HEALTH AND ETHICS POLICIES OF THE AMA HOUSE OF DELEGATES

H-5.000 Abortion
(See also: Contraception; Pregnancy)

H-5.982 Late-Term Pregnancy Termination Techniques

(1) The term 'partial birth abortion' is not a medical term. The AMA will use the term "intact dilatation and extraction"(or intact D&X) to refer to a specific procedure comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental or manual conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester. Because 'partial birth abortion' is not a medical term it will not be used by the AMA.

(2) According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.

(3) The viability of the fetus and the time when viability is achieved may vary with each pregnancy. In the second-trimester when viability may be in question, it is the physician who should determine the viability of a specific fetus, using the latest available diagnostic technology.

(4) In recognition of the constitutional principles regarding the right to an abortion articulated by the Supreme Court in Roe v. Wade, and in keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery. (BOT Rep. 26, A-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07)

H-5.983 Pregnancy Termination

The AMA adopted the position that pregnancy termination be performed only by appropriately trained physicians (MD or DO); and encourages any specialty society which has adopted a contrary position to review and modify its position to comply with that of the AMA. (Res. 520, A-95; Reaffirmed: CSA Rep. 8, A-03)

H-5.985 Fetal Tissue Research

The AMA reaffirms its position in support of the use of fetal tissue obtained from induced abortion for scientific research. (Res. 540, A-92; Reaffirmed: CSA Rep. 8, A-03)

H-5.988 Accurate Reporting on AMA Abortion Policy

Our AMA HOD cautions members of the Board of Trustees, Councils, employees and members of the House of Delegates to precisely state current AMA policy on abortion and related issues in an effort to minimize public misperception of AMA policy and urges that our AMA continue efforts to refute misstatements and misquotes by the media with reference to AMA abortion policy. (Sub. Res. 21, A-91; Reaffirmed: Sunset Report, I-01)

H-5.989 Freedom of Communication Between Physicians and Patients

It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient;

(2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship;

(3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and

(4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians

and their patients. (Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07)

H-5.990 Policy on Abortion

The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures. (Res. 158, A-90; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-5.991 RU-486 Availability

The AMA supports the legal availability of mifepristone (RU-486) for appropriate research and, if indicated, clinical practice. (Res. 100, A-90; Amended: Res. 507, A-99)

H-5.992 Fetal Tissue Transplantation Research

Our AMA (1) supports continued research employing fetal tissue obtained from induced abortion, including investigation of therapeutic transplantation; and (2) demands that adequate safeguards be taken to isolate decisions regarding abortion from subsequent use of fetal tissue, including the anonymity of the donor, free and non-coerced donation of tissue, and the absence of financial inducement. (Res. 170, I-89; Reaffirmed by Res. 91, A-90; Modified: Sunset Report, I-00)

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-5.994 Use of Fetal Tissue for Legitimate Scientific Research

The AMA supports (1) the concept of the use of fetal tissue for legitimate scientific research, including transplantation; and (2) continued federal funding for such research. (Res. 26, I-88; Reaffirmed: Res. 91, A-90; Reaffirmed: Sunset Report, I-00)

H-5.995 Abortion

Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of 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. (Sub. Res. 43, A-73; Reaffirmed: I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CMS Rep. 1, I-00)

H-5.997 Violence Against Medical Facilities and Health Care Practitioners and Their Families

The AMA supports the right of access to medical care and opposes (1) violence and all acts of intimidation directed against physicians and other health care providers and their families and (2) violence directed against medical facilities, including abortion clinics and family planning centers, as an infringement of the individual's right of access to the services of such centers. (Res. 82, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Res. 422, A-95; Reaffirmation I-99)

H-5.998 Public Funding of Abortion Services

The AMA reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population. (Sub. Res. 89, I-83; Reaffirmed: CLRPD Rep. 1, I-93 Reaffirmed: BOT Rep. 12, A-05)

H-10.000 Accident Prevention/Unintentional Injuries
(See also: Accident Prevention: Motor Vehicles; Firearms: Safety and Regulation; Sports and Physical Fitness)

H-10.966 Prevention of Fires Related to Cigarette Smoking

The AMA (1) supports studies to determine the feasibility and practicality of establishing a standard for self-extinguishing cigarettes and requiring cigarette manufacturers to meet that standard; (2) supports the concept of self-extinguishing cigarettes for the purpose of reducing fire related deaths, injuries and loss of property; and (3) reiterates its opposition to all smoking. (Sub. Res. 6, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

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)

H-10.968 Public Health Impact On Railroads

Our AMA urges the Department of Transportation to work with other appropriate federal agencies and medical specialty societies to study the impact of railroad traffic as it pertains to emergency access to hospitals and emergency evacuations in the case of hazardous material contamination. (Res. 417, I-99)

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)

H-10.970 Use of Protective Eyewear by Athletes

Our AMA supports the use of protective eyewear for sports participants who have had intraocular surgery or eye trauma, or are functionally one-eyed individuals, and for all other sports participants engaged in high-risk eye injury sports, as advocated by the American Academy of Pediatrics and the American Academy of Ophthalmology. (Res. 404, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-10.972 Blocked Fire Exits

AMA policy is that fire exits remain unlocked at all meetings of Federation members. The AMA will issue a statement that physicians should make certain that the observable fire exits are unlocked at any public gathering which they attend. (Res. 428, A-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-10.973 Helmets for Recreational Skiing and Other Winter Sports in Children and Adolescents

The AMA supports the voluntary use of helmets and protective headgear for children and adolescents during recreational skiing and snowboarding. As of September 1997, there is insufficient scientific evidence to support a policy of mandatory helmet use. The AMA encourages further research into the epidemiology and outcome of head injuries to children and adolescents from recreational skiing and snowboarding and research on the development of helmets to prevent or reduce the severity of these injuries. The AMA encourages the American Society for Testing and Materials to finalize standards for ski helmets and study the effectiveness of ski helmets in preventing serious brain trauma. (CSA Rep. 1, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-10.974 Assurance of the Public's Health Aboard Cruise Ships

The AMA, through federal legislation or international treaty as appropriate, urge the development of standards for the provision of

medical care, including emergency medical care, for passengers aboard cruise ships entering or leaving United States ports. (Res. 429, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

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)

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-10.980 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)

H-10.981 Prohibition on the Public Sale of Fireworks

Our AMA (1) encourages accurate reporting of fireworks related injuries, deaths, and fires;

(2) supports all efforts designed to prohibit the public sale, including those by mail order, of all fireworks;

(3) will work with appropriate medical and related organizations and national government agencies to achieve prohibition on the public sale of fireworks;

(4) supports existing efforts to educate physicians, parents, children, and community leaders about the dangers of fireworks; and

(5) encourages the adoption of federal legislation prohibiting the sale of fireworks and their use, with the exception of those used for professional displays. (Res. 419, A-92; Reaffirmed: CSA Rep. 8, A-03)

H-10.982 Injury Prevention

Our AMA (1) supports the CDC's efforts to (a) conduct research, (b) develop a national program of surveillance and focused interventions to prevent injuries, and (c) evaluate the effectiveness of interventions, implementation strategies, and injury prevention programs;

(2) supports a Public Health Service public information campaign to inform the public and its policymakers of the injury problem and the potential for effective intervention;

(3) supports the development of a National Center for Injury Control at the CDC; and

(4) encourages state and local medical societies to support, in conjunction with state and local health departments, efforts to make injury control a priority, and advise the leadership of the United States Congress of this unqualified support; and the AMA remains open to working with all interested parties in efforts to deal with and lessen the effects of violence in our society. (Res. 410, A-92; Reaffirmed by BOT Rep. 19 - I-94; Reaffirmed by BOT Rep. 34, A-95; Modified and Reaffirmed by BOT Rep. 52, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-10.983 Swimming Safety

Our AMA (1) strongly supports barrier fencing and pool covers for residential pools, early water safety, and water awareness programs and (2) encourages swimming pool manufacturers and pool chemical suppliers to distribute educational materials that promote swimming and water safety. (Res. 72, A-91; Reaffirmed: Sunset Report, I-01)

H-10.984 Farm-Related Injuries

Our AMA (1) emphasizes the need for more complete data on farm-related and other types of traumatic and occupational injuries;

(2) reaffirms its support of regional medical facilities and programs having well-trained medical personnel and emergency care facilities capable of responding effectively to farm-related and other types of injuries. Physicians in rural areas should assume leadership roles in developing these facilities;

(3) advises manufacturers to improve machinery and farm implements so they are less likely to injure operators and others. Safety instructions should accompany each sale of a machine such as a power auger or tractor. Hazard warnings should be part of each power implement;

(4) encourages parents, teachers, physicians, agricultural extension agencies, voluntary farm groups, manufacturers, and other sectors of society to inform children and others about the risks of agricultural injuries and about approaches to their prevention;

(5) endorses the concept of making injury surveillance and prevention programs ongoing activities of state and local departments of public health; and

(6) encourages the inclusion of farm-related injury issues as part of the training program for medical students and residents involved in a rural health experience. (BOT Rep. U, A-91; Reaffirmed: Sunset Report, I-01)

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-10.986 Use of Non-Toxic Aversive Additives

The AMA (1) in conjunction with other professional organizations, encourages individual manufacturers to consider adding non-toxic aversive products to either existent or newly introduced formulations when such have been deemed as having significant toxic potentials in order to provide safety in poison prevention; (2) believes that such actions should be publicized as intended to augment, but in no way replace, other poison prevention programs such as child-resistant containers, appropriate packaging and labeling, parental education, etc; and (3) supports continuing efforts by the household products and drug industries to identify methods of reducing the incidence of accidental poisonings.. (Sub. Res. 119, I-89; Modified by Sub. Res. 505, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-10.987 Use of Helmets in Bicycle Safety

Our AMA (1) supports appropriate efforts to educate parents and children about bicycle safety, including the use of bicycle helmets, and (2) supports working with the American Academy of Pediatrics and other appropriate organizations to ensure widespread distribution of information and educational materials about bicycle safety, including the use of bicycle helmets, to both medical and non-medical audiences. (Sub. Res. 72, I-89; Reaffirmed: Sunset Report, A-00)

H-10.988 Water Craft Safety

The AMA supports state legislation providing for adequate education in the careful operation of water craft; and advocates the wearing of personal flotation devices by all children participating in recreational boating. (Res. 2, I-89; Modified by Res. 426, I-95; Reaffirmed and Modified: CLRPD Rep. 1, A-05)

H-10.989 Better Fire Prevention in Public Buildings

The AMA urges state public authorities to consider enactment of uniform fire protection codes in public buildings, for the risks such furnishings hold for the emission of toxic gases as well as intense heat, and at least in the case of new construction, the introduction of expanded sprinkler systems and fully automatic smoke detectors. (Res. 32, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

H-10.990 Fluorescent Markings on Train Cars

The AMA supports legislation or regulation requiring train cars to be marked with fluorescent paint. (Res. 157, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-10.991 Preventing Death and Disability from Fires by the New-Rapid Response Automatic Sprinklers and Smoke Detectors

Our AMA supports (1) cooperation in public education campaigns of federal and local governments and professional fire organizations to promote fire prevention and fire safety;

(2) legislation that will require smoke detectors and will encourage rapid-response automatic sprinklers in all new residential and commercial buildings;

(3) legislation that will require smoke detectors and rapid-response automatic sprinklers in all existing high-rise buildings (i.e., buildings with six or more stories or with occupiable floors more than 75 feet above the lowest level of fire department vehicle access);

(4) granting of appropriate monetary concessions to property owners by federal, state, and local taxing bodies, and insurance carriers as inducements to outfit new and existing structures with automatic fire detection and suppression systems;

(5) development and marketing of fire detection and suppression equipment products that are increasingly effective and less costly and more affordable to an even greater share of the U.S. population; and

(6) cooperation between medical associations and local government officials to achieve the above objectives. (CSA Rep. G, A-86; Reaffirmed: Sub. Res. 219, I-91; Reaffirmed: Sunset Report, I-01)

H-10.992 Preventing Tap Water Scald Burns

The AMA supports requiring that new residential water heaters have a pre-set thermostat setting of 120 degrees Fahrenheit. (Res. 95, A-84; Reaffirmed: A-89; Reaffirmed by CLRPD Rep. 3, I-94; Reaffirmed: CSA Rep. 6, A-04)

H-10.994 Maximum Temperature in Water Heaters

The AMA endorses the development of educational programs describing the dangers of excessively heated water. (Sub. Res. 36, I-82; Reaffirmed: Res. 95, A-84; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-10.995 Use of Technology to Prevent Explosions

The AMA (1) endorses the use of available technology to reduce the number of volatile liquid and gas container explosions which occur and, thereby, reduce the amount of pain and suffering due to burns caused by these explosions and (2) encourages manufacturers of automobiles, boats, and other vehicles, as well as makers of containers of volatile liquids and gases, to incorporate appropriate safety technology into the development of their products. (Res. 59, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep.

8, A-03)

H-10.996 Playground Equipment Labeling

The AMA commends the Consumer Product Safety Commission for the intense and detailed attention given to the study of playground injuries and offers its assistance in further educating the public to the relative hazard of injury when paved surfaces are beneath such playground equipment as slides, swings, and climbers. (BOT Rep. T, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-10.997 Medical Profession Endorsement of Flame Resistant Apparel Not Mandated by Present Law

Our AMA (1) commends the textile, garment and retail industries for their concern about the safety of the American people in voluntarily extending the manufacture, sale, labeling, and promotion of resistant garments or fabric not mandated by law; and (2) encourages the textile and garment industries to expand the development and production of flame-resistant and flame-retardant fabrics for use in clothing for all ages, bedding, draperies, and decorative fabrics and supports AMA staff involvement in public education programs with government and industry on the importance of using flame-resistant materials in order to reduce the hazard of burn injuries. (Res. 1, A-75; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-10.998 Impact-Resistant Lens

Our AMA recommends that physicians providing eye care which involves spectacles of any kind, including sunglasses, should continue to prescribe impact-resistant lenses whenever this is medically feasible. (BOT Rep. Y, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-15.000 Accident Prevention: Motor Vehicles
(See also: Accident Prevention)

H-15.952 Texting While Driving: Preventing Disaster

Our AMA encourages physicians to educate their patients regarding the public health risks of text messaging while operating motor vehicles or machinery and will advocate for state legislation prohibiting the use of hand held communication devices to text message while operating motor vehicles or machinery. (Res. 217, I-08)

H-15.953 Guidance for Installation and Use of Car Seats

Our AMA favors the development and distribution of more simplified and readily usable manuals for the proper installation and utilization of effective child and infant car seats. (Res. 408, A-04)

H-15.954 Older Driver Safety

(1) Our AMA recognizes that the safety of older drivers is a growing public health concern that is best addressed through multi-sector efforts to optimize vehicle design, the driving environment, and the individual's driving capabilities, and:
(a) believes that because physicians play an essential role in helping patients slow their rate of functional decline, physicians should increase their awareness of the medical conditions, medications, and functional deficits that may impair an individual's driving performance, and counsel and manage their patients accordingly;
(b) encourages physicians to familiarize themselves with driver assessment and rehabilitation options, refer their patients to such programs whenever appropriate, and defer recommendations on permanent driving cessation until establishing that a patient's driving safety cannot be maintained through medical interventions or driver rehabilitation;
(c) urges physicians to know and adhere to their state's reporting statutes for medically at-risk drivers; and
(d) encourages continued scientific investigation into strategies for the assessment and management of driving safety in the clinical setting.

(2) Our AMA encourages physicians to use the Physician's Guide to Assessing and Counseling Older Drivers as an educational tool to assist them in helping their patients. (CSA Rep. 6, A-03)

H-15.955 Restrictions on New Adolescent Drivers - Development of Model State Legislation on Graduated Driving Laws

Our AMA, recognizing the developmental driving issues that continue to threaten the lives of adolescents, will strengthen our model state legislation on graduated driver's licenses to: (1) require adolescents to obtain a provisional driving license (separate from a learner's permit); (2) require experienced adult supervision for adolescent drivers during the provisional driving period; and (3) limit the number of passengers in vehicles driven by adolescents during the provisional driving period. (Res. 408, A-99)

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-15.957 Flooding

The AMA encourages automobile manufacturers to address concerns about entrapment in automobiles caused by electrical failure due to fire, water damage, accident or other causes, particularly as such failure may make electric windows or door locks inoperable. (Sub. Res. 414, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-15.958 Fatigue, Sleep Disorders, and Motor Vehicle Crashes

Our AMA: (1) defines sleepiness behind the wheel as a major public health issue and encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups;
(2) recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions.
(3) recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep.
(4) encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness-testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment.
(5) urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology.
(6) recommends that physicians: (a) become knowledgeable about the diagnosis and management of sleep-related disorders; (b) investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories; (c) inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries; (d) advise patients about possible medication-related effects that may impair their ability to safely operate a motor vehicle or other machinery; (e) inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries; and (f) become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice.
(7) encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state.
(8) recommends that guidelines be developed for the licensing of commercial and private drivers with sleep-related and other medical disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries.
(9) reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries. (CSA Rep. 1, A-96; Appended: Res. 418, I-99)

H-15.960 Motor Vehicle and Bicycle Safety

The AMA supports legislation that would make safety belt non-use by any occupants in automobiles and other enclosed motor vehicles a "primary offense" in all states; supports extension of motorcycle helmet laws to include motorized vehicles such as mopeds, scooters and all-terrain vehicles, and to cover all age groups; and supports legislation that would require helmet usage for riders of bicycles, including passengers. (Res. 226, A-95; Reaffirmed: BOT Rep. 12, A-05)

H-15.961 Safety for Passengers in the Back of Pickup Trucks

The AMA supports legislation that would prohibit passengers from riding in the cargo bed of a pickup truck. (Res. 409, I-93; Reaffirmed: BOT Rep. 28, A-03)

H-15.962 Air Bags and Preventing Crash Injuries

Our AMA (1) encourages the U.S. Department of Transportation to expand efforts to determine the efficacy of air bags in preventing serious injuries and the efficacy and safety of the air bag combined with the lap-shoulder belt in preventing such injuries;

(2) urges the U.S. Department of Transportation to convene a national medical and scientific committee including physicians from outside of federal agencies and nonphysician members to advise the U.S. Department of Transportation on the collection and evaluation of vehicle-related injury data, including that related to air bags and their efficacy;

(3) encourages motor vehicle manufacturers to continue efforts to improve the safety of vehicles, focusing especially on active and passive restraints and strengthening passenger compartments; and

(4) encourages physicians to take an active role in encouraging the use of automobile active and passive restraints among the general public, including infants and children. (BOT Rep. H, I-92; Reaffirmation I-01)

H-15.963 Daytime Visible Headlights

The AMA (1) supports and encourages the voluntary use of headlights during daytime driving by all U.S. citizens; and (2) will seek federal legislation requiring all new vehicles sold in the United States to have daytime running lights as standard equipment. (Res. 416, A-92; Modified: Res. 427, A-03; Reaffirmed: CSA Rep. 8, A-03)

H-15.964 Police Chases and Chase-Related Injuries

The AMA encourages (1) the conduct of well-planned research projects to provide more precise information on the frequency and severity of injuries associated with the use of police and other emergency vehicles; (2) communities, aided by government officials and medical scientists, to develop guidelines on the use of police vehicles that indicate when, how, and how long pursuits should be carried out and to address other key aspects of police pursuit; and (3) responsible government agencies to develop, test, and use instruments and techniques with advanced technologies, for example, coding and tracking devices, to discourage, eliminate, or replace high-speed chases. (CSA Rep. C, A-92; Reaffirmed: CSA Rep. 8, A-03)

H-15.966 Preventing Underride Motor Vehicle Crash Injury

The AMA supports a federal action, regulatory or legislative as appropriate, that would require rear and side impact guards on all new tractor trailers. (Res. 426, A-92; Reaffirmed: BOT Rep. 28, A-03)

H-15.967 Injuries Resulting from Pickup Trucks

Our AMA supports the development of model state legislation prohibiting any person from riding in the back of a pickup truck without the use of appropriate restraint devices and protection when the pickup truck is traveling on public roads. (Sub. Res. 15, A-91; Reaffirmed: Sunset Report, I-01)

H-15.968 School Bus Safety and Braking and Steering Systems

Our AMA encourages (1) manufacturers of school buses to exceed the braking and steering system requirements of the U.S. Department of Transportation, making these systems as safe and easy to use as possible; (2) school bus manufacturers and federal agencies to continue their efforts to improve the safety of school buses and of school bus transportation programs, including driver education programs; and (3) physicians with an interest in children's problems, primary and secondary school education programs, or public health to evaluate pupil transportation systems in their own communities. (BOT Rep. N, A-91; Modified: Sunset Report, I-01)

H-15.969 Side-Impact Standard

Our AMA (1) encourages the U.S. Department of Transportation to study the feasibility of mandating softer, more forgiving padding at the sides and in the interiors of motor vehicles to mitigate injuries in crashes, and (2) encourages motor vehicle manufacturers and the U.S. Department of Transportation to continue studies on identifying better ways of protecting occupants of cars in side, side-front, side-rear, and other types of crashes. (BOT Rep. AA, A-91; Reaffirmed: Sunset Report, I-01)

H-15.970 Trucks and Highway Safety

The AMA (1) reaffirms its recommendation in Report I (I-82) to establish a reduction in highway injuries and deaths as a national goal; special attention should be given to this goal by the governmental, business, engineering, legal, and medical sectors;
(2) urges vehicle manufacturers to improve the safety of trucks and truck cabs, placing emphasis on antiskid braking systems, steering, tires and restraint systems for drivers;
(3) encourages adoption of strict standards on drug and alcohol use, similar to those for locomotive engineers, for truck drivers; and
(4) encourages regulators and truck fleet supervisors to give greater attention to drivers' performances and crash records, and to remove drivers with poor records from the highway. (BOT Rep. KK, I-90; Reaffirmed: Sunset Report, I-00)

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)

H-15.972 Licensing People to Drive

It is the policy of the AMA (1) to encourage research into the many components and activities of the driving task and into the development of more accurate testing devices;
(2) that physicians continue to warn patients about the possibility of untoward side effects from medications, particularly those that might impair driving;
(3) that the physician attempt to give competent advice about the wisdom of the patient's driving, while keeping in mind the obligation to protect the community and obey the law; and
(4) that the physician, if uncertain about the patient's ability to drive, consider recommending that the state licensing agency arrange a driving test. (BOT Rep. L, A-90; Reaffirmed: Sunset Report, I-00)

H-15.973 Operational and Accessible Safety Belts in Rental Cars and Taxicabs

Our AMA supports developing model legislation that would require (1) rental agencies to ensure that all vehicles with passive belt systems are delivered to renters with passive restraints in operational condition and with directions as to their use; and (2) taxicab companies or drivers to ensure that their vehicles have operational and readily accessible safety belts for passengers. (Sub. Res. 71, I-89; Reaffirmed: Sunset Report, A-00)

H-15.974 Passive Restraints in Rented Cars

Our AMA supports the concept that all rental automobiles with passive restraints should be delivered with passive restraints attached and in working condition, with proper written instructions for their use. (Res. 28, A-89; Reaffirmed: Sunset Report, A-00)

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-15.976 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)

H-15.977 Seat Belts in Taxicabs

The AMA reaffirms its support for the presence of properly functioning safety belt equipment in all vehicles where practical, and urges the public to use seat belts in all vehicles at all times, and specifically in taxicabs for drivers and passengers. (Sub. Res. 1, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-15.978 Voluntary Highway Lights-On Campaign

The AMA advocates and encourages the institution of voluntary lights-on efforts during daylight hours for all motor vehicles not already automatically equipped with daytime running lights on American highways. (Res. 104, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06)

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-15.981 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)

H-15.982 Mandatory Seat Belt Utilization Laws

The AMA (1) supports mandatory seat belt utilization laws which do not simultaneously relieve automobile manufacturers of their responsibility to install passive restraints; (2) favors informing state medical societies about the status of mandatory seat belt utilization laws which simultaneously relieve automobile manufacturers of their responsibility to install passive restraints; and (3) urges reconsideration of the administrative regulation of the U.S. Department of Transportation that would release automobile manufacturers from the responsibility of providing passive restraints when mandatory seat belt utilization for two-thirds of the U.S. population is attained. (Sub. Res. 133, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-15.983 Promoting Safety Belt Use Through Insurance Mechanisms

The AMA favors provision of additional death benefits by insurers on the basis of the deceased's use of a safety belt at the time of a fatal automobile accident. (Res. 121, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-15.986 Automatic (i.e., Passive) Restraints to Prevent Injuries and Deaths from Motor Vehicle Accidents

The AMA (1) reaffirms its policy which supports mandatory seat belt utilization laws;
(2) reaffirms its support for mandated child passenger restraint laws;
(3) supports immediate implementation of a program requiring passive restraints (preferably air cushions) in all new domestic and foreign automobiles;
(4) supports legislation to promote availability of effective seat belts in school buses in the U.S.; and
(5) supports legislative action to promote availability of effective seat belts in all motor vehicles in public use (e.g., public and private buses, taxicabs, and any other vehicles carrying passengers). (Sub. Res. 2, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmation A-04; Reaffirmed: BOT Rep. 29, A-04)

H-15.988 Modification of Three-Point Shoulder Harness Seat Belt to Enable Use by Small Children

The AMA (1) recognizes the value of using appropriately designed three-point safety belt restraints to reduce auto-related injuries and fatalities; (2) supports auto industry modifications in restraints for safe use by children and small adults; and (3) supports the development of standards required for such modifications by appropriate authorities. (Sub. Res. 33, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed and Modified: CSA Rep. 8, A-05)

H-15.990 Automobile-Related Injuries

The AMA (1) Encourages physicians to increase their awareness of the still largely overlooked problem of motor vehicle-related injuries and to discuss with their patients how they can avoid or prevent such injuries.
(2) Calls for the establishment of a reduction in motor vehicle injuries as a national goal.
(3) Reaffirms its support for the development of effective passive crash protection systems for occupants of motor vehicles.
(4) Strongly endorses and encourages the use of active restraints, such as lapbelts, lapbelt-shoulder harnesses, and those that are approved for children.
(5) Encourages motor vehicle manufacturers to develop automobiles with stronger passenger compartments that would more effectively protect occupants, and with interiors having fewer protuberant objects and hard surfaces that could cause injuries in crashes.
(6) Continues to support state and federal legislative efforts to strengthen drunk driving laws and their enforcement.
(7) Encourages national and federal organizations, such as the National Institutes of Health, the National Highway Transportation Safety Agency, and the National Science Foundation, and appropriate private groups, to devote more of their resources to research concerning vehicle-related injuries and their prevention.
(8) Urges states to review their standards for the construction and maintenance of roads and highways. The standards should be based on current engineering knowledge and good practice, particularly as related to use of skid-resistant surfaces; shoulder grading; drivers' lines of vision; removal of obstructions; and separation of opposing traffic streams.
(9) Encourages state and local officials to monitor streets, roads, and highways to identify sites with disproportionate risks of crashes, in order to take appropriate remedial actions.
(10) Encourages continued study of the effect of increasing the legal age at which young persons may drink alcoholic beverages and supports increased study of behavioral factors in crashes, such as those relating to education, training and driving experience; school, family and work problems; aggression; depression and personality disorders; use of drugs; and criminal behavior.
(11) Believes that, before the adoption of passive crash protection systems and devices to reduce motor vehicle injuries, industry and government demonstrate through field studies that such systems and devices are effective, safe, cost-effective and acceptable to drivers. (CSA Rep. I, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-15.992 Motor Vehicle Accidents

Our AMA (1) recognizes motor vehicle-related trauma as a major public health problem, the resolution of which requires a leadership role by physicians in concert with safety experts; and (2) strongly encourages other medical and health care organizations, as well as departments of health and transportation, to endorse the concept of motor vehicle related trauma as a public health problem, thereby lending its treatment to traditional public health measures. (BOT Rep. LL, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-15.993 Child Passenger Safety

Our AMA (1) urges all physicians and health care professionals to consider ways to encourage the protection of children in motor vehicles through the use of appropriate child passenger restraining devices and safety belts and (2) endorses and supports the efforts of other appropriate organizations, through its First Ride-Safe Ride program, to motivate and assist physicians and health care professionals and hospitals to inform parents of the importance of protecting children in motor vehicles with appropriate restraining systems. (Res. 27, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation and Modified: Sunset Report, I-01)

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-15.995 Medical Advisory Boards in Driver Licensing

Our AMA (1) endorses the establishment of state motor vehicle department medical advisory boards to improve licensure of vehicle operators and to reduce incidence of injury and death and (2) urges state medical associations to encourage establishment of such boards and to work actively with them. (Res. 2, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-15.996 Tractor Roll Bars

Our AMA urges (1) action requiring use of roll bars and seat belts on tractors; (2) development of educational programs in tractor safety; and (3) that the National Highway Safety Bureau be notified of this action. (Res. 21, I-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-15.997 Elderly's Eligibility for Automobile Insurance and Licensure

Although physicians are willing to examine applicants and determine whether or not the applicant meets specified physical standards for automobile liability insurance or for licenses to operate motor vehicles, the determination of what standards should be required or whether the driver is insurable and should be licensed to drive is the responsibility of the insurance companies concerned and of the state agencies issuing licenses. (Res. 9, I-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-15.998 Driver Education in Secondary Schools

The AMA believes that driver education should be an integral part of the secondary school curriculum and offered to all students, and encourages state and local medical societies and all physicians to do everything possible to support proper programs in their states and communities. (BOT Rep. M, I-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-15.999 Automobile Safety Standards

The AMA supports proper legislation to establish safety standards for automobiles and will continue to offer to government, industry, and other interested parties its advice and consultation on the medical aspects of automotive safety. (Sub. Res. 36, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98)

H-20.000 Acquired Immunodeficiency Syndrome
(See also: Blood, Public Health)

H-20.897 Prevalence of HIV in Minority Populations

Our AMA supports the Centers for Disease Control and Prevention in its efforts to evaluate the effectiveness of existing HIV

prevention programs directed toward minority populations. (Res. 907, I-08)

H-20.898 Global HIV/AIDS Prevention

Our AMA supports continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives or grantee pledges of opposition to prostitution. (Res. 439; A-08)

H-20.899 HIV Testing

Our AMA endorses routine HIV screening/testing for individuals on admission to the hospital, visit to the emergency room or doctor's office as deemed appropriate by the attending physician. It is AMA policy that: (1) this testing should be a voluntary program in which patients may opt out if they desire not to be tested; (2) HIV screening permission be incorporated into general health care consent forms and that separate written consent is not recommended; (3) prevention counseling should not be a requirement for this testing program; (4) when tests are positive, appropriate public health measures be instituted for surveillance, prevention of transmission and dissemination of the virus; and (5) when positive HIV patients are identified, appropriate linkage to HIV care be established. (Res. 2, A-07)

H-20.900 HIV, Sexual Assault, and Violence

Our AMA:

(1) Urges that any legislative vehicle to establish a national HIV reporting mechanism include adequate safeguards to identify, screen, and protect victims of domestic violence who may either be HIV-positive or a contact of an HIV-positive individual; and

(2) Believes that HIV testing should be offered to all victims of sexual assault, that these victims should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained. (CSA Rep. 4, A-03)

H-20.901 HIV, Immigration, and Travel Restrictions

Our AMA:

(1) Supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649);

(2) Recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information;

(3) Supports keeping HIV infection on the list of communicable diseases of "Public Health Significance" for purposes of immigration law and supports excluding immigrants infected with HIV from settling permanently in the United States;

(4) Recommends that non-immigrant travel into the United States not be restricted because of HIV status; and

(5) Recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose. (CSA Rep. 4, A-03)

H-20.902 Sanctions for Willfully Infecting Others with HIV

Our AMA requests that states provide sanctions for an HIV-infected individual who knowingly and willingly risks infecting an unsuspecting person when that person subsequently discovers his/her risk and makes a complaint to the authorities. Preemptive sanctions are not being endorsed by this recommendation. (CSA Rep. 4, A-03)

H-20.903 HIV/AIDS and Substance Abuse

Our AMA:

(1) Urges federal, state, and local governments to increase funding for drug treatment so that drug abusers have immediate access to appropriate care, regardless of ability to pay. Experts in the field agree that this is the most important step that can be taken to reduce the spread of HIV infection among intravenous drug abusers;

(2) Advocates development of regulations and incentives to encourage retention of HIV-positive and AIDS-symptomatic patients in drug treatment programs so long as such placement is clinically appropriate;

(3) Encourages the availability of opioid maintenance for persons addicted to opioids. Federal and state regulations governing opioid maintenance and treatment of drug dependent persons should be reevaluated to determine whether they meet the special needs of intravenous drug abusers, particularly those who are HIV infected or AIDS symptomatic. Federal and state regulations that are based on incomplete or inaccurate scientific and medical data that restrict or inhibit opioid maintenance therapy should be removed;

(4) Urges development of educational, medical, and social support programs for intravenous drug abusers and their sexual or needle-sharing partners to reduce risk of HIV infection, as well as risk of other bloodborne and sexually transmissible diseases. Such efforts must target (a) pregnant intravenous drug abusers and those who may become pregnant to address the current and future health care needs of both mothers and newborns and (b) adolescent substance abusers, especially homeless, runaway, and detained adolescents who are seropositive or AIDS symptomatic and those whose lifestyles place them at risk for contracting HIV infection;

(5) Encourages public authorities to employ vigorous efforts to reduce the risk of transmission of HIV infection through contact with debris found in shooting galleries and other places where drugs are injected, by identifying and barring access to or disinfecting such sites;

(6) Will monitor and disseminate the results of current efforts to assess recovery rates, pinpoint effective strategies (including needle-exchange programs), collect ethnographic data, execute outcome evaluations, and track recidivism rates in programs aimed at reducing the spread of HIV infection among intravenous drug abusers; and

(7) Will disseminate to the profession and the public credible, up-to-date information on HIV infection and substance abuse through its publications, conferences, and participation in appropriate forums and demonstration projects. (CSA Rep. 4, A-03)

H-20.904 HIV/AIDS Education and Training

(1) Public Information and Awareness Campaigns

Our AMA:

a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.

