

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-24)

Report of the Organized Medical Staff Section Reference Committee

Christopher Gribbin, MD, Chair

1 Your Reference Committee recommends the following consent calendar for acceptance:
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4 **RECOMMENDED FOR ADOPTION**

- 5
6 1. Resolution 8 – Establish a Council on Artificial Intelligence and Digital
7 Technology
8

9 **RECOMMENDED FOR ADOPTION AS AMENDED**

- 10
11 2. Resolution 2 – Advocacy for More Stringent Regulations/Restrictions on the
12 Distribution of Marijuana
13 3. Resolution 4 – Support Before, During, and After Hospital Closure or Reduction
14 in Services
15 4. Resolution 5 – The Hazards of Prior Authorization
16 5. Resolution 10 – Mentorship to Combat Prior Authorization
17

18 **RECOMMENDED FOR ADOPTION IN LIEU OF**

- 19
20 6. Resolution 3 – Augmented Intelligence and Organized Medical Staff
21

22 **RECOMMENDED FOR REFERRAL**

- 23
24 7. Resolution 7 – The Role of Contracted Physicians on the Medical Executive
25 Committee
26

27 **RECOMMENDED FOR NOT ADOPTION**

- 28
29 8. Resolution 1 – The AMA Will Actively Pursue Unionization/Collective Bargaining
30 to Protect Patients' Quality of Care and Medical Staff
31 9. Resolution 6 – Continuity of Care in the Hospital
32 10. Resolution 9 – Endorsing More Stringent Measures to Minimize Injuries as a
33 Result of the Widespread Use of E-Scooters

RECOMMENDED FOR ADOPTION

(1) RESOLUTION 8 – ESTABLISH A DEDICATED COUNCIL
ON ARTIFICIAL INTELLIGENCE AND DIGITAL
TECHNOLOGY

RECOMMENDATION A:

Resolution 8 be adopted.

RECOMMENDATION B:

**Resolution 8 be held back and forwarded for
consideration at a future meeting of the AMA House of
Delegates as necessary.**

Resolved, That our American Medical Association form a new, permanent Council dedicated to the overall field of artificial/augmented intelligence and digital technology insofar as it affects the delivery of healthcare (Directive to Take Action).

Your Reference Committee heard support for Resolution 8 with near universal support for the need of a dedicated mechanism for better understanding and reviewing different forms of artificial intelligence within the AMA. The Committee found itself in agreement with these sentiments and despite noting the potentially significant fiscal note believed the results would likely justify the increased cost over time. The Committee also considered that Res. 606, brought by New England, is already before the House of Delegates and contains a nearly identical call for a new council “focused on digital health, technology, informatics, and augmented/artificial intelligence...”

Given the existence of an already existing item of business at the House, the Committee was reluctant to recommend advancing a second item. At the same time, the Committee believed a show of support from the OMSS would benefit the ultimate goal of establishing a new council. The Committee thus recommends that Resolution 8 be adopted by the OMSS and held back, so as not to be duplicative but to still give the OMSS Delegate and Alternate Delegate confirmation of the support of the OMSS Assembly and allow them to fully advocate for the adoption of Resolution 606.

RECOMMENDED FOR ADOPTION AS AMENDED

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3 (2) RESOLUTION 2 – ADVOCACY FOR MORE STRINGENT
4 REGULATIONS/RESTRICTIONS ON THE
5 DISTRIBUTION OF MARIJUANA
6

7 **RECOMMENDATION A:**

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9 **The resolve in Resolution 2 be amended by addition and**
10 **deletion to read as follows:**

11
12 Resolved, That our American Medical Association ~~advocate~~
13 ~~for study possible legislative, legal or regulations~~ regulatory
14 means to make the cannabis industry pay for increasing
15 costs of medical and social care for people affected by the
16 problems caused by ~~marijuana~~ cannabinoids similar to the
17 regulations advocates for smoking cessation in the United
18 States (Directive to Take Action).
19

20 **RECOMMENDATION B:**

21
22 **Resolution 2 be adopted as amended.**

23
24 **RECOMMENDATION C:**

25
26 **Resolution 2 be immediately forwarded for**
27 **consideration at the 2024 Annual Meeting of the AMA**
28 **House of Delegates.**
29

30 Resolved, That our American Medical Association advocate for regulations to make the
31 cannabis industries pay for increasing costs of medical and social care for people affected
32 by the problems caused by marijuana similar to the regulations advocates for smoking
33 cessation in the United States (Directive to Take Action).
34

35 Your Reference Committee heard support for Resolution 2 with many members agreeing
36 that a model of financial assistance similar to what was established under the landmark
37 tobacco settlement of 1998 should be a goal for the healthcare industry. The Committee
38 wondered whether seeking such a goal through regulations, however, is the wisest move
39 and instead believed that expanding the directive to also include legislation and legal
40 action would better position the resolution going forward. Likewise, the Committee
41 believed expanding the scope of the resolution beyond marijuana and into all
42 cannabinoids would similarly be advantageous.
43

44 The Committee considered that one barrier to effective advocacy in this area is the lack
45 of solid, factual information to ground the assertions that increased access to
46 cannabinoids can be solidly linked to deleterious medical and social outcomes. The
47 Committee is aware that the recent announcements on the part of the Biden
48 administration to re-classify marijuana from a Schedule I drug to a Schedule III drug still
49 requires a long regulatory path that will presumably include some study, but that an

1 approach cannot be relied upon. The Committee believed that, absent other attempts,
2 the AMA could reasonably engage in such a study itself, thus giving it the information it
3 will need to authoritatively advocate for such broad financial settlements.

4
5 Your Reference Committee thus recommends that Resolution 2 be adopted as amended
6 and immediately forwarded for consideration by the House of Delegates at the 2024
7 Annual Meeting.

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9
10 (3) RESOLUTION 4 – SUPPORT BEFORE, DURING, AND
11 AFTER HOSPITAL CLOSURE OR REDUCTION IN
12 SERVICES

13
14 **RECOMMENDATION A:**

15
16 **The first resolve in Resolution 4 be deleted.**

17
18 ~~Resolved, that our American Medical Association work with~~
19 ~~state and federal legislators to enact laws and regulations~~
20 ~~that require for-profit healthcare entities be held to the same~~
21 ~~financial and quality of care reporting standards as not-for-~~
22 ~~profit entities and that should either indicate areas of~~
23 ~~concern, that the state be required to intervene (Directive to~~
24 ~~Take Action); and be it further~~

25
26 **RECOMMENDATION B:**

27
28 **The third resolve in Resolution 4 be deleted.**

29
30 ~~Resolved, that our AMA will work with appropriate~~
31 ~~stakeholders to study new models of oversight and~~
32 ~~healthcare planning that address such issues as:~~

- 33 ~~a) Mandatory concurrent, ongoing financial and quality~~
34 ~~reporting by healthcare organizations to an appropriate~~
35 ~~oversight entity to facilitate early identification of any~~
36 ~~hospital in financial distress;~~
37 ~~b) A process to intervene when such financial instability is~~
38 ~~detected;~~
39 ~~c) A process to ensure adequate funding to maintain the~~
40 ~~healthcare delivery system and to ensure access to~~
41 ~~healthcare for all individuals;~~

42 ~~(Directive to Take Action); and be it further~~

43
44 **RECOMMENDATION C:**

45
46 **Resolution 4 be adopted as amended.**

47

1
2
3 **RECOMMENDATION D:**

4
5 **Resolution 4 be immediately forwarded for**
6 **consideration at the 2024 Annual Meeting of the AMA**
7 **House of Delegates.**
8

9 Resolved, that our American Medical Association work with state and federal legislators
10 to enact laws and regulations that require for-profit healthcare entities be held to the same
11 financial and quality of care reporting standards as not-for-profit entities and that should
12 either indicate areas of concern, that the state be required to intervene (Directive to Take
13 Action); and be it further

14
15 Resolved, that our AMA will work with appropriate federal and state bodies to assure that
16 whenever there is a threatened, or actual, hospital closure a process be instituted to
17 safeguard the continuity of patient care and preserve the physician-patient relationship.
18 Such a process should:

19 a) Assure adequate capacity exists in the immediate service area surrounding the
20 hospital closure, including independent health resources, physicians, and support
21 personnel to provide for the citizens of that area;

22 b) Allow that in said circumstances, restrictive covenants, records access, and
23 financial barriers which prevent the movement of physicians and their patients to
24 surrounding hospitals should be waived for an appropriate period of time
25 (Directive to Take Action); and be it further

26
27 Resolved, that our AMA will work with appropriate stakeholders to study new models of
28 oversight and healthcare planning that address such issues as:

29 a) Mandatory concurrent, ongoing financial and quality reporting by healthcare
30 organizations to an appropriate oversight entity to facilitate early identification of any
31 hospital in financial distress;

32 b) A process to intervene when such financial instability is detected;

33 c) A process to ensure adequate funding to maintain the healthcare delivery
34 system and to ensure access to healthcare for all individuals (Directive to Take Action);
35 (Directive to Take Action); and be it further

36
37 Resolved, that our AMA will proactively offer support to physicians, residents and fellows,
38 patients, and civic leaders affected by threatened or actual healthcare facility closures or
39 significant reductions in services via provision of information, resources, and effective,
40 actionable advocacy (Directive to Take Action).

41
42 Your Reference Committee heard support for Resolution 4 and found itself generally
43 supportive as well. The Committee considered that the claims in the first resolve clause
44 around different standards of reporting for non-profit and for-profit organizations to be
45 slightly under-considered. The Committee did not believe it had a firm enough grasp on
46 what these differences are and as such felt reluctant to endorse a course of action that
47 could significantly affect how some hospitals and other care facilities are run. As such,
48 the Committee felt the clause could be eliminated without harming the larger goals of
49 Resolution 4, absent further information about the professed differences.
50

1 The Committee likewise gave significant discussion to the third resolve clause, generally
2 agreeing that a study of new models would likely be fruitful but concerned that such
3 studies would come at a prohibitive cost. The Committee noted no disagreement or
4 distaste for the clause, aside from financial concerns. It ultimately felt that removal of this
5 clause would help the other components of the resolution to pass.
6

7 Your Reference Committee thus recommends that Resolution 4 be adopted as amended
8 and immediately forwarded to the House of Delegates.
9

10
11 (4) RESOLUTION 5 – THE HAZARDS OF PRIOR
12 AUTHORIZATION

13
14 **RECOMMENDATION A:**

15
16 **The first resolve in Resolution 5 be amended by**
17 **addition and deletion to read as follows:**

18
19 Resolved, that our American Medical Association ~~believes~~
20 advocates that low-cost noninvasive procedures that meet
21 existing standard Medicare guidelines costing less than
22 \$100 should not require prior authorization (~~New HOD~~
23 Policy Directive to Take Action); and be it further
24

25 **RECOMMENDATION B:**

26
27 **The second resolve in Resolution 5 be deleted.**

28
29 ~~Resolved, that our AMA support that physicians who have~~
30 ~~been documented as “low utilizers” should be excluded from~~
31 ~~prior authorization for at least three years (New HOD~~
32 ~~Policy); and be it further~~
33

34 **RECOMMENDATION C:**

35
36 **The fourth resolve in Resolution 5 be amended by**
37 **deletion to read as follows:**

38
39 Resolved, that our AMA support that patients be allowed to
40 sue insurance carriers which preclude any and all clauses
41 in signed contracts should there be an adverse outcome as
42 a result of an inordinate delay ~~of more than one week~~ in care
43 (New HOD Policy).
44

45 **RECOMMENDATION D:**

46
47 **Resolution 5 be adopted as amended.**
48

1 **RECOMMENDATION E:**

2
3 **Resolution 5 be immediately forwarded for**
4 **consideration at the 2024 Annual Meeting of the AMA**
5 **House of Delegates.**
6

7 Resolved, that our American Medical Association believes that low-cost noninvasive
8 procedures costing less than \$100 should not require prior authorization (New HOD
9 Policy); and be it further

10
11 Resolved, that our AMA support that physicians who have been documented as “low
12 utilizers” should be excluded from prior authorization for at least three years (New HOD
13 Policy); and be it further

14
15 Resolved, that our AMA support that physicians be allowed to bill insurance companies
16 for all full time employee hours required to obtain prior authorization (New HOD Policy);
17 and be it further

18
19 Resolved, that our AMA support that patients be allowed to sue insurance carriers which
20 preclude any and all clauses in signed contracts should there be an adverse outcome as
21 a result of an inordinate delay of more than one week in care (New HOD Policy).
22

23 Your Reference Committee heard support for Resolution 5 with some suggestions for
24 amendments to improve it and reduce the opportunities for it to considered for
25 reaffirmation. The Committee also agreed with some technical suggestions, such as
26 removing the dollar amount in the first resolve clause and the one-week timeframe in the
27 fourth; the sense of the Committee was that reworking those components would improve
28 the resolution’s longevity. Both testifiers and the Committee also questioned the use of
29 the term “low utilizers,” finding the term unclear based on the rest of the resolution. It
30 also wondered if the logic behind physicians that are not heavy users of prior
31 authorizations being the least impactful wasn’t potentially incorrect—it could also be true
32 that physicians that are highly skilled and practiced with prior authorization could be
33 more effective at cost containment, and thus better trusted.
34

35 Considering the support from the Online Forum, your Reference Committee
36 recommends that Resolution 5 be adopted as amended and immediately forwarded to
37 the House of Delegates.
38

39
40 (5) **RESOLUTION 10 – MENTORSHIP TO COMBAT PRIOR**
41 **AUTHORIZATION**

42
43 **RECOMMENDATION A:**

44
45 **The first resolve in Resolution 10 be amended by**
46 **addition and deletion to read as follows:**
47

48 Resolved, that our American Medical Association study the
49 development of a template for a mentorship program for

1 early career physicians as a means to reduce excessive
2 healthcare costs as well as improve physician practice
3 sustainability and wellbeing, with a report back by Annual
4 2025 (Directive to Take Action); ~~and be it further~~

5
6 **RECOMMENDATION B:**

7
8 **The second resolve in Resolution 10 be deleted.**

9
10 ~~Resolved, that our AMA develop modules of education~~
11 ~~centered on the economics of utilization of testing,~~
12 ~~pharmaceuticals, and procedures in various categories of~~
13 ~~common and exceptional medical care (Directive to Take~~
14 ~~Action); and be it further~~

15
16 **RECOMMENDATION C:**

17
18 **The third resolve in Resolution 10 be deleted.**

19
20 ~~Resolved, that our AMA work with affected stakeholders,~~
21 ~~including government legislators and regulators,~~
22 ~~pharmaceutical and business interests, healthcare systems,~~
23 ~~and patient representatives as well as physicians on~~
24 ~~substitution of mentorship for frequent prior authorization~~
25 ~~requests (Directive to Take Action); and be it further~~

26
27 **RECOMMENDATION D:**

28
29 **Resolution 10 be adopted as amended with a change in**
30 **title to read:**

31
32 **STUDYING A MENTORSHIP PROGRAM**

33
34 **RECOMMENDATION E:**

35
36 **Resolution 10 be immediately forwarded for**
37 **consideration at the 2024 Annual Meeting of the AMA**
38 **House of Delegates.**

39
40 Resolved, that our American Medical Association study the development of a template for
41 a mentorship program for early career physicians as a means to reduce excessive
42 healthcare costs with a report back by Annual 2025 (Directive to Take Action); and be it
43 further

44
45 Resolved, that our AMA develop modules of education centered on the economics of
46 utilization of testing, pharmaceuticals, and procedures in various categories of common
47 and exceptional medical care (Directive to Take Action); and be it further

48
49 Resolved, that our AMA work with affected stakeholders, including government legislators
50 and regulators, pharmaceutical and business interests, healthcare systems, and patient

1 representatives as well as physicians on substitution of mentorship for frequent prior
2 authorization requests (Directive to Take Action).

3
4 Your Reference Committee heard mixed testimony on Resolution 10 with many
5 members in support of continued efforts to promote mentorship opportunities between
6 young physicians and more established ones, but several also noting that new
7 mentorship programs could be prohibitively costly and that the structure of these
8 programs could perhaps be more effective if they were directed at payors instead of
9 legislators or regulators. This final point was particularly present for the Committee,
10 which found the fourth resolve clause to be unclear.

11
12 The Committee considered that the AMA in general and other sections like the Young
13 Physicians Section (YPS) and the Resident and Fellows Section (RFS) already have
14 mentorship programs in place and that one of the perennial concerns for those programs
15 isn't the lack of programming but rather the rates of attrition as members move from RFS
16 to YPS and then again from YPS to the House of Delegates itself.

17
18 Finally, the Committee agreed that as written the resolution is likely to yield a high fiscal
19 note and that the financial burden may prove a barrier to enactment. The Committee
20 believed striking the second and third resolve clauses and placing the focus on the call
21 for a study in the first resolve clause could mitigate this possibility. The Committee thus
22 recommends that Resolution 10 be adopted as amended and immediately advanced to
23 the House of Delegates for the 2024 Annual Meeting.

RECOMMENDED FOR ADOPTION IN LIEU OF

(6) RESOLUTION 3 – AUGMENTED INTELLIGENCE AND ORGANIZED MEDICAL STAFF

RECOMMENDATION A:

That Alternate Resolution 3 be adopted in lieu of Resolution 3:

AUGMENTED INTELLIGENCE AND ORGANIZED MEDICAL STAFF

Resolved, That our American Medical Association modify policy H-225.957, “Principles for Strengthening the Physician-Hospital Relationship,” by addition:

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, protection from interruption of delivery of care, and working continuously to improve patient care and health outcomes—including but not limited to the development, selection, and implementation of augmented intelligence—with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.

(Modify Current HOD Policy); and be it further

Resolved, that our AMA recognizes that organized medical staff should be an integral part at the outset of choosing, developing, and implementing augmented intelligence and digital health tools in hospital care. That consideration is consistent with organized medical staffs’ primacy in overseeing safety of patient care, as well as assessing other negative unintended consequences such as interruption of, or overburdening, the physician in delivery of care (New HOD Policy).

RECOMMENDATION B:

Alternate Resolution 3 be immediately forwarded for consideration at the 2024 Annual Meeting of the AMA House of Delegates.

1 Resolved, that our American Medical Association recognizes as leaders in hospital
2 medicine, organized medical staff have a duty of protecting safety within their institutions
3 and have a unique opportunity to ensure that the evolution of augmented intelligence in
4 hospitals benefits medical care without unintended consequences for patients and
5 physicians (New HOD Policy); and be it further
6

7 Resolved, that our AMA recognizes as physicians, physicians have a duty of protecting
8 safety within their institutions and organizations and have a unique opportunity to ensure
9 that the evolution of augmented intelligence in medical practices benefits medical care
10 without unintended consequences for patients and physicians (New HOD Policy).
11

12 Your Reference Committee heard near universally strong support for Resolution 3 on the
13 Online Forum. The only notable disagreement the Committee considered was that the
14 resolve clauses could potentially be strengthened by adopting a different approach to
15 codifying the centrality and primacy of the medical staff as protectors of patient safety
16 and quality of care delivered. The Committee heard proposed alternate language and
17 ultimately believed that the most fruitful approach to achieve the desired outcome would
18 be to modify the AMA's existing policy on physician-hospital relationships to specifically
19 call in the use of augmented intelligence coupled with new policy that outlines even more
20 specifically the role of the organized medical staff in oversight of patient care.
21

22 Because the change of approach effectively would eliminate Resolution 3's original
23 language, the Committee thus recommends that Alternate Resolution 3 be adopted in
24 lieu of Resolution 3 and be immediately forwarded to the House of Delegates for
25 consideration.

RECOMMENDED FOR REFERRAL

(7) RESOLUTION 7 – THE ROLE OF CONTRACTED
PHYSICIANS ON THE MEDICAL EXECUTIVE
COMMITTEE

RECOMMENDATION:

Resolution 7 be referred.

Resolved, That our American Medical Association encourage that hospital medical staff bylaws require that all physicians who run for medical staff elected offices must submit a disclosure statement that clearly identifies any potential conflicts of interest between duties as a contracted physician for the hospital and those of an elected medical staff officer (Directive to Take Action); and be it further

Resolved, that our AMA encourage that hospital medical staff bylaws require that physicians seeking to run for medical staff elected office must disclose their paid contractual relationship with the hospital during the campaign period and well in advance of an election with the conflict disclosed on the ballot itself (Directive to Take Action); and be it further

Resolved, that our AMA encourage that hospital medical staff bylaws require that any physician on the medical executive committee (MEC) must recuse if there is a conflict of interest involving another medical staff during any discussions of privileges or any other matter pertaining to the physician under scrutiny by the MEC (Directive to Take Action); and be it further

Resolved, that our AMA encourage that hospital medical staff bylaws require that the contracted physician be afforded the same rights to continue on medical executive committee (MEC) leadership as any other member of the MEC even if the contract with the hospital is cancelled or terminated as long as the physician remains in good standing on the active medical staff (Directive to Take Action); and be it further

Resolved, that this resolution be incorporated into the AMA Medical Staff Bylaws (Directive to Take Action).

Your Reference Committee heard testimony supporting Resolution 7 but with the concern that several components may fall under reaffirmation at the House of Delegates. Testifiers generally agreed that several of the provisions called for in the resolution either already exist under current AMA policy or, in the case of inclusion in the AMA Medical Staff Bylaws, have already been incorporated. Nevertheless, the general sentiment was one of support for ensuring that disclosures and conflicts of interest be treated seriously and enshrined in standard operating procedures for medical staffs.

The Committee agreed with the issues raised by testifiers. It additionally considered that while the Organized Medical Staff Section and the AMA as a whole had given consideration to the protections and obligations placed on a medical staff leader after the termination of a contract, the issue may still need further consideration. The Committee

1 appreciated the dedication to protection of rights and privileges for individual physicians,
2 however it recognized that most contracts and bylaws already call for co-termination of
3 privileges once a contract with a facility is lost.

4
5 Because some provisions in Resolution 7 are likely already addressed while others
6 require a deeper look, and because the expertise for answering such questions is far
7 more likely to lie within the organized medical staff experts as opposed to the HOD as a
8 whole, the Committee recommends that Resolution 7 be referred to the Organized
9 Medical Staff Section Governing Council for a report back to the section at a time to be
10 determined.

RECOMMENDED FOR NOT ADOPTION

(8) RESOLUTION 1 – THE AMA WILL ACTIVELY PURSUE UNIONIZATION/COLLECTIVE BARGAINING TO PROTECT PATIENTS’ QUALITY OF CARE AND MEDICAL STAFF

RECOMMENDATION:

Resolution 1 be not adopted.

Resolved, that our American Medical Association will urgently study the issues involved with unionization and/or collective bargaining and make it a reality as soon as possible before serious irreversible harm is done to physicians’ practices and well-being and patients’ quality of care (Directive to Take Action).

Your Reference Committee heard testimony supporting the intent of Resolution 1, but questioning if the resolution was needed at this time. Testifiers noted the Organized Medical Staff Section has advanced resolutions to the House of Delegates in the past with similar requests as Resolution 1 with the result being the creation of AMA policy (H-405.946) supporting efforts to strengthen medical staff specifically through collective bargaining and/or unionization. The AMA Counsel on Ethical & Judicial Affairs is also currently drafting a report, due at Interim 2024, that will speak to support for collective action on the part of physicians. Additionally, at least two resolutions supporting unionization and/or collective bargaining have already been introduced to the House of Delegates for consideration at the 2024 Annual Meeting.

Given that there is already existing policy on the subject, an active report in development due to be released yet this year, and two other resolutions already accepted by the House of Delegates for consideration, the Committee recommends that the OMSS avoid any duplicative action and that Resolution 1 be not adopted and that the OMSS Delegate and Alternate Delegate instead offer strong support to the items of business already before the House, with a particular emphasis on the need for timely support.

(9) RESOLUTION 6 – CONTINUITY OF CARE IN THE HOSPITAL

RECOMMENDATION:

Resolution 6 be not adopted.

Resolved, that our American Medical Association advocate that all Accreditation Council for Graduate Medical Education (ACGME) programs return to a model of continued care of the patient by the admitting intern or resident with shifts to be as long as 12 hours with night call coverage by a colleague intern or resident and night call covered on a every third or fourth night basis (Directive to Take Action); and be it further

1 Resolved, that our AMA support that a resident who is on night call can sign out early after
2 seeing patients in the morning and an intern can come in the next day one hour later so
3 as to get proper rest, thus allowing continuing care of the patient from the day of admit to
4 the day of discharge (Directive to Take Action).

5
6 Your Reference Committee heard testimony that was largely unsupportive of Resolution
7 6, although many also stated they sympathized with the intent of it. Testifiers generally
8 said they did not believe that the provisions offered in the resolution could realistically be
9 achieved, both because the models in place for residents are already too engrained and
10 because, in some cases, a return to a continued care model as described by Resolution
11 6 was not one they could see working within their own healthcare facility or system. The
12 Committee agreed that finding ways to ensure that a resident has a full understanding of
13 a patient's condition(s) is a challenge, however Committee members were doubtful that
14 the methods outlined in the resolution would alleviate such concerns.

15
16 Given the lack of support in testimony and the Committee's own reservations, the
17 Committee recommends that Resolution 6 be not adopted.

18
19
20 (10) RESOLUTION 9 – MORE STRINGENT MEASURES TO
21 MINIMIZE INJURIES AS A RESULT OF THE
22 WIDESPREAD USE OF E-SCOOTERS

23
24 **RECOMMENDATION:**

25
26 **Resolution 9 be not adopted.**

27
28 Resolved, that our American Medical Association advocate for more education to teach
29 the public about the safety of e-scooters (Directive to Take Action); and be it further

30
31 Resolved, that our AMA s advocate for more stringent measures to safeguard e-scooter
32 use, such as required training, required helmet use, and required bike lane use (Directive
33 to Take Action).

34
35 Your Reference Committee heard testimony that was supportive of Resolution 9,
36 although some questioned if it was appropriate for the Organized Medical Staff Section
37 given the subject's tenuous connection to medical staff issues. The Committee
38 considered that the AMA already has existing policy addressing the need to better inform
39 and protect patients from injury due to non-motorized vehicles, including bicycles and
40 scooters. After reviewing the existing policy, the Committee found itself conceptually in
41 support of Resolution 9, but believing that it did not present enough new policy or action
42 to avoid a likely placement on the House of Delegates' reaffirmation calendar. The
43 Committee would appreciate hearing more from the author or other interested parties
44 offering suggestions for what kind of improved measures should be taken and how they
45 are likely to reduce the risk of injuries that are unique or otherwise particularly
46 associated with e-scooters. Absent these perspectives, the Committee thus
47 recommends that Resolution 9 be not adopted.

- 1 Doctor Chair, this concludes the report of the Organized Medical Staff Section Reference
- 2 Committee. I would like to thank Dr. Heather Smith and Dr. Martin Trichtinger as well as
- 3 all those who testified before the Committee.

Christopher Gribbin, MD
Chair, OMSS Reference Committee

Heather Smith, MD

Martin Trichtinger, MD