

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

The following reports, 1–3, were presented by Willarda V. Edwards, MD, Chair, Council on Constitution and Bylaws; and Marilyn Laughead, MD, Chair, Council on Long Range Planning and Development:

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

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

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

Consistent with AMA Policy G-600.110 that recommends 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. The Councils found many directives calling for a report that was subsequently provided, but the original directive asking for the report was never rescinded. Similarly, other directives specify an action that our 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), but the directive still remained in the AMA Policy Compendium. The Councils also found numerous instances where multiple policies contained the same content, or where the policy was obsolete.

These recommendations to sunset have the support of other AMA councils and sections whose input was sought to develop the proposed action and/or rationale. The Appendix contains the original text of all directives proposed for sunset, a rationale as to why the policy should be rescinded, and, where appropriate, link to the reports that the HOD requested. All policies proposed for sunset will be retained in the AMA's historical archives. Also, the Councils emphasize that this report is distinct from the annual sunset reports submitted by each council.

RECOMMENDATIONS

The Councils recommend that the following directives be sunset, as they are obsolete, redundant or accomplished and that the remainder of this report be filed: (Rescind HOD Policy)

- [H-10.975 Promoting Protective Guards and Helmet Use in In-Line Skating](#)
- [H-10.987 Use of Helmets in Bicycle Safety](#)
- [H-15.976 Daytime Use of Low Beam Headlights](#)
- [H-30.979 Prevention of Drunken Driving](#)
- [H-30.989 Nationwide Legal Drinking Age of 21 Years](#)
- [H-45.999 Implied Consent for Alcohol Level Tests in Pilots](#)
- [D-60.979 Childhood Anaphylactic Reactions](#)
- [D-60.986 Access to Asthma Medication at School](#)
- [D-65.994 Physician Participation in the Interrogation of Prisoners and Detainees](#)
- [D-65.997 Humane Treatment of Prisoners and Detainees](#)
- [D-70.982 Fair Payment for Separate Services](#)
- [H-85.960 Certification of Cause of Death](#)
- [H-85.985 Minimum Autopsy Rates for Teaching Hospitals](#)
- [D-85.996 End-of-Life Care and Advance Care Planning](#)
- [D-90.996 Increase Funding for School and Preschool Services for Individuals with Intellectual Disabilities/Developmentally Disabled Children](#)
- [H-95.970 Training of Medical Review Officers](#)
- [H-95.992 Heroin Reclassification](#)
- [D-95.994 Safe Disposal of Used Syringes, Needles, and Other Sharps in the Community](#)
- [D-100.986 FDA Rejection of Over-The-Counter Status for Emergency Contraception Pills](#)
- [D-100.993 Drug and Vaccine Shortages](#)
- [D-110.992 Fourth Tier Pharmaceutical Benefits](#)
- [D-120.991 Physician Prescribing Data and Use of DEA Activities](#)

- [D-135.984 Protective National Ambient Air Quality Standard \(NAAQS\) for Nitrogen Oxides](#)
- [D-140.959 Exhibition of Plasticized Bodies Without Known Informed Consent](#)
- [D-140.960 Support of American Medical Association Code of Ethics](#)
- [D-140.988 National Advance Care Planning Day](#)
- [H-140.911 National Advance Care Planning Day](#)
- [D-150.980 Appropriate Supplementation of Vitamin D](#)
- [D-160.940 Free Clinics for the Uninsured](#)
- [D-160.980 Elimination of the 48-Hour Signature Rule](#)
- [D-165.952 National Health Care Policy Agenda](#)
- [D-165.968 State-Based Demonstration Projects of Our AMA Plan for Reform to Expand Health Care Coverage to the Uninsured](#)
- [D-165.980 Tort Reform](#)
- [D-165.998 Health Plan Coverage for Over-the-Counter Drugs](#)
- [H-170.982 Education of Students on the Hazards of Ultraviolet Radiation \(Tanning Rays\)](#)
- [D-170.996 Teaching Sexual Education to Disabled Youth in School](#)
- [D-170.997 Sun Protection Programs in Elementary Schools](#)
- [D-190.987 AMA Advocacy of Prompt Pay Initiatives](#)
- [D-190.990 Federal Funding for Liability for Physicians Working in Free Clinics](#)
- [D-200.977 National Health Service Corps: Stronger AMA Representation in Decision Making Process](#)
- [D-200.984 Incentive Programs to Improve Access to Care in Underserved Areas](#)
- [D-220.971 The Joint Commission Standards for Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluations](#)
- [D-230.997 Economic Loyalty Criteria for Medical Staff Privileges](#)
- [D-235.988 Membership in the Medical Staff](#)
- [D-245.997 Promotion by Physicians and Hospitals of Breastfeeding](#)
- [D-255.984 Expedite the Immigrant Visa Process for Physicians](#)
- [D-255.986 Practice of Not Granting Appropriate Visas to International Medical Graduates](#)
- [D-255.987 J-1 Visa Service Requirement](#)
- [D-255.988 J-1 Visa Waiver Application](#)
- [D-260.997 Retain CLIA Cytology PT Program as Educational](#)
- [D-265.989 Medical-Legal Partnerships to Improve Health and Well Being](#)
- [D-265.991 Pilot Program on Independent Experts and Testimony in Civil Cases](#)
- [D-265.993 Expert Witness in Medical Liability Issues: Qualifications and Code of Conduct](#)
- [D-270.989 Improvements to the Maintenance of Certification Process](#)
- [D-275.991 License Reciprocity Between States](#)
- [D-285.967 Physician Identity and Credit Protection for Blue Cross Blue Shield Association Breach of Confidentiality](#)
- [D-285.968 Health Insurance Code of Conduct](#)
- [D-285.973 Clinical Integration](#)
- [D-285.999 Mandatory Use of Hospitalists](#)
- [D-295.324 Transforming the Medical Education Learning Environment](#)
- [D-295.995 Adoption of Sexual Orientation Nondiscrimination and Gender Identity in LCME Accreditation](#)
- [D-305.971 Legal Injunction on Medical School Tuition Increases](#)
- [D-305.988 Strategies to Address Medical School Tuition Increases](#)
- [D-310.985 Measure Effectiveness of AMA Anti-discrimination Policy](#)
- [D-315.987 Patient Confidentiality and the USA Patriot Act](#)
- [D-330.920 Provider Enrollment and Chain of Ownership System \(PECOS\) Enrollment](#)
- [D-330.937 Make Medicare a Defined Contribution Open Economic System](#)
- [D-330.947 Educational Materials for Physicians on Medicare Part D](#)
- [D-330.956 Medicare Provider Enrollment System \(PECOS\)](#)
- [D-330.986 Private Contracting Under Medicare](#)
- [D-335.986 Telephone Appeals and the New Medicare Appeals Process](#)
- [D-345.990 Educating Physicians and Patients About the Mental Health Parity Act](#)
- [D-345.995 Responding to Depression, Suicide, Substance Use, and Addiction on College Campuses](#)

- [D-375.993 Confidentiality of Peer Review](#)
- [D-380.995 Support the Removal of Limiting Charges for Physicians Services Under Medicare](#)
- [D-385.964 Regional Medical Corporation](#)
- [D-385.967 Support of Legal Partnership](#)
- [D-385.975 Balance Billing for all Payers](#)
- [D-385.994 Managed Care Organization Reimbursement Formulas](#)
- [D-390.972 Recovery Audit Contractors](#)
- [D-435.983 Guam Professional Liability Crisis in Red Alert](#)
- [D-435.984 Tort Reform](#)
- [D-435.986 Risk Management Related to the Administrative Side of Care](#)
- [H-440.937 FDA Investigating the Safety of Tanning Parlor Devices](#)
- [D-440.986 Appropriate Reimbursements and Carve-Outs for Vaccines](#)
- [D-450.970 Medical Care Outside the United States](#)
- [D-450.979 Post-Discharge Test Results](#)
- [D-460.985 Incidence of Autism, Asperger's and Other Pervasive Developmental Disorders](#)
- [D-478.989 Accuracy of Internet Physician Profiles](#)
- [D-480.978 Cardiac Rhythm Management Device Evaluation](#)
- [D-480.980 Direct-To-Consumer Advertising and Provision of Genetic Testing](#)
- [D-480.998 Minimal Standards for Medical Product Reuse](#)
- [D-490.980 Support for Smoke-Free Public Places Legislation in Guam](#)
- [D-490.981 Congress Repeal 38 USC §1715, Thus Allowing Veterans Health Administration Health Facilities to Develop Smoke-Free Campuses](#)
- [D-495.997 Support of Legislation Regarding Fire-Safe Cigarettes](#)
- [D-515.986 Update on Youth and School Violence](#)
- [D-515.991 Labeling of Video Game Content](#)
- [D-515.993 Support for Legislative Action and Improved Research on the Health Response to Violence and Abuse](#)

APPENDIX - Text Of Directive And Rationale For Sunset

H-10.975 Promoting Protective Guards and Helmet Use in In-Line Skating

The AMA: (1) strongly recommends that all in-line skaters wear protective helmets, wrist guards, and elbow and knee pads, (2) encourages efforts to educate adults and children about in-line skating safety; (3) encourages the availability of safety equipment at the point of in-line skate purchase or rental; (4) encourages the use of appropriate safety equipment by participants in sporting and recreational activities; and (5) encourages manufacturers to design safety equipment that is appropriate for use in a wide range of activities, with a particular emphasis on multiple-use helmets. (Sub. Res. 403, A-95; Reaffirmed CSA Rep. 19, A-99; Reaffirmed: CSAPH Rep. 1, A-09)

Rationale: Duplicative of other policies, including H-470.974, Athletic Helmets and H-10.969, In-Line Skating. Also, see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, In-Line Skating, of all policies on the topic.

H-10.987 Use of Helmets in Bicycle Safety

Our AMA supports appropriate efforts to educate parents and children about bicycle safety, including the use of bicycle helmets. (Sub. Res. 72, I-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10)

Rationale: Superseded by several policies, including H-10.985, Bicycle Helmets and Safety and H-10.977, Helmets and Preventing Motorcycle- and Bicycle-Related Injuries. Also, see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, Helmets for Riders of Motorized or Non-motorized Cycles, of all policies on the topic.

H-15.976 Daytime Use of Low Beam Headlights

The AMA encourages drivers to use their lights during the day, especially at dusk and dawn; when driving conditions are difficult, such as in areas of construction or heavy traffic; and during adverse weather, such as fog and heavy rain. (BOT Rep. N, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

Rationale: Policy as written is obsolete: state laws govern the use of high and low beam headlights in general, in conditions of insufficient light/adverse weather, and in construction areas. Also, superseded by Policy H-15.978, Voluntary Highway Lights-On Campaign, which remains relevant.

H-30.979 Prevention of Drunken Driving

Our AMA reaffirms its existing policy encouraging automobile industry efforts to develop a safety module that thwarts operation of a car by an intoxicated person. (Sub. Res. 42, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BOT Rep. 17, A-01; Reaffirmed: CSAPH Rep. 1, A-11)

Rationale: Redundant of more comprehensive Policy H-30.969, Ignition Interlock System. Also, see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, Prevention of Drunken Driving, of all policies on the topic.

H-30.989 Nationwide Legal Drinking Age of 21 Years

Our AMA (1) encourages each state medical society to seek and support legislation to maintain at least 21 as the minimum legal drinking age; and (2) urges all physicians to educate their patients about the dangers of alcohol abuse and operating a motor vehicle while under the influence of alcohol. (Sub. Res. 95, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed and Modified: CSA Rep. 8, A-05)

Rationale: Redundant of more comprehensive policies, including Policies H-30.986, Alcohol and the Driver, and H-30.945, Drivers Impaired by Alcohol. Also, see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, Prevention of Drunken Driving, of all policies on the topic.

H-45.999 Implied Consent for Alcohol Level Tests in Pilots

FAA regulations should be amplified to include an implied consent clause in which an individual, in accepting a permit or obtaining a license to pilot aircraft, or signing a contract to fly aircraft for compensation, would, in effect, be consenting to sobriety examinations should an airport official, Aviation Medical Examiner, or governmental official have reason to suspect that the individual had been drinking before or during flight. This implied consent clause should also include the acceptance of or willingness to submit to a blood-alcohol determination or a drunk-o-meter test (alcohol content of expired air). (BOT Rep. K, I-65; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

Rationale: Obsolete, as FAA regulation §91.17 embodies the elements of this AMA policy. Also, see CCB/CLRPD 3-A-14 for proposed consolidation policy, Drug and Alcohol Use in Aviation, of all policies on the topic.

D-60.979 Childhood Anaphylactic Reactions

Our AMA will: (1) summarize the most recent scientific literature pertaining to the increased incidence of anaphylactic reactions in children; (2) develop specific strategies aimed at reducing the incidence of anaphylactic reactions among children; and (3) support legislative efforts to ensure that children have appropriate access to necessary medical interventions for the treatment of asthma and acute anaphylactic reactions in school settings. (Res. 518, A-06)

Rationale: CSAPH Report 1-A-07 provided the requested information and established Policy D-60.976, Childhood Anaphylactic Reactions, which remains current (with the editorial updates proposed for accuracy in CCB/CLRPD Report 2-A-14).

D-60.986 Access to Asthma Medication at School

Our AMA will urge the states that have not yet adopted legislation ensuring the right of children to carry and self-administer asthma metered-dose inhalers to pass such legislation. (Sub. Res. 912, I-04)

Rationale: Superseded by D-60.976, Childhood Anaphylactic Reactions, which remains current (with the editorial updates proposed for accuracy in CCB/CLRPD Report 2-A-14).

D-65.994 Physician Participation in the Interrogation of Prisoners and Detainees

Our American Medical Association Council on Ethical and Judicial Affairs, with input from all appropriate AMA stakeholders, will delineate clearly for physicians the boundaries of ethical practice with respect to participation in the interrogation of prisoners and detainees. (Res. 1, I-05)

Rationale: CEJA issued Report 10-A-06 and established Policy E-2.068, Physician Participation in Interrogation, which remains current.

D-65.997 Humane Treatment of Prisoners and Detainees

Our AMA endorses ongoing formal review of US interrogation practices of prisoners and detainees. (Sub. Res. 12, A-04)

Rationale: CEJA issued Report 10-A-06 and established Policy E-2.068, Physician Participation in Interrogation, which remains current.

D-70.982 Fair Payment for Separate Services

Our AMA will: (1) continue to oppose the inappropriate bundling practices of insurance carriers through the incorrect use of CPT codes; (2) take appropriate action to encourage that all third party payers accept, utilize and reimburse physicians based on the most current version of CPT codes and modifiers and that inappropriate bundling of such codes be prohibited; (3) support legislative measures that will enforce the correct coding concept, that if two or more medically necessary services are payable when provided on different dates, they must not be less payable when provided on the same date; and (4) report back at I-02 (Res. 705, I-01; Reaffirmation A-05; Reaffirmation I-07; Reaffirmation A-10)

Rationale: BOT Report 10-I-02 was provided as requested. AMA has more comprehensive policies, including H-70.962, Changes in the Bundling of Medical Services by Managed Care Plans, and H-70.949, Bundling of Codes for Physician Services.

H-85.960 Certification of Cause of Death

Our AMA affirms that the reporting of vital events is an integral part of patient care and that physicians are the appropriate parties to certify cause of death. (Sub. Res. 419, A-02; Reaffirmed: CSAPH Rep. 1, A-12; Reaffirmed: Res. 718, A-12)

Rationale. Duplicative of H-85.996, Improvement in Accuracy of Death Certificates. Also see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, Improving Death Certification Completion, of all policies on the topic.

H-85.985 Minimum Autopsy Rates for Teaching Hospitals

Our AMA (1) urges the federal government to provide for payment, under its programs, for autopsies as a valuable element in determining the quality of medical care and enhancing the quality of medical education; (2) reaffirms its current policy regarding autopsies, which (a) proposes ways to increase the utilization and effectiveness of the autopsy; (b) supports the use of a national computerized autopsy data bank to validate technological methods of diagnosis for medical research and to validate death certificates; and (c) urges government reimbursement for autopsy to signify its recognition as a necessary medical procedure. (Sub. Res. 79, A-87; Reaffirmed by Sub. Res. 703, A-97; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

Rationale: Item 1 is duplicative of several more comprehensive policies, including H-85.964, Autopsy Payment and Performance Standards for Third Party Payers, and H-85.989, Autopsies. Item 2 is redundant of more comprehensive policies, including H-85.993, Autopsies, H-85.980, Autopsy for Pathological Correlation, and H-85.978, Autopsy as the Practice of Medicine. Item 3 is redundant of H-85.989, Autopsies. Also see CCB/CLRPD 3-A-14 for proposed policy consolidation, Importance of Autopsies, of all policies on the topic.

D-85.996 End-of-Life Care and Advance Care Planning

1. Our AMA will identify opportunities to educate physicians and the public about advance care planning, such as through continued participation in National Healthcare Decisions Day or other national forums. 2. The Council on Ethical and Judicial Affairs or other body within our AMA will develop an educational session on advance care planning for the Annual or Interim Meeting of the House of Delegates. 3. The Council on Ethical and Judicial Affairs will review and, as appropriate, update its ethical guidance on issues relating to decisions at the end of life. 4. Our AMA will meet with interested parties to lead and direct the national discussion on end-of-life issues. (BOT Rep. 11, A-09; Reaffirmed: BOT Rep. 14, I-09; Appended: Res. 3, A-11)

Rationale: Redundant of other AMA policies, including H-85.965, Advance Care Planning and E-2.191, Advance Care Planning. In 2010, CEJA conducted a special Open Forum on advance care planning with background materials posted online. AMA has joined with the American Bar Association and others in National Health Decisions Day.

D-90.996 Increase Funding for School and Preschool Services for Individuals with Intellectual Disabilities/Developmentally Disabled Children

Our AMA will seek passage of federal regulation and/or legislation increasing school funding for services for preschool and school-aged individuals with intellectual disabilities/developmentally disabled children in the educational setting. (Res. 432, A-05; Reaffirmed in lieu of Res. 535, A-06; Modified: CMS Rep. 3, I-11)

Rationale: Our AMA sent a letter to the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies requesting full funding for the National Institutes of Health and public health programs that deal with funding for services for preschool and school-aged individuals with intellectual and development disabilities. Also, see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, Early Intervention for Children with Developmental Delay, of all policies on the topic.

H-95.970 Training of Medical Review Officers

Our AMA advocates that a provision be included in all federal legislation covering employee drug testing which requires that all physicians who serve as Medical Review Officers have received continuing medical education credit for instruction in this field. (Res. 227, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)

Rationale. Duplicative of policies H-95.971, Medical Review Officers as Licensed Physicians, and H-95.960, MDs/DOs as Medical Review Officers.

H-95.992 Heroin Reclassification

Our AMA (1) believes that the Federal Drug Enforcement Administration should not transfer heroin from Schedule I to Schedule II under the Controlled Substance Act; and (2) encourages a broader physician education in the management of patients with chronic pain. (CSA Rep. B, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10)

Rationale: Item 1 is duplicative of more comprehensive policy H-55.991 Use of Heroin in Terminally Ill Cancer Patients With Severe Chronic Pain, which is being editorially updated for accuracy in CCB/CLRPD Report 2-A-14. Item 2 is redundant of other more comprehensive policies, including D-120.976, Pain Management, D-120.979, DEA Regulations and the Ability of Physicians to Prescribe Controlled Medication Rationally, Safely, and Without Undue Threat of Prosecution, D-120.971, Promoting Pain Relief and Preventing Abuse of Controlled Substances, H-280.958 Pain Control in Long-Term Care, D-300.996, Voluntary Continuing Education for Physicians in Pain Management, D-295.982, Model Pain Management Program For Medical School Curricula, D-160.981 Promotion of Better Pain Care, and D-120.971 Promoting Pain Relief and Preventing Abuse of Controlled Substances.

D-95.994 Safe Disposal of Used Syringes, Needles, and Other Sharps in the Community

(1) Our AMA will support action at the national, state, and local levels of government in collaboration with the solid waste industry, sharps and pharmaceutical manufacturers, and pharmaceutical distributors and appropriate health care organizations, including local, state and medical specialty societies, to identify, develop, implement, and evaluate strategies to ensure safe sharps disposal in the community. (2) Our AMA will continue to maintain an active presence in national efforts to develop

solutions to the problem of safe sharps disposal in the community. (3) A report on our AMA's ongoing activities on this issue be prepared for the Annual 2002 meeting of the House of Delegates. (CSA Rep. 2, A-01; Reaffirmed: CSAPH Rep. 1, A-11)

Rationale: Item 1 has been accomplished; Item 2 is embodied in Policy D-95.993 (our AMA served on the advisory committee of the Coalition for Safe Community Needle Disposal). CSA Report 3-A-02 provided the requested report in Item 3. Also, see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, Safe Disposal of Used Syringes, Needles, and Other Sharps, of all policies on the topic.

D-100.986 FDA Rejection of Over-The-Counter Status for Emergency Contraception Pills

Our AMA will: (1) issue a public statement to oppose the unprecedented actions of the Acting Director of the United States Food and Drug Administration in overruling the approval of over-the-counter access to the Plan B pill, and urge the reconsideration of this decision immediately; (2) work with the American College of Obstetricians and Gynecologists, Physicians for Reproductive Choice and Health, local and state medical societies, and other interested organizations to continue its efforts to increase access to emergency s, including further lobbying of the FDA and Congress to make emergency contraception available over-the-counter; and (3) report back on the issue of increasing access to emergency contraception at the 2004 Interim Meeting. (Res. 443, A-04)

Rationale: Extensive reporting in the public press noting AMA policy effectively constituted a public statement of the AMA's opposition to the FDA's handling of the original application from Barr Pharmaceuticals. Our AMA contacted Barr Pharmaceuticals to determine the best way for organized medicine to help the Plan B manufacturer secure FDA approval for OTC sales and thereby increase access to emergency contraception. BOT Report 2-I-04 provided the requested update. Other AMA policy on the subject exists, including H-75.985, Access to Emergency Contraception, and H-120.947, Preserving Patients' Ability to Have Legally Valid Prescriptions Filled.

D-100.993 Drug and Vaccine Shortages

Our AMA will: (1) ask the Secretary of Health and Human Services to: (a) establish a departmental task force to explore the causes of drug, diagnostic agent, and vaccine shortages and maldistribution and to identify appropriate solutions to these problems (including liability, reimbursement, and availability to the most vulnerable populations) so that the health of the public is adequately protected. This task force should include (but is not limited to) representatives from the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), and the Agency for Health Care Research and Quality (AHRQ); (b) require this task force to seek the input of the pharmaceutical industry, wholesalers/distributors, physician and pharmacy organizations, and consumers in addressing the problem of drug, diagnostic agent, and vaccine shortages; and (c) as part of this initiative, commission one or more studies by an appropriate body of experts to identify and recommend solutions for the underlying breakdowns in both the drug, diagnostic agent, and vaccine manufacturing and distribution systems that lead to shortages; (2) work with the FDA to expand its list of "medically necessary products" to be more inclusive of important medicines, vaccines, and diagnostic agents; and will urge the FDA to monitor production, inventory, and planned cessation of production of "medically necessary products" in order to more effectively intervene when the public health is threatened. (3) will work with the FDA to educate physicians on how to report potential drug and vaccine shortages to the Agency; (4) in collaboration with the Federation, the FDA, the CDC, the pharmaceutical industry, and pharmacy associations, determine the feasibility, including costs, of establishing an effective means to communicate timely information about drug and vaccine shortages, including information about alternative therapies, to physicians; and (5) report back to the HOD at 2002 Annual Meeting. (BOT Rep. 7, I-01; Reaffirmation A-05)

Rationale: BOT Report 11-A-02 summarized AMA efforts to ensure the availability of influenza vaccines. BOT Report 17-A-02 reported on AMA and other organizations' activities to minimize shortages, including a Department of Health and Human Services investigation, recommendations from the National Vaccine Advisory Committee of the National Vaccine Program Office to strengthen the supply of routinely recommended vaccines, and the Institute of Medicine's preparation of a report on vaccine and antimicrobial agent shortages. Our AMA has more current and comprehensive policy on drug shortages: Policy H-100.956, National Drug Shortages; and on vaccine shortages: H-440.877, Distribution and Administration of Vaccines, H-440.851, Influenza Vaccine Availability and Distribution, and H-440.875, Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines.

D-110.992 Fourth Tier Pharmaceutical Benefits

Our AMA will (1) investigate the prevalence and impact in the health insurance industry of tiered pharmaceutical benefits that significantly affect patients who have diseases requiring expensive drugs for their treatment, and report back to the House of Delegates at the 2005 Interim Meeting; and (2) work with the insurance industry to ensure that patients with catastrophic diseases have an upper limit on copayments and deductibles sufficient to keep therapy affordable. (Res. 835, I-04; Reaffirmation A-08)

Rationale: CMS Report 2-I-05 was issued as requested, and it reaffirmed Policy H-125.991(5), Drug Formularies and Therapeutic Interchange, and established Policy H-185.953, Health Insurance Coverage of Specialty Pharmaceuticals. Our AMA corresponded with the Blue Cross Blue Shield Association and America's Health Insurance Plans and held individual meetings with several national health plans. Also, CMS Report 5-I-06 provided further updates and established Policy H-280.991, Policy Directions for the Financing of Long-Term Care, which includes the issue of insurance for those with chronic or catastrophic diseases.

D-120.991 Physician Prescribing Data and Use of DEA Activities

Our AMA encourages physicians to report aggressive or inappropriate activities by sales representatives to our AMA. (BOT Rep. 11, I-01; Modified: CSAPH Rep. 1, A-11)

Rationale: More comprehensive policy exists: D-315.988, Use of Physician and Patient Prescribing Data in the Pharmaceutical Industry.

D-135.984 Protective National Ambient Air Quality Standard (NAAQS) for Nitrogen Oxides

Our AMA will: (1) submit comments during the public comment period on the NAAQS standards supporting the establishment of a new hourly standard for nitrogen oxides; and (2) specifically support an hourly standard in the range of 50-75 ppb. (Res. 523, A-09)

Rationale: The AMA signed on to a letter with the American Thoracic Society and other health care organizations commenting on EPA's proposal to revise the national Ambient Air Quality Standard for nitrogen oxides (NOx.) The letter supported the establishment of stricter average annual standards, the adoption of an hourly standard, and urged careful consideration on the placement of NOx monitoring devices.

D-140.959 Exhibition of Plasticized Bodies Without Known Informed Consent

Our AMA will request that the United States or international authorities investigate if the bodies for the Premier Exhibition Inc. "Bodies Revealed" exhibits were obtained according to international human rights norms. (Res. 7, A-11)

Rationale: Action requested was accomplished. Our AMA sent a letter on September 22, 2011 to the Department of State – Bureau of Democracy, Human Rights, and Labor calling on it to participate in a thorough investigation of the manner in which plasticized remains have been obtained to assure international human rights norms, including informed consent for the donation, were followed.

D-140.960 Support of American Medical Association Code of Ethics

Our AMA will publicize its Code of Medical Ethics to physicians, medical students, and medical schools and create educational programs involving the Code. (Res. 2, A-11)

Rationale: Our AMA's Code of Medical Ethics has been promoted in various AMA publications, including AMA Wire, referenced in blogs by AMA leaders, and in Virtual Mentor, the AMA's online ethics journal. CEJA also presented an educational session on the Code of Medical Ethics during the Council's Open Forum at the 2011 Interim Meeting. When the newly modernized Code is released in 2014, it too will be widely promoted to all segments of the medical profession.

D-140.988 National Advance Care Planning Day

Our AMA will: (1) proclaim the day after Thanksgiving annual Advance Care Planning Day; and (2) work with members of the Federation to create local, state, and national programs to educate professionals and the public about the importance and process of advance care planning. (Res. 6, A-01; Reaffirmed: CEJA Rep. 8, A-11)

Rationale: Item 1 is obsolete. AMA now joins with the American Bar Association and others to support National Health Decisions Day. Item 2 is duplicative of other more comprehensive policies, including H-85.965, Advance Care Planning and H-140.977, Residency Training in Medical-Legal Aspects of End-of-Life Care, and online educational materials are available. Also see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, Educating Physicians about Advance Care Planning, of all policies on the topic.

H-140.911 National Advance Care Planning Day

Our AMA proclaims the day after Thanksgiving to be annual Advance Care Planning Day. (Res. 6, I-00; Reaffirmed: CEJA Rep. 6, A-10)

Rationale: Obsolete. AMA now joins with the American Bar Association and others in National Health Decisions Day.

D-150.980 Appropriate Supplementation of Vitamin D

Our AMA urges the Food and Nutrition Board of the Institute of Medicine to re-examine the Daily Reference Intake Values for Vitamin D in light of new scientific findings. (Res. 425, A-08)

Rationale: In November 2010, the Food and Nutrition Board of the Institute of Medicine issued updated reference values for Vitamin D and Calcium. Other current AMA policy exists: D-150.979, Appropriate Supplementation of Vitamin D, which commits our AMA to continued advocacy on this issue.

D-160.940 Free Clinics for the Uninsured

Our AMA congratulates the AMA Foundation for providing funding to free clinics through the Healthy Communities/Healthy America grants. (CMS Rep. 1, A-09)

Rationale: Action requested was accomplished in 2009.

D-160.980 Elimination of the 48-Hour Signature Rule

Our AMA will request, from the appropriate agencies of the federal government, data that supports the mandate that verbal orders from a physician be signed within 48 hours of their issue; and in the absence of adequate supporting data, our AMA shall request that this requirement be rescinded and publicize in the professional and lay press our request and its rationale. (Res. 503, A-08; Reaffirmed: Sub. Res. 844, I-08)

Rationale: In meetings with staff and through correspondence to the Centers for Medicare & Medicaid Services, the AMA urged the agency to remove the requirement that physicians sign verbal orders within 48 hours of giving them. Redundant of more recent and comprehensive policy: D-160.987, 48-Hour Signature Rule, which commits our AMA to continued advocacy on this issue.

D-165.952 National Health Care Policy Agenda

1. Our AMA will synthesize current AMA policy for the specific purpose of advocating a comprehensive, patient-centered National Health Care Policy Agenda. 2. This Agenda will strongly address the most important issues affecting physicians and patients in the United States, such as public- and private-sector financing and delivery, care for the uninsured, wellness and personal responsibility, liability, patient safety, and health information technology, and recommend comprehensive and workable solutions. 3. Our AMA will develop an appropriate mechanism to present a draft of the National Health Care Policy Agenda to members of the House of Delegates at the earliest opportunity prior to the 2007 Annual Meeting to allow delegates an appropriate period of time to review and offer feedback prior to the 2007 Annual Meeting. 4. A forum on the National Health Care Policy Agenda will be held at the 2007 Annual Meeting to debate and offer feedback to the Board of Trustees. 5. Once finalized, our AMA will use the National Health Care Policy Agenda as a framework for discussion with leaders of United States medicine, business, health care, employers, and government. 6. Our AMA will present the National Health Care Policy Agenda to the President of the United States, the Congress, the American people, and the major political parties by August 31, 2007, so that it can appropriately frame and drive the health care policy debate in the 2008 presidential election. (Res. 607, I-06)

Rationale: Actions requested were accomplished. Content for a national health care policy agenda was drafted and sent to delegates, alternate delegates and society executives in advance of the 2007 Annual Meeting; a web-based discussion facility allowed feedback; and a two-hour discussion forum was convened at A-07 to allow delegates to provide feedback. The final National Health Care Policy Agenda was transmitted as requested and published online.

D-165.968 State-Based Demonstration Projects of Our AMA Plan for Reform to Expand Health Care Coverage to the Uninsured
Our AMA will: (1) support federal legislation and/or regulation that would authorize the establishment of state-based demonstration projects to implement refundable, advanceable tax credits inversely related to income as a means of expanding health insurance coverage to the uninsured; and (2) report back to the House of Delegates at the 2004 Interim Meeting on the status of federal legislative and/or regulatory efforts to authorize the establishment of state-based tax credit demonstration projects. (Sub. Res. 704, I-03; Modified: CMS Rep. 8, A-08)

Rationale: BOT Report 13-I-04 was issued as requested, and established Policy D-165.959, State-Based Demonstration Projects to Expand Health Coverage to the Uninsured.

D-165.980 Tort Reform

(1) Our AMA will convene, as soon as possible, a new coalition comprised of our AMA, state and national medical specialty associations to develop and implement a comprehensive strategic plan that will address all aspects of the growing professional liability crisis, including but not limited to: (a) seeking Federal and state professional liability reform legislation, including a cap on non-economic damages; (b) evaluating and developing methods for improving the adequacy of reimbursement for professional liability expenses under Federal, state and private health insurance programs; and (c) developing mechanisms aimed at reducing the incidence of professional liability lawsuits and their associated costs. (2) As a complement to new coalition activities on tort reform, our AMA convene an initial planning/strategy meeting on state tort reform, through our AMA Advocacy Resource Center at the January 2002 AMA State Health Legislation meeting. (3) In advancing any Federal legislative solution to the professional liability crisis, that our AMA closely follow existing policy H-435.964, relating to Federal non-preemption of state constitutional, statutory, regulatory and common laws on professional liability. (4) Our Board of Trustees report back to the House of Delegates at the Annual 2002. (Sub. Res. 212, I-01; Reaffirmation A-10; Reaffirmed: Res. 206, A-11; Reaffirmed in lieu of Res. 205, I-11)

Rationale: BOT Report 35-A-02, issued as requested, detailed the history of the liability reform issue, updated the House of Delegates on the current efforts, outlined strategies to effectuate change, and outlined AMA actions taken including the convening of a steering committee representing state and medical specialty societies to develop a unified approach and to pool resources. The requested planning/strategy meeting was held in 2002. Also, Policy H-435.964, Federal Preemption of State Professional Liability Laws, remains current. Our AMA's website details current activities.

D-165.998 Health Plan Coverage for Over-the-Counter Drugs

Our AMA, consistent with Policy H-185.956, will continue to advocate for a wider choice of health plans that would provide greater variation in benefits (CMS Rep. 1, I-98; Modified and Reaffirmed: CMS Rep. 4, A-08)

Rationale: Redundant of more recent comprehensive policies, including H-110.997, Cost of Prescription Drugs, and H-100.964, Drug Issues in Health System Reform. Also, Policy H-185.956, Health Plan Coverage for Over-the-Counter Drugs, remains current.

H-170.982 Education of Students on the Hazards of Ultraviolet Radiation (Tanning Rays)

The AMA supports working with the U.S. Department of Education to include in the curriculum appropriate information for teachers to educate their students about the hazards of ultraviolet radiation. (Res. 204, A-91; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09)

Rationale: Redundant of more comprehensive Policy H-440.980, Education on the Harmful Effects of UVA and UVB Light. Also see CCB/CLRPD Report 3-A-14 for consolidation policy, Protecting the Public from Dangers of Ultraviolet Radiation.

D-170.996 Teaching Sexual Education to Disabled Youth in School

Our AMA will encourage the Department of Education to: (1) ensure that mentally and/or physically disabled youth receive effective and comprehensive sexual health education; and (2) offer sexual health education counseling targeted to mentally and/or physically disabled youth. (Res. 406, A-05)

Rationale: Actions requested were accomplished. Our AMA sent letters to the American School Health Association, the US Department of Education, and the Centers for Disease Control encouraging these organizations to ensure that mentally and/or physically disabled youth receive effective and comprehensive sexual health education and that the Department of Education offer sexual health education counseling targeted to mentally and/or physically disabled youth. The letters also emphasized that, although AMA supports the need for all students to get appropriate sexual health education, mentally and physically disabled youth need not be singled out for such action. The AMA has more current and comprehensive policy: Policy H-170.968, Sexuality Education, Abstinence, and Distribution of Condoms in Schools

D-170.997 Sun Protection Programs in Elementary Schools

Our AMA will work with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, and other appropriate entities to encourage elementary schools to develop sun protection policies. (Res. 403, A-05)

Rationale: Actions requested were accomplished. Our AMA sent letters to the US Department of Education, CDC/DASH and the National Association of State Boards of Education noting its willingness to work with them to encourage elementary schools to develop sun protection policies with the goal to raise awareness of this issue among teachers, parents and children.

D-190.987 AMA Advocacy of Prompt Pay Initiatives

Our AMA shall: (1) continue to advocate Policy H-190.981, and monitor and report to the House of Delegates on delayed payment to physicians by health plans, as appropriate; and (2) study the issue of how ERISA impedes the application of state prompt pay laws and report back at the 2002 Interim Meeting with recommendations on eliminating ERISA impediments to application and enforcement of state prompt pay statutes. (Sub. Res. 715, A-02; Reaffirmation I-04; Reaffirmation A-10)

Rationale: BOT 16-I-02 provided the requested report and established Policy D-385.984, ERISA Preemption and State Prompt Pay Laws, which remains current.

D-190.990 Federal Funding for Liability for Physicians Working in Free Clinics

Our AMA shall implement a plan to have regulations and funding for Section 194 of the HIPAA bill approved, which states that liability coverage for physicians volunteering in free clinics will be provided through the US Public Health Service, and will continue to monitor the implementation of Section 194 of HIPAA. (Res. 226, A-02; Appended: BOT Rep. 17, A-04)

Rationale: Congress enacted FTCA medical malpractice protection for volunteer Free Clinic health care professionals through Section 194 of HIPAA (Public Law 104-91) by amending section 224 of the Public Health Service Act [42 U.S.C. 233, 42 U.S.C. 233(o)]. This protection was extended by the Affordable Care Act (ACA) (Public Law 111-148) making board members, officers, employees, and contractors also eligible for FTCA coverage.

D-200.977 National Health Service Corps: Stronger AMA Representation in Decision Making Process

1. Our AMA will work to enhance public health and other specialty physician, medical school and medical student representation in the decision making process of the National Health Service Corps with the goals of increasing popularity and efficiency of the program in accordance with existing policies adopted by our AMA's House of Delegates. 2. Our AMA will report back on the progress of its efforts at the 2011 Annual Meeting of the House of Delegates. (Res. 216, I-10)

Rationale: BOT Report 10-A-11 provided the requested report. Our AMA, along with the Association of American Medical Colleges, American Academy of Family Physicians, American Academy of Pediatrics, American Medical Student Association, American Osteopathic Association, American Psychiatric Association, the National Rural Health Association and other National Health Service Corps (NHSC) stakeholders, also engaged in raising awareness regarding the importance and value of the NHSC program. In January 2011, AMA staff met with officials from the Health Resources and Services Administration during the Council on Graduate Medical Education (COGME) meeting to discuss opportunities to promote the NHSC program, and NHSC representatives at Medical Student Section and Resident and Fellow Section regional meetings assisted with efforts to solicit input from medical students and residents on ways to improve and promote the NHSC program. Numerous AMA policies support the NHSC, including H-200.984, National Health Service Corps Reauthorization, D-200.980, Effectiveness of Strategies to Promote Physician Practice in Underserved Areas, and H-465.988, Educational Strategies for Meeting Rural Health Physician Shortage

D-200.984 Incentive Programs to Improve Access to Care in Underserved Areas

1. Our American Medical Association, in collaboration with state and medical specialty societies, will continue to collect and disseminate information on the efficacy of various types of incentive and other programs designed to promote recruitment and retention of physicians in underserved areas. 2. Based on the analysis of the efficacy of the various types of incentive programs, our AMA will advocate to the federal government, the states, and the private sector for enhanced support for successful models. 3. A report on the outcomes of further study and actions taken related to incentive programs to improve access to care in underserved areas will be prepared for the 2008 Interim Meeting of the House of Delegates. (CME Rep. 4, A-07)

Rationale: CME Report 1-I-08 provided the requested report and reaffirmed Policy H-200.978, Loan Repayment Programs for Primary Care Careers, which remains current.

D-220.971 The Joint Commission Standards for Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluations

1. Our AMA will: (a) study The Joint Commission's accreditation standards related to the Focused Professional Practice Evaluations and the Ongoing Professional Practice Evaluations within hospital medical staffs with regard to the complexity, the time commitment, the cost and the potential liability for hospital medical staffs to implement these procedures and with regard to the impact of these new standards to improve the safety and the quality of care for our patients; and (b) report back to the House of Delegates its findings related to Focused Professional Practice Evaluations and the Ongoing Professional Practice Evaluations and make available electronic resources to assist physicians in meeting this Joint Commission standard. 2. Our AMA will develop enduring materials to assist organized medical staffs to understand and lead the implementation of Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation, to ensure these processes promote and protect physician clinical autonomy and are not used for the purpose of economic credentialing. (Res. 723, A-09; Appended: BOT Rep. 5, I-10)

Rationale: BOT Report 5-I-10 provided the requested report and reaffirmed Policy H-375.997, Voluntary Medical Peer Review, which remains current. The AMA Physician's Guide to Medical Staff Organization Bylaws, available as a free eBook for AMA members, comprehensively addresses the issue of focused and ongoing professional practice evaluation (FPPE/OPPE). The Guide provides sample bylaws language on a number of FPPE/OPPE-related topics and provides information to help organized medical staffs understand and lead the implementation of FPPE/OPPE. Additionally, the Organized Medical Staff Section hosted an education program on FPPE/OPPE, which was subsequently made available as an online webcast but is no longer available due to the CME credit expiring.

D-230.997 Economic Loyalty Criteria for Medical Staff Privileges

Our AMA will: (1) strongly oppose the implementation of economic loyalty criteria; (2) draft model legislation for dissemination to the Federation, that would prohibit the implementation of economic loyalty criteria; and (3) notify the American Hospital Association and other hospital associations of AMA policy opposing economic loyalty criteria. (Res. 804, I-00; Reaffirmation A-05)

Rationale: Actions requested were accomplished in 2001. Redundant of more recent policies: H-230.958, Economic Loyalty Criteria for Medical Staff Privileges and D-225.985, Preventing Elimination of Medical Staffs and Independent Peer Review Through Hospital Economic Loyalty Policies.

D-235.988 Membership in the Medical Staff

Our AMA will study how hospital medical staffs integrate and monitor the activities of allied health professionals, including but not limited to physician assistants and nurse practitioners with regard to patient care, safety, quality and ethical issues. (Res. 736, A-09)

Rationale: The study was completed in 2010. The AMA Organized Medical Staff Section website includes a slide presentation with study highlights.

D-245.997 Promotion by Physicians and Hospitals of Breastfeeding

Our AMA will investigate the factors contributing to the differences in breastfeeding rates between various racial and ethnic groups with a report back that includes possible actions to be taken to address these factors. (Res. 412, A-04)

Rationale: CSAPH Report 2-A-05 provided the requested report and established Policy H-245.982, AMA Support for Breastfeeding, which remains current.

D-255.984 Expedite the Immigrant Visa Process for Physicians

Our AMA will lobby Congress and the federal government to exempt physicians with H-1B Visas who fulfilled their J-1 Visa waiver requirements from any immigration caps. (Res. 234, A-06)

Rationale: In 2006, AMA sent a letter addressing the need to reauthorize the Conrad 30 J-1 Visa program, the expansion of waiver slots from 30-50, and immigration cap exemptions for H-1B visa exemptions for those completing their J-1 Visa service requirements to the Chairman and Ranking members of the Senate and House Judiciary committees. AMA has more current and comprehensive policy: D-255.985, Conrad 30 - J-1 Visa Waivers and D-255.993, J-1 Visas and Waivers.

D-255.986 Practice of Not Granting Appropriate Visas to International Medical Graduates

Our AMA will request that the State Department expedite granting of otherwise appropriate visas to International Medical Graduates who pass United States Medical Licensing Exams. (Res. 232, A-06)

Rationale: In 2006, our AMA sent a letter urging the Department of State to take action to expedite granting of visas to International Medical Graduates who have passed the United States Licensing Exams. Also, more current and comprehensive policy exists, including Policy D-255.989, Expeditious Security Clearance and Visa Processing of Physicians.

D-255.987 J-1 Visa Service Requirement

Our AMA will lobby the US Department of State to change the current J-1 Visa waiver policy to allow for exceptions on a "case-by-case" basis where the continuous service requirement can be waived, such as in cases of documented abusive and intolerable employment conditions. (BOT Rep. 11, A-06)

Rationale: Our AMA's Washington Office staff has lobbied the U. S. Department of State to change the current J-1 Visa Waiver from 3 years of continuous service to 3 years of cumulative service on a case-by-case basis.

D-255.988 J-1 Visa Waiver Application

Our AMA will lobby the relevant federal agencies to process the paperwork for J-1 Visa waivers expeditiously. (Res. 712, I-05)

Rationale: More current and comprehensive exists: Policy D-255.989, Expeditious Security Clearance and Visa Processing of Physicians.

D-260.997 Retain CLIA Cytology PT Program as Educational

Our AMA will advocate to the relevant government agencies that the cytology proficiency testing program, a long dormant provision of the Clinical Laboratory Improvement Amendments of 1988 that began implementation in 2005, remain as an educational pilot program at least through 2007 or until such time as the Clinical Laboratory Improvement Advisory Committee can review the scientific data and provide an opinion on the validity of the grading criteria, the clinical relevance of the grading criteria, the importance of using field validated Pap test slides, and the need for a testing frequency of once a year. (Res. 526, A-05)

Rationale: The AMA sent a letter to CMS advocating that the cytology proficiency testing program remain an educational pilot until 2007 or until the Clinical Laboratory Improvement Advisory Committee (CLIA) has provided opinions on the listed issues. When the issue was first raised, the AMA contacted the Centers for Medicare & Medicaid Services and worked with the Kansas Medical Society to ensure that changes, considered to charges for educational workshops, will not be implemented.

D-265.989 Medical-Legal Partnerships to Improve Health and Well Being

Our AMA: (1) encourages physicians to develop medical-legal partnerships (MLPs) to help identify and resolve diverse legal issues that affect patients' health and well-being; (2) will work with physician groups and other key stakeholder organizations such as the American Bar Association and the Legal Services Corporation to: (a) educate physicians on the impact of unmet legal needs on the health of patients; (b) will provide physicians with information on screening for such unmet legal needs in their patients; and (c) provide physicians, hospitals and health-centers with information on establishing a Medical-Legal Partnership; and (3) will create a model medical-legal partnership agreement for physicians to utilize as guidance when entering into such an agreement. (BOT Rep. 15, A-10)

Rationale: Our AMA met with representatives of the American Bar Association (ABA), as well as representatives from the National Center for Medical-Legal Partnership (MLP) in order create synergies with the ABA regarding efforts to meet the unmet medico-legal needs of patients. The AMA developed a model MLP agreement and worked with the ABA and National Center for MLP to ensure maximum dissemination of these materials to physicians and other health care providers.

D-265.991 Pilot Program on Independent Experts and Testimony in Civil Cases

Our American Medical Association (1) applauds the expert witness pilot program established by the Chattanooga-Hamilton County Medical Society and the Chattanooga Bar Association that addresses issues surrounding the admissibility of expert testimony in civil cases and the ability of a trial judge to call an independent expert; and (2) will monitor the progress of the expert witness pilot program established by the Chattanooga-Hamilton County Medical Society and the Chattanooga Bar Association and report to the House of Delegates. (Res. 2, I-05)

Rationale: BOT Report 3-I-06 provided the requested report: The AMA applauded the Medical Society and the Bar Association for the unique partnership they formed, and their joint efforts to eliminate expert witness testimony that does not meet the requirements set forth in Rule 702 of the Tennessee Rules of Evidence, and encouraged them to continue their important work on this issue and provide updates on the Project as it moves forward.

D-265.993 Expert Witness in Medical Liability Issues: Qualifications and Code of Conduct

1. Our AMA will develop model state legislation that would adopt standards similar to Federal Rule of Civil Procedure 26(a)(2)(B) applicable to experts testifying in medical liability cases in state court. 2. The AMA's Expert Witness Affirmation Statement will be posted on the AMA web site. (BOT Rep. 8, I-04)

Rationale: Accomplished. Our AMA developed and disseminated the requested model state legislation, "An Act to provide for the regulation of expert witnesses in medical injury actions."

D-270.989 Improvements to the Maintenance of Certification Process

By September 15, 2008, our AMA Board of Trustees will write a letter to the American Board of Medical Specialties (ABMS) asking that it work with its 24 member boards to: a. coordinate with each other, the ABMS, specialty societies and the AMA to ensure that the demands of Maintenance of Certification (MOC) are reasonable; b. educate physicians and increase their understanding of the MOC process and its requirements; c. solicit physician input and feedback regarding MOC implementation; d. make transparent all recertification-related costs; e. work to minimize the disruption of physician practice due to MOC requirements; and f. ensure that the number of MOC-related testing dates and the locations of testing sites are ample enough to minimize the burden on physician practices and their time away from clinical care. (Res. 323, A-08; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 313, A-12)

Rationale: Our AMA notified the American Board of Medical Specialties of the House action. Other more comprehensive policy exists: H-275.923, Maintenance of Certification / Maintenance of Licensure.

D-275.991 License Reciprocity Between States

Our AMA will work jointly with the Federation of State Medical Boards, through its Committee on Portability, to examine license reciprocity between states in order to improve the ability of physicians to practice in other states. (Res. 307, I-01; Reaffirmation A-05)

Rationale: Redundant of more recent policy D-275.994, Facilitating Credentialing for State Licensure, which commits our AMA to continued action on licensure reciprocity.

D-285.967 Physician Identity and Credit Protection for Blue Cross Blue Shield Association Breach of Confidentiality

Our American Medical Association will: (1) urge the Blue Cross and Blue Shield Association (BCBSA) to offer expanded protections for physicians affected by the BCBSA security breach in August 2009 by extending the credit protection plans to at least five years, offering more than one company for credit protection, increasing the amount of identity theft insurance to adequately protect physicians, and publicly reporting confirmed cases of identity theft linked to this security breach; (2) urge the BCBSA to provide physicians affected by the BCBSA breach easy access to credit monitoring reports without cost; (3) strongly urge the BCBSA to provide legal protection and indemnification to physicians for any losses that result from this or any data security breach; (4) request that health insurers involved in a future data breach or any other security issue immediately notify physicians; (5) advocate that the personal information of physicians and other health care practitioners be stored electronically only in encrypted form to reduce the likelihood for future breach and loss of data; and (6) study the issues of breaches of physicians' sensitive personal information with recommendation for further action and report back at the 2010 Annual Meeting of the House of Delegates. (Sub. Res. 817, I-09; Reaffirmation I-10)

Rationale: BOT 7-A-10 provided details on the BCBSA data breach, the AMA action plan established when the AMA first became aware of the breach, and educational resources to assist physicians in the event of a potential identity theft. In March 2010, our AMA communicated with BCBSA to underscore the importance of expanded protection to physicians, and communicated to BCBSA and other Health Insurance Plans the following requests: that health insurers involved in future data breaches or any other security issue immediately notify affected physicians; that the personal information of physicians be stored electronically only in encrypted form to reduce the likelihood for future breaches and loss of data; and that the remedies outlined in the 2009 resolution be provided to protect affected physicians. Our AMA also developed resources to address potential issues with identity theft, including "How to protect yourself if in danger of identity theft," "What you need to know about the new HIPAA Breach Notification Rule," and "HIPAA Security Rule: Frequently asked questions regarding encryption of personal health information," and "What you need to know about the new health privacy and security requirements."

D-285.968 Health Insurance Code of Conduct

Our AMA will: 1. develop a Health Insurer "Code of Conduct" setting forth clear and concise principles addressing both medical care policies and payment issues; 2. seek concurrence among health insurers in complying with this "Code of Conduct;" 3. develop a mechanism to monitor compliance with this "Code of Conduct;" and 4. widely disseminate information regarding this "Code of Conduct," and health insurer compliance, to physicians and consumers. (Res. 823, I-08; Reaffirmation A-09)

Rationale: BOT Report 30-A-09 was issued to document progress on this issue. In May 2010, the AMA released The Code of Conduct, which was endorsed by 68 state and specialty medical societies. Per an AMA press release, "The principles shine light on health insurer practices that influence the health care of patients, including cancellation of coverage, medical services spending, access to care, fair contracting and patient confidentiality, medical necessity, benefit management, administrative simplification, physician profiling, corporate integrity and claims processing."

D-285.973 Clinical Integration

Our AMA will work with state medical societies to develop a white paper to educate physicians regarding clinical integration, including: (a) defining clinical integration; (b) researching Federal Trade Commission and Department of Justice advisories on clinical integration; (c) monitoring the progress of clinically integrated groups; (d) making policy and legislative recommendations; (e) developing a program to educate physicians about the benefits to physicians and patients, as well as the threats, concerning creating clinically integrated physician practices. (Res. 714, A-06)

Rationale: Our AMA developed the requested resources, including "How physicians can improve quality and increase their value in the health care market through medical practice integration" to provide guidance on integration issues. This document outlines various strategies for physician practice integration—including physician practice mergers, financial integration and clinical integration.

D-285.999 Mandatory Use of Hospitalists

Our AMA will continue its advocacy of Policy H-285.932, in both its private sector and Joint Commission activities by opposing the mandatory use of hospitalists and providing resources and support to physicians facing implementation of mandatory hospitalist policies. (Sub. Res. 714, I-98; Reaffirmed: BOT Rep. 15, A-05; Reaffirmed in lieu of Res. 734, A-05)

Rationale: AMA has extensive policy on the voluntary use of hospitalists, including Policies H-225.960, Voluntary Use of Hospitalists and Required Consent, and H-285.964, Admitting Officer and Hospitalist Programs. Policy H-285.932 no longer exists in PolicyFinder as BOT Report 15-A-05 consolidated it into Policy H-285.964.

D-295.324 Transforming the Medical Education Learning Environment

Our AMA: (1) will collaborate with relevant individuals and stakeholder groups, including the Liaison Committee on Medical Education, the Association of American Medical Colleges, and the Accreditation Council for Graduate Medical Education, to

identify or develop tools useful in evaluating the learning environment; (2) will conduct a literature review on the learning environment and identify existing gaps in tools to measure the learning environment and assess its outcomes. Finalize and widely disseminate the literature review, including information on: a) available valid and reliable tools and the best strategies for their use to measure the learning environment; b) evidence-based characteristics of a positive learning environment; c) successful models of learning environment change; and d) evidence for the linkage between a positive learning environment and learner outcomes, including quality patient care; (3) based on results of a literature review on the learning environment, our AMA will work with funding agencies and partner institutions, such as medical schools and teaching hospitals, to design, implement, and evaluate model programs and work with the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education with the aim of using the results to bring about learning environment change; and (4) will report back to the AMA House of Delegates on the outcomes of the efforts to bring about learning environment change at the 2011 Annual Meeting. (CME Rep. 7, A-09)

Rationale: CME Report 4-A-11 provided the requested report. Also, the directives are reflected in our AMA's ongoing Accelerating Change in Medical Education initiative.

D-295.995 Adoption of Sexual Orientation Nondiscrimination and Gender Identity in LCME Accreditation

Our AMA will urge the Liaison Committee on Medical Education to expand its current accreditation standard to include a nondiscriminatory statement related to all aspects of medical education, and to specify that the statement must address sexual orientation and gender identity. (Res. 305, A-99; Modified: BOT Rep. 11, A-07)

Rationale: LCME's Accreditation Standard C, The Learning Environment, MS-31, states, "In a medical education program, there should be no discrimination on the basis of age, creed, gender identity, national origin, race, sex, or sexual orientation in any of the program's activities."

D-305.971 Legal Injunction on Medical School Tuition Increases

The AMA will support filing an amicus brief in support of the plaintiff students, if or when *Kashmiri, et al. v. Regents of the University of California* is appealed. (BOT Action in response to referred for decision Res. 833, I-04)

Rationale: Obsolete. In July 2003, plaintiff students filed a class action lawsuit in San Francisco County Superior Court on behalf of themselves and other then-current and former University of California students, alleging that UC breached contracts with the students regarding the price of their education by raising the Professional Degree and Educational Fees beginning in Spring 2003. In August 2004, the court granted plaintiffs a preliminary injunction preventing UC from charging professional student subclass members who remained enrolled in their programs further increases in the Professional Degree Fee. In March 2006, the court ruled in favor of the plaintiffs on all three breach of contract claims and awarded each of the three subclasses of plaintiffs monetary damages, as well as a permanent injunction preventing any further increases of the Professional Degree Fee for the Professional Student Subclass. That decision was affirmed on appeal and is now final.

D-305.988 Strategies to Address Medical School Tuition Increases

Our AMA will: (1) monitor proposals for medical school tuition increases and continue to work with the AMA Medical Student Section and other student groups, along with state and county medical societies, national medical specialty societies and the Association of American Medical Colleges (AAMC) to address the serious issue of rising tuition and medical student debt and to oppose any mid-year or retroactive tuition increases; (2) encourage medical schools to alert students of the probability of escalation of tuition costs and provide entering students with an estimate of tuition costs for the four years; (3) encourage federal and state agencies to review and expand options for financial aid (scholarship and loan repayment programs) for medical students, resident physicians, and young physicians by developing programs that address areas of existing and emerging national and local need; (4) continue to encourage medical schools to provide yearly financial planning/debt management counseling to medical students and the institutions that sponsor residency training to make available similar services for resident physicians; (5) encourage and work with medical schools to broaden their fundraising activities directed at obtaining revenue for medical student scholarships or for capping/decreasing tuition; (6) continue to work for a stable funding mechanism for undergraduate medical education; (7) monitor and report to the House of Delegates at regular intervals, beginning in June of 2004, on progress in limiting medical school tuition and in developing mechanisms to reduce student debt; and (8) help develop specific strategies to address the problem of mid-year and retroactive tuition increases, and report back at the 2003 Interim Meeting. (CME Rep. 2, I-02; Reaffirmation I-03; Reaffirmation I-06)

Rationale: CME Report 3-I-03 was submitted as requested and established Policy H-305.934, Medical School Tuition and Opposition to Tax Increases, which remains current. Also, our AMA has other recent and comprehensive policies, including Policies D-295.933, Transparency In Medical Schools' Utilization of Funds From Tuition and Fee Increases, H-305.929, Proposed Revisions to AMA Policy on the Financing of Medical Education Programs, and H-305.928, Proposed Revisions to AMA Policy on Medical Student Debt.

D-310.985 Measure Effectiveness of AMA Anti-discrimination Policy

Our American Medical Association will utilize the existing Graduate Medical Education Census, with the assistance of the International Medical Graduates Section to examine trends and patterns in the selection of international medical graduates by residency program directors, and report back to the House of Delegates at the 2004 Annual Meeting. Our AMA will utilize the GME E-letter to communicate its policies of anti-discrimination to all residency program directors. (Res. 308, A-03)

Rationale: CME Report 7-A-04 provided the requested report, reaffirmed Policy H-255.982, Equality in Licensure and Reciprocity, and established Policy D-310.983, Measure Effectiveness of AMA Anti-Discrimination Policy, which remains current.

D-315.987 Patient Confidentiality and the USA Patriot Act

Our AMA will: (1) study the potential impact of the USA Patriot Act on patient confidentiality; (2) develop recommendations for physicians who are contacted for information about patients pursuant to provisions of the USA Patriot Act; (3) advocate for such modifications to the USA Patriot Act as may be necessary to protect patient confidentiality and minimize legal liability for physicians; (4) advocate that Section 215 of the USA Patriot Act sunset as scheduled, or, if the Act is reauthorized, for amendments to Section 215 in accordance with the recommendations presented in Board of Trustees Report 29-A-05; (5) develop educational materials to inform physicians of the federal disclosure requirements of the Patriot Act as amended in 2006; and (6) advocate for further amendments to the Patriot Act, including the repeal of the one year non-disclosure order. (BOT Rep. 29, A-05; Appended: BOT Rep. 16, A-07)

Rationale: BOT Report 16-A-07 provided the requested report, and guidance on how to respond to Patriot Act “production” or “gag” order was posted on AMA website. During the original development of the USA Patriot Act, the AMA communicated with the Senate and House Judiciary Committees on section 215 regarding the confidentiality of medical records. The letter outlined the AMA’s recommendations for modifications of section 215 of the act, on the protection of confidentiality of the patient-physician relationship. The Patriot Act was signed into law in March 2006 with many of the modifications recommended by AMA. However, the repeal of the one year non-disclosure order was not included in the final bill. On August 3, 2007, H.R.1 was signed into law. This legislation, “Implementing Recommendations of the 9/11 Commission Act of 2007,” further modified and made additions to many of the provisions of the USA Patriot Act. Title VIII: “Protecting Privacy and Civil Liberties While Effectively Fighting Terrorism,” provides for opportunities for federal agencies to review privacy and civil liberty concerns when proposing, developing, and implementing efforts to protect the nation against terrorism.

D-330.920 Provider Enrollment and Chain of Ownership System (PECOS) Enrollment

1. Our AMA will: (a) urgently implore the Centers for Medicare and Medicaid Services (CMS) to have the enrollment deadline for PECOS to be returned to the original January 2011 date; (b) urge CMS to develop a simplified mechanism to determine whether a physician is enrolled in PECOS, modeled after the NPI website; and (c) inform its members of the significance and complexity of the PECOS program. 2. If our AMA is unsuccessful in having the PECOS deadline moved back, our AMA will report any harmful fallout to physicians or patients due to the PECOS program at the 2010 Interim Meeting. 3. Our AMA will urge CMS to eliminate the problems that physicians have encountered with PECOS. 4. Our AMA encourages CMS to commit to preventing such errors in any future processing of online applications or any other data-gathering questionnaires soliciting physician information. 5. Our AMA will immediately prevail upon CMS at its highest level, preferably its newly appointed Director, Donald Berwick, MD, to postpone or suspend the January 3, 2011 deadline for physician enrollment in PECOS, until such time as (a) physicians have been adequately informed and educated about their obligation to enroll in PECOS and (b) CMS has provided a straightforward, facile method for re-enrollment in Medicare, which is its method for enrolling physicians in PECOS. 6. Our AMA will immediately take measures to alert the public and organizations that advocate for Medicare participants about the impending crisis in access to health care. (Res. 132, A-10; Appended: Res. 221, I-10; Appended: Res. 228, I-10)

Rationale: Our AMA advocated strongly to CMS to move the deadline by which referring/ordering physicians must be enrolled from July 6 which was moved from January 1 following passage of the Affordable Care Act back to the prior date established by CMS of January 1, 2011. While CMS did not elect to move the date back to January, due to AMA advocacy efforts CMS said they would not start rejecting claims on July 6 if the referring/ ordering physician named on a claim was not yet enrolled in PECOS so long as their legal name and NPI were on the claim. CMS said it will give physicians at least 30 days notice prior to instituting claims edits and that they do not plan on doing so until the vast majority of physicians who refer/order are enrolled. Due to years of advocating for a more streamlined system, the new administration is troubleshooting more enrollment problems and has been working to solicit physician feedback on how to make the process better. The AMA developed a comprehensive document outlining improvements that are needed in the Patient Protection and Affordable Care Act. AMA staffers are engaged in ongoing talks with Congress and the Administration on the need to enact these changes. The AMA was very aggressive in trying to secure changes to the PECOS system; consequently, CMS indefinitely postponed the implementation of the ordering and referring policy until almost all physicians are registered in the PECOS system and physicians can be educated about the new requirements. AMA Media Relations issued a media statement on July 2, 2010, highlighting AMA efforts to get CMS not to reject claims of physicians not enrolled in PECOS.

D-330.937 Make Medicare a Defined Contribution Open Economic System

Our AMA will (1) continue to support reform of Medicare by moving to a defined contribution approach that returns last dollar responsibility and control to patients; and (2) will develop its plan of action with a report back at the 2006 Interim Meeting. (Res. 112, A-06)

Rationale: BOT Report 4-I-06 provided the requested information. It summarized existing policy and reported the existence of Council on Legislation draft federal legislation on balance billing. As stand-alone legislation is difficult to pass, our AMA seeks to have its reform proposals included in any relevant Medicare legislation. More current and comprehensive policy exists: H-330.889, Strengthening Medicare for Current and Future Generations.

D-330.947 Educational Materials for Physicians on Medicare Part D

Our AMA will (1) prepare a report on available educational programs for physicians on Medicare Part D issues, and (2) make available appropriate educational materials targeted for physicians on Medicare Part D issues, so that they may best assist patients and effectively meet their responsibilities, under Medicare Part D laws and regulations. (Res. 105, A-05; Reaffirmation A-06)

Rationale: In 2005, our AMA co-branded a flyer with the Centers for Medicare and Medicaid Services that discussed the availability of valuable subsidies for Medicare patients with limited incomes and encourages physicians to urge their patients to apply for the subsidies through the Social Security Administration. Following the January 2006 start-up of the new Medicare drug benefit, the AMA arranged for CMS officials to meet specialty society Washington representatives on implementation problems in Part D. The AMA workgroup identified formulary exceptions and prior authorizations as a major new hassle factor. Under the AMA's leadership, the workgroup collaborated with America's Health Insurance Plans to develop a standard 1-page form for exceptions and prior authorizations that would be accepted by all Medicare drug plans.

D-330.956 Medicare Provider Enrollment System (PECOS)

Our AMA will advocate that the CMS: (1) find an immediate solution to the Provider Enrollment Chain and Ownership System problems, so that enrollment applications are processed in a timely manner, and provide a definitive date when this backlog of applications will be resolved; (2) assure interest penalties be paid to providers, who have been unable to bill for extended periods of time; (3) establish a process whereby, upon request, the carrier is authorized to advance funds to physicians who do not yet have their enrollment number due to the enrollment backlog; (4) not proceed with the National Provider Identifier initiative until such time as providers are assured that prepayment will be provided for all delayed processing of enrollment; and (5) determine how the enrollment/PECOS delay may be impacting the submission of HIPAA compliant electronic claims. (Res. 132, A-04)

Rationale: The AMA testified on Medicare Provider Enrollment System problems to the System (PECOS) Practicing Physicians Advisory Council, and the Council adopted a number of AMA's recommendations. Due to AMA's advocacy, CMS devoted an additional \$5 million for the timely processing of enrollment applications. On an ongoing basis, the AMA is working with the Office of HIPAA standards about the issuance of the National Provider Identifier to avoid problems experienced with Medicare. The AMA strongly advocated PECOS improvement and CMS has now reduced the backlog of Medicare enrollment applications to levels below those that existed before the transition to PECOS. Contractors should be required to process 90 percent of enrollment applications within 30 days and 99 percent within 60 days.

D-330.986 Private Contracting Under Medicare

Our AMA will actively lobby Congress for the passage of: "The Senior's Health Care Freedom Act" (HR 2867) as introduced by Representative Patrick Toomey (R-PA). (Res. 245, A-00; Reaffirmation A-04; Reaffirmation A-08)

Rationale: Our AMA has lobbied for this bill since its inception. It was last introduced by Rep. Ronald "Ron" Paul as H.R. 151 (112th): Seniors' Health Care Freedom Act of 2010. Redundant of more recent policy: H-385.961, Medicare Private Contracting, which commits our AMA to continued advocacy on this issue.

D-335.986 Telephone Appeals and the New Medicare Appeals Process

Our AMA will: (1) urge the Centers for Medicare and Medicaid Services to rescind the present Medicare rule requiring that all first-level appeals or redetermination requests be in writing except when the physician is requesting that the claim be reopened so that a minor error or omission, made by the physician, can be corrected; and (2) advocate for an alternative rule, allowing for a telephone appeal process to correct a minor clerical error or omission, regardless of whether the error was made by the physician or the carrier. (Res. 111, A-06)

Rationale: When CMS published a proposed rule that changed the way the agency recouped overpayments to providers and suppliers under Medicare fee-for-service program, our AMA submitted comments that included a request that CMS rescind the current Medicare rule requiring first level appeals or determinations be placed in writing when a physician requests a reopening to correct a minor error/omission. Our AMA also encouraged CMS to establish a phone appeal process to correct such errors/omissions.

D-345.990 Educating Physicians and Patients About the Mental Health Parity Act

Our AMA will develop information to be posted on our AMA's Web site that would educate physicians and the public about the benefits afforded by recently passed Mental Health Parity legislation (Res. 206, I-08)

Rationale: In 2008, our AMA issued the requested press release and posted it to its website. The Oct. 27, 2008 issue of AMNews explained the coverage requirements of the Mental Health Parity Act, and subsequent AMNews issues praised the passage of the act and provided details.

D-345.995 Responding to Depression, Suicide, Substance Use, and Addiction on College Campuses

Our AMA: (1) Council on Medical Service will evaluate health insurance coverage of full-time undergraduate and graduate students. (2) Will recommend that any such insurance coverage should have full parity for mental health and substance abuse treatment, which is consistent with established AMA policy (H-185.974, AMA Policy Database). (3) Will recommend that colleges and universities increase the availability and ensure the quality and quantity of on-site mental health and substance abuse clinical services and/or improve access to appropriate community services. (4) Will advocate for the elimination of college and university policies that discriminate against students who disclose or seek treatment for depression, substance use disorders, or other mental health issues, including policies that mandate suspension or withdrawal from school for students who request or

receive psychiatric or addiction medicine services. (5) Will encourage the Association of American Medical Colleges (AAMC) to develop similar programs in medical schools. (6) Will encourage clinical staff of campus health services and campus counseling services of colleges and universities to improve their skills in screening, brief intervention and referral for students' problem drinking. (7) Will seek funding in cooperation with interested partners to educate physicians and the media to focus attention on the issues and linkages of substance use and addiction, mental disorders, and suicide among college students. (CSAPH Rep. 8, A-06)

Rationale: CMS Report 7-A-07 issued the requested report and established Policy H-165.846, Adequacy of Health Insurance Coverage Options, which remains current. Also, our AMA staff had extensive conversations with three major organizations concerned with suicide – the Jed Foundation, Substance Abuse and Mental Health Services Administration, and the Bazelon Center of Mental Health Law. Also, directive is also redundant with Policies H-295.979, Substance Abuse, H-515.981, Family Violence-Adolescents as Victims and Perpetrators, and H-425.993, Health Promotion and Disease Prevention.

D-375.993 Confidentiality of Peer Review

Our American Medical Association will develop and seek federal legislation consistent with Policies H-230.957, "Access to Hospital Records," H-375.972, "Lack of Federal Peer Review Confidentiality Protection," and H-375.973, "Protecting Physicians at the Peer Review Process in the Current Managed Care Environment." (Sub. Res. 922, I-04; Reaffirmation A-05)

Rationale: In 2005, the Council on Legislation (COL) developed draft Process federal legislation that would accomplish the directive of Substitute Resolution 922 and embody all three AMA policies to prohibit discovery of records, information, and documents obtained during the course of professional review proceedings. In consideration of the recently adopted amendment to the Florida Constitution providing patients the right to access records relating to any adverse medical incident, COL asked AMA staff to discuss this matter with the General Counsel of the Florida Medical Association (FMA), who opined that the draft federal legislation would, if enacted, preempt Florida's constitutional amendment and not allow access to peer review records. COL discussed the potential unintended consequences of disclosure of peer review records to physicians for purposes other than defending a medical staff dispute. The draft legislation therefore included language to narrow the exception for disclosure to physicians to the defense of medical staff disputes. The Board of Trustees adopted the draft federal legislation at its April 2005 meeting.

D-380.995 Support the Removal of Limiting Charges for Physicians Services Under Medicare

Our AMA will immediately call upon Congress for the removal of limiting charges for physicians' services under Medicare and preemption of state laws limiting charges for physicians' services and report on progress to the AMA House of Delegates annually, at both the annual and the interim meetings. (Res. 218, A-08)

Rationale: AMA worked closely with Rep. Tom Feeney (R-FL) on the introduction of H.R. 4736, "a bill to amend part B of title XVIII of the Social Security Act to repeal limiting charges under the Medicare Program for non-participating physicians and to preempt State laws that prohibit balance billing". The legislation would remove limiting charges under Medicare and preempt state laws limiting charges for physician services. AMA worked with the Federation to encourage members to cosponsor H.R. 4736. A recent proposed rule from the Centers for Medicare and Medicaid Services (CMS) provided that a beneficiary's treating physician be able to directly request either expedited or standard plan reconsideration on behalf of the beneficiary without having been appointed the beneficiary's personal representative. The AMA submitted comments stating that this is a very important and welcome rule that will ensure that beneficiaries receive medically necessary medication and physicians will be relieved of an administrative burden that can consume significant staff and physician time.

D-385.964 Regional Medical Corporation

Our American Medical Association will, in partnership with others from the Federation, develop materials for physicians that will assist them in developing models for regional medical corporations. (Res. 819, I-09)

Rationale: Our AMA produced a series of educational resources on regional medical corporations and other practice integration options viewed through the lens of emerging payment and health care delivery models brought about by health system reform, including Competing in the Marketplace: How Physicians Can Improve Quality and Increase their Value in the Health Care Market through Medical Practice Integration; ACOs, CO-OPs and other Options: A "How-To" Manual for Physicians Navigating a Post-Health Reform World and Pathways for Physician Success under Healthcare Payment and Delivery Reforms.

D-385.967 Support of Legal Partnership

Our AMA will study and distribute to AMA members a white paper or similar research on any and all legal arrangements that would allow the receiving and distribution of "bundled" payments to participating physicians without requiring hospital employment, and advocate for legal arrangements between private practice physicians and hospitals that support the independent practice of medicine and give physicians equal status when/if "bundling" payments are made. (Res. 115, A-09)

Rationale: Our AMA developed extensive resources on evaluating and negotiating payment options, including bundled payments.

D-385.975 Balance Billing for all Payers

Our AMA will: (1) prepare legislation to allow physicians to balance bill regardless of the payer and seek sponsors for this in the US Congress; (2) support federal and state legislation and regulation that permits physicians and hospitals to cancel or reduce

copayments for hardship cases without change in fee schedules; and (3) make balance billing a high priority and report back to the House of Delegates at the 2005 Interim Meeting with a plan of action on balance billing for all payers. (Sub. Res. 113, A-05; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06)

Rationale: In September 2007, the Board of Trustees approved Council on Legislation's model federal legislation allowing physicians to balance bill regardless of the payer. The draft legislation would preempt state laws that prohibit balance billing and, in addition, permit balance billing by non-participating physicians under the Medicare program. The Board of Trustees issued BOT Report 16-I-05 as requested. Also, the AMA sent a letter to the National Association of Insurance Commissioners, National Conference of State Legislatures and the National Conference of Insurance Legislators informing them of the AMA's new policy and encouraging them to ask their constituents to recognize, support and implement policies consistent with AMA efforts and initiatives. Other more recent and comprehensive policies exist, including D-380.996, Balance Billing for All Physicians, H-330.951, Non-Routine Waiver of Copayments and Deductibles Under Medicare Part B for Indigent Patients, and H-330.922, Waiver of Copayments of Certain Medicare Patients.

D-385.994 Managed Care Organization Reimbursement Formulas

Our AMA will continue to develop resources that serve to assist physicians in reviewing and understanding their contractual agreements, including payment methodologies. (CMS Rep. 6, A-00; Reaffirmed: CMS Rep. 6, A-10)

Rationale: AMA has developed several online resources to help physicians, including Annotated Model Physician Employment Agreement, National Managed Care Contract, and the Annotated Model Co-Management Service Line Agreement.

D-390.972 Recovery Audit Contractors

Our AMA will work with Congress to seek to overturn the mandate for the Centers for Medicare and Medicaid Services to continue the services of the Recovery Audit Contractors' pilot projects in Florida, New York and California. (Res. 214, A-06; Reaffirmed: Sub Res. 603, I-06)

Rationale: In section 306 of the Medicare Modernization Act of 2003, the United States Congress directed the Department of Health and Human Services (DHHS) to conduct a three-year demonstration program to detect and correct improper payments in the Medicare fee-for-service program. DHHS, through its Centers for Medicare and Medicaid Services (CMS) branch, began the program in 2005, using Recovery Audit Contractors to perform the actual work of reviewing, auditing, and identifying improper Medicare payments. At the inception of the program, it focused on Medicare payments in the states of California, New York and Florida. The program eventually expanded to Massachusetts and South Carolina before ending in March 2007. By the end of the demonstration, the program had recovered nearly \$693.6M on behalf of CMS. In 2006, our AMA sent letters to Senators and Members of Congress on committees of jurisdiction from the affected states calling for the discontinuation of the program and developed outreach materials concerning the RAC appeals process. Educational materials and recent AMA advocacy efforts related to recovery audit contractors are available online.

D-435.983 Guam Professional Liability Crisis in Red Alert

Our AMA will (1) continue to work with the national specialty societies and state medical societies, as well as the medical societies of Guam and other US territories to reform the medical liability system and (2) assess the inclusion of Guam and other US territories on the AMA's medical liability crisis map. (Sub. Res. 203, A-05)

Rationale: Other more recent policy exists, including H-165.838, Health System Reform Legislation. The 2014 Medical Liability Reform NOW details recent AMA efforts and identifies current states in crisis.

D-435.984 Tort Reform

Our AMA will: (1) continue to pursue MICRA-based reform as the top priority; (2) continue to pursue liability reform efforts by any and all legislative options that would fundamentally change our medical liability system to create fair and equitable remuneration for injured patients and to promote patients' access to health care; and (3) report on its coalition building activities on efforts to reform our civil justice system and make this report available to the general membership by the 2005 Annual Meeting. (Sub Res. 921, I-04)

Rationale: BOT Report 17-A-05 presented the requested report. This 2004 policy is redundant of more recent policies, including H-435.964, Federal Preemption of State Professional Liability Laws, and H-165.838, Health System Reform Legislation. The 2014 Medical Liability Reform NOW details current AMA efforts to pursue tort reform.

D-435.986 Risk Management Related to the Administrative Side of Care

Our AMA will work with appropriate stakeholders to promote risk management educational programs focused on the administrative procedures of medical facilities, including billing practices, to help reduce the number of medical malpractice suits filed. (Res. 701, I-04)

Rationale: Our AMA sent correspondence to the BlueCross Blue Shield Association and to the Administrative Side of Care America's Health Insurance Plans notifying them of the AMA's Resolution. The AMA also held individual meetings with several national health plans addressing these issues. AMA continues to work with and follow legislative proposals and activities of organizations promoting alternative dispute resolution proposals.

H-440.937 FDA Investigating the Safety of Tanning Parlor Devices

The AMA supports the continued action by dermatologists and other practitioners, in cooperation with state medical societies, to promote state and local legislation to regulate tanning parlors. (Sub. Res. 415, A-92; Sub. Res. 217, I-94; Reaffirmed and Modified: CSA Rep. 6, A-04; Reaffirmed: Res. 440, A-05)

Rescind. Duplicative of more comprehensive Policy H-440.967, Public Information Program Addressing the Dangers of UVA Exposure. Also see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, Protecting the Public from Dangers of Ultraviolet Radiation, of all policies on the topic.

D-440.986 Appropriate Reimbursements and Carve-Outs for Vaccines

Our AMA shall use all possible means to pursue adequate reimbursements and carve-outs for vaccines and their administration from all payers with a report back at the 2002 Interim Meeting. (Res. 104, A-02; Reaffirmation I-10)

Rationale: BOT 20-A-03 presented the requested report and established Policy D-70.975, Appropriate Reimbursements and Carve-Outs for Vaccines, which remains current. Also, redundant of other recent and comprehensive policy: H-440.860, Financing of Adult Vaccines: Recommendations for Action.

D-450.970 Medical Care Outside the United States

Our AMA will advocate the development of model state legislation which encompasses our nine AMA principles above and which can be used to regulate insurance companies and any other business that refers patients for non-local care. (CMS Rep. 1, A-08)

Rationale: In 2009, the AMA Board of Trustees approved the Council on Legislation's model bill entitled Medical Tourism Business Practices Act, that includes the HOD-adopted principles: (a) medical care outside of the U.S. must be voluntary; (b) financial incentives to travel outside the U.S. for medical care should not inappropriately limit the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options; (c) patients should only be referred for medical care to institutions that have been accredited by recognized international accrediting bodies; (d) prior to travel, local follow-up care should be coordinated and financing should be arranged to ensure continuity of care when patients return from medical care outside the U.S.; (e) coverage for travel outside the U.S. for medical care must include the costs of necessary follow-up care upon return to the U.S.; (f) patients should be informed of their rights and legal recourse prior to agreeing to travel outside the U.S. for medical care; (g) access to physician licensing and outcome data, as well as facility accreditation and outcomes data, should be arranged for patients seeking medical care outside the U.S.; (h) the transfer of patient medical records to and from facilities outside the U.S. should be consistent with HIPAA guidelines; and (i) patients choosing to travel outside the U.S. for medical care should be provided with information about the potential risks of combining surgical procedures with long flights and vacation activities. Also, our AMA has additional current and comprehensive policy: H-450.937, Medical Care Outside the United States.

D-460.985 Incidence of Autism, Asperger's and Other Pervasive Developmental Disorders

Our AMA will work with the Centers for Disease Control and Prevention (CDC) and other appropriate medical specialty societies to study the reported increase in incidence of autism, Asperger's and other pervasive developmental disorders, and to specifically evaluate the population-based data on this issue currently being generated by the CDC. (Sub Res. 503, A-03; Reaffirmed in lieu of Res. 535, A-06)

Rationale: Our AMA sent a letter was sent to the CDC informing them of the AMA's interest in their ongoing population-based study and asking that this data be shared with the AMA when feasible. Also, see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, Early Intervention for Children with Developmental Delay, of all policies on the topic.

D-450.979 Post-Discharge Test Results

1. Our AMA will alert organized medical staffs of the results of the study, "Improving Patient Care: Patient Safety Concerns Arising from Test Results that Return after Hospital Discharge," published in the July 19, 2005, issue of the Annals of Internal Medicine, which shows that many patients are discharged from hospitals with tests pending and physicians are often unaware of the potentially actionable tests results returning post-discharge and urges the medical staffs to develop processes for addressing the issue. 2. Our AMA Board of Trustees will work with the American Hospital Association to develop a joint statement about the importance of coordinating post-discharge care and forwarding test results to the patient's primary care physician and, if different, the physician assuming care for a patient after hospital discharge. (Res. 732, A-06)

Rationale: Accomplished. Our AMA received approval to reprint the article, and distributed it to medical staffs with a call for them to develop processes to address the cited issue.

D-478.989 Accuracy of Internet Physician Profiles

Our AMA will investigate: (1) the publication of physician information on Internet Web sites; and (2) potential solutions to erroneous physician information contained on Internet Web sites with report back at the 2008 Interim Meeting. (Res. 612, A-08; Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed in lieu of Res. 717, A-12)

Rationale: BOT Report 27-A-09 provided the requested information. More current and comprehensive policy exists: D-478.980, Anonymous Cyberspace Evaluations of Physicians.

D-480.978 Cardiac Rhythm Management Device Evaluation

Our American Medical Association will follow the progress of the Heart Rhythm Society (HRS) project that aims to develop a consensus document that will generate recommendations on the perioperative management of patients with Cardiovascular Implantable Electronic Devices (CIED) and will participate in the peer review process of that report. (BOT Action in response to referred for decision Res. 703, A-09)

Rationale: In 2013, the Report of the American College of Cardiology Foundation Appropriate Use Criteria Task Force, Heart Rhythm Society, American Heart Association, American Society of Echocardiography, Heart Failure Society of America, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, and Society for Cardiovascular Magnetic Resonance released “Appropriate Use Criteria for Implantable Cardioverter-Defibrillators and Cardiac Resynchronization Therapy.”

D-480.980 Direct-To-Consumer Advertising and Provision of Genetic Testing

Our AMA will study the issues of direct to consumer advertising of genetics tests and the provision of genetics testing to patients on the Internet or other vehicles not directly involving the patient’s physician, taking into consideration appropriate mechanisms to regulate this practice. (Res. 522, A-07)

Rationale: BOT Report 7-A-08 provided the requested report and amended Policies D-480.987, Direct-to-Consumer Marketing and Availability of Genetic Testing, and H-55.979, Genetic Susceptibility Testing for Hereditary Cancers.

D-480.998 Minimal Standards for Medical Product Reuse

(1) Our AMA will encourage the development of a set of guidelines for processing medical supplies and instruments which may be reused. (2) These guidelines address the issues of product performance, safety and sterility. (3) These guidelines be distributed to the health care industry. (Res. 502, A-99; Reaffirmed: CSAPH Rep. 1, A-09)

Rationale: Accomplished. In 2011, the Food and Drug Administration has developed draft guidance on Processing/Reprocessing Medical Devices in Health Care Settings: Validation Methods and Labeling.

D-490.980 Support for Smoke-Free Public Places Legislation in Guam

Our AMA will support the passage of comprehensive smoke-free public places legislation in Guam. (Res. 405, A-05)

Rationale: Our AMA prepared a letter to Guam’s 28th legislature with AMA model ordinance “Eliminating Smoking in all Workplaces and Public Places Except Freestanding Bars.” Our AMA has current and comprehensive policy on smoking smoke-free public spaces, including H-490.913, Smoke-Free Environments and Workplaces, and H-490.911, Smoke-Free America.

D-490.981 Congress Repeal 38 USC §1715, Thus Allowing Veterans Health Administration Health Facilities to Develop Smoke-Free Campuses

Our AMA will work to have Congress repeal 38 USC §1715, thus allowing Veterans Health Administration health facilities to develop smoke-free campuses. (Res. 713, I-04; Reaffirmation I-08)

Rationale: In August 2008, the VA established a Smoke-Free Policy for VA health care facilities. Our AMA has other more current and comprehensive policy, including H-490.913, Smoke-Free Environments and Workplaces.

D-495.997 Support of Legislation Regarding Fire-Safe Cigarettes

Our AMA will seek federal legislation to require that all cigarettes sold in the United States be self-extinguishing. (Res. 903, I-06)

Rationale: All states have enacted laws requiring cigarettes to meet certain fire standards for self-extinguishing when not being smoked. The laws require cigarettes to exhibit a greater likelihood of self-extinguishing using a prescribed laboratory test method developed by ASTM International (formerly, the American Society for Testing and Materials). These cigarettes are known as Fire Standards Compliant (FSC) cigarettes.

D-515.986 Update on Youth and School Violence

Our AMA will re-examine its role in implementing current AMA policies related to violence prevention, and include such issues in a strategic issue paper. (CSAPH Rep. 2, I-07)

Rationale: In 2008 the Board of Trustees included violence prevention as an objective of the Medicine and Public Health Center of Expertise, which no longer exists.

D-515.991 Labeling of Video Game Content

Our AMA will actively campaign for appropriate labeling of any video game that depicts acts of violence or aggressive acts so that these videos will be made available for purchase by adults only. (Res. 421, A-05)

Rationale: Our AMA prepared a letter stating that while the Entertainment Software Rating Board currently labels video games using content descriptors and rating symbols to suggest appropriate age levels for video games, many games do not contain appropriate descriptors indicating violent and aggressive content. The letter further states that in 2000 our AMA along with five other medical associations issued a Joint Statement on the Impact of Entertainment Violence on Children. Also, our AMA has more current and comprehensive policies, including H-515.974, Mass Media Violence and Film Ratings, and D-60.974, Emotional and Behavioral Effects of Video Game and Internet Overuse.

D-515.993 Support for Legislative Action and Improved Research on the Health Response to Violence and Abuse

Our AMA, in conjunction with other members of the Federation and the National Advisory Council on Violence and Abuse will: (1) identify and actively support state and federal legislative proposals designed to increase scientific knowledge, promote public and professional awareness, enhance recognition and ensure access to appropriate medical services for patients who have experienced violence and/or abuse; (2) actively support legislation and congressional authorizations designed to increase the nation's health care infrastructure addressing violence and abuse including proposals like the Health CARES (Child Abuse Research, Education and Services) Network; (3) actively support expanded funding for research on the primary prevention of violence and abuse, the cost of violence and abuse to the health care system, and the efficacy of interventions and methods utilized in the identification and treatment of victims of violence and abuse; (4) actively study the best practices in diagnosis and management of family violence (including an analysis of studies not reviewed in the recent US Preventive Services Task Force Recommendations on Screening for Family Violence) and present a report that identifies future research and practice recommendations; and (5) invite a Federation-wide task force to review and promote the best practices in the identification, management and prevention of family violence. (Res. 438, A-04)

Rationale: CSA Report 7-A-05 provided the requested information, and established Policies H-515.963, Diagnosis and Management of Family Violence and D-515.992, Diagnosis and Management of Family Violence, which remain current. There also are other current and comprehensive policies, including H-515.965, Family and Intimate Partner Violence, H-185.976, Insurance Discrimination Against Victims of Domestic Violence, and H-515.979, Violence as a Public Health Issue. Also, the National Advisory Council on Violence and Abuse no longer exists.

2. AMA POLICY DIRECTIVES WHICH HAVE BEEN ACCOMPLISHED IN PART

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

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 Council on Constitution and Bylaws and the Council on Long Range Planning and Development, as part of the AMA Policy Project, reviewed various D and H category policies from the AMA Policy Compendium, and noted that a number of policies embody directives that have been accomplished. Also, in the course of preparing CCB/CLRPD Reports 1 and 3, the councils discovered several policies where editorial modifications were necessary for accuracy and/or completeness.

These recommendations to rescind in part or modify have the support of other AMA councils and sections whose input was sought. The Appendices contain the original text of all referenced policies, a link to either the report(s) that the HOD requested and/or a rationale as to why a policy recommendation should be rescinded or modified.

To make the AMA Policy Compendium as current as possible yet not circumvent the normal sunset review process that occurs every ten years, the Councils have determined that these modifications are editorial in nature. Thus, any recommendation to sunset a policy in part will not reset the sunset clock, unless otherwise noted. All policies proposed for sunset will be retained in the AMA's historical archives.

This report also includes recommendations on several policies assigned to the Councils as part of the annual sunset review.

RECOMMENDATIONS

The Councils recommend that the House of Delegates policies listed in Appendix A to this report be acted upon in the manner indicated and that the remainder of this report be filed.

APPENDIX A - Recommended Actions on Policies Accomplished in Part

Policy Number	Title	Recommended Action
H-5.993	Right to Privacy in Termination of Pregnancy	Retain. Still relevant.

Policy Number	Title	Recommended Action
H-10.977	Helmets and Preventing Motorcycle- and Bicycle-Related Injuries	Rescind Item 5: Model legislation, "To Require That Bicycle Riders Wear Safety Helmets At All Times When Riding Bicycles," was developed. Also, see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, Helmets for Riders of Motorized or Non-motorized Cycles.
H-10.985	Bicycle Helmets and Safety	1) Rescind Item 1: Duplicative of H-10.977, Helmets and Preventing Motorcycle- and Bicycle-Related Injuries. Also, see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, Helmets for Riders of Motorized or Non-motorized Cycles. 2) Rescind Item 4: Model legislation, "To Require That Bicycle Riders Wear Safety Helmets At All Times When Riding Bicycles," was developed..
D-20.993	Promotion of Rapid HIV Test	Rescind Item 2: CSAPH Report 2-I-06 provided the requested update and updated Policy D-20.992, Routine HIV Screening.
H-30.945	Drivers Impaired by Alcohol	Rescind Item 6: Duplicative of H-30.969, Ignition Interlock System. Also, see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, Prevention of Drunken Driving.
H-30.986	Alcohol and the Driver	Rescind Item 5: Duplicative of H-30.969, Ignition Interlock System. Also, see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, Prevention of Drunken Driving.
H-35.968	Averting a Collision Course Between New Federal Law and Existing State Scope of Practice Laws	Rescind Item 2(c): BOT Report 8-I-12 provided the requested update. BOT Report 32-A-13 provided additional details.
H-35.972	Need to Expose and Counter Nurse Doctoral Programs (NDP) Misrepresentation	Rescind mandate to report back in Item 6: CME Report 4-A-12 provided the requested update.
H-55.991	Use of Heroin in Terminally Ill Cancer Patients With Severe Chronic Pain	Modify as follows: The <u>Our</u> AMA remains opposed to legislation <u>or any other action</u> that would reschedule heroin from Schedule 1 to <u>Schedule 2 of the Controlled Substances Act.</u>
D-60.976	Childhood Anaphylactic Reactions	1) Retitle, "Asthma and Childhood Anaphylactic Reactions." 2) Modify (1)g for accuracy as follows: ... adopt the School Guidelines for Managing Students with Food Allergies distributed by the Food Allergy and Anaphylaxis Network <u>FARE (Food Allergy Research & Education).</u>
D-70.953	Medicare's Proposal to Eliminate Payments for Consultation Service Codes	Rescind Item 5: BOT Report 9-A-11 provided the requested action plan.
H-85.978	Autopsy as the Practice of Medicine	Rescind Item 3: Duplicative of H-85.964, Autopsy Payment and Performance Standards for Third Party Payers, a more comprehensive policy. Also see CCB/CLRPD 3-A-14 for proposed policy consolidation, <u>Importance of Autopsies.</u>
D-85.997	Lessons Learned from Terri Schiavo	Rescind Item 2: Accomplished. Our AMA's Ethics website includes the requested materials. Also, see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, Encouraging the Use of Advance Directives and Health Care Powers of Attorney.
D-130.971	The Future of Emergency and Trauma Care	Rescind Item 4: BOT Report 3-I-07 provided the requested update.
D-130.976	Implications of the November 2003 Emergency Medical Treatment and Labor Act (EMTALA) Final Rule	Rescind Item 3: BOT Report 2-I-05 provided the requested update and established Policy D-130.975, Advocacy Efforts to Persuade All Health Payers to Pay for EMTALA-Mandated Services.
D-130.984	Payment for Emergency Services	Rescind Item 1: CMS Report 5-A-03 provided the requested update.
D-160.995	Physician and Nonphysician Licensure and Scope of Practice	Rescind Item 4: CME Report 2-A-02 provided the requested report.
D-165.966	Giving States New Options to Improve Coverage for the Poor	Rescind Item 4: CMS Report 1-A-05 provided the requested update.
H-180.951	Tax Treatment of Health Insurance: Comparing Tax Credits and Tax Deductions	Rescind Item 2: CMS Report 8-A-08 provided the requested report and amended several policies, including Policies H-165.865, Principles for Structuring a Health Insurance Tax Credit; D-180.987, Elimination of Federal Government Discrimination Against Individuals Who Purchase Health Insurance; H-165.920, Individual Health Insurance; and H-165.920, Individual Health Insurance.

Policy Number	Title	Recommended Action
H-185.949	Centers for Medicare and Medicaid Services Policy on Hospital Acquired Conditions - Present on Admission	Rescind Item 1(F): BOT Report 10-I-08 provided the requested report.
D-200.977	National Health Service Corps: Stronger AMA Representation in Decision Making Process	Rescind Item 2: BOT Report 10-A-11 provided the requested report.
D-200.979	Barriers to Primary Care as a Medical School Choice	Rescind Item 2: CME Report 8-A-10 provided the requested report.
D-200.985	Strategies for Enhancing Diversity in the Physician Workforce	Rescind Items 5 and 6: CME Report 7-A-08 and CME Report 1-I-08 provided the requested updates.
D-215.995	Specialty Hospitals and Impact on Health Care	Rescind Item 6: BOT Report 22-A-05 provided the requested update.
D-275.995	Licensure and Credentialing Issues	Retain and reaffirm Item 1: Still relevant. Rescind Item 2: Redundant of D-275.994(2), last reaffirmed by CME in 2012 Rescind Item 3: Accomplished in 2000 [also note that the item is inaccurate as written] Retain and reaffirm Item 4: Still relevant.
H-295.876	Equal Fees for Osteopathic and Allopathic Medical Students	Rescind Item 2b: CME Report 14-A-06 provided the requested update. CME Report 2-I-08 provided additional updates.
H-295.979	Substance Abuse	1) Rescind Item 1: Duplicative of Policies H-295.987, Impairment Prevention and Treatment in the Training Years, and H-295.979, Substance Abuse. 2) Rescind Item 2: Duplicative of Policy H-295.922, Establishing Essential Requirements for Medical Education in Substance Abuse. Also see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, Impairment Prevention and Treatment in the Training Years.
D-300.980	Opposition to Increased CME Provider Fees	Rescind Item 3: CME Report 7-A-12 presented the requested report.
D-300.984	Physician Reentry	Rescind Item 6: CME Report 1-I-09 provided the requested report.
D-305.963	Securing Medicare GME Funding for Research and Ambulatory Non-Hospital Based Outside Rotations During Residency	Rescind Item 4: CME Report 3-I-09 provided the requested update.
D-305.975	Long-Term Solutions to Medical Student Debt	Rescind Item 1: CME Report 13-A-06 provided the requested report.
D-310.967	Resident Pay During Orientation	Rescind Item 2: The resolution was transmitted to each medical school, residency program director, and directors of medical education at US teaching hospitals, and an item was also included in an issue of the GME E-letter. The Accreditation Council for Graduate Medical Education also was notified of the House action.
D-310.972	Protection Against Delayed Residency Program Closure	Rescind Item 4: CME Report 4-A-09 provided the requested update.
D-315.984	Ownership of Claims Data	Rescind Item 6: BOT Report 8-I-07 provided the requested report.
H-350.962	Reauthorization of the Indian Health Care Improvement Act	Rescind Item 2: BOT Report 28-A-08 provided the requested report.
H-355.995	National Practitioner Data Bank	Rescind Item 2: Duplicative of H-355.999, Minimum Reporting Requirements to National Practitioner Data Bank. Also see CCB/CLRPD Report 3-A-14 for proposed consolidation policies, Opposition to the National Practitioner Data Bank, and National Practitioner Data Bank.
H-375.972	Lack of Federal Peer Review Confidentiality Protection	Rescind directive to report back at A-04, as action was accomplished. AMA continues to support federal legislation to prohibit discovery of records, information and documents obtained during peer review proceedings.
D-375.997	Peer Reviewer Immunity	Rescind request to report back in Item 2: BOT Report 25-A-02 provided the requested update, and established Policy D-375.996, Peer Review Immunity.
D-390.984	Payment by Health Insurance Plans of Medicare Deductibles and Copayments	Rescind Item 2: BOT Report 11-I-03 provided the requested update.

Policy Number	Title	Recommended Action
D-400.988	PLI-RVU Component of RBRVS Medicare Fee Schedule	Rescind Item 4: BOT Report 15-A-04 provided the requested progress update.
H-406.989	Work of the Task Force on the Release of Physician Data	Rescind Item 6(c): CME Report 10-A-12 provided the requested report.
H-435.967	Report of the Special Task Force and the Advisory Panel on Professional Liability	Retain. Still relevant.
H-440.876	Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients	Rescind directive to report back in Item 2.
D-440.951	One-Year Public Health Training Options for all Specialties	Rescind Item 2: CME Report 8-A-08 provided the requested report.
D-440.958	Universal Defibrillator Connectivity	Rescind Item 2: Accomplished. Our AMA sent letters to the National Conference of State Legislatures, National Association of EMS Physicians, National Association of State EMS Officials; FDA's Center for Devices and Radiological Health, Medical Device Manufacturers Association, Biomedical Engineering Society, Association for the Advancement of Medical Instrumentation; and the American Heart Association stating the need for universal connectivity for all defibrillators is great and extends beyond the use of universal connector pads to incompatibility between various defibrillators leading to possible negative patient outcomes and increased cost.
D-440.969	Protect Children from Skin Cancer	Rescind Item 2: Accomplished. Our AMA sent correspondence to Dr. David Schultz, FDA Director for the Center for Devices and Radiological Health requesting a fair hearing on the safety and efficacy of UVA bulbs. Dr. Shultz replied in a letter that described the numerous actions already being taken by the FDA to protect children from the dangers of indoor tanning and extending an invitation to meet with him and present any new data. Our AMA conveyed this to the American Academy of Dermatology which then arranged a meeting with FDA officials. Also see CCB/CLRPD Report 3-A-14 for proposed consolidation policy, Protecting the Public from Dangers of Ultraviolet Radiation.
D-450.981	Protecting Patients Rights	Rescind Item 3: BOT Report 18-A-06 provided the requested update.

APPENDIX B - Current Policies

H-5.993 Right to Privacy in Termination of Pregnancy

The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities. (Res. 49, I-89; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: Sub. Res. 206, A-04)

H-10.977 Helmets and Preventing Motorcycle- and Bicycle-Related Injuries

It is the policy of the AMA to: (1) encourage physicians to counsel their patients who ride motorized and non-motorized cycles to use approved helmets and appropriate protective clothing while cycling; (2) encourage patients and families to inform and train children about safe cycle-riding procedures, especially on roads and at intersections, the need to obey traffic laws, and the need for responsible behavior; (3) encourage community agencies, such as those involving law enforcement, schools, and parent-teacher organizations, to promote training programs for the responsible use of cycles; (4) urge manufacturers to improve the safety and reliability of the vehicles they produce and to support measures to improve cycling safety; (5) *prepare model state legislation for cyclists' mandatory use of helmets while cycling*; and (6) advocate further research on the effectiveness of helmets and on the health outcomes of community programs that mandate their use. (CSA Rep. 3, I-93; Reaffirmed: CSA Rep. 6, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-10.985 Bicycle Helmets and Safety

It is the policy of the AMA (1) to actively support bicycle helmet use and encourage physicians to educate their patients about the importance of bicycle helmet use; (2) to encourage the manufacture, distribution, and utilization of safe, effective, and reasonably priced bicycle helmets; (3) to encourage the availability of helmets at the point of bicycle purchase; and (4) to develop

model state/local legislation requiring the use of bicycle safety helmets, and calling for all who rent bicycles to offer the rental of bicycle safety helmets for all riders and passengers. (Res. 7, I-90; Modified by Sub. Res. 208, A-94; Reaffirmed: CSA Rep. 6, A-04)

D-20.993 Promotion of Rapid HIV Test

Our AMA will: (1) work with any and all local and state medical societies, and other interested US and international organizations, to increase access to and utilization of Food and Drug Administration-approved rapid HIV testing in accordance with the quality assurance guidelines for rapid HIV testing developed by the Centers for Disease Control and Prevention. Additionally, pre- and post-test counseling should be performed in accordance with guidelines established by the CDC; and (2) *report back on its efforts to increase access to FDA-approved HIV rapid testing at the 2006 Interim Meeting.* (Res. 511, A-05)

H-30.945 Drivers Impaired by Alcohol

The AMA: (1) acknowledges that all alcohol consumption, even at low levels, has a negative impact on driver skills, perceptions, abilities, and performance and poses significant health and safety risks. The AMA will be involved in efforts to educate physicians, the public, and policy makers about this issue and urges national, state, and local medical associations and societies, together with public health, transportation safety, insurance industry, and alcohol beverage industry professionals to renew and strengthen their commitment to preventing alcohol-impaired driving; (2) encourages physicians to participate in educating the public about the hazards of chemically impaired driving; (3) urges public education messages that now use the phrase “drunk driving,” or make reference to the amount one might drink without fear of arrest, be replaced with messages that indicate that “all alcohol use, even at low levels, impairs driving performance and poses significant health and safety risks;” (4) urges all states to pass legislation mandating all drivers convicted of first and multiple DUI offenses be screened for alcoholism and provided with referral and treatment when indicated; (5) further recommends the following measures be taken to reduce repeat DUI offenses: (a) Aggressive measures be applied to first-time DUI offenders (e.g., license suspension and administrative license revocation), (b) Stronger penalties be leveled against repeat offenders, including second-time offenders, (c) Such legal sanctions must be linked, for all offenders, to substance abuse assessment and treatment services, to prevent future deaths in alcohol-related crashes and multiple DUI offenses, (d) The AMA calls upon the states to coordinate law enforcement, court system, and motor vehicle departments to implement forceful and swift penalties for second-time DUI convictions to send the message that those who drink and drive might receive a second chance but not a third; *and (6) encourages the National Highway Traffic Safety Administration to investigate the feasibility of technologies that would prevent an automobile from being started or driven by an individual with an excessive blood alcohol level.* (CSA Rep. 14, A-97; Reaffirmed: BOT Rep. 17, A-01; Reaffirmed in lieu of Res. 435, A-05)

H-30.986 Alcohol and the Driver

Our AMA (1) favors public information and education against any drinking by drivers; (2) supports 0.04 percent blood-alcohol level as per se illegal for driving, and urges incorporation of that provision in all state drunk driving laws; (3) supports 21 as the legal drinking age, supports strong penalties for providing alcohol to persons younger than 21, and stronger penalties for providing alcohol to drivers younger than 21; (4) urges adoption by all states of legislation calling for administrative suspension or revocation of driver licenses after conviction for driving under the influence, and mandatory revocation after a specified number of repeat offenses; and (5) *encourages industry efforts to develop a safety module that thwarts operation of a car by an intoxicated person.* (CSA Rep. A, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Modified: Sub. Res. 401, I-97; Reaffirmed: BOT Rep. 17, A-01; Reaffirmation A-09)

H-35.968 Averting a Collision Course Between New Federal Law and Existing State Scope of Practice Laws

1. Our AMA will: (A) work to repeal new Public Health Service Act Section 2706, so-called provider “Non-Discrimination in Health Care,” as enacted in PPACA, through active direct and grassroots lobbying of and formal AMA written communications and/or comment letters to the Secretary of Health and Human Services and Congressional leaders and the chairs and ranking members of the House Ways and Means and Energy and Commerce and Senate Finance Committees; and (B) promptly initiate a specific lobbying effort and grassroots campaign to repeal the provider portion of the Patient Protection and Affordable Care Act’s “Non-Discrimination in Health Care” language, including direct collaboration with other interested components of organized medicine. 2. Our AMA will: (A) create and actively pursue legislative and regulatory opportunities to repeal the so called “Non-discrimination in Health Care” clause in Public Health Service Act Section 2706, as enacted in the Patient Protection and Affordable Care Act; (B) lead a specific lobbying effort and grassroots campaign in cooperation with members of the federation of medicine and other interested components of organized medicine to repeal the provider portion of PPACA’s “Non-Discrimination in Health Care” language; *and (C) report back at the 2013 Annual Meeting.* (Res. 220, A-10; Appended: Res. 241, A-12; Appended: BOT Rep. 8, I-12)

H-35.972 Need to Expose and Counter Nurse Doctoral Programs (NDP) Misrepresentation

1. It is the policy of our AMA that institutions offering advanced education in the healing arts and professions shall fully and accurately inform applicants and students of the educational programs and degrees offered by an institution and the limitations, if any, on the scope of practice under applicable state law for which the program prepares the student. 2. Our AMA disapproves of questions developed for the United States Medical Licensing Examination (USMLE) being used for purposes other than the assessment of physicians-in-training and physicians. 3. Our AMA, with the Council of Medical Specialty Societies, and members of the Federation, will continue to work with the National Board of Medical Examiners (NBME) to assure that accurate information continues to be presented in communications about the use of USMLE questions in the Doctor of Nursing Practice

(DNP) examination. 4. Our AMA, through its representatives to the NBME, will continue to provide feedback as plans for the restructuring of the USMLE are developed and implemented. 5. Our AMA will request the NBME to emphasize in future publications that the DNP certification examination is not for the purposes of licensure of nurses. 6. Our AMA will continue to monitor the use of questions developed for the USMLE and COMLEX by any group for purposes other than the assessment of physicians-in-training and physicians *and report back to the House of Delegates by the 2012 Annual Meeting*. (Res. 211, A-06; Appended: CME Rep. 10, A-10)

H-55.991 Use of Heroin in Terminally Ill Cancer Patients With Severe Chronic Pain

The AMA remains opposed to legislation that would reschedule heroin from Schedule 1 to Schedule 2. (BOT Rep. TT, A-87; Reaffirmed: Sunset Report, I-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07)

D-60.976 Childhood Anaphylactic Reactions

Our AMA will: (1) urge all schools, from preschool through 12th grade, to: (a) develop Medical Emergency Response Plans (MERP); (b) practice these plans in order to identify potential barriers and strategies for improvement; (c) ensure that school campuses have a direct communication link with an emergency medical system (EMS); (d) identify students at risk for life-threatening emergencies and ensure these children have an individual emergency care plan that is formulated with input by a physician; (e) designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting families; (f) train school personnel in cardiopulmonary resuscitation; (g) *adopt the School Guidelines for Managing Students with Food Allergies distributed by the Food Allergy and Anaphylaxis Network*; and (h) ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff are familiar with using this equipment; (2) work to expand to all states laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis; (3) support increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis; (4) urge the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies; (5) urge physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan; and (6) work to allow all first responders to carry and administer epinephrine in suspected cases of anaphylaxis. (CSAPH Rep. 1, A-07)

D-70.953 Medicare's Proposal to Eliminate Payments for Consultation Service Codes

1. Our American Medical Association opposes all public and private payer efforts to eliminate payments for inpatient and outpatient consultation service codes, and supports legislation to overturn recent Center for Medicare & Medicaid Services' (CMS) action to eliminate consultation codes. 2. Our AMA will work with CMS and interested physician groups through the CPT Editorial Panel to address all concerns with billing consultation services either through revision or replacement of the current code sets or by some other means. 3. Our AMA will, at the conclusion of the CPT Editorial Panel's work to address concerns with billing consultation services, work with CMS and interested physician groups to engage in an extensive education campaign regarding appropriate billing for consultation services. 4. Our AMA will: (a) work with the Centers for Medicare & Medicaid Services to consider a two-year moratorium on RAC audit claims based on three-year rule violations for E/M services previously paid for as consultations; and (b) pursue Congressional action through legislation to reinstate payment for consultation codes within the Medicare Program and all other governmental programs. 5. *Our AMA will develop and implement an action plan for policy D-70.953 and report back to the HOD at the 2011 Annual Meeting*. 6. Our AMA will petition the CMS to limit RAC reviews to less than one year from payment of claims. (Res. 807, I-09; Appended: Sub. Res. 212, I-10; Reaffirmation A-12; Appended: Res. 216, A-12)

H-85.978 Autopsy as the Practice of Medicine

It is the policy of our AMA: (1) that the performance of autopsies constitutes the practice of medicine; (2) in conjunction with the pathology associations represented in the AMA House, to continue to implement all the recommendations regarding the effects of decreased utilization of autopsy on medical education and research, quality assurance programs, insurance claims processing, and cost containment; and (3) *to initiate a program for the appropriate reimbursement of autopsies including efforts aimed at having the autopsy take its rightful place as a Medicare Part B reimbursable physician service*. (Sub. Res. 172, A-90; Modified: Res. 512, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10)

D-85.997 Lessons Learned from Terri Schiavo

1. Our AMA will communicate with key health insurance organizations, both private and public, to encourage them and their institutional members to include information regarding advance directives and related forms and will also communicate with state Departments of Motor Vehicles to recommend the distribution of information about advance directives to individuals obtaining or renewing a driver's license. 2. *Our AMA Ethics Resource Center will update its web content regarding advance directives, including links to other appropriate resources with permission from the relevant organizations*. (BOT Rep. 22, A-06)

D-130.971 The Future of Emergency and Trauma Care

Our AMA will: (1) expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care; (2) with the advice of specific specialty societies, advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to

attract physicians to these specialties; (3) continue to advocate for the following: a. Insurer payment to physicians who have delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status, b. Financial support for providing EMTALA-mandated care to uninsured patients, c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service, d. Federal and state liability protections for physicians providing EMTALA-mandated care; (4) *report on progress in addressing these issues to the AMA House of Delegates at the 2007 Interim Meeting*; (5) disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation; (6) support demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care; (7) support the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(6), shows evidence that physicians would benefit by such extension; and (8) if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(6), shows evidence that physicians would benefit by extension of the FTCA, our AMA will conduct a legislative campaign, coordinated with national specialty societies, targeted toward extending FTCA protections to all EMTALA-mandated care, and the AMA will assign high priority to this effort. (BOT Rep. 14, I-06; Reaffirmation A-07; Reaffirmation A-08; BOT action in response to referred for decision Res. 204, A-11; Appended: Res. 221, I-11)

D-130.976 Implications of the November 2003 Emergency Medical Treatment and Labor Act (EMTALA) Final Rule

Our AMA will: (1) ask the EMTALA Technical Advisory Group (TAG) and the Centers for Medicare and Medicaid Services (CMS) for assistance in ameliorating the differential economic and staffing burdens on certain categories of facilities, including but not limited to academic health centers, trauma centers, critical access hospitals, and safety net hospitals, which are likely to receive high volumes of patients as a result of the EMTALA regulations; (2) work with the EMTALA TAG and CMS to ensure that physicians staffing emergency departments and on-call emergency services be appropriately compensated for providing EMTALA mandated services; (3) initiate additional advocacy strategies to implement H-130.970(5) that states: "All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize and "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer" *and report back at the 2005 Interim Meeting*; (4) with input from all interested Federation members, coordinate an effort to educate the membership about emergency department coverage issues and the efforts to resolve them; (5) seek to require all insurers, both public and private, to pay promptly and fairly all claims for services mandated by EMTALA for all plans they offer, or face fines and penalties comparable to those imposed on providers; and (6) seek to have CMS require all states participating in Medicaid, as a condition of continued participation, establish and adequately fund state Emergency Medical Services funds which physicians providing EMTALA-mandated services may bill, and from which those physicians shall receive prompt and fair compensation. (CME Rep. 3, A-05; Reaffirmation A-07; Reaffirmed in lieu of Res. 605, I-08)

D-130.984 Payment for Emergency Services

(1) *Our AMA shall investigate and explore creative sources and options for new, expanded, and a non-traditional source of funding necessary to support day to day delivery and all emergency health services for report back A-03.* (2) Such emergency health services shall be defined to mean the full spectrum of access and capacity, including but not limited to: primary and specialty care access, on call services, intensive care capacity, EMTALA related requirements, trauma care and bioterrorism preparedness. (Sub. Res. 204, A-02; Reaffirmation A-07)

D-160.995 Physician and Nonphysician Licensure and Scope of Practice

Our AMA will: (1) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (2) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; (3) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups; and (4) *encourage the Association of American Medical Colleges to undertake a study of medical practice in a multidisciplinary environment and the educational infrastructure and processes necessary to ensure the preparation of physicians (MDs and DOs) for such practice using the expertise of the Council on Medical Education and the Council on Medical Service and report back at the June 2002 meeting of the House of Delegates.* (CME Rep. 1, I-00; Reaffirmed: CME Rep. 2, A-10)

D-165.966 Giving States New Options to Improve Coverage for the Poor

Our AMA will (1) advocate that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes, including combining refundable, advanceable tax credits inversely related to income to purchase health insurance coverage with converting Medicaid from a categorical eligibility program to one that allows for coverage of additional low-income persons based solely on financial need; (2) advocate for changes in federal rules and federal financing to support the ability of states to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping federal funds; (3) continue to work with interested state medical associations, national medical specialty societies, and other relevant organizations to further develop such state-based options for improving health insurance coverage for low-income persons; and (4) *direct the Council of Medical Service to conduct a study of various alternatives and*

demonstration projects for expanding health insurance coverage for low-income persons and on progress concerning development of new state options for improving the effectiveness of public health safety net programs and report back at the 2005 Annual Meeting. (Res. 118, A-04; Reaffirmed: CMS Rep. 1, A-05; Modified: CMS Rep. 8, A-08; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed: CMS Rep. 5, I-11)

H-180.951 Tax Treatment of Health Insurance: Comparing Tax Credits and Tax Deductions

Our AMA: (1) supports the use of appropriately structured and adequately funded tax credits as the most effective mechanism for enabling uninsured individuals to obtain health insurance coverage; and (2) will study the tax ramifications of eliminating the employee income tax exclusion for employment-based health insurance, including the possible impact on both payroll taxes (e.g., FICA and Medicare tax to employees and employers) and individual income taxes at the state, city and county levels, with a report back at the 2008 Annual Meeting. (CMS Rep. 5, I-07; Reaffirmed in lieu of Res. 113, A-09; Reaffirmation A-10)

H-185.949 Centers for Medicare and Medicaid Services Policy on Hospital Acquired Conditions - Present on Admission

1. Our AMA will: (a) continue its strong opposition to non-payment for conditions outlined in the Hospital Acquired Condition -- Present on Admission (HAC-POA) policy that are not reasonably preventable through the application of evidence-based guidelines developed by appropriate medical specialty organizations based on non-biased, well-designed, prospective, randomized studies; (b) ask CMS or other appropriate bodies to monitor and evaluate practice changes made as a result of HAC-POA law, and associated outcomes, and report back on best practices; (c) educate physicians about the HAC-POA law and its implications for patient care, coding requirements and payment; (d) continue its education and advocacy of CMS, Members of Congress and the public about the unintended consequences of non-payment for hospital acquired conditions that may not in fact be preventable, and that adversely affect access to and quality of care; (e) oppose the use of payment and coverage decisions of governmental and commercial health insurance entities as determinative of the standard of care for medical practice and advocate that payment decisions by any third party payer not be considered in determining standards of care for medical practice; (f) study the impact of increased work load and documentation requirements imposed on physicians by hospitals in response to the HAC-POA policy, and the need to protect physicians from potential liability or claims of incorrect completion of such documents to report back at the 2008 Interim Meeting; and (g) continue to study the effect of HAC-POA penalty programs on professional liability; potential institutional demands to control or micro-manage doctors' professional decision-making; and efforts to develop evidence-based information about which events may be truly preventable as opposed to those whose frequency can be reduced by appropriate intervention. 2. Our AMA will: (a) continue its efforts to advocate against expansion of the Hospital Acquired Conditions - Present on Admission policy to physicians; (b) communicate to the Administration how burdensome the HAC-POA policy is for physicians and the Medicare program; (c) work with federal agencies to further monitor the HAC-POA program evaluation, and offer constructive input on its content and design; and (d) maintain efforts with our hospital association colleagues, such as the American Hospital Association, to monitor HAC-POA policy and its impact. (BOT Rep. 17, A-08; Appended: BOT Rep. 2, I-10)

D-200.977 National Health Service Corps: Stronger AMA Representation in Decision Making Process

1. Our AMA will work to enhance public health and other specialty physician, medical school and medical student representation in the decision making process of the National Health Service Corps with the goals of increasing popularity and efficiency of the program in accordance with existing policies adopted by our AMA's House of Delegates. 2. *Our AMA will report back on the progress of its efforts at the 2011 Annual Meeting of the House of Delegates. (Res. 216, I-10)*

D-200.979 Barriers to Primary Care as a Medical School Choice

1. In collaboration with relevant specialty societies, our AMA will take the following actions related to reimbursement for primary care physician services: a. Continue to advocate for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions. b. Work to assure that private payers fully recognize the value of E&M services, incorporating the RUC recommended increases adopted for the most current Medicare RBRVS. 2. *In collaboration with relevant specialty societies, our AMA will study the following related to new models of provision of primary care services (such as the medical home concept): a. the impact on primary care physician work-life balance and satisfaction, b. the growth/expansion of such models in the public and private sectors, c. the availability of expanded public- and private-sector funding at the national and local levels to support implementation of such models. d. the impact on primary care physician compensation. e. options that explore additional funding. The results of the study shall be reported no later than the 2010 Annual Meeting of the AMA House of Delegates.* 3. Our AMA supports existing programs and advocate for the introduction of new programs in the public and private sectors that decrease the debt load of physicians who choose to practice in a primary care specialty. 4. Our AMA will continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. 5. Our AMA will collaborate with appropriate organizations to support the development of innovative models to recruit medical students interested in primary care, to train primary care physicians, and to enhance the image of primary care practice. 6. Our AMA will collaborate with appropriate organizations in urging medical schools to develop policies and to allocate appropriate resources to activities and programs that encourage students to select primary care specialties, including: a. admissions policies b. utilization of primary care physicians in the roles of teachers, mentors, and role models, and c. educational experiences in community-based primary care settings. 7. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) to develop an accreditation environment and novel pathways that promote innovations in training that use progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model. 8. Our AMA will advocate for

public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide graduate medical education for resident physicians and fellows in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. 9. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide undergraduate medical education for students in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. 10. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919. (CME Rep. 3, I-08; Appended: CME Rep. 8, A-10)

D-200.985 Strategies for Enhancing Diversity in the Physician Workforce

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups. 2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas. 3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community. 4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty. 5. *Through the identification of models and strategies at the national and state/regional levels, our AMA will study and report back at the 2009 Annual Meeting on the following: a. The status of efforts to assure adequate funding for diversity initiatives; b. The current status of underservice and access to care in the US (regionally and by population); and c. The recruitment and retention of physicians to practice in underserved areas and to work with underserved populations.* 6. *Our AMA will collaborate with the AAMC, the Educational Commission for Foreign Medical Graduates, and the Federation of State Medical Boards to study the contribution of international medical graduates to the overall diversity and distribution of the US medical workforce and report at the 2008 Annual Meeting.* (CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13)

D-215.995 Specialty Hospitals and Impact on Health Care

Our AMA will: (1) oppose efforts to either temporarily or permanently extend the 18-month moratorium on physician referrals to specialty hospitals in which they have an ownership interest; (2) support changes in the inpatient and outpatient Medicare prospective payment systems to eliminate the need for cross-subsidization by more accurately reflecting the relative costs of hospital care; (3) support federal legislation and/or regulations that would fix the flawed methodology for allocating Medicare and Medicaid Disproportionate Share Hospital (DSH) payments to help ensure the financial viability of safety-net hospitals so they can continue to provide adequate access to health care for indigent patients; (4) encourage physicians who contemplate formation of a specialty hospital to consider the best health interests of the community they serve. Physicians should explore the opportunities to enter into joint ventures with existing community hospitals before proceeding with the formation of a physician-owned specialty hospital; (5) oppose the enactment of federal certificate of need (CON) legislation and support state medical associations in their advocacy efforts to repeal current CON statutes and to oppose the reinstatement of CON legislation or its expansion to physician-owned ambulatory health care facilities; and (6) *continue to monitor the specialty hospital issue and report back to the House of Delegates at the 2005 Annual Meeting.* (BOT Rep. 15, I-04; Reaffirmation A-09)

D-275.995 Licensure and Credentialing Issues

Our AMA will: (1) support recognition of the Federation of State Medical Boards' (FSMB) Credentials Verification Service by all licensing jurisdictions; (2) work jointly with the FSMB to take measures to encourage increased standardization of credentials requirements, and improved portability by increased use of reciprocal relationships among all licensing jurisdictions; (3) communicate, either directly by letter or through its publications, to all hospitals and licensure boards that the Joint Commission on Accreditation of Healthcare Organizations encourages recognition of both the Educational Commission for Foreign Medical Graduates' Certification Verification Service and the AMA's Masterfile as primary source verification of medical school credential; and (4) encourage the National Commission on Quality Assurance (NCQA) and all other organizations to accept the Federation of State Medical Boards' Credentials Verification Service, the Educational Commission for Foreign Medical Graduates' Certification Verification Service, and the AMA Masterfile as primary source verification of credentials. (Res. 303, I-00; Reaffirmation A-04)

H-295.876 Equal Fees for Osteopathic and Allopathic Medical Students

1. Our AMA, in collaboration with the American Osteopathic Association, discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training. 2. Our AMA (a) encourages equitable fees for allopathic and osteopathic medical students in access to clinical electives, while respecting the rights of individual allopathic and osteopathic medical schools to set their own policies related to visiting students, and (b) *will continue to monitor and report back*

at the 2009 Annual Meeting on the adequacy of clinical resources and placements for allopathic and osteopathic medical students. (Res. 809, I-05; Appended: CME Rep. 6, A-07)

H-295.979 Substance Abuse

The AMA (1) reaffirms its position which recognizes the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; (2) urges medical schools to include substance abuse prevention programs in their curriculum; and (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse. (Res. 106, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 10, I-98; Reaffirmed: BOT Rep. 17, I-99; Reaffirmed: CME Rep. 11, A-07)

D-300.980 Opposition to Increased CME Provider Fees

1. Our AMA will (a) communicate its appreciation to the Accreditation Council for Continuing Medical Education (ACCME) Board of Directors for their responsiveness to AMA's requests this past year; (b) continue to work with the ACCME to: (i) reduce the financial burden of institutional accreditation and state recognition; (ii) reduce bureaucracy in these processes, (iii) improve continuing medical education, and (iv) encourage the ACCME to show that the updated accreditation criteria improve patient care; and (c) continue to work with the ACCME to (i) mandate meaningful involvement of state medical societies in the policies that affect recognition and (ii) reconsider the fee increases to be paid by the state-accredited providers to ACCME. 2. Our AMA will continue to work with the ACCME to accomplish the directives in policy D-300.980, "Opposition to Increased Continuing Medical Education (CME) Provider Fees." 3. *The Council on Medical Education will monitor the results of the activities addressing policy D-300.980 with a report back to the House of Delegates at its 2012 Annual Meeting as to the status of the costs of CME and what further actions, if any, need to be taken.* (CME Rep. 14, A-10; Appended: CME Rep. 9, A-11; Modified: CCB/CLRPD Rep. 4, A-12)

D-300.984 Physician Reentry

Our AMA: 1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs. 2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice. 3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics. 4. Will support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to PREPs. 5. Will make available to all interested parties the physician reentry program (PREP) system Guiding Principles for use as a basis for all reentry programs: a. Accessible: The PREP system is accessible by geography, time and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is commensurate with the assessed clinical and educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions or the health care system. b. Collaborative: The PREP system is designed to be collaborative to improve communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible. c. Comprehensive: The PREP system is comprehensive to maximize program utility. Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice. d. Ethical: The PREP system is based on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statutes. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed. e. Flexible: The PREP system is flexible in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians. f. Modular: Physician reentry programs are modularized, individualized and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need. g. Innovative: Innovation is built into a PREP system allowing programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians. Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation. h. Accountable: The PREP system has mechanisms for assessment and is open to evaluation. Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician's competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of the measures are established. Standardization of measures exist across programs to assess whether or not national standards are being met. i. Stable: A funding scheme is in place to ensure the PREP system is financially stable over the long-term. Adequate funding allows physician reentry programs to operate at sufficient and appropriate capacity. j. Responsive: The PREP system makes refinements, updates and other changes when necessary. Physician reentry programs are equipped to address systemic changes such as changes in regulations. Additionally, the PREP system is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster. 6. *Will, as part of its Initiative to Transform Medical Education*

strategic focus and in support of its members and Federation partners, develop model program standards utilizing PREP system Guiding Principles with a report back at the 2009 Interim Meeting. (CME Rep. 6, A-08; Reaffirmed: CME Rep. 11, A-12)

D-305.963 Securing Medicare GME Funding for Research and Ambulatory Non-Hospital Based Outside Rotations During Residency

Our AMA will: 1. Advocate for the Centers for Medicare and Medicaid Services (CMS) (both federal Medicare and federal/state Medicaid) funding for the time residents and fellows spend in research, didactic activities, and extramural educational activities required for the Accreditation Council for Graduate Medical Education (ACGME) accreditation during their training. 2. Continue to work with organizations such as the Association of American Medical Colleges (AAMC) and the Council on Graduate Medical Education (COGME), to make recommendations to change current Graduate Medical Education (GME) funding regulations during residency training, which currently limit funding for research, extramural educational opportunities, and flexible GME training programs and venues. 3. Monitor any public and/or private efforts to change the financing of medical services (health system reform) so as to advocate for adequate and appropriate funding of GME. 4. *Prepare a Council on Medical Education report for the 2009 Interim Meeting that broadly addresses issues of GME funding that includes examples of successful state and regional innovations.* 5. Advocate for funding for training physician researchers from sources in addition to CMS such as the National Institutes of Health, the Agency for Healthcare Research and Quality, the Veterans Administration, and other agencies. (CME Rep. 4, I-08; Reaffirmed: CME Rep. 3, I-09)

D-305.975 Long-Term Solutions to Medical Student Debt

Our AMA will: (1) through its Council on Medical Education, continue a comprehensive study of medical education financing, with a report back to the House of Delegates at the 2005 Annual Meeting; (2) encourage medical schools and state medical societies to consider the creation of self-managed, low-interest loan programs for medical students, and collect and disseminate information on such programs; (3) advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas; (4) work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment; (5) collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided; and (6) encourage the National Health Services Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas. (CME Rep. 3, I-04; Reaffirmation I-06; Appended: Res. 321, A-12; Reaffirmation A-13)

D-310.967 Resident Pay During Orientation

Our AMA will: (1) advocate that all resident and fellow physicians should be compensated, and receive benefits, at a level commensurate with the pay that they will receive while in their training program, for all days spent in required orientation activities prior to the onset of their contractual responsibilities; *and (2) ask the Accreditation Council for Graduate Medical Education to amend its institutional requirements so that institutions are required to compensate resident and fellow physicians, and provide benefits, for time spent in required orientation activities at a level commensurate with the pay that the resident or fellow shall receive while in their program. (Res. 302, A-07)*