B) Can be a catalyst to bring the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;

c) Strongly urges the communications industry to develop voluntary guidelines for public service advertising regarding HIV/AIDS, in consultation with the health care community and government officials;

d) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;

e) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;

f) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.

g) Recognizes National HIV Testing Day and encourages AMA members to promote participation in voluntary HIV testing and counseling through community and media outreach, health fairs, and free testing sites across the country.

(2) HIV/AIDS Education in Schools

Our AMA:

a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;

b) Commends school administrations, boards of education, teachers, health educators, and all others who have helped implement HIV curricula in school systems and urges continuance of such efforts. Appropriate means must be found to provide HIV education for those who are not currently receiving such education through the school system, including individualized educational materials;

c) Supports efforts to obtain adequate funding from local, state, and national sources for the immediate development and implementation of HIV educational programs as part of comprehensive health education in the schools.

(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers

a) Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in drug treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies. Such efforts should assure: (i) educational programs covering practical and didactic aspects of universal precautions and infectious control procedures be conducted for all health care workers, and especially for physicians who practice invasive procedures; (ii) an easily accessible method of receiving the most current authoritative information on HIV; (iii) readily available training in HIV counseling and education; (iv) continuing education and training on techniques related to nonjudgmental history taking of sexual practices and drug use; (v) identification of effective ways to change those behaviors that place a person at risk of HIV infection; (vi) a review of methods other than education and counseling that might be effective in preventing the spread of HIV; and (vii) special attention to reducing the spread of HIV among intravenous drug users;

b) Recognizing that it is unlikely that the care of HIV-infected persons will be provided entirely by specialists and referral centers, our AMA supports publishing information and offering training to encourage large numbers of physicians and other health care workers to become involved in the care of HIV-infected patients;

c) Our AMA supports HIV/AIDS educational programs addressing home health care and the training of nonprofessional home care givers, with special attention to infection control;

d) Our AMA encourages immediate publication of peer-reviewed reports of any case of HIV transmission from skin or mucous membrane exposure, and any case of a health care worker with occupation-related HIV infection;

e) Our AMA supports the development and issuance of educational advisories for physicians, to assist them in halting the spread of HIV/AIDS by giving practical and medically sound advice to all individuals.

(4) Medical Students and Resident Education and Training

Our AMA:

a) Supports collaborating in a survey of medical schools and residency programs to review and report on HIV programs and policies;

b) Urges institutions and medical educators responsible for the education of medical students and resident physicians to assume the responsibility to ensure that: (i) the educational program includes attention to the basic and clinical sciences and to the related ethical and social issues associated with the current epidemic of HIV infection; (ii) the student and resident physician is instructed in practice techniques that will minimize the risk of acquiring infection from the care of patients with HIV infection; (iii) support systems are developed to assist students and resident physicians in coping with the difficulties associated with the study and treatment of patients with HIV infection; (iv) the variety of patient illnesses necessary for the educational experience is not distorted by a responsibility for caring for an excessive patient population with HIV infection; (iv) an institutional policy statement is in effect that addresses the role in medical education of a student or resident physician infected with HIV; (v) an institutional policy statement is in effect that addresses the responsibility of the institution to indemnify the student or resident physician who is infected with HIV as a result of contact with assigned patients;

c) Urges medical schools and teaching hospitals to disseminate to medical students and residents the Centers for Disease Control and Prevention guidelines delineating precautions to be observed in the care of patients with HIV/AIDS. (CSA Rep. 4, A-03; Appended: Res. 516, A-06)

H-20.905 HIV/AIDS Research

(1) Information on the HIV Epidemic

Our AMA:

a) Vigorously supports the need for adequate government funding for research, both basic and clinical, in relation to HIV/AIDS epidemic. Research on HIV should be prioritized, funded, and implemented in an expeditious manner consistent with appropriate scientific rigor, and the results of research should form the basis for future programs of prevention and treatment;

b) Requests the Secretary of the Department of Health and Human Services to make available information on HIV expenditures, services, programs, projects, and research of agencies under his/her jurisdiction and, to the extent possible, of all other federal agencies for purposes of study, analysis, and comment. The compilation should be sufficiently detailed that the nature of the expenditures can be readily determined;

c) Supports ongoing efforts of the Centers for Disease Control and Prevention to periodically monitor the incidence and prevalence of HIV infection in the U.S. population as a whole, as well as in groups of special interest such as adolescents and minorities;

d) Encourages federal and state agencies, in cooperation with medical societies and other interested organizations, to study and report means to increase access to quality care for women and children who are HIV-infected;

e) Encourages further research to assess the risk of HIV transmission in specific surgical techniques and how any such risk may be decreased;

f) Supports exploring ways to increase public awareness of the benefits of animal studies in HIV/AIDS research.

(2) Lookback Studies

Our AMA encourages the cooperation of the medical community and patients in scientifically sound look-back studies designed to further define the risk of HIV transmission from an infected physician to a patient and to determine if there is any scientific basis for the development of a list of exposure-prone procedures. A panel of experts should be assembled to translate available look-back information into a meaningful statement on the estimated true risk of transmission and the need, if any, for additional studies.

(3) Community Research Initiatives

Our AMA supports the objectives of community-based research to reduce HIV disease and encourages periodic review of progress toward these objectives. (CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08)

H-20.906 Health and Disability Coverage for Health Care Workers at Risk for HIV and Other Serious Infectious Diseases

(1) Health Insurance

A currently held health insurance policy of a health care worker should not be terminated, coverage reduced or restricted, or premiums increased solely because of HIV infection.

(2) Disability Coverage

a) Each health care worker should consider the risks of exposure to infectious agents posed by his/her type of practice and the likely consequences of infection in terms of changes needed in that practice mode and select disability insurance coverage accordingly. The policy selected should contain a reasonable definition of "sickness" or "disability," an own-occupation clause, and guaranteed renewability, future insurability, and partial disability provisions;

b) In making determinations of disability, carriers should take into consideration the recommendations of the professional and institutional staff with whom an infected health care worker is associated, including the worker's own personal physician;

c) Since there are a variety of disability insurance coverages available and a diversity of practice modes, each health care professional should individually assess his/her risk of infection and that of his/her employees and select disability coverage accordingly. (CSA Rep. 4, A-03)

H-20.907 Financing Care for HIV/AIDS Patients

Our AMA:

(1) Believes that current private insurance and existing public programs, coupled with a significant expansion of state risk pools, provide the best approach to assuring adequate access to health expense coverage for HIV-infected persons and persons with AIDS. However, as the disease patterns and costs become more defined, it may be necessary to reevaluate this conclusion. Continued study of this issue is imperative;

(2) Supports the development of a clinical staging system based on severity of HIV disease as a replacement for the AIDS diagnosis as a basis for determining health, disability, and other benefits;

(3) Supports increased funding for reimbursement and other incentives by public and private payers to encourage (a) expanded availability for therapies and interventions widely accepted by physicians as medically appropriate for the prevention and control of HIV disease and (b) for alternatives to in-patient care of persons with HIV disease, including intermediate care facilities, skilled nursing facilities, home care, residential hospice, home hospice, and other support systems;

(4) Supports government funding of all medical services that are deemed appropriate by both the patient and physician for pregnant seropositive women lacking other sources of funding;

(5) Supports broad improvements in and expansion of the Medicaid program as a means of providing increased coverage and financial protection for low-income AIDS patients;

(6) Supports, and favors considering introduction of, legislation to modify the Medicaid program to provide for a yearly dollar increase in the federal share of payments made by states for care of all patients in proportion to the amount of increase in costs incurred by each state program for care of HIV-positive individuals and patients with AIDS over the preceding year;

(7) Encourages the appropriate state medical societies to seek establishment in their jurisdictions of programs to pay the private insurance premiums from state and federal funds for needy persons with HIV and AIDS; and strongly supports full appropriation of the amounts authorized under the Ryan White CARE Act of 2000;

(8) Supports consideration of an award recognition program for physicians who donate a portion of their professional time to testing and counseling HIV-infected patients who could not otherwise afford these services. (CSA Rep. 4, A-03)

H-20.908 Medical Care of HIV-Infected Patients

(1) Ethical Responsibilities of Physicians

Our AMA believes that a physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is HIV seropositive. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice. Physicians who are unable to provide the services required by HIV-infected patients should make referrals to those physicians or facilities equipped to provide such services. It is in the best interest of the patient for the physician to focus on treatment of the disease, rather than on making value judgments about how the disease was contracted.

(2) General Considerations

Our AMA:

a) Encourages its constituent societies to facilitate the availability of physicians and health care services for HIV/AIDS patients;

b) Advocates development of optimal care programs for HIV-positive and AIDS-symptomatic infants and their families. Such programs should include support systems to help parents care for these infants and simplified foster-care arrangements for children whose parents are unable to provide such care;

c) Supports efforts to provide physicians with an awareness of the role that can be played in patient care by self-help and support groups for HIV-infected patients;

d) Will continue its efforts with the Social Security Administration to explore ways of educating physicians on the disability evaluation of HIV-infected patients.

(3) Pharmacotherapy and HIV Infection

a) Physicians should inquire of a patient with HIV infection whether the patient is taking unprescribed medications or drugs manufactured by a pharmaceutical company with an unfamiliar name. Appropriate action should be based on the circumstances, but the patient should be made aware of the possible ineffectiveness and complications of such medications;

b) The Food and Drug Administration, in consultation with other federal agencies, drug manufacturers, and health care associations, should continue to review ways to improve drug trials and the associated drug approval processing to expedite evaluations and expand the availability of drugs with demonstrated effectiveness to prevent HIV infection, treat any stage of HIV disease, and reduce symptom expression in HIV-infected persons;

c) Our AMA supports using its resources in cooperation with other health organizations and agencies to facilitate the distribution of information on available drug therapies for the prevention and treatment of HIV disease.

(4) Tuberculosis Screening

Physicians should evaluate all HIV-positive patients for tuberculosis and all tuberculin-positive patients for HIV infection.

(5) Sexual and Drug History

Physicians should take a sexual and substance abuse history, sufficient to identify the usual modes of HIV transmission, on every adolescent and adult patient, with a more comprehensive history taken when warranted. (CSA Rep. 4, A-03)

H-20.909 HIV-Infected Aviation Pilots

The AMA urges the Federal Aviation Administration (FAA) to ensure: (1) that a pilot who has risk factors for HIV infection determine his/her serostatus and (2) that the serostatus of the HIV-infected pilot be kept confidential and shared only with those having a need to know this information for the treatment of the pilot or the safety of others. An HIV-infected pilot should confidentially make this status known to medical examiners of the FAA. On a case-by-case basis, guided by current scientific studies and an examination of the pilot, medical reviewers should determine the impact of the disease on the pilot's ability to safely perform his/her flight responsibilities. Certification or decertification of flight privileges should be based on the individualized medical assessment. (CSA Rep. 4, A-03)

H-20.910 HIV-Infected Children

Our AMA:

(1) Supports day-care, preschool, and school attendance of HIV-infected children;

(2) Encourages the physician responsible for care of an HIV-infected child in a day-care, preschool, or school setting to receive information from the school on other infectious diseases in the environment and temporarily remove the HIV-infected child from a setting that might pose a threat to his/her health;

(3) Encourages that HIV-infected children who are adopted or placed in a foster-care setting have access to special health care benefits to encourage adoption or foster-care. (CSA Rep. 4, A-03)

H-20.911 Reporting of HIV- and HBV-Infected Physicians

Our AMA opposes mandatory reporting of HIV- and HBV-infected physicians to state licensing boards until there is conclusive evidence that such infected physicians pose a significant risk to patients. (CSA Rep. 4, A-03)

H-20.912 Guidance for HIV-Infected Physicians and other Health Care Workers

(1) General Considerations

a) A health care worker who performs invasive procedures and has reasonable cause to believe he/she is infected with HIV should determine his/her serostatus or act as if that serostatus is positive; and

b) As a general rule or until there is scientific information to the contrary, the HIV-infected health care worker should be permitted to provide health care services as long as there is no significant risk of patient infection and no compromise in physical or mental ability of the health care worker to perform the health care procedures.

(2) Patient Care Duties

a) A physician or other health care worker who performs exposure-prone procedures and becomes HIV-positive should disclose his/her serostatus to a state public health official or local review committee;

b) An HIV-infected physician or other health care worker should refrain from conducting exposure-prone procedures or perform such procedures with permission from the local review committee and the informed consent of the patient;

c) When the scientific basis for patient protection policy decisions are unclear, HIV-infected physicians or other health care workers must err on the side of protecting patients.

(3) Local Review Committee

a) If an HIV-infected physician or other health care worker performs invasive medical procedures as a part of his/her duties, then the individual should request that an ad hoc committee be constituted to consider which activities can be continued without risk of infection to patients. Membership on the review committee should be flexible to meet various needs. It should include an infectious disease specialist familiar with HIV transmission risks, the pertinent hospital department chair, a hospital administrator, an epidemiologist, the infected health care worker's personal physician, the infected health care worker, and others as appropriate. Committee members should be unbiased and at least some of the members should be familiar with the performance of the infected health care worker.

B) This review committee may recommend to the appropriate authority restrictions upon the infected persons' practice, if it believes there is a significant risk to patients' welfare. A confidential review system should be established by the committee to monitor the health care worker's fitness to engage in invasive health care activities. Any restrictions or modifications to health care activities that may affect patient safety should be determined by the committee based on current medical and scientific information. When determining practice limitations for HIV-positive physicians, the panel might consider: (i) morbidity and mortality experience of the physician in question; (ii) frequency with which the physician performs the following: procedures that have been associated with injuries to physicians in the course of surgery; procedures that are conducted in confined or difficult to visualize anatomical spaces; procedures where a physician's blood is likely to come in to contact with a patient's mucosal surfaces, open surgical wounds, or blood stream; and procedures that have been known to be involved in HBV transmission;

c) Where restrictions, limitations, modifications, or a change in health care activities are recommended, the committee should do its utmost to assist the health care worker to obtain financial and social support for these changes. Consideration should be given to adapting programs for impaired health care workers to serve those who are HIV infected;

d) The committee should be empowered to monitor the HIV-infected physician or other health care worker for compliance with any practice limitations established by the committee, provide advice on the need to inform patients of the infected worker's HIV status, monitor the infected person's compliance with universal precautions, and assess the effects of the disease on clinical competency. Physicians and others who participate in making these decisions must be protected from legal challenges and personal legal responsibility;

e) Any HIV-infected health care worker who repeatedly violates local committee-imposed practice limitations and/or universal precautions should be reported to appropriate authorities, such as the state licensure board, for possible discipline;

f) If intra-institutional confidentiality cannot be assured, health care facilities should make arrangements with other organizations such as local or state medical societies to perform the functions of the ad hoc committee; and

g) HIV-infected health care workers not affiliated with a hospital may also use this procedure to form an ad hoc review committee.

4. Review Committee Liability

a) State medical societies should be encouraged to survey hospitals and review their own coverage to determine whether existing liability insurance for those serving on peer review or Physicians Health Committees provides protection for those serving on review committees for HIV-infected physicians;

b) Our AMA should assist in the establishment of review committees by providing model state legislation that would afford committee members protection in state and federal courts and when they operate in good faith. Further, our AMA should prepare a protocol outlining how review committees would operate and further specify the definition of significant risk.

(5) Confidentiality

a) Our AMA expresses its commitment to HIV-infected physicians concerning confidentiality of HIV serostatus, protection against discrimination, involvement in legislation affecting HIV-infected physicians, financial support through such means as insurance disability guidelines, and assistance with alternative careers through its Physician Health Program;

b) Our AMA believes the confidentiality of the HIV-infected physician should be protected as with any HIV patient; and

c) Knowledge of the health care worker's HIV serostatus should be restricted to those few professionals who have a medical need to know. Except for those with a need to know, all information on the serostatus of the health care worker must be held in the strictest confidence.

(6) HIV-Infected Medical Students and Resident Physicians

a) Our AMA strongly supports indemnification of medical students and resident physicians infected with HIV as a result of contact with assigned patients. Our AMA supports examining possible mechanisms to achieve the intent of this recommendation, realizing that the issues for medical students and resident physicians differ;

b) An equivalent level and manner of health care provided to medical students, residents, and other employees with other medical conditions should be provided to those with HIV infection.

(7) Liability Coverage for HIV-Infected Physicians

Our AMA will continue the dialogue with liability insurance companies to monitor issues surrounding liability coverage for HIV-infected physicians and will establish guidelines for any collection or use of HIV serostatus data by professional liability carriers. Serostatus information should be treated with strict privacy and nondisclosure assurances. Discussions with liability insurance companies should include the position that to date there are no scientific grounds to require testing of physicians for HIV status. (CSA Rep. 4, A-03)

H-20.913 Prevention and Control of HIV and other Bloodborne Pathogens in Health Care Settings

(1) Employees of the health care system who might be at risk of contact with infected blood or other body fluids must be afforded all available and practical protection to assure a low level of personal risk of occupational infection. Universal precautions and all other applicable infection control measures must be understood and consistently used to safeguard the health of all personnel. Hospitals should establish procedures to ensure that these precautions are strictly enforced and that educational programs covering proper infection control procedures are available for all health care workers;

(2) Our AMA uses the terminology "significant risk" in AMA policies, correspondence, and official actions when indicating the threshold of risk that is appropriate for restrictions on medical practice of physicians infected with bloodborne pathogens that can be transmitted to patients; and the AMA recommends that other medical associations, federal agencies, and courts also use the terminology "significant risk" consistently;

(3) Medical training should not unreasonably expose students, residents, and other health care workers to HIV infection from patients. Invasive techniques should be taught in situations where identified risks of HIV infection have been reduced as much as possible;

(4) Health care workers should be aware of the legal requirement to adhere to Occupational Safety and Health Administration regulations on bloodborne diseases. Our AMA will monitor the impact of these regulations on physicians, physicians' offices, and health institutions;

(5) Our AMA endorses and recommends adherence to the Centers for Disease Control and Prevention (CDC) guidelines for infection control and encourages institutions to develop recommendations to suit specific procedures and situations that may not be covered by currently published guidelines. In conjunction with other medical and public health organizations, the CDC should continue to review current policies for determination of occupational exposure to HIV so that they more accurately assess the true risk of seroconversion due to occupational exposure;

(6) Our AMA recommends separate guidelines for HIV-infected and hepatitis B (HBV)-infected health care workers because of substantial differences in rates, risks, modes, and consequences of transmission;

(7) Health care employers whose employees or students in-training are at risk for occupational exposure to bloodborne pathogens should ensure that timely post-exposure counseling and prophylaxis, in accordance with relevant Public Health Services guidelines, are available to health care workers, including students, after an exposure;

(8) Medical schools and other health professions schools should develop payment systems for post-exposure chemoprophylaxis for students exposed to bloodborne pathogens in the course of their studies and training; a payment mechanism must be instituted to cover all necessary expenses of counseling, testing, and therapy for exposed health care workers, including students exposed while in clinical training;

(9) Health care employers whose employees or students in-training are at risk for occupational exposure to bloodborne pathogens should evaluate and make use of appropriate techniques and technologies, including safer medical devices, to prevent occupational exposure to bloodborne pathogens;
(10) Our AMA will work with relevant federal agencies, medical societies, and public health organizations to study methods and recommend guidelines for institutions to allow immediate access to care and counseling for health care workers exposed to HIV;

(11) Our AMA will explore the feasibility of developing a voluntary office visitation program to assess the policies, procedures, and education programs that are in place concerning prevention of HIV/HBV transmissions. This effort would include exploring the feasibility of developing minimal guidelines for physician offices. (CSA Rep. 4, A-03)

H-20.914 Discrimination Based on HIV Seropositivity

Our AMA:

(1) Remains cognizant of and concerned about society's perception of, and discrimination against, HIV-positive people;

(2) Condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease, including HIV infection; this includes Congressional mandates calling for the discharge of otherwise qualified individuals from the armed services solely because of their HIV seropositivity;

(3) Encourages vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate against persons based on disease; and

(4) Encourages medical staff to work closely with hospital administration and governing bodies to establish appropriate policies regarding HIV-positive patients. (CSA Rep. 4, A-03)

H-20.915 HIV/AIDS Reporting, Confidentiality, and Notification

(1) Reporting

Our AMA strongly recommends that all states, territories, and the District of Columbia adopt a requirement for the confidential reportability of HIV seropositivity of all patients to appropriate public health authorities for the purpose of contact tracing and partner notification. Strict confidentiality must be maintained by each local and state public health authority.

(2) Confidentiality

a) Our AMA supports uniform protection, at all levels of government, of the identity of those with HIV infection or disease, consistent with public health requirements;

b) Patients should receive general information on the limits of confidentiality of medical records at the initial medical visit. Specific information on the limits of confidentiality should be provided before the patient receives HIV-related services or when the patient is counseled about HIV testing;

c) Physicians should be able, without fear of legal sanction, to confidentially discuss a patient's HIV serostatus only with those other health care providers who need this information to properly plan and provide quality medical care to the patient; and

d) Our AMA will continue to address, through the Council on Ethical and Judicial Affairs, the patient confidentiality and ethical issues raised by known HIV antibody-positive patients who refuse to inform their sexual partners or modify their behavior.

(3) Contact Tracing and Partner Notification

Our AMA:

a) Strongly recommends that states adopt a system for contact tracing and partner notification in each community that, while protecting to the greatest extent possible the confidentiality of patient information, provides clear guidelines for public health authorities who need to trace the unsuspecting sexual or needle-sharing partners of HIV-infected persons;

b) Requests that states make provisions in any contact-tracing and notification program for adequate safeguards to protect the confidentiality of HIV-seropositive persons and their contacts, for counseling of the parties involved, and for the provision of information on counseling, testing, and treatment resources for partners who might be infected;

c) In collaboration with state medical societies, supports legislation on the physician's right to exercise ethical and clinical judgment regarding whether or not to warn unsuspecting and endangered sexual or needle-sharing partners of HIV-infected patients; and

d) Promulgates the standard that a physician attempt to persuade an HIV-infected patient to cease all activities that endanger unsuspecting others and to inform those whom he/she might have infected. If such persuasion fails, the physician should pursue notification through means other than by reliance on the patient, such as by the Public Health Department or by the physician directly. (CSA Rep. 4, A-03; Reaffirmation A-07)

H-20.916 Breastfeeding and HIV Seropositive Women

Our AMA believes that, where safe and alternative nutrition is widely available, HIV seropositive women should be counseled not to breastfeed and not to donate breast milk. HIV testing of all human milk donors should be mandatory, and milk from HIV-infected donors should not be used for human consumption. (CSA Rep. 4, A-03)

H-20.917 Neonatal Screening for HIV Infection

Our AMA:

(1) Urges the U.S. Public Health Service, other appropriate federal agencies, private researchers, and health care industries to continue to pursue research, development, and implementation of diagnostic tests and procedures for more accurate demonstration of HIV infection in the newborn; and supports the widespread use of such tests in early diagnosis;

(2) Favors giving consideration to rapid HIV testing of newborns, with maternal consent, when the maternal HIV status has not been determined during pregnancy or labor; and

(3) Supports voluntary, routine HIV testing of neonates in states with a high prevalence of HIV infection with maintenance of strict confidentiality. When treatment modalities with proven benefits for infected neonates are available, our AMA supports mandatory HIV testing of all newborns in high prevalence areas. (CSA Rep. 4, A-03)

H-20.918 Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission

In view of the significance of the finding that treatment of HIV-infected pregnant women with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements:

(1) Given the prevalence and distribution of HIV infection among women in the United States, the potential for effective early treatment of HIV infection in both women and their infants, and the significant reduction in perinatal HIV transmission with treatment of pregnant women with appropriate antiretroviral therapy, routine education about HIV infection and testing should be part of a comprehensive health care program for all women. The ideal would be for all women to know their HIV status before considering pregnancy.

(2) Universal HIV testing of all pregnant women, with patient notification of the right of refusal, should be a routine component of perinatal care. Basic counseling on HIV prevention and treatment should also be provided to the patient, consistent with the principles of informed consent.

(3) The final decision about accepting HIV testing is the responsibility of the woman. The decision to consent to or refuse an HIV test should be voluntary. When the choice is to reject testing, the patient's refusal should be recorded. Test results should be confidential within the limits of existing law and the need to provide appropriate medical care for the woman and her infant.

(4) To assure that the intended results are being achieved, the proportion of pregnant women who have accepted or rejected HIV testing and follow-up care should be monitored and reviewed periodically at the appropriate practice, program or institutional level. Programs in which the proportion of women accepting HIV testing is low should evaluate their methods to determine how they can achieve greater success.

(5) Women who are not seen by a health care professional for prenatal care until late in pregnancy or after the onset of labor should be offered HIV testing at the earliest practical time, but not later than during the immediate postpartum period.

(6) When HIV infection is documented in a pregnant woman, proper post-test counseling should be provided. The patient should be given an appropriate medical evaluation of the stage of infection and full information about the recommended management plan for her own health. Information should be provided about the potential for reducing the risk of perinatal transmission of HIV infection to her infant through the use of antiretroviral therapy, and about the potential but unknown long-term risks to herself and her infant from the treatment course. The final decision to accept or reject antiretroviral treatment recommended for herself and her infant is the right and responsibility of the woman. When the woman's serostatus is either unknown or known to be positive, appropriate counseling should also be given regarding the risks associated with breast-feeding for both her own disease progression and disease transmission to the infant.

(7) Appropriate medical treatment for HIV-infected pregnant women should be determined on an individual basis using the latest published Centers for Disease Control and Prevention recommendations. The most appropriate care should be available regardless of the stage of HIV infection or the time during gestation at which the woman presents for prenatal or intrapartum care.

(8) To facilitate optimal medical care for women and their infants, HIV test results (both positive and negative) and associated

management information should be available to the physicians taking care of both mother and infant. Ideally, this information will be included in the confidential medical records. Physicians providing care for a woman or her infant should obtain the appropriate consent and should notify the other involved physicians of the HIV status of and management information about the mother and infant, consistent with applicable state law.

(9) Continued research into new interventions is essential to further reduce the perinatal transmission of HIV, particularly the use of rapid HIV testing for women presenting in labor and for women presenting in the prenatal setting who may not return for test results. The long-term effects of antiretroviral therapy during pregnancy and the intrapartum period for both women and their infants also must be evaluated. For both infected and uninfected infants exposed to perinatal antiretroviral treatment, long-term follow-up studies are needed to assess potential complications such as organ system toxicity, neurodevelopmental problems, pubertal development problems, reproductive capacity, and development of neoplasms.

(10) Health care professionals should be educated about the benefits of universal HIV testing, with patient notification of the right of refusal, as a routine component of prenatal care, and barriers that may prevent implementation of universal HIV testing as a routine component of prenatal care should be addressed and removed. Federal funding for efforts to prevent perinatal HIV transmission, including both prenatal testing and appropriate care of HIV-infected women, should be maintained. (CSA Rep. 4, A-03)

H-20.919 Patient Disclosure of HIV Seropositivity

Our AMA encourages patients who are HIV seropositive to make their condition known to their physicians and other appropriate health care providers. (CSA Rep. 4, A-03)

H-20.920 HIV Testing

(1) General Considerations

a) Persons who suspect that they have been exposed to HIV should be tested so that appropriate treatment and counseling can begin for those who are seropositive;

b) HIV testing should be consistent with testing for other infections and communicable diseases;

c) HIV testing should be readily available to all who wish to be tested, including having available sites for confidential testing;

d) The physician's office and other medical settings are the preferred settings in which to provide HIV testing;

e) Physicians should work to make HIV counseling and testing more readily available in medical settings.

(2) Informed Consent Before HIV Testing

a) Our AMA supports the standard that individuals should knowingly and willingly give consent before a voluntary HIV test is conducted, in a manner that is the least burdensome to the individual and to those administering the test. Physicians must be aware that most states have enacted laws requiring informed consent before HIV testing;

b) Informed consent should include the following information: (i) patient option to receive more information and/or counseling before deciding whether or not to be tested and (ii) the patient should not be denied treatment if he or she refuses HIV testing, unless knowledge of HIV status is vital to provide appropriate treatment; in this instance, the physician may refer the patient to another physician for care;

c) It is the policy of our AMA to review the federal laws including the Veteran's Benefits and Services Act, which currently mandates prior written informed consent for HIV testing within the Veterans Administration hospital system, and subsequently to initiate and support amendments allowing for HIV testing without prior consent in the event that a health care provider is involved in accidental puncture injury or mucosal contact by fluids potentially infected with HIV in federally operated health care facilities;

d) Our AMA supports working with various state societies to delete legal requirements for consent to medically indicated HIV testing that are more extensive than requirements generally imposed for informed consent to medical care.

(3) HIV Testing Without Explicit Consent

a) Explicit consent should not always be required prior to HIV testing. Physicians should be allowed, without explicit informed consent, and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;

b) General consent for treatment of patients in the hospital should be accepted as adequate consent for the performance of HIV testing;

c) Model state and federal legislation should be developed to permit physicians, without explicit informed consent and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;

d) Our AMA will work with the Centers for Disease Control and Prevention, the American Hospital Association, the Federation, and other appropriate groups to draft and promote the adoption of model state legislation and hospital staff guidelines to allow HIV testing of a patient maintaining privacy, but without explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids; and to allow HIV testing, without any consent, where a health care worker has been placed at risk by exposure to body fluids of a deceased patient.

(4) HIV Testing Procedures

a) Appropriate medical organizations should establish rigorous proficiency testing and quality control procedures for HIV testing laboratories on a frequent and regular basis;

b) Physicians and laboratories should review their procedures to assure that HIV testing conforms to standards that will produce the highest level of accuracy;

c) Appropriate medical organizations should establish a standard that a second blood sample be taken and tested on all persons found to be seropositive or indeterminate for HIV antibodies on the first blood sample. This practice is also advised for any unexpected negative result;

d) Appropriate medical organizations should establish a policy that results from a single unconfirmed positive ELISA test never be reported to the patient as a valid indication of HIV infection;

e) Appropriate medical organizations should establish a policy that laboratories specify the HIV tests performed and the criteria used for positive, negative, and indeterminate Western blots or other confirmatory procedures;

f) Our AMA recommends that training for HIV blood test counselors encourage patients with an indeterminate Western blot to be advised that three-to-six-month follow-up specimens may need to be submitted to resolve their immune status. Because of the uncertain status of their contagiousness, it is prudent to counsel such patients as though they were seropositive until such time as the findings can be resolved.

(5) Routine HIV Testing

a) Routine HIV testing should include appropriately modified informed consent and modified pre-test and post-test counseling procedures;

b) Hospitals, clinics and physicians may adopt routine HIV testing based on their local circumstances. Such a program is not a substitute for universal precautions. Local considerations may include (i) the likelihood that knowledge of a patient's serostatus will improve patient care and reduce HIV transmission risk; (ii) the prevalence of HIV in patients undergoing invasive procedures; (iii) the costs, liabilities and benefits; and (iv) alternative methods of patient care and staff protection available to the patient;

c) State medical associations should review and seek modification of state laws that restrict the ability of hospitals and other medical facilities to initiate routine HIV testing programs.

(6) Voluntary HIV Testing

a) Voluntary HIV testing should be provided with informed consent for individuals who may have come into contact with the blood, semen, or vaginal secretions of an infected person in a manner that has been shown to transmit HIV infection. Such testing should be encouraged for patients for whom the physician's knowledge of the patient's serostatus would improve treatment. Voluntary HIV testing should be regularly provided for the following types of individuals who give an informed consent: (i) patients at sexually transmissible disease clinics; (ii) patients at drug abuse clinics; (iii) individuals who are from areas with a high incidence of AIDS or who engage in high-risk behavior and are seeking family planning services; and (iv) patients who are from areas with a high incidence of AIDS or who engage in high-risk behavior requiring surgical or other invasive procedures;

b) The prevalence of HIV infection in the community should be considered in determining the likelihood of infection. If voluntary HIV testing is not sufficiently accepted, the hospital and medical staff may consider requiring HIV testing.

(7) Mandatory HIV Testing

a) Our AMA opposes mandatory HIV testing of the general population;

b) Mandatory testing for HIV infection is recommended for (i) all entrants into federal and state prisons; (ii) military personnel; (iii) donors of blood and blood fractions; breast milk; organs and other tissues intended for transplantation; and semen or ova for artificial conception;

c) Our AMA will review its policy on mandatory testing periodically to incorporate information from studies of the unintended consequences or unexpected benefits of HIV testing in special settings and circumstances.

(8) HIV Test Counseling

a) Pre-test and post-test voluntary counseling should be considered an integral and essential component of HIV testing. Full pre-test and post-test counseling procedures must be utilized for patients when HIV is the focus of the medical attention, when an individual presents to a physician with concerns about possible exposure to HIV, or when a history of high-risk behavior is present;

b) Post-test information and interpretation must be given for negative HIV test results. All negative results should be provided in a confidential manner accompanied by information in the form of a simple verbal or written report on the meaning of the results and the offer, directly or by referral, of appropriate counseling;

c) Post-test counseling is required when HIV test results are positive. All positive results should be provided in a confidential face-to-face session by a professional properly trained in HIV post-test counseling and with sufficient time to address the patient's concerns about medical, social, and other consequences of HIV infection.

(9) HIV Testing of Health Care Workers

a) Our AMA supports HIV testing of physicians, health care workers, and students in appropriate situations;

b) Employers of health care workers should provide, at the employer's expense, serologic testing for HIV infection to all health care workers who have documented occupational exposure to HIV;

c) Our AMA opposes HIV testing as a condition of hospital medical staff privileges;

d) Physicians and other health care workers who perform exposure-prone patient care procedures that pose a significant risk of transmission of HIV infection should voluntarily determine their serostatus at intervals appropriate to risk and/or act as if their serostatus were positive. The periodicity will vary according to locale and circumstances of the individual and the judgment should be made at the local level. Health care workers who test negative for HIV should voluntarily redetermine their HIV serostatus at an appropriate period of time after any significant occupational or personal exposure to HIV. Follow-up tests should occur after a time interval exceeding the length of the "antibody window.

(10) Counseling and Testing of Pregnant Women for HIV

Our AMA supports the position that there should be universal HIV testing of all pregnant women, with patient notification of the right of refusal, as a routine component of perinatal care, and that such testing should be accompanied by basic counseling and awareness of appropriate treatment, if necessary. Patient notification should be consistent with the principles of informed consent.

(11) HIV Home Test Kits

a) Our AMA opposes Food and Drug Administration approval of HIV home test kits. However, our AMA does not oppose approval of HIV home collection test kits that are linked with proper laboratory testing and counseling services, provided their use does not impede public health efforts to control HIV disease;

b) Standardized data should be collected by HIV home collection test kit manufacturers and reported to public health agencies;

c) A national study of HIV home collection test kit users should be performed to evaluate their experience with telephone counseling;

d) A national interagency task force should be established, consisting of members from government agencies and the medical and public health communities, to monitor the marketing and use of HIV home collection test kits.

(12) College Students

Our AMA encourages undergraduate campuses to conduct confidential, free HIV testing with qualified staff and counselors. (CSA Rep. 4, A-03; Appended: Res. 515, A-06; Reaffirmed: BOT Rep. 1, A-07)

H-20.921 HIV/AIDS to be Considered as a Communicable and a Sexually Transmitted Disease

(1) Our AMA supports the classification of HIV/AIDS as a communicable and a sexually transmitted disease and the control measures attendant to its classification;

(2) State and local health department systems, in cooperation with other concerned organizations, are the appropriate mechanisms for determining whether HIV infection will be designated a sexually transmitted or communicable disease in that state;

(3) All precautions to prevent the spread of the HIV virus from patient to physician or other health care worker and from physician or other health care worker to the patient should be treated in the same manner as any other communicable or infectious disease, consistent with good medical practice. (CSA Rep. 4, A-03)

H-20.922 HIV/AIDS as a Global Public Health Priority

In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:

(1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;

(2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;

(3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;

(4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;

(5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;

(6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through prostitutes;

(7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions; and

(8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic. (CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08)

H-25.000 Aging
(See also: Long Term Care; Medicare; Medicare: Carrier Review; Medicare: PRO)

H-25.990 Eye Exams for the Elderly

Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings. (Res. 813, I-05)

H-25.991 Alzheimer's Disease

The AMA encourages: (1) physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias;
(2) physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services;
(3) studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders; and
(4) studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders. (CSA Rep. 6, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-25.992 Senior Suicide

It is the policy of the AMA to (1) educate physicians to be aware of the increased rates of suicide among the elderly and to encourage seniors to consult their physicians regarding depression and loneliness; and (2) to encourage local, regional, state, and national cooperation between physicians and advocacy agencies for these endangered seniors. (Res. 107, I-90; Reaffirmed: Sunset Report, I-00)

H-25.993 Senior Care

Our AMA supports accelerating its ongoing efforts to work responsibly with Congress, senior citizen groups, and other interested parties to address the health care needs of seniors. These efforts should address but not be limited to: (1) multiple hospital admissions in a single calendar year; (2) long-term care; (3) hospice and home health care; and (4) pharmaceutical costs. (Sub Res. 181, I-89; Reaffirmed: Sunset Report, A-00)

H-25.994 Increased Liaison, Communication and Educational Efforts with the Elderly

The AMA supports (1) increasing communications and understanding between organized medicine and the elderly; (2) continuing contact with organizations such as the AARP, offering speakers for their meetings, and pursuing other steps to improve their understanding of physicians' problems and concerns; and (3) encouraging state and county medical societies to undertake similar efforts to increase liaison with the elderly. (Res. 133, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04)

H-25.995 Exercise Programs for the Elderly

The AMA recommends that physicians: (1) stress the importance of exercise for older patients and explain its physiological and psychological benefits;
(2) obtain a complete medical history and perform a physical examination that includes exercise testing for quantification of cardiovascular and physical fitness as appropriate, prior to the specific exercise prescription;
(3) provide appropriate follow-up of patients' exercise programs; and
(4) encourage all patients to establish a lifetime commitment to an exercise program. (CSA Rep. C, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-25.996 Retirement and Hiring Practices

It is urged that physicians, individually and through their constituent and component medical societies, continue to stress the need to reappraise policies calling for compulsory retirement and age discrimination in hiring from the standpoint of health among older people, and that they participate actively and lend medical weight in the efforts of other groups to create a new climate of opportunity for the older worker. (Committee on Aging Report, I-62; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-25.997 Dignity and Self Respect

The AMA believes that medical care should be available to all our citizens, regardless of age or ability to pay, and believes ardently in helping those who need help to finance their medical care costs. But the AMA does not believe that tax dollars of the working people of America should be used to finance medical care for any person who is financially able to pay for it. Furthermore, the AMA believes in preserving dignity and self respect of all individuals at all ages and believes that people should not be set apart or isolated on the basis of age. The AMA believes that the experience, perspective, wisdom and skill of individuals of all ages should be utilized to the fullest. (AMA President's Address, A-61; Reaffirmed: CLRPD C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-25.998 Policy Recommendations in the Field of Aging

It is the policy of the AMA that: (1) Older individuals should not be isolated;
(2) a health maintenance program is necessary for every individual;
(3) more persons interested in working with the older people in medical and other professional fields are needed;
(4) more adequate nursing home facilities are an urgent health need for some older people in many communities;
(5) further development of service and facilities is required;
(6) extension of research on both medical and socioeconomic aspects of aging is vital;
(7) local programs for older persons, especially those which emphasize the importance of self-help and independence by the senior citizen, should be a major concern of medicine, both collectively and individually; and
(8) local medial society committees along with other leaders in community service, should be equipped to appraise the advantage or disadvantage of proposed housing for older people. (CMS Rep. A, I-60; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset

Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-25.999 Health Care for Older Patients

The AMA: (1) endorses and encourages further experimentation and application of home-centered programs of care for older patients and recommends further application of other new experiments in providing better health care, such as rehabilitation education services in nursing homes, chronic illness referral centers, and progressive patient care in hospitals; (2) recommends that there be increased emphasis at all levels of medical education on the new challenges being presented to physicians in health care of the older person, on the growing opportunities for effective use of health maintenance programs and restorative services with this age group, and on the importance of a total view of health, embracing social, psychological, economic, and vocational aspects, and (3) encourages continued leadership and participation by the medical profession in community programs for seniors. (Committee on Aging Report, I-60; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-30.000 Alcohol and Alcoholism
(See also: Accident Prevention: Motor Vehicles; Drug Abuse; Pregnancy)

H-30.939 Increasing Taxes on Alcoholic Beverages

It is AMA policy that federal, state, and local tax rates on alcoholic beverages be based on the grams of ethanol present in the beverage, not on the fluid volume of beverages such as beer, wine, and distilled spirits. (Res. 438, A-05)

H-30.940 AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages

(1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Educational Act.

(2.) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underaged use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace); and (c) recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof).

(3.) Actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; (b) opposes the use of the radio and television to promote drinking; (c) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; (d) urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and (e) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.

(4.) (a) Urges producers and distributors of alcoholic beverages to discontinue advertising directed toward youth, such as promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (c) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking; and (d) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol. (CSA Rep. 1, A-04; Reaffirmation A-08)

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)

H-30.942 Screening and Brief Interventions For Alcohol Problems

(1) Our AMA in conjunction with medical schools and appropriate specialty societies advocates curricula, actions and policies that will result in the following steps to assure the health of patients who use alcohol: (a) Primary care physicians should establish routine alcohol screening procedures (e.g., CAGE) for all patients, including children and adolescents as appropriate, and medical and surgical subspecialists should be encouraged to screen patients where undetected alcohol use could affect care. (b) Primary care physicians should learn how to conduct brief intervention counseling and motivational interviewing. Such training should be incorporated into medical school curricula and be subject to academic evaluation. Physicians are also encouraged to receive additional education on the pharmacological treatment of alcohol use disorders and co-morbid problems such as depression, anxiety, and post-traumatic stress disorder. (c) Primary care clinics should establish close working relationships with alcohol treatment specialists, counselors, and self-help groups in their communities, and, whenever feasible, specialized alcohol and drug treatment programs should be integrated into the routine clinical practice of medicine. (2) Our AMA urges the National Committee on Quality Assurance to consider developing a HEDIS (Health Plan Employer Data and Information Set) measure for problem drinking or alcohol use disorders. (CSA Rep. 14, I-99; Reaffirmation I-01)

H-30.943 Alcoholism And Alcohol Abuse Among Women

The AMA recognizes the prevalence of alcohol abuse, and dependence among women, as well as current barriers to diagnosis and treatment. The AMA urges physicians to be alert to the presence of alcohol-related problems among women and to screen all patients for alcohol abuse and dependence. The AMA encourages physicians to educate women of all ages about their increased risk of damage to the nervous system, liver and heart disease from alcohol and about the effect of alcohol on the developing fetus. The AMA encourages adequate funding for research to explore the nature and extent of alcoholism among women, effective treatment modalities for women with alcoholism, and variations in alcohol use and abuse among ethnic and other subpopulations. The AMA encourages all medical education programs to provide greater coverage on alcohol as a significant source of morbidity and mortality in women. (CSA Rep. 5, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-30.944 National Alcohol Screening Day

The AMA endorses and promotes National Alcohol Screening day; and AMA members are encouraged to participate as screeners during National Alcohol Screening Day. (Res. 427, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

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-30.948 Thiamin Addition to Alcohol

The AMA: (1) encourages appropriate local, state and federal agencies to increase their efforts to: (a) improve the overall nutritional and health status of individuals with alcohol dependency and (b) reduce alcohol dependency. (2) The AMA encourages appropriate well-designed studies to evaluate the effectiveness and cost-effectiveness of adding thiamine to alcoholic beverages to prevent Wernicke-Korsokoff syndrome. (CSA Rep. 3, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-30.950 Alcoholism in the Elderly

It is the policy of the AMA to: (1) Work with others to develop new guidelines for physicians concerning the prevention, diagnosis and treatment of alcoholism in the elderly, with suggestions on how to overcome diagnostic and treatment barriers. These guidelines should be disseminated widely among primary care practitioners.
(2) Encourage medical educators to consider expanding instructional material on alcohol and aging at all levels of medical education, particularly in residency and/or postgraduate training.
(3) Urge relevant foundations, universities and government agencies to sponsor clinical studies on alcoholism in the elderly. Among topics that need to be explored are the treatment implications of any differences between early and late-onset alcoholics; the influences of various family structures and functions on the treatment of the elderly alcoholic; the possible development of more accurate alcoholism screening instruments for use with the elderly; securing additional data on treatment outcome to demonstrate whether therapy is cost effective and beneficial to the patient and society, and to identify the most efficacious modalities by type of elderly patient; the value of brief treatment interventions with the elderly patient in terms of arresting the development of the disease and reducing medical complications; and participation of physicians in home health care programs as possible models for one type of physician intervention.
(4) Cooperate with other groups, such as the American Association of Retired Persons and appropriate government agencies, in public education programs for the elderly concerning alcohol-related problems. (CSA Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-30.951 Boating Under the Influence

It is the policy of the AMA to: (1) support legislation for education on alcohol and drug consumption for the safe operation of recreational water craft; and (2) support stringent enforcement of regulations regarding boating under the influence of alcohol and other drugs. (Res. 405, I-93; Reaffirmed: CSA Rep. 8, A-03)

H-30.952 Education Grant Support From the Licensed Beverage Information Council

The AMA will: (1) not accept funding directly from beer, wine, and distilled spirits companies for the support of any AMA program; (2) continue to accept educational grants from the Licensed Beverage Information Council (LBIC) in order to augment its current educational activities designed to protect the health of the public, provided that the following criteria are followed: (a) the AMA continues to apply the Standards for Commercial Support of Continuing Medical Education of the ACCME, but in the selection of topics and faculty, and in program development, the AMA will be independent of LBIC input; (b) the AMA maintains complete control of the promotion and distribution of the CME materials produced and accepts no accompanying informational materials to its programs without prior review and approval; and (c) all AMA video or printed continuing education programs must contain a message to physicians that explains the AMA policy regarding alcohol abuse and dependence. (BOT Rep. AAA, A-93; Reaffirmed: CLRPD Rep. 5, A-03)

H-30.955 Sequelae of Alcohol Intake

The AMA (1) will initiate and maintain an intensive campaign to encourage all physicians to take an alcohol history from all their teenage and adult patients and to warn them of the serious sequelae of alcohol consumption; and (2) will apprise all physicians of the many reasons that doctors often loathe to intervene with patients who abuse alcohol as outlined in the Journal of the American Medical Association, Volume 267, No. 5, "Patients Who Drink Too Much." (Res. 408, A-92; Reaffirmed: CSA Rep. 8, A-03)

H-30.958 Ethyl Alcohol and Nicotine as Addictive Drugs

The AMA (1) identifies alcohol and nicotine as drugs of addiction which are gateways to the use of other drugs by young people;
(2) urges all physicians to intervene as early as possible with their patients who use tobacco products and have problems related to alcohol use, so as to prevent adverse health effects and reduce the probability of long-term addition;
(3) encourages physicians who treat patients with alcohol problems to be alert to the high probability of co-existing nicotine problems; and
(4) reaffirms that individuals who suffer from drug addiction in any of its manifestations are persons with a treatable disease. (Res. 28, A-91; Reaffirmed by CSA Rep. 14, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

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)

H-30.960 Physician Ingestion of Alcohol and Patient Care

Our AMA, believing that the possibility, or even the perception, of any alcohol-induced impairment of patient care activities is inconsistent with the professional image of the physician, (1) urges that physicians engaging in patient care have no significant body content of alcohol and (2) urges that all physicians, prior to being available for patient care, refrain from ingesting an amount of alcohol that has the potential to cause impairment of performance or create a "hangover" effect. (BOT Rep. Y, A-91; Reaffirmed: Sunset Report, I-01)

H-30.961 Student Life Styles

Our AMA (1) supports educational programs for students that deal with the problem of alcoholism and drugs, and (2) encourages educational institutions to continue or institute efforts to eliminate the illegal and inappropriate use of alcohol and other drugs on their premises or at their functions. (Res. 159, A-91; Reaffirmed: Sunset Report, I-01)

H-30.962 Driving Under the Influence

The AMA urges states to retitle the crime Driving Under the Influence (DUI) since one is under the influence of however much one has consumed, regardless of outward signs of intoxication. (Res. 29, I-90; Reaffirmed: Sunset Report, I-00)

H-30.964 Task Force on Drunken Driving

The AMA (1) supports all efforts to remove drunken drivers from the nation's roadways; and (2) urges state and local medical societies to develop local task forces on drunken driving to include physicians, prosecuting attorneys, law enforcement officials, legislators, and community groups. (Res. 22, A-90; Reaffirmed: Sunset Report, I-00)

H-30.966 Posting of DUI Laws Where Alcohol is Sold

It is the policy of the AMA to draft model legislation requiring state motor vehicle licensing bureaus and any store, restaurant or bar that sells alcohol to post local DUI penalties. (Res. 288, A-90; Reaffirmed: Sunset Report, I-00)

H-30.967 Drunk Driving

It is the policy of the AMA to (1) intensify its efforts to reduce blood alcohol limits in state legal definitions of drunk driving; (2) seek to encourage the development of reliable surveillance and testing mechanisms to detect and discourage drunk driving; and (3) seek to promote rehabilitation programs in addition to programs that focus on penalties. (Res. 204, A-90; Reaffirmed: Sunset Report, I-00)

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)

H-30.970 The Use of AMA Funds for the Purchase of Alcohol

The use of alcohol in moderation continues to be acceptable and legal behavior in our society. Because of this, the Association should serve as an example and encourage individual responsibility as the key to moderation. The prohibition of funding for alcohol at AMA-sponsored events would be counterproductive to this position. The Association should continue to be a leader in educating physicians and the public on the dangers of alcoholism. (BOT Rep. M, I-89; Reaffirmed: Sunset Report, A-00)

H-30.972 Alcohol Abuse and the War on Drugs

Our AMA (1) supports documenting the strong correlation between alcohol abuse and other substance abuse; (2) reaffirms the concept that alcohol is an addictive drug and its abuse is one of the nation's leading drug problems; and (3) encourages state medical societies to work actively with drug task forces and study committees in their respective states to assure that their scope of study includes recognition of the strong correlation between alcohol abuse and other substance abuse and recommendations to decrease the immense number of health, safety, and social problems associated with alcohol abuse. (Sub. Res. 97, I-89; Reaffirmed: Sunset Report, A-00)

H-30.974 Return to Work Following Successful Rehabilitation for the Disease Alcoholism and Other Chemical Dependencies

Our AMA reaffirms the concept that successful treatment of patients with the disease alcoholism, or other chemical dependencies, followed by appropriate medical supervision and monitoring on a continuing basis, will allow most individuals to return to meaningful, productive employment and resume full responsibility of their normal job assignment or profession. (Res. 191, A-89; Reaffirmed: BOT Rep. 18, I-93; Reaffirmed: CSA Rep. 8, A-03)

H-30.975 Regulating the Availability of Alcoholic Beverages

Our AMA supports the development of model state legislation that would reduce the availability of alcoholic beverages by eliminating their sale at gasoline retailers. (Sub. Res. 142, A-89; Reaffirmed: Sunset Report, A-00)

H-30.977 Alcoholism as a Disease

The AMA urges change in federal laws and regulations to require that the Veterans Administration determine benefits eligibility on the basis that alcoholism is a disease. (Res. 112, A-88; Reaffirmed: Sunset Report, I-98)

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)

H-30.983 Medical Education on Alcoholism and Other Chemical Dependencies

The AMA supports (1) taking a leadership role in educating or causing changes in physician education for exposure to early identification, treatment and prevention of alcoholism and other chemical dependencies; and (2) public education efforts in coordination with other interested groups on an ongoing basis. (Res. 67, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 10, A-99)

H-30.985 Alcohol-Related Injuries Requiring Medical Care

Injuries requiring medical care have been identified by the AMA as one of the most serious consequences of the use of alcoholic beverages. (BOT Rep. T, I-85; Reaffirmed by CLRPD Rep. 2, I-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)

H-30.989 Nationwide Legal Drinking Age of 21 Years

The AMA (1) encourages each state medical society to seek and support legislation to maintain at 21 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)

H-30.995 Alcoholism as a Disability

(1) The AMA believes it is important for professionals and laymen alike to recognize that alcoholism is in and of itself a disabling and handicapping condition. (2) The AMA encourages the availability of appropriate services to persons suffering from multiple disabilities or multiple handicaps, including alcoholism. (3) The AMA endorses the position that printed and audiovisual materials pertaining to the subject of people suffering from both alcoholism and other disabilities include the terminology "alcoholic person with multiple disabilities or alcoholic person with multiple handicaps." Hopefully, this language clarification will reinforce the concept that alcoholism is in and of itself a disabling and handicapping condition. (CSA Rep. H, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed by CSA Rep. 14, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-30.996 Alcoholism Insurance

Our AMA supports (1) continued efforts to stimulate provision of a broad continuum of alcoholism treatment benefits by insurers that follow the plan of the National Institute on Alcohol Abuse and Alcoholism; and (2) continued encouragement for consideration by state legislatures of legislation providing for truth in benefits advertising and clarity of contract language. (Sub. Res. 67, A-80; Reaffirmed: CLRPD Rep. B, I-90; Modified: Sunset Report, I-00)

H-30.997 Dual Disease Classification of Alcoholism

The AMA reaffirms its policy endorsing the dual classification of alcoholism under both the psychiatric and medical sections of the International Classification of Diseases. (Res. 22, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed by CSA Rep. 14, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-30.998 Recommendations for AMA Involvement in Alcoholism Activities

To further emphasize the seriousness of alcoholism and the importance of the physician's role in prevention and treatment of this disease, our AMA: (1) encourages relevant medical specialty societies to inform their membership about opportunities for treatment and early intervention, especially among women alcoholics and children of alcoholics;

(2) encourages the broadcasting industry and appropriate advertising agencies to formulate a sustained public service campaign on the medical and social hazards of excessive alcohol use;

(3) reaffirms that effective and comprehensive treatment for alcoholic persons requires the involvement of a physician; and

(4) urges that quality of treatment not be sacrificed to cost considerations. (CSA Rep. E, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

H-30.999 Admission of Alcoholics to General Hospitals

The AMA encourages insurance companies and prepayment plans to remove unrealistic limitations on the extent of coverage afforded for the treatment of alcoholism, recognizing that alcoholism is a chronic illness and that multiple hospital admissions under medical supervision may be essential to arresting the progress of the disease. (CMS Rep. G, I-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-35.000 Allied Health Professions
(See also: Health Workforce; Mental Health; Nursing)

H-35.970 Doctor of Nursing Practice

1. Our American Medical Association opposes participation of the National Board of Medical Examiners in any examination for Doctors of Nursing Practice (DrNP) and refrain from producing test questions to certify DrNP candidates.

2. AMA policy is that Doctors of Nursing Practice must practice as part of a medical team under the supervision of a licensed physician who has final authority and responsibility for the patient. (Res. 214, A-08)

H-35.971 Diagnosis of Disease and Diagnostic Interpretation of Tests Constitutes Practice of Medicine to be Performed by or Under the Supervision of Licensed Physicians

It is AMA policy that:
(1) the diagnosis of disease and diagnostic interpretation of a study or studies for a specific patient constitutes the practice of

medicine;
(2) a PhD clinical lab scientist or other non-physician laboratory personnel work under the supervision of a physician under their applicable scopes of work to perform a study or studies that will be the basis of a diagnostic interpretation for a specific patient; and (3) the Medicare physician fee schedule compensate only authorized persons for the diagnostic interpretation of a specific patient and should not provide payments directly to non-physician lab personnel working under the supervision of a physician to perform a laboratory study or studies. (Res. 904, I-06)

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

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. (Res. 211, A-06)

H-35.973 Scopes of Practice of Physician Extenders

Our AMA supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care. (Res. 213, A-02)

H-35.974 Prescribing by Allied Health Practitioners

Our AMA willl work with national specialty societies to monitor the status of any initiatives to introduce legislation that would permit prescribing by psychologists and other allied health practitioners, and develop in concert with state medical associations specific strategies aimed at successfully opposing the passage of any such future legislation. (Sub. Res. 203, A-02)

H-35.975 Ratio of Physician to Physician Extenders

Our AMA endorses the principle that the appropriate ratio of physician to physician extenders should be determined by physicians at the practice level, consistent with good medical practice, and state law where relevant. (CME Rep. 10, I-98; Reaffirmed: CME Rep. 2, A-08)

H-35.976 Channeling of Eye Examinations to Optometrists

The AMA issue a letter to all third party payers stating organized medicine's strong opposition to: (a) channeling enrollees to optometrists and other non-physicians; (b) designating optometrists as primary eye care providers; (c) shifting patients from ophthalmologists to optometrists; and (d) excluding ophthalmologists from performing refractive eye examinations, routine eye examinations, or primary eye care. The AMA, state medical societies, and national medical specialty societies seek introduction of legislation prohibiting third party payers from mandating that routine and refractive examinations be performed by optometrists rather than by ophthalmologists. (Res. 213, A-98)

H-35.977 Rescission of the Balanced Budget Act Provision on Nurse Practitioner Payment and Billing Enhancements

Our AMA supports the introduction of legislation that would rescind Section 4511 of the Balanced Budget Act of 1997, which enables Nurse Practitioners and Clinical Nurse Specialists to be paid directly. (Res. 211, A-98)

H-35.978 Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital

The AMA encourages hospital medical staffs to have a process whereby physicians will have input to and provide review of education programs provided by their hospital for the benefit of allied health professionals working in that hospital, for the education of patients served by that hospital, and for outpatient educational programs provided by that hospital. (BOT Rep. B, A-93; Adopts Res. 317, A-92; Reaffirmed: CME Rep. 2, A-03)

H-35.982 Direct Access to Physical Therapy

Our AMA (1) affirms that the ordering of medical services for patients constitutes the practice of medicine and that legislation to authorize non-physicians to prescribe physical therapy and other medical care services should be opposed; and (2) encourages physicians who prescribe physical therapy to closely monitor their prescriptions to ensure that treatment is appropriate. (Res. 203, A-89; Reaffirmed: Sunset Report, A-00)

H-35.984 Proper Visual Identification of Nonphysicians Who See Patients

To avoid misunderstandings and possible misrepresentations, the AMA encourages all allied health care personnel to have visual identification of their professional position in the health care setting. (Sub. Res. 58, I-87; Reaffirmed: Sunset Report, I-97; Modified

and Reaffirmed: CSAPH Rep. 3, A-07)

H-35.985 AMA Role in Allied Health Education and Accreditation

The AMA reaffirms its commitment to promoting quality in allied health education. (CME Rep. E, I-86; Amended by Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed in lieu of Res. 705, I-07)

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)

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-35.988 Independent Practice of Medicine by "Nurse Practitioners"

The AMA, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine and surgery in all of its branches. (Sub. Res. 53, I-82; Reaffirmed: A-84; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: BOT Rep. 28, A-03)

H-35.989 Physician Assistants

(1) The AMA opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.
(2) A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of his or her practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician assistant, or (c) would authorize the unlicensed practice of medicine.
(3) The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.
(4) While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure

appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to his physician assistant.
(5) The AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.
(6) In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed. (BOT/CME/CMS Joint Rep., I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation A-99)

H-35.990 Non-Physician Measurement of Body Functions

In the public interest, the AMA recommends that non-physicians who perform tests such as blood pressure or blood sugar measurements advise the examinee to communicate these findings to a licensed physician. (Sub. Res. 59, I-80; CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-35.992 Reimbursement for Allied Health Personnel

Our AMA believes that (1) reimbursement systems should pay physicians or their institutions directly for the services of allied health personnel; and (2) such personnel should be under the supervision of practicing physicians. (BOT Rep. A, NCCMC Rec. 41, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: BOT Rep. H, A-93; Reaffirmation A-00)

H-35.993 Opposition to Direct Medicare Payments for Physician Extenders

Our AMA reaffirms its opposition to any legislation or program which would provide for Medicare payments directly to physician extenders, or payment for physician extender services not provided under the supervision and direction of a physician. (CMS Rep. N, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

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)

H-35.996 Status and Utilization of New or Expanding Health Professionals in Hospitals

(1) The services of certain new health professionals, as well as those professionals assuming an expanded medical service role, may be made available for patient care within the limits of their skills and the scope of their authorized practice. The occupations concerned are those whose patient care activities involve medical diagnosis and treatment to such an extent that they meet the three criteria specified below: (a) As authorized by the medical staff, they function in a newly expanded medical support role to the physician in the provision of patient care. (b) They participate in the management of patients under the direct supervision or direction of a member of the medical staff who is responsible for the patient's care. (c) They make entries on patients' records, including progress notes, only to the extent established by the medical staff. Thus this statement covers regulation of such categories as the new physician-support occupations generically termed physician assistants, and those allied health professionals and nurses functioning in an expanded medical support role. It is not intended to cover regulation of nurses and allied health professionals performing their regular and customary roles, nor nurse practitioners functioning within the legal definition of nursing.

(2) The hospital governing authority should depend primarily on the medical staff to recommend the extent of functions which may be delegated to, and services which may be provided by, members of these emerging or expanding health professions. To carry out this obligation, the following procedures should be established in medical staff bylaws: (a) Application for use of such professionals by medical staff members must be processed through the credentials committee or other medical staff channels in the same manner as applications for medical staff membership and privileges. (b) The functions delegated to and the services provided by such personnel should be considered and specified by the medical staff in each instance, and should be based upon the individual's professional training, experience, and demonstrated competency, and upon the physician's capability and competence to supervise such an assistant. (c) In those cases involving use by the physician of established health professionals functioning in an expanded medical support role, the organized medical staff should work closely with members of the appropriate discipline now employed in an administrative capacity by the hospital (for example, the director of nursing services) in delineating such functions. (BOT Rep. G, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-35.999 Medicine and Pharmacy Relations

(1) The contribution of pharmacy as an independent profession in assisting physicians toward the constant goal of improved patient care is recognized and commended; and (2) The AMA urges physicians to encourage and support the continued growth of pharmacy as a valuable and necessary member of the health team. (Res. 96, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-40.000 Armed Forces
(See also: Veterans - Medical Care; War)

H-40.969 CHAMPUS Payment

(1) The AMA urges the Department of Defense to raise to at least Medicare levels those CHAMPUS maximum allowable charges (CMACs) that are presently below Medicare allowable charges. (2) The AMA urges the Department of Defense to eliminate price controls and encourage competition under TRICARE through true pluralism in the health plan choices available to beneficiaries, consistent with AMA Policy H-165.890, which proposes advocating transformation of the current Medicare program through an invigorated marketplace. Consistent with Policy H-165.890, this approach should use a defined contribution by CHAMPUS, regardless of the health plan chosen. (3) Until TRICARE introduces a contracting approach that increases competition and sets physician payments through the marketplace, the AMA urges the Department of Defense to assure that all TRICARE programs pay physicians at a minimum of CMAC levels, consistent with Policy H-40.972. (BOT Rep. 1, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 2, I-08)

H-40.970 The Uniformed Services University of the Health Sciences

The AMA fully supports the continuation of the Uniformed Services University of the Health Sciences as an institution and urges the Executive and Legislative Branches of the United States Government to fulfill their responsibility to our armed forces by fully funding the Uniformed Services University of the Health Sciences. (Res. 315, A-96; Reaffirmed: CME Rep. 2, A-06)

H-40.972 CHAMPUS Balance Billing Requirements

Policy of the AMA states that CHAMPUS should (1) raise its resource-based relative value scale monetary conversion factor so that the national average CHAMPUS Maximum Allowable Charge schedule is increased to an overall level equaling the national average payment levels of private third party payers, and (2) eliminate charge limits under CHAMPUS, at least for its under-65 population if not for all of its beneficiaries. (Res. 236, I-94; BOT Rep. 24, A-96; Reaffirmed by BOT Rep. 1, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-40.973 Support of the Uniformed Services University of the Health Sciences

The AMA vigorously supports the continuance of the Uniformed Services University of the Health Sciences as vital to the continued strength, morale, and operational readiness of the military services. (Sub. Res. 306, I-93; Reaffirmed: CME Rep. 2, A-03)

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)

H-40.977 Pay Equity for Physicians in Active and Reserve Uniformed Services

For reservists called to active duty or on short-term mobilization assignments, the AMA supports the adjustment of pay and allowances upwards to approach pay and allowances for those with similar rank and qualifications in regular and long-term reserve status. (Sub. Res. 233, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, I-04)

H-40.979 Reserve Physicians In-Training

Our AMA supports the position that, at the time of national emergency, residents and fellows called to support their country in military service should be placed, when possible, in positions consistent with their specialty and level of training. (Res. 67, A-91;

Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, I-04)

H-40.981 Liability Insurance Costs Caused by Military Service

Our AMA supports petitioning Congress, the President, and other relevant authorities to seek appropriate amendments to the Soldiers and Sailors Relief Act in order to provide adequate professional liability protections for physicians called to active military duty. (Sub. Res. 133, I-90; Modified: Sunset Report, I-00)

H-40.983 Active and Reserve Physicians

(1) Our AMA requests the Residency Review Committees and Specialty Boards to develop flexible policies to ensure that (a) resident physicians and fellows who are members of the active or reserve components of the uniformed services of the United States retain their academic and training status within their respective training programs during periods of reserve activation or active duty with the uniformed services; and (b) active duty or deployment time with the uniformed services during a residency or fellowship should be credited toward the usual training period for eligibility for matriculation and Board examinations when the trainee's experiences have been educationally appropriate. (2) Our AMA strongly encourages state licensing boards to waive requirements for continuing medical education credits for physicians during periods of reserve or national guard activation or active duty with the uniformed services. (Res. 187, I-90; Modified: Sunset Report, I-00; Reaffirmed: CME Rep. 2, I-04)

H-40.984 Physician Reservists

It is the policy of the AMA to encourage reservist physicians to contact their local societies and inform them when and if they are called to active duty. (Res. 166, I-90; Modified: Sunset Report, I-00)

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-40.991 Support of the Civilian Military Contingency Hospital System (CMCHS)

The AMA (1) recommends that the AHA and the Department of Defense clarify the CMCHS; and (2) supports education of the AMA and AHA membership on the potential impact of the CMCHS. (Sub. Res. 124, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: BOT Rep. 29, A-04)

H-40.992 Prohibition of Pay Allowances to Military Physicians Serving in Managerial and Administrative Positions

The AMA opposes legislative or regulatory prohibition of the application of various special pay allowances to military physicians serving in executive and managerial positions. (Sub. Res. 30, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: BOT Rep. 12, A-05)

H-40.993 Support of the Civilian-Military Contingency Hospital System

The AMA supports the CMCHS and urges U.S. civilian hospitals, when requested, to provide all possible support to the Department of Defense CMCHS in this important effort which will enable the U.S. to prepare for the treatment of casualties from any future conventional military conflict. (Sub. Res. 17, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CMS Rep. 10, A-03)

H-40.994 Military Physicians in Graduate Medical Education Programs

Our AMA opposes any arbitrary attempt to limit the percentage of resident physicians in military graduate education or training programs. (Res. 71, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-40.995 Graduate Medical Education in the Military

Our AMA: (1) strongly supports and endorses the graduate medical education programs of the military services and recognizes the potential benefit to the military services of recruitment, retention and readiness programs; and (2) is gravely concerned that closures of military medical centers and subsequent reduction of graduate medical education programs conducted therein will not only impede the health care mission of the Department of Defense, but also harm the health care of the nation by increasing the drain on trained specialists available to the civilian sector. (Sub. Res. 1, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

H-40.996 Appointment of Assistant Secretary of Defense for Health Affairs

Our AMA believes that the U.S. President should nominate a physician experienced in military medicine for appointment as Assistant Secretary of Defense for Health Affairs. (Res. 123, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

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)

H-40.998 Variable Incentive Pay Program

Our AMA, through letters to the President and appropriate members of the Congress and through such other means as are appropriate, strongly supports timely re-enactment of the Variable Incentive Pay Program for physicians in military service. (Res. 91, A-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-40.999 Medical Representation of Joint Chiefs of Staff

Under supervision of qualified medical officers of the three military services, medical representation is essential to effect coordination of the medical and health aspects of tactical, strategic and long range planning in the Joint Staff, the Combined Staff and the Special Command Staffs. (BOT Rep. L, I-59; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-45.000 Aviation Medicine

H-45.978 Inflight Medical Emergencies

Our AMA urges: (1) urges that decisions to expand the contents of inflight emergency medical kits and place emergency lifesaving devices onboard commercial passenger aircraft be based on empirical data and medical consensus; inflight medical supplies and equipment should be tailored to the size and mission of the aircraft, with careful consideration of flight crew training requirements; and (2) the Federal Aviation Administration to work with appropriate medical specialty societies and the airline industry to develop and implement comprehensive inflight emergency medical systems that ensure:
(a) rapid 24-hour access to qualified emergency medical personnel on the ground;
(b) at a minimum, voice communication with qualified ground-based emergency personnel;
(c) written protocols, guidelines, algorithms, and procedures for responding to inflight medical emergencies;
(d) efficient mechanisms for data collection, reporting, and surveillance, including development of a standardized incident report form;
(e) adequate medical supplies and equipment aboard aircraft;
(f) routine flight crew safety training;
(g) periodic assessment of system quality and effectiveness; and
(h) direct supervision by physicians with appropriate training in emergency and aerospace medicine. (CSA Rep. 3, I-99)

H-45.979 Air Travel Safety

Our AMA : (1) encourages the ongoing efforts of the Federal Aviation Administration, the airline industry, the Aerospace Medical Association, the American College of Emergency Physicians, and other appropriate organizations to study and implement regulations and practices to meet the health needs of airline passengers and crews, with particular focus on the medical care and treatment of passengers during in-flight emergencies; and (2) encourages physicians to inform themselves and their patients on the potential medical risks of air travel and how these risks can be prevented; and become knowledgeable of medical resources, supplies, and options that are available if asked to render assistance during an inflight medical emergency. (CSA Rep. 5, I-98; Appended: CSA Rep. 3, I-99)

H-45.980 Airborne Infections on Commercial Flights

(1) Under usual aircraft operation procedures, cabin air quality does not present a significant risk for transmission of airborne infections. (2) The AMA supports efforts of the Aerospace Medicine Association and other groups to educate physicians and the public about the public health risks associated with flying with airborne transmissible diseases. (3) The AMA supports the ongoing research of organizations such as the American Society of Heating, Refrigeration and Air Conditioning Engineers and the National Institute of Occupational Safety and Health to determine standards for cabin air quality. (CSA Rep. 10, A-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-45.981 Improvement in US Airlines Aircraft Emergency Kits

Our AMA urges federal action to require all US air carriers to report data on inflight medical emergencies, specific uses of inflight medical kits and emergency lifesaving devices, and unscheduled diversions due to inflight medical emergencies; this action should further require the Federal Aviation Administration to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of inflight medical emergencies and issue recommendations regarding the contents of inflight medical kits and the use of emergency lifesaving devices aboard commercial aircraft. (Res. 507, A-97; Amended: CSA Rep. 3, I-99)

H-45.982 Laser Lights

The AMA strongly supports a moratorium on laser light demonstrations and shows near critical flight zones involving landing and departing aircraft until the Federal Aviation Administration has investigated methods to prevent the exposure of air crew to laser lights capable of causing physiological impairment of air crews. (Res. 402, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-45.983 Medical Oxygen Therapy on Scheduled Commercial Air Service

Our AMA (1) supports the accommodation of passengers requiring medical oxygen therapy on scheduled commercial aircraft and in airports; (2) recommends that regulatory agencies, medical specialty societies, commercial air carriers, airport authorities, and other interested parties develop a coordinated system, with uniform guidelines specifying acceptable procedures and equipment for the use of medical oxygen in airports and aboard commercial aircraft, that will permit passengers to schedule oxygen with the least possible administrative and financial difficulty and to have available to them an uninterrupted source of oxygen from departure to destination; and (3) urges that any revised system to improve the accommodation of passengers requiring medical oxygen ensure the safety and security of other airline passengers and airport personnel. (Res. 519, A-95; Amended CSA Rep. 4, I-99)

H-45.984 Proposed Excessive Federal Fees for Aviation Medical Examiners

The AMA opposes any regulation requiring aviation medical examiners (AMEs) to attend seminars with excessive registration fees and opposes any legislation imposing a fee for serving as an AME for the Federal Aviation Administration. (Res. 209, I-93; Reaffirmed: CME Rep. 2, A-03)

H-45.986 Protection of Insurance Coverage for Medical Attendants Aboard Non-Scheduled Aircraft

Our AMA supports seeking appropriate action, including legislation if necessary, which would result in an exemption or exception to the exclusion of benefits clauses of insurance policies for all medical care providers and others when they are participating in medical aircraft flights, even though such flights might otherwise be considered as "non-scheduled." (Sub. Res. 144, A-91; Reaffirmed: Sunset Report, I-01)

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)

H-45.989 Child Safety Restraint Use in Aircraft

Our AMA supports (1) the use of appropriate restraint systems for all children on all commercial airline flights; and (2) working with the Federal Aviation Administration to establish criteria for appropriate child restraint systems. (Sub. Res. 163, I-89; Reaffirmed: CSA Rep. 5, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

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-45.991 Safety Training Which Includes Medical Training for Commercial Airline Crews

Our AMA urges the Federal Aviation Administration to require safety training programs for commercial airlines cabin crews which includes, at a minimum, instructions in first aid; CPR; the Heimlich maneuver; and the location, function, operation, and maintaintence of emergency medical kits and life-saving medical equipment. (Res. 160, A-88, Rescinded: Sunset Report, I-98; Reinstated and amended, CSA Rep. 3, I-99)

H-45.992 Airplane Safety

The AMA urges (1) the appropriate federal agencies to review, fully enforce and, where necessary, strengthen security measures at airports; and (2) that regulations be changed to require that all personnel entering, working on, or delivering anything to a commercial aircraft which carries passengers be required to pass through the same security measures as passengers. (Res. 60, A-88; Reaffirmed: CSA Rep. 5 and Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-45.993 Support of Residencies in Aerospace Medicine

The AMA offers its encouragement and assistance to the Congress, the Executive Office, NASA, the Department of Defense, and the FAA in providing support to residency training programs in aerospace medicine. (Res. 19, I-87; Reaffirmed: CME Rep. 2, A-05)

H-45.994 Continuation of Medical Research on Manned Space Flights

1. Our AMA supports the continuation of the NASA and other programs for conducting medical research and other research with potential health care benefits on manned space flights, including the continued development and subsequent operation of the international space station.

2. Our AMA (a) publicly supports the National Aeronautics and Space Administration's new commitment for manned space exploration of the moon, Mars, and other celestial bodies for the benefits to medicine and advances in patient care and (b) supports the continuation of NASA research to accomplish safe, human space exploration as this research has demonstrated and may have potential future benefits to medicine and advances in patient care. (Sub. Res. 118, A-86; Modified by Sub. Res. 217, A-94; Reaffirmed: CSA Rep. 6, A-04; Appended and Reaffirmed: Res. 502, A-07)

H-45.996 Emergency Equipment on Commercial Aircraft

AMA policy is to pursue federal legislation mandating US commercial passenger aircraft to carry adequate medical supplies and equipment on each flight to allow onboard physicians and other healthcare professionals to administer reasonable emergency medical care to adult and pediatric passengers. (BOT Rep. P, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Appended: Res. 203, I-97; Reaffirmation A-99; Amended: CSA Rep. 3, I-99)

H-45.997 In-Flight Emergency Care

Our AMA supports legislative provisions that grant any physician, other medical professional, or airline employee, acting in the role of a Good Samaritan during an inflight medical emergency, an umbrella of immunity against legal or personal redress by the airline, the passengers, or the persons involved in the medical emergency. (BOT Rep. S, I-83; CLRPD Rep. 1, I-93; Reaffirmed by Sub. Res. 201, I-96; Amended: CSA Rep. 3, I-99)

H-45.998 Aircraft Shoulder Harness

The AMA supports the National Transportation Safety Board position that the FAA take action to require the installation of approved shoulder harnesses for all seat locations in general aviation aircraft. (Res. 124, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed and Modified: CSA Rep. 8, A-05)

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)

H-50.000 Blood
(See also: Acquired Immunodeficiency Syndrome)

H-50.974 Revision of the Lifetime Deferral for Blood Donation of the Men Who Have Sex with Men (MSM) Population

Our AMA recognizes that based on existing scientific evidence and risk assessment models, a shift to a 5-year deferral policy for blood donation from men who have sex with men (MSM) is supportable. (CSAPH Rep. 5, A-08)

H-50.975 Safety of Blood Donations and Transfusions

Our AMA:

(1) Supports working with blood banking organizations to educate prospective donors about the safety of blood donation and blood transfusion;

(2) Supports the use of its publications to help physicians inform patients that donating blood does not expose the donor to the risk of HIV/AIDS;

(3) Encourages physicians to inform high-risk patients of the value of self-deferral from blood and blood product donations; and

(4) Supports providing educational information to physicians on alternatives to transfusion. (CSA Rep. 4, A-03)

H-50.976 Blood Bank Look-Back Programs

Our AMA supports the concept of blood bank look-back recipient notification programs as a means of protecting patients and reducing the possible spread of infections. (CSA Rep. 4, A-03)

H-50.977 Blood Donor Recruitment

Our AMA: (1) advocates to the federal government for the establishment of a national volunteer blood donor education and recruitment campaign to assure an adequate and readily available blood supply; and (2) supports scientifically-based policies that ensure the safety of the nation’s blood supply. (Sub. Res. 401, A-02)

H-50.978 Leukoreduction of Blood and Blood Products

Pending further scientific studies, our AMA will advocate that both leukoreduced and non-leukoreduced blood products should be made available, and that it should be the physician's prerogative to determine whether or not to use leukoreduced blood, relative to each specific patient’s needs. (Res. 507, A-01; Reafirrmed: Res. 512, I-01)

H-50.979 Use of Blood Therapeutically Drawn from Hemochromatosis Patients

Our AMA: (1) encourages physicians to explain to their patients that hereditary hemochromatosis (HH) has a genetic basis, that the disease is not transmissible via blood transfusions, and that the blood from persons with HH is not necessarily unsuitable for direct transfusion; and (2) recommends against the unlabeled use for direct transfusion of blood drawn therapeutically from persons with hereditary hemochromatosis (HH) until a means to ensure their altruistic intent is available, such as when therapeutic phlebotomies are available at no charge to persons requiring them. (CSA Rep. 1, A-99)

H-50.980 Increasing Bone Marrow Screening

Our AMA supports efforts to increase blood donor awareness of bone marrow screening through the addition of a question on the questionnaire required for blood donation or through focused queries or invitations presented during the blood donation process that will assess the donor’s interest in obtaining information about bone marrow donation, and that information be provided to those donors who indicate an interest. (Res. 502, I-98; Modified: CSAPH Rep. 7, A-07)

H-50.981 Crossover Use of Donated Blood

The AMA does not encourage blood collection programs to "crossover" blood units donated for autologous use to the allogeneic blood supply. (CSA Rep. 11, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-50.982 Autologous Blood Transfusions

The AMA (1) supports the collection of autologous blood from candidates for elective surgery who are without contraindications to phlebotomy and when such donations are medically indicated because transfusion is likely to be needed; and (2) supports efforts to remove economic barriers to the collection and use of autologous blood for transfusion, in order to promote its wider use. (CSA Rep. A, I-92; Modified: CSA Rep. 8, A-03)

H-50.985 Nationwide Reporting of Elevated Blood Lead Levels

Our AMA supports regulation to require uniform, nation-wide, laboratory-based reporting of elevated blood-lead (Pb-B) levels to state health departments and to the CDC. (CSA Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

H-50.986 Blood Donations by Donors over 65 Years of Age

The AMA supports and encourages the increased continued donation of blood by healthy adult donors over age 65. (Res. 36, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-50.987 Autologous Transfusions for Elective Surgery

The AMA urges all physicians to educate patients with regard to autologous blood donations prior to elective surgical procedures when such donations are medically indicated and when transfusion is likely to be needed. (Res. 117, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-50.988 Autologous Blood Transfusions

The AMA believes that autologous blood transfusion is the safest form of transfusion therapy and endorses the use of this method of transfusion therapy. (CSA Rep. H, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-50.990 Blood Shortage and Collection

In response to a continuing need for blood for transfusion and decreasing supplies of allogeneic blood, our AMA supports programs that encourage donation of blood to the allogeneic supply by health volunteer donors; and the AMA encourages physicians to participate in promotional efforts to encourage blood donation, and urges the American Blood Commission to actively participate in these programs. (Res. 41, A-82; Reaffirmed: CLRPD Rep. A, I-92; Modified by CSA Rep. 11, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-50.993 Blood Donor Incentives

Our AMA opposes current and future legislative efforts to mandate specific or nationally uniform blood donor incentives, and urges constituent members to oppose legislative proposals on the state level that would tend to limit or impose blood donor incentives at the local level. (Res. 2, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-50.995 Voluntary Donations of Blood and Blood Banking

Our AMA reaffirms its policy on voluntary blood donations (C-63); and directs attention to the need for adequate donor selection and post-transfusion follow-up procedures. Our AMA (1) endorses the FDA's existing blood policy as the best approach to assure the safety and adequacy of the nation’s blood supply;
(2) supports current federal regulations and legislation governing the safety of all blood and blood products provided they are based on sound science;
(3) encourages the FDA to continue aggressive surveillance and inspection of foreign establishments seeking or possessing United States licensure for the importation of blood and blood products into the United States;
(4) requests periodic reports from the FDA on the safety of imported blood and blood products; and
(5) urges regulatory agencies and collection agencies to balance the implementation of new safety efforts with the need to maintain adequate quantities of blood to meet transfusion needs in this country. (BOT Rep. V, A-71; Reaffirmed: CLRPD Rep. C, A-89; Appended: Res. 507, A-98; Appended: CSA Rep. 4, I-98; Reaffirmed: CSA Rep. 1, A-99; Amended & Appended: Res. 519, A-01)

H-50.996 Blood for Medical Use

(1) Blood transfusions and the use of other bodily tissues or substances or biological substances in rendering medical care to patients are often essential to save the life of a patient or to protect his health. Protecting the welfare of patients requires that blood for transfusions and bodily tissues or substances and biological substances be available and that use when needed be encouraged and not burdened with unreasonable restrictions and increased costs.

(2) When liability for damages in the absence of negligence is imposed following injury resulting from the administration of blood transfusions, bodily tissues or substances or biological substances, the cost of medical care is increased and inevitably the availability of medical care is adversely affected.

(3) The public interest requires and the state medical associations are urged to seek the enactment of appropriate state legislation which will provide that any person or organization involved in the collection, processing, distribution, or administration of blood or other bodily tissues or substances or biological substances for medical use shall be liable for any injury suffered by a patient only if the injury was proximately caused by the negligence of such person or organization. (BOT Rep. M, I-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-50.997 Blood Donors

Our AMA encourages state medical associations to actively promote state legislation to provide that persons age 18 or over may donate blood without parental permission or authorization. (BOT Rep. BB, A-69; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-50.998 Definition of Blood as a Medical Service

The AMA (1) endorses the concept that the procurement, processing, distribution, or use of human blood and other human tissues is the rendering of medical services by all who participate therein, not the selling of a commodity; (2) reaffirms the position that, beyond assurances that all such participants shall be responsible to exercise the highest standards of professional judgment and procedure, the results of medical services cannot be guaranteed; and (3) supports legislative action at the federal level to implement this concept and position and urges the constituent medical societies to support similar action in their respective jurisdictions. (Res. 21, I-67; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-50.999 Blood Banks

In recent years there has been a dramatic growth of blood banking facilities in the United States. The procurement of human blood and its transfusion to patients are medical procedures which require the direction and supervision of a physician. The ultimate objective of these procedures is the welfare of persons who require blood or blood derivatives. The medical profession has primary responsibility for the care and treatment of patients, and, therefore, has a paramount interest in evaluating facilities and procedures for blood procurement, storage and use. (BOT Rep. I, I-63; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-55.000 Cancer

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)

H-55.979 Genetic Susceptibility Testing for Hereditary Cancers

Policy of the AMA states:

(1) That physicians who feel unprepared to provide comprehensive genetic test counseling should refer candidates for genetic susceptibility testing to specialized care centers with experience and expertise in hereditary cancers or to investigators for relevant research, where family history can be confirmed and they can be tested if they so choose.

(2) That genetic susceptibility testing, including that marketed directly to consumers, should be provided only in the context of fully informed consent and comprehensive pre- and post-test counseling by a qualified health care professional. (CSA Rep. 7, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Modified: BOT Rep. 7, A-08)

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; and (4) encourages physicians to educate their patients concerning the correct way to perform skin self-examination. (Sub. Res. 505, A-96; Reaffirmation I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-55.981 Carcinoma of the Colon and Rectum

Our AMA supports: (1) Appropriate screening programs to detect colorectal cancer in individuals who are older than 50 years of age or have risk factors. (2) The general recommendations of major health care organizations for colorectal cancer (CRC), which are as follows: annual fecal occult blood testing, beginning at age 50, and flexible sigmoidoscopy every 3 to 5 years from age 50, for persons at average risk. Colonoscopy and/or double-contrast barium enema procedures, which screen the entire colon, should be considered as appropriate alternatives. (3) Persons at increased risk for CRC (family history of CRC, previous adenomatous polyps, inflammatory bowel disease, previous resection of CRC, genetic syndromes) receiving more intensive screening efforts. (4) Physicians becoming aware of genetic alterations that influence the development of CRC, and of diagnostic and screening tests that may become available in this area. (Sub. Res. 513, I-95; Appended: CSA Rep. 7, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-55.983 Reimbursement and Coverage Implications of Clinical Trials in Treatment of Cancer

The AMA recommends that CMS and other third party payers not deny coverage and reimbursement for the costs of medical care to patients entered in qualifying clinical trials of therapeutic regimens at any Phase. Covered costs should include those usually covered (hospital care and physician and other health care services), as well as the costs of all FDA-approved agents utilized in the trial, regardless of whether use is for an on-label or off-label indication. Qualifying clinical trials must satisfy all of the following inclusion criteria: (1) Treatment is provided with a therapeutic intent (intent refers to an intention to improve patient outcome, relative to survival or quality of life);

(2) Treatment is being provided pursuant to a clinical trial which has been approved by the National Cancer Institute (NCI) or any of its cancer centers, Regional Cooperative Oncology Groups or community clinical oncology programs, the FDA in the form of an investigational new drug exemption, the Department of Veterans Affairs, or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants;

(3) The proposed therapy has been reviewed and approved by a qualified institutional review board;

(4) The facility and personnel providing the treatment are capable of doing so by virtue of their experience or training;

(5) There is no noninvestigational therapy that is clearly superior to the protocol treatment; and

(6) The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as noninvestigational therapy. (Res. 502, A-93; Reaffirmed: CMS Rep. 10, A-03)

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)

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)

H-55.986 Home Chemotherapy and Antibiotic Infusions

Our AMA (1) endorses the use of home injections and/or infusions of FDA approved drugs and group C drugs (including chemotherapy and/or antibiotic therapy) for appropriate patients under physicians' supervision, and encourages CMS and/or other insurers to provide adequate reimbursement for such treatment; and (2) supports educating legislators and administrators about the benefits of such treatments in terms of cost saving, increased quality of life and decreased morbidity, and about the need to provide access to such treatments by appropriate reimbursement policies. (Res. 186, I-89; Reaffirmed: Sunset Report and Reaffirmation A-00)

H-55.987 Viability of Cancer Clinical Research - Patient Accrual

Our AMA: (1) Recognizes the necessary leadership role of clinical oncologists and supports working closely with the American Society of Clinical Oncology, the American Society for Therapeutic Radiology and Oncology and other appropriate organizations to encourage referral of patients to qualified oncologists who serve as investigators in clinical trials. The AMA also supports examining, in depth, the potential for the greater involvement of community-based physicians either through referral to or by direct participation in peer-review clinical protocols.

(2) Supports clearly defining the logistical impediments to participation in clinical research for community physicians.

(3) Supports working to develop mechanisms to overcome problems with patient accrual in clinical cancer research.

(4) Supports enhancing its position as an intermediary in more closely aligning the expressed objectives of community physicians to be involved in clinical research and of academic physicians to enhance the scientific and clinical knowledge base. This includes actively working with NCI and research institutions and centers to ensure that community physicians and academic physicians collaborate and cooperate at each step of the research process in order to optimize research design, patient accrual, evaluation, and the

implementation of findings.

(5) Supports working with the American Society of Clinical Oncology, the American Society for Therapeutic Radiology and Oncology and other appropriate organizations to develop simplified uniform consent forms for major cancer clinical trials. (CSA Rep. G, A-89; Reaffirmed: CSA Rep. 13 and Sunset Report, A-00)

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-55.989 Testicular Cancer Self-Examination

The AMA urges promotion of national awareness of the problem of testicular cancer and supports programs of education in the proper method of self-examination to lead to early detection of testicular cancer. (Res. 28, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-55.990 Cancer Risk of Pesticides in Agricultural Workers

The AMA: (1) urges the EPA and other responsible state and federal regulatory agencies to continue their efforts at safeguarding human and environmental health, and especially the health of agricultural workers who may be exposed to pesticides; (2) urges physicians to utilize the resources of local or regional poison control centers or the National Pesticide Information Center for the composition and toxicity of specific pesticides; and (3) through its scientific journals and publications, supports alerting physicians to the potential hazards of agricultural pesticides. (CSA Rep. B, I-87; Reaffirmed by CSA Rep. 4 - I-94; Reaffirmation I-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06)

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)

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)

H-55.993 Early Detection of Breast Cancer

(1) The AMA supports public education efforts to help women recognize their important role in breast self-examination and to encourage them to report immediately to their physicians any changes that they notice.

(2) The AMA encourages physicians to educate their patients in the process of breast cancer detection, emphasizing the technique of self-examination of their breasts.

(3) Physicians requesting mammographic examinations should refer their patients to radiologists who use properly functioning equipment that provides the best image resolution at the lowest level of radiation exposure.

(4) Physicians are encouraged to recognize the importance of mammography as an effective screening device to detect early breast cancer.

(5) The AMA encourages pharmaceutical companies to include in the packaging of their contraceptives, and all female hygiene products, materials which promote the package and correct techniques of breast self-examination, and which stress the importance of physician breast examinations and appropriate use of screening mammography. (CSA Rep. A, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Res. 501, I-95; Reaffirmed and Modified: CSA Rep. 8, A-05)

H-55.994 Coverage of Chemotherapy in Physicians' Offices

The AMA advocates that physicians who bill any third party payer for administering chemotherapy should ensure that the services

billed for are described adequately and fully on the appropriate claim form and that the chemotherapy descriptors and code numbers provided by CPT are utilized. (CMS Rep. C, I-82; Reaffirmed: CLRPD Rep. A, I-92; Modified and Reaffirmed: CMS Rep. 10, A-03)

H-55.995 Medicare Coverage of Outpatient Chemotherapy Drugs

Carriers should recognize and encourage the administration of chemotherapy in physicians' offices, wherever practical and medically acceptable, as being more cost-effective than administration in many other settings. (CMS Rep. J, A-82; Amended: CLRPD Rep. A, I-92; Reaffirmed: CMS Rep. 10, A-03)

H-55.996 Carcinogen Regulation

Our AMA should advise federal regulatory agencies of the importance of providing a comment period of at least 90 days following the proposal of a regulation, so that there may be an extensive, in-depth peer review of the proposed policy or rule. Publication of the scientific data in peer-reviewed journals would allow full consideration of the issue by the scientific community at large. (CSA. Rep. A, I-80; CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-55.997 Refusal of Third Party Payers to Pay for Reconstructive Surgery of the Breast to Correct Deformities

Our AMA believes that reconstruction of the breast for rehabilitation of the postmastectomy cancer patient should be considered reconstructive surgery rather than aesthetic surgery. (Sub. Res. 174, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

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)

H-55.999 Symptomatic and Supportive Care for Patients with Cancer

Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient. It is also recognized that the substantial cost of cancer management must be a continuing concern of the practicing physician caring for the cancer patient. (CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 514, I-00)

H-60.000 Children and Youth
(See also: Contraception; Health Education; Infant Health; Pregnancy; Sports and Physical Fitness)

H-60.931 Toy Safety

Our AMA supports: (1) educational campaigns to raise awareness among the public regarding the safety of toys and other child-related products that are recalled; and (2) national legislation aimed at improving toy safety. (Res. 415, A-08)

H-60.932 Ensuring the Best In-School Care for Children with Diabetes

Our AMA policy is that physicians, physicians-in-training, and medical students should serve as advocates for pediatric patients with diabetes to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections. (CSAPH Rep. 4, A-08)

H-60.933 Reauthorization of BPCA and PREA

Our AMA will advocate that the US Congress complete work on reauthorization of the Best Pharmaceuticals in Children Act and the Pediatric Research Equity Act with appropriate incentives to support ongoing pediatric research and continued public funding of clinical research for those pediatric drugs that have no commercial sponsor. (Res. 524, A-07)

H-60.934 Internet Pornography: Protecting Children and Youth Who Use the Internet

Our AMA:

(1) Recognizes the positive role of the Internet in providing health information to children and youth.
(2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.
(3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.
(4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet use.
(5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet use. (BOT Rep. 10, I-06)

H-60.935 The National Children's Study

Our AMA: (1) endorses the National Children's Study (NCS) and the study's goal to generate scientific knowledge which will enhance health care for children and families throughout the life cycle; (2) strongly supports continued funding of the NCS at levels necessary to begin enrollment in 2007 as scheduled; and (3) will transmit the actions of the House of Delegates directly to appropriate federal officials, the United States Congress and leadership of the NCS. (Res. 430, A-06)

H-60.936 Safety and Efficacy of Selective Serotonin Reuptake Inhibitors (SSRIs) in Children and Adolescents

Our AMA recommends that selective serotonin reuptake inhibitors (SSRIs) should remain available for use in children and adolescents, including unlabeled uses, subject to the exercise of prudent clinical judgment and development of clinical guidelines for treatment. Current clinical evidence indicates that fluoxetine is an effective SSRI in children and adolescents with major depressive disorder. (CSA Rep. 10, A-05)

H-60.937 Teen and Young Adult Suicide in the United States

Our AMA recognizes teen and young-adult suicide as a serious health concern in the US. (Res. 424, A-05)

H-60.938 Adolescent Sexual Activity

1. Our AMA (a) endorses the joint position "Protecting Adolescents: Ensuring Access to Care and Reporting Sexual Activity and Abuse"; and (b) supports the following principles for consideration in development of public policy:
(i) Sexual activity and sexual abuse are not synonymous and that many adolescents have consensual sexual relationships;
(ii) It is critical that adolescents who are sexually active receive appropriate confidential health care and screening;
(iii) Open and confidential communication between the health professional and adolescent patient, together with careful clinical assessment, can identify the majority of sexual abuse cases;
(iv) Physicians and other health care professionals must know their state laws and report cases of sexual abuse to the proper authority in accordance with those laws, after discussion with the adolescent and/or parent as appropriate;
(v) Federal and state laws should support physicians and other health care professionals in their role in providing confidential health care to their adolescent patients; and
(vi) Federal and state laws should affirm the authority of physicians and other health care professionals to exercise appropriate clinical judgment in reporting cases of sexual activity.

2. Our AMA will (a) develop and disseminate to national medical specialty societies and state medical associations information that includes guidance on removing barriers faced by sexually active adolescents who seek confidential health care; and (b) develop model legislation which supports AMA policy regarding adolescent sexual activity and confidentiality. (Res. 825, I-04)

H-60.939 Proposed Legislative Changes in Head Start Program Administration and Funding

Our AMA supports: (1) keeping the Head Start program in the Department of Health and Human Services; and (2) providing every eligible child with access to and the opportunity to fully participate in a community-based Head Start program. (Res. 442, A-04)

H-60.940 Partner Co-Adoption

Our AMA will support legislative and other efforts to allow the adoption of a child by the same-sex partner, or opposite sex non-married partner, who functions as a second parent or co-parent to that child. (Res. 204, A-04)

H-60.941 Effects of Alcohol on the Brains of Underage Drinkers

Our AMA encourages increased medical and policy research on the harmful effects of alcohol on adolescents and young adults and on the design and implementation of environmental strategies to reduce youth access to, and high consumption of, alcohol. (CSA Rep. 11, A-03)

H-60.942 Childhood Asthma: Emerging Patterns and Prospects for Novel Therapies

(1) Our AMA encourages physicians to: (a) educate parents of children with asthma on the assessment and reduction of known risk factors for childhood asthma; and (b) where necessary, refer patients and their families to comprehensive asthma education programs based on evaluated models. (2) Our AMA encourages and supports public health departments to examine risk factors for childhood asthma and work with medicine to develop appropriate treatment and educational resources for physicians and for families with asthmatic children. (CSA Rep. 2, A-02)

H-60.943 Bullying Behaviors Among Children and Adolescents

Our AMA: (1) recognizes bullying as a complex and abusive behavior with potentially serious social and mental health consequences for children and adolescents. Bullying is defined as a pattern of repeated aggression; with deliberate intent to harm or disturb a victim despite apparent victim distress; and a real or perceived imbalance of power (e.g., due to age, strength, size), with the more powerful child or group attacking a physically or psychologically vulnerable victim;

(2) advocates for federal support of research: (a) for the development and effectiveness testing of programs to prevent or reduce bullying behaviors, which should include rigorous program evaluation to determine long-term outcomes; (b) for the development of effective clinical tools and protocols for the identification, treatment, and referral of children and adolescents at risk for and traumatized by bullying; (c) to further elucidate biological, familial, and environmental underpinnings of aggressive and violent behaviors and the effects of such behaviors; and (d) to study the development of social and emotional competency and resiliency, and other factors that mitigate against violence and aggression in children and adolescents;

(3) urges physicians to (a) be vigilant for signs and symptoms of bullying and other psychosocial trauma and distress in children and adolescents; (b) enhance their awareness of the social and mental health consequences of bullying and other aggressive behaviors; (c) screen for psychiatric comorbidities in at-risk patients; (d) counsel affected patients and their families on effective intervention programs and coping strategies; and (e) advocate for family, school, and community programs and services for victims and perpetrators of bullying and other forms of violence and aggression;

(4) advocates for federal, state, and local resources to increase the capacity of schools to provide safe and effective educational programs by which students can learn to reduce and prevent violence. This includes: (a) programs to teach, as early as possible, respect and tolerance, sensitivity to diversity, and interpersonal problem-solving; (b) violence reduction curricula as part of education and training for teachers, administrators, school staff, and students; (c) age and developmentally appropriate educational materials about the effects of violence and aggression; (d) proactive steps and policies to eliminate bullying and other aggressive behaviors; and (e) parental involvement;

(5) advocates for expanded funding of comprehensive school-based programs to provide assessment, consultation, and intervention services for bullies and victimized students, as well as provide assistance to school staff, parents, and others with the development of programs and strategies to reduce bullying and other aggressive behaviors; and

(6) urges parents and other caretakers of children and adolescents to: (a) be actively involved in their child’s school and community activities; (b) teach children how to interact socially, resolve conflicts, deal with frustration, and cope with anger and stress; and (c) build supportive home environments that demonstrate respect, tolerance, and caring and that do not tolerate bullying, harassment, intimidation, social isolation, and exclusion. (CSA Rep. 1, A-02)

H-60.944 Use of Psychotropic Drugs in Children, Adolescents, and Young Adults

Our AMA: (1) endorses efforts to train additional qualified clinical investigators in pediatrics, child psychiatry, and therapeutics to carry out studies related to the effects of psychotropic drugs in children, adolescents, and young adults; and (2) promotes efforts to educate physicians about the appropriate use of psychotropic medications in the treatment of children, adolescents, and young adults. (Res. 504, I-00; Modified with change in title: Res. 506, A-05)

H-60.945 Neonatal Circumcision

Our AMA: (1) encourages training programs for pediatricians, obstetricians, and family physicians to incorporate information on the use of local pain control techniques for neonatal circumcision; (2) supports the general principles of the 1999 Circumcision Policy Statement of the American Academy of Pediatrics, which reads as follows:"Existing scientific evidence demonstrates potential medical benefits of newborn male circumcision; however, these data are not sufficient to recommend routine neonatal circumcision. In circumstances in which there are potential benefits and risks, yet the procedure is not essential to the child's current well-being, parents should determine what is in the best interest of the child. To make an informed choice, parents of all male infants should be given accurate and unbiased information and be provided the opportunity to discuss this decision. If a decision for circumcision is made, procedural analgesia should be provided;" and (3) urges that as part of the informed consent discussion, the risks and benefits of pain control techniques for circumcision be thoroughly discussed to aid parents in making their decisions. (CSA Rep. 10, I-99)

H-60.946 Need for Adequate Training of Teachers to Identify Potentially Dangerous Children and the Provision of Adequate Insurance Coverage to Provide for their Treatment

Our AMA: (1) supports teacher education initiatives to better enable them to identify children at risk for psychiatric illnesses, substance abuse, and potentially dangerous behaviors; and (2) reaffirms its support for parity of coverage for mental illness. (Sub. Res. 118, A-99)

H-60.947 Guns in School Settings

Our AMA recommends: (1) all children who take guns or other weapons to school should receive an evaluation by a psychiatrist or an appropriately trained mental health professional; and (2) that children who are determined by such evaluation to have a mental illness should receive appropriate treatment. (Res. 402, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-60.948 Child Protection Legislation

The AMA opposes legislation that would: (1) hinder, obstruct or weaken investigations of suspected child and adolescent abuse, and (2) hamper or interfere with child protection statutes. (Sub. Res. 219, I-97; Reaffirmed: BOT Rep. 33, A-07)

H-60.949 Opposition to Parental Rights Amendments

The AMA opposes state or federal legislative proposals (sometimes but not always known as "Parental Rights Amendments") that might give parents the right under law to harm a child or adolescent, and educate its members and the public regarding the potentially dangerous effects such initiatives represent to the public health and particularly to the health of our children. (BOT Rep. 24, A-97; Reaffirmed: BOT Rep. 33, A-07)

H-60.950 Diagnosis and Treatment of Attention Deficit/Hyperactivity Disorder in School-Age Children

Our AMA: (1) encourages physicians to utilize standardized diagnostic criteria in making the diagnosis of ADHD, such as the American Psychiatric Association's DSM-IV, as part of a comprehensive evaluation of children and adolescents presenting with attentional or hyperactivity complaints; (2) urges that attention be directed toward establishing developmentally appropriate criteria for the diagnosis and treatment of ADHD in adults; (3) encourages the creation and dissemination of practice guidelines for ADHD by appropriate specialty societies and their use by practicing physicians and assist in making physicians aware of their availability; (4) encourages efforts by medical schools, residency programs, medical societies, and continuing medical education programs to increase physician knowledge about ADHD and its treatment; (5) encourages the use of individualized therapeutic approaches for patients diagnosed with ADHD, which may include pharmacotherapy, psycho-education, behavioral therapy, school-based and other environmental interventions, and psychotherapy as indicated by clinical circumstances and family preferences; (6) encourages physicians and medical groups to work with schools to improve teachers' abilities to recognize ADHD and appropriately recommend that parents seek medical evaluation of potentially affected children; and (7) encourages further research on the relative risks and benefits of medication used to treat ADHD, including evaluation of the impact of labeling changes on access to treatment and physician prescribing. (CSA Rep. 5, A-97; Modified: CSAPH Rep. 10, A-07)

H-60.951 Aspiration Hazard of Peanuts and Other Nuts

The AMA supports the American Society of Anesthesiologists in its efforts to educate the public of the hazard of aspiration that peanuts and other nuts present to children. (Res. 430, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-60.952 AMA Support for the United Nations Convention on The Rights of the Child

Our AMA supports the United Nations Convention on the Rights of the Child and urges the Administration and Congress to support the Convention by ratifying it after considering any appropriate Reservations, Understandings, and Declarations. (BOT Rep. 44, A-96; Reaffirmed: Res. 2, I-00)

H-60.955 Screening Pediatric and Adolescent Injury Victims for Drugs and Alcohol

Our AMA: (1) supports drug and alcohol screening as an appropriate component of a comprehensive medical evaluation for pediatric and adolescent injury victims when clinically indicated; and (2) encourages physicians to actively pursue appropriate referral and treatment when clinically indicated for all pediatric and adolescent injury patients who test positive for the presence of drugs or alcohol. (Res. 408, I-94; Reaffirmation I-01)

H-60.956 Lead Poisoning Among Children

The AMA: (1) encourages physicians and public health departments to regularly screen all children under the age of six for lead exposure through history-taking and when appropriate by blood lead testing. The decision to employ blood testing should be made based on prevalence studies of blood lead levels in the local pediatric population. Findings from these studies will determine whether universal or targeted screening should be employed; and (2) encourages the reporting of all children with elevated blood levels to the appropriate health department in their state or community. 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)

H-60.957 First Aid Training for Child Day Care Workers

The AMA will work with the state medical societies, in conjunction with the child day care industry in the states, to promote already existing standards relating to safety guidelines in child day care facilities which recommend that all licensed child day care facilities have a minimum of one employee on site and available during all business hours who is currently certified in first aid, including adult/pediatric and infant CPR and foreign body airway management. (Res. 213, I-94; Reaffirmed: CSA Rep. 6, A-04)

H-60.958 Rights of Minors to Consent for STD/HIV Prevention, Diagnosis and Treatment

The AMA urges state and local medical societies to work with their respective health departments and communities to develop and support appropriate legislation to decrease the spread of sexually transmitted diseases (STDs) in minors, specifically by allowing minors to consent for the means of prevention, diagnosis and treatment of STDs, including AIDS. (Res. 421, A-94; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-08)

H-60.959 Uniformity of State Adoption and Child Custody Laws

The AMA urges: (1) state medical societies to support the adoption of a Uniform Adoption Act that places the best interest of the child as the most important criteria; (2) the National Conference of Commissioners on Uniform State Laws to include mandatory pre-consent counseling for birth parents as part of its proposed Uniform Adoption Act; and (3) state medical societies to support adoption of child custody statutes that place the "best interest of the child" as the most important criterion determining custody, placement, and adoption of children. (Sub. Res. 219, I-93; Reaffirmed: BOT Rep. 28, A-03)

H-60.962 Enforcement of Child Labor Laws

The AMA will work in conjunction with all appropriate organizations and specialty societies to enhance physician awareness of the problems and dangers associated with the illegal employment of children. (Sub. Res. 222, I-92; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: BOT Rep. 33, A-07)

H-60.963 Preventable Airway Obstructions in Children

The AMA will develop, disseminate, and promote educational programs to apprise the public of the dangers of airway obstruction hazards in children and on methods to prevent these hazards. (Res. 412, A-92; Reaffirmed: CSA Rep. 8, A-03)

H-60.965 Confidential Health Services for Adolescents

Our AMA:

(1) reaffirms that confidential care for adolescents is critical to improving their health;

(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;

(3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;

(4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);

(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;

(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding

confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;

(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;

(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and

(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care. (CSA Rep. A, A-92; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed by BOT Rep. 9, A-98; Reaffirmed: Res. 825, I-04; Reaffirmation A-08)

H-60.966 Recommendations for Ensuring the Health of the Adolescent Athlete

(1) The preparticipation athletic examination should remain focused on ensuring the safety of the adolescent athlete by assessing for health problems that could interfere with athletic performance and vice versa. (2) When possible, this assessment should include an interview with the adolescent to determine attitudes toward and use of illegal and ergogenic drugs, as well as use of alcohol and tobacco. (3) Athletes should be assessed for special health problems, such as anemia, amenorrhea in women, food and water restriction, and bulimia. Athletes also should be questioned about weight control methods. (4) All adolescent athletes should be provided information about the health hazards associated with use of drugs and alcohol, tobacco, ergogenic agents, excessive measures to control weight, and sexually transmissible diseases and unwanted pregnancies. (CSA Rep. B, A-92; Amended: CSA Rep. 8, A-03)

H-60.969 Childhood Immunizations

(1) The AMA will lobby Congress to provide both the resources and the programs necessary, using the recommendations of the National Vaccine Advisory Committee and in accordance with the provision set forth in the National Vaccine Injury Compensation Act, to ensure that children nationwide are immunized on schedule, thus representing progress in preventive medicine. (2) The AMA endorses the recommendations on adolescent immunizations developed by the Advisory Committee for Immunization Practices and approved by both the American Academy of Family Physicians and the American Academy of Pediatrics. (3) The AMA will develop model state legislation to require that students entering middle or junior high school be adequately immunized according to current national standards. (4) The AMA encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation. (5) The AMA will continue to work with managed care groups and state and specialty medical societies to support a dedicated preventive health care visit at 11-12 years of age. (Res. 542, A-92; CSA Rep. 4, I-95; Reaffirmed by BOT Rep. 24, A-97; Reaffirmation A-05)

H-60.970 Minimizing Iron Poisoning

The AMA urges its constituent organizations and members to instruct patients about the potential dangers of iron-containing medication and, in particular, urges new mothers to discard unneeded iron supplements after pregnancy has been completed, or at the very least to store them in child-resistant containers as well as in cabinets well beyond the reach of children. (Res. 550, A-92; Reaffirmed: CSA Rep. 8, A-03)

H-60.971 Removal of High Alcohol Content from Medications Targeted for Use by Children and Youth

Our AMA encourages pharmaceutical companies that manufacture medications which are high in alcohol concentrations to limit the alcohol content of their medications to the minimum amount necessary as determined solely by the physical and chemical characteristics of the medication. (Sub. Res. 507, I-91; Reaffirmed: Sunset Report, I-01)

H-60.972 Banning Food Commercials Aimed at Children

It is the policy of the AMA to join with appropriate organizations, including the American Academy of Pediatrics, in educating the public about the adverse effects of food advertising aimed at children. (Sub. Res. 220, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmation A-07)

H-60.973 Provision of Health Care and Parenting Classes to Adolescent Parents

It is the policy of the AMA (1) to encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings which provide health care for infant and mother, and child development classes in addition to current high school courses and (2) to support programs directed toward increasing high school graduation rates, improving parenting skills and decreasing future social service dependence of teenage parents. (Res. 422, I-91; Reaffirmed: Sunset Report, I-01)

H-60.974 Children and Youth With Disabilities

It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities;
(2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted;
(3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child;
(4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities receive appropriate school health services;
(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system;
(6) to inform physicians of available educational resources, such as the National Center for Networking Community Based Services, and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and
(7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations. (CSA Rep. J, I-91; Modified: Sunset Report, I-01)

H-60.975 Political Influence and the American Teenage Study

Our AMA (1) reaffirms its support for the long standing, uniformly accepted and merit-based scientific peer review system utilized by federal research agencies, including the National Institutes of Health; and (2) deplores the use of political influence to override decisions to support research proposals when those decisions were derived from scientific peer review. (Res. 526, I-91; Modified: Sunset Report, I-01; Reaffirmed: Res. 725, I-03)

H-60.976 Genetic and Medical History of the Adopted

It is the policy of the AMA (1) to assist the appropriate bodies to develop a medical and genetic history form which would become, and remain, protected information and part of an adopted individual's permanent record on their entry into the fostercare/adoption system; and (2) to draft model state legislation which clearly mandates all appropriate agencies to furnish to the adoptive parents, when possible, the appropriate medical and genetic family history furnished by birth parents, with a mechanism to protect the confidentiality of all parties. (Res. 512, I-91; Reaffirmed: Sunset Report, I-01)

H-60.977 Lead Poisoning Threat to Children

Our AMA supports evaluating the adequacy of existing and proposed guidelines concerning environmental lead exposure (including the CDC's Strategic Plan for the Elimination of Childhood Lead Poisoning), and supports appropriate initiatives designed to more effectively protect young children from exposure to lead. (Sub. Res. 60, A-91; Reaffirmed: Sunset Report, I-01)

H-60.979 Physician-Based Physical Activity and Exercise Counseling Protocols for Youth and Adolescents

It is the policy of the AMA, in collaboration with appropriate agencies, to assist in the development of physician-based physical activity assessment and counseling protocols for youth and adolescents, including the development of training materials to instruct physicians in the use of these protocols. (Res. 186, I-90; Reaffirmed: Sunset Report, I-00)

H-60.980 Child and Adolescent Suicide

It is the policy of the AMA to express its opposition to media presentations which directly or indirectly encourage suicide in young children and adolescents. (Res. 115, I-90; Modified: Sunset Report, I-00)

H-60.981 Adolescent Health

It is the policy of the AMA to work with other concerned health, education, and community groups in the promotion of adolescent health to: (1) develop policies that would guarantee access to needed family support services, psychosocial services and medical services; (2) promote the creation of community-based adolescent health councils to coordinate local solutions to local problems; (3) promote the creation of health and social service infrastructures in financially disadvantaged communities, if comprehensive continuing health care providers are not available; and (4) encourage members and medical societies to work with school administrators to facilitate the transformation of schools into health enhancing institutions by implementing comprehensive health education, creating within all schools a designated health coordinator and ensuring that schools maintain a healthy and safe environment. (Res. 252, A-90; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-60.982 Physical and Mental Health Care For Incarcerated Youth

It is the policy of the AMA to actively pursue implementation of the recommendations contained in the AMA CSA report on the

Health Status of Detained and Incarcerated Youths. (Res. 229, A-90; Modified: Sunset Report, I-00)

H-60.983 Statement of Concern Regarding Destructive Themes Contained in Rock Music

(1) The AMA is concerned about the possible impact of destructive themes depicted in certain types of popular rock music. The vivid depiction of drug and alcohol use, suicide, violence, demonology, sexual exploitation, racism and bigotry could be harmful to some young people, especially vulnerable children and adolescents who are socially alienated from traditional value systems and positive support groups. (2) The AMA urges four activities: (a) parents should be aware of the themes depicted in music; monitor the concerts their children attend, the music videos they watch, and the albums they purchase and discuss the potential harmful effects of music themes with their children; (b) physicians should know about potentially destructive themes in some forms of rock music, and should work to increase awareness of patients and communities about these themes; (c) members of the entertainment industry, including sponsors of concerts, agents, and entertainers, should exercise greater responsibility in presenting music to young people; and (d) all music industry companies should voluntarily label albums in compliance with recently agreed upon labeling standards. (CSA Rep. E, A-90; Reaffirmed in lieu of Res. 414, I-94; Reaffirmed by Res. 420, A-95; Reaffirmed: CSA Rep. 8, A-05)

H-60.986 Health Status of Detained and Incarcerated Youth

Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;

(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.

(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.

(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system. (CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01)

H-60.988 The Dangers of Shaking a Child

The AMA supports publicizing the danger of severe injuries caused by shaking a child, encourages its members to establish and/or support existing educational programs for parents that would help prevent severe injuries due to shaking a child, and encourages educators in our school systems to be aware of and to inform their students about the dangers of shaking a child. (Sub. Res. 39, I-88; Reaffirmation I-96; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-60.989 Sexually Oriented Advertising to Youth

The AMA (1) endorses the idea that advertising campaigns can present youth in positive settings that promote healthy lifestyles and themes for youth to emulate, while presenting products for consideration without relying on sexual themes; (2) encourages advertising associations to work with public and private sector organizations concerned with adolescent health to develop guidelines, especially in teen-oriented publications, that would refrain from the intentional association of suggestive and stimulating sexual messages in product advertising; and (3) supports continued research regarding the health effects of sexual themes in the media on youth. (Res. 169, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-60.990 Child Pornography

The AMA (1) encourages and promotes awareness of child pornography issues among physicians; (2) promotes physician awareness of the need for follow-up psychiatric treatment for all victims of child pornography; (3) encourages research on child abuse (including risk factors, psychological and behavioral impact, and treatment efficacy) and dissemination of the findings; and (4) wherever possible, encourages international cooperation among medical societies to be alert to and intervene in child pornography activities. (BOT Rep. Z, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

H-60.991 Providing Medical Services through School-Based Health Programs

(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they

meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children. (CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05)

H-60.992 Missing and Exploited Children

To enhance physician involvement with issues related to missing and exploited children, the AMA supports the following statements and activities: (1) Child abductions and runaway behaviors are harmful and emotionally upsetting, divisive, and chaos-producing to victims and their families. Any disappearance of a child constitutes a family crisis with both victims and families at high risk for developing physical and emotional problems. Any child who is the object of a custody dispute is vulnerable to parental snatching, running away and/or being abused.
(2) Medical interventions, including family therapy, should occur immediately after a child is reported missing; if the child returns home or is found dead, physicians and other health care professionals should continue to monitor the victim patient and/or the patient's family.
(3) Children abducted by family members or strangers should be considered victims of child abuse and such occurrences should be designated as reportable instances of child abuse under state statutes.
(4) Prevention efforts should focus on reducing family stress, combatting alcoholism and drug abuse, dealing with poor marital relationships including divorce mediation and counseling, and providing supportive services for families at risk.
(5) All shelter services that are presently available to runaways and homeless youths should contain a high quality health care component. Comprehensive standards of health care should be developed for the national network of runaway centers. Physicians should be consultants to and work with governing boards of these agencies.
(6) Children's medical records should be intelligible and include a complete medical history, distinguishing physical characteristics and detailed information, as outlined in the Child Identification Form developed by the AMA. The AMA encourages physicians to utilize this form in their practice settings. Pediatricians and family physicians should encourage parents to arrange for the speedy transfer of the child's previous medical records and physicians should respond promptly to such requests. The parent's refusal to comply with this request should warrant further questioning of the parents or a report of a possible missing child.
(7) At prevention, diagnostic and treatment levels, physicians should attempt to identify troubled children and their families early and ensure that appropriate treatment takes place or that referrals are made to the other medical specialists or community resources.
(8) The primary care physician, medical examiner and dentist are key members of the missing child identification team, and should be knowledgeable about the steps to be taken (completing the NCIC forms) immediately after a child is reported missing.
(9) Physicians should actively promote the practice of obtaining clear and readable fingerprints and footprints as a technically useful way to document these unique physical characteristics of children.
(10) State medical societies should consider establishing committees on child abuse and neglect, with the topic of missing and exploited children included in the charge of responsibilities.
(11) The AMA supports continued research on abducted children (both parent and stranger abductions), runaways, homeless youth and their families, and how physicians can help them.
(12) All levels of medical education should emphasize the diagnosis, comprehensive treatment and prevention of problems associated with families that suffer from stress and that may be related to problems of alcoholism, drug abuse, domestic violence and marital dysfunction. Educational programs should address the reactions of physicians to these complex and frustrating social problems.
(13) The AMA supports cooperating with the American Academy of Pediatrics, the American Psychiatric Association, the American College of Obstetricians and Gynecologists, and the College of American Pathologists in developing and disseminating information about the health care needs of missing children and effective prevention strategies.
(14) The AMA supports cooperating with the American Bar Association, the American Psychiatric Association, law enforcement agencies and the National Center for Missing and Exploited Children in considering the problem of identifying and tracking perpetrators of child abductions. (BOT Rep. O, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06)

H-60.994 Herpes Simplex and School Children

The AMA reaffirms the rights of children with herpes infections to a quality education, condemns exclusion of such children from regular classes with other children, and encourages state legislation which would mandate that children with herpes not be excluded from regular classes. (Res. 99, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-60.996 Missing Children Identification

The AMA supports (1) development of a means of identifying children; and (2) education of the public and parents on the fingerprinting and documentation of characteristic identifying marks as a matter of record, should it be necessary to assist officials in locating a missing child. (Res. 98, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04)

H-60.998 Ipecac as Household Poison Emetic

(1) As an important preventive measure, the AMA supports advising parents of young children to have available, e.g., in the medicine cabinet, a one-ounce bottle of Syrup of Ipecac for use in the event of accidental poisoning, with the label of each such bottle of Syrup of Ipecac indicating the name of the substance, the proper dosage and the contraindications to its use.

(2) Our AMA recommends that a physician, an emergency room, or a poison control center be called for advice before administering Syrup of Ipecac. (Sub. Res. 94, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

H-60.999 Fragmentation of Child Health Care by the Schools

Our AMA (1) believes that mass screening of school children, particularly in fragmented organ system screening programs, should be undertaken only with the approval of the local medical society; and

(2) encourages state and local societies to develop with the schools methods of referral so that each child can have a physician to carry out necessary periodic evaluations of the child as a whole, rather than have the child's care involved in fragmented, disjointed programs. (Res. 19, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-65.000 Civil and Human Rights
(See also: Minorities; Women)

H-65.974 Gender-Based Violence

Our AMA: (1) opposes inhumane treatment of people of both genders; (2) encourages the World Health Association, the World Medical Association, and other relevant organizations to continue studying and monitoring gender-based violence throughout the world; and (3) encourages the development of programs to educate and alert all cultures to remaining practices of inhumane treatment based on gender and promote recognition of abusive practices and adequate health care for victims thereof. (Res. 404, A-06)

H-65.975 Discrimination Against Persons with Diabetes

Our AMA opposes: (1) forcing insulin requiring/dependent persons with diabetes to remove themselves from public view to administer injections; and (2) discrimination against persons with diabetes in both public and work places. (Res. 510, A-05)

H-65.976 Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement. (Res. 414, A-04; Modified: BOT Rep. 11, A-07)

H-65.977 Culturally Sensitive Communication

Our AMA supports access to care for all patients and also support effective culturally sensitive communication between physicians and patients, for which translation services are sometimes necessary. (Sub. Res. 805, A-02)

H-65.978 Nondiscrimination in Responding to Terrorism

Our AMA declares its opposition to discrimination against patients, physicians or other health care workers on the basis of religion, culture, nationality, or country of medical education or health care training. (Res. 1, I-01)

H-65.979 Sexual Orientation and/or Gender Identity as an Exclusionary Criterion for Youth Organization

Our AMA asks youth oriented organizations to reconsider exclusionary policies that are based on sexual orientation or gender identity. (Res. 414, A-01; Modified: BOT Rep. 11, A-07)

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)

H-65.981 Human Rights and Health Professionals

The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims. (Sub. Res. 615, A-97; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: Sub. Res. 10, A-05)

H-65.982 Texas Hopwood Decision

The AMA supports the position of the state of Texas in appeals of the Hopwood decision. (Res. 323, A-96; Reaffirmed by Res. 328, A-98)

H-65.983 Nondiscrimination Policy

The AMA affirms that it has not been its policy now or in the past to discriminate with regard to sexual orientation or gender identity. (Res. 1, A-93; Reaffirmed: CCB Rep. 6, A-03; Modified: BOT Rep. 11, A-07)

H-65.985 Inappropriate Federal Prosecution

The AMA (1) encourages state and county medical societies to investigate suspected violations of civil rights or denial of due process in federal prosecutions involving physicians; and (2) will respond to any requests for assistance from these societies once they have investigated, if they find that such a violation has taken place. (Sub. Res. 516, I-92; Reaffirmation A-99)

H-65.987 Gender Exploitation in the Workplace

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

H-65.988 Organizations Which Discriminate

The AMA (1) encourages holding educational or business meetings or social gatherings in facilities of organizations and clubs which do not refuse membership on the basis of gender, race or religion; and (2) encourages its constituent societies to follow a similar policy. (Res. 62, A-87; Reaffirmed: CLRPD Rep. 3, I-97; Reaffirmed: CEJA Rep. 7, 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-65.991 Persecution of Physicians for Political Reasons and Participation by Doctors in Violations of Human Rights

The AMA (1) reiterates its endorsement of the 1975 World Medical Association Declaration of Tokyo which provides guidelines for physicians in cases of torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment; (2) opposes participation by physicians in the torture or inhuman treatment or punishment of individuals in relation to detention and imprisonment; and (3) expresses its sympathy to those physicians who have been subject to imprisonment or torture because of their humanitarian efforts to improve the health of their patients. (Res. 91, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: Sub. Res. 10, A-05)

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-65.993 Abuse of Medicine for Political Purposes

The AMA opposes the use of the practice of medicine to suppress political dissent wherever it may occur. (Res. 127, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CEJA Rep. 2, A-05)

H-65.994 Medical Care in Countries in Turmoil

The AMA (1) supports the provision of food, medicine and medical equipment to noncombatants threatened by natural disaster or military conflict within their country through appropriate relief organizations; (2) expresses its concern about the disappearance of physicians, medical students and other health care professionals, with resulting inadequate care to the sick and injured of countries in turmoil; (3) urges appropriate organizations to transmit these concerns to the affected country's government; and (4) asks appropriate international health organizations to monitor the status of medical care, medical education and treatment of medical personnel in these countries, to inform the world health community of their findings, and to encourage efforts to ameliorate these problems. (Sub. Res. 133, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CLRPD Rep. 1, A-05)

H-65.995 Equal Rights

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

H-65.996 Equal Rights for Men and Women

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

H-65.997 Human Rights

Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment. (BOT Rep. M, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 12, A-04)

H-65.999 Equal Opportunity

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

H-70.000 Coding and Nomenclature
(See also: Health Insurance; Health Insurance: Benefits and Coverage; Health Insurance: Claim Forms and Claims Processing; Medicare; Physician Payment; Physician Payment: Medicare; Physician Fees)

H-70.918 Medicare Evaluation and Management Medical Decision Making Guidelines

It is AMA policy that: (1) all Medicare contractors disclose any Medical Decision Making tool or score sheet used in audits; (2) all Medicare contractors have a process to resolve conflicts of interpretation on Medical Decision Making tools and/or score sheets between practicing physicians and contractor clinical auditors; and (3) any Medical Decision Making tool or score sheet must be based on the factors for arriving at complexity, as defined in the CPT Book. (BOT Action in response to referred for decision Res. 712, A-06)

H-70.919 Use of CPT Editorial Panel Process

Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetic statements and modifiers. (BOT Rep. 4, A-06; Reaffirmation A-07; Reaffirmation I-08)

H-70.920 Medicare Patient Access to Implantable Morphine Pumps

AMA policy is that: (1) issues related to the re-valuation of the intrathecal pump procedure codes be resolved through the existing mechanism of the Relative Value Update Committee Five-Year Review; (2) issues related to the addition of new codes and guidelines for reporting the procedures related to intrathecal programmable pumps should work with the existing CPT editorial processes; and (3) valuation of new codes be completed through the existing valuation process. (BOT Rep. 18, I-04)

H-70.921 Update on Revision of CPT E&M Codes and Development of Clinical Examples

Our AMA policy is that future efforts to substantially revise Evaluation and Management (E&M) codes should only occur under the auspices of the CPT Editorial Panel and then through a broadly inclusive process that provides for significant and meaningful input from state medical associations, medical specialty societies and public and private payers. (BOT Rep. 26, I-04)

H-70.922 Qualified Support for the HHS Advisory Committee on Regulatory Reform's Recommendation to Eliminate the E&M Guidelines

Our AMA supports the decision of the Health and Human Services Advisory Committee on Regulatory Reform to eliminate the E&M Guidelines in their current form with the expectation that the final outcome of any legislative or regulatory change will provide fair treatment of physicians and their patients; that decisions regarding appropriateness of care and coding will be made by appropriately trained and experienced physicians who are fair and objective; that there be a system to review outliers consistent with AMA policy embodied in the California Pilot Plan; and that physicians be accorded appropriate due process. (Res. 818, A-02)

H-70.923 Conscious Sedation Reimbursement

Our AMA vigorously advocates for appropriate payment of CPT conscious sedation codes. (BOT Rep. 9, A-02)

H-70.924 Litigation Center Cases to Combat Automatic Downcoding and/or Recoding

The Litigation Center continues to initiate or support lawsuits that seek redress from insurers who engage in inappropriate or inaccurate downcoding and/or recoding practices. (BOT Rep. 31, A-02)

H-70.925 CPT Editorial Panel Representation

(1) The CPT Editorial Panel shall be kept at a size compatible with its functioning as an efficient and effective editorial board and should not be subject to the requirement of formal slotted seats for individual specialty societies. (2) While the role of the CPT Advisory Committee as clinical and technical experts to the CPT Editorial Panel is important, necessary, and currently of satisfactory composition, the need to expand as the practice of medicine changes or the scope of the CPT code set changes should be regularly evaluated. (BOT Rep. 34, A-02)

H-70.926 Reasonable Time Limitations on Post-Payment Audits and Recoupments by Third Party Payers

Our AMA policy is that post-payment audits, post-payment downcodes and other similar requests for recoupment by third party payers be made within one year of the date the claim is submitted or within the same amount of time permitted for submission of the claim, whichever is less. (Res. 815, A-01; Reaffirmation I-04; Reaffirmation A-08)

H-70.927 Prevention of Misuse of Current Procedural Terminology (CPT)

Our AMA: (1) in order to avoid harm to physicians and patients, shall continue to pursue proper use of CPT codes, guidelines and modifiers by software claims editing vendors and their customers; and (2) will explore additional ways to work with state medical associations to provide coding advocacy for members. (Sub. Res. 819, A-00; Reaffirmed in lieu of Res. 722, A-05; Reaffirmation A-06; Reaffirmation A-07)

H-70.928 Documentation Audits by Medicare Intermediaries

(1) Our AMA encourages CMS to direct Medicare carriers and intermediaries to adopt a focused approach to identifying fraud and abuse with specific recommendations to: (a) substantially limit the number of random audits currently being conducted;
(b) focus future audits on physicians whose billing profiles significantly deviate from the profiles of similar specialty physicians, and on physicians whose previous audits have suggested problematic billing practices;
(c) limit future audits on physicians when audits find that their documentation supports submitted bills;
(d) correct reimbursement for both under-coding as well as over-coding; and
(e) report the number, type and cost of errors identified by such audits, with specific delineation of the number, percentage, and cost of bills: (i) corrected, (ii) down-coded by auditors, (iii) up-coded by auditors, (iv) reasonably coded, but incorrect, (v) unreasonably

coded suggesting fraud and abuse, and (vi) where the decision of auditors is reversed on appeal.

(2) Our AMA encourages Medicare carriers to recognize that it burdensome and may be unreasonable to expect a physician to obtain, review and/or copy medical records not maintained by that physician, but controlled by a hospital, nursing home, or other agency. (Res. 808, A-00)

H-70.929 E&M Guidelines and Ad Hoc Task Force

(1) Our AMA should advocate forcefully with CMS, in writing and otherwise, a simple pilot implementation of a revised version of the peer review plan ("California Plan") as follows:
(a) Eliminate all random review of E&M services now.
(b) Carriers may identify "outliers" using methods at their discretion.
(c) Carriers would review these statistical outliers against their own internal criteria.
(d) Carriers would refer suspect E&M services to peer reviewers identified by state medical associations with input from state specialty societies. The physicians selected should be board certified, actively practicing, and should represent a cross section of practitioners by locale. The Carriers would pay for this review.
(e) Any post-payment review of E&M services would also rely on peer review before any adverse actions are taken.
(f) The initial purpose of the peer review should be educational.
(g) There should be an appeal process at all levels of review.

(2) Our HOD reaffirm its commitment to existing AMA policy regarding medical documentation and the E&M code guidelines. (Sub. Res. 803, A-00; Reaffirmed: Sub. Res. 815, I-00)

H-70.930 Insurers Excessive Documentation Requirements and Claims Submission

Our AMA opposes the practice of requiring the automatic and mandatory submission of medical record documentation for all Level 4 and/or Level 5 Evaluation and Management (E & M) codes. (Res. 827, A-00)

H-70.931 Medicare Coverage for Cardiovascular Stress Testing

Our AMA policy advocates the inclusion of the following diagnoses and their ICD-9 codes as evidence of medical necessity and therefore appropriate for reimbursement when accompanying a claim for the performance of exercise stress testing (93015-93018): hyperlipidemia (272.0-272.7), fatigue (780.79), chest pain (786.50-786.59), neck or jaw pain, interscapular pain, syncope or near syncope dyspnea (786.00-786.06), and palpitations (785.1). (Res. 809, A-00)

H-70.932 The Use of Time as an Adjunct to Document E/M Services

(1) The documentation of time, to the exclusion or other dimensions of clinical care is insufficient to document optimal clinical care for patients.

(2) The CPT Editorial Panel periodically evaluate the CPT codes and descriptors pertaining to the current Evaluation and Management Services, and make adjustments, as necessary, in compliance with their established processes.

(3) Our AMA continues to support the principle that the medical record should first and foremost be a tool of clinical care and communication.

(4) Our AMA urges CMS to allow physicians to use time as an adjunct to other clinical documentation in demonstrating their coding compliance with any given level of service.

(5) Medical record documentation of information intended to be used as an adjunct to clinical information (e.g., time, work between encounters, patient severity) should be sufficient, along with documentation associated with the primary criteria for code selection, for a clinical peer to determine whether a particular level of service has been met for coding purposes. (BOT Rep. 7, A-00)

H-70.933 E&M Guidelines and AMA Position

(1) Our AMA expresses outrage that the practice of medicine is characterized as abusive and fraudulent; and vigorously oppose the harassment of honest physicians.

(2) Physicians must be protected from unwarranted allegations of fraud and abuse and onerous criminal and civil penalties and/or sanctions due to inadvertent errors in coding and/or interpretation of documentation guidelines by public or private payers or law enforcement agencies.

(3) Our AMA, in the best interests of its members and their patients, continues to participate in the discussions with CMS about improvement of documentation guidelines and provide appropriate assistance through the CPT Editorial Panel including technical assistance and the coordination of input from state and specialty medical societies.

(4) Our AMA makes every effort to ensure that eventual CMS documentation guidelines for evaluation and management (E&M) services are patient centered, simplified, clinically relevant, realistic and practical and do not require either excessive physician time or documentation beyond that needed for good patient care.

(5) Our AMA reaffirm its strong rejection of a numeric counting system for documenting the medical record and request our AMA and the CPT editorial panel to expand its evaluation to other alternatives for medical records documentation.

(6) Our AMA urges CMS to eliminate random audits of all E&M services and instead use a focused review program that emphasizes the identification of statistical outliners.

(7) Our AMA uses all possible means to ensure that no adverse determination regarding physician services be made without prior, appropriate, peer review; through procedures conforming to due process.

(8) Our AMA supports adequate testing of revised guidelines through pilot tests that: (a) are scientifically valid and include a representative sample of all types of practice settings and geographic regions; (b) include issues such as cost of compliance, patient and physician satisfaction, and the effect of a peer review model; (c) involve our AMA in the design, implementation and evaluation of pilot programs.

(9) Our AMA strongly urges the CMS's Office of Program Integrity (OPI) to create an option regarding post-payment audit appeals that: (a) allows a physician to submit additional documentation on the cases previously audited while retaining his/her right to appeal without admitting liability and (b) does not require that the physician agree to a statistically valid random sample in order to have the ability to appeal and not admit liability.

(10) Our AMA urges CMS to revise the carriers' use of the extrapolation technique, using the following two step process. (a) once the carrier identifies a problem the carrier must provide the physician with an opportunity for a telephone discussion or a face-to-face meeting, in which the carrier must adequately explain how to correct the billing problem in the future, (b) if the physicians' future billing activities are found in error, CMS may recoup overcharges based on actual errors found.

(11) Our AMA urges CMS to suspend critical care audits until CMS clarifies critical care policies and billing requirements.

(12) Our AMA recommends to CMS that frequency requirements of the mandated E&M audits be maintained at or reduced to the1998 levels. (Res. 804, I-98; Amended: Res. 831 and Reaffirmed: Res. 836, A-99; Reaffirmed: BOT Rep. 6, A-00; Reaffirmed: Sub. Res. 815, I-00)

H-70.934 E&M Documentation Code Guidelines

Our AMA: (1) reaffirms its commitment to the "California Plan" for E&M code documentation and will work to have the Centers for Medicare & Medicaid Services (CMS) rescind the current E&M Code Guidelines;

(2) will take all appropriate action to have CMS and its carriers suspend all present and future audits under the onerous E&M Code Guidelines;

(3) if unsuccessful in achieving these goals by working with CMS, our AMA seeks an interim agreement with CMS to allow physicians to utilize the guidelines proposed by the AMA to CMS in May, 1999, as well as the 1995 and 1997 guidelines, until such time that there is final agreement with CMS on a documentation system that is consistent with AMA policy; and

(4) will immediately pursue simultaneous legal and legislative action including investigative congressional hearings of CMS, to force CMS to stop its random pre-payment audit and review activities until it completes and reports pilot studies of a peer review outlier program. (Sub. Res. 813, I-99; Reaffirmed: Sub. Res. 815, I-00)

H-70.935 Medicare Global Surgical Guidelines

Our AMA endorses the January 1, 1998 Medicare Global Period Guidelines that allow: (1) the Medicare global surgical period to commence no more than 24 hours before surgery; and (2) the pre-operative period excludes the examination of the patient to determine the need for surgery or other courses of treatment. (Res. 106, A-00)

H-70.936 Improvement of CPT Coding System

Our AMA: (1) in the design and production of the new CPT-5 coding system, will eliminate existing ambiguity and inconsistency, and strive to make the system more comprehensive and less subjective; and (2) will actively promote and encourage universal adherence to CPT codes and modifiers by governmental and private third party payers. (Res. 804, I-99)

H-70.937 Bundling and Downcoding of CPT Codes

Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers;

(2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards;

(3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and

(4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers. (Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-01; Reaffirmation I-04; Reaffirmation A-06; Reaffirmation A-07)

H-70.938 Certified Professional Coders

Our AMA will: (1) continue to monitor the development of certification programs for procedure coders; (2) provide technical assistance, when appropriate, about the correct use of CPT codes to developers of certifying examinations, to assure adherence with CPT coding guidelines; (3) oppose compensation for coders based on a percentage of their "adjustment" of CPT codes.
The members of the AMA be encouraged to report to the AMA any instances of these financial incentives given to coders. (BOT Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-70.939 Definition of Consultation: CMS vs. CPT 4 Coding Manual

(1) Our AMA and the Federation make known to CMS that redefining consultation to achieve cost savings is unacceptable to the medical profession. (2) That if necessary the AMA seek regulatory and/or legislative relief to overcome this regulatory decision on the part of CMS. (3) Our AMA urges the CPT Editorial Panel to review the CPT definitions for consultations and make any needed clarifications. (Res. 822, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-70.940 AMA Program to Readily Retrieve Billing Code Data by Payee within a Practice

Our AMA promotes the development of a software communications standard for medical coding and billing software programs, similar in purpose to the HL-7 and DICOM standards. (Res. 805, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-70.941 CMS Implementation of Commercial Off-the-Shelf Edits of CPT Codes

Our AMA: (1) continues to support the activities of its Correct Coding Policy Committee (CCPC) and urges the Centers for Medicare & Medicaid Services to accept CCPC recommendations relating to coding edits, whether from both the Correct Coding Initiative or the commercial off-the-shelf edits; (2) utilizes appropriate and vigorous advocacy efforts to ensure that any Medicare payment or coding policies, including the proprietary edits implemented on October 1, 1998, be made available to the public; and (3) continues to use advocacy tools and opportunities in both the public and private sectors to promote the appropriate use of CPT codes, guidelines, and modifiers; ensure that patients receive all needed services and the benefits to which they are entitled; protect the integrity of CPT; ensure accurate reporting of physicians' services; and ensure accurate payments for services provided. (BOT Rep. 35 , I-98; Reaffirmed: Res. 813, A-99)

H-70.942 Negotiated Rulemaking for Lab Tests

Our AMA will: (1) continue working with the other organizations represented in the negotiated rulemaking process to achieve consensus on improved, simplified, predictable, and consistent Medicare coverage and administrative policies for lab tests; (2) seek to repeal Section 4317 of the BBA granting the Secretary of HHS authority to require submission of diagnosis codes with every lab test claim, and all claims for services provided by an entity other than the ordering physician; and (3) develop a strategy to address remaining issues in the administration of Medicare's lab test benefit following the negotiated rulemaking, including onerous requirements arising from the OIG model compliance plan for clinical laboratories, carrier education, and dissemination of information about coverage policies to patients and physicians. (BOT Rep. 38, I-98; Reaffirmed: BOT Rep. 11, A-99)

H-70.943 CMS Regulations and Carrier Directives

Our AMA institutes necessary dialogue with the CMS and other appropriate entities to require the CMS and local Part B Carriers to furnish each physician with any and all directives that affect how CPT codes are processed and paid. (Res. 838, A-98; Reaffirmed: BOT Rep. 8, I-00)

H-70.946 Rebundling of Vaccine Codes

Our AMA will work with the American Academy of Pediatrics and other specialty societies to strongly oppose any attempts by insurers to inappropriately bundle immunization codes or to require inaccurate coding for reimbursement purposes. (Res. 804, A-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-70.947 CMS's Denial of Payment For Lack of Diagnostic Code

Our AMA: (1) as part of the negotiated rulemaking process petition CMS to change the regulation that requires certain specific disease codes for reimbursement and instead allow the use of any medically appropriate disease or symptom code for payment to be made to physicians and other providers for laboratory and diagnostic procedures; and (2) develops model state legislation to require that all third party payers provide reimbursement for appropriate diagnostic tests and procedures regardless of the outcome of these tests and procedures. Res. 259, A-98; Reaffirmation A-99)

H-70.948 Exclusion of Preoperative Services from Surgical Global Fee

The AMA: (1) strongly protests the effort to lower surgical fees by third party redefinition of the surgical global periods promulgated by the Centers for Medicare & Medicaid Services; (2) supports efforts to counter this change in definition of a global period through negotiation, legislation and litigation as required, including the filing of an amicus curiae brief. (Res. 830, I-97; Reaffirmed by Sub. Res. 846, A-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-70.949 Bundling of Codes for Physician Services

Our AMA: (1) advocates and will take steps to ensure that public and private payers do not bundle services inappropriately by encompassing individually coded services under other separately coded services unless specifically addressed in CPT guidelines; and (2) will enhance and fully coordinate its activities to prevent the inappropriate bundling of CPT codes (and other coding systems for supplies, injections, etc) used for payment by both public and private payers on these activities to the House of Delegates at the 1998 Annual Meeting. (Sub. Res. 814, I-97; Reaffirmed: Res. 814, A-00; Reaffirmed: BOT Rep. 8, I-00; Reaffirmed: CMS Rep. 2, A-01; Reaffirmation A-07)

H-70.950 Unacceptable Editing of the CPT-4 Code Book

The AMA (1) urges that the CPT Editorial Panel, through its regular editorial process, review the issue of the appropriateness of codes for laboratory panel tests, and consider, with input from the national medical specialty societies, reinstatement of appropriate codes for combinations of tests; and (2) advocates that all appropriate laboratory screening tests be covered by the Medicare program. (Sub. Res. 831, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-70.951 Medical Necessity Coding

(1)The AMA (a) immediately seeks both legislative and judicial relief from ICD-9 coding requirements for reimbursement of medical and laboratory services; and (b) supports only medical record review for medical necessity determinations, and then only when inappropriate or illegal behavior is suspected. (2) That until full implementation of this policy is achieved, our AMA seeks regulatory relief that would give physicians flexibility in assigning ICD-9 codes. (3) Our AMA advocates to all those private payers who do require ICD-9 codes for diagnostic studies that physicians should have the flexibility to assign any clinically appropriate diagnosis code. (Res. 806, I-97; Appended and Reaffirmed: Res. 816, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-70.952 Medicare Guidelines for Evaluation and Management Codes

Our AMA (1) seeks Federal regulatory changes to reduce the burden of documentation for evaluation and management services;

(2) will use all available means, including development of new Federal legislation and/or legal measures, if necessary, to ensure appropriate safeguards for physicians, so that insufficient documentation or inadvertent errors in the patient record, that does not meet evaluation and management coding guidelines in and of itself, does not constitute fraud or abuse;

(3) urges CMS to adequately fund Medicare Carrier distribution of any documentation guidelines and provide funding to Carriers to sponsor educational efforts for physicians;

(4) will work to ensure that the additional expense and time involved in complying with documentation requirements be appropriately

reflected in the Resource Based Relative Value Scale (RBRVS);

(5) will facilitate review and corrective action regarding the excessive content of the evaluation and management documentation guidelines in collaboration with the national medical specialty societies and to work to suspend implementation of all single system examination guidelines until approved by the national medical specialty societies affected by such guidelines,

(6) continues to advise and educate physicians about the guidelines, any revisions, and their implementation by CMS,

(7) urges CMS to establish a test period in a specific geographic region for these new guidelines to determine any effect their implementation will have on quality patient care, cost effectiveness and efficiency of delivery prior to enforcement of these mandated regulations;

(8) opposes adoption of the Medicare evaluation and management documentation guidelines for inclusion in the CPT; and

(9) AMA policy is that in medical documentation the inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required. (Sub. Res. 801, I-97; Reaffirmation I-00)

H-70.953 Excessive Documentation Requirements for Fraud and Abuse

The AMA will work to assure that physicians are not subjected to excessive and unreasonable documentation requirements when ordering laboratory services, home health and durable medical equipment and/or when justifying a CPT code. (Res. 810, A-97; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-04)

H-70.954 Improper Use of AMA-CPT by Carriers/Software Programs

Our AMA: (1) continues to seek endorsement of Current Procedural Terminology (CPT) as the national coding standard for physician services; in collaboration with state and specialty societies, will urge the Secretary of HHS and CMS and all other payers to adopt CPT as the single uniform coding standard for physician services in all practice settings; and will oppose the incorrect use of CPT by insurers and others, taking necessary actions to insure compliance with licensing agreements, which include provisions for termination of the agreement;

(2) will work with the American Academy of Pediatrics and other specialty societies to support state and federal legislation requiring insurers to follow the coding as defined in the Current Procedural Terminology Manual and interpreted by the CPT Assistant for all contracts in both the public and private sectors, as long as the CPT process is simple, user friendly, and does not undergo frequent changes; and

(3) seeks legislation and/or regulation to ensure that all insurance companies and group payers recognize all published CPT codes including modifiers. (Sub. Res. 801, A-97; Appended: Res. 806, A-98; Appended: Res. 814, I-99; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-04; Reaffirmation A-06; Reaffirmation A-07)

H-70.956 Coding for Medically Indicated Diagnostic and Surveillance Services

The AMA will continue to advocate to third party payers' acceptance of symptoms, signs, ill-defined conditions, and supplementary classification of factors influencing health status (V codes), as valid, medically necessary reasons for patient encounters, work toward expansion of these codes for screening examinations where appropriate, and urge payers to provide reimbursement for these services within the parameters of the patient's health insurance coverage. (BOT Rep. 4, A-97; Reaffirmed: CMS Rep. 9, A-07)

H-70.957 Diagnosis Information and Laboratory Test Panels

The AMA: (1) strongly objects to, and will consider legal injunctive relief against, the Department of Health and Human Services Office of the Inspector General's (OIG) model compliance plan for clinical laboratories and Centers for Medicare & Medicaid Services (CMS) Medicare policies that have led laboratories to require an "acceptable" diagnosis for each laboratory test ordered by physicians; and (2) urges CMS to prohibit Medicare carriers from routinely requiring that laboratories submit diagnosis information for laboratory tests that are individually ordered by physicians. (CMS Rep. 11, A-97; Reaffirmed by CMS Rep. 7, A-98; Reaffirmation A-99)

H-70.958 Modify Medicare ICD-9 "Fifth Digit Coding" Requirements

The AMA will: (1) request that CMS ensure that its Medicare carriers fully understand and implement the distinction between coding to the "highest level of specificity" within a code category, and that coding for the condition(s) to the "highest degree of certainty" for that visit. For this purpose, symptoms, signs, abnormal test results or other reason for the visit are appropriate and acceptable diagnoses; and (2) will use all appropriate vehicles to communicate to physicians the correct method to report ICD-9-CM codes to

describe diagnoses and other reasons for the physician-patient encounter; and for dealing with claim denials for 5th digit specificity. (Sub. Res. 803, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-70.960 Documentation Requirements for Physician Care Plan Oversight

The AMA will (1) continue to work with CMS so that CPT codes 99375 and 99376, for Care Plan Oversight, are recognized for payment to all physicians; (2) the AMA CPT Editorial Panel will consider revising the Care Plan Oversight codes to more accurately reflect medical practice; (3) will work with CMS to develop documentation requirements that are more consistent with standard medical practice and are not time based; and (4) the CPT Editorial Panel will continue to monitor CMS's implementation of documentation requirements. (BOT Rep. 12, A-96; Reaffirmed: CMS Rep. 8, A-06)

H-70.961 Evaluation and Management Codes

Our AMA will work with the CMS to continue to refine evaluation and management coding; and will work with CMS to publish the specialty specific physical exam criteria in a timely fashion. (Res. 804, A-96; Reaffirmation I-00)

H-70.962 Changes in the Bundling of Medical Services by Managed Care Plans

Our AMA will introduce or support legislation or regulation that would require that managed care plans be monitored and prohibited from the arbitrary and inappropriate bundling of services to reduce payment to participating physicians; and that the medically indicated patient services such as consultations and diagnostic procedures provided by physicians on the same day be paid on a separate basis in conformity with the AMA Current Procedural Terminology (CPT) coding policy and not inappropriately bundled as they currently are by managed care plans. (Res. 811, A-96; Reaffirmed: Res. 814, A-00; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-01; Reaffirmation A-05; Reaffirmation I-07; Reaffirmed in lieu of Res. 831, I-08)

H-70.964 Bundling of Ventilator and Management Codes

The AMA requests CMS to unbundle the payment for ventilator management codes from daily evaluation and management consultation codes. (Res. 806, A-94; Reaffirmed: CMS Rep. 5, A-04)

H-70.965 CPT Coding of Emergency Interventions

The AMA will: (1) communicate to third party payers the need to recognize and to make appropriate payment for CPT codes 99354 and 99355; and (2) educate physicians about the usage of the prolonged service codes in CPT, particularly as they might be used to report emergency situations in physicians' offices. (BOT Rep. 17, I-93; Reaffirmed and Modified: CMS Rep. 7, A-05)

H-70.966 Current Procedural Terminology Process

It is the policy of the AMA that the CPT Editorial Panel continue its policy of not making coding decisions that are influenced by economic or budgetary considerations. It is the responsibility of the AMA/Specialty Society RVS Update Committee to consider implementation issues such as economic factors when it recommends work values for new and revised CPT codes. (BOT Rep. 19, I-93; Reaffirmed: CMS Rep. 7, A-05; Reaffirmation A-07)

H-70.971 Affirmation of CPT as Exclusive System for Coding Claims

The AMA (1) affirms the use of CPT codes as the exclusive system of describing physician services on claims submitted to Medicare and all other private and public payers; and (2) authorizes its Board of Trustees to take all necessary actions to assure the continued use of CPT as the sole method for coding physician services on claims submitted to Medicare. (Res. 816, I-92; Reaffirmed: BOT Rep. 4, I-98; Reaffirmation I-04)

H-70.972 Physicians' Current Procedural Terminology

The AMA (1) continues to seek ways to increase its efforts to communicate with specialty societies and state medical associations concerning the actions and deliberations of the CPT Maintenance process; (2) urges the national medical specialty societies to ensure that their representatives to the CPT process are fully informed as to their association's policies and coding preferences; and (3) urges those specialty societies that have not nominated individuals to serve on the CPT Advisory Committee to do so. (BOT Rep. MM, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07)

H-70.973 AMA CPT Editorial Panel and Process

The AMA will continue (1) to work to improve the CPT process by encouraging specialty societies to participate fully in the CPT process; (2) to enhance communications with specialty societies concerning the CPT process and subsequent appeals process; and (3)

to assist specialty societies, as requested, in the education of their members concerning CPT coding issues. (Sub. Res. 806, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07)

H-70.974 CPT Coding System

The AMA supports the use of CPT by all third party payers and urges them to implement yearly changes to CPT on a timely basis. (Sub. Res. 809, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07)

H-70.976 Limitation of Use of Time Component of Current Procedural Terminology (CPT-4) Coding

Our AMA (1) adopts as policy that the time element in the new Evaluation and Management codes in the CPT-4 manual may be used to assist physicians and their staffs in determining appropriate levels of coding;

(2) opposes the use of the time elements to (a) judge how many of any given type of visit may be performed in any one hour; and (b) deny or downgrade services submitted based on a cumulative time;

(3) adopts as policy that there shall be no list of diagnoses used by third party payers to compare against the Evaluation and Management codes in such a fashion as to deny, downgrade, or in any other way seek to limit the submission of any CPT-4 code visit;

(4) will monitor attempts by the third party payers to institute such time limits and diagnosis limits; and

(5) will work with third party payers to prevent them from attempting to adopt and institute policies that would impose such time and diagnosis criteria. (Res. 823, A-92; Reaffirmation I-00)

H-70.980 Bundling CPT Codes

Our AMA, through its CPT Editorial Panel and Advisory Committee, will continue to work with CMS to provide physician expertise commenting on the medical appropriateness of code bundling initiatives for Medicare payment policies. (Sub. Res. 801, I-91; Reaffirmed: Res. 814, A-00)

H-70.982 Primary Health Care Reimbursement Coding

Our AMA, through the Current Procedural Terminology Editorial Panel, will continue to revise and clarify the publication Current Procedural Terminology (CPT) to appropriately allow the accurate reporting of evaluation and management services provided by all physicians. (Sub. Res. 155, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed in lieu of Res. 831, I-08)

H-70.983 AMA Input to Diagnosis and Procedure Coding

It is the policy of the AMA (1) to continue liaison with the National Center for Health Statistics in matters concerning diagnosis coding; and (2) that further appropriate mechanisms be explored for enhanced communication between the National Center for Health Statistics and the AMA. (Sub. Res. 120, I-90; Reaffirmed: Sunset Report, I-00)

H-70.984 CPT Coding for Evaluation and Management Services

Our AMA (1) urges national medical specialty societies and state medical associations to cooperate to the greatest degree possible with the AMA/CMS pilot tests (of the CPT Editorial Panel's draft revised coding system); and (2) urges all appropriate organizations to review the proposed visit coding revisions and to voice their specific concerns or recommendations for change to the CPT Editorial Panel. (BOT Rep. WW, I-90; Reaffirmation I-00)

H-70.985 Preservation of Evaluation/Management CPT Codes

It is the policy of the AMA to (1) oppose the bundling of procedure and laboratory services within the current CPT Evaluation/Management (E/M) services;

(2) oppose the compression of E/M codes and support efforts to better define and delineate such services and their codes;

(3) seek feedback from its members on insurance practices that advocate bundling of procedures and laboratory services with or the compression of codes in the CPT E/M codes, and express its views to such companies on behalf of its members;

(4) continue to work with the PPRC and all other appropriate organizations to insure that any modifications of CPT E/M codes are appropriate, clinically meaningful, and reflective of the considered views of organized medicine; and

(5) work to ensure that physicians have the continued opportunity to use CPT as a coding system that is maintained by the medical profession. (Sub. Res. 98, A-90; Reaffirmed by Res. 850, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation I-00)

H-70.986 CPT Coding Initiatives

Because of the increasing level of interest in CPT coding and its importance to medicine, it is the policy of the AMA: (1) that those national medical specialty societies not represented on the CPT Advisory Committee be urged to nominate a physician to serve on this committee; (2) that national medical specialty societies be urged to accelerate the provision of necessary information that is requested by the CPT Editorial Panel; and (3) that the AMA, in conjunction with state medical associations and national medical specialty societies, intensify its efforts to oppose unilateral deletion of CPT codes by third party payers, to facilitate the elimination of local codes, and to ensure uniform application of coding principles.

Our AMA will continue to develop appropriate informational and educational materials to assist members in using the CPT codes; and continue its efforts to make CPT available to physicians in a low cost and efficient manner. (BOT Rep. CC, A-90; Appended by Sub. Res. 823, A-98; Reaffirmation A-07)

H-70.987 Diagnostic Coding Requirements

Our AMA (1) supports requesting the Secretary of the Department of Health and Human Services to allow the use of three- and four-digit ICD-9-CM codes as a simpler, more efficient and wholly adequate method of diagnostic coding; and (2) with the involvement of appropriate specialty societies, supports continuing to work for additional modifications in the diagnostic coding guidelines needed to make the guidelines more reflective of the operation and organization of physicians' office practices. (Sub. Res. 151, I-89; Reaffirmed: Sunset Report, A-00)

H-70.989 ICD-9-CM Coding

Our AMA supports repeal of the ICD-9-CM coding requirement for physician services under Medicare. (Res. 77, A-89; Reaffirmed: Sunset Report, A-00)

H-70.990 ICD-9-CM Coding and Civil Money Penalties

Our AMA (1) supports legislation to repeal or substantially ameliorate the threat of federal civil money penalty liability for failure to utilize ICD-9-CM coding in the filing of Medicare claims; (2) supports amendments to the quasi-criminal Medicare civil money penalty process by providing to those charged with civil offenses the same rights now available to defendants in criminal proceedings; and (3) supports efforts to assure that CMS's implementation of the coding requirement is undertaken with a view to minimizing compliance difficulties to physicians and their office staff. (Sub. Res. 182, A-89; Reaffirmed: Sunset Report, A-00)

H-70.991 Coding and Payment for Patient Management in Ambulatory Settings and Skilled Nursing Facilities

Our AMA (1) endorses the role and responsibility of the physician in supervising patient care in non-office ambulatory settings and/or extended care facilities and supports fair and equitable payment for those services; (2) supports conducting a comprehensive review of CPT codes to ensure that there are appropriate codes for management and supervision in ambulatory and/or extended care settings; and (3) encourages CMS and insurers to establish equitable payment for such CPT codes. (Res. 198, A-89; Reaffirmed: BOT Rep. 3, A-95; Reaffirmed: CMS Rep. 1, A-00; Reaffirmation I-03; Reaffirmation I-07)

H-70.992 CPT Coding

The AMA continues to support a national uniform descriptor system including, but not limited to, the following initiatives: (1) accelerate the process followed by the AMA CPT Editorial Panel, as feasible, to effect expeditiously changes by adding or deleting codes and nomenclature in order to keep CPT-4 as the best single source for up-to-date reference;
(2) encourage CMS to direct Medicare carriers to refrain from unilateral deletion of CPT descriptors; and (3) work with national medical specialty societies and state medical associations to review the current status of local carrier descriptor systems and work with CMS to develop an oversight mechanism to monitor carrier compliance with CMS directives on the appropriate use of the national coding system. (Sub. Res. 47, A-89; Reaffirmed: Sunset Report, A-00)

H-70.993 Uniform Use of CPT Coding

Our AMA supports development, in consultation with state medical associations, of educational programs for both physicians and health insurance carriers as to the advantages of the implementation of CPT coding. (Res. 27, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-70.994 Coding of Physician and Non-Physician Services

(1) Our AMA opposes the development of modifiers to physicians' CPT to identify services rendered by non-physicians, but supports efforts to develop appropriate coding systems for non-physician services. (2) The AMA CPT Editorial Panel continues to identify areas where services performed by non-MD/DOs may be separately coded so that the AMA/Specialty Society RVS Update Committee (RUC) and the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board may develop work relative values which are reflective of the differential level of work between MD/DO and non-MD/DO services. (BOT Rep. H, A-88; Appended: CMS Rep. 16, A-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-70.995 Collapsing the Codes

Our AMA (1) opposes any health insurance code collapsing policies that result in unfair payment practices; (2) encourages CMS and third parties to accept physician claims reported in applicable CPT codes and to report back to physicians and patients using the same codes or terminology, regardless of reimbursement methodology and levels; (3) favors providing assistance, when needed, to state and county medical associations to assure that local carrier code collapsing decisions have appropriate medical input. (BOT Rep. JJ, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-70.997 Medicare and Current Procedural Terminology

Our AMA supports the use by Medicare and its fiscal intermediaries of the AMA CPT-4, with all current and subsequent revisions, as the official terminology for claims processing. (Res. 123, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CMS Rep. 7, A-05)

H-70.998 Revision of CPT

Our AMA continues to support taking all appropriate measures, including meetings if necessary, to ensure that no CPT updating process proceed without providing for input from knowledgeable physicians, including a cross section of affected and related specialties, to allow these physicians to carefully review all changes suggested for inclusion in CPT prior to their acceptance. (Sub. Res. 54, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-07)

H-70.999 Third Party Modification of Terminology Systems

Our AMA (1) opposes the modification of procedural descriptions or conversions to different terminologies by third party employees without appropriate professional medical consultation; and (2) considers the uses of any terminology system containing data so modified invalid and inappropriate for purposes of reimbursement, measures of practice patterns, peer review, utilization review, or such other related uses. (Res. 102, A-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-04)

H-75.000 Contraception
(See also: Abortion; Pregnancy)

H-75.985 Access to Emergency Contraception

It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter. (CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04)

H-75.986 Drug Interactions Between Oral Contraceptives and Antibiotics

It is the policy of the AMA that: (1) women who are prescribed rifampin concomitantly with oral contraceptives are faced with a significant risk of oral contraceptive failure and should be counseled about the additional use of nonhormonal contraceptive methods during the course of rifampin therapy; and (2) women using combined oral contraceptives should be informed about the small risk of interactions with antibiotics and that it is not possible to identify in advance the women who may be at risk of oral contraceptive failure. Women who are not comfortable with the small risk of interaction should be counseled about the additional use of nonhormonal contraceptive methods. Women who have had previous oral contraceptive failures or who develop breakthrough bleeding during concomitant use of antibiotics and oral contraceptives should be counseled about the use of alternate methods of contraception if they engage in intercourse during the period of concomitant use, as they may be part of the subset of women at high risk of contraceptive failure. (CSA Rep. 8, A-00)

H-75.987 Reducing Unintended Pregnancy

Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process; and (2) supports reducing unintended pregnancies as a national goal. (Res. 512, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-75.988 Extension of Medicaid Coverage for Family Planning Services

The AMA supports legislation that will allow states to extend Medicaid coverage, based on the eligibility standard applied for children and pregnant women, for contraceptive education and services for at least two years postpartum for all eligible women. (Sub. Res. 201, I-93; Reaffirmed: BOT Rep. 28, A-03)

H-75.989 Public Aid Coverage for Implantable Progestin

Our AMA urges (1) state societies to lobby for public aid coverage for implantable progestin and other methods of contraception in their respective states; and (2) pharmaceutical manufacturers to reduce the price of implantable progestin for those segments of the population that are economically disadvantaged. (Res. 503, I-91; Reaffirmed: Sunset Report, I-01)

H-75.990 Development and Approval of New Contraceptives

Our AMA (1) supports congressional efforts to increase public funding of contraception and fertility research;
(2) urges the FDA to consider the special health care needs of Americans who are not adequately served by existing contraceptive products when considering the safety, effectiveness, risk and benefits of new contraception drugs and devices;
(3) encourages contraceptive manufacturers to conduct post-marketing surveillance studies of contraceptive products to document the latter's long-term safety, effectiveness and acceptance, and to share that information with the FDA; and
(4) to continue to monitor and work toward the reform of the National Childhood Vaccine Injury Act with the view that it may eventually provide a useful model for product liability reform with respect to contraception products. (BOT Rep. O, I-91; Reaffirmed: Sunset Report, I-01)

H-75.991 Requirements or Incentives by Government for the Use of Long-Acting Contraceptives

(1) Involuntary use of long-acting contraceptives because of child abuse raises serious questions about a person's fundamental right to refuse medical treatment, to be free of cruel and unusual punishment, and to procreate. The state's compelling interest in protecting children from abuse may be served by less intrusive means than imposing contraception on parents who have committed child abuse. The needs of children may be better met by providing close supervision of the parents, appropriate treatment and social services, and foster placement care when necessary. There is not sufficient evidence to demonstrate that long-acting contraceptives are an effective social response to the problem of child abuse. Before long-acting contraceptives could be considered as a response to individual cases of child abuse, the issue would need to be addressed by society broadly. Society must be careful about taking shortcuts to save resources when constitutional rights are involved.

(2) Serious questions are raised by plea bargains, or negotiations with child welfare authorities, that result in the use of long-acting contraceptives. Such agreements are made in inherently coercive environments that lack procedural safeguards. In addition, cultural and other biases may influence decisions by the state to seek the use of a long-acting contraceptive.

(3) If welfare or other government benefits were based on the use of long-acting contraceptive agents, individuals would be required to assume a potentially serious health risk before receiving their benefits. Government benefits should not be made contingent on the acceptance of a health risk.

(4) Individuals should not be denied access to effective contraception because of their indigence. Use of long-acting contraceptives should be covered by Medicaid and other health insurance programs, both public and private.

(5) Long-acting contraceptives may be medically contraindicated. Assessing the health risks of long-acting contraceptives is substantially outside the purview of courts and legislatures. (BOT Rep. EE, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmation A-04)

H-75.992 Family Planning Clinic Funds

Our AMA supports the concept of adequate funding for family planning programs. (Res. 102, A-90; Reaffirmed: Sunset Report, I-00)

H-75.993 Contraceptive Research

Our AMA encourages the development of federally funded programs to support the continued development of safe and effective contraceptives. (Res. 283, A-90; Reaffirmed: Sunset Report, I-00)

H-75.994 Contraception and Sexually Transmitted Diseases

Our AMA, in cooperation with state, county, and specialty medical societies, encourages physicians to educate their patients about sexually transmitted diseases, including HIV disease, and condom use. While such counseling may not be appropriate for all contraception patients, physicians should be encouraged to provide this information to any contraception patient who may benefit from being more aware of the risks of sexually transmitted diseases. (BOT Rep. E, A-89; Reaffirmation A-99; Reaffirmed and Title Change: CSA Rep. 4, A-03)

H-75.995 Contraceptive Advertising

Our AMA supports the concept of providing accurate and balanced information on the effectiveness, safety and risks/benefits of contraception in all public media and urges that such advertisements include appropriate information on the effectiveness, safety and risk/benefits of various methods. (Res. 4, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-75.996 Media Advertising and Public Service Announcements Regarding Contraception and Safe Sexual Practices

The AMA urges the print and broadcast media to permit advertising and public service announcements regarding contraception and safe sexual practices as a matter of public health awareness. (Res. 114, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-75.998 Opposition to HHS Regulations on Contraceptive Services for Minors

(1) Our AMA continues to oppose regulations that require parental notification when prescription contraceptives are provided to minors through federally funded programs, since they create a breach of confidentiality in the physician-patient relationship. (2) The Association encourages physicians to provide comparable services on a confidential basis where legally permissible. (Sub. Res. 65, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: Res. 825, I-04)

H-75.999 Teenage Pregnancy

Our AMA believes that (1) the teenage girl whose sexual behavior exposes her to possible conception should have access to medical consultation and the most effective contraceptive advice and methods consistent with her physical and emotional needs; and (2) the physician so consulted should be free to prescribe or withhold contraceptive advice in accordance with their best medical judgment. (BOT Rep. I, A-71; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-80.000 Crime
(See also: Legal Medicine; Prisons; Violence and Abuse)

H-80.994 Use of all Appropriate Medical Forensic Techniques in the Criminal Justice System

Our AMA supports the availability and use of all appropriate medical forensic techniques in the criminal justice system. (Sub. Res. 4, A-00)

H-80.995 Evaluation of the Use of DNA Identification Testing in Criminal Proceedings

(1) A national standard for uniform quality control guidelines should be developed which would govern: (a) the handling and storing of forensic DNA samples; (b) minimum requirements for the training and experience of personnel who perform and interpret DNA test results; (c) appropriate control procedures to minimize the adverse effects of contamination and degradation; (d) an objective standard for identifying separate DNA bands and declaring a match between two or more DNA samples; and (e) the creation and use of population databases which accurately reflect the ethnic composition of populations amongst which matches might be sought. Also, blind proficiency tests should be conducted of all laboratories which perform DNA testing in order to assure that quality control measures are being observed.

(2) The independent validation of each probe used for DNA identification testing should be conducted.

(3) Further research is needed to determine the effects of contamination and degradation on forensic samples.

(4) The process of discovery is meant to provide both sides, and in particular the defendant, with all relevant evidence indicating the

defendant's guilt or innocence. Given the complexities involved in the performance and interpretation of DNA profiling, discovery in criminal trials should extend to all information regarding the execution of the testing procedures, including quality control or corrective steps taken, a copy of the banding patterns, the existence of contamination or degradation, the statistical basis for calculations of probabilities of random matches, and justification for declaring the samples a match.

(5) Wherever feasible, the state should retain DNA evidence samples to allow for independent DNA testing on the part of the defense. In cases where evidence exists and has the potential for reliable DNA testing but the state declines to perform the tests, the defense should be allowed to perform its own DNA testing. If the defendant is indigent, then the resources necessary in order to conduct independent DNA testing should be provided by the state.

(6) Because of the importance of verifying the validity of DNA test results in an individual case, a defendant must have access to a qualified expert for the presentation of his or her case. Given that indigent defendants must be afforded access to necessary expert resources in order to mount a reasonable defense, indigent defendants should have the right to the free services of an expert witness qualified to testify regarding the testing and interpretation of DNA prints. Where the independent testing of DNA samples is feasible, indigent defendants should be entitled to free testing.

(7) DNA testing of individuals for information in criminal cases should be conducted only where a warrant has been issued on the basis of a high degree of individualized suspicion. The genetic privacy of suspects should be respected. Maintaining the files of any individual who is no longer a suspect in a particular crime raises serious concerns regarding potential violations of privacy. Therefore it may not be appropriate to retain such files.

(8) The establishment and use of DNA databanks for convicted criminals is appropriate if usage is limited to law enforcement personnel who are investigating a crime. Any individual or personalized information which may be obtained from DNA prints should be accorded the same confidentiality as medical records.

(9) There is a need to establish, in each criminal case, whether the results of DNA testing
are sufficiently valid to be put before a jury. It may be advisable for courts to establish, as a matter of law, whether the execution of the DNA testing procedures in a particular case is sufficiently valid to be put before the jury. If the results of the DNA tests are valid enough to be reviewed by a jury, then all further issues of fact regarding the validity of the DNA evidence should go to the weight of the evidence. (BOT Rep. FF, I-91; Reaffirmed: Sunset Report, I-01)

H-80.996 Scientific Status of Refreshing Recollection by the Use of Hypnosis

The AMA believes that (1) With witnesses and victims concerning refreshing recollection, the use of hypnosis should be limited to the investigative process. Specific safeguards should be employed to protect the welfare of the subject and the public, and to provide the kind of record that is essential to evaluate the additional material obtained during and after hypnosis; (2) A psychological assessment of the subject's state of mind should be carried out prior to the induction of hypnosis in an investigative context, and informed consent should be obtained; (3) Hypnosis should be conducted by a skilled psychiatrist or psychologist, who is aware of the legal implications of the use of hypnosis for investigative purposes; a complete taped and/or precise written record of the clinician's prior knowledge of the case must be made; complete videotape recordings of the pre-hypnotic evaluation and history, the hypnotic session, and the post-hypnotic interview, showing both the subject and the hypnotist, should be obtained; (4) Ideally, only the subject and the psychiatrist or psychologist should be present; (5) Some test suggestions of known difficulty should be given to provide information about the subject's ability to respond to hypnosis; (6) The subject's response to the termination of hypnosis and the post-hypnotic discussion of the experience of hypnosis are of major importance in discussing the subject's response; (7) Medical responsibility for the health and welfare of the subject cannot be abrogated by the investigative intent of hypnosis; and (8) Continued research should be encouraged. (CSA Rep. K, I-84; Reaffirmed: CSA Rep. 5, A-94; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CSA Rep. 6, A-04)

H-80.998 Rape Victim Services

The AMA supports the function and efficacy of rape victim services, encourages rape crisis centers to continue working with local police to help rape victims, and encourages physicians to support the option of having a rape victim counselor present while the victim is receiving medical care. (Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-80.999 Rape Victims

Our AMA supports the preparation and dissemination of information intended to maintain and improve the skills needed by all practicing physicians involved in providing care to rape victims. (Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-85.000 Death and Vital Records
(See also: Ethics)

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-85.959 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)

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)

H-85.961 Accuracy, Importance, and Application of Data from the US Vital Statistics System

Our AMA: (1) supports the integration into undergraduate, graduate, and continuing medical education of instruction on the use and proper completion of vital records of birth, fetal death, and death. The presence and effectiveness of this education could be monitored through the Liaison Committee on Medical Education (LCME) annual questionnaire to medical schools, the joint AMA/Association of American Medical Colleges survey of residency programs, questions on the United States Medical Licensing Examinations, and questions on certifying examinations in the individual specialties; (2) encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the mother and infant, as this information is the basis for the health and medical information on birth certificates. (CSA Rep. 6, I-00; Reaffirmed: Sub. Res. 419, A-02)

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)

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)

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)

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)

H-85.966 Hospice Coverage and Underutilization

The policy of the AMA is that: (1) The use of hospice care be actively utilized to provide the patient and family with appropriate physical and emotional support, but not preclude or prevent the use of appropriate palliative therapies to continue to treat the underlying malignant disease, if the patient is showing response to such palliative therapy; (2) The goal of terminal care is to relieve patient suffering and not necessarily to cure incurable disease; (3) Appropriate active palliation should be a covered hospital benefit; and (4) The initiation of hospice care may be done at the discretion of the attending physician without stopping whatever medical care is being rendered if the physician believes the patient is in the last six months of life. (Res. 515, A-94; Reaffirmed: CMS Rep. 5, A-04)

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)

H-85.968 Patient Self Determination Act

The AMA will: (1) lend its administrative, legislative, and public relations support to assuring that the specific wishes of the individual patient as specified in his or her advance directive be strictly honored in or out of the hospital setting; (2) encourage all physicians and their patients to execute an advance directive prior to the time of severe acute or terminal illness; and (3) promote efforts to develop a national system to assist emergency medical personnel to rapidly ascertain a person's wishes with regard to resuscitation, regardless of his or her state of location. (Res. 228, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmation A-06; Reaffirmed: BOT Rep. 22, A-06; Reaffirmed: BOT Rep. 9, A-08)

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)

H-85.972 The Compassionate Care of the Terminally Ill

The AMA will work with appropriate entities to promote the awareness of modern high-quality hospice-type care to all those who prefer such care and urges physicians to advise patients about this option, which can be exercised directly, when competent, or via advance directive when incompetent. (Res. 705, A-92; Reaffirmed: CSA Rep. 8, A-03)

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)

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)

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)

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)

H-85.981 Improving the Accuracy of Death Certificates

Our AMA (1) in cooperation with other organizations, supports developing a program to improve the accuracy of death certificates;

(2) supports evaluating the advisability and feasibility of having quality assurance programs review the accuracy of death certificates;

(3) supports developing recommendations to encourage documentation of risk factors such as poverty, smoking and alcoholism; and

(4) encourages the practice of amending the completed death certificate to enhance accuracy and effectiveness. (Sub. Res. 76, I-89; Reaffirmed: Sunset Report, A-00)

H-85.985 Minimum Autopsy Rates for Teaching Hospitals

The 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)

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-85.989 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-85.991 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-85.993 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)

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-85.996 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)

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)

H-90.000 Disabled

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)

H-90.977 Impairment and Disability Evaluations

It is the policy of the AMA: (1) that in settings where impairment and disability evaluations are required, physicians should determine medical impairment and their functional consequences, including those associated with HIV infection, using medically established and approved guidelines; and (2) to encourage physicians to contribute their medical expertise to disability determinations. (CSA Rep. 8, I-99; Reaffirmed and Title Change: CSA Rep. 4, A-03)

H-90.978 Community Mobility Devices

The AMA urges physicians, who treat patients with impaired mobility outside the home, to work with state medical associations and appropriate medical specialty societies to identify state agencies and community service organizations that provide local transportation assistance to disabled individuals, and that such information be made readily accessible to disabled patients. (CMS Rep. 10, A-97; Reaffirmed: CMS Rep. 9, A-07)

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-90.981 Accessibility of Computer Usage to Blind Persons

The AMA endorses the concept that the computer industry should strive to make usage of computers more accessible to blind persons. (Res. 508, A-95; Reaffirmed: CLRPD Rep. 1, A-05)

H-90.983 Assistance of Handicapped Individuals onto Aircraft of Less Than Thirty Seats

The AMA urges assistance by airline personnel of handicapped individuals using commercial aircraft of fewer than thirty seats. (Sub. Res. 206, A-94; Reaffirmed: CSA Rep. 6, A-04)

H-90.986 SSI Benefits for Children with Disabilities

The AMA will use all appropriate means to inform members about national outreach efforts to find and refer children who may qualify for Supplemental Security Income benefits to the Social Security Administration and promote and publicize the new rules for determining disability. (Res. 420, A-92; Reaffirmed: CMS Rep. 10, A-03)

H-90.987 Equal Access for Physically Challenged Physicians

Our AMA supports the adoption of guidelines for equal access to all hospital facilities for physically challenged physicians as part of the standards of the JCAHO. (Res. 816, I-91; Reaffirmed: Sunset Report, I-01)

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)

H-90.996 Education of Handicapped Children

Our AMA supports efforts to ensure an appropriate role for physicians in the development of special education programs for handicapped children. (BOT Rep. I, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-90.997 International Year of Disabled Persons

Our AMA (1) supports the worldwide objective of the United Nations to establish goals and programs that will enrich the lives of citizens with disabilities; (2) approves the aims of the U.S. Council for the International Year of Disabled Persons to integrate such people into community life and increase their educational and occupational opportunities; and (3) supports enhanced public awareness of the problems and needs of persons with disabilities through a public relations effort. (Res. 19, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-90.998 Excluding Handicapped from Contact Sports

Our AMA strongly disapproves of Policy Interpretation No. 5 of Section 504 of the Rehabilitation Act of 1973 (PL 93-112), which provides that high school or college students who have lost an organ, limb or appendage, but who are otherwise qualified, may not be

excluded by their respective institutions from participation in contact sports. (Res. 98, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

H-90.999 Access to Public Buildings for Handicapped Persons

Our AMA encourages implementation of requirements that provide access to public facilities for handicapped and wheelchair bound persons. (Sub. Res. 89, A-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-95.000 Drug Abuse
(See also: Alcohol and Alcoholism; Accident Prevention: Motor Vehicles; Pregnancy)

H-95.947 Prescription Drug Monitoring to Prevent Abuse of Controlled Substances

Our AMA:
(1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
(2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
(3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interaoperative, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;
(4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions; and
(5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians. (BOT Rep. 3, A-08)

H-95.948 Research on Drug Abusing Populations

Our AMA encourages federal and state agencies to support research to:

(1) Determine the number and demographic characteristics of the drug abusing population, with particular emphasis on intravenous drug users and the characteristics and conditions under which intravenous drug equipment is shared;

(2) Develop effective strategies for preventing the initiation of intravenous drug use and for the treatment of intravenous drug users. (CSA Rep. 4, A-03)

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)

H-95.950 Consensus Statement of the Physician Leadership On National Drug Policy

Our AMA: (1) promotes medical approaches to substance use disorders by continuing to encourage physician involvement in case identification, diagnostic assessment, clinical therapeutic interventions, medical evaluation and management, and ongoing chronic disease management, as appropriate, for cases of alcohol and other drug addiction; and (2) continues to believe that the legalization of illegal drugs would be contrary to the best interests of the public health and that support for the positions of the Physician Leadership on National Drug Policy ought not be construed as support for such legalization. (CSA Rep. 9, I-99)

H-95.951 Role of Self-Help in Addiction Treatment

The AMA: (1) recognizes that (a) patients in need of treatment for alcohol or other drug-related disorders should be treated for these medical conditions by qualified professionals in a manner consonant with accepted practice guidelines and patient placement criteria; and (b) self-help groups are valuable resources for many patients and their families and should be utilized by physicians as adjuncts to a treatment plan; and (2) urges managed care organizations and insurers to consider self-help as a complement to, not a substitute for, treatment directed by professionals, and to refrain from using their patient's involvement in self-help activities as a basis for denying authorization for payment for professional treatment of patients and their families who need such care. (Res. 713, A-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-95.952 Medical Marijuana

(1) Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.

(2) Our AMA recommends that marijuana be retained in Schedule I of the Controlled Substances Act pending the outcome of such studies.

(3) Our AMA urges the National Institutes of Health (NIH) to implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research into the medical utility of marijuana. This effort should include: a) disseminating specific information for researchers on the development of safeguards for marijuana clinical research protocols and the development of a model informed consent on marijuana for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of marijuana for clinical research purposes; c) confirming that marijuana of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the Drug Enforcement Agency who are conducting bona fide clinical research studies that receive Food and Drug Administration approval, regardless of whether or not the NIH is the primary source of grant support.

(4) Our AMA believes that the NIH should use its resources and influence to support the development of a smoke-free inhaled delivery system for marijuana or delta-9-tetrahydrocannabinol (THC) to reduce the health hazards associated with the combustion and inhalation of marijuana.

(5) Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. (CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01)

H-95.953 Informing Physicians About the Potential Misuses of Dextromethorphan

The AMA will undertake a physician education process to educate especially pediatricians and primary care physicians about the dangers of misuse of dextromethorphan by young people. (Res. 407, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-95.954 The Reduction of Medical and Public Health Consequences of Drug Abuse

Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use;

(2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society;

(3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction;

(4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection;

(5) encourages the undertaking of comprehensive research into the potential effects, both positive and adverse, of relaxing existing drug prohibitions and controls and, that, until the findings of such research can be adequately assessed, the AMA reaffirm its opposition to drug legalization;

(6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and

(7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients. (CSA Rep. 8, A-97; Reaffirmed: CSA Rep. 12, A-99; Appended: Res. 416, A-00; Reaffirmation I-00)

H-95.955 Substance Abuse Among Physicians

(1) The AMA defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely

in professional activities and will address all such conditions in its Physician Health Program. (2) The AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians, to develop case finding mechanisms for all types of physician impairments, and to collect data on the prevalence of conditions affecting physician health. (3) The AMA encourages additional research in the area of physician impairment, particularly in the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems. (CSA Rep. 1, A-95; Reaffirmed: BOT Rep. 17, I-99)

H-95.956 Harm Reduction Through Addiction Treatment

The AMA endorses the concept of prompt access to treatment for chemically dependent patients, regardless of the type of addiction, and the AMA will work toward the implementation of such an approach nationwide. The AMA affirms that addiction treatment is a demonstrably viable and efficient method of reducing the harmful personal and social consequences of the inappropriate use of alcohol and other psychoactive drugs and urges the Administration and Congress to provide significantly increased funding for treatment of alcoholism and other drug dependencies and support of basic and clinical research so that the causes, mechanisms of action and development of addiction can continue to be elucidated to enhance treatment efficacy. (Res. 411, A-95; Appended: Res. 405, I-97; Reaffirmation I-03)

H-95.957 Methadone Maintenance in Private Practice

Our AMA: (1) reaffirms its position stated in the 1971 guideline on Oral Methadone Maintenance Techniques in the Management of Morphine-Type Dependence that, "the use of properly trained practicing physicians as an extension of organized methadone maintenance programs in the management of those patients whose needs for allied services are minimal" (called "medical" maintenance) should be evaluated further;

(2) supports the position that "medical" methadone maintenance may be an effective treatment for the subset of opioid dependent patients who have attained a degree of behavioral and social stability under standard treatment and thereby an effective measure in controlling the spread of infection with HIV and other blood-borne pathogens but further research is needed;

(3) encourages additional research that includes consideration of the cost of "medical" methadone maintenance relative to the standard maintenance program (for example, the cost of additional office security and other requirements for the private office-based management of methadone patients) and relative to other methods to prevent the spread of blood-borne pathogens among intravenous drug users;

(4) supports modification of federal and state laws and regulations to make newly approved anti-addiction medications available to those office-based physicians who are appropriately trained and qualified to treat opiate withdrawal and opiate dependence in accordance with documented clinical indications and consistent with sound medical practice guidelines and protocols; and

(5) urges that guidelines and protocols for the use of newly approved anti-addiction medications be developed jointly by appropriate national medical specialty societies in association with relevant federal agencies and that continuing medical education courses on opiate addiction treatment be developed by these specialty societies to help designate those physicians who have the requisite training and qualifications to provide therapy within the broad context of comprehensive addiction treatment and management. (CSA Rep. 2 - I-94; Reaffirmed: CSA Rep. 12 and Append Res. 412, A-99; Reaffirmation I-00)

H-95.958 Syringe and Needle Exchange Programs

The AMA: (1) encourages needle exchange programs; (2) will initiate and support legislation revoking the 1988 federal ban on funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription. (Res. 231, I-94; Reaffirmed Ref. Cmt. D, I-96; Modified by CSA Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-95.959 Expanding Treatment for the Heroin Addict Population

The AMA supports the development of interim methadone maintenance clinics, which include appropriate medical services, while awaiting transfer to a full-service clinic. (Sub. Res. 402, A-93; Reaffirmed: CSA Rep. 12, A-99; Reaffirmed and Title Change: CSA Rep. 4, A-03)

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; (3) urges that MROs obtain continuing medical education through courses offered by appropriate recognized medical specialty societies; and (4) vigorously opposes legislation that is inconsistent with these policies. (Res. 312, A-92;

Reaffirmed: CME Rep. 2, A-03)

H-95.961 Policy on Illegal Drug Use

The AMA discourages and condemns illegal drug use, and encourages physicians to do all in their power to discourage the use of illegal drugs in their communities and to refuse to assist anyone in obtaining drugs for non-medical use. (Res. 523, A-92; Reaffirmed: CSA Rep. 8, A-03)

H-95.962 Inhalant Abuse

The AMA supports education and awareness among medical professionals and the public regarding inhalant abuse. (Res. 513, A-92; Reaffirmation A-99)

H-95.963 Standardization of Collection and Custody Procedures of Body Fluid Specimens

It is the policy of the AMA to seek to have standardized procedures, containers and forms developed that will satisfy the requirements of all requesting entities which will reduce the hassle which currently exists in processing specimens for drug screens and for insurance applications. (Res. 501, I-91; Reaffirmed: Sunset Report, I-01)

H-95.964 New Guidelines and Regulations for Methadone Maintenance Treatment

The AMA (1) supports the development of new methadone treatment guidelines and regulations with a shift of emphasis from administrative process to performance-based standards of care with greater reliance on the physician's clinical judgment and scientific data in determination of treatment; and (2) encourages the appropriate governmental agencies to provide the needed resources to allow the development of realistic methadone treatment outcome standards with provisions to allow for differences among methadone maintenance treatment program patient populations. (Res. 416, I-91; Reaffirmed: CSA Rep. 12, A-99; Reaffirmation I-00)

H-95.965 Residential Treatment for Drug-Addicted Women

Our AMA encourages state medical societies to support an exemption in public aid rules that would allow for the coverage of residential drug treatment programs for women with child-bearing potential. (Res. 405, I-91; Reaffirmed: Sunset Report, I-01)

H-95.966 Triplicate Prescriptions for Schedule II Through Schedule V Drugs

Our AMA continues to oppose proposed legislation by the Congress calling for use of triplicate prescription forms for Schedule II through Schedule V drugs. (Res. 159, I-90; Reaffirmed: Sunset Report, I-00)

H-95.967 Drug Abuse

Our AMA encourages every physician to make a commitment to join his/her community in attempting to reduce drug abuse and that said commitment encourage involvement in at least one of the following roles:

(1) donation of time to talk to local civic groups, schools, religious institutions, and other appropriate groups about drug abuse;

(2) join or organize local groups dedicated to drug abuse prevention;

(3) talk to youth groups about brain damage and other deleterious effects of drug abuse; and

(4) educate and support legislators, office holders and local leaders toward ending the drug abuse crisis. (Sub. Res. 36, I-90; Modified: Sunset Report, I-00)

H-95.968 Substance Abuse Hotline

It is the policy of the AMA (1) not to establish a substance abuse hotline, but to continue to respond to inquiries about all physician health issues, including substance abuse issues, on an individual basis; (2) to encourage physicians with substance use disorders to contact their state physician health program since that program is probably best able to render assistance; and (3) to publicize the existence and availability of the Drug Abuse Information and Treatment Referral Hotline as an alternative and secondary source of referral information. (BOT Rep. U, I-90; Reaffirmed: Sunset Report, I-00)

H-95.969 Drug Abuse in the United States - Treatment Effectiveness And Capacity - A Preliminary Report

Given the need throughout the health care delivery field for more effective and efficient forms of treatment, it is important to

investigate the potential for better patient-treatment matching in treating alcohol and drug abusers. Researchers usually try to isolate each element of treatment in order to study it scientifically. In practice, however, several treatment approaches are typically used simultaneously or sequentially. In general, there have been too few well-controlled studies of combined interventions to permit final conclusions about their overall effectiveness in alcohol and drug abuse patients. The available findings are somewhat unimpressive, however, given the scope and intensity of the many combined treatment programs. One reason for the lack of impressive findings may have to do with patient characteristics which determine the amount of change which will occur with any treatment, and perhaps the degree to which additional treatment will result in additional measurable change. In highly motivated good-prognosis patients, for example, one well-chosen intervention - or even standard treatment - may produce maximal amounts of change, making the impact of additional interventions unmeasurable and, by implication, unnecessary. In poor-prognosis patients, on the other hand, the overall amount of change possible may be very limited, making a significant difference between one or many interventions difficult to demonstrate. Finding patient variables (i.e., prior drinking pattern, psychiatric morbidity) that are strongly predictive of treatment outcome may help identify patients expected to benefit least - and most - from multiple interventions. The AMA believes immediate attention should be given to all of these areas of urgently needed action, and commits itself to continued participation in the formulation, dissemination, and evaluation of the national responses to the problems of alcohol and drug abuse. (BOT Rep. Y, A-90; Reaffirmed: CME Rep. 10, I-98; Reaffirmed: CME Rep. 11, A-07)

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)

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)

H-95.973 Increased Funding for Drug Treatment

Our AMA (1) urges Congress to substantially increase its funding for drug treatment programs; (2) urges Congress to increase funding for the expansion and creation of new staff training programs; and (3) urges state medical societies to press for greater commitment of funds by state and local government to expand the quantity and improve the quality of the drug treatment system. (Res. 116, I-89; Reaffirmed: Sunset Report, A-00)

H-95.975 Substance Abuse as a Public Health Hazard

Our AMA: (1) recognizes that substance abuse in the major public health problem in the United States today and that its solution requires a multifaceted approach;

(2) declares substance abuse its number one public health priority;

(3) supports taking a positive stance as the leader in matters concerning substance abuse and addiction;

(4) supports studying innovative approaches to the elimination of substance abuse dependencies and their resultant street crime, including approaches which have been used in other nations; and

(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances. (Res. 7, I-89; Appended: Sub. Res. 401, Reaffirmed: Sunset Rep., I-99)

H-95.976 Drug Abuse in the United States - the Next Generation

Our AMA is committed to efforts that can help prevent this national problem from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:

(1) supports cooperation in activities of organizations such as the National Association for Perinatal Addiction Research and Education (NAPARE) in fostering education, research, prevention, and treatment of substance abuse;

(2) encourages the development of model substance abuse treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;

(3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;

(4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration with the Partnership for a Drug-Free America in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;

(5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Federal Office for Substance Abuse Prevention to continue to support research and demonstration projects around effective prevention and intervention strategies;

(6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco dependence as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;

(7) affirms the concept that substance abuse is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and

(8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction. (BOT Rep. Y, I-89; Reaffirmed: Sunset Report, A-00)

H-95.977 Medical Direction of Methadone Treatment

Our AMA urges that the operation of methadone treatment programs be under the direction of physicians who are knowledgeable and competent in the treatment of addiction. (Sub. Res. 84, A-89; Reaffirmed: CSA Rep. 12, A-99; Reaffirmation I-00)

H-95.978 Drug Abuse in the United States - Strategies for Prevention

Our AMA: (1) Urges the Substance Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical strategies that are most effective in ameliorating risk factors.

(2) Urges the Center for Substance Abuse Prevention to continue to support community-based prevention strategies which include: (a) Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level. (b) Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of drug and alcohol abuse prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction. (c) Development of innovative programs that train and involve parents, educators, physicians, and other community leaders in "state of the art" prevention approaches and skills.

(3) Urges major media programming and advertising agencies to encourage the development of more accurate and prevention-oriented messages about the effects of drug and alcohol abuse.

(4) Supports the development of advanced educational programs to produce qualified prevention specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial, and other special populations.

(5) Supports investigating the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of prevention activities.

(6) Urges federal, state, and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on prevention and eradication of alcohol and drug abuse. (BOT Rep. H, A-89; Reaffirmed: CSA Rep. 12, A-99; Reaffirmation I-01)

H-95.979 Curtailing Prescription Drug Abuse While Preserving Therapeutic Use - Recommendations for Drug Control Policy

Our AMA (1) opposes expansion of multiple-copy prescription programs to additional states or classes of drugs because of their documented ineffectiveness in reducing prescription drug abuse, and their adverse effect on the availability of prescription medications for therapeutic use; (2) supports continued efforts to address the problems of prescription drug diversion and abuse through physician education, research activities, and efforts to assist state medical societies in developing proactive programs; and (3) encourages further research into development of reliable outcome indicators for assessing the effectiveness of measures proposed to

reduce prescription drug abuse. (BOT Rep. PP, A-89; Reaffirmed: Sunset Report, A-00)

H-95.980 Increased Funding for Drug-Related Programs

The AMA supports the expansion of those drug rehabilitation programs which provide an environment for medical and other professional counseling, education and behavior change, and voluntary HIV testing for persons at risk for HIV. (Res. 35, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-95.981 Drug Abuse in the United States - A Policy Report

The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) encourage recognition that federal efforts at supply reduction and enforcement should be accompanied by increased efforts to reduce the demand for illicit drugs;
(2) renew and expand federal leadership to reduce the demand for illicit drugs;
(3) expand treatment programs, including treatment on demand for intravenous drug abusers;
(4) lead a coordinated approach to adolescent drug education;
(5) develop community programs for youth at risk;
(6) continue to appoint a high ranking official of the Executive Branch to coordinate federal drug policy;
(7) encourage a variety of private initiatives and carefully evaluate the use of limited workplace drug testing;
(8) extend greater protection against discrimination in the employment and provision of services to drug abusers;
(9) make a long-term commitment to expanded research and data collection;
10) broaden the focus of national and local policy from drug abuse to substance abuse; and
(11) recognize the complexity of the problem of substance abuse and oppose drug legalization. (BOT Rep. NNN, A-88; Reaffirmed: CLRPD 1, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

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)

H-95.983 Drug Dependencies as Diseases

The AMA (1) endorses the proposition that drug dependencies, including alcoholism, are diseases and that their treatment is a legitimate part of medical practice, and (2) encourages physicians, other health professionals, medical and other health related organizations, and government and other policymakers to become more well informed about drug dependencies, and to base their policies and activities on the recognition that drug dependencies are, in fact, diseases. (Res. 113, A-87; Reaffirmed by CSA Rep. 14, A-97; Reaffirmed: Sunset Report, I-97 Reaffirmed: CME Rep. 10, I-98; Reaffirmed: CME Rep. 11, A-07)

H-95.984 Issues in Employee Drug Testing

The AMA (1) reaffirms its commitment to educate physicians and the public about the scientific issues of drug testing; (2) supports monitoring the evolving legal issues in drug testing of employee groups, especially the issues of positive drug tests as a measure of health status and potential employment discrimination resulting therefrom; (3) takes the position that urine drug and alcohol testing of employees should be limited to (a) preemployment examinations of those persons whose jobs affect the health and safety of others, (b) situations in which there is reasonable suspicion that an employee's (or physician's) job performance is impaired by drug and/or alcohol use, (c) monitoring as part of a comprehensive program of treatment and rehabilitation of alcohol and drug abuse or dependence; and (d) urine, drug and alcohol testing of all physicians and appropriate employees of health care institutions may be appropriate under these same conditions. and (4) urges employers who choose to establish drug testing programs to use confirmed, positive test results in employees primarily to motivate those employees to seek appropriate assistance with their alcohol or drug problems, preferably through employee assistance programs. (CSA Rep. A, A-87; Reaffirmed: Sub. Res. 39, A-90, CSA Rep. D, I-90; BOT Rep. I, A-90; CSA Rep. 2, I-95; Reaffirmed: BOT Rep. 17, I-99)

H-95.985 Drug Screening and Mandatory Drug Testing

The AMA believes that physicians should be familiar with the strengths and limitations of drug screening techniques and programs. Due to the limited specificity of the inexpensive and widely available screening techniques, forensically acceptable testing programs must include highly specific, technically more complicated and more expensive confirmation techniques, which unequivocally establish the identities and quantities of drugs. Results from such drug testing programs can yield accurate evidence of prior exposure to drugs. Drug testing does not provide any information about pattern of use of drugs, abuse of or dependence on drugs, or about

mental or physical impairments that may result from drug use. Physicians need to be aware of the objectives of a drug testing program in which they participate, and they should be satisfied that the selection of subjects to be tested and the screening and confirming techniques that are used meet the objectives. Since physicians often are called upon to interpret results, they should be familiar with the pharmacokinetic properties of the drugs to be tested and the use to which the results will be put. (CSA Rep. J, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-95.986 State Legislation to Monitor Prescription of Schedule II Drugs

The AMA believes that it is important for each state to assess its own drug diversion problem and, taking into consideration the strengths of various available programs, to tailor remedial action to the specific problems of the state involved. (BOT Rep. G, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-95.987 "Opium" Perfume

The AMA opposes the advertising practice of naming products for controlled substances, implying that their use is exciting and desirable. (Sub. Res. 20, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-95.989 Drug Paraphernalia

The AMA opposes the manufacture, sale and use of drug paraphernalia. (BOT Rep. N, A-82; Reaffirmed: Sub. Res. 108, A-87; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-95.990 Drug Abuse Related to Prescribing Practices

Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices: (1) Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (a) Determination of the nature and extent of the prescription drug abuse problem; (b) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (c) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (d) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.
(2) Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (a) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (b) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms. (CSA Rep. C, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-95.991 Referral of Patients to Chemical Dependency Programs

Our AMA urges its members to acquaint themselves with the various chemical dependency programs available for the medical treatment of alcohol and drug abuse and, where appropriate, to refer their patients to them promptly. (Res. 31, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

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)

H-95.993 Use of Barbiturates in Medical Practice

Our AMA (1) opposes any attempt to remove short-acting barbiturates and other sedative-hypnotics from medical practice by rescheduling them from Schedule II to Schedule I of the Controlled Substances Act; and (2) supports an educational program among physicians, through scientific journals, continuing education courses and other appropriate means, which would emphasize that: (a) The physician should make an independent determination for each patient as to whether drug therapy is necessary or whether symptoms can be alleviated by other methods. (b) If drugs are indicated, the physician again should determine in each case whether substances other than sedative-hypnotics can be used. (c) Benzodiazepines can replace short-acting barbiturates in most outpatient therapy where sedation is needed. Nevertheless, the physician should be aware that additional research is necessary to ascertain

possible toxic effects of long-term use of either the benzodiazepines or the short-acting barbiturates. Thus, the duration of use of any of these drugs should be kept as brief as possible, consistent with the patient's well-being. (d) The physician should keep in mind that benzodiazepines also have the potential for abuse and production of dependence; that the patient's drug taking history and current behavior pattern should be carefully evaluated before prescribing these substances, as well as short-acting barbiturates. (CSA Rep. A, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-95.994 Statement on Use of Amphetamines in Obesity

Our AMA believes that the Drug Enforcement Administration of the Department of Justice should be offered every encouragement in the prosecution of those few individuals who prescribe CSA II amphetamine drugs for non-medical reasons in order to profit at the expense of patients who are drug dependent. (CSA Rep. C, part 2, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-95.995 Health Aspects of Marijuana

Our AMA (1) discourages marijuana use, especially by persons vulnerable to the drug's effects and in high-risk situations; (2) supports the determination of the consequences of long-term marijuana use through concentrated research; and (3) supports the modification of state law to reduce the severity of penalties for possession of marijuana. (CSA Rep. D, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-95.997 Marijuana

Our AMA: (1) recommends personal possession of insignificant amounts of that substance be considered a misdemeanor with commensurate penalties applied; (2) believes a plea of marijuana intoxication not be a defense in any criminal proceedings; and (3) urges that educational efforts be expanded to all segments of the population. (BOT Rep. J, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-95.998 AMA Policy Statement on Cannabis (Marijuana)

Our AMA believes that (1) cannabis is a dangerous drug and as such is a public health concern;

(2) sale and possession of marijuana should not be legalized;

(3) handling of offenders should be individualized; and

(4) additional research should be encouraged. (BOT Rep. K, I-69; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

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)

H-100.000 Drugs
(See also Drugs: Advertising; Drugs: Cost; Drugs: Labeling and Packaging; Drugs: Prescribing and Dispensing; Drugs: Substitution)

H-100.963 Essential Medicines for the Developing World

Our AMA: (1) supports universities engaging nontraditional partners, including public-private partnerships, grant-making organizations, nonprofits, and developing-world research institutions, in order to create new opportunities for neglected disease drug development; and (2) supports the protection of fair access to essential medicines in developing countries. (Res. 515, A-08)

H-100.964 Drug Issues in Health System Reform

The AMA: (1) consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package.
(2) supports consumer choice of at least two options for their pharmaceutical benefits program. This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited.
(3) reaffirms AMA Policy H-110.997, supporting the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourage physicians to supplement medical judgments with cost considerations in making these choices.

(4) reaffirms AMA Policies H-120.974 and H-125.992, opposing the substitution of FDA B-rated generic drug products.
(5) supports a managed pharmaceutical benefits option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA criteria defined in AMA Policy H-110.997 and that drug formulary systems employed are consistent with standards defined in AMA Policy H-125.991.
(6) supports prospective and retrospective drug utilization review (DUR) as a quality assurance component of pharmaceutical benefits programs, provided the DUR program is consistent with Principles of Drug Use Review defined in AMA Policy H-120.978.
(7a) encourages physicians to counsel their patients about their prescription medicines and when appropriate, to supplement with written information; and supports the physician's role as the "learned intermediary" about prescription drugs.
(7b) encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information.
(8) recognizes the role of the pharmacist in counseling patients about their medicines in order to reinforce the message of the prescribing physician and improve medication compliance.
(9) reaffirms AMA Policies H-115.995 and H-115.997, opposing FDA-mandated patient package inserts for all marketed prescription drugs.
(10) opposes payment of pharmacists by third party payers on a per prescription basis when the sole purpose is to convince the prescribing physician to switch to a less expensive "formulary" drug because economic incentives can interfere with pharmacist professional judgment.
(11) reaffirms AMA Policy H-120.991, supporting the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge, and to oppose legislation or regulation whose intent is to ban drug sampling.
(12) supports CEJA's opinion that physicians have an ethical obligation to report adverse drug or device events; supports the FDA's MedWatch voluntary adverse event reporting program; and supports FDA efforts to prevent public disclosure of patient and reporter identities.
(13) opposes legislation that would mandate reporting of adverse drug and device events by physicians that would result in public disclosure of patient or reporter identities.
(14) reaffirms AMA Policy H-120.988, supporting physician prescribing of FDA-approved drugs for unlabeled indications when such use is based upon sound scientific evidence and sound medical opinion, and supporting third party payer reimbursement for drugs prescribed for medically accepted unlabeled uses.
(15) encourages the use of three compendia (AMA's DRUG EVALUATIONS; United States Pharmacopeial-Drug Information, Volume I; and American Hospital Formulary Service-Drug Information) and the peer-reviewed literature for determining the medical acceptability of unlabeled uses.
(16) reaffirms AMA Policy H-100.989, supporting the present classification of drugs as either prescription or over-the-counter items and opposing the establishment of a pharmacist-only third (transitional) class of drugs.
(17) reaffirms AMA Policy H-120.983, urging the pharmaceutical industry to provide the same economic opportunities to individual pharmacies as given to mail service pharmacies. (BOT Rep. 53, A-94; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CSA Rep. 3, A-97; Amended: CSA Rep. 2, I-98; Renumbered: CMS Rep. 7, I-05)

H-100.965 Improved Notice of Drug Shortages

Our AMA: (1) will develop and seek sponsorship and passage of legislation in the Congress requiring that all manufacturers of Food and Drug Administration-approved pharmaceutical products be required to give the FDA public notice of the anticipated voluntary or involuntary, permanent or temporary, discontinuance of manufacture or marketing of such a product; and (2) recommends that when such termination or interruption is voluntary and not due to circumstances beyond the control of the manufacturer, at least six months' advance notice of termination or interruption be required by such legislation. (Res. 503, A-04)

H-100.966 Tracking and Punishing Distributors of Counterfeit Pharmaceuticals

Our AMA supports legislation making the production and distribution of counterfeit pharmaceuticals a felony. (Res. 924, I-03; Reaffirmation I-06)

H-100.967 Patient Privacy and Pharmaceutical Sales Representatives

Our AMA opposes the presence, inclusion or involvement of pharmaceutical sales representatives in clinical situations without the full knowledge and informed consent of patients. (Res. 8, A-03)

H-100.968 Improving the Quality of Geriatric Pharmacotherapy

Our AMA believes that the Food and Drug Administration should encourage manufacturers to develop low dose formulations of medications commonly used by older patients in order to meet the special needs of this group; require geriatric-relevant labeling for over-the-counter medications; provide incentives to pharmaceutical manufacturers to better study medication effects in the frail elderly and oldest-old in pre- and post-marketing clinical trials; and establish mechanisms for data collection, monitoring, and analysis

of medication-related problems by age group. (CSA Rep. 5, A-02)

H-100.969 Assuring the Safety and Quality of Foreign-Produced Pharmaceuticals

Our AMA supports: (1) the inspection of all foreign manufacturers of pharmaceutical chemicals and products which are exported to the United States to assure compliance with U.S. standards; and (2) periodic surveillance inspections of all foreign pharmaceutical manufacturers with timely follow-up inspection of all foreign manufacturers that have been identified as having serious manufacturing deficiencies. (Res. 512, A-99; Reaffirmation I-06; Reaffirmation A-08; Reaffirmed: Res. 508, A-08)

H-100.970 Informational Campaign on Diethylstilbesterol

Our AMA: (1) continues to encourage education on the consequences of diethylstilbestrol exposure so that medical students, physicians and other health care professionals receive satisfactory knowledge of the signs and symptoms of DES exposure in both the mother and her children; and (2) encourages research efforts on DES exposure and the future health of those affected. (Res. 501, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-100.971 Preserving the Doctor-Patient Relationship

The AMA and interested physicians will continue to work with the Food and Drug Administration to prevent the unnecessary intrusion of the government and other regulatory bodies into the doctor-patient relationship, especially as it concerns the prescription of medication. (Sub. Res. 510, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-100.972 Misuse of the DEA License Number

Our AMA: (1) affirms its opposition to use of the Drug Enforcement Administration (DEA) license number for any purpose other than for verification to the dispenser that the prescriber is authorized by federal law to prescribe the substance; and will explore measures to discourage or eliminate the use of physicians' DEA license numbers as numerical identifiers in insurance processing and other data bases, either through legislation, regulation or accommodation with organizations which currently insist on collection of this sensitive data; (2) seeks to have its proposed legislation introduced, which would limit the use of DEA numbers to those federal and state entities that use the number to oversee and enforce the law regarding the manufacture, distribution, and dispensing of controlled substances; and (3) continues to advocate for the adoption of the AMA's Medical Education number as the unique identifier for physicians. (Res. 510, A-94; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-97; Appended: Sub. Res. 207, I-97; Reaffirmed by Sub. Res. 205, A-98; Reaffirmed Sub. Res. 207, I-00; Reaffirmation A-06)

H-100.973 Combating Antimicrobial Resistance through Education

Our AMA: (1) encourages the federal government, the World Health Organization, the World Medical Association, and the International Federation of Pharmacists to promote more effective education concerning the appropriate use of antibiotics;

(2) strongly urges physicians to educate their patients about their antimicrobial therapy, the importance of compliance with the prescribed regimen, and the problem of antimicrobial resistance;

(3) will continue to educate physicians and physicians-in-training about the appropriate prescribing of antimicrobial agents;

(4) encourages the use of antibiotic resistance management programs; these education-based programs should be multidisciplinary and cooperative (i.e., including infectious disease physicians, infection-control specialists, microbiology laboratory personnel, and clinical pharmacists); and

(5) encourages continued scientific research on the issue of antibiotic resistance. (Sub. Res. 521, A-94; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation I-98; Modified: CSA Rep. 3, A-00; Reaffirmation I-07)

H-100.976 Benzodiazepine Education

Our AMA encourages physicians interested in the true addictive nature of benzodiazepines and their rational use to seek information from appropriate sources of information such as the American Psychiatric Association's Task Force Report, Benzodiazepine Dependence, Toxicity and Abuse. (CSA Rep. E, A-92; Amended: CSA Rep. 8, A-03)

H-100.979 Repeal of Offensive Federal Regulations

The AMA urges the Drug Enforcement Administration to develop an alternative system for identifying partially filled prescriptions for Schedule II drugs that does not reveal diagnostic information. (Sub. Res. 511, A-92; Reaffirmed: BOT Rep. 28, A-03)

H-100.980 Food and Drug Administration

(1) AMA policy states that a strong and adequately funded FDA is essential to ensuring that safe and effective medical products are made available to the American public as efficiently as possible. (2) Our AMA: (a) continue to monitor and respond appropriately to legislation that affects the FDA and to regulations proposed by the FDA; (b) continue to work with the FDA on controversial issues concerning food, drugs, biologics, radioactive tracers and pharmaceuticals, and devices to try to resolve concerns of physicians and to support FDA initiatives of potential benefit to patients and physicians; and (c) continue to affirm its support of an adequate budget for the FDA so as to favor the agency's ability to function efficiently and effectively. (3) Our AMA will continue to monitor and evaluate proposed changes in the FDA and will respond as appropriate. (Sub. Res. 548, A-92; BOT Rep. 32, A-95; BOT Rep. 18, A-96; Reaffirmed: BOT Rep. 7, I-01; Reaffirmation I-07)

H-100.981 United States Pharmacopoeial Convention Meetings

Our AMA encourages each state medical association and each college of medicine to send a delegate to the United States Pharmacopoeial Convention Quinquennial Meetings every five years beginning in 1995. (Res. 156, A-90; Reaffirmed: Sunset Report, I-00)

H-100.982 Confidentiality of Drug Enforcement Agency Numbers

Our AMA (1) believes that the Drug Enforcement Agency should refrain from divulging a physician's DEA number unless there is a valid reason for doing so; (2) believes that insurance companies and pharmaceutical companies should use a physician's state medical license number to identify a physician in the computer files instead of the DEA number when controlled substances are not involved; (3) will develop model legislation to restrict the use of the DEA number for monitoring the prescribing of controlled substances only; and (4) supports legislation or regulations to prevent insurance companies and other entities from using DEA registration numbers for identification of physicians. (Res. 123, I-89; Reaffirmed Rules & Credentials Cmt., A-96; Reaffirmation A-97; Sub. Res. 221, A-97; Reaffirmed by Sub. Res. 205, A-98; Reaffirmation A-99; Appended: Res. 701, I-03; Reaffirmation A-06)

H-100.984 News Media Access to New Scientific Developments

Our AMA encourages the National Institutes of Health and the FDA to mandate that all information developed in any clinical trials, or any adverse drug or device reaction reports, be first released to the medical and scientific communities prior to being released to the public. (Sub. Res. 169, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-07)

H-100.985 Need for Requirements of Ongoing Quality Assurance of the Bioavailability of Purity of Prescription Pharmaceuticals

Our AMA (1) believes that all pharmaceutical manufacturers should be required by federal law or regulation to perform effective and meaningful ongoing quality assurance studies of the biologic efficacy and purity of prescription medications which they are marketing; and (2) encourages the FDA to use published rules and regulations in their process and evaluation of Abbreviated New Drug Applications. (Sub. Res. 90, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-08)

H-100.986 Ethical Concerns and Development of New Medications

Our AMA supports the position that research and development of new medications should be based on scientific evidence. (Sub. Res. 252, A-89; Reaffirmed: Sunset Report, A-00)

H-100.987 Insufficient Testing of Pharmaceutical Agents in Children

The AMA supports the FDA's efforts to encourage the development and testing of drugs in the pediatric age groups in which they are used. (Sub. Res. 17, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-100.988 Homeopathic Pharmacopoeia

Since a few states still license homeopathic physicians, a pharmacopoeia (standard of drug identity) is essential to homeopathic practice. Therefore, the AMA feels it is undesirable at present to amend that section of the Federal Food, Drug and Cosmetic Act which confers official status on the Homeopathic Pharmacopoeia. (BOT Rep. I, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-100.989 A Transitional Class for Drugs

The AMA supports the present classification of drugs as either prescription or over-the-counter items and opposes the establishment of a third transitional class of drugs. (Sub. Res. 80, I-84; BOT Rep. 53, A-94; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed; CSA

Rep. 6, A-04; Reaffirmation A-08)

H-100.990 Guidelines for Parenteral Anti-Neoplastics

The AMA supports the guidelines of the National Institutes of Health (NIH) on the safety of parenteral anti-neoplastic agent administration, concluding that the NIH recommendations are at this time the most reasonable means of reducing the level of exposure for health care personnel in the hospital environment. (CSA Rep. D, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04)

H-100.991 Drug Availability

Our AMA urges HHS to consider all drugs approved by the FDA for marketing as eligible for reimbursement. (Res. 79, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed and Modified: CSA Rep. 8, A-05)

H-100.992 FDA

(1) Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.

(2) The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.

(3) It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history. (Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-06; Appended: Sub. Res. 509, A-06; Reaffirmation I-07)

H-100.993 Recommendations on Drug Development and Drug Regulation

(1) The FDA must be given the funds and quality personnel to perform its tasks effectively and efficiently. Career opportunities must be made more attractive in terms both of salary and scientific career opportunities. (2) The FDA should be encouraged to make use of foreign data generated by reputable foreign scientists. This would reduce the reduplicative efforts now required and avoid the questionable ethics of demanding clinical trials for strictly regulatory purposes. (3) The FDA should be encouraged to confer with industry and clinical investigators during the IND phase of drug application. Sponsors should design their protocols and report forms in collaboration with the FDA and the involved clinical investigators. Thus, the pharmaceutical company sponsor may be secure in the knowledge that the early clinical trials so constructed will provide the FDA with information necessary to its new drug application. (4) The FDA should develop a system of grants that will encourage through appropriate funding a few research efforts investigating those drugs for which there may be no mass market, but which promise to fill an important need in rare but serious diseases. (5) The AMA supports the funding of an adequate budget for the FDA so as to favor the agency's ability to function efficiently and effectively. (CSA Rep. B, Parts 1, 2, 4, 5, I-78; Reaffirmed: CLRPD Rep. C, A-89; BOT Rep. 32, I-94; Reaffirmed and Modified: CSA Rep. 6, A-04)

H-100.994 International Cooperation and Standards in the Experimentation and Approval for Use of Drugs

Our AMA recommends that the FDA, in cooperation with regulatory medical and scientific bodies of other countries of high standards, including but not limited to Canada, Great Britain, Switzerland, Sweden, and West Germany, establish uniform standards for clinical investigation of drugs, acceptable to all participating countries, with the objective of minimizing risk to patient populations from unnecessary and duplicative tests. (Res. 76, part 1, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-100.995 Support of American Drug Industry

Our AMA continues to support the American pharmaceutical manufacturing industry in its efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy for the benefit of the American people. (Sub. Res. 20, A-74; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-100.997 Drugs of Choice

Our AMA opposes any proposal that would establish a classification of drugs of choice for any specific clinical entity through governmental regulation. (Res. 117, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-105.000 Drugs: Advertising
(See also: Drugs; Drugs: Cost; Drugs: Labeling and Packaging; Drugs: Prescribing and Dispensing; Drugs: Substitution)

H-105.988 Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices

It is the policy of our AMA:

1. That our AMA considers acceptable only those product-specific DTC advertisements that satisfy the following guidelines:

(a) The advertisement should be indication-specific and enhance consumer education about both the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.

(b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.

(c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products.

(d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.

(e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.

(f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.

(g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.

(h) In general, product-specific DTC advertisements should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTC advertisements, a disclaimer should be prominently displayed.

(i) The use of actual health care professionals, either practicing or retired, in DTC to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.

(j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.

(k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.

2. That our AMA opposes product-specific DTC advertisements, regardless of medium, that do not follow the above AMA guidelines.

3. That the FDA review and pre-approve all DTC advertisements for prescription drug or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.

4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTC.

5. That DTC advertisements for newly approved prescription drug or implantable medical device products not be run until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTC for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it.

6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTC advertisements.

7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTC, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.

8. That our AMA supports the concept that when companies engage in DTC, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.

9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-specific DTC and with the Council on Ethical and Judicial Affairs (CEJA) Ethical Opinion E-5.015 and to adhere to the ethical guidance provided in that Opinion.

10. That the Congress should request the Agency for Healthcare Research and Quality (AHRQ) to perform periodic evidence-based reviews of DTC in the United States to determine the impact of DTC on health outcomes and the public health. If DTC is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTC regulation or, if necessary, to prohibit DTC in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.

11. That our AMA continues to monitor DTC, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTC, as necessary.

12. That our AMA supports "help-seeking" or "disease awareness" advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA). (BOT Rep. 38 and Sub. Res. 513, A-99; Reaffirmed: CMS Rep. 9, Amended: Res. 509, and Reaffirmation I-99; Appended & Reaffirmed: Sub. Res. 503, A-01; Reaffirmed: Res. 522, A-02; Reaffirmed: Res. 914, I-02; Reaffirmed: Sub. Res. 504, A-03; Reaffirmation A-04; Reaffirmation A-05; Modified: BOT Rep. 9, A-06; Reaffirmed in lieu of Res. 514, A-07)

H-105.992 Pharmaceutical Advertising

Our AMA supports calling upon the pharmaceutical industry to work with the AMA to promote print and electronic advertising that will educate the American public not only as to the beneficial effects of their over-the-counter products but also to the potential adverse effects of indiscriminate use of those same products. (Res. 92, I-89; Reaffirmed: Sunset Report, A-00)

H-110.000 Drugs: Cost
(See also: Drugs; Drugs: Advertising; Drugs: Labeling and Packaging; Drugs: Prescribing and Dispensing; Drugs: Substitution)

H-110.989 Pay for Delay Arrangements by Pharmaceutical Companies

Our AMA supports the Federal Trade Commission in its efforts to stop "pay for delay" arrangements by pharmaceutical companies. (Res. 520, A-08)

H-110.990 Cost Sharing Arrangements for Prescription Drugs

Our AMA:

1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;

2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and

health outcomes; and

3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition. (CMS Rep. 1, I-07; Reaffirmation A-08)

H-110.991 Price of Medicine

Our AMA (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications, and (2) will pursue legislation requiring pharmacies to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication. (CMS Rep. 6, A-03; Appended: Res. 107, A-07)

H-110.992 Study of Actions to Control Pharmaceutical Costs

Our AMA will monitor the relationships between pharmaceutical benefits managers and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs. (Sub. Res. 114, A-01; Reaffirmed: Res. 533, A-03)

H-110.995 Excessive Cost of Prescription Drugs

The AMA expresses its concern to the Pharmaceutical Manufacturers Association, including its CEO, and others as appropriate about the cost of prescription drugs as well as the inability of many patients to afford essential prescription drugs. (Sub. Res. 202, I-91; Reaffirmed: Res. 520, A-99)

H-110.996 Cost of Prescription Drugs

The AMA (1) supports entering into dialogue with pharmaceutical company representatives and other appropriate agencies to explore ways to reduce the costs of brand name drugs through such mechanisms as a more cost-effective research and development process, more modest promotional activities, product liability reform and streamlining the FDA requirements for new drug approval, and (2) supports increasing physician awareness about the cost of drugs prescribed for their patients. (Res. 173, A-91; Reaffirmed: Res. 520, A-99)

H-110.997 Cost of Prescription Drugs

Our AMA:

(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;

(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;

(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;

(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;

(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;

(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and

(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients. (BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep.3, I-

00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06)

H-110.998 Cost of New Prescription Drugs

Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs. (Res. 112, I-89; Reaffirmed: Res. 520, A-99)

H-115.000 Drugs: Labeling and Packaging
(See also: Drugs; Drugs: Advertising; Drugs: Cost; Drugs: Prescribing and Dispensing; Drugs: Substitution)

H-115.970 Usage of Brand and Generic Name for Prescription Medications

Our AMA encourages the American Hospital Association, National Nursing Home Association, as well as complementary state and local associations, to consider the use of both generic and common brand names for medications on containers, communications, and other applicable areas in health care settings. (Sub. Res. 509, A-07)

H-115.971 Safety and Efficacy of Selective Serotonin Reuptake Inhibitors (SSRIs) in Children and Adolescents

Our AMA recognizes that the current product labeling (package insert) of antidepressant drugs, including the Black Box warnings, is a precautionary statement intended to reinforce the need for careful monitoring of patients with depression and other psychiatric disorders during the initiation of treatment. This product labeling should not be interpreted in a way that would decrease access for patients who may benefit from these drugs. (CSA Rep. 10. A-05)

H-115.972 Over-the-Counter Inhalers in Asthma

Our AMA: (1) supports strengthening the product labeling for over-the-counter (OTC) epinephrine inhalers to better educate users about patterns of inappropriate use; to include clear statements that the use of OTC inhalers can be dangerous; to urge users to seek medical care if symptoms do not improve or if they meet criteria for the presence of persistent disease; and to encourage explicit discussions with physicians about dosage when these products are used; (2) encourages the FDA to reexamine whether OTC epinephrine inhalers should be removed from the market; and (3) In the event that these products continue to be marketed OTC, further information should be obtained to determine whether OTC availability is a risk factor for asthma morbidity and mortality. (CSA Rep. 2, A-99)

H-115.973 Medication Scoring

Our AMA: (1) recommends to pharmaceutical manufacturers that, when appropriate, tablets be scored on both sides and so constructed that they will more readily divide in half and not fragment upon attempts at division; and (2) opposes third party policies that mandate the use of pill-splitting or pill-breaking to reduce pharmaceutical or healthcare costs without proper input from the pharmaceutical manufacturers and practicing physicians. (Res. 510, A-95; Appended: Sub. Res. 513, A-00)

H-115.974 Prescription Labeling

Our AMA recommends (1) That when a physician desires to prescribe a brand name drug product, he or she do so by designating the brand name drug product and the phrase "Do Not Substitute" (or comparable phrase or designation, as required by state law or regulation) on the prescription; and when a physician desires to prescribe a generic drug product, he or she do so by designating the USAN-assigned generic name of the drug on the prescription.

(2) That, except where the prescribing physician has indicated otherwise, the pharmacist should include the following information on the label affixed to the container in which a prescription drug is dispensed: in the absence of product substitution, (a) the brand and generic name of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; and (d) the name of the manufacturer or distributor.

(3) When generic substitution occurs: (a) the generic name (or, when applicable, the brand name of the generic substitute ["branded" generic name]) of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; (d) the manufacturer or distributor; and (e) either the phrase "generic for [brand name prescribed]" or the phrase "substituted for [brand name prescribed]".

(4) When a prescription for a generic drug product is refilled (e.g., for a patient with a chronic disease), changing the manufacturer or distributor should be discouraged to avoid confusion for the patient; when this is not possible, the dispensing pharmacist should satisfy the following conditions: (a) orally explain to the patient that the generic drug product being dispensed is from a different manufacturer or distributor and, if possible (e.g., for solid oral dosage forms), visually show the product being dispensed to the patient; (b) replace the name of the prior generic drug manufacturer or distributor on the label affixed to the prescription drug

container with the name of the new generic drug manufacturer or distributor and, show this to the patient; (c) affix to the primary label an auxiliary (sticker) label that states, "This is the same medication you have been getting. Color, size, or shape may appear different;" and (d) place a notation on the prescription record that contains the name of the new generic drug manufacturer or distributor and the date the product was dispensed. (BOT Rep. 1, A-95; Amended: CSA Rep. 2, I-99; Modified Res. 512, I-00; Reaffirmed: CSA Rep. 6, A-02; Reaffirmed: CSAPH Rep. 2, A-07; Reaffirmed: Sub. Res. 509, A-07)

H-115.975 Controlled Vocabulary for Extended Use Drug Formulations

The AMA encourages appropriate groups and agencies to establish a "controlled vocabulary" to identify clearly and without ambiguity extended (sustained) release (action) tablet and capsule formulations of medications. (Sub. Res. 517, A-94; Reaffirmed: CSA Rep. 6, A-04)

H-115.979 Policy to Reduce Waste from Pharmaceutical Sample Packaging

(1) Our AMA adopts the following policy to reduce waste materials from pharmaceutical sample packaging: (a) each sample container should be a small as possible, and (b) each container and the packaging material used inside or outside the container should be composed of biodegradable and recycled materials whenever possible.
(2) Our AMA urges the FDA to modify any rules that may be in conflict with this policy.
(3) Our AMA supports making a copy of this policy available to all AMA members and all major pharmaceutical companies, and encourages members to register complaints with representatives of pharmaceutical companies that do not meet these standards.
(4) Our AMA supports discussions with the Pharmaceutical Research and Manufacturers of America to achieve nationwide adherence to these or similar guidelines. (Res. 508, I-91; Modified: Sunset Report, I-01)

H-115.980 Distinctive Labeling of Vials and Ampules, Prefilled Syringes, Ophthalmic Solutions and Related Liquid Medications

It is the policy of the AMA to: (1) participate, along with representatives from the pharmaceutical profession, the pharmaceutical industry, and other interested parties, in developing and implementing appropriate guidelines aimed at developing easily identifiable labeling to further optimize the safe use of vials, ampules, prefilled syringes, ophthalmic solutions, and other related liquid medications; and (2) urge the National Patient Safety Foundation to work with other medical organizations, the FDA and the pharmaceutical industry, to develop a consistent nationwide policy on drug-specific size, shape, and label color for injectable drug containers. (Res. 209, A-91; Appended: Res. 508, A-00)

H-115.981 FDA Mandated Patient Information Sheets

Our AMA supports making every effort to convince the FDA to discontinue mandatory patient information sheets in estrogen prescriptions in order to promote compliance in taking prescribed medication for the improvement of the health of patients. If the mandatory patient information sheets cannot be discontinued, the AMA supports making every effort to convince the FDA to change mandatory patient information sheets in estrogen prescriptions to present a more balanced evaluation of the benefits and risks. (Res. 218, A-91; Reaffirmed: Sunset Report, I-01)

H-115.982 Sample Medication Packaging

Our AMA requests that all pharmaceutical companies distributing medicine samples to physicians' offices voluntarily comply with the request that all sample medicines being distributed be packaged in such a way that a blank space be included in the packaging material so that the physician can write specific instructions on the sample container as to how the medicine should be taken. (Res. 203, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmation A-07)

H-115.983 Expiration Dates and Beyond-Use Dates of Prescription Drug Products

Our AMA: (1) supports the inclusion of expiration dates on the containers/labels of prescription drug products and recommends that expiration dates be determined by pharmaceutical manufacturers using scientifically based stability testing with subsequent approval by the Food and Drug Administration (FDA);

(2) urges the pharmaceutical industry, in collaboration with purchasers, the FDA, and the United States Pharmacopeia (USP), to determine whether lengthening of expiration dates will provide clinical and/or economic benefits or risks for patients and, if this is the case, to conduct longer stability testing on their drug products;

(3) recommends that pharmacists place a beyond-use date on the labeling of all prescription medications dispensed to patients, and that the beyond-use date be based on the recommendations in the most recent edition of the United States Pharmacopeia and National Formulary (currently USP 24-NF 19) (official January 1, 2000); and

(4) encourages the USP, in collaboration with pharmaceutical manufacturers, pharmacy organizations, and the FDA, to continue to explore the development of appropriate stability tests for the determination of scientifically sound beyond-use dates for repackaged products. (BOT Rep. O, I-90; BOT Rep. 1, A-95; Appended: Res. 527 and Reaffirmed: Res. 520, A-00; Modified: CSA Rep. 1, A-01; Reaffirmed: Res. 515, A-02; Reaffirmation A-07)

H-115.984 Product Identification of Generic Drugs

The AMA supports working with the appropriate organizations to: (1) develop a coding system for the identification of all solid medication forms; (2) encourage imprinting, when feasible, each tablet, capsule or other solid dosage form of generic prescription drug with its unique code and the name or other distinctive mark identifying the manufacturer; and (3) encourage compilation of this coding system into a reference and disseminate it to physicians, pharmacists and law enforcement agencies in an appropriate manner. (Res. 44, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-115.985 Warning Labels on Over-The-Counter Iron Preparations and Dietary Supplements

The AMA (1) urges physicians to warn diagnosed patients with hereditary hemochromatosis against the use of over-the-counter iron preparations and dietary supplements containing iron; (2) believes that therapeutic doses of iron should be used only to treat iron-deficiency anemia; and (3) believes that the prophylactic use of iron preparations should be reserved for individuals at high risk of developing iron deficiency. (CSA Rep. E, I-86; Amended by Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-115.988 Qualitative Labeling of All Drugs

The AMA supports efforts to promote the qualitative labeling of all drugs, requiring both active and inactive ingredients of over-the-counter and prescription drugs to be listed on the manufacturer's label or package insert. (Res. 96, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; BOT Rep. 1, A-95; Reaffirmed: CSA Rep. 8, A-05)

H-115.989 Protective Packaging

The AMA supports the pharmaceutical industry's efforts to develop and market tamper-resistant packaging for over-the-counter medications. (Res 75, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-115.992 Imprint Identification of Legend Drugs

Our AMA recommends that, when feasible, manufacturers imprint legibly on legend drugs in solid dosage form some mark identifying the drug. (Sub. Res. 16, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-115.993 Drug Identification

Our AMA encourages physicians to familiarize themselves with the proper use of drug identification in their individual practices, and supports actions of pharmaceutical manufacturers and appropriate state or federal governmental actions to assure implementation of a nationwide program of imprinting solid medication forms. (Res. 115, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-115.994 Physicians' Desk Reference

Our AMA believes that the FDA should adopt a standard paragraph for publication, whenever the information contained in the official labeling of prescription drugs is published, to read substantially as follows: This official labeling statement of necessity represents a summary of the information available upon which approval for marketing in interstate commerce of this drug product was based. This official labeling should not be regarded as a legal standard of acceptable or accepted medical practice nor as a substitute for clinical judgment or experience nor as a limitation on usage of the drug in medical practice. The official labeling statements approved by the Federal FDA establish the parameters governing advertising or promotion of the drug product. (Sub. Res. 30, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-115.995 Patient Instructional Leaflets (PIL)

(1) Our AMA advocates the following basic principles in any program for supplying drug information to patients: (a) Not all prescription drugs require PILs. Only special classes of agents need expanded patient information. (b) The PIL is not and should not be considered the basic vehicle for drug information to the patient; this is a function which must be retained by the prescribing physician. Instead, the PIL should be considered an educational adjunct to reinforce the physician's discussion and instruction to the patient. (c) PILs should not be mandatory for all patients. (d) The physician must have the prerogative to determine whether the PIL is in the patient's best interest. (e) PILs should present a fair balance of benefits and risks without undue emphasis on adverse effects that could be alarming to the patient. (f) The PIL should enumerate only selected, significant, documented side effects and adverse

reactions. It should not contain a long list of possible, suspected, rare or undocumented side effects as is done in the pack-age insert for physicians. (g) PILs should be dispensed by the physician or by the pharmacist as directed by the physician. (h) PILs should not be developed unilaterally by the federal government but should represent a cooperative effort by the major organizations of medicine and pharmacy.

(2) The impact of PILs on the quality of medical care should be evaluated in carefully controlled studies. (CSA Rep. B, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-05)

H-115.996 Generic Labeling for Drugs Crossing International Borders

(1) Physicians who need information on foreign drugs should consult their local drug information center and the AMA for information from the international drug data file and other sources. (2) The establishment of a national toll-free number for drug nomenclature is unnecessary. (BOT Rep. C, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-115.997 Patient Package Inserts

The AMA continues to oppose mandatory patient package inserts for all drugs approved for marketing by the FDA. (Sub. Res. 3, A-77; Reaffirmed: CLRPD Rep. C, A-89; BOT Rep. 53, A-94; Reaffirmed: CSA Rep. 8, A-05)

H-120.000 Drugs: Prescribing and Dispensing
(See also: Drugs; Drugs: Advertising; Drugs: Cost; Drugs: Labeling and Packaging; Drugs: Substitution)

H-120.942 Personal Medication Supply in Times of Disaster

Our AMA policy is that: (a) it is reasonable and prudent for patients with chronic medical conditions to maintain an emergency reserve of their prescription medications; (b) patients with chronic medical conditions should carry on their person a current list of their prescription medications, which includes indications, doses, and the prescriber's and dispensing pharmacist's contact information; and (c) patients with chronic medical conditions should discuss options with their physician for ensuring that they have an adequate supply of prescription medications in the event of a disaster or other potential emergency. (BOT Rep. 15, A-08)

H-120.943 Adequate Prescription Medication Supply

Our AMA urges health plans to: (1) define a month's supply as a minimum of 31 days and three month's supply as a minimum of 93 days, so that patients are not shorted on their one-month or three-month supply of prescription drugs; and (2) allow prescription refills to provide the appropriate number of doses for the time period specified by the physician. (Res. 510, A-07)

H-120.944 Standards, Laws, and Regulations Addressing Pain Medications and Medical Practice

1. AMA policy is that states should examine their pain policies and seek to improve them, based on the Federation of State Medical Boards Model Policy and/or criteria established by the Wisconsin Pain & Policies Study Group.

2. AMA policy is that the impact of state-based prescription drug monitoring programs on medical care, including appropriate pain management, should be evaluated.

3. Our AMA will urge the Drug Enforcement Administration to work with physician organizations and other relevant stakeholders to reconstruct a document similar to "Prescription Pain Medications: Frequently Asked Questions and Answers for Health Care Professionals and Law Enforcement Personnel" to serve as a legitimate resource for physicians, regulators, and law enforcement personnel. (CSAPH Rep. 6, A-07)

H-120.945 AMA Action on Non FDA-Approved Compounded Medications

Our AMA:

1. recognizes that compounding pharmacies must comply with current United States Pharmacopeia and National Formulary (USP-NF) compounding monographs, when available, and recommends that they be required to conform with USP-NF General Chapters on pharmaceutical compounding to ensure the uniformity, quality, and safety of compounded medications;

2. recognizes the accreditation program of the Pharmacy Compounding Accreditation Board (PCABTM) and the PCABTM Seal of Accreditation as a means to identify compounding pharmacies that adhere to quality and practice standards, including those set forth in the USP-NF, for the preparation of individualized medications for specific patients;

3. encourages all state boards of pharmacy to require compounding pharmacies in their states to obtain the PCABTM Seal of

Accreditation or, alternatively, to satisfy comparable standards that have been promulgated by the state in its laws and regulations governing pharmacy practice; and

4. encourages state boards of pharmacy and the National Association of Boards of Pharmacy (NABP), the umbrella organization for state boards of pharmacy, to work with the United States Food and Drug Administration (FDA) to identify and take appropriate enforcement action against entities that are illegally manufacturing medications under the guise of pharmacy compounding. (BOT Action in response to referred for decision Res. 521, A-06)

H-120.946 Support of Efforts to Lift Regulatory Restrictions Upon the Number of Opioid Dependent Patients Any One Certified Physician May Treat with Buprenorphine

Our AMA supports efforts to lift regulatory restrictions upon the number of opioid dependent patients any one certified physician may treat with buprenorphine. (Res. 541, A-06)

H-120.947 Preserving Patients' Ability to Have Legally Valid Prescriptions Filled

1. Our AMA reaffirms our policies supporting responsibility to the patient as paramount in all situations and the principle of access to medical care for all people; and supports legislation that requires individual pharmacists or pharmacy chains to fill legally valid prescriptions or to provide immediate referral to an appropriate alternative dispensing pharmacy without interference. In the event that an individual pharmacist or pharmacy chain refers a patient to an alternative dispensing source, the individual pharmacist or the pharmacy chain should return the prescription to the patient and notify the prescribing physician of the referral.

2. Our AMA supports the concept of advance prescription for emergency contraception for all women in order to ensure availability of emergency contraception in a timely manner. (Sub. Res. 6, A-05; Appended: BOT Rep. 18, I-06; Reaffirmed and Appended: BOT Rep. 2, A-08)

H-120.948 Positive Verification of Contact Lens Prescriptions

Our AMA will support positive prescription verification for contact lenses and recommend that the federal government monitor the effects of the Fairness to Contact Lens Consumers Act (FCLCA) on the accuracy of prescriptions. (Res. 225, A-04)

H-120.949 Guidance for Physicians on Internet Prescribing

Our AMA provides the following guidance for physicians on the appropriate use of the Internet in prescribing medications:

(a) Criteria for an acceptable patient (clinical) encounter and follow-up:
Physicians who prescribe medications via the Internet shall establish, or have established, a valid patient-physician relationship, including, but not limited to, the following components. The physician shall:
(i) obtain a reliable medical history and perform a physical examination of the patient, adequate to establish the diagnosis for which the drug is being prescribed and to identify underlying conditions and/or contraindications to the treatment recommended/provided;
(ii)have sufficient dialogue with the patient regarding treatment options and the risks and benefits of treatment(s);
(iii) as appropriate, follow up with the patient to assess the therapeutic outcome;
(iv) maintain a contemporaneous medical record that is readily available to the patient and, subject to the patient's consent, to his or her other health care professionals; and
(v) include the electronic prescription information as part of the patient medical record.
Exceptions to the above criteria exist in the following specific instances:
treatment provided in consultation with another physician who has an ongoing professional relationship with the patient, and who has agreed to supervise the patient's treatment, including use of any prescribed medications; and on-call or cross-coverage situations.

(b) Licensure
Physicians who prescribe medications via the Internet across state lines, without physically being located in the state(s) where the patient (clinical) encounter(s) occurs, must possess appropriate licensure in all jurisdictions where patients reside.
An exception to this requirement is when the clinical encounter with the patient, as described in recommendation 1(a) above, occurs in the state where the physician is licensed and his or her practice is located, and the state where the patient resides allows electronic prescriptions from out-of-state prescribers.

(c) Security of patient information
Physicians who prescribe via the Internet should transmit prescriptions over a secure network (i.e., provisions for password protection, encrypted electronic prescriptions, or other reliable authentication techniques [e.g., AMA Internet ID]) in order to protect patient privacy.

(d) Disclosure of identifying information on web sites
Physicians who practice medicine via the Internet, including prescribing, should clearly disclose physician-identifying information on the web site, including (but not necessarily limited to) name, practice location (address and contact information), and all states in which licensure is held. Posting of actual physicians' license numbers (e.g., the DEA number) is unnecessary.

(e) Liability exposure
Physicians should be aware that they may increase their liability exposure by prescribing medications to individuals solely through online interactions (e.g., online questionnaire or online consultation). (BOT Rep. 7, A-03; Reaffirmed: BOT Rep. 3, I-04; Reaffirmed: