-07, remains a viable policy.

D-295.947 A Balanced Medical Curriculum

1. Our AMA, through its Initiative to Transform Medical Education and in collaboration with relevant groups, will study ways to apportion relevant content related to the six Accreditation Council for Graduate Medical Education core competencies across the medical education continuum. 2. Our AMA will (a) collaborate with other groups to define changes to the clinical education environment that would support medical student and resident physician acquisition of appropriate core competencies, and (b) continue to advocate for appropriate funding for education to support these changes. 3. A report will be prepared for the 2009 Annual Meeting of the House of Delegates summarizing actions taken and successes achieved in bringing about educational program and clinical learning environment change.

Rationale: [CME Report 7-A-09](#) provided the requested information, and established Policy [D-295.324](#), Transforming the Medical Education Learning Environment.

D-295.948 Report on the Status of Education in Substance Abuse and Addiction in America's Medical Schools and Residency Programs

Our AMA Council on Medical Education will produce a report of the status of education in substance use and addiction in America's medical schools and residency programs.

Rationale: [CME Report 11-A-07](#) provided the requested information, and established Policy [D-295.946](#), The Status of Education in Substance Use Disorders in America's Medical Schools and Residency Programs. Also, see Policies [H-95.982](#), Substance Abuse in Medical Schools, [H-295.922](#), Establishing Essential Requirements for Medical Education in Substance Abuse, and [H-300.962](#), Recognition of Those Who Practice Addiction Medicine.

D-295.950 Equal Fees for Osteopathic and Allopathic Medical Students

Our AMA will: (1) collect data to address the following questions: (a) whether allopathic medical students have access to electives at DO-granting schools and, if so, whether the fees charged are the same as or higher than the fees charged to students from other osteopathic medical schools; and (b) whether osteopathic medical students are charged the same or higher fees for electives taken at allopathic medical school than the fees charged to students from other allopathic medical schools; and (2) prepare a report based on the information collected for the 2007 Annual Meeting of the House of Delegates, with a final recommendation related to Resolution 809 (I-05).

Rationale: [CME Report 6-A-07](#) provided the requested information, and established Policy [H-295.876](#), Equal Fees for Osteopathic and Allopathic Medical Students.

D-295.956 Medical Student Clinical Training and Education Conditions

Our AMA will: (1) commend the LCME for addressing the issue of the medical student learning environment including student hours assigned during the clinical years; (2) strongly encourage the LCME to continue to monitor work hour policies for medical students, to evaluate student work hours and educational environment in the clinical setting during regular accreditation reviews and to determine any impact on medical students resulting from the enforcement of duty-hour standards by the ACGME; (3) request that the LCME modify its standard on medical student hours and its accompanying annotation to state as follows: ED-38. The committee [responsible for the curriculum] should give careful attention to the impact of the amount of work required, including the frequency of examinations and their scheduling during the preclinical years; and on-call hours during the clinical years. ANNOTATION: In addition to monitoring the amount of classroom time and examination frequency, attention should be paid to the hours that medical students work during the clinical years and the educational value of their clinical activities. Students' duty hours should be set taking into account the effects of fatigue and sleep deprivation on learning and patient care. Medical student hours should not exceed resident duty hours as delineated by the Accreditation Council for Graduate Medical Education (ACGME); and (4) monitor the action of the LCME and report back to the House of Delegates when final action has been taken.

Rationale: [CME Report 5-A-06](#) provided the requested information, and established Policy [D-295.951](#), Medical Student Clinical Education and Training Conditions: A Follow-up Report on LCME Actions.

D-295.986 Evaluating the Impact of Hospital Mergers on Clinical Education for Medical Students and Resident Physicians

Our AMA will study the impact of hospital mergers on access to clinical educational opportunities for medical students and resident physicians.

Rationale: Accomplished. Also, see [D-225.995](#), Hospital Merger Study.

D-300.982 Opposition to Increase CME Provider Fees

Our AMA will study and report back at the 2009 Interim Meeting on the system of intrastate accreditation, including the ACCME fee structure for state accreditors and their providers, the concept of equivalency, and the new criteria for compliance, and the impact these changes will have on state accreditors and their providers.

Rationale: [CME Reports 5-I-09](#) and [14-A-10](#) provided the requested information, and established Policy [D-300.980](#), Opposition to Increased CME Provider Fees.

D-300.985 Revisiting PhRMA Code

1. Our AMA will study the impact of any industry, accreditation or governmental CME guidelines and on accredited CME providers and report back at the 2007 Annual Meeting of the House of Delegates. 2. Our AMA (a) will continue its system for regular communications with state medical society accreditors to monitor the impact of any continuing medical education (CME) guidelines, standards, or applicable regulations on the delivery of CME at the state level, and (b) will continue to monitor trends in financing and availability of CME at all levels with a report back at the 2009 Annual Meeting of the House of Delegates.

Rationale: [CME Reports 5-A-07](#) and [6-A-09](#) provided the requested information. The latter notes that the Council will continue to monitor the state of the CME enterprise and report back as appropriate.

D-300.986 Updated ACCME Standards for Commercial Support

Our AMA will: (1) create opportunities for ongoing dialogue with AMA members and CME providers to discuss effective mechanisms for resolving conflicts of interest and assuring independent and balanced content in certified CME activities; (2) communicate actively with the ACCME during the early implementation of the updated Standards for Commercial Support, in

such a manner that will ensure workable options for resolving conflicts of interest and bias issues; and (3) report back to the House at the 2007 Annual Meeting concerning these activities.

Rationale: [BOT Report 27-A-07](#) provided the requested information. The summary of the informational report noted that our AMA has a process for monitoring the implementation of the ACCME Updated Standards for Commercial Support. It also noted that dialogue with AMA members, CME providers and the ACCME, and data from the field indicates that CME providers have identified appropriate mechanisms for resolving conflicts of interest, thus demonstrating compliance with the Standards for Commercial Support, and reported that there is no evidence to indicate that compliance with the Standards has resulted in the elimination of clinical experts as CME faculty or a decrease in the number of certified CME activities.

D-300.987 Updated ACCME Standards for Commercial Support

Our AMA will (1) communicate actively with the Accreditation Council for Continuing Medical Education regarding the implementation of the updated Standards for Commercial Support, including the Interpretation and Application of Standard 2.3, Resolution of Personal Conflicts of Interest, in such a manner that will ensure workable options for resolving conflicts of interest and bias issues, which will not unfairly or unduly prohibit or impede the free flow of scientific information or discourage participation by physicians in CME activities; and (2) work with ACCME in taking appropriate actions to prevent any future misinterpretation of these guidelines, and report back to the House at the 2005 Annual Meeting.

Rationale: [BOT Report 11-A-05](#) provided the requested information and established Policy [D-300.986](#) (see above); Subsequent [BOT Report 27-A-07](#) provided additional information.

D-300.990 CME Validation Criteria

Our AMA (1) will express its support to the American Academy of Family Physicians for its evidence-based continuing medical education initiative and to the Accreditation Council for Continuing Medical Education for its valid clinical content standards; and (2) PRA program will continue to monitor the use of evidence-based standards for CME, reporting back to the House of Delegates as major changes occur.

Rationale: Our AMA sent the requested letters to the American Academy of Family Physicians and the Accreditation Council for Continuing Medical Education.

D-300.997 Use of Medical Education Numbers In Continuing Medical Education

Our AMA will disseminate this policy widely and recommend that such policy be adopted by other organizations, including national certification boards and similar entities.

Rationale: Accomplished. Resolution 301-A-01 referred to the use of social security numbers as file identifiers; see [H-300.946](#), Inappropriate Use of Social Security Numbers in CME Accreditation.

D-305.976 Federal Student Loan Program Interest Rates

Our AMA will: (1) analyze models of federal student loan and student loan consolidation program interest rate regulations (including fixed and variable rates) and make recommendations to maximize their effectiveness in addressing medical education debt and patient access to health care; (2) utilize data from the study of federal student loan and student loan consolidation program interest rate regulations to enhance its lobbying efforts toward the reauthorization of the Higher Education Act; and (3) report back to the House of Delegates at the 2005 Annual Meeting and the 2006 Interim Meeting regarding the reauthorization of the Higher Education Act of 1965 and any regulations promulgated thereunder.

Rationale: BOT Reports [13-I-05](#) and [5-I-06](#) provided the requested information, and reaffirmed Policy [D-305.976](#), Federal Student Loan Program Interest Rates. Also, see [D-305.978](#), Mechanisms to Reduce Medical Student Debt, [D-305.970](#), Proposed Revisions to AMA Policy on Medical Student Debt, and [D-305.980](#), Immediate Legislative Solutions to Medical Student Debt.

D-310.969 Fellowship Application Reform

Our AMA will: (1) continue to collaborate with the Council of Medical Specialty Societies and other appropriate organizations toward the goal of establishing a plan to standardize the application and selection process for specialty and subspecialty fellowship training; (2) report back to the House of Delegates at the 2009 Annual Meeting on progress towards the goal of standardizing the application and selection process for specialty and subspecialty fellowship training; and (3) encourage all subspecialties to use the same application cycle and such application cycle should not commence before 12 months in advance of the resident starting the fellowship, when feasible.

Rationale: [CME Report 3-A-07](#) provided the requested report, and established Policy [D-310.969](#), Fellowship Application Reform. Also, see Policy [D-310.958](#), Fellowship Application Reform.

D-310.970 Improving Parental Leave Policies for Residents

Our AMA will study and encourage the Accreditation Council for Graduate Medical Education's participation in such study of (1) the feasibility of considering guaranteed paid maternity leave for residents of no less than six weeks duration, with the possibility of unpaid maternity leave of an additional six weeks; (2) written leave policies for residents for paternity and adoption; and (3) the effect of such maternity, paternity, and adoption leave policies on residency programs, with report back to the House of Delegates at the 2008 Annual Meeting.

Rationale: [CME Report 11-A-08](#) provided the requested information, and established Policy [D-310.963](#), Family and Medical Leave Act Policies for Residents and Fellows.

D-310.975 Fellowship Application Reform

Our AMA will: (1) encourage the Electronic Residency Application Service, the National Resident Matching Program, the San Francisco Matching Program, the Council of Medical Specialty Societies and its member organizations, and the American Board of Medical Specialties and its member medical specialty boards to develop a plan to standardize the application and selection process for each specialty. The plan should assure that: (a) the process provides adequate time for the resident to be exposed to all subspecialties within a specialty before he/she must apply to a fellowship training program; (b) a consistent application and match process and timeline is adopted across all available subspecialties within each specialty; and (c) a process is developed which gives both applicants and programs ample time to evaluate each other before generating their ranking lists; and (2) report back to the House of Delegates at the 2007 Annual Meeting on progress toward achieving a standardized application and selection process for fellowship training positions.

Rationale: [CME Report 5-A-09](#) provided the requested information, and established Policy [D-310.958](#), Fellowship Application Reform.

D-315.985 Electronic Medical Record and Privacy Protections

Our AMA will develop policy regarding use, patient control, and privacy of patient information in the electronic medical record.

Rationale: [BOT Report 19-A-07](#) provided the requested report, and established Policy [D-315.984](#), Ownership of Claims Data Also, see Policies [H-315.978](#), Privacy and Confidentiality, [H-315.975](#), Police, Payer, and Government Access to Patient Health Information, and [H-315.990](#), Confidentiality of Computerized Patient Records.

D-315.986 Guiding Principles, Collection and Warehousing of Electronic Medical Record Information

Our AMA will: (1) develop guiding principles for the collection, warehousing, and use of electronic medical record information and claims data by third parties, including clearinghouses, other vendors, and payers; (2) explore the development of a claims data warehouse or clearinghouse for physicians, and report back at the 2006 Annual Meeting on its progress; and (3) explore the development of an electronic medical record repository for use by all physicians that adheres to existing AMA policies on core data standards, and confidentiality, integrity and security of patient medical record information, and that our AMA, recognizing that the cost of implementing the foregoing resolutions could be substantial, look into funding mechanisms to implement the directives as outlined.

Rationale: [BOT Reports 13-A-06](#) and [19-A-07](#) provided the requested report, and established Policy [D-315.984](#), Ownership of Claims Data Also, see Policies [H-315.978](#), Privacy and Confidentiality, [H-315.975](#), Police, Payer, and Government Access to Patient Health Information, and [H-315.990](#), Confidentiality of Computerized Patient Records.

D-315.997 Preservation of Medical Records

Our AMA will: (1) work with other appropriate organizations to further study and develop principles and criteria for the retention of medical records; and (2) monitor progress in information technology leading to development of a practical and secure personal electronic medical record.

Rationale: Accomplished. See [E-7.05](#), Retention of Medical Records.

D-320.990 Appropriate Use of Preauthorization

Our AMA will notify state and specialty societies of the model legislation developed by the Advocacy Resource Center titled “Appropriate Use of Preauthorization Act.”

Rationale: Our AMA sent detailed information on the AMA’s model legislation, “Appropriate Use of Preauthorization Act” to all state medical associations and national medical specialty societies.

D-330.953 Affordability of the Medicare Prescription Drug Programs

Our AMA will refer to the appropriate Council: (1) the issue of exploring reasonable mechanisms for medications to be safely re-imported, under Food and Drug Administration guidance, from other countries and report its results back to the House of Delegates at the 2004 Interim Meeting; (2) the issue of allowing Medicare to collectively negotiate drug prices with the pharmaceutical industry, as one large entity; and report back to the House of Delegates at the 2004 Interim Meeting; (3) the idea of individual states being allowed to collectively negotiate drug prices with the pharmaceutical industry, and report back to the House of Delegates at the 2004 Interim Meeting; and (4) other mechanisms to bring down the price of prescription drugs in the United States, as well as other possible federal price control mechanisms, and report back to the House of Delegates at the 2004 Interim Meeting.

Rationale: [BOT Report 3-I-04](#) provided the requested information, and established Policy [D-100.983](#), Prescription Drug Importation and Patient Safety.

D-330.955 Division of Medicare into a Program for Elderly and a Program for the Disabled

Our AMA will (1) refer to the appropriate Council the issue of dividing Medicare into two programs--one for seniors and one for the disabled--which will allow a more appropriate analysis of budgetary, policy, and strategic planning of the two programs; and (2) report its results back to the House of Delegates at the 2005 Annual Meeting.

Rationale: [CMS Report 2-A-05](#) provided the requested information, and established Policy [D-330.948](#), Medicare Demonstration Projects.

D-335.985 Carrier Advisory Committees

Our AMA will study the current function of Carrier Advisory Committees and make any relevant recommendation for change.

Rationale: In 2006, Medicare was undergoing Medicare Contractor Administration reform, and our AMA urged CMS in a comment letter dated June 16, 2006 to maintain a Carrier Advisory Committee presence requirement in each state. Also, see Policy [D-330.974](#), Support for Maintaining the Medicare Carrier Advisory Committee and Carrier Medical Director.

D-345.988 Suicide in Physicians and Physicians-in-Training

Our AMA will pursue the formation of an expert panel to address the risk factors for suicide across the continuum of medical education and clinical practice in order to develop recommendations and solutions to prevent suicide in medical students, resident physicians, and physicians.

Rationale: An internal AMA working group, which is being overseen by the Vice President for Science, Medicine and Public Health and the Vice President for Medical Education, was established to begin work on the formation of an expert panel to address the risk factors for suicide across the continuum of medical education and clinical practice.

D-345.989 Preventing Suicide in Physicians

Our AMA will collaborate with appropriate state and specialty societies to prepare an updated review of the literature on the incidence and risk factors of suicide by physicians and medical students; and such a study of suicide by physicians and medical trainees will include specific recommendations designed to reduce the incidence of suicide by physicians at all stages of training and practice.

Rationale: [CSAPH Report 2-A-10](#) provided the requested information, and established Policy [D-345.988](#) (see above).

D-345.991 Access to Psychiatric Beds and Impact on Emergency Medicine

Our AMA will work with relevant stakeholders, such as the American College of Emergency Physicians, the American Psychiatric Association, the National Association of EMS Physicians, and the American Ambulance Association, to study and develop recommendations regarding the national scope of the problem of psychiatric bed availability and its impact on the nation's emergency and general medicine resources, including emergency department overcrowding.

Rationale: [CMS Reports 2-A-08](#) and [CMS 3-A-09](#) provided the requested information, and established Policy [H-130.940](#) Emergency Department Boarding and Crowding.

D-345.992 Promoting Parity for the Treatment of Mental Illness and Substance Use Disorders

Our AMA will work in conjunction with interested state and specialty societies to prepare a report which includes a summary and analysis of existing parity legislation and a review of the research on the impact of parity on access, quality, and the cost of health care at both the state and federal level.

Rationale: Accomplished. Our AMA strongly supported mental health parity legislation during the 110th Congress and worked with multiple stakeholder groups toward the enactment of legislation that would provide parity for mental health treatment and addiction and substance abuse treatment. Legislation was passed and signed into law as part of the Emergency Economic Stabilization Act of 2008. Also, see [H-185.974](#), Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs.

D-345.996 Depression and Suicide on College Campuses

Our AMA will: (1) work in conjunction with all appropriate specialty societies to prepare a report on depression, substance abuse, and suicide on college campuses and will include in its report a review of available scientific data on the efficacy of prevention programs aimed at reducing the incidence of depression, substance abuse, and suicide on college campuses; (2) review the existing data on access to and utilization of college mental health and substance abuse services; and (3) advocate for the development of guidelines concerning appropriate access to psychiatric, addiction medicine, and other mental health and substance abuse services on college campuses.

Rationale: [CSAPH 8-A-06](#) provided the requested information, and established Policy [D-345.995](#), Responding to Depression, Suicide, Substance Use, and Addiction on College Campuses.

D-350.989 Health Insurance Differences Contribute to Health Care Disparities and Poorer Outcomes

Our AMA: (1) will ask the National Medical Association, the National Hispanic Medical Association and other member organizations of the Commission to End Health Care Disparities to specifically address in its mission, advocacy and actions, the contribution of differences in insurance status to health care disparities; (2) will urge the Agency for Healthcare Research and Quality to specifically investigate the impact of insurance based segregation of Medicaid patients in different settings on racial and ethnic health care disparities and make appropriate evidence-based recommendations; and (3) will provide a report back on the progress of its efforts at the 2012 Annual Meeting of the AMA House of Delegates.

Rationale: Our AMA sent letters to the [Commission to End Health Care Disparities](#) and to Dr. Carolyn Clancy, Executive of AHRQ, urging both organizations to address the issue of disparities in health insurance. [BOT 23-A-12](#) provided the requested report.

D-355.999 National Practitioner Data Bank

Our AMA will provide regular updates on the National Practitioner Data Bank to the AMA House of Delegates.

Rationale: See Policy [H-355.993](#), National Practitioner Data Bank.

D-370.989 Organ Donation Procurement

Our AMA will send a communication to the United Network for Organ Sharing (UNOS) encouraging it to convene in the next few years a series of meetings that would fulfill the intent of the resolution and offering AMA representation at such meetings.

Rationale: Our AMA sent the requested letter to the United Network for Organ Sharing.

D-375.989 Inappropriate Peer Review

Our AMA will study the issue of abuse of the peer review process.

Rationale: [BOT Report 24-A-08](#) provided the requested information. The informational report stated that Policy [H-375.983](#), Appropriate Peer Review Procedures, was quite detailed, provided importance guidance to medical staffs of the procedural safeguards that minimize the likelihood of inappropriate peer review, and any amendments to the policy that might create further complexity could obscure its value as an understandable guideline.

D-375.992 Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations

The AMA will: (1) make available a document entitled “Principles for Incident-Based Peer Review” as an appendix to the next revision of the Physician’s Guide to Medical Staff Organization Bylaws; (2) develop and make available a document entitled “Principles for Incident-Based Peer Review” to all state medical societies and hospital medical staffs in the United States; and (3) consolidate the AMA’s complete peer review policies into a single policy or document that is user-friendly and available through PolicyFinder.

Rationale: Accomplished. [BOT Reports 17-I-04](#) and [23-A-05](#); The [Principles](#) are available online, as is the [AMA Physician’s Guide to Medical Staff Organization Bylaws](#).

D-383.986 Managed Care Environment

Our AMA will prepare an action plan and model legislation for states to enhance the bargaining power of physicians on behalf of their practices and their patients in this new environment, and conduct a study to determine model state laws to regulate the uneven relationship between health plans and physicians. Recommendations will be presented to the House of Delegates at the 2007 Annual Meeting.

Rationale: [BOT Report 29-A-07](#) provided the requested information. The informational report our AMA’s [Advocacy Resource Center](#) and its [Private Sector Advocacy](#) unit will continue to work with the Federation in determining the appropriate legislative and advocacy strategies related to the issues raised in Resolution 217-A-06, particularly in light of the existing marketplace dynamics and individual state political environments.

D-383.987 State Managed Care Legislation

Our AMA will prepare and distribute to states model legislation to allow for more complete state review processes of future mergers and acquisitions of health plans.

Rationale: Accomplished.

D-385.961 Physician Tax Credits for Uncompensated Care

Our AMA will study methods, including potential tax credits or deductions, to support physicians who provide uncompensated or under-compensated care.

Rationale: [CMS Report 2-I-11](#) provided the requested information. The informational report reiterates the council’s belief that in the current political and economic environment, in which there are budgetary pressures to spend health care dollars in the most effective and efficient manner, that limited available resources should be directed toward expanding health insurance coverage for all Americans. Instead of promoting the concept of tax deductions and/or credits for the provision of uncompensated care, the focus of AMA policy and advocacy should be on advocating for legislative and regulatory changes that would ensure that physicians get paid for services rendered.

D-385.970 Tiering System for Third-Party Payers

Our AMA will publish a National Health Insurers Report Card (NHIRC), and include in the metrics for the NHIRC the frequency of prior authorization or precertification of services and pharmaceuticals.

Rationale: Accomplished. See 2012 report [online](#).

D-385.971 Gain-Sharing

Our AMA will conduct a study and prepare a report on gain-sharing arrangements between physicians and hospitals.

Rationale: [CMS Reports 4-I-08](#), [6-A-09](#), and [1-A-11](#) provided the requested information, established Policy [H-390.849](#), Medicare Physician Payment Reform; and reaffirmed Policy [D-330.924](#), Reform the Medicare System. Also, see Policy [D-385.963](#), Health Care Reform Physician Payment Models. In 2010, our AMA produced the white paper “[Pathways for Physician Success Under Healthcare Payment and Delivery Reforms](#),” which distinguishes gain-sharing from shared savings models in the context of discussing a full range of payment models.

D-385.972 National Provider Identification (NPI) Implementation

Our AMA will: (1) send to the Centers for Medicare and Medicaid Services and the major private sector payers a letter communicating our concerns regarding the failure to pay physicians in a timely manner due to these carriers’ implementation of the National Provider Identification and ask these payers to move expeditiously to end these payment delays; and (2) bring a status report on this action at its 2008 Annual Meeting.

Rationale: Accomplished. Our AMA communicated its concerns to Medicare, the payer identified as most problematic for physicians following the NPI implementation, as well as CMS. [BOT 22-A-08](#) provided the requested update.

D-385.998 Private Sector Advocacy Activities Update

Our AMA will continue to aggressively advocate in the private and public sector to level the playing field between physicians and health care payers including the development of a negotiating unit, free of antitrust constraints, within organized medicine and with no affiliation with national trade unions, as advocated by Substitute Resolution 258 (A-98) and report back at A-99.

Rationale: Accomplished. See [website](#) for current AMA activities.

D-390.965 Sustainable Growth Rate and Medicare

Our AMA will (1) continue to express its extreme disappointment in the failure of the US Congress to protect access to medical care for Medicare beneficiaries by ensuring a fair and reasonable physician payment update; and (2) report back to the AMA House of Delegates at the 2008 Annual Meeting on the progress of major Medicare reform.

Rationale: [BOT 34-A-08](#) provided the requested information. The informational report noted that 2008 was the 7th year in a row that physicians faced draconian Medicare pay cuts, and that as the 44th President and 111th Congress take office in 2009 that our AMA remained committed to securing passage of Medicare program payment reforms that would provide needed financial support for medical practices.

D-390.968 Educate the Public on Potential Lack of Access to Health Care for Medicare Recipients

Our AMA will: (a) work to ensure that the February 2007 National Advocacy Conference provides a highly effective forum to educate public policy makers, the public and the media about the need for long-term Medicare physician payment reform; (b) work with state medical societies to schedule programs throughout the year in the states aimed at educating the local population, patients, policy makers and the media about the impact of the pending Medicare physician payment cuts on access to care in those states; and (c) evaluate the need for an additional program in Washington, DC, at a later date in 2007, if another opportunity for face-to-face advocacy by physicians from across the country with their representatives in Congress is deemed necessary to successful achievement of the AMA's Medicare payment advocacy objectives for 2007.

Rationale: Accomplished in 2007 as directed.

D-390.973 Opting Out of Medicare Information Dissemination

Our AMA will place on the members-only section of the AMA web site a link to the information outlining the steps physicians need to take in order to opt out of Medicare.

Rationale: As requested, materials are [online](#).

D-405.994 Pending Litigation Regarding Medical Errors

Our AMA Board will observe how these cases progress.

Rationale: Accomplished. Our AMA continues to protect patient access to hospitals, physicians, and other health care providers.

D-405.995 Defining “Loss of Practice” in Catastrophic Events

Our AMA will study how the insurance industry defines loss of practice in situations resulting from major catastrophes.

Rationale: [CME Report 6-A-07](#) provided the requested information, and established Policy [D-405.993](#), Defining “Loss of Practice” in Catastrophic Events.

D-410.994 Radiology Benefits Managers: Practicing Medicine Without the Patient

Our AMA will address the intrusion of radiology benefit managers (RBMs) into the doctor-patient interaction (e.g., denying one diagnostic test in favor of another) by a) studying the prevalence of forced test substitution and denial of requested imaging services by RBMs contracted by third-party payers; b) advocating against such practices; c) supporting the use of appropriate use criteria (AUC) developed by medical societies and physicians with expertise in the specialty relevant to the condition of the patient as an alternative to RBMs; and d) report back progress on this issue at the 2009 Interim Meeting.

Rationale: [CMS 5-I-09](#) provided the requested information, and established Policy [H-320.946](#), Radiology Benefits Manager.

D-410.997 Criminalization of Physician Departure from Guidelines and Standards

Our AMA will study and report back at the 2005 Annual Meeting as to: (1) the need for a national clarification of the terms guidelines (parameters, algorithms, etc.) vs. standards (mandating compliance) for medical care and resource allocation; (2) the legal, moral, and ethical impact of appropriate departure from guidelines or standards, the clarification of what constitutes appropriate departure, and the rights of physicians and other health care providers accused of non-compliance with a guideline or standard; and (3) the legal, moral and ethical impact of the criminalization of medical decisions and actions of physicians and other health care providers who appropriately depart from such guidelines and standards.

Rationale: [BOT Report 28-A-05](#) provided the requested information, and established Policy [H-410.959](#), Criminalization of Physician Departure from Guidelines and Standards. Also, see Policies [H-160.946](#), The Criminalization of Health Care Decisionmaking and [D-160.999](#), Opposition to Criminalizing Health Care Decisions.

D-420.996 SSRI Use During Pregnancy

Our AMA will work with all appropriate specialty societies to: (1) prepare a report summarizing the research on the use of SSRI antidepressants during pregnancy; and (2) promulgate appropriate guidelines concerning the detection and treatment of depression during pregnancy.

Rationale: [CSAPH Report 13-A-07](#) provided the requested information, and established Policy [D-420.995](#), Use of Serotonin Reuptake Inhibitors in Pregnancy.

D-435.971 Combating Enhanced Lawsuit Funding

Our AMA will: 1) examine, state by state, laws addressing the financing of medical malpractice lawsuits by private equity sources and other lenders; 2) support those states where financing of medical malpractice lawsuits by private equity sources and other lenders is now illegal, and devise strategies to combat efforts in those states considering overturning such protections; and 3) report back to the House of Delegates on this issue at the 2011 Interim Meeting.

Rationale: [BOT 1-I-11](#) provided the requested information.

D-435.972 Hospitals Suing Physicians to Recover the Cost of Professional Liability Settlements

Our AMA will: (1) investigate and report to the House of Delegates about the practice and the implications of hospitals settling professional liability claims and then suing physicians whose actions were the basis for the claims, for all or part of the value of the settlements; and (2) develop model language that could be incorporated in contracts for employment and contracts for services between physicians and hospitals, to help protect physicians from hospitals making unilateral decisions to settle professional liability claims brought against the hospital and then having to defend against a claim brought by the hospital against the physician for all or part of the value of the settlement.

Rationale: [BOT 1-A-10](#) provided the requested information. The informational report noted that our AMA's investigation uncovered only anecdotal evidence that indemnification suits by hospitals against physicians were becoming more commonplace, and expected due to the changing relationship between hospitals and the physicians on its medical staff. Physicians now are employed by hospitals or work under a closed department arrangement in which a special group has exclusive privileges for a designated hospital department; consequently the hospital is likely to enter into contracts with physicians, which may include a provision under which a physician is bound to indemnify the hospital fully against liability. Model contract language to prevent post-settlement suits by hospitals against physicians was offered.

D-435.976 Protection From Liability Arising From Care Rendered to Patients During Officially Declared Disasters

1. Our AMA will develop and disseminate to state medical societies model legislation to give qualified physicians (MDs and DOs) automatic medical liability immunity in the event of a state or federally declared disaster or emergency, unless it is proven by clear and convincing evidence that a physician acted with malicious intent, wanton disregard for a patient's well being, or similar willful misconduct. 2. AMA's existing model state legislation, "An Act to Prohibit the Criminalization of Healthcare Decision Making," will be revised to proscribe conduct reflecting criminal intent, and specifically refer to physician volunteers responding to a federally declared emergency or disaster, without regard to whether the disaster occurs within a state where the volunteer physician is licensed to practice.

Rationale: Accomplished.

D-435.982 Frivolous Lawsuit Management

Our AMA will develop a plan to advocate to deter frivolous medical liability suits.

Rationale: [BOT 13-A-07](#) provided the requested information, and reaffirmed existing Policy [H-435.973](#), Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability.

D-440.952 Fighting the Obesity Epidemic

1. Our AMA Council on Science and Public Health (CSAPH) will critically evaluate the clinical utility of measuring body mass index (BMI) and/or waist circumference in the diagnosis and management of overweight and obesity, with input from leading researchers and key stakeholder organizations, with a report back at the 2007 AMA Interim Meeting. 2. Our AMA will consider convening relevant stakeholders to further examine the issue of incentives for healthy lifestyles. 3. Our AMA Council on Medical Service and CSAPH will collaborate to evaluate the relative merits of bariatric surgery and the issue of reimbursement for improving health outcomes in individuals with a BMI greater than 35.

Rationale: [CSAPH 1-A-08](#) provided the requested information, and established Policy [D-440.971](#), Recommendations for Physician and Community Collaboration on the Management of Obesity.

D-440.953 Need for Action for Access to Immunization

1. Our AMA: (a) will intensify its efforts to advocate that manufacturers and distributors make vaccines affordable to medical practices and ensure adequate and timely supply of vaccines to those practices; (b) advocates that purchasers of health care provide their employees and other participants with first-dollar coverage for all Centers for Disease Control and Prevention (CDC)-recommended immunizations; (c) advocates to public and private payers to pay for both the cost plus acquisition costs (storage, inventory, insurance, spoilage/wastage, etc.) of CDC-recommended vaccines and their administration with no patient cost-sharing; (d) advocates to other appropriate organizations the need to assure that when immunizations are given in locations other than the patient's medical home, a process exists to ensure communication to the medical home and the state immunization registry documenting what immunizations have been given; and (e) will study the impact on vaccine supply to medical practices, hospitals and other medical facilities that results from the large contracts with preferential distribution between vaccine

manufacturers/distributors and large non government purchasers such as national retail health clinics with particular attention to patient outcomes for clinical preventive services and chronic disease management. 2. A report on the current status of these issues will be provided to the AMA House of Delegates at the 2008 Annual Meeting.

Rationale: [CSAPH Report 4- I-08](#) provided the requested information, and established Policy [H-440.860](#), Financing of Adult Vaccines: Recommendations for Action.

D-440.963 Promoting Four Principles of Hand Awareness

Our AMA will advocate that the Centers for Disease Control and Prevention, the Department of Health and Human Services, the National Environmental Health Association and the Society of Healthcare Epidemiology of America collaborate to use the Four Principles of Hand Awareness, as delineated in AMA Policy H-440.894, as a social marketing tool so that the public hears a consistent, scientifically valid message to help prevent the spread of infectious disease, to benefit the public's health.

Rationale: Our AMA contacted the CDC to learn about ongoing activities with respect to hand-washing, and sent a letter advocating that CDC continue these activities and also employ social marketing to enhance their uptake. Also, see Policy [H-440.894](#) Support of Four Principles of Hand Awareness.

D-440.960 Prohibiting the Sale of Tanning Parlor Ultraviolet Rays to Those Under 18 Years of Age

Our AMA will: (1) develop model state legislation to prohibit the sale of tanning parlor ultraviolet rays to those under 18 years of age except as prescribed by a physician and will widely disseminate this model legislation to its component societies; and (2) request that the FDA Center for Devices and Radiological Health immediately hold fair hearings on the safety and efficacy of ultraviolet-A (UVA) bulbs as used in indoor tanning facilities and make their findings publicly available. A status report on this effort will be provided at the 2006 Interim Meeting.

Rationale: [BOT 1-I-06](#) provided the requested information. The informational report noted that our AMA developed and disseminated the model state legislation, and submitted a letter to the director of the Center for Devices and Radiological Health of the Food and Drug Administration requesting that it convene a fair hearing on the safety and efficacy of ultraviolet bulbs, as used in indoor tanning facilities. Also, see Policies [D-440.969](#), Protect Children from Skin Cancer, [H-170.982](#), Education of Students on the Hazards of Ultraviolet Radiation (Tanning Rays), [H-440.959](#) Tanning Parlors; [H-440.967](#), Public Information Program Addressing the Dangers of UVA Exposure; and [H-440.980](#), Education on the Harmful Effects of UVA and UVB Light.

D-440.970 Federal Financing of Poison Center Network

Our AMA will review the Institute of Medicine recommendations for the future of the nation's network of poison centers, take appropriate action, and provide an informational report to the House of Delegates.

Rationale: [CSAPH Report 1-A-06](#) provided the requested information. A copy of the letter our AMA sent to DHHS Secretary Leavitt expressing its supporting of the recommendations in the Institute of Medicine report was included.

D-440.977 Chronic Wasting Disease

Our AMA will study the health issues associated with chronic wasting disease, including but not limited to, facilities processing both game and non-game animals.

Rationale: [CSAPH Report 3-A-05](#) provided the requested information, and established Policy [D-150.990](#), Chronic Wasting Disease: Implications for Human Health. Also, see Policy [H-150.959](#), Risk of Transmission of Bovine Spongiform Encephalopathy to Humans in the United States.

D-440.952 Fighting the Obesity Epidemic

1. Our AMA Council on Science and Public Health (CSAPH) will critically evaluate the clinical utility of measuring body mass index (BMI) and/or waist circumference in the diagnosis and management of overweight and obesity, with input from leading researchers and key stakeholder organizations, with a report back at the 2007 AMA Interim Meeting. 2. Our AMA will consider convening relevant stakeholders to further examine the issue of incentives for healthy lifestyles. 3. Our AMA Council on Medical Service and CSAPH will collaborate to evaluate the relative merits of bariatric surgery and the issue of reimbursement for improving health outcomes in individuals with a BMI greater than 35.

Rationale: [CSAPH Report 1-A-08](#) provided the requested information; established Policy [H-440.866](#), The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity; and amended Policy [D-440.971](#), Recommendations for Physician and Community Collaboration on the Management of Obesity.

D-450.969 Improve the Recertification Process

Our AMA encourages the American Board of Medical Specialties to develop methods to demonstrate that board recertification improves patient outcomes, and will review and report back to the House of Delegates on the evolving data on the relationship between recertification and improving patient outcomes at the 2011 Annual Meeting.

Rationale: [CME Report 3-A-10](#) provided the requested information; established Policy [H-275.923](#), Maintenance of Certification/Maintenance of Licensure; and amended Policy [H-275.978](#), Medical Licensure.

D-450.971 Evaluating the Physician Quality Reporting Initiative

Through its committee structure, our AMA will examine and evaluate the implementation and data relating to the Physicians Quality Reporting Initiative and report back to the House of Delegates at the 2008 Interim Meeting on compliance of the program

with AMA Principles and Guidelines on Pay-for-Performance as well as any benefits, unintended consequences and negative effects for patients and physicians.

Rationale: [BOT 2-I-08](#) provided the requested information.

D-450.985 Health Insurance Company Report Cards

Our AMA will: (1) develop a model health insurance company report card which measures, at a minimum, performance standards for patient satisfaction, physician satisfaction, hospital satisfaction, use of rapid electronic payment, and medical loss ratio; and (2) encourage state medical societies to use this template to produce local or statewide report cards.

Rationale: Accomplished. Available [online](#).

D-450.998 Addressing the Disruptive Physician

1. Our AMA will: (a) identify and study behavior by physicians that is disruptive to high quality patient care, and (b) define the term “disruptive physician” and disseminate guidelines for managing the disruptive physician. 2. Our AMA: (a) will work with The Joint Commission and other interested parties to develop a definition of disruptive behavior by a physician to include the actions that would rise to the level of true abusive behavior; (b) will work with The Joint Commission and other interested parties to include rules for an appeals process that comply with due process for physicians accused of disruptive behavior; (c) will work to ensure that allegations of disruptive behavior by physicians will be handled by the organized medical staff through its established bylaws; and (d) Board of Trustees will request that the Council on Ethical and Judicial Affairs update Policy E-9.045, Physicians with Disruptive Behavior.

Rationale: [CEJA Report 3-I-09](#) responded to the potential updating of Policy [E-9.045](#), Physicians with Disruptive Behavior. Also, The Joint Commission published a clarification and definition of “disruptive behavior” in the April 2009 issue of its publication Perspectives, and implemented standard LD.03.01.01 on January 1, 2009. Also, see Policy [H-225.956](#), Behaviors That Undermine Safety; Lastly, our AMA’s [Model Medical Staff Code of Conduct](#) is online.

D-455.995 Imaging Safety and Standardization

Our AMA will continue to promote and fund its successful work on the promotion of interoperability and use of imaging data and presentation to improve patient safety for the next 18 months, convening key industry and specialty providers to adopt this groundbreaking accomplishment; and the results of the initiative to promote the interoperability and use of imaging data and presentation to improve patient safety will be reported back to the House of Delegates by the 2009 Interim Meeting, or sooner if goals are met prior to the 2009 Annual Meeting.

Rationale: [BOT 1-I-09](#) provided the requested information, and established Policy [D-455.994](#), Standardizing Portable Medical Imaging Formats to Enhance Safe, Timely, Efficient Care.

D-455.996 Development of Standards for MRI Equipment and Interpretation to Improve Patient Safety

1. Our AMA will convene a meeting of medical stakeholders to identify optimal approaches for magnetic resonance imaging (MRI) standardization that would serve clinical needs. Invitees will include representatives from the following medical specialty societies: American Association of Neurological Surgeons; American Congress of Neurosurgery; American Academy of Neurology; American College of Radiology; American Academy of Orthopaedic Surgeons; American College of Cardiology; American Academy of Ophthalmology; American Academy of Otolaryngology – Head and Neck Surgery Foundation. 2. Once optimal approaches that serve clinical needs have been identified, our AMA will convene a joint meeting of medical and other stakeholders, e.g., payers, vendor standardization organizations, accreditors, and major MRI manufacturers that would be impacted by MRI standardization. Invitees will include representatives from the following organizations: Centers for Medicare and Medicaid Services/other payers; National Electrical Manufacturers Association (NEMA); Digital Imaging and Communications in Medicine Standards Committee of NEMA; Intersocietal Commission for the Accreditation of MRI Laboratories; Intersocietal Accreditation Commission; Institute for Magnetic Resonance Safety, Education, and Research; GE; Siemens; Philips; Toshiba; Hitachi; and FONAR. 3. Our AMA will recommend that stakeholders agree to a voluntary system of MRI standardization and accreditation, and focus on developing solutions across professional, payer, and industry partners that promote interoperability and use of MRI data and presentation and will urge the development of a timetable that would result in 50% interoperability within one year. 4. If voluntary efforts fail and/or vendors and others are reticent to act, our AMA will advocate for mandated change through legislative channels.

Rationale: Accomplished. See Policies [D-455.994](#), Standardizing Portable Medical Imaging Formats to Enhance Safe, Timely, Efficient Care, and [D-478.996](#), Information Technology Standards and Costs.

D-455.997 Development of Standards for MRI Equipment and Interpretation to Improve Patient Safety

Our AMA will convene a meeting(s) with representatives from magnetic resonance imaging manufacturers, radiology and other interested medical specialties, and imaging facilities, with the goals of: (1) agreeing to standards in electronic imaging formats (e.g., left to right, axial, coronal, sagittal); (2) developing standards of data manipulation and localization consistent throughout all units for best interpretation of the data; and (3) ensuring that each electronic format is equipped with the capability of loading and launching its contained images on the physician’s computer; and a report of the meeting(s) will be issued to the House of Delegates at the 2007 Annual Meeting.

Rationale: [BOT Report 30-A-07](#) provided the requested information, and established Policy [D-455.996](#), Development of Standards for MRI Equipment and Interpretation to Improve Patient Safety (see above).

D-460.981 Support for Federally-Funded Medical Research

Our AMA will call for an increase in 2005 appropriations for NIH and the Agency for Healthcare Research and Quality sufficient to allow the US to take advantage of the recently completed campaign to double the nation's investment in biomedical research.

Rationale: Our AMA lobbied the House and Senate Appropriations Committees to increase funding for the National Institutes of Health and the Agency for Healthcare Research and Quality.

D-478.983 Physicians and Electronic Social Networking

Our AMA will study the issue of physicians' use of social networking, as exemplified on sites such as Facebook and Twitter, and report back to our AMA House of Delegates at the 2010 Interim Meeting.

Rationale: [CEJA Report 8-I-10](#) provided the requested information, and established Policy [E-9.124](#), Professionalism in the Use of Social Media.

D-478.985 Supporting the Establishment of Guidelines Regarding Online Professionalism

Our American Medical Association will initiate discussions with partner organizations towards developing a consensus for online professionalism in the medical community that may be used by medical schools to guide the development of policies outlining expectations of professionalism on the Internet for students and, our AMA will, during its efforts to update and modernize the AMA Code of Medical Ethics, include a section regarding online professionalism.

Rationale: [CEJA Report 8-I-10](#) provided the requested information, and established Policy [E-9.124](#), Professionalism in the Use of Social Media.

D-478.987 Request that CMS Lower the Minimum Threshold for e-Prescribing Rebate from 50% to 25% for 2009

In order for physicians to be able to receive the 2% Medicare rebate for electronic prescribing, our AMA will request that the Centers for Medicare & Medicaid Services lower the required threshold percentage of visits with eligible prescriptions sent to pharmacies electronically in calendar year 2009, from 50% to 25%, thereby allowing a later start of e-prescribing during 2009 without physicians being penalized for the considerable backlog in e-prescribing certification.

Rationale: Our AMA repeatedly expressed concerns to CMS about the need for flexibility in the e-prescribing incentive program and the burden that the 50% requirement places on medical practices, and stressed that once an e-prescribing system is in use, physicians should not have to continually report that they are using it. In 2010, when CMS proposed to reduce the minimum threshold from 50% of eligible claims to just 25 claims, our AMA provided detailed comments on the e-prescribing proposals; and urged CMS to finalize the reduced threshold for 2010, to allow flexibility for physicians who may not be able to report 25 claims because controlled substances are prescribed and for other reasons, and to lower the threshold for 2009 to 25 as well.

D-480.982 RFID Labeling in Humans

Our AMA will study the medical and ethical implications of the use of radio frequency identification chips in humans.

Rationale: [CEJA Report 5-A-07](#) provided the requested information, and established Policy [E-2.40](#), Radio Frequency ID Devices in Humans.

D-495.995 Active Support for "Screen Out"

Our AMA will inform all state and specialty societies about "Screen Out!" and encourage them to endorse this program, promote the AMA Alliance's "Screen Out!" Web site link, and encourage petition and letter-writing campaigns to ask the Motion Picture Association of America to rate all new movies with smoking "R."

Rationale: Our AMA sent the requested letters to all Federation entities seeking their support of the AMA Alliance program.

D-500.997 Issuing a Postage Stamp to Commemorate the First Surgeon General's Report on Smoking and Health (1964)

Our AMA will (1) urge the Citizens' Stamp Advisory Committee to recommend that a postage stamp be issued in 2014 to commemorate the 50th anniversary of the release of the first Surgeon General's report on smoking and health on January 11, 1964; and (2) implement this action by sending a sign-on letter to the Citizens' Stamp Advisory Committee, with endorsements by national medical specialty societies, state medical associations, and other appropriate health organizations.

Rationale: Our AMA's request was scheduled to be addressed by the committee in July 2010. In August 2010, our AMA was informed that the committee denied the request for a commemorative stamp. The issue of a stamp commemorative of the first Surgeon's General Report on Tobacco cannot be reconsidered for another 3 years.

D-500.998 Smoking and Health to Remain a Top Priority for the CDC After Reorganization

Our AMA will: (1) strengthen its support of tobacco control and encourage the Centers for Disease Control and Prevention to keep smoking and health as a top priority; (2) urge the Director of the Centers for Disease Control and Prevention to ensure the high status and visibility of its tobacco cessation program; and (3) urge the Director of the Centers for Disease Control and Prevention to strengthen the visibility of its Office on Smoking and Health by elevating its stature within the organizational structure of the agency so that the Office on Smoking and Health reports directly, or once removed, to the CDC director and that this be reflected on the organizational chart.

Rationale: Accomplished. Our AMA, through its SmokeLess States initiative, sent a letter to the Director of the CDC, which recommended that the [Office of Smoking and Health](#) remain a vital part of the CDC reorganization and that any

attempt to dissolve or remove the organization would greatly affect centralized efforts and the “one-stop shopping” goal of the federal government.

D-510.995 Health Care for Veterans and Their Families

Our AMA will: (1) work with state and specialty societies to review the report of the President’s Commission on Care for America’s Returning Wounded Warriors; and (2) prepare a report to the House of Delegates for the 2008 Annual Meeting with a critical assessment of the Commission’s recommendations for ensuring timely access to necessary and appropriate medical and mental health care services for soldiers returning from Iraq and Afghanistan and their families.

Rationale: [BOT Report 6-A-08](#) provided the requested information, and established Policy [D-510.994](#), Health Care for Veterans and Their Families.

D-515.981 Surveying Violence in the Non Hospital Work Environment

Our AMA will survey its membership regarding violence and threats directed toward physicians and health care personnel in the non-hospital work environment, and a report will be ready for the 2012 Interim Meeting with suggested solutions including advocating for legislative action to help protect patients, health care personnel, and physicians from violent and threatening work environments.

Rationale: [BOT Report 2-I-12](#) provided the requested information, updated Policy [H-515.966](#), and reaffirmed Policy [H-515.982](#), Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse.

D-515.987 Prevention of Violence in Schools

Our AMA will continue to study the timely issue of violence in our schools, including youth violence prevention and early identification and intervention, and issue a report at the 2007 Annual Meeting of the House of Delegates.

Rationale: [CSAPH Report 2-I-07](#) provided the requested information, and established [Policy D-515.986](#), Update on Youth and School Violence.

D-515.988 Warning Labels on Video Games

Our AMA Council on Science and Public Health will: (1) work in conjunction with all appropriate specialty societies to prepare a report reviewing and summarizing the research data on the emotional and behavioral effects, including addiction potential, of video games; and (2) develop recommendations for physicians, parents and legislators based on the findings of this report.

Rationale: [CSAPH Report 12-A-07](#) provided the requested information, and established Policy [D-60.974](#), Emotional and Behavioral Effects of Video Game and Internet Overuse.

D-525.995 Investigating the Continued Gender Disparities in Physician Salaries

Our AMA, in collaboration with any appropriate affiliate bodies or professional organizations (e.g., the Women’s Physician Congress), will study gender disparities in physician salaries and professional development (eg, promotions, tenure), the causes of the disparities; and report back at the 2008 Annual Meeting with recommendations on how best to advocate to eliminate the disparities identified. This study shall be stratified by age, specialty, practice type and academic vs. non-academic employment.

Rationale: [BOT Report 19-A-08](#) provided the requested information, and established Policy [D-200.981](#), Gender Disparities in Physician Income and Advancement.

D-600.959 Specialty Society Representation in the House of Delegates - Five Year Review

Our Board of Trustees will undertake a study of membership requirements with respect to the five-year review process given a declining membership in the organization.

Rationale: [BOT Report 1-I-12](#) completed the requested study, and amended Policies [G-600.020](#), Admission of Specialty Organizations to our AMA House, and [G-600.022](#), Admission of Professional Interest Medical Associations to our AMA House.

D-620.992 Association Services and Physician Organization

Our AMA: 1) will direct the appropriate AMA Council to study and report back to the AMA at the 2012 Annual Meeting on emerging physician practice environments, how services that the AMA and state medical associations currently provide to their members relate to those various practice environments, and what additional services should be provided in order to better serve the needs of all physicians; and 2) will develop a comprehensive strategic plan to address those changes in federal laws and regulations that are necessary to support and safeguard physicians as they pursue new business models, including anti-trust and other laws and regulations that adversely impact physicians’ ability to organize.

Rationale: [BOT Report 10-A-12](#) provided the requested information and offered details regarding AMA plans to achieve the requested changes. Also, AMA Advocacy 2012 objectives specifically focused on achieving legislative and regulatory advances federally and in the states to promote physician-led innovation in health reform, and a newly formed AMA issue team on physician-led delivery innovation has focused on this as one of its three major objectives.

2. GOVERNANCE POLICY CONSOLIDATION: LODGING, MEETING VENUES AND SOCIAL FUNCTIONS

Reference committee hearing: see report of [Reference Committee F](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

See Policy [G-630.140](#)

The House of Delegates adopted as amended CCB/CLRPD Report 3-A-12, Joint Council Review of all House Governance Policies. In doing so, it also referred back four policies for a revised policy consolidation statement: D-600.975, “AMA Assembly Meeting Space”; G-630.130, “Discrimination”; G-630.140, “Lodging, Meeting Venues and Social Functions”; and G-630.141, “Future AMA Meetings in Smoke-Free Facilities/Hotels.” In its 2012 report, CCB/CLRPD had recommended that G-630.130, G-630.140, and G-630.141 be retained but consolidated into a single comprehensive policy statement, and that D-600.975 be sunset since it was already AMA practice to locate section meetings in the same hotel as the HOD when possible. Testimony in reference committee from the sections asked for referral with a report back and the suggestion D-600.975 become a part of the consolidated statement rather than be sunset.

RECOMMENDATION

The Council on Constitution and Bylaws and Council on Long Range Planning and Development recommend that Policies D-600.975, G-630.130, and G-630.141 be consolidated into Policy G-630.140 as follows, and that the remainder of this report be filed:

G-630.140, “Lodging, Meeting Venues and Social Functions”

AMA policy on lodging and accommodations includes the following: (1) Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors. (2) Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity. (3) All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy. (4) It is the policy of our AMA not to hold meetings or pay member, officer or employee dues in any club, restaurant, or other institution that has exclusionary policies based on gender, race, color, religion, national origin, gender identity, or sexual orientation. (5) Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.

APPENDIX – Relevant AMA policy

D-600.975 AMA Assembly Meeting Space

Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.

G-630.130 Discrimination

It is the policy of our AMA not to hold meetings or pay member, officer or employee dues in any club, restaurant, or other institution that has exclusionary policies based on gender, race, color, religion, national origin, gender identity, or sexual orientation.

G-630.140 Lodging, Meeting Venues, And Social Functions

AMA policy on lodging and accommodations includes the following: (1) Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors. (2) Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.

G-630.141 Future AMA Meetings in Smoke-Free Facilities/Hotels

All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless

intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.

3. CCB-CLRPD SUNSET REVIEW OF 2003 HOUSE POLICIES

Reference committee hearing: see report of [Reference Committee F](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

In 1984, the House of Delegates first established a sunset mechanism for House policies (Policy G-600.110) and updated that policy in 2012. Under the sunset mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the AMA policy database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to our AMA's ability to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

The sunset review process includes the following steps:

- Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism;
- Such policies shall be assigned to the appropriate AMA councils for review;
- Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset;
- 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;
- For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification;
- The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

As part of the sunset review process, the Council on Constitution and Bylaws (CCB) and the Council on Long Range Planning and Development (CLRPD) jointly reviewed House policies and directives that were assigned to them for the 2013 cycle. The councils' recommendations along with the rationale for sunsetting or reaffirming the directive or policy at hand are presented in the Appendix, which also includes the original text of the policy or directive.

The councils also want to bring to the attention of the House that there were several additional 2003 policies that related to women in medicine. Rather than include those policies in this joint report, the councils examined all policies on the subject from across the years, not just 2003, with an eye toward consolidating related policies and rescinding those that are obsolete or duplicative. Those recommendations for sunset and consolidation are in CCB/CLRPD Report 4-I-13, AMA Policies on Women Physicians for Sunset and Consolidation.

RECOMMENDATION

The Council on Constitution and Bylaws and the Council on Long Range Planning and Development recommend that the policies listed in the Appendix be acted upon in the manner indicated and that the remainder of this report be filed

APPENDIX

Policy	Rationale
D-235.996 Preservation of Medical Staff Self-Governance. Our AMA will request the Litigation Center of the AMA consider providing assistance for appropriate cases regarding the protection of medical staff self-governance.	Sunset. The directive was accomplished. Medical staff self-governance cases are the purview of the The Litigation Center . Some notable cases involving medical staff are highlighted online.

Policy	Rationale
D-250.996 Outreach to the Iraqi Medical Community. Our AMA will actively encourage the Federation's medical societies to reach out to their counterpart societies in Iraq with diplomacy and resources.	Sunset. Our AMA provided expert assistance in establishing the Iraqi Physicians Association. Also, AMA leaders attended White House meetings on Iraqi healthcare, including building of a children's hospital in cooperation with Project Hope.
D-250.997 Post-War Medical Volunteers and Supplies. Our AMA will: (1) communicate with federal agencies about the physician specialties it represents, the interest of physicians to provide aid to Iraq, and our AMA's capabilities to assist in rebuilding Iraq's health care system with workforce, teaching, supplies and equipment, and (2) work with federal agencies coordinating relief and reconstruction and serve as a liaison between such agencies and societies represented in our AMA that want to provide assistance in Iraq.	Sunset. Our AMA worked with the United States Army to facilitate a request for supplies and personnel in Iraq. Also, our AMA included notices in various communications at least twice during the summer of 2003 to solicit volunteers/donations.
D-250.998 International Medical Volunteers. Our AMA, using its existing infrastructure and within current resources, will support the efforts of international and domestic medical volunteer endeavors such as the International Health Volunteers Organization and encourage their development.	Sunset. JAMA's career center maintains a roster of international and domestic volunteer opportunities . Also, our AMA's Office of International Medicine has an online listing of international volunteer opportunities .
D-445.999 Assessment of the AMA Appearance Program. (1) A Representation Program Advisory Team (RPAT), co-chaired by the Senior Vice President (SVP) for Governance and Operations and the SVP for Communications, was established. This team, made up of senior staff appointed by the EVP, developed recommendations for consideration by the Board Chair. The Team will meet at least monthly to review data collected on the program and provide feedback to the Chair. To date this team has: (a) Recommended goals for an AMA Representation Program that includes the current AMA Representation Program aligned with priorities set by the AMA Board at its annual planning session in February 2001. These goals include annual and biannual objectives to start with the term of the new Board Chair. (b) Identified key groups or audiences where interaction with these entities would further these objectives. The priorities established with the Board would be primary considerations for assignments made by the Chair. (c) Developed strategies for seeking appearance opportunities to these entities. This includes identification of potentials for secondary visits and consideration of using staff in lieu of trustees where appropriate. An approved template is a primary consideration by the Chair in making trustee assignments or approving staff substitutions recommended by the EVP. (d) Established criteria for providing feedback to the Board on the effectiveness of the program, including an evaluation feedback mechanism from the entity visited. (e) Activity considering a change to the name of the program. (2) The AMA representation program will involve members of the sections located in the geographic area of the appearance whenever possible to increase outreach to the AMA members and potential AMA members represented by the sections.	Sunset. The action requested has been accomplished. As directed, our AMA established the Appearance Program, which over time, has evolved into what is now called the Representation Program.
H-440.935 Transferable Pension Benefits for Public Health Professionals. Our AMA (1) endorses the concept of separable and portable pension plans for all public health professionals, which would permit professionals employed at a public health agency in one state to move to a public health agency in another state and retain pension benefits; and (2) encourages and supports continued communications between the American Association of Public Health Physicians and the Office of the Assistant Secretary of Health regarding that office's study of the portability of pensions for public health officials.	Sunset. Our AMA acted on this directive in 1992 when first adopted. AMA conveyed its policy to several organizations, including the Office of the Assistant Secretary of Health/US Department of Health and Human Services and the Council of State Governments. In the healthcare shortage context, AMA and others continue to explore options to attract and retain a trained and adequately staffed healthcare workforce to deal with demands in the upcoming years. AMA has more recent directives and policies on various aspects of public health.

Policy	Rationale
H-440.936 Elimination of Polarization Between the Private and Public Sector Medical Communities. The AMA urges county and state medical societies to create an ex officio position without vote on their governing bodies for the respective public health officer of their jurisdiction so that proper interchange between the private and public health communities can take place.	Sunset. Our AMA acted on this directive in 1992 when first adopted. More recent policy (H-440.960) promotes liaison committees between physicians in private practice and those in public health.
H-520.996 Arms Reduction. The AMA encourages the President and Congress to continue the process of bilateral and verifiable nuclear arms reduction.	Retain. Still relevant.

4. AMA POLICIES ON WOMEN PHYSICIANS FOR SUNSET AND CONSOLIDATION

Reference committee hearing: see report of [Reference Committee F](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

In CCB/CLRPD Report 3-A-13, the Council on Constitution and Bylaws (CCB) and the Council on Long Range Planning and Development (CLRPD) jointly reviewed House policies and directives that were assigned to them for the 2013 cycle. As noted in that report, there were several 2003 policies that related to women physicians. The Councils reviewed those policies and others from across the years with an eye toward consolidating related policies, and their recommendations for sunset and consolidation are included in this joint report.

In considering policies for consolidation, the Councils employed the following approach:

- Search the current AMA policy database.
- Identify outmoded and outdated policies.
- Group similar policies (or parts of policies) together into one section. To facilitate review and comparison, all pertinent AMA policies or policy elements reflected in the consolidation are cited in their entirety.
- Edit the language of each proposed policy so that it is coherent and easily understood, without altering its meaning or intent.
- Recommend that the House adopt the consolidated policies on women physicians in their entirety and that the House sunset current AMA policies that are duplicative or outmoded.

In proposing recommendations for sunset, retention and consolidation, CCB and CLRPD collaborated with the Women Physicians Congress and the Council on Medical Education. Four appendixes are attached to this report to facilitate comparison and tracking of proposed policy changes and contain the Councils' joint rationale for the recommendations along with the original text of these policies.

RECOMMENDATIONS

The Council on Constitution and Bylaws and Council on Long Range Planning and Development recommend that the following statements be adopted and the remainder of the report be filed.

1. That the following policies (see Appendix A) be retained because they are still relevant:
 - [H-200.951 Strategies for Enhancing Diversity in the Physician Workforce](#)
 - [H-310.976 Gender-Based Questioning in Residency Interviews](#)
 - [H-525.981 Discrimination of Women Physicians in Hospital Locker Facilities](#)
 - [H-525.992 Women in Medicine](#)
 - [H-525.998 Women in Organized Medicine](#)
 - [D-200.981 Gender Disparities in Physician Income and Advancement](#)
2. That the following policies (see Appendix B) be sunset because they already have been implemented, are obsolete, or are superseded by other policies:
 - [H-295.964 Enforcement of AMA Policy on Sexual Exploitation and Harassment](#)

- [H-295.970 Sexual Harassment and Exploitation between Medical Supervisors and Trainees](#)
 - [D-65.998 Elimination of Discrimination of Women](#)
 - [D-200.987 Physician Re-Entry](#)
 - [D-295.962 Prevention of Harassment and Discrimination of Women in Medicine](#)
 - [D-305.986 Recognizing Spouse and Dependent Care Expenses in Determining Medical Education Financial Aid](#)
 - [D-310.959 Provision of Child Care by Residency and Fellowship Training Programs](#)
 - [D-310.963 Family and Medical Leave Act Policies for Residents and Fellows](#)
 - [D-525.995 Investigating the Continued Gender Disparities in Physician Salaries](#)
 - [D-525.996 Prevention of Harassment and Discrimination of Women in Medicine](#)
3. That the following consolidated policies (see Appendix C) be added to the AMA policy database:
- [H-65.xxx Equal Opportunity](#)
 - [H-405.xxx Policies for Maternity, Family and Medical Necessity Leave](#)
4. That the following policies (see Appendix D) be sunset due to consolidation:
- [H-65.987 Gender Exploitation in the Workplace](#)
 - [H-65.995 Equal Rights](#)
 - [H-65.996 Equal Rights for Men and Women](#)
 - [H-65.999 Equal Opportunities](#)
 - [H-310.920 Impact of Specialty Board Mandated Residency Completion Dates on Parental Leave During Residency Training](#)
 - [H-420.961 Education-Policies for Maternity, Family and Medical Necessity Leave for Residents and Employed Physicians](#)
 - [H-420.966 Parental Leave](#)
 - [H-420.967 Maternity Leave Policies](#)
 - [H-420.987 Maternity Leave for Residents](#)
 - [H-420.996 Maternity Leave for House staff](#)

APPENDIX A – AMA policies on women physicians recommended for retention

H-200.951 Strategies for Enhancing Diversity in the Physician Workforce

Our AMA supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities. (CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08)

Retain. Policy still relevant.

H-310.976 Gender-Based Questioning in Residency Interviews

The AMA (1) opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination; (2) supports inclusion in the AMA Fellowship and Residency Interactive Database Access (FREIDA) system information on residency Family and Medical Leave policies; and (3) supports monitoring the Accreditation Council for Graduate Medical Education as it proposes changes to the “Common Requirements” and the “Institutional Requirements” of the “Essentials of Accredited Residencies,” to ensure that there is no gender-based bias. (Res. 125, I-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CME Rep. 2, A-08)

Retain. Policy still relevant.

H-525.981 Discrimination of Women Physicians in Hospital Locker Facilities

The AMA, in an effort to promote professional equality as guaranteed by the law, requests that appropriate organizations require: that male and female physicians have equitable locker facilities including equal equipment, similar luxuries and equal access to uniforms. (Res. 810, A-93; Modified and Reaffirmed: CCB Rep. 6, A-03)

Retain. Policy still relevant.

H-525.992 Women in Medicine

Our AMA reaffirms its policy of commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine. (BOT Rep. G, A-89; Reaffirmed:

Sunset Report, A-00; Reaffirmed: CLRPD Rep. 1, A-10)

Retain. Policy still relevant.

H-525.998 Women in Organized Medicine

Our AMA: (1) reaffirms its policy advocating equal opportunities and opposing sex discrimination in the medical profession; (2) supports the concept of increased tax benefits for working parents; (3) (a) supports the concept of proper child care for families of working parents; (b) reaffirms its position on child care facilities in or near medical centers and hospitals; (c) encourages business and industry to establish employee child care centers on or near their premises when possible; and (d) encourages local medical societies to survey physicians to determine the interest in clearinghouse activities and in child care services during medical society meetings; (4) reaffirms its policy supporting flexibly scheduled residencies and encourages increased availability of such programs; and (5) supports that the AMA Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures be updated by the AMA Women Physicians Congress, and forwarded to the House of Delegates for approval, and include not only resources for training programs but also private practice settings. To facilitate wide distribution and easy access, the Guidelines will be placed on the AMA Web site. (BOT Rep. T, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation A-00; Modified: CME Rep. 3, A-03)

Retain. Policy still relevant. BOT Report 25-I-04 presented the Guidelines, which are posted on the WPC website. The AMA also provides confidential assistance with gender discrimination.

D-200.981 Gender Disparities in Physician Income and Advancement

Our AMA: (1) encourages medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist; (2) supports physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations; (3) urges medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession; (4) will collect and publicize information on best practices in academic medicine and nonacademic medicine that foster gender parity in the profession; and (5) will provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit. (BOT Rep. 19, A-08)

Retain. Policy still relevant.

APPENDIX B: AMA policies on women physicians recommended for sunset**H-295.964 Enforcement of AMA Policy on Sexual Exploitation and Harassment**

It is the policy of the AMA: (1) to instruct its representatives to the Accreditation Council for Graduate Medical Education (ACGME) to urge the ACGME to incorporate into the Institutional Requirements of the Essentials of Accredited Residencies in Graduate Medical Education the requirement that all residency training institutions develop a written policy and grievance procedure which addresses sexual harassment and exploitation between educators and medical trainees; and (2) to urge all medical schools to develop and implement the recommendations of Report B of the Council on Ethical and Judicial Affairs (A-89) addressing sexual harassment and exploitation between educators and medical trainees. (Res. 285, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 3, A-03)

Sunset. Actions requested were accomplished. Institutional requirements now require “written policies covering sexual and other forms of harassment.” Policy duplicative of H-295.955 Teacher-Learner Relationship In Medical Education.

H-295.970 Sexual Harassment and Exploitation between Medical Supervisors and Trainees

The AMA believes that: (1) all medical training programs should develop and implement a policy that addresses sexual harassment and exploitation in the medical education environment; (2) such policies should include a discussion distinguishing consensual relationships from harassment; (3) such policies should contain a grievance procedure, including a mechanism to assure that the rights of all parties to due process are rigorously observed; and (4) information regarding that institution’s policies pertaining to sexual harassment and grievance procedures must be readily available to all parties. (CEJA Rep. B, A-89; Res. 301, I-94; Reaffirmed: CME Rep. 3, A-03)

Sunset. Policy duplicative of H-295.955 Teacher-Learner Relationship In Medical Education.

D-65.998 Elimination of Discrimination of Women

Our Board of Trustees believes that existing AMA policy addresses the need for equitable treatment of men and women, and recommends an examination of AMA policy to the extent that gaps exist in this area. (BOT Rep. 21, I-01; Reaffirmation A-05)

Sunset. Action requested was accomplished.

D-200.987 Physician Re-Entry

Our AMA, in collaboration with appropriate state and specialty societies, the Accreditation Council on Graduate Medical Education, the American Board of Medical Specialties, and the Federation of State Medical Boards, will study the issue of physician re-entry into practice after a leave of absence from practice or a limitation of certain aspects of practice, including a consideration of issues related to retraining, certification, and credentialing. The study on physician re-entry into practice will also assess the overall impact of re-entry issues on the physician workforce. (Res. 316, A-06)

Sunset. Study accomplished and results reported to HOD in CME Report 6-A-08, which resulted in new policy, D-300.984 Physician Reentry.

D-295.962 Prevention of Harassment and Discrimination of Women in Medicine

The AMA Model Harassment and Discrimination Grievance Policy and Procedure will be widely distributed throughout the medical education community and placed on the AMA Web site. (CME Rpt. 3, A-03)

Sunset. Action requested was accomplished. Guidelines are posted on the WPC website. Also, duplicative of H-525.998, Women in Organized Medicine, which is recommended for retention.

D-305.986 Recognizing Spouse and Dependent Care Expenses in Determining Medical Education Financial Aid

Our AMA will: (1) work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that dependent health insurance, dependent care, and dependent living expenses be included both as part of the “cost of attendance” and as an educational expense for the purposes of student budgets and financial aid in medical schools; (2) encourage medical schools to include spouse and dependent health insurance, dependent care, and dependent living expenses as part of the “cost of attendance” and as an educational expense for the purposes of student budgets and financial aid; (3) ask its Council on Medical Education, Section on Medical Schools, and Women Physicians Congress to consider options to carry out the intentions of current House of Delegates’ policy on the issue of spouse and dependent health insurance, dependent care, and dependent living expenses; and (4) report back on actions taken on this resolution, and their results, to the House of Delegates at the 2004 Annual Meeting. (Res. 301, A-03)

Sunset. CME Report 6-A-04 provided the requested update.

D-310.959 Provision of Child Care by Residency and Fellowship Training Programs

Our AMA will begin collecting more comprehensive data on the provision of child care services or stipends for child care by residency and fellowship programs using the FREIDA database and will evaluate the progress made in the provision of child care and different models being utilized by training programs. (Res. 309, A-09)

Sunset. Comprehensive policy exists, H-525.998 Women in Organized Medicine.

D-310.963 Family and Medical Leave Act Policies for Residents and Fellows

Our AMA: 1. Encourages the Accreditation Council for Graduate Medical Education to study the feasibility of requiring training institutions to offer paid FMLA-qualified leave for residents of no less than six weeks’ duration, and to permit unpaid FMLA-qualified leave of an additional six weeks. 2. Will propose to the American Board of Medical Specialties member boards that they standardize their policies regarding parental leave, absence from training, and the timing of entrance into the board certification examination process, so that at a minimum, all residents are allowed six weeks’ absence of training for FMLA-qualified leave per academic year without disproportionately increasing the length of training, or postponing certification. 3. Opposes requiring residents to serve any more service time than they took in leave that qualifies under the federal Family and Medical Leave Act. 4. Will convene a group of appropriate interested parties, including the ACGME and the ABMS, to discuss options for standardization of FMLA-qualified leave policies that would not disproportionately increase length of training or result in postponement of certification. (CME Rep. 11, A-08)

Sunset. Action requested was accomplished. Recommendations were transmitted to each medical school, residency program director, and directors of medical education at US teaching hospitals via the Medical Education Bulletin. An item was also included in an issue of the GME E-letter. The American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education were notified of the House action.

D-525.995 Investigating the Continued Gender Disparities in Physician Salaries

Our AMA, in collaboration with any appropriate affiliate bodies or professional organizations (e.g., the Women’s Physician Congress), will study gender disparities in physician salaries and professional development (e.g., promotions, tenure), the causes of the disparities; and report back at the 2008 Annual Meeting with recommendations on how best to advocate to eliminate the disparities identified. This study shall be stratified by age, specialty, practice type and academic vs. non-academic employment. (Res. 306, A-07)

Sunset. Study accomplished and reported to the HOD via BOT Rep. 19- A-08, which resulted in new policy, D-200.981 Gender Disparities in Physician Income and Advancement.

D-525.996 Prevention of Harassment and Discrimination of Women in Medicine

(1) The AMA Women Physicians Congress will continue to monitor and disseminate information on harassment and discrimination of women in medicine. (2) Our AMA will: (a) encourage the collection of grievance policies and procedures by the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education; (b) encourage institutions belonging to the Association of American Medical Colleges Council of Teaching Hospitals to continue to distribute, at resident orientation, a copy of their institution’s sexual harassment policy; (c) forward this report to the American Hospital Association; and (d) support existing programs that address harassment, discrimination, and sexism. (3) Our AMA will approve the Guidelines for Preventing and Addressing Harassment in the Medical Profession for posting on the AMA web site, and other distribution where appropriate. (CME Rep. 3, A-03; Modified: BOT Rep. 25, I-04)

Sunset. Study accomplished and reported to the HOD via BOT Rep. 25-I-04. The referenced Guidelines are posted on the WPC website.

APPENDIX C: AMA policies on women physicians recommended for consolidation

H-65.xxx Equal Opportunity

Our AMA: (1) declares it is opposed to any exploitation and discrimination in the workplace based on gender; (2) affirms the concept that equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender; (3) affirms the concept of equal rights for men and women; and (4) endorses the principle of equal opportunity of employment and practice in the medical field.

Consolidate. H-65.987 (#1), H-65.995 (#2), H-65.996 (#3) and H-65.999 (#4).

H-405.xxx Policies for Maternity, Family and Medical Necessity Leave

AMA adopts as policy the following guidelines for, and encourage the implementation of, Maternity, Family and Medical Necessity Leave for Medical Students and Physicians: (1) The 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 written leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement; (2) Recommended components of maternity 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; (i) leave policy for adoption; and (j) leave policy for paternity. (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 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 maternity leave without the loss of status. (4) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their maternity leave policies a six-week minimum leave allowance, with the understanding that no woman should be required to take a minimum leave; (5) Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave; (6) 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) 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 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) Our AMA endorses the concept of paternity leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice; (9) 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) 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) 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) Our AMA encourages flexibility in residency training programs, incorporating maternity leave and alternative schedules for pregnant house staff; and (13) 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 .

Consolidate. H-420.961 Education – Policies for Maternity, Family and Medical Necessity Leave for Residents and Employed Physicians (#1, 2, 4, 5,6, 7, 9, 10 and 11); H-420.966 Parental Leave (#8); H-420.967 Maternity Leave Policies (#1, 2, 3); H-420.996 Maternity Leave for House Staff (#12); and H-310.920 Impact of Specialty Board Mandated Residency Completion Dates on Parental Leave During Residency Training (#13).

APPENDIX D: AMA Policies on women physicians recommended for sunset due to consolidation

H-65.987 Gender Exploitation in the Workplace

Our AMA declares it is opposed to any exploitation and discrimination in the workplace based on gender. (Res. 195, A-90; Reaffirmation A-00; Reaffirmation A-05)

Sunset. Consolidated with H-65.xxx Equal Opportunity.

H-65.995 Equal Rights

Our AMA affirms the concept that equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of sex. (Res. 69, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmation A-05)

Sunset. Consolidated with H-65.xxx Equal Opportunity.

H-65.996 Equal Rights for Men and Women

The AMA affirms the concept of equal rights for men and women. (Res. 104, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmation A-05)

Sunset. Consolidated with H-65.xxx Equal Opportunity.

H-65.999 Equal Opportunity

Our AMA endorses the principle of equal opportunity of employment and practice in the medical field. (Sub. Res. 61, part 1, A-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CEJA Rep. 6, A-10)

Sunset. Consolidated with H-65.xxx Equal Opportunity.

H-310.920 Impact of Specialty Board Mandated Residency Completion Dates on Parental Leave During Residency Training

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. (Res. 326, A-09)

Sunset. Consolidated with H-405.xxx Policies for Maternity, Family and Medical Necessity Leave.

H-420.961 Education – Policies for Maternity, Family and Medical Necessity Leave for Residents and Employed Physicians

AMA adopts as policy the following guidelines for, and encourage the implementation of, Maternity and Family Leave for Residency Programs and Employed Medical Staffs: (1) The AMA urges medical schools, residency training programs, medical specialty boards, and the Accreditation Council for Graduate Medical Education to incorporate and/or encourage development of written leave policies, including parental leave, family leave, and medical leave; (2) Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave; (3) 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; (4) 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 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; (5) 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; (6) 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; and (7) 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. Residency program directors 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. (CME Rep. 6, A-98; Reaffirmation I-03)

Sunset. Consolidated with H-405.xxx Policies for Maternity, Family and Medical Necessity Leave.

H-420.966 Parental Leave

Our AMA endorses the concept of paternity leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice. (Res. 242, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)

Sunset. Consolidated with H-405.xxx Policies for Maternity, Family and Medical Necessity Leave.

H-420.967 Maternity Leave Policies

Over the past decade, the medical community has made significant progress in responding to the unique needs of women medical students and physicians, including the issue of maternity leave. The continuation and enhancement of these efforts should be encouraged. Therefore, (1) The 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 written maternity leave policies as part of the physician's standard benefit agreement. (2) Recommended components of maternity leave policies for 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; (i) leave policy for adoption; and (j) leave policy for paternity. (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 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 maternity leave without the loss of status. (3) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their maternity leave policies a six-week minimum leave allowance, with the understanding that no woman should be required to take a minimum leave. (BOT Rep. HH, I-90; Modified: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)

Sunset. Consolidated with H-405.xxx Policies for Maternity, Family and Medical Necessity Leave.

H-420.987 Maternity Leave for Residents

The AMA believes that: (1) Residency program directors should review federal law concerning maternity leave and note that for policies to be in compliance, pregnant residents must be allowed the same sick leave or disability benefits as other residents who are ill or disabled. (2) The duration of disability leave should be determined by the pregnant resident's physicians, based on the individual's condition and needs. (3) All residency programs should develop a written policy on maternity and paternity leave for residents that addresses: (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; (i) leave policy for adoption; and (j) leave policy for paternity. (4) Resident numbers and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other residents' workloads. (5) Residents should be able to return to their training program after disability leave without loss of training status. (BOT Rep. Z, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

Sunset. Consolidated with H-405.xxx Policies for Maternity, Family and Medical Necessity Leave.

H-420.996 Maternity Leave for House staff

Our AMA encourages flexibility in residency training programs, incorporating maternity leave and alternative schedules for pregnant house staff. (Sub. Res. 89, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)

Sunset. Consolidated with H-405.xxx Policies for Maternity, Family and Medical Necessity Leave.