D-310.972 Protection Against Delayed Residency Program Closure

Our AMA will: (1) Work closely with the Accreditation Council for Graduate Medical Education to contribute to, review and comment on any new ACGME policies related to residency closures, regardless of cause. (2) Work with the American Board of Medical Specialties to encourage all its member certifying boards to develop a mechanism to accommodate the discontinuities in training which arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training. (3) Work with the ACGME to monitor closing programs, including encouraging programs to immediately notify residents of pending closures and to promptly transfer residents to alternate accredited programs as soon as feasible with the least disruption to training; and strongly encourage programs which accept transferred residents to minimize extensions to total training time. (4) *Use the National GME Census and work with the ACGME to assess how much disruption occurred in the training of residents as a result of program closures caused by Hurricane Katrina and report back at the 2009 Annual Meeting with further recommendations.* (5) Work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure. (CME Rep. 7, A-06; Reaffirmed: CME Rep. 4, A-09)

D-315.984 Ownership of Claims Data

Our AMA will: (1) encourage physicians to include language designed to buttress rights associated with claims data ownership and access when contracting with health plan payers and other third parties; (2) continue to educate physicians on providing public and private health plan payers the “minimum necessary,” as defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and regulations thereunder, protected health information necessary to achieve the purpose of a disclosure; (3) assist physicians wishing to register a complaint against health plan payers that have used claims data to form a database, or that have permitted access to or sale of the database or its contents without explicit patient and/or physician authorization, beyond

the scope permitted by HIPAA with the Department of Health and Human Services Office of Civil Rights; (4) advocate to the Department of Health and Human Services, Office of the National Coordinator of Health Information Technology and/or other appropriate agencies for rules and regulations ensuring appropriate physician ownership and access rights to claims data, and appropriate protection of claims data held by various parties; (5) continue to monitor federal and state activities impacting the exchange of physician-generated health information, including claims data; and (6) *continue to strengthen opportunities for physician ownership of and access to patient claims data, create model contract language to assist physicians in strengthening their rights in this area, and report back to the House of Delegates on the status of these activities.* (BOT Rep. 19, I-06)

H-350.962 Reauthorization of the Indian Health Care Improvement Act

Our AMA (1) supports reauthorization of the Indian Health Care Improvement Act and (2) *will report back on this issue at the 2008 Annual Meeting.* (Res. 221, A-07)

H-355.995 National Practitioner Data Bank

It is the policy of the AMA to (1) work with HHS to establish a mechanism to inform physicians when an inquiry to the Data Bank has been made; (2) *reaffirm its policy that reports, other than licensure revocation, in the Data Bank should be purged after five years;* and (3) support efforts to require the same Data Bank reporting requirements for physicians, dentists and other licensed health care practitioners. (Sub. Res. 41, I-90; Modified: Sunset Report, I-00; Reaffirmation A-09)

H-375.972 Lack of Federal Peer Review Confidentiality Protection

Our AMA will seek to vigorously pursue enactment of federal legislation to prohibit discovery of records, information, and documents obtained during the course of professional review proceedings. Our AMA will immediately work with the Administration and Congress to enact legislation that is consistent with Policy H-375.972 *and report back to the House of Delegates at the 2004 Annual Meeting.* (Res. 221, I-96; Reaffirmed: BOT Rep. 13, I-00; Reaffirmation A-01; Reaffirmed: BOT Rep. 8, I-01; Reaffirmed: CMS Rep. 6, I-02; Appended: Res. 925, I-03; Reaffirmation A-05; Reaffirmed: BOT Rep. 13, I-11)

D-375.997 Peer Reviewer Immunity

Our AMA will: (1) recommend medical staffs adopt/implement staff by laws that are consistent with HCQIA and AMA policy by communicating the guidelines from AMA policy H-375.983 widely through appropriate media to the relevant organizations and institutions, including a direct mailing to all medical staff presidents in the United States, indicating that compliance is required to conform to HCQIA and related court decisions; (2) monitor legal and regulatory challenges to peer review immunity and non discoverability of peer review records/proceedings and continue to advocate for adherence to AMA policy, reporting challenges to peer review protections to the House of Delegates and produce an additional report with recommendations that will protect patients and physicians in the event of misdirected or negligent peer review at the local level while retaining peer review immunity for the process *and report back at Annual 2002;* and (3) continue to work to provide peer review protection under federal law. (BOT Rep.8, I-01; Reaffirmation A-05)

D-390.984 Payment by Health Insurance Plans of Medicare Deductibles and Copayments

Our AMA will: (1) seek legislation to compel all insurers paying secondary to Medicare to be required to pay the deductibles and coinsurance owed after the Medicare payment is made; (2) advise physicians that they are legally entitled to the Medicare co-payments and are required to bill the patients for them, because of existing Medicare fraud and abuse laws, *and report back at the 2003 Interim Meeting to membership on the legality and measures that physicians may take when secondary carriers will not pay, and this does not apply to Medicare and Medicaid dual eligibles;* and (3) seek federal legislation to require that a secondary plan not manage the primary Medicare benefit by imposing limits as if it were primary. (Res. 105 and 106, A-03; Reaffirmed: BOT Rep. 28, A-13)

D-400.988 PLI-RVU Component of RBRVS Medicare Fee Schedule

Our AMA will: (1) continue its current activities to seek correction of the inadequate professional liability insurance component in the Resource-Based Relative Value Scale Formula; (2) continue its current activities to seek action from the Centers for Medicare & Medicaid Services to update the Professional Liability Insurance Relative Value Units (PLI-RVU) component of the RBRVS to correctly account for the current relative cost of professional liability insurance and its funding; (3) support federal legislation to provide additional funds for this correction and update of the PLI-RVU component of the RBRVS, rather than simply making adjustments in a budget-neutral fashion; and (4) *report back to the House of Delegates at the 2004 Annual Meeting on the progress of the activities pertaining to PLI-RVU portion of the RBRVS.* (Res. 707, I-03; Reaffirmed: BOT Rep. 18, A-05)

H-406.989 Work of the Task Force on the Release of Physician Data

1. Our AMA Council on Legislation will use the Release of Claims and Payment Data from Governmental Programs as a basis for draft model legislation. 2. Our AMA will create additional tools to assist physicians in dealing with the release of physician data. 3. Our AMA will continue to monitor the status of, and take appropriate action on, any legislative or regulatory opportunities regarding the appropriate release and use of physician data and its use in physician profiling programs. 4. Our AMA will monitor new and existing Web sites and programs that collect and use data on patient satisfaction and take appropriate action when safeguards are not in place to ensure the validity of the results. 5. Our AMA will continue and intensify its extensive efforts to educate employers, healthcare coalitions and the public about the potential risks and liabilities of pay-for-performance and public reporting programs that are not consistent with AMA policies, principles, and guidelines. 6. Our AMA: A) opposes

the public reporting of individual physician performance data collected by certification and licensure boards for purposes of MOC and MOL; B) supports the principle that individual physician performance data collected by certification and licensure boards should only be used for the purposes of helping physicians to improve their practice and patient care, unless specifically approved by the physician; and C) will report how certification and licensure boards are currently using, or may potentially use, individual physician performance data (other than for individual physician performance improvement) that is reported for purposes of Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC) and Maintenance of Licensure (MOL) and report back to the HOD no later than the 2012 Annual Meeting. (BOT Rep. 18, A-09; Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed in lieu of Res. 808, I-10; Appended: Res. 327, A-11)

H-435.967 Report of the Special Task Force and the Advisory Panel on Professional Liability

(1) It is the policy of the AMA that effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform. The AMA's MICRA-based federal tort reform provisions include: (a) a \$250,000 ceiling on non-economic damages, (b) the offset of collateral sources of plaintiff compensation, (c) decreasing incremental or sliding scale attorney contingency fees, (d) periodic payment of future awards of damages, and (e) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than six years after birth. (2) Our AMA also supports federal reform to achieve: (a) a certificate of merit requirement as a prerequisite to filing medical liability cases; (b) statutory criteria that outline expert witness qualifications; and (c) demonstration projects to implement potentially effective alternative dispute resolution (ADR) mechanisms. (3) Our AMA supports medical product liability reform, applicable to the producers of pharmaceuticals and medical devices, as an important state and federal legislative reform objective. (4) Any health system reform proposal that fails to include MICRA type reform, or an alternative model proven to be as effective in a state, will not be successful in containing costs, providing access to health care services, and promoting the quality and safety of health care services. Under no circumstances would support for federal legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states. Federal preemptive legislation that endangers effective state-based reform will be actively opposed. (BOT Rep. 53, I-93; Reaffirmation A-00; Reaffirmation I-03; Reaffirmed: Sub. Res. 910, I-03; Reaffirmation A-04)

H-440.876 Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients

1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents *and report back on this issue at the 2008 Annual Meeting.* (Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07)

D-440.951 One-Year Public Health Training Options for all Specialties

1. Our AMA encourages additional funding for public health training for more physicians. 2. *Our AMA, through its Council on Medical Education, will monitor the progress of the Institute of Medicine (IOM) study, Training Physicians for Public Health Careers, and provide an updated report based on the IOM study recommendations to the 2008 Annual Meeting.* 3. Our AMA, in conjunction with other appropriate organizations, supports the work of relevant groups to initiate the development of specific physician competencies for physicians engaged in public health practice. 4. Our AMA will inform medical students and physicians of existing opportunities for physician training in preparation for public health practice. (CME Rep. 12, A-07)

D-440.958 Universal Defibrillator Connectivity

Our AMA will: (1) support the development and use of universal connectivity for all defibrillators; *and (2) work with and support members of EMS departments, and state and federal legislators to strongly urge manufacturers to voluntarily adopt universal connectivity for all defibrillators.* (Res. 511, A-06)

D-440.969 Protect Children from Skin Cancer

Our AMA will: (1) support the enactment of federal legislation to: (a) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR §1040.20 [a][9]) by anyone under the age of 18; and (b) require a United States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; and (2) *urge the Food and Drug Administration's Center For Devices and Radiological Health to hold a fair hearing as soon as possible on the safety and efficacy of UVA bulbs, as used in indoor tanning facilities.* (Res. 440, A-05; Reaffirmation A-11; Reaffirmation A-12)

D-450.981 Protecting Patients Rights

Our AMA will: (1) continue to advocate for the repeal of the flawed sustainable growth rate formula without compromising our AMA's principles for pay-for-performance; (2) develop a media campaign and public education materials to teach patients and other stakeholders about the potential risks and liabilities of pay-for-performance programs, especially those that are not consistent with AMA policies, principles, and guidelines; *and (3) provide a report back to the House of Delegates at its 2006 Annual Meeting.* (Sub. Res. 902, I-05; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmation I-06; Reaffirmation A-07)

3. AMA POLICY CONSOLIDATIONS

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

In AMA Policy G-600.111, Consolidation and Reconciliation of AMA Policy, our AMA House of Delegates endorsed the concept of consolidating policies in order to make information on existing AMA policy more accessible and to increase the readability of our AMA Policy Database and our AMA PolicyFinder Program. The policy consolidation process allows for: (a) rescinding outmoded and duplicative policies and (b) combining policies that relate to the same topic.

For this year's joint CCB/CLRPD policy consolidation report, the councils employed the following approach:

- Search the current AMA policy database.
- Identify categories where there were outmoded and outdated policies.
- Group similar policies (or parts of policies) together into a single policy. 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 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 other AMA councils to finalize the recommendations and then sought the input of various AMA sections. In seeking the input, CCB and CLRPD emphasized that the intent was not to usurp the role of any other council but to clean up policy as much as possible, pursuant to AMA Policy G-600.111, and in a coordinated, cross-council effort.

The topics for this 2014 policy consolidation include the following:

- [Developmental Delay/Intellectual Disability](#)
- [Disposal of Used Syringes, Needles, and Other Sharps](#)
- [In-Line Skating](#)
- [Helmets for Riders of Motorized or Non-motorized Cycles](#)
- [All-Terrain Vehicles](#)
- [Impaired Driving](#)
- [Persons with Hearing Disorders](#)
- [Physician Participation in Department of Defense Reserve Components](#)
- [Drug and Alcohol Use in Aviation](#)
- [Skin Cancer Prevention](#)
- [Screening and Treatment for Breast and Cervical Cancer Risk Reduction](#)
- [Breast Reconstructive Surgery](#)
- [Uniform Cancer Staging](#)
- [Lead Poisoning](#)
- [Death Certificate Completion](#)
- [Autopsies](#)
- [Hospice Care](#)
- [Advance Care Planning](#)
- [Palliative Care](#)
- [MDs/DOs as Medical Review Officers](#)
- [Substance Use Prevention](#)
- [Disabled Parking](#)
- [CPR Training](#)
- [Proficiency of Physicians in Basic and Advanced Cardiac Life Support](#)
- [Good Samaritans](#)

- [National Practitioner Data Bank](#)
- [Human Rights and Freedom](#)

In the interests of transparency and because of the multiplicity of topics covered, the councils have used a slightly different format for this consolidation report. Appendix A presents the proposed consolidation policy; Appendix B presents the entire text of all policies the councils considered for consolidation; and Appendix C presents selected policies showing editorial modifications and the step-by-step consolidation process for selected policies.

RECOMMENDATIONS

The Council on Constitution and Bylaws and Council on Long Range Planning and Development recommend that the House of Delegates adopt the following recommendations, and file the remainder of this report:

1. That the following consolidated policies (see Appendix A) be added to the AMA policy database:
 - [H-10.xxx, In-Line Skating](#) [See Policy [H-10.963](#)]
 - [H-10.xxx, Helmets for Riders of Motorized and Non-motorized Cycles](#) [See Policy [H-10.964](#)]
 - [H-15.xxx, All-Terrain Vehicles](#) [See Policy [H-15.951](#)]
 - [H-30.xxx, Prevention of Impaired Driving](#) [See Policy [H-30.936](#)]
 - [H-35.xxx, Treatment of Persons with Hearing Disorders](#) [See Policy [H-35.967](#)]
 - [H-40.xxx, Physician Participation in Department of Defense Reserve Components](#) [See Policy [H-40.967](#)]
 - [H-45.xxx, Drug and Alcohol Use in Aviation](#) [See Policy [H-45.976](#)]
 - [H-55.xxx, Uniform Cancer Staging](#) [See Policy [H-55.970](#)]
 - [H-55.xxx, Screening and Treatment for Breast and Cervical Cancer Risk Reduction](#) [See Policy [H-55.971](#)]
 - [H-55.xxx, Early Detection and Prevention of Skin Cancer](#) [See Policy [H-55.972](#)]
 - [H-55.xxx, Breast Reconstruction](#) [See Policy [H-55.973](#)]
 - [H-60.xxx, Reducing Lead Poisoning](#) [See Policy [H-60.924](#)]
 - [H-65.xxx, Support of Human Rights and Freedom](#) [See Policy [H-65.965](#)]
 - [H-70.xxx, Good Palliative Care](#) [See Policy [H-70.915](#)]
 - [H-85.xxx, Improving Death Certification Accuracy and Completion](#) [See Policy [H-85.953](#)]
 - [H-85.xxx, Importance of Autopsies](#) [See Policy [H-85.954](#)]
 - [H-85.xxx, Hospice Care](#) [See Policy [H-85.955](#)]
 - [H-85.xxx, Educating Physicians about Advance Care Planning](#) [See Policy [H-85.956](#)]
 - [H-90.xxx, Medical Care of Persons with Developmental Disabilities](#) [See Policy [H-90.968](#)]
 - [H-90.xxx, Early Intervention for Individuals with Developmental Delay](#) [See Policy [H-90.969](#)]
 - [H-90.xxx, Disabled Parking](#) [See Policy [H-90.970](#)]
 - [H-95.xxx, Safe Disposal of used Syringes, Needles and Other Sharps in the Community](#) [See Policy [H-95.942](#)]
 - [H-95.xxx, MDs/Dos as Medical Review Officers](#) [See Policy [H-95.943](#)]
 - [H-130.xxx, Delivery of Health Care by Good Samaritans](#) [See Policy [H-130.937](#)]
 - [H-130.xxx, Cardiopulmonary Resuscitation and Defibrillators](#) [See Policy [H-130.938](#)]
 - [H-140.xxx, Encouraging the Use of Advance Directives and Health Care Powers of Attorney](#) [See Policy [H-140.845](#)]
 - [H-295.xxx, Impairment Prevention and Treatment in the Training Years](#) [See Policy [H-140.845](#)]
 - [H-300.xxx, Proficiency of Physicians in Basic and Advanced Cardiac Life Support](#) [See Policy [H-300.945](#)]
 - [H-355.xxx, Opposition to the National Practitioner Data Bank](#) [See Policy [H-355.975](#)]
 - [H-355.xxx, National Practitioner Data Bank](#) [See Policy [H-355.976](#)]
 - [H-355.xxx, Reporting of Resident Physicians to the National Practitioner Data Bank](#) [See Policy [H-355.977](#)]
 - [H-440.xxx, Protecting the Public from Dangers of Ultraviolet Radiation](#) [See Policy [H-440.839](#)]
2. That the following policies be rescinded due to consolidation (see Appendix B):
 - [D-90.995 Early Intervention for Children with Developmental Delay](#)
 - [H-90.973 Designation of the Intellectually Disabled as a Medically Underserved Population](#)
 - [H-90.972 Advancements in Advocacy and Medical Care of Persons with Developmental Disabilities](#)
 - [H-90.975 Enhancing Physicians' Interest in Medical Care for People with Profound Developmental Disabilities](#)

- [H-90.976 Medical and Dental Care for People With Developmental Disabilities](#)
- [D-270.997 Increased Funding for Physician Training and Reimbursement for Health Care of Individuals with Intellectual Disabilities/Developmentally Disabled Individuals](#)
- [H-95.949 Safe Disposal of Used Syringes, Needles, and Other Sharps in the Community](#)
- [H-95.999 Disposable Syringes](#)
- [D-95.993 Safe Disposal of Used Needles and Syringes in the Community: Update on AMA Activities](#)
- [H-10.969 In-Line Skating](#)
- [D-10.998 In-Line Skating](#)
- [H-10.967 Preventing Scooter Injuries](#)
- [H-10.980 Motorcycles and Bicycle Helmets](#)
- [H-10.985 Bicycle Helmets and Safety](#)
- [H-10.977 Helmets and Preventing Motorcycle- and Bicycle-Related Injuries](#)
- [H-15.980 Motorcycle Safety](#)
- [H-15.994 State Motorcycle Helmet Laws](#)
- [H-15.956 Options for Improving Motorcycle Safety](#)
- [H-15.971 Receipt of Federal Highway Funds and Motorcycle Helmet Laws](#)
- [D-15.995 ATV Safety](#)
- [H-15.975 Protection of Life- All-Terrain Vehicles](#)
- [H-15.981 Safety Requirements for ATV Operation](#)
- [H-30.945 Drivers Impaired by Alcohol](#)
- [H-30.969 Ignition Interlock System](#)
- [H-170.970 Teenage Drinking and Driving](#)
- [H-30.986 Alcohol and the Driver](#)
- [H-30.959 Mandatory Loss of Driver's License for Drivers Under Age 21 with Any Blood Alcohol Level](#)
- [H-30.941 Prevention of Repeat Driving Under the Influence \(DUI\) Offenses: The Issues of Diversion and Treatment and Vehicle Incapacitation](#)
- [H-35.994 Treatment of Persons with Hearing Disorders](#)
- [H-35.987 Medical Acts by Unlicensed Individuals](#)
- [H-35.986 The Practice of Audiology](#)
- [H-40.997 Endorsement of Participation in Armed Forces Medical Reserve Programs](#)
- [H-40.986 Physician Participation in Department of Defense Reserve Components](#)
- [H-40.976 Recruitment and Retention of Reserve Military Medical Personnel](#)
- [H-45.990 Programs Which Reduce Drug and Alcohol Use in All Facets of Aviation](#)
- [H-45.987 Drugs, Drinking, and Flying Pilots in General Aviation](#)
- [H-55.980 Skin Cancer Self-Examination](#)
- [H-55.976 Skin Cancer Prevention Education in Communities of Color](#)
- [H-440.865 Sunscreen Labeling](#)
- [H-440.959 Tanning Parlors](#)
- [H-440.967 Public Information Program Addressing the Dangers of UVA Exposure](#)
- [D-440.969 Protect Children from Skin Cancer](#)
- [H-440.980 Education on the Harmful Effects of UVA and UVB Light](#)
- [H-55.984 Screening and Treatment for Breast and Cervical Cancer](#)
- [H-55.985 Screening and Education Programs for Breast and Cervical Cancer Risk Reduction](#)
- [H-55.997 Breast Reconstructive Surgery](#)
- [H-55.978 Expanding Post-Mastectomy Options for Cancer Survivors](#)
- [H-55.992 Reimbursement for Breast Reconstruction](#)
- [H-60.977 Lead Poisoning Threat to Children](#)
- [H-60.956 Lead Poisoning Among Children](#)
- [H-440.854 Lead Levels in Children](#)
- [H-440.943 Lead-Based Paints](#)
- [H-85.974 Improving Death Certificate Completion](#)
- [H-85.986 Accurate Completion of Death Certificates](#)
- [H-85.996 Improvement in Accuracy of Death Certificates](#)
- [H-85.980 Autopsy for Pathological Correlation](#)

- [H-85.989 Autopsies](#)
- [H-85.993 Autopsies](#)
- [H-85.969 Preserving the Vital Role of the Autopsy in Medical Education](#)
- [H-85.964 Autopsy Payment and Performance Standards for Third Party Payers](#)
- [H-85.978 Autopsy as the Practice of Medicine](#)
- [H-85.973 Financial Incentives for Autopsies](#)
- [H-85.999 Hospices](#)
- [H-85.958 Palliative Care and End-of-Life Care](#)
- [H-85.991 Hospice Program Regulations for Medicare Qualification](#)
- [H-85.994 Hospice Standards](#)
- [H-85.962 Length-of-Life Criteria for Hospice Care](#)
- [H-85.963 Medicare Hospice Benefit](#)
- [H-85.965 Advance Care Planning](#)
- [H-140.969 Physician Education Regarding the Patient Self-Determination Act](#)
- [H-140.977 Residency Training in Medical-Legal Aspects of End-of-Life Care](#)
- [H-140.856 Encouraging Young Adults to Establish Advance Directives and Select Health Care Proxies](#)
- [H-140.946 Advance Directive for Each Nursing Home Resident](#)
- [D-140.976 Advance Health Care Directive](#)
- [H-140.976 Living Wills and Health Care Powers of Attorney](#)
- [D-85.997 Lessons Learned from Terri Schiavo](#)
- [D-440.948 Advance Directive](#)
- [D-330.938 Advance Health Care Directives to Medicare Enrollees](#)
- [D-70.962 Palliative Care and End-of-Life Care](#)
- [H-85.958 Palliative Care and End-of-Life Care](#)
- [H-85.967 Good Care of the Dying Patient](#)
- [H-90.979 Guidelines for Certifying Need for Handicapped Parking Privileges](#)
- [H-90.991 Handicapped Parking Spaces](#)
- [H-95.960 MDs/DOs as Medical Review Officers](#)
- [H-95.971 Medical Review Officers as Licensed Physicians](#)
- [H-295.987 Impairment Prevention and Treatment in the Training Years](#)
- [H-295.979 Substance Abuse](#)
- [H-95.982 Substance Abuse in Medical Schools](#)
- [H-130.944 Cardiopulmonary Resuscitation Training](#)
- [H-440.890 Availability of Automated External Defibrillators](#)
- [H-130.983 Teaching of Cardiopulmonary Resuscitation to All High School Students](#)
- [H-130.944 Cardiopulmonary Resuscitation Training](#)
- [D-440.958 Universal Defibrillator Connectivity](#)
- [H-300.999 Proficiency in Advanced Cardiac Life Support](#)
- [H-130.997 Cardiopulmonary Resuscitation](#)
- [H-295.906 Cardiopulmonary Resuscitation and Basic Life Support Training for First-Year Medical Students](#)
- [D-435.990 Delivery of Health Care by Good Samaritans](#)
- [H-130.986 Good Samaritan Law](#)
- [H-130.989 Protocol for Emergency Medical Services \(EMS\) Personnel and the Bystander Physician](#)
- [H-130.995 International Liability Regulations Pertaining to Emergency Care](#)
- [H-450.950 Revise National Practitioner Data Bank Criteria](#)
- [H-355.987 National Practitioner Data Bank](#)
- [H-355.991 National Practitioner Data Bank](#)
- [H-355.993 National Practitioner Data Bank](#)
- [H-355.999 Minimum Reporting Requirements to National Practitioner Data Bank](#)
- [H-355.995 National Practitioner Data Bank](#)
- [H-355.985 National Practitioner Data Bank](#)
- [H-355.996 Notification of Physicians by the National Practitioner Data Bank](#)
- [H-355.984 Removal of Overruled Disciplinary Actions Reports from the National Practitioner Data Bank](#)
- [H-355.992 Reporting Impaired Physicians to the National Practitioner Bank](#)

- [H-355.983 Reporting of Malpractice Information in the National Practitioner Data Bank](#)
- [D-355.997 Reporting of Resident Physicians](#)
- [H-355.980 Opposition to Inclusion of Liability Payments Made on Behalf of Residents in the National Practitioner Data Bank](#)
- [H-65.992 Continued Support of Human Rights and Freedom](#)
- [H-65.990 Civil Rights Restoration](#)
- [H-65.980 Support of Hate Crimes Prevention Legislation](#)

APPENDIX A - - AMA Policies Recommended for Consolidation (Organized by Topic)

Developmental Delay/Intellectual Disability

H-90.xxx, Early Intervention for Individuals with Developmental Delay

(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.

Consolidation of D-90.995 and H-90.973

H-90.xxx, Medical Care of Persons with Developmental Disabilities

(1) Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities. (2) Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals. (3) Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: (a) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them.

Consolidation of H-90.972, H-90.976, H-90.972, D-270.997, H-90.976, and H-90.975 [see Appendix C for detailed chart]

Disposal of Used Syringes, Needles, and Other Sharps

H-95.xxx, Safe Disposal of used Syringes, Needles and Other Sharps in the Community

(1) Our AMA recognizes that used sharps in the community pose a public health hazard in diverse ways to workers and to the public. (2) The AMA requests manufacturers of disposable hypodermic needles and syringes to adopt designs to prevent reuse, and to include in the packaging clear directions for their correct disposal. (3) Our AMA continues to support the mission of the Coalition for Safe Community Needle Disposal. (CSA Rep. 3, A-02; Modified: CCB/CLRPD Rep. 4, A-12)

Consolidation of H-95.949, H-95.999 and D-95.993

In-Line Skating

H-10.xxx, Safe In-Line Skating

(1) Our AMA encourages physicians to counsel patients, and their parents when appropriate, that full protective equipment should be worn and appropriate safety measures be taken to prevent in-line skating injuries. Consistent with recommendations of the American Academy of Pediatrics, prevention efforts should include the following: (a) Full protective gear should be worn at all times. This would include wrist guards, elbow pads, kneepads, and a helmet. The helmet should be certified by the ASTM, the

ANSI, or the Snell Foundation. (b) Unsafe activities such as hitching or truck surfing, which is latching onto a moving vehicle, should be avoided. (c) Training for beginners should be encouraged, and novice skaters should start in an indoor or outdoor rink rather than on the street. (d) Skaters should not skate in the dark and should learn to look for road debris or defects that could cause them to lose their balance. (e) Skaters, especially children with balance problems, physical disabilities, or uncorrected vision or hearing problems should do so in a rink or another protected place. (2) Our AMA encourages federal agencies and industries to support research on patterns of equipment use and frequency of protective equipment use for in-line skating. (3) Our AMA will continue to work with the Consumer Product Safety Commission, Centers for Disease Control and Prevention, national in-line skating organizations, and medical specialty societies, the AMA Alliance and the Federation to encourage in-line skaters to wear protective equipment. (4) Our AMA encourages medical specialty societies and state and local medical societies to advocate for state and local legislation to improve the safety of in-line skating through: (a) the use of appropriate protective equipment (especially helmets); (b) the designation of protected areas for in-line skating; (c) prohibitions against hitching a ride behind a moving vehicle; (d) the assurance that protective equipment is available at skating rental shops; and (e) the provision of training and educational materials. Such legislation should include a surveillance component to monitor compliance. (CSA Rep. 19, A-99; Reaffirmed: CSAPH Rep. 1, A-09)

Consolidation of H-10.969 and D-10.998

Helmets for Riders of Motorized or Non-motorized Cycles

H-10.xxx, Helmets for Riders of Motorized and Non-motorized Cycles

General Helmet Use: Our AMA: (1) encourages physicians to counsel their patients who ride motorized and non-motorized cycles to use approved helmets and appropriate protective clothing while cycling; (2) encourages patients and families to inform and train children about safe cycle-riding procedures, especially on roads and at intersections, the need to obey traffic laws, and the need for responsible behavior; (3) encourages community agencies, such as those involving law enforcement, schools, and parent-teacher organizations, to promote training programs for the responsible use of cycles; (4) urges manufacturers to improve the safety and reliability of the vehicles they produce and to support measures to improve cycling safety; (5) advocates further research on the effectiveness of helmets and on the health outcomes of community programs that mandate their use; (6) encourages efforts to investigate the impact of helmet use by riders of motorcycles and all bicycles, in order to establish the risk of major medical trauma from not wearing helmets, the costs added to the health care system by such behavior, and the payers of these added costs (i.e., private insurance, uncompensated care, Medicare, Medicaid, etc.); (7) supports the exploration of ways to ensure the wearing of helmets through the use of disincentives or incentives such as licensing fees, insurance premium adjustments and other payment possibilities.

Bicycles: Our AMA: (1) actively supports bicycle helmet use and encourages physicians to educate their patients about the importance of bicycle helmet use; (2) encourages the manufacture, distribution, and utilization of safe, effective, and reasonably priced bicycle helmets; and (3) encourages the availability of helmets at the point of bicycle purchase.

Scooters: Our AMA: (1) recommends the use of protective gear (certified helmets, elbow and knee pads, closed-toe shoes) for riders of scooters, especially children and adolescents; (2) encourages physicians to counsel patients, and their parents when appropriate, that full protective equipment should be worn and appropriate safety measures should be taken to prevent scooter injuries (e.g., riding away from traffic, and close supervision of riders under the age of eight); and (3) urges companies that manufacture or sell scooters to include appropriate information about the safe use of scooters on the scooters themselves, on or inside scooter packaging, on their web sites, and at the point of sale.

Motorcycles: Our AMA: (1) encourages physicians to be aware of motorcycle risks and safety measures and to counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs; (2) endorses the concept of legislative measures to require the use of helmets when riding or driving a motorcycle; (3) supports federal regulatory rules to make the receipt of federal highway funds by a state dependent on passage of mandatory motorcycle helmet laws by that state; (4) urges constituent societies to support the enactment or preservation of state motorcycle helmet laws; and (5) supports rider education legislation, which is more easily implemented and more effective than legislation requiring manufacturers to emphasize the dangers of operating motorcycles.

Consolidation of H-10.985 (as proposed for modification in CCB/CLRPD Report 2-A-14), H-10.977 (as proposed for modification in CCB/CLRPD Report 2-A-14), H-10.980, H-15.956, H-15.971, H-15.994, H-15.980 and H-10.967 [See Appendix C for detailed chart]

All-Terrain Vehicles

H-15.xxx, All-Terrain Vehicles

Our AMA: supports publicizing the dangers of all-terrain vehicles, especially to persons unlicensed to drive other vehicles; encourages manufacturers and dealers of ATVs to provide information regarding the safe operation of such vehicles; and seeks federal legislation to require sellers of all-terrain vehicles in the United States to promote the sale and use of suitable helmets to be used when operating or riding as a passenger on ATVs; and federal and state legislation and/or regulation to maximize safety of ATV operation including but not limited to (a) wearing suitable helmets and protective gear when operating or riding as a passenger on an ATV, (b) providing some safety instruction and training to all operators of ATVs, and (c) ensuring appropriate licensure for all operators of ATVs.

Consolidation of H-15.975, H-15.981 and D-15.995

Impaired Driving**H-30.xxx, Prevention of Impaired Driving**

Our AMA: (1) acknowledges that all alcohol consumption, even at low levels, has a negative impact on driver skills, perceptions, abilities, and performance and poses significant health and safety risks; (2) supports 0.04 percent blood-alcohol level as per se illegal for driving, and urges incorporation of that provision in all state drunk driving laws; and (3) supports 21 as the legal drinking age, strong penalties for providing alcohol to persons younger than 21, and stronger penalties for providing alcohol to drivers younger than 21.

Education: Our AMA: (1) favors public information and education against any drinking by drivers; (2) supports efforts to educate physicians, the public, and policy makers about this issue and urges national, state, and local medical associations and societies, together with public health, transportation safety, insurance, and alcohol beverage industry professionals to renew and strengthen their commitment to preventing alcohol-impaired driving; (3) encourages physicians to participate in educating patients and the public about the hazards of chemically impaired driving; (4) urges public education messages that now use the phrase “drunk driving,” or make reference to the amount one might drink without fear of arrest, be replaced with messages that indicate that “all alcohol use, even at low levels, impairs driving performance and poses significant health and safety risks;” (5) encourages state medical associations to participate in educational activities related to eliminating alcohol use by adolescents; and (6) supports and encourages programs in elementary, middle, and secondary schools, which provide information on the dangers of driving while under the influence of alcohol, and which emphasize that teenagers who drive should drink no alcoholic beverages whatsoever; and will continue to work with private and civic groups such as Mothers Against Drunk Driving (MADD) to achieve those goals.

Legislation: Our AMA: (1) supports the development of model legislation which would provide for school education programs to teach adolescents about the dangers of drinking and driving and which would mandate the following penalties when a driver under age 21 drives with any blood alcohol level (except for minimal blood alcohol levels, such as less than .02 percent, only from medications or religious practices): (a) for the first offense - mandatory revocation of the driver’s license for one year and (b) for the second offense - mandatory revocation of the driver’s license for two years or until age 21, whichever is greater; (2) urges state medical associations to seek enactment of the legislation in their legislatures; (3) urges all states to pass legislation mandating all drivers convicted of first and multiple DUI offenses be screened for alcoholism and provided with referral and treatment when indicated; (4) urges adoption by all states of legislation calling for administrative suspension or revocation of driver licenses after conviction for driving under the influence, and mandatory revocation after a specified number of repeat offenses; and (5) encourages passage of state traffic safety legislation that mandates screening for substance use disorder for all DUI offenders, with those who are identified with substance use disorder being strongly encouraged and assisted in obtaining treatment from qualified physicians and through state and medically certified facilities.

Treatment: Our AMA: (1) encourages that treatment of all convicted DUI offenders, when medically indicated, be mandated and provided but in the case of first-time DUI convictions, should not replace other sanctions which courts may levy in such a way as to remove from the record the occurrence of that offense; and (2) encourages that treatment of repeat DUI offenders, when medically indicated, be mandated and provided but should not replace other sanctions which courts may levy. In all cases where treatment is provided to a DUI offender, it is also recommended that appropriate adjunct services should be provided to or encouraged among the family members actively involved in the offender’s life;

Repeat Offenders: Our AMA: (1) recommends the following measures be taken to reduce repeat DUI offenses: (a) aggressive measures be applied to first-time DUI offenders (e.g., license suspension and administrative license revocation), (b) stronger penalties be leveled against repeat offenders, including second-time offenders, (c) such legal sanctions must be linked, for all offenders, to substance abuse assessment and treatment services, to prevent future deaths in alcohol-related crashes and multiple DUI offenses; and (2) calls upon the states to coordinate law enforcement, court system, and motor vehicle departments to implement forceful and swift penalties for second-time DUI convictions to send the message that those who drink and drive might receive a second chance but not a third.

On-board devices: Our AMA: (1) supports further testing of on-board devices to prevent the use of motor vehicles by intoxicated drivers; this testing should take place among the general population of drivers, as well as among drivers having alcohol-related problems; (2) encourages motor vehicle manufacturers and the U.S. Department of Transportation to monitor the development of ignition interlock technology, and plan for use of such systems by the general population, when a consensus of informed persons and studies in the scientific literature indicate the systems are effective, acceptable, reasonable in cost, and safe; and (3) supports continued research and testing of devices which may incapacitate vehicles owned or operated by DUI offenders without needlessly penalizing the offender’s family members.

Consolidation of H-30.945 (as proposed for amendment in CCB/CLRPD Report 2-A-14), H-30.969, H-170.970, H-30.986 (as proposed for amendment in CCB/CLRPD Report 2-A-14), H-30.959 and H-30.941 [See Appendix C for detailed chart]

Persons with Hearing Disorders**H-35.xxx Treatment of Persons with Hearing Disorders**

(1) Our AMA believes that physicians should remain the primary entry point for care of patients with hearing impairment and continue to supervise and treat hearing, speech, and equilibrium disorders. (2) Our AMA expressly opposes statements that the practice of audiology includes the diagnosis and treatment of hearing disorders; affirms that it is in the public interest that a medical assessment of any hearing or balance malfunction be made by a physician knowledgeable in diseases of the ear; reasserts that audiologists are individuals who perform non-medical testing, evaluating, counseling, instruction and rehabilitation of individuals whose communication disorders center in whole or in part in hearing function; and affirms its respect for the

contribution which audiologists have made and continue to make to patient welfare and quality health care in their assistance in the treatment of hearing disorders. (3) Should there be ambiguities in the statutory language of any state which defines audiology, state, and/or specialty medical societies should take steps to seek a legislative amendment to that statute to secure language that describes appropriately the practice of audiology. Misrepresentation by audiologists of their skills and/or the scope of their practice should be reported to appropriate state authorities.

Consolidation of H-35.994, H-35.987 and H-35.986

Physician Participation in Department of Defense Reserve Components

H-40.xxx, Physician Participation in Department of Defense Reserve Components

(1) Our AMA endorses voluntary physician participation in the military reserve components' medical programs as a means of actively aiding national defense while preserving the right of the individual physician to practice his/her profession without interruption in peace time. (2) Our AMA supports the U.S. Department of Defense by publicizing its needs for physicians in active duty military service and in the reserve components and guard, and encourages the active support and participation of physicians in active duty military service and in the reserves. (3) Our AMA will (a) continue to work with all appropriate parties in developing and proposing a multi-faceted approach toward rejuvenation and improvement in recruitment and retention in the military reserves; (b) work to assure that retired military medical personnel become eligible for reserve status; (c) support enactment of federal laws to assist physicians in the transition from medical practice to active military service; (d) promote use of existing laws for selective service and retirement credits as models for development of practical equitable criteria to be applied; and (e) support improvements in professional utilization of military medical personnel during both active duty periods and "weekend drill." (4) Our AMA supports the development of a statutory system of limitations on call-up, retention and recall of reservists in order to provide stability and predictability to reserve status and duty, with the basis for such a system to be defined statutorily using credits or "points" to prioritize options available to individual reservists as to call-up, retention, rotation and recall.

Consolidation of H-40.997, H-40.986, and H-40.976

Drug and Alcohol Use in Aviation

H-45.xxx, Drug and Alcohol Use in Aviation

(1) Our AMA urges the FAA to establish programs for personnel involved in all facets of aviation that reduce the impact of drug and alcohol use in order to further aviation safety. (2) Our AMA encourages continued studies by the Federal Aviation Administration of problems in the use of alcohol by pilots in general aviation and flight crews of commercial airlines.

Consolidation of H-45.990 and 45.987

Skin Cancer Prevention

H-55.xxx, Early Detection and Prevention of Skin Cancer

Our AMA: (1) encourages all physicians to (a) perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday; (b) examine their patients' skins for the early detection of melanoma and nonmelanoma skin cancer; (c) urge their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; and (d) educate their patients concerning the correct way to perform skin self-examination; (2) supports mechanisms for the education of lay professionals, such as hairdressers and barbers, on skin self-examination to encourage early skin cancer referrals to qualified health care professionals; and (3) supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color. Our AMA will continue to work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color.

Consolidation of H-55.980, and H-55.976

H-440.xxx, Protecting the Public from Dangers of Ultraviolet Radiation

Tanning Parlors: Our AMA supports: (1) educational campaigns on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; (2) legislation to strengthen state laws to make the consumer as informed and safe as possible; (3) dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; (4) collaboration between medical societies and schools to achieve the inclusion of information in the health curricula on the hazards of exposure to tanning rays; (5) the enactment of federal legislation to: (a) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR §1040.20 [a][9]) by anyone under the age of 18; and (b) require a United States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; (6) warning the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units, particularly the FDA's findings warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (7) working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including posted warnings in commercial tanning salons and spas; (8) an educational campaign in conjunction with various concerned national specialty societies to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to

reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers; and (9) intensified efforts to enforce current regulations.

Sunscreens. Our AMA supports: (1) the development of sunscreens that will protect the skin from a broad spectrum of ultraviolet radiation, including both UVA and UVB; and (2) the labeling of sunscreen products with a standardized ultraviolet (UV) logo, inclusive of ratings for UVA and UVB, so that consumers will know whether these products protect against both types of UV radiation. Terms such as low, medium, high and very high protection should be defined depending on standardized sun protection factor level.

Consolidation of H-440.865, H-440.959, H-440.967, H-440.980, and D-440.969 (as proposed for amendment in CCB/CLRPD Report 2-A-14) [See Appendix C for *detailed chart*]

Screening and Treatment for Breast and Cervical Cancer Risk Reduction

H-55.xxx, Screening and Treatment for Breast and Cervical Cancer Risk Reduction

(1) Our AMA supports programs to screen all women for breast and cervical cancer and that government funded programs be available for low income women; the development of public information and educational programs with the goal of informing all women about routine cancer screening in order to reduce their risk of dying from cancer; and increased funding for comprehensive programs to screen low income women for breast and cervical cancer and to assure access to definitive treatment. (2) Our AMA encourages state and local medical societies to monitor local public health screening programs to ensure that they are linked to treatment resources in the public or private sector.

Consolidation of H-55.985 and H-55.984

Breast Reconstructive Surgery

H-55.xxx, Breast Reconstruction

Our AMA: (1) believes that reconstruction of the breast for rehabilitation of the postmastectomy cancer patient should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided.

Consolidation of H-55.997, H-55.978 and H-55.992

Uniform Cancer Staging

H- 55.xxx, Uniform Cancer Staging

Our AMA (1) supports the tumor, node involvement, metastasis (TNM) system accepted by the American Joint Committee on Cancer and the Union for International Cancer Control for staging of cancer; (2) urges that this system be used in any published articles or information and be included as a requirement in Instructions to Authors; (3) encourages each state association to use this system in any educational forum or scientific meeting which it sponsors; and (4) supports general utilization of the Cancer Staging Manual developed by the American Joint Committee on Cancer.

Consolidation of H-55.988 and H-55.988 [names of organizations/committees updated for accuracy]

Lead Poisoning

H-60.xxx Reducing Lead Poisoning

Our AMA: (1) supports regulations and policies designed to protect young children from exposure to lead; (2) urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure; (3) encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories. (4) promotes community awareness of the hazard of lead-based paints; and (5) urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.

Consolidation of H-60.977, H-60.956, H-440.943 and H-440.854

Death Certificate Completion

H-85.xxx, Improving Death Certification Accuracy and Completion

Our AMA: (1) acknowledges that the reporting of vital events is an integral part of patient care; (2) urges physicians to ensure completion of all state vital records carefully and thoroughly with special attention to the use of standard nomenclature, using legible writing and accurate diagnoses; and (3) supports notifying state medical societies and state departments of vital statistics

of this policy and encouraging their assistance and cooperation in implementing it. Our AMA also: (1) supports the position that efforts to improve cause of death statistics are indicated and necessary; (2) endorses the concept that educational efforts to improve death certificates should be focused on physicians, particularly those who take care of patients in facilities where patients are likely to die, namely in acute hospitals, nursing homes and hospices; and (3) supports the concept that training sessions in completion of death certificates should be (a) included in hospital house staff orientation sessions and clinical pathologic conferences; (b) integrated into continuing medical education presentations; (c) mandatory in mortality conferences; and (d) included as part of in-service training programs for nursing homes, hospices and geriatric physicians. Our AMA further: (1) promotes and encourages the use of ICD-10-CM codes among physicians as they complete medical claims, hospital discharge summaries, death certificates, and other documents; (2) supports cooperating with the National Center for Health Statistics (NCHS) in monitoring the four existing models for collecting tobacco-use data; (3) urges the NCHS to identify appropriate definitions, categories, and methods of collecting risk-factor data, including quantification of exposure, for inclusion on the U.S. Standard Certificates, and that subsequent data be appropriately disseminated; and (4) continues to encourage all physicians to report tobacco use, exposure to environmental tobacco smoke, and other risk factors using the current standard death certificate format. (CSA Rep. 3, A-04)

Consolidation of H-85.974, H-85.986, H-85.996 and H-85.959

Autopsies

H-85.xxx, Importance of Autopsies

(1) Our AMA supports seeking the cooperation of the National Advisory Council on Aging of the National Institutes of Health in recommending to physicians, hospitals, institutes of scientific learning, universities, and most importantly the American people the necessity of autopsy for pathological correlation of the results of the immeasurable scientific advancements which have occurred in recent years. Our AMA believes that the information garnered from such stringent scientific advancements and correlation, as well as coalitions, should be used in the most advantageous fashion; and that the conclusions obtained from such investigations should be widely shared with the medical and research community and should be interpreted by these groups with the utmost scrutiny and objectivity. (2) Our AMA: (a) supports the efforts of the Institute of Medicine and other national organizations in formulating national policies to modernize and promote the use of autopsy to meet present and future needs of society; (b) promotes the use of updated autopsy protocols for medical research, particularly in the areas of cancer, cardiovascular, occupational, and infectious diseases; (c) promotes the revision of standards of accreditation for medical undergraduate and graduate education programs to more fully integrate autopsy into the curriculum and require postmortems as part of medical educational programs; (d) encourages the use of a national computerized autopsy data bank to validate technological methods of diagnosis for medical research and to validate death certificates for public health and the benefit of the nation; (e) requests The Joint Commission to consider amending the Accreditation Manual for Hospitals to require that the complete autopsy report be made part of the medical record within 30 days after the postmortem; (f) supports the formalization of methods of reimbursement for autopsy in order to identify postmortem examinations as medical prerogatives and necessary medical procedures; (g) promotes programs of education for physicians to inform them of the value of autopsy for medical legal purposes and claims processing, to learn the likelihood of effects of disease on other family members, to establish the cause of death when death is unexplained or poorly understood, to establish the protective action of necropsy in litigation, and to inform the bereaved families of the benefits of autopsy; and (h) promotes the incorporation of updated postmortem examinations into risk management and quality assurance programs in hospitals. (3) Our AMA reaffirms the fundamental importance of the autopsy in any effective hospital quality assurance program, and urges physicians and hospitals to increase the utilization of the autopsy so as to further advance the cause of medical education, research and quality assurance. (4) Our AMA representatives to the Liaison Committee on Medical Education ask that autopsy rates and student participation in autopsies continue to be monitored periodically and that the reasons that schools do or do not require attendance be collected. Our AMA will continue to work with other interested groups to increase the rate of autopsy attendance. (5) Our AMA requests that the National Committee on Quality Assurance (NCQA) and other accrediting bodies encourage the performance of autopsies to yield benchmark information for all managed care entities seeking accreditation. (6) Our AMA calls upon all third party payers, including CMS, to provide adequate payment directly for autopsies, and encourages adequate reimbursement by all third party payers for autopsies. (7) It is the policy of our AMA: (a) that the performance of autopsies constitutes the practice of medicine; and (b) in conjunction with the pathology associations represented in the AMA House, to continue to implement all the recommendations regarding the effects of decreased utilization of autopsy on medical education and research, quality assurance programs, insurance claims processing, and cost containment. (8) Our AMA affirms the importance of autopsies and opposes the use of any financial incentives for physicians who acquire autopsy clearance.

Consolidation of H-85.980, H-85.989, H-85.993, H-85.969, H-85.964, H-85.978 (as proposed for amendment in CCB/CLRPD Report 2) and H-85.973 [See Appendix C for detailed chart]

Hospice Care

H-85.xxx, Hospice Care

Our AMA: (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care; (2) encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment; (3) supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare;

(4) believes that each patient admitted to a hospice program should have his or her designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program; (5) supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers; and (6) seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure.

Consolidation of H-85.999, H-85.958, H-85.991, H-85.994, H-85.962, and H-85.963

Advance Care Planning

H-85.xxx, Educating Physicians about Advance Care Planning

Our AMA: (1) will continue efforts to better educate physicians in the skills necessary to increase the prevalence and quality of meaningful advance care planning, including the use of advance directives, and to improve recognition of and adherence to a patient's advance care decisions; (2) supports development of materials to educate physicians about the requirements and implications of the Patient Self-Determination Act, and supports the development of materials (including, but not necessarily limited to, fact sheets and/or brochures) which physicians can use to educate their patients about advance directives and requirements of the Patient Self-Determination Act; and (3) encourages residency training programs, regardless of or in addition to current specialty specific ACGME requirements, to promote and develop a high level of knowledge of and ethical standards for the use of such documents as living wills, durable powers of attorney for health care, and ordering DNR status, which should include medical, legal, and ethical principles guiding such physician decisions. This knowledge should include aspects of medical case management in which decisions are made to limit the duration and intensity of treatment.

Consolidation of H-85.965, H-140.969, and H-140.977

H-140.xxx Encouraging the Use of Advance Directives and Health Care Powers of Attorney

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives.

Consolidation of H-140.856, H-140.946, D-140.976, H-140.976, D-85.997 (as proposed for amendment in CCB/CLRPD Report 2-A-14), D-440.948, and D-330.938 [detailed chart provided in Appendix C shows editorial changes]

Palliative Care

H-70.xxx, Good Palliative Care

Our AMA: (1) encourages all physicians to become skilled in palliative medicine; (2) recognizes the importance of providing interdisciplinary palliative care for patients with disabling chronic or life-limiting illness to prevent and relieve suffering and to support the best possible quality of life for these patients and their families; (3) encourages education programs for all appropriate health care professionals, and the public as well, in care of the dying patient; and the care of patients with disabling chronic or life-limiting illness; (4) supports improved reimbursement for health care practices that are important in good care of the dying patient, such as the coordination and continuity of care, "maintenance" level services, counseling for patient and family, use of multidisciplinary teams, and effective palliation of symptoms; (5) encourages physicians to become familiar with the use of current coding methods for reimbursement of hospice and palliative care services; (6) advocates for reimbursement of Evaluation and Management (E/M) codes reflecting prolonged time spent on patients' care outside of the face-to-face encounter in non-hospital settings; (7) continues to monitor the development and performance on the CMS 30-day mortality measures and enrollments in the Medicare hospice program and the VA hospice programs and continues to work to have CMS exclude palliative patients from mortality measures; (8) supports efforts to clarify coding guidance or development of codes to capture "comfort care," "end-of-life care," and "hospice care;" (9) encourages research in the field of palliative medicine to improve

treatment of unpleasant symptoms that affect quality of life for patients; and (10) encourages research into the needs of dying patients and how the care system could better serve them.

Consolidation of D-70.962, H-85.958, and H-85.967

MDs/DOs as Medical Review Officers

H-95.xxx, MDs/DOs as Medical Review Officers

Our AMA: (1) reaffirms its policy that only licensed MDs/DOs with knowledge of substance use disorders should serve as Medical Review Officers (MROs); (2) reaffirms its policy that all MDs/DOs who serve as MROs should obtain continuing medical education credit in this subject area; (3) vigorously advocates that any legislation concerning drug testing in the workplace include a provision for a Medical Review Officer (MRO) who will review all positive test results and further that only a licensed physician may serve as the MRO and further that this physician MRO has knowledge of substance abuse disorders and has appropriate medical training to interpret and evaluate an individual's positive test results together with his or her medical history and any other relevant biomedical information; and (4) vigorously opposes legislation that is inconsistent with these policies.

Consolidation of H-95.960 and H-95.971

Substance Use Prevention

H-295.xxx, Impairment Prevention and Treatment in the Training Years

Our AMA: (1) reaffirms the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; (2) strongly encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents and fellows; (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse; (4) advocates (a) further study (and continued monitoring of other studies) concerning the problem of substance abuse among students, residents, and faculty in U.S. medical schools, and (b) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians.

Consolidation of H-295.987, H-295.979 and H-95.982

Disabled Parking

H-90.xxx, Disabled Parking

Our AMA: (1) encourages physicians to become familiar with laws in their states for certifying a patient's need for disabled parking privileges; and (2) supports efforts to educate the public on the appropriate use of parking spaces for the disabled.

Consolidation of H-90.979 and H-90.991 ["handicapped" has been changed to "disabled" as the latter is the accepted terminology]

CPR Training

H-130.xxx, Cardiopulmonary Resuscitation (CPR) and Defibrillators

Our AMA: (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation; (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs; (3) encourages the American public to become trained in CPR and the use of automated external defibrillators; (4) advocates the widespread placement of automated external defibrillators; (5) supports increasing government and industry funding for the purchase of automated external defibrillator devices; (6) endorses federal regulation and/or legislation increasing funding for cardiopulmonary resuscitation and defibrillation training of community organization personnel; and (7) supports the development and use of universal connectivity for all defibrillators.

Consolidation of H-130.944, H-440.890, H-130.983, H-130.944 and D-440.958 (as proposed for amendment in CCB/CLRPD Report 2-A-14)

Proficiency of Physicians in Basic and Advanced Cardiac Life Support

H-300.xxx, Proficiency of Physicians in Basic and Advanced Cardiac Life Support

Our AMA: (1) believes that all licensed physicians should become proficient in basic CPR and in advanced cardiac life support commensurate with their responsibilities in critical care areas; (2) recommends to state and county medical associations that programs be undertaken to make the entire physician population, regardless of specialty or subspecialty interests, proficient in basic CPR; and (3) encourages training of cardiopulmonary resuscitation and basic life support to first-year medical students, preferably during the first term.

Consolidation of H-300.999, H-130.997 and H-295.906

Good Samaritans

H-130.xxx, Delivery of Health Care by Good Samaritans

(1) Our AMA will work with state medical societies to educate physicians about the Good Samaritan laws in their states and the extent of liability immunity for physicians when they act as Good Samaritans. (2) Our AMA encourages state medical societies in states without “Good Samaritan laws,” which protect qualified medical personnel, to develop and support such legislation. (3) Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, the AMA supports the following basic guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance. For the purpose of this policy, “bystander physicians” shall refer to those physicians rendering assistance voluntarily, in the absence of pre-existing patient-physician relationships, to those in need of medical assistance, in a service area in which the physician would not ordinarily respond to requests for emergency assistance. (a) Bystander physicians should recognize that prehospital EMS systems operate under the authority and direction of a licensed EMS physician, who has both ultimate medical and legal responsibility for the system. (b) A reasonable policy should be established whereby a bystander physician may assist in an emergency situation, while working within area-wide EMS protocols. Since EMS providers (non-physicians) are responsible for the patient, bystander physicians should work collaboratively, and not attempt to wrest control of the situation from EMS providers. (c) It is the obligation of the bystander physician to provide reasonable self-identification. (d) Where voice communication with the medical oversight facility is available, and the EMS provider and the bystander physician are collaborating to provide care on the scene, both should interact with the local medical oversight authority, where practicable. (e) Where voice communication is not available, the bystander physician may sign appropriate documentation indicating that he/she will take responsibility for the patient(s), including provision of care during transportation to a medical facility. Medical oversight systems lacking voice communications capability should consider the addition of such communication linkages to further strengthen their potential in this area. (f) The bystander physician should avoid involvement in resuscitative measures that exceed his or her level of training or experience. (g) Except in extraordinary circumstances or where requested by the EMS providers, the bystander physician should refrain from providing medical oversight of EMS that results in deviation from existing EMS protocols and standing orders. (4) Our AMA urges the International Civil Aviation Organization to make explicit recommendations to its member countries for the enactment of regulations providing “Good Samaritan” relief for those rendering emergency medical assistance aboard air carriers and in the immediate vicinity of air carrier operations.

Consolidation of D-435.990, H-130.986, H-130.989 and H-130.995

National Practitioner Data Bank

H-355.xxx, Opposition to the National Practitioner Data Bank

(1) Our AMA communicates to legislators the fundamental unfairness of the civil judicial system as it now exists, whereby a jury, rather than a forum of similarly educated peers, determines if a physician has violated the standards of care and such results are communicated to the National Practitioner Data Bank; and impresses on our national legislators that only when a physician has been disciplined by his/her state licensing agency should his/her name appear on the National Practitioner Data Bank. (2) Our AMA affirms its support for the Federation of State Medical Boards Action Data Bank and seeks to abolish the National Practitioner Data Bank. (3) Our AMA urges HHS to retain an independent consultant to (a) evaluate the utility and effectiveness of the National Practitioner Data Bank, (b) evaluate the confidentiality and security of the reporting, processing and distribution of Data Bank information, and (c) provide the findings and recommendations to the National Practitioner Data Bank Executive Committee and the General Accounting Office. (4) Our AMA will take appropriate steps to have Congress repeal Section 4752 (f) of OBRA 1990 requiring peer review organizations and private accreditation entities to report any negative action or finding to the Data Bank. (5) Our AMA seeks to amend the Health Care Quality Improvement Act of 1986 to allow a physician, at the time the physician notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report; (6) Our AMA opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on his or her behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers for purposes of credentialing or reimbursement. (7) Our AMA (a) urges HHS to work with the Federation of State Medical Boards to refine its National Practitioner Data Bank breakdown of drug violation reporting into several categories; (b) urges the HHS to analyze malpractice data gathered by the Physician Insurance Association of America and recommend to Congress that a threshold of at least \$30,000 for the reporting of malpractice payments be established as soon as possible; (c) will continue to work with HHS to allow physicians an expanded time period to verify the accuracy of information reported to the Data Bank prior to its release in response to queries; (d) will work with HHS and the Office of Management and Budget to reduce the amount of information required on the request for information disclosure form and to improve the design of the form to allow for more efficient processing of information; and (e) will continue to work with HHS to improve its mechanism to distribute revisions and clarifications of Data Bank policy and procedure. (8) Our AMA will review questions regarding reportability to the Data Bank and will provide periodic updates on this issue to the AMA House of Delegates.

Consolidation of H-450.950, H-355.987, H-355.991 and H-355.993

H-355.xxx, National Practitioner Data Bank

(1) Our AMA believes that (1) the National Practitioner Data Bank requirements should be modified so that settlements and judgments of less than \$30,000 are not reported or recorded; (2) reports, other than licensure revocation, in the Data Bank should be purged after five years; (3) proctoring of physicians for the purpose of investigation should not be reportable; (4) physicians

should not be required to turn over copies of their Data Bank file to anyone not authorized direct access to the Data Bank; and (5) any physician's statement included in the Data Bank file should automatically accompany any adverse report about that physician in distributions from the Data Bank. (2) Our AMA will (a) work with HHS to establish a mechanism to inform physicians when an inquiry to the Data Bank has been made; and (b) support efforts to require the same Data Bank reporting requirements for physicians, dentists and other licensed health care practitioners. (3) Our AMA: (a) opposes all efforts to open the National Practitioner Data Bank to public access; (b) strongly opposes public access to medical malpractice payment information in the National Practitioner Data Bank; and (c) opposes the implementation by the National Practitioner Data Bank of a self-query user fee. (4) Our AMA supports using all necessary efforts to direct the National Practitioner Data Bank to send all notifications to physicians by certified mail return receipt requested, and supports using all necessary efforts at the federal level to direct the National Practitioner Data Bank to begin the sixty day appeal process from the date the physician receives notification. (5) Our AMA will work with the appropriate federal agencies to ensure that the National Practitioner Data Bank reflects all disciplinary actions on appeal, and to remove from the physician's record reported decisions which have been overruled. (6) Our AMA will continue to monitor the issue of reporting impaired physicians to the National Practitioner Data Bank and will seek further clarification of ambiguities or misinterpretations of the reporting requirements for impaired physicians.

Consolidation of H-355.999, H-355.995, H-355.985 (as proposed for amendment by CCB/CLRPD 2-A-14), H-355.996, H-355.984, and H-355.992

H-355.xxx Reporting of Resident Physicians to the National Practitioner Data Bank

(1) Our AMA: (1) seeks opportunities to limit reports concerning residents to the National Practitioner Data Bank to only those situations where a final adverse action has been taken by a medical licensing jurisdiction; (2) opposes attempts to extend reports concerning residents to the National Practitioner Data Bank beyond those covered in Item 1 of this policy; and (3) advocates for legislation amending, as appropriate, the NPDB reporting requirements regarding resident physicians to be consistent with this policy, and opposes the expansion of existing reporting requirements. (2) Our AMA: (a) fully supports the mandatory and prompt notification of residents by the appropriate hospital authority when they are named along with a hospital and/or others in the hospital in malpractice suits; (b) opposes the inclusion in the National Practitioner Data Bank of information on liability payments made on behalf of residents named in malpractice suits for incidents that occur during the required supervised activities of their residency training; (c) seeks the immediate suspension of the policy whereby information on residents named in malpractice suits for incidents which occur during the required supervised activities of their residency training is reported to the National Practitioner Data Bank when liability payments are made on their behalf; and (d) will work with the Association of American Medical Colleges and other interested parties to reinvigorate its efforts to successfully change National Practitioner Data Bank policy through legislative or other means in accordance with this policy. (3) Our AMA will continue to monitor the types of information reported about resident physicians to federal and state agencies, especially the National Practitioner Data Bank and state medical licensing boards.

Consolidation of H-355.983, D-355.997, and H-355.980

Human Rights and Freedom

H-65.xxx, Support of Human Rights and Freedom

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Consolidation of H-65.992, H-65.990 and H-65.980

APPENDIX B - AMA Policies Recommended for Sunset Due to Consolidation (Organized by Topic)

Developmental Delay/Intellectual Disability

D-90.995 Early Intervention for Children with Developmental Delay.

Our AMA will work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and urges physicians to assist parents in obtaining access to appropriate individualized early intervention services. (Res. 419, A-05; Reaffirmed in lieu of Res. 535, A-06; Reaffirmed in lieu of Res. 109, A-12)

H-90.973 Designation of the Intellectually Disabled as a Medically Underserved Population.

Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population. (CMS Rep. 3, I-11)

H-90.972 Advancements in Advocacy and Medical Care of Persons with Developmental Disabilities. Our AMA: (1) encourages clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with Developmental Disabilities; (2) encourages medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (3) encourages medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with Developmental Disabilities, will improve quality in clinical care; (4) encourages the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with Developmental Disabilities so as to improve health outcomes; and (5) supports a cooperative effort between physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with Developmental Disabilities. (Res. 315, A-12)

H-90.975 Enhancing Physicians' Interest in Medical Care for People with Profound Developmental Disabilities.

Our AMA will: (1) advocate for the highest quality medical care for persons with profound developmental disabilities; (2) encourage support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; (3) encourage medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (4) encourage medical schools and graduate medical education programs to establish and encourage enrollment in electives rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (5) inform physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them. (Res. 320, A-07)

H-90.976 Medical and Dental Care for People With Developmental Disabilities

Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: 1. All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives. 2. An individual's medical condition and welfare must be the basis of any medical decision. (Res. 818, I-03; Reaffirmation A-08)

D-270.997 Increased Funding for Physician Training and Reimbursement for Health Care of Individuals with Intellectual Disabilities/Developmentally Disabled Individuals

Our AMA seek legislation increasing the: (1) funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and increasing the reimbursement for the health care of these individuals; and (2) insurance industry and government reimbursement to reflect the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals. (Res. 237, A-01; Reaffirmed: BOT Rep. 22, A-11; Modified: CMS Rep. 3, I-11)

Disposal of Used Syringes, Needles, and Other Sharps

H-95.949 Safe Disposal of Used Syringes, Needles, and Other Sharps in the Community

Our AMA recognizes that used sharps in the community pose a public health hazard in diverse ways to workers and to the public. (CSA Rep. 2, A-01; Reaffirmed: CSAPH Rep. 1, A-11)

H-95.999 Disposable Syringes

The AMA requests manufacturers of disposable hypodermic needles and syringes to adopt designs to prevent reuse, and to include in the packaging clear directions for their correct disposal. (Sub. Res. 26, A-67; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

D-95.993 Safe Disposal of Used Needles and Syringes in the Community: Update on AMA Activities

Our AMA shall continue to support the mission of the Coalition for Safe Community Needle Disposal. (CSA Rep. 3, A-02; Modified: CCB/CLRPD Rep. 4, A-12)

In-Line Skating

H-10.969 In-Line Skating

Our AMA encourages physicians to counsel patients, and their parents when appropriate, that full protective equipment should be worn and appropriate safety measures be taken to prevent in-line skating injuries. Consistent with recommendations of the American Academy of Pediatrics, prevention efforts should include the following: (1) Full protective gear should be worn at all times. This would include wrist guards, elbow pads, kneepads, and a helmet. The helmet should be certified by the ASTM, the ANSI, or the Snell Foundation. (2) Unsafe activities such as hitching or truck surfing, which is latching onto a moving vehicle, should be avoided. (3) Training for beginners should be encouraged, and novice skaters should start in an indoor or outdoor rink rather than on the street. (4) Skaters should not skate in the dark and should learn to look for road debris or defects that could cause them to lose their balance. (5) Skaters, especially children with balance problems, physical disabilities, or uncorrected

vision or hearing problems who skate should do so in a rink or another protected place. (CSA Rep. 19, A-99; Reaffirmed: CSAPH Rep. 1, A-09)

D-10.998 In-Line Skating

(1) Our AMA will encourage federal agencies and industries to support research on patterns of equipment use and frequency of protective equipment use for in-line skating. (2) Our AMA will work with the Consumer Product Safety Commission, Centers for Disease Control and Prevention, national in-line skating organizations, and medical specialty societies, Alliance and Federation to encourage in-line skaters to wear protective equipment. (3) Our AMA will encourage medical specialty societies and state and local medical societies to advocate for state and local legislation to improve the safety of in-line skating through: (a) the use of appropriate protective equipment (especially helmets); (b) the designation of protected areas for in-line skating; (c) prohibitions against hitching a ride behind a moving vehicle; (d) the assurance that protective equipment is available at skating rental shops; and (e) the provision of training and educational materials. (4) Such legislation should include a surveillance component to monitor compliance. (CSA Rep. 19, A-99; Reaffirmed: CSAPH Rep. 1, A-09)

Helmets for Riders of Motorized or Non-motorized Cycles

H-10.967 Preventing Scooter Injuries

Our AMA: (1) recommends the use of protective gear (certified helmets, elbow and knee pads, closed-toe shoes) for riders of scooters, especially children and adolescents; (2) encourages physicians to counsel patients, and their parents when appropriate, that full protective equipment should be worn and appropriate safety measures should be taken to prevent scooter injuries (e.g., riding away from traffic, and close supervision of riders under the age of eight); and (3) urges companies that manufacture or sell scooters to include appropriate information about the safe use of scooters on the scooters themselves, on or inside scooter packaging, on their web sites, and at the point of sale. (Res. 411, I-00; Reaffirmed: CSAPH Rep. 1, A-10)

H-10.980 Motorcycles and Bicycle Helmets

Our AMA (1) encourages efforts to investigate the impact of helmet use by riders of motorcycles and all bicycles, in order to establish the risk of major medical trauma from not wearing helmets, the costs added to the health care system by such behavior, and the payers of these added costs (i.e., private insurance, uncompensated care, Medicare, Medicaid, etc.); and (2) will explore ways to ensure the wearing of helmets through the use of disincentives or incentives such as licensing fees, insurance premium adjustments and other payment possibilities. (Res. 423, I-92; Modified and Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)

H-10.985 Bicycle Helmets and Safety

It is the policy of the AMA (1) to actively support bicycle helmet use and encourage physicians to educate their patients about the importance of bicycle helmet use; (2) to encourage the manufacture, distribution, and utilization of safe, effective, and reasonably priced bicycle helmets; (3) to encourage the availability of helmets at the point of bicycle purchase; and (4) to develop model state/local legislation requiring the use of bicycle safety helmets, and calling for all who rent bicycles to offer the rental of bicycle safety helmets for all riders and passengers. (Res. 7, I-90; Modified by Sub. Res. 208, A-94; Reaffirmed: CSA Rep. 6, A-04)

H-10.977 Helmets and Preventing Motorcycle- and Bicycle-Related Injuries

It is the policy of the AMA to: (1) encourage physicians to counsel their patients who ride motorized and non-motorized cycles to use approved helmets and appropriate protective clothing while cycling; (2) encourage patients and families to inform and train children about safe cycle-riding procedures, especially on roads and at intersections, the need to obey traffic laws, and the need for responsible behavior; (3) encourage community agencies, such as those involving law enforcement, schools, and parent-teacher organizations, to promote training programs for the responsible use of cycles; (4) urge manufacturers to improve the safety and reliability of the vehicles they produce and to support measures to improve cycling safety; (5) prepare model state legislation for cyclists' mandatory use of helmets while cycling; and (6) advocate further research on the effectiveness of helmets and on the health outcomes of community programs that mandate their use. (CSA Rep. 3, I-93; Reaffirmed: CSA Rep. 6, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-15.980 Motorcycle Safety

The AMA supports rider education legislation, which is more easily implemented and more effective than legislation requiring manufacturers to emphasize the dangers of operating motorcycles. (BOT Rep. N, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSA Rep. 6, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-15.994 State Motorcycle Helmet Laws

The AMA (1) endorses the concept of legislative measures to require the use of helmets when riding or driving a motorcycle; (2) urges constituent societies to support the enactment or preservation of state motorcycle helmet laws; and (3) will join, when requested, with constituent societies to support the enactment or preservation of state motorcycle helmet laws. (Res. 77, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation I-96; Reaffirmed: CSA Rep. 6, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-15.956 Options for Improving Motorcycle Safety

Our AMA encourages physicians to (1) be aware of motorcycle risks and safety measures and (2) counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the

safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs. (CSA Rep. 6, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-15.971 Receipt of Federal Highway Funds and Motorcycle Helmet Laws

The following is the policy of the AMA: that the AMA seek federal regulatory rules to make the receipt of federal highway funds by a state dependent on passage of mandatory [motorcycle] helmet laws by that state. (Res. 221, A-90; Reaffirmation I-96; Reaffirmed: CSA Rep. 6, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

All-Terrain Vehicles

D-15.995 ATV Safety

Our AMA will seek: (1) federal legislation to require sellers of all terrain vehicles (ATVs) in the United States to promote the sale of and use of suitable helmets to be used when operating or riding as a passenger on ATVs; and (2) federal and state legislation and/or regulation to maximize safety of ATV operation including but not limited to (a) wearing suitable helmets and protective gear when operating or riding as a passenger on an ATV, (b) providing some safety instruction and training to all operators of ATVs, and (c) ensuring appropriate licensure for all operators of ATVs. (Res. 433, A-05)

H-15.975 Protection of Life- All-Terrain Vehicles

The AMA supports publicizing the dangers of all-terrain vehicles, especially to persons unlicensed to drive other vehicles. (Res. 77, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-15.981 Safety Requirements for ATV Operation

The AMA (1) urges states to adopt requirements for ATV operation; and (2) encourages manufacturers of ATVs and dealers to provide information regarding the safe operation of such vehicles. (Sub. Res. 51, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CSA Rep. 8, A-05)

Prevention of Impaired Driving

H-30.945 Drivers Impaired by Alcohol

The AMA: (1) acknowledges that all alcohol consumption, even at low levels, has a negative impact on driver skills, perceptions, abilities, and performance and poses significant health and safety risks. The AMA will be involved in efforts to educate physicians, the public, and policy makers about this issue and urges national, state, and local medical associations and societies, together with public health, transportation safety, insurance industry, and alcohol beverage industry professionals to renew and strengthen their commitment to preventing alcohol-impaired driving; (2) encourages physicians to participate in educating the public about the hazards of chemically impaired driving; (3) urges public education messages that now use the phrase "drunk driving," or make reference to the amount one might drink without fear of arrest, be replaced with messages that indicate that "all alcohol use, even at low levels, impairs driving performance and poses significant health and safety risks;" (4) urges all states to pass legislation mandating all drivers convicted of first and multiple DUI offenses be screened for alcoholism and provided with referral and treatment when indicated; (5) further recommends the following measures be taken to reduce repeat DUI offenses: (a) Aggressive measures be applied to first-time DUI offenders (e.g., license suspension and administrative license revocation), (b) Stronger penalties be leveled against repeat offenders, including second-time offenders, (c) Such legal sanctions must be linked, for all offenders, to substance abuse assessment and treatment services, to prevent future deaths in alcohol-related crashes and multiple DUI offenses, (d) The AMA calls upon the states to coordinate law enforcement, court system, and motor vehicle departments to implement forceful and swift penalties for second-time DUI convictions to send the message that those who drink and drive might receive a second chance but not a third; and (6) encourages the National Highway Traffic Safety Administration to investigate the feasibility of technologies that would prevent an automobile from being started or driven by an individual with an excessive blood alcohol level. (CSA Rep. 14, A-97; Reaffirmed: BOT Rep. 17, A-01; Reaffirmed in lieu of Res. 435, A-05)

H-30.969 Ignition Interlock System

(1) Our AMA supports further testing of on-board devices to prevent the use of motor vehicles by intoxicated drivers; this testing should take place among the general population of drivers, as well as among drivers having alcohol-related problems. (2) Our AMA encourages motor vehicle manufacturers and the U.S. Department of Transportation to monitor the development of ignition interlock technology, and plan for use of such systems by the general population, when a consensus of informed persons and studies in the scientific literature indicate the systems are effective, acceptable, reasonable in cost, and safe. (BOT Rep. N, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 17, A-01; Reaffirmed: CSAPH Rep. 1, A-11)

H-170.970 Teenage Drinking and Driving

The AMA supports and encourages programs in elementary, middle, and secondary schools, which provide information on the dangers of driving while under the influence of alcohol, and which emphasize that teenagers who drive should drink no alcoholic beverages whatsoever; and will work with private and civic groups such as Mothers Against Drunk Driving (MADD) to achieve the goals and intent of this resolution. (Sub. Res. 407, A-95; Reaffirmed: CSA Rep. 8, A-05)

H-30.986 Alcohol and the Driver

Our AMA (1) favors public information and education against any drinking by drivers;

(2) supports 0.04 percent blood-alcohol level as per se illegal for driving, and urges incorporation of that provision in all state drunk driving laws; (3) supports 21 as the legal drinking age, supports strong penalties for providing alcohol to persons younger than 21, and stronger penalties for providing alcohol to drivers younger than 21; (4) urges adoption by all states of legislation calling for administrative suspension or revocation of driver licenses after conviction for driving under the influence, and mandatory revocation after a specified number of repeat offenses; and (5) encourages industry efforts to develop a safety module that thwarts operation of a car by an intoxicated person. (CSA Rep. A, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Modified: Sub. Res. 401, I-97; Reaffirmed: BOT Rep. 17, A-01; Reaffirmation A-09)

H-30.959 Mandatory Loss of Driver's License for Drivers Under Age 21 with Any Blood Alcohol Level

Our AMA: (1) supports the development of model legislation which would provide for school education programs to teach adolescents about the dangers of drinking and driving and which would mandate the following penalties when a driver under age 21 drives with any blood alcohol level (except for minimal blood alcohol levels, such as less than .02 percent, only from medications or religious practices): (a) for the first offense - mandatory revocation of the driver's license for one year and (b) for the second offense - mandatory revocation of the driver's license for two years or until age 21, whichever is greater; (2) urges state medical associations to seek enactment of the legislation in their legislatures; and (3) encourages state medical associations to participate in educational activities related to eliminating alcohol use by adolescents. (BOT Rep. T, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)

H-30.941 Prevention of Repeat Driving Under the Influence (DUI) Offenses: The Issues of Diversion and Treatment and Vehicle Incapacitation

Our AMA encourages: (1) passage of state traffic safety legislation that mandates screening for substance use disorder for all DUI offenders. Those who are identified with substance use disorder should be strongly encouraged and assisted in obtaining treatment from qualified physicians and through state and medically certified facilities; (2) treatment of all convicted DUI offenders, when medically indicated, should be mandated and provided but in the case of first-time DUI convictions, should not replace other sanctions which courts may levy in such a way as to remove from the record the occurrence of that offense; (3) treatment of repeat DUI offenders, when medically indicated, should be mandated and provided but should not replace other sanctions which courts may levy. In all cases where treatment is provided to a DUI offender, it is also recommended that appropriate adjunct services should be provided to or encouraged among the family members actively involved in the offender's life; and (4) continued research and testing of devices which may incapacitate vehicles owned or operated by DUI offenders without needlessly penalizing the offender's family members. (BOT Rep. 17, A-01; Reaffirmed: CSAPH Rep. 1, A-11)

Persons with Hearing Disorders

H-35.994 Treatment of Persons with Hearing Disorders

The AMA believes that physicians should (1) remain the primary entry point for care of patients with hearing impairment; and (2) continue to supervise and treat hearing, speech, and equilibratory disorders. (Res. 88, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sub. Res. 506, I-93; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)

H-35.987 Medical Acts by Unlicensed Individuals

The AMA: (1) expressly opposes statements that the practice of audiology includes the diagnosis and treatment of hearing disorders; (2) affirms that it is in the public interest that a medical assessment of any hearing or balance malfunction be made by a physician knowledgeable in diseases of the ear; (3) reasserts that audiologists are individuals who perform non-medical testing, evaluating, counseling, instruction and rehabilitation of individuals whose communication disorders center in whole or in part in hearing function; and (4) affirms its respect for the contribution which audiologists have made and continue to make to patient welfare and quality health care in their assistance in the treatment of hearing disorders. (Res. 106, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

H-35.986 The Practice of Audiology

(1) Should there be ambiguities in the statutory language of any state which defines audiology, state, and/or specialty medical societies should take steps to seek a legislative amendment to that statute to secure language that describes appropriately the practice of audiology. (2) Misrepresentation by audiologists of their skills and/or the scope of their practice should be reported to appropriate state authorities. (CME Rep. F, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: BOT Rep. 34, A-06)

Physician Participation in Department of Defense Reserve Components

H-40.997 Endorsement of Participation in Armed Forces Medical Reserve Programs

Our AMA endorses voluntary physician participation in the military reserve components' medical programs as a means of actively aiding national defense while preserving the right of the individual physician to practice his profession without interruption in peace time. (Res. 39, I-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CLRPD Rep. 1, A-10)

H-40.986 Physician Participation in Department of Defense Reserve Components

The AMA (1) supports the U.S. Department of Defense by publicizing its needs for physicians in active duty military service and in the reserve components and guard, and (2) encourages the active support and participation of physicians in active duty military service and in the reserves. (Sub. Res. 70, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)

H-40.976 Recruitment and Retention of Reserve Military Medical Personnel

(1) The AMA will (a) work with all appropriate parties in developing and proposing a multi-faceted approach toward rejuvenation and improvement in recruitment and retention in the military reserves; (b) work to assure that retired military medical personnel become eligible for reserve status; (c) support enactment of federal laws to assist physicians in the transition from medical practice to active military service; (d) promote use of existing laws for selective service and retirement credits as models for development of practical equitable criteria to be applied; and (e) support improvements in professional utilization of military medical personnel during both active duty periods and “weekend drill.” (2) The AMA supports the development of a statutory system of limitations on call-up, retention and recall of reservists in order to provide stability and predictability to reserve status and duty, with the basis for such a system to be defined statutorily using credits or “points” to prioritize options available to individual reservists as to call-up, retention, rotation and recall. (Sub. Res. 234, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)

Drug and Alcohol Use in Aviation**H-45.990 Programs Which Reduce Drug and Alcohol Use in All Facets of Aviation**

The AMA urges the FAA to establish programs for personnel involved in all facets of aviation that reduce the impact of drug and alcohol use in order to further aviation safety. (Res. 162, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-45.987 Drugs, Drinking, and Flying Pilots in General Aviation

It is the policy of the AMA to encourage continued studies by the Federal Aviation Administration of problems in the use of alcohol by pilots in general aviation and flight crews of commercial airlines. (Sub Res. 79, I-90; Modified: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10)

Skin Cancer Prevention**H-55.980 Skin Cancer Self-Examination**

The AMA (1) encourages all physicians to perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday; (2) encourages physicians to examine their patients’ skins for the early detection of melanoma and nonmelanoma skin cancer; (3) urges physicians to encourage their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; (4) encourages physicians to educate their patients concerning the correct way to perform skin self-examination; and (5) supports mechanisms for the education of lay professionals, such as hairdressers and barbers, on self skin examination to encourage early skin cancer referrals to qualified health care professionals. (Sub. Res. 505, A-96; Reaffirmation I-98; Reaffirmed: CSAPH Rep. 2, A-08; Appended: Res. 504, A-13)

H-55.976 Skin Cancer Prevention Education in Communities of Color

Our AMA: (1) supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color; and (2) will work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color. (Res. 510, A-10)

H-440.865 Sunscreen Labeling

Our AMA recommends: (1) labeling sunscreen products with a standardized ultraviolet (UV) logo, inclusive of ratings for UVA and UVB, so that consumers will know whether these products protect against both types of UV radiation; and (2) that terms such as low, medium, high and very high protection are defined depending on standardized sun protection factor level. (Res. 414, A-08)

H-440.959 Tanning Parlors

It is the policy of the AMA to (1) continue to support an educational campaign on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; and (2) support legislation to strengthen state laws to make the consumer as informed and safe as possible. (Res. 157, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10)

H-440.967 Public Information Program Addressing the Dangers of UVA Exposure

The AMA: (1) supports using its public education capabilities to warn the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units; (2) endorses the findings released by the FDA warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (3) supports working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including

posted warnings in commercial tanning salons and spas; (4) supports, in conjunction with various concerned national specialty societies, an educational campaign to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers; (5) supports intensified efforts to enforce current regulations; and (6) encourages the development of sunscreens that will protect the skin from a broad spectrum of ultraviolet radiation, including both UVA and UVB. (Sub. Res. 103, A-88; Res. 418, I-94; Appended: Res. 407, I-99; Reaffirmed: Res. 440, A-05)

D-440.969 Protect Children from Skin Cancer

Our AMA will: (1) support the enactment of federal legislation to: (a) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR §1040.20 [a][9]) by anyone under the age of 18; and (b) require a United States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; and (2) urge the Food and Drug Administration's Center For Devices and Radiological Health to hold a fair hearing as soon as possible on the safety and efficacy of UVA bulbs, as used in indoor tanning facilities. (Res. 440, A-05; Reaffirmation A-11; Reaffirmation A-12)

H-440.980 Education on the Harmful Effects of UVA and UVB Light

Our AMA: (1) supports the dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; and (2) urges medical societies to work with all schools to include information in their health curricula on the hazards of exposure to tanning rays. (Res. 162, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Appended: Res. 407 and Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09)

Screening and Treatment for Breast and Cervical Cancer Risk Reduction

H-55.984 Screening and Treatment for Breast and Cervical Cancer

The AMA: (1) supports increased funding for comprehensive programs to screen low income women for breast and cervical cancer and to assure access to definitive treatment; and (2) encourages state and local medical societies to monitor local public health screening programs to assure that they are linked to treatment resources in the public or private sector. (Res. 411, A-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)

H-55.985 Screening and Education Programs for Breast and Cervical Cancer Risk Reduction

Our AMA supports (1) programs to screen all women for breast and cervical cancer and that government funded programs be available for low income women and (2) the development of public information and educational programs with the goal of informing all women about routine cancer screening in order to reduce their risk of dying from cancer. (Res. 418, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)

Breast Reconstructive Surgery

H-55.997 Breast Reconstructive Surgery

1. Our AMA believes that reconstruction of the breast for rehabilitation of the postmastectomy cancer patient should be considered reconstructive surgery rather than aesthetic surgery. 2. Our AMA supports education for physicians and breast cancer patients on breast reconstruction and its availability. (Sub. Res. 174, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CMS Rep. 6, A-10; Appended: Res. 922, I-12)

H-55.978 Expanding Post-Mastectomy Options for Cancer Survivors

Our AMA recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy. (Res. 107, A-03; Reaffirmed: CMS Rep. 4, A-13)

H-55.992 Reimbursement for Breast Reconstruction

The AMA recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided. (Res. 36, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CMS Rep. 7, A-05)

Uniform Cancer Staging

H-55.988 Uniform Cancer Staging

The AMA (1) endorses the tumor, node involvement, metastasis (TNM) system accepted by the American Joint Committee and the International Union Against Cancer for staging of cancer; (2) urges that this system be used in any published articles or information and be included as a requirement in Instructions to Authors; and (3) encourages each state association to use this system in any educational forum or scientific meeting which it sponsors. (Res. 61, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed and Modified: CSAPH Rep. 2, A-08)

H-55.998 Staging of Cancer

Our AMA endorses for general utilization the Cancer Staging Manual developed by the American Joint Committee on Cancer. (CSA Rep. I, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10)

Lead Poisoning**H-60.977 Lead Poisoning Threat to Children**

Our AMA supports regulations and policies designed to protect young children from exposure to lead. (Sub. Res. 60, A-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 7, A-10)

H-60.956 Lead Poisoning Among Children

The AMA: (1) encourages physicians and public health departments to screen children based on current recommendations and guidelines (2) encourages the reporting of all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories. (CSA Rep. 6 - I-94; Reaffirmed: CSA Rep. 6, A-04; Modified: CSAPH Rep. 7, A-10)

H-440.854 Lead Levels in Children

Our AMA urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with exposure to blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure. (CSAPH Rep. 7, A-10)

H-440.943 Lead-Based Paints

It is the policy of the AMA (1) to promote community awareness of the hazard of lead-based paints; and (2) to urge paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold. (Res. 420, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 7, A-10)

Death Certificate Completion**H-85.974 Improving Death Certificate Completion**

Our AMA (1) supports the position that efforts to improve cause of death statistics are indicated and necessary; (2) endorses the concept that educational efforts to improve death certificates should be focused on physicians, particularly those who take care of patients in facilities where patients are likely to die, namely in acute hospitals, nursing homes and hospices; and (3) endorses the concept that training sessions in completion of death certificates should be (a) included in hospital house staff orientation sessions and clinical pathologic conferences; (b) integrated into continuing medical education presentations; (c) mandatory in mortality conferences; and (d) included as part of in-service training programs for nursing homes, hospices and geriatric physicians. (Res. 305, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)

H-85.986 Accurate Completion of Death Certificates

The AMA encourages legible writing and accurate diagnoses on death certificates and supports taking steps, including special emphasis in its educational programs, to make certain that physicians fill out death certificates carefully, accurately and legibly. (Res. 3, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-85.996 Improvement in Accuracy of Death Certificates

Our AMA: (1) acknowledges that the reporting of vital events is an integral part of patient care; (2) urges physicians to ensure completion of all state vital records carefully and thoroughly with special attention to the use of standard nomenclature; and (3) supports notifying state medical societies and state departments of vital statistics of this policy and encouraging their assistance and cooperation in implementing it. (Sub. Res. 8, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Modified: CSA Rep. 6, I-00; Reaffirmed: CSAPH Rep. 1, A-10)

H-85.959 Tobacco Coding and Death Certificates

Our AMA: (1) promotes and encourages the use of ICD10CM codes among physicians as they complete medical claims, hospital discharge summaries, death certificates, and other documents; (2) supports cooperating with the National Center for Health Statistics (NCHS) in monitoring the four existing models for collecting tobacco-use data; (3) urges the NCHS to identify appropriate definitions, categories, and methods of collecting risk-factor data, including quantification of exposure, for inclusion on the U.S. Standard Certificates, and that subsequent data be appropriately disseminated; and (4) continues to encourage all physicians to report tobacco use, exposure to environmental tobacco smoke, and other risk factors using the current standard death certificate format. (CSA Rep. 3, A-04)

Autopsies

H-85.980 Autopsy for Pathological Correlation

Our AMA (1) supports seeking the cooperation of the National Advisory Council on Aging of the National Institutes of Health in recommending to physicians, hospitals, institutes of scientific learning, universities, and most importantly the American people the necessity of autopsy for pathological correlation of the results of the immeasurable scientific advancements which have occurred in recent years; (2) believes that the information garnered from such stringent scientific advancements and correlation, as well as coalitions, should be used in the most advantageous fashion; and (3) believes that the conclusions obtained from such investigations should be widely shared with the medical and research community and should be interpreted by these groups with the utmost scrutiny and objectivity. (Res. 61, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10)

H-85.989 Autopsies

The AMA (1) endorses the efforts of the Institute of Medicine and other national organizations in formulating national policies to modernize and promote the use of autopsy to meet present and future needs of society; (2) promotes the use of updated autopsy protocols for medical research, particularly in the areas of cancer, cardiovascular, occupational, and infectious diseases; (3) promotes the revision of standards of accreditation for medical undergraduate and graduate education programs to more fully integrate autopsy into the curriculum and require postmortems as part of medical educational programs; (4) encourages the use of a national computerized autopsy data bank to validate technological methods of diagnosis for medical research and to validate death certificates for public health and the benefit of the nation; (5) requests the JCAHO to consider amending the Accreditation Manual for Hospitals to require that the complete autopsy report be made part of the medical record within 30 days after the postmortem; (6) endorses the formalization of methods of reimbursement for autopsy in order to identify postmortem examinations as medical prerogatives and necessary medical procedures; (7) promotes programs of education for physicians to inform them of the value of autopsy for medical legal purposes and claims processing, to learn the likelihood of effects of disease on other family members, to establish the cause of death when death is unexplained or poorly understood, to establish the protective action of necropsy in litigation, and to inform the bereaved families of the benefits of autopsy; and (8) promotes the incorporation of updated postmortem examinations into risk management and quality assurance programs in hospitals. (CSA Rep. G, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Sub. Res. 703, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-85.993 Autopsies

The AMA (1) reaffirms the fundamental importance of the autopsy in any effective hospital quality assurance program; and (2) urges physicians and hospitals to increase the utilization of the autopsy so as to further advance the cause of medical education, research and quality assurance. (Sub. Res. 11, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed in lieu of Res. 312, A-12)

H-85.969 Preserving the Vital Role of the Autopsy in Medical Education

(1) The AMA representatives to the Liaison Committee on Medical Education ask that autopsy rates and student participation in autopsies continue to be monitored periodically and that the reasons that schools do or do not require attendance be collected. (2) The AMA will continue to work with other interested groups to increase the rate of autopsy attendance. (CME Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)

H-85.964 Autopsy Payment and Performance Standards for Third Party Payers

Our AMA: (1) request that the National Committee on Quality Assurance (NCQA) and other accrediting bodies encourage the performance of autopsies to yield benchmark information for all managed care entities seeking accreditation; (2) calls upon all third party payers, including CMS, to provide adequate payment directly for autopsies; and (3) encourages adequate reimbursement by all third party payers for autopsies. (Sub. Res. 703, A-97; Modified: Sub. Res. 801, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10)

H-85.978 Autopsy as the Practice of Medicine

It is the policy of our AMA: (1) that the performance of autopsies constitutes the practice of medicine; (2) in conjunction with the pathology associations represented in the AMA House, to continue to implement all the recommendations regarding the effects of decreased utilization of autopsy on medical education and research, quality assurance programs, insurance claims processing, and cost containment; and (3) to initiate a program for the appropriate reimbursement of autopsies including efforts aimed at having the autopsy take its rightful place as a Medicare Part B reimbursable physician service. (Sub. Res. 172, A-90; Modified: Res. 512, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10)

H-85.973 Financial Incentives for Autopsies

Our AMA affirms the importance of autopsies and opposes the use of any financial incentives for physicians who acquire autopsy clearance. (CSA Rep. G, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)

Hospice Care

H-85.999 Hospices

Our AMA (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and (2) urges that this position be widely publicized in order to encourage extension and

third party coverage of this provision for terminal care. (Sub. Res 82, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10)

H-85.958 Palliative Care and End-of-Life Care

Our AMA: 1. Recognizes the importance of providing interdisciplinary palliative care for patients with disabling chronic or life-limiting illness to prevent and relieve suffering and to support the best possible quality of life for these patients and their families. 2. Encourages research in the field of palliative medicine to improve treatment of unpleasant symptoms that affect quality of life for patients with advanced, chronic illness. 3. Encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment. (BOT Rep. 5, A-06)

H-85.991 Hospice Program Regulations for Medicare Qualification

The AMA supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare. (Res. 174, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: BOT Rep. 29, A-04)

H-85.994 Hospice Standards

The AMA believes that each patient admitted to a hospice program should have his or her designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program. (Sub. Res. 46, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CMS Rep. 7, A-05; Reaffirmation A-07)

H-85.962 Length-of-Life Criteria for Hospice Care

Our AMA supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers. (Res. 118, I-00; Reaffirmed: CMS Rep. 6, A-10)

H-85.963 Medicare Hospice Benefit

Our AMA will seek amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure. (Res. 101, A-99; Reaffirmed: BOT Rep. 23, A-09)

Advance Care Planning

H-85.965 Advance Care Planning

The AMA will continue efforts to better educate physicians in the skills necessary to increase the prevalence and quality of meaningful advance care planning, including the use of advance directives, and to improve recognition of and adherence to a patient's advance care decisions. (Res. 4, I-96; Reaffirmed: CEJA Rep. 7, A-06; Reaffirmed: BOT Rep. 9, A-08; Reaffirmed: BOT Rep. 14, I-09)

H-140.969 Physician Education Regarding the Patient Self-Determination Act

The AMA supports development of materials (including, but not necessarily limited to, articles in AMNews, JAMA, This Week, and other appropriate AMA publications) to educate physicians about the requirements and implications of the Patient Self-Determination Act, and supports the development of materials (including, but not necessarily limited to, fact sheets and/or brochures) which physicians can use to educate their patients about advance directives and requirements of the Patient Self-Determination Act. (Res. 250, A-91; Reaffirmed: Sub. Res. 229, A-97; Reaffirmed: Res. 3, A-99; Reaffirmed: CEJA Rep. 8, A-09)

H-140.977 Residency Training in Medical-Legal Aspects of End-of-Life Care

OurAMA encourages residency training programs, regardless of or in addition to current specialty specific ACGME requirements, to promote and develop a high level of knowledge of and ethical standards for the use of such documents as living wills, durable powers of attorney for health care, and ordering DNR status, which should include medical, legal, and ethical principles guiding such physician decisions. This knowledge should include aspects of medical case management in which decisions are made to limit the duration and intensity of treatment. (Res. 66, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-11)

H-140.856 Encouraging Young Adults to Establish Advance Directives and Select Health Care Proxies

Our AMA encourages health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies. (Res. 7, A-10)

H-140.946 Advance Directive for Each Nursing Home Resident

The AMA encourages nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall

accompany the resident patient upon transfer to another facility. (Sub. Res. 229, A-97; Reaffirm: Res. 3, A-99; Reaffirmed: BOT Rep. 9, A-08)

D-140.976 Advance Health Care Directive

Our AMA will: (1) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD) as soon as reasonably possible; (2) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (3) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (4) create other strategies to help physicians encourage all their patients to complete their DPAHC/AD; (5) work with Congress and the Department of Health and Human Services to make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD as soon as reasonably possible; and (6) advocate for the implementation of secure electronic advance health care directives. (Res. 603, I-04; Reaffirmed: Res. 209, A-05; Reaffirmation A-06; Reaffirmed: BOT Rep. 22, A-06; Appended: Res. 4, A-07; Reaffirmed: BOT Rep. 9, A-08; Reaffirmed: BOT Rep. 14, I-09)

H-140.976 Living Wills and Health Care Powers of Attorney

Our AMA encourages every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas. (Res. 201, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CEJA Rep. 6, A-10)

D-85.997 Lessons Learned from Terri Schiavo

1. Our AMA will communicate with key health insurance organizations, both private and public, to encourage them and their institutional members to include information regarding advance directives and related forms and will also communicate with state Departments of Motor Vehicles to recommend the distribution of information about advance directives to individuals obtaining or renewing a driver's license. 2. Our AMA Ethics Resource Center will update its web content regarding advance directives, including links to other appropriate resources with permission from the relevant organizations. (BOT Rep. 22, A-06)

D-440.948 Advance Directive

Our AMA will work with members of Congress to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives. (Res. 922, I-07)

D-330.938 Advance Health Care Directives to Medicare Enrollees

Our AMA will work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives. (Res. 8, A-06)

Palliative Care

D-70.962 Palliative Care and End-of-Life Care

Our AMA: 1. Encourages all physicians to become skilled in palliative medicine techniques and to become familiar with the use of current coding methods for reimbursement of hospice and palliative care services. 2. Advocates for reimbursement of Evaluation and Management (E/M) codes reflecting prolonged time spent on patients' care outside of the face-to-face encounter in non-hospital settings. 3. Will: (a) continue to monitor the development and performance on the CMS 30-day mortality measures, and enrollments in the Medicare hospice program and the VA hospice programs, (b) support efforts to clarify coding guidance or development of codes to capture "comfort care," "end-of-life care," and "hospice care," and (c) continue to work to have CMS exclude palliative patients from mortality measures. (BOT Rep. 5, A-06; Appended: BOT Rep. 12, A-13)

H-85.958 Palliative Care and End-of-Life Care

Our AMA: 1. Recognizes the importance of providing interdisciplinary palliative care for patients with disabling chronic or life-limiting illness to prevent and relieve suffering and to support the best possible quality of life for these patients and their families. 2. Encourages research in the field of palliative medicine to improve treatment of unpleasant symptoms that affect quality of life for patients with advanced, chronic illness. 3. Encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment. (BOT Rep. 5, A-06)

H-85.967 Good Care of the Dying Patient

The AMA: (1) encourages research into the needs of dying patients and how the care system could better serve them; (2) encourages education programs for all appropriate health care professionals, and the public as well, in care of the dying patient; and (3) supports improved reimbursement for health care practices that are important in good care of the dying patient, such as the coordination and continuity of care, "maintenance" level services, counseling for patient and family, use of multidisciplinary teams, and effective palliation of symptoms. (CSA Rep. 2, A-94; Reaffirmed: CSA Rep. 8, A-05)

Disabled Parking**H-90.979 Guidelines for Certifying Need for Handicapped Parking Privileges**

The AMA encourages physicians to become familiar with laws in their states for certifying a patient's need for handicapped parking privileges. (Sub. Res. 513, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-90.991 Handicapped Parking Spaces

The AMA supports efforts to educate the public on the appropriate use of parking spaces for the handicapped. (Res. 118, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

MDs/DOs as Medical Review Officers**H-95.960 MDs/DOs as Medical Review Officers**

The AMA (1) reaffirms its policy that only licensed MDs/DOs with knowledge of substance use disorders should serve as Medical Review Officers (MROs); (2) reaffirms its policy that all MDs/DOs who serve as MROs should obtain continuing medical education credit in this subject area; and (3) vigorously opposes legislation that is inconsistent with these policies. (Res. 312, A-92; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 2, A-13)

H-95.971 Medical Review Officers as Licensed Physicians

It is the policy of the AMA to vigorously advocate that any legislation concerning drug testing in the workplace include a provision for a Medical Review Officer (MRO) who will review all positive test results and further that only a licensed physician may serve as the MRO and further that this physician MRO has knowledge of substance abuse disorders and has appropriate medical training to interpret and evaluate an individual's positive test results together with his or her medical history and any other relevant biomedical information. (Res. 228, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)

Substance Use Prevention**H-295.987 Impairment Prevention and Treatment in the Training Years**

The AMA (1) reaffirms the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; and (2) strongly encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents and fellows. (Sub. Res. 25, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-295.979 Substance Abuse

The AMA (1) reaffirms its position which recognizes the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; (2) urges medical schools to include substance abuse prevention programs in their curriculum; and (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse. (Res. 106, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 10, I-98; Reaffirmed: BOT Rep. 17, I-99; Reaffirmed: CME Rep. 11, A-07)

H-95.982 Substance Abuse in Medical Schools

The AMA advocates (1) further study (and continued monitoring of other studies) concerning the problem of substance abuse among students, residents, and faculty in U.S. medical schools; and (2) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents and faculty which could significantly impact on this problem and potentially reduce the risk of future impairment among physicians. (Res. 111, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 10, I-98; Reaffirmed: CME Rep. 11, A-07)

CPR Training**H-130.944 Cardiopulmonary Resuscitation Training**

Our AMA endorses federal regulation and/or legislation increasing funding for cardiopulmonary resuscitation and defibrillation training of community organization personnel. (Res. 431, A-05)

H-440.890 Availability of Automated External Defibrillators

Our AMA: (1) advocates the widespread placement of automated external defibrillators; (2) supports increasing government and industry funding for the purchase of automated external defibrillator devices; and (3) encourages the American public to become trained in CPR and the use of automated external defibrillators. (Res. 413, A-02; Res. 424, A-04; Reaffirmed in lieu of Res. 208, I-11)

H-130.983 Teaching of Cardiopulmonary Resuscitation to All High School Students

The AMA supports publicizing the importance of teaching CPR, including the use of automated external defibrillation, and strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs. (Sub. Res. 67, A-86; Reaffirmed: Sunset Report, I-96; Modified: Res. 401, A-05)

H-130.944 Cardiopulmonary Resuscitation Training

Our AMA endorses federal regulation and/or legislation increasing funding for cardiopulmonary resuscitation and defibrillation training of community organization personnel. (Res. 431, A-05)

D-440.958 Universal Defibrillator Connectivity

AMA will: (1) support the development and use of universal connectivity for all defibrillators; and (2) work with and support members of EMS departments, and state and federal legislators to strongly urge manufacturers to voluntarily adopt universal connectivity for all defibrillators. (Res. 511, A-06)

Proficiency of Physicians in Basic and Advanced Cardiac Life Support**H-300.999 Proficiency in Advanced Cardiac Life Support**

Our AMA believes that all licensed physicians should become proficient (1) in basic CPR; and (2) in advanced cardiac life support commensurate with their responsibilities in critical care areas. (Sub. Res. 44, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmation A-13)

H-130.997 Cardiopulmonary Resuscitation

Our AMA recommends to state and county medical associations that programs be undertaken to make the entire physician population, regardless of specialty or subspecialty interests, proficient in basic CPR. (BOT Rep. N, A-74; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10)

H-295.906 Cardiopulmonary Resuscitation and Basic Life Support Training for First-Year Medical Students

Our AMA encourages training of cardiopulmonary resuscitation and basic life support to first-year medical students, preferably during the first term. (Res. 305, A-97; Reaffirmed: CME Rep. 3, I-99; Reaffirmed: CME Rep. 2, A-09)

Good Samaritan**D-435.990 Delivery of Health Care by Good Samaritans**

Our American Medical Association will work with state medical societies to educate physicians about the Good Samaritan laws in their states, and the extent of liability immunity for physicians when they act as Good Samaritans. (Res. 201, A-03; Reaffirmed: BOT Rep. 28, A-13)

H-130.986 Good Samaritan Law

The AMA encourages state medical societies in states without “good samaritan laws,” which protect qualified medical personnel, to develop and support such legislation. (Res. 135, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: BOT Rep. 12, A-05)

H-130.989 Protocol for Emergency Medical Services (EMS) Personnel and the Bystander Physician

Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, the AMA supports the following basic guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance. For the purpose of this policy, “bystander physicians” shall refer to those physicians rendering assistance voluntarily, in the absence of pre-existing patient-physician relationships, to those in need of medical assistance, in a service area in which the physician would not ordinarily respond to requests for emergency assistance. (1) Bystander physicians should recognize that prehospital EMS systems operate under the authority and direction of a licensed EMS physician, who has both ultimate medical and legal responsibility for the system. (2) A reasonable policy should be established whereby a bystander physician may assist in an emergency situation, while working within area-wide EMS protocols. Since EMS providers (non-physicians) are responsible for the patient, bystander physicians should work collaboratively, and not attempt to wrest control of the situation from EMS providers. (3) It is the obligation of the bystander physician to provide reasonable self-identification. (4) Where voice communication with the medical oversight facility is available, and the EMS provider and the bystander physician are collaborating to provide care on the scene, both should interact with the local medical oversight authority, where practicable. (5) Where voice communication is not available, the bystander physician may sign appropriate documentation indicating that he/she will take responsibility for the patient(s), including provision of care during transportation to a medical facility. (Medical oversight systems lacking voice communications capability should consider the addition of such communication linkages to further strengthen their potential in this area.) (6) The bystander physician should avoid involvement in resuscitative measures that exceed his or her level of training or experience. (7) Except in extraordinary circumstances or where requested by the EMS providers, the bystander physician should refrain from providing medical oversight of EMS that results in deviation from existing EMS protocols and standing orders. (BOT Rep. X, A-84; Reaffirmed by CLRPD Rep. 3, I-94; Modified: CSA Rep. 5, A-05)

H-130.995 International Liability Regulations Pertaining to Emergency Care

Our AMA urges the International Civil Aviation Organization to make explicit recommendations to its member countries for the enactment of regulations providing “Good Samaritan” relief for those rendering emergency medical assistance aboard air carriers and in the immediate vicinity of air carrier operations. (Sub. Res. 73, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)

National Practitioner Data Bank

H-450.950 Revise National Practitioner Data Bank Criteria

Our AMA: (1) communicates to legislators the fundamental unfairness of the civil judicial system as it now exists, whereby a jury, rather than a forum of similarly educated peers, determines if a physician has violated the standards of care and such results are communicated to the National Practitioner Data Bank; and (2) impresses on our national legislators that only when a physician has been disciplined by his/her state licensing agency should his/her name appear on the National Practitioner Data Bank. (Res. 809, I-99; Reaffirmed: BOT Rep. 31, I-00; Reaffirmation & Reaffirmed: Res. 216, A-01; Reaffirmed: CME Rep. 2, A-11)

H-355.987 National Practitioner Data Bank

Our AMA affirms its support for the Federation of State Medical Boards Action Data Bank and calls for the dissolution of the National Practitioner Data Bank. (Sub. Res. 814, A-93; Reaffirmed by Sub. Res. 807, I-95; Reaffirmed by CME Rep. 3, A-96; Reaffirmed by Ref. Cmt. H, A-96; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: BOT Rep. 31, I-00; Reaffirmed: CMS Rep. 6, A-10)

H-355.991 National Practitioner Data Bank

It is the policy of the AMA to seek to abolish the National Practitioner Data Bank. (Res. 828, I-91; Reaffirmed by Ref. Cmt. H, A-96; Reaffirmed: Sub. Res. 812, I-97; Reaffirmed: BOT Rep. 31, I-00; Reaffirmed: CMS Rep. 6, A-10)

H-355.993 National Practitioner Data Bank

Our AMA: (1) urges HHS to retain an independent consultant to (a) evaluate the utility and effectiveness of the National Practitioner Data Bank, (b) evaluate the confidentiality and security of the reporting, processing and distribution of Data Bank information, and (c) provide the findings and recommendations to the National Practitioner Data Bank Executive Committee and the General Accounting Office; (2) will take appropriate steps to have Congress repeal Section 4752 (f) of OBRA 1990 requiring peer review organizations and private accreditation entities to report any negative action or finding to the Data Bank; (3) opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on his or her behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers for purposes of credentialing or reimbursement; (4) seeks to amend the Health Care Quality Improvement Act of 1986 to allow a physician, at the time the physician notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report; (5) urges HHS to work with the Federation of State Medical Boards to refine its National Practitioner Data Bank breakdown of drug violation reporting into several categories; (6) urges the HHS to analyze malpractice data gathered by the Physician Insurance Association of America and recommend to Congress that a threshold of at least \$30,000 for the reporting of malpractice payments be established as soon as possible; (7) will continue to work with HHS to allow physicians an expanded time period to verify the accuracy of information reported to the Data Bank prior to its release in response to queries; (8) will work with HHS and the Office of Management and Budget to reduce the amount of information required on the request for information disclosure form and to improve the design of the form to allow for more efficient processing of information; (9) will continue to work with HHS to improve its mechanism to distribute revisions and clarifications of Data Bank policy and procedure; and (10) will review questions regarding reportability to the Data Bank and will provide periodic updates on reportability issues to the AMA House of Delegates. (Sub. Res. 7, A-91; Reaffirmation & Reaffirmed: Res. 216, A-01; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)

H-355.999 Minimum Reporting Requirements to National Practitioner Data Bank

Our AMA believes that (1) the National Practitioner Data Bank requirements should be modified so that settlements and judgments of less than \$30,000 are not reported or recorded; (2) reports, other than licensure revocation, in the Data Bank should be purged after five years; (3) proctoring of physicians for the purpose of investigation should not be reportable; (4) physicians should not be required to turn over copies of their Data Bank file to anyone not authorized direct access to the Data Bank; and (5) any physician's statement included in the Data Bank file should automatically accompany any adverse report about that physician in distributions from the Data Bank. (Sub. Res. 80, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation & Reaffirmed: Res. 216, A-01; Reaffirmation A-09)

H-355.995 National Practitioner Data Bank

It is the policy of the AMA to (1) work with HHS to establish a mechanism to inform physicians when an inquiry to the Data Bank has been made; (2) reaffirm its policy that reports, other than licensure revocation, in the Data Bank should be purged after five years; and (3) support efforts to require the same Data Bank reporting requirements for physicians, dentists and other licensed health care practitioners. (Sub. Res. 41, I-90; Modified: Sunset Report, I-00; Reaffirmation A-09)

H-355.985 National Practitioner Data Bank

Our AMA: (1) opposes all efforts to open the National Practitioner Data Bank to public access; (2) strongly opposes public access to medical malpractice payment information in the National Practitioner Data Bank; and (3) opposes the implementation by the National Practitioner Data Bank of a self-query user fee. (Res. 824, I-93; Reaffirmed: BOT Rep. 31, I-00; Reaffirmation & Reaffirmed: Res. 216, A-01; Reaffirmed: CME Rep. 2, A-11)

H-355.996 Notification of Physicians by the National Practitioner Data Bank

Our AMA (1) reaffirms its policy and supports using all necessary efforts to direct the National Practitioner Data Bank to send all notifications to physicians by certified mail return receipt requested; and (2) supports using all necessary efforts at the federal level to direct the National Practitioner Data Bank to begin the sixty day appeal process from the date the physician receives notification. (Res. 185, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CMS Rep. 6, A-10)

H-355.984 Removal of Overruled Disciplinary Actions Reports from the National Practitioner Data Bank

The AMA will work with the appropriate federal agencies to ensure that the National Practitioner Data Bank reflects all disciplinary actions on appeal, and to remove from the physician's record reported decisions which have been overruled. (Res. 807, A-96; Reaffirmed: BOT Rep. 34, A-06)

H-355.992 Reporting Impaired Physicians to the National Practitioner Bank

Our AMA will continue to monitor the issue of reporting impaired physicians to the National Practitioner Data Bank and will seek further clarification of ambiguities or misinterpretations of the reporting requirements for impaired physicians. (BOT Rep. J, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)

H-355.983 Reporting of Malpractice Information in the National Practitioner Data Bank

Our AMA: (1) seeks opportunities to limit reports concerning residents to the National Practitioner Data Bank to only those situations where a final adverse action has been taken by a medical licensing jurisdiction; and (2) opposes attempts to extend reports concerning residents to the National Practitioner Data Bank beyond those covered in this policy. (CME Rep. 3, A-96; Reaffirmed & Appended: Res. 242, A-01; Reaffirmed: CME Rep. 4, I-01; Reaffirmed: CME Rep. 2, A-11)

D-355.997 Reporting of Resident Physicians

Our AMA will: (1) continue to monitor the types of information reported about resident physicians to federal and state agencies, especially the National Practitioner Data Bank and state medical licensing boards; and (2) draft and advocate for legislation amending, as appropriate, the NPDB reporting requirements regarding resident physicians to be consistent with policy H-355.983, and oppose the expansion of existing reporting requirements. (CME Rep. 4, I-01; Reaffirmed: CME Rep. 2, A-11)

H-355.980 Opposition to Inclusion of Liability Payments Made on Behalf of Residents in the National Practitioner Data Bank

Our AMA: (1) fully supports the mandatory and prompt notification of residents by the appropriate hospital authority when they are named along with a hospital and/or others in the hospital in malpractice suits; (2) opposes the inclusion in the National Practitioner Data Bank of information on liability payments made on behalf of residents named in malpractice suits for incidents that occur during the required supervised activities of their residency training; (3) seeks the immediate suspension of the policy whereby information on residents named in malpractice suits for incidents which occur during the required supervised activities of their residency training is reported to the National Practitioner Data Bank when liability payments are made on their behalf; and (4) will work with the Association of American Medical Colleges and other interested parties to reinvigorate its efforts to successfully change National Practitioner Data Bank policy through legislative or other means in accordance with this policy. (Sub. Res. 803, I-99; Reaffirmation & Reaffirmed: Res. 216, A-01; Appended and Reaffirmed: Res. 233, A-05)

Human Rights and Freedom**H-65.992 Continued Support of Human Rights and Freedom**

Our AMA continues (1) to support the dignity of the individual, human rights and the sanctity of human life, and (2) to oppose any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies. (Sub. Res. 107, A-85; Modified by CLRPD Rep. 2, I-95; Reaffirmation A-00; Reaffirmation A-05; Modified: BOT Rep. 11, A-07)

H-65.990 Civil Rights Restoration

The AMA reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age. (BOT Rep. LL, I-86; Amended by Sunset Report, I-96; Modified: Res. 410, A-03; Reaffirmation A-05)

H-65.980 Support of Hate Crimes Prevention Legislation

Our AMA: (1) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States; (2) urges expedient passage of appropriate hate crimes prevention legislation in accordance with AMA policy H-65.992 through letters to members of Congress; and (3) registers support for hate crimes prevention legislation, via letter, with the President of the United States. (Res. 228, I-98; Reaffirmed: BOT Rep. 23, A-09)

APPENDIX C - Consolidation Details and Editorial Changes for Selected Policies

Proposed Consolidation H-90.xxx, Medical Care of Persons with Developmental Disabilities

Original Policy	Items of Original Policies (with editorial modifications shown)
H-90.972	(1) Our AMA encourages; (4a) encourages -clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with D developmental D disabilities; (2b) encourages -medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with D developmental D disabilities; (3c) encourages -medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with D developmental D disabilities, will to improve quality in clinical care; (4d) encourages -the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with D developmental D disabilities so as to improve health outcomes;
H-90.975	(3e) encourage -medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (4f) encourage -medical schools and graduate medical education programs to establish and encourage enrollment in electives rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled;
H-90.972	and (5g) supports a cooperative effort cooperation between among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with Developmental Disabilities.
D-270.997	(2) Our AMA seeks legislation (a) to increase increasing the; (4) funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increasing the reimbursement for the health care of these individuals; and (2b) insurance industry and government reimbursement to that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals.
H-90.976	(3) Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: 1- (a) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and -2- (b) An individual's medical condition and welfare must be the basis of any medical decision.
H-90.975	Our AMA will- (1) advocates for the highest quality medical care for persons with profound developmental disabilities; (2) encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and (5) informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them.

Proposed Consolidation H-10.xxx, Helmets for Riders of Motorized and Non-motorized Cycles

Original Policy	Items of Original Policies (with editorial modifications shown)
H-10.977	General Helmet Use: It is the policy of the Our AMA to: (1) encourages physicians to counsel their patients who ride motorized and non-motorized cycles to use approved helmets and appropriate protective clothing while cycling; (2) encourages patients and families to inform and train children about safe cycle-riding procedures, especially on roads and at intersections, the need to obey traffic laws, and the need for responsible behavior; (3) encourages community agencies, such as those involving law enforcement, schools, and parent-teacher organizations, to promote training programs for the responsible use of cycles; (4) urges manufacturers to improve the safety and reliability of the vehicles they produce and to support measures to improve cycling safety;
H-10.977	(65) advocates further research on the effectiveness of helmets and on the health outcomes of community programs that mandate their use.
H-10.980	(6) encourages efforts to investigate the impact of helmet use by riders of motorcycles and all bicycles, in order to establish the risk of major medical trauma from not wearing helmets, the costs added to the health care system by such behavior, and the payers of these added costs (i.e., private insurance, uncompensated care, Medicare, Medicaid, etc.); (7) supports the exploration of will explore ways to ensure the wearing of helmets through the use of disincentives or incentives such as licensing fees, insurance premium adjustments and other payment possibilities.
H-10.985	Bicycles: It is the policy of the Our AMA: (1) to actively supports bicycle helmet use and encourages physicians to educate their patients about the importance of bicycle helmet use; (2) to encourages the manufacture, distribution, and utilization of safe, effective, and reasonably priced bicycle helmets; and (3) to encourages the availability of helmets at the point of bicycle purchase.
H-10.967	Scooters: Our AMA: (1) recommends the use of protective gear (certified helmets, elbow and knee pads, closed-toe shoes) for riders of scooters, especially children and adolescents; (2) encourages physicians to counsel patients, and their parents when appropriate, that full protective equipment should be worn and

	appropriate safety measures should be taken to prevent scooter injuries (e.g., riding away from traffic, and close supervision of riders under the age of eight); and (3) urges companies that manufacture or sell scooters to include appropriate information about the safe use of scooters on the scooters themselves, on or inside scooter packaging, on their web sites, and at the point of sale.
H-15.956	Motorcycles. Our AMA: (1) encourages physicians to (4) be aware of motorcycle risks and safety measures and (2) to counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs.
H-15.994	The AMA (42) endorses the concept of legislative measures to require the use of helmets when riding or driving a motorcycle; (2) urges constituent societies to support the enactment or preservation of state motorcycle helmet laws;
H-15.971	(3) The following is the policy of the AMA: that the AMA seek supports federal regulatory rules to make the receipt of federal highway funds by a state dependent on passage of mandatory [motorcycle] helmet laws by that state.
H-15.994	and (3) will join, when requested, with (4) urges constituent societies to support the enactment or preservation of state motorcycle helmet laws.
H-15.980	(5) supports rider education legislation, which is more easily implemented and more effective than legislation requiring manufacturers to emphasize the dangers of operating motorcycles.

Proposed Consolidation H-30.xxx, Prevention of Impaired Driving

Original Policy	Items of Original Policies (with editorial modifications shown)
H-30.945	The Our AMA: (1) acknowledges that all alcohol consumption, even at low levels, has a negative impact on driver skills, perceptions, abilities, and performance and poses significant health and safety risks.
H-30.986	(2) supports 0.04 percent blood-alcohol level as per se illegal for driving, and urges incorporation of that provision in all state drunk driving laws; (3) supports 21 as the legal drinking age; and supports strong penalties for providing alcohol to persons younger than 21, and stronger penalties for providing alcohol to drivers younger than 21;
H-30.986	<u>Education:</u> Our AMA (1) favors public information and education against any drinking by drivers;
H-30.945	(2) The AMA will be involved in supports efforts to educate physicians, the public, and policy makers about this issue and urges national, state, and local medical associations and societies, together with public health, transportation safety, insurance industry, and alcohol beverage industry professionals to renew and strengthen their commitment to preventing alcohol-impaired driving; (23) encourages physicians to participate in educating the public and patients about the hazards of chemically impaired driving; (34) urges public education messages that now use the phrase “drunk driving,” or make reference to the amount one might drink without fear of arrest, be replaced with messages that indicate that “all alcohol use, even at low levels, impairs driving performance and poses significant health and safety risks;”
H-30.959	(35) encourages state medical associations to participate in educational activities related to eliminating alcohol use by adolescents.
H-170.970	(6) The AMA supports and encourages programs in elementary, middle, and secondary schools, which provide information on the dangers of driving while under the influence of alcohol, and which emphasize that teenagers who drive should drink no alcoholic beverages whatsoever; and will <u>continue to</u> work with private and civic groups such as Mothers Against Drunk Driving (MADD) to achieve <u>those goals</u> and intent of this resolution.
H-30.959	<u>Legislation:</u> Our AMA: (1) supports the development of model legislation which would provide for school education programs to teach adolescents about the dangers of drinking and driving and which would mandate the following penalties when a driver under age 21 drives with any blood alcohol level (except for minimal blood alcohol levels, such as less than .02 percent, only from medications or religious practices): (a) for the first offense - mandatory revocation of the driver’s license for one year and (b) for the second offense - mandatory revocation of the driver’s license for two years or until age 21, whichever is greater; (2) urges state medical associations to seek enactment of the legislation in their legislatures;
H-30.945	(43) urges all states to pass legislation mandating all drivers convicted of first and multiple DUI offenses be screened for alcoholism and provided with referral and treatment when indicated.
H-30.986	(4) urges adoption by all states of legislation calling for administrative suspension or revocation of driver licenses after conviction for driving under the influence, and mandatory revocation after a specified number of repeat offenses;
H-30.941	Our AMA encourages: (4) and (5) encourages passage of state traffic safety legislation that mandates screening for substance use disorder for all DUI offenders, with those those who are identified with substance use disorder should be strongly encouraged and assisted in obtaining treatment from qualified physicians and through state and medically certified facilities
H-30.941	<u>Treatment:</u> Our AMA: (1) encourages that treatment of all convicted DUI offenders, when medically indicated, should be mandated and provided but in the case of first-time DUI convictions, should not replace other sanctions which courts may levy in such a way as to remove from the record the occurrence of that offense; and encourages that (3) treatment of repeat DUI offenders, when medically indicated, should be

	mandated and provided but should not replace other sanctions which courts may levy. In all cases where treatment is provided to a DUI offender, it is also recommended that appropriate adjunct services should be provided to or encouraged among the family members actively involved in the offender's life; and;
H-30.945	Repeat Offenders: Our AMA (5) further (1) recommends the following measures be taken to reduce repeat DUI offenses: (a) aggressive measures be applied to first-time DUI offenders (e.g., license suspension and administrative license revocation), (b) stronger penalties be leveled against repeat offenders, including second-time offenders, (c) such legal sanctions must be linked, for all offenders, to substance abuse assessment and treatment services, to prevent future deaths in alcohol-related crashes and multiple DUI offenses.; (d) (2) calls upon the states to coordinate law enforcement, court system, and motor vehicle departments to implement forceful and swift penalties for second-time DUI convictions to send the message that those who drink and drive might receive a second chance but not a third;
H-30.969	On-board Devices: (4) Our AMA (1) supports further testing of on-board devices to prevent the use of motor vehicles by intoxicated drivers; this testing should take place among the general population of drivers, as well as among drivers having alcohol-related problems; (2) Our AMA encourages motor vehicle manufacturers and the U.S. Department of Transportation to monitor the development of ignition interlock technology, and plan for use of such systems by the general population, when a consensus of informed persons and studies in the scientific literature indicate the systems are effective, acceptable, reasonable in cost, and safe; and
H-30.941	(43) supports continued research and testing of devices which may incapacitate vehicles owned or operated by DUI offenders without needlessly penalizing the offender's family members.

Proposed Consolidation H-444.xxx, Protecting the Public from Dangers of Ultraviolet Radiation

Original Policy	Items of Original Policies (with editorial modifications shown)
H-440.959	Tanning Parlors: It is the policy of the Our AMA supports: to (1) continue to support an educational campaigns on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; and (2) support legislation to strengthen state laws to make the consumer as informed and safe as possible.
H-440.980	(43) supports the dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; and (24) urges collaboration between medical societies to work with all and schools to include information in their health curricula on the hazards of exposure to tanning rays.
D-440.969	(45) support the enactment of federal legislation to: (a) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR §1040.20 [a][9]) by anyone under the age of 18; and (b) require a United States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer;
H-440.967	(46) supports using its public education capabilities to warning the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units; (2) endorses, including the FDA's findings released by the FDA warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (37) supports working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including posted warnings in commercial tanning salons and spas; (48) supports, in conjunction with various concerned national specialty societies, an educational campaign in conjunction with various concerned national specialty societies to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers; (59) supports intensified efforts to enforce current regulations;
H-440.967	Suncreens: Our AMA: (61) encourages the development of sunscreens that will protect the skin from a broad spectrum of ultraviolet radiation, including both UVA and UVB; and
H-440.865	Our AMA recommends: (1) (2) the labeling of sunscreen products with a standardized ultraviolet (UV) logo, inclusive of ratings for UVA and UVB, so that consumers will know whether these products protect against both types of UV radiation; and (2) that Terms such as low, medium, high and very high protection are should be defined depending on standardized sun protection factor level.

Proposed Consolidation H-85.xxx, Importance of Autopsies

Original Policy	Items of Original Policies (with editorial modifications shown)
H-85.980	(1) Our AMA (4) supports seeking the cooperation of the National Advisory Council on Aging of the National Institutes of Health in recommending to physicians, hospitals, institutes of scientific learning, universities, and most importantly the American people the necessity of autopsy for pathological correlation of the results of the immeasurable scientific advancements which have occurred in recent years; Our AMA; (2) believes that the information garnered from such stringent scientific advancements and correlation, as well as coalitions, should be used in the most advantageous fashion; and (3) believes that the conclusions obtained from such investigations should be widely shared with the medical and research community and should be interpreted by these groups with the utmost scrutiny and objectivity.
H-85.989	(2) The Our AMA (4): (a) supports endorses the efforts of the Institute of Medicine and other national

	organizations in formulating national policies to modernize and promote the use of autopsy to meet present and future needs of society; (2b) promotes the use of updated autopsy protocols for medical research, particularly in the areas of cancer, cardiovascular, occupational, and infectious diseases; (3c) promotes the revision of standards of accreditation for medical undergraduate and graduate education programs to more fully integrate autopsy into the curriculum and require postmortems as part of medical educational programs; (4d) encourages the use of a national computerized autopsy data bank to validate technological methods of diagnosis for medical research and to validate death certificates for public health and the benefit of the nation; (5e) requests the JCAHO <u>The Joint Commission</u> to consider amending the Accreditation Manual for Hospitals to require that the complete autopsy report be made part of the medical record within 30 days after the postmortem; (6f) endorses <u>supports</u> the formalization of methods of reimbursement for autopsy in order to identify postmortem examinations as medical prerogatives and necessary medical procedures; (7g) promotes programs of education for physicians to inform them of the value of autopsy for medical legal purposes and claims processing, to learn the likelihood of effects of disease on other family members, to establish the cause of death when death is unexplained or poorly understood, to establish the protective action of necropsy in litigation, and to inform the bereaved families of the benefits of autopsy; and (8h) promotes the incorporation of updated postmortem examinations into risk management and quality assurance programs in hospitals.
H-85.993	(3) Our <u>The AMA</u> (4) reaffirms the fundamental importance of the autopsy in any effective hospital quality assurance program; and (2) urges physicians and hospitals to increase the utilization of the autopsy so as to further advance the cause of medical education, research and quality assurance.
H-85.969	(4) Our <u>The AMA</u> representatives to the Liaison Committee on Medical Education ask that autopsy rates and student participation in autopsies continue to be monitored periodically and that the reasons that schools do or do not require attendance be collected. (2) The <u>Our</u> <u>AMA</u> will continue to work with other interested groups to increase the rate of autopsy attendance.
H-85.964	Our AMA; (4) request that the National Committee on Quality Assurance (NCQA) and other accrediting bodies encourage the performance of autopsies to yield benchmark information for all managed care entities seeking accreditation;
H-85.964	(2g) calls upon all third party payers, including CMS, to provide adequate payment directly for autopsies; and (3) encourages adequate reimbursement by all third party payers for autopsies.
H-85.978	(7) It is the policy of our AMA: (4a) that the performance of autopsies constitutes the practice of medicine; (2b) in conjunction with the pathology associations represented in the AMA House, to continue to implement all the recommendations regarding the effects of decreased utilization of autopsy on medical education and research, quality assurance programs, insurance claims processing, and cost containment;

Proposed Consolidation H-140.xxx Encouraging the Use of Advance Directives and Health Care Powers of Attorney

Original Policy	Items of Original Policies (with editorial modifications shown)
H-140.856	Our AMA; will (1) encourages health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies.
H-140.946	(2) The AMA will encourages nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility.
D-140.976	(3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD) as soon as reasonably possible; (24) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (35) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems;
H-140.976	(6) Our AMA encourages every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas.
D-85.997	(7) (a) Our AMA will communicate with key health insurance organizations, both private and public, to encourage them and their institutional members to include information regarding advance directives and related forms; and will also communicate with <u>recommend to</u> state Departments of Motor Vehicles to recommend the distribution of information about advance directives to individuals obtaining or renewing a driver's license.
D-140.976	(8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD <u>as soon as reasonably possible</u>
D-440.948	<u>and</u> (b) Our AMA will work with members of Congress to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives.
D-330.938	(9) Our AMA will work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives.
D-140.976	(10) create other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (611) advocate for the implementation of secure electronic advance health care directives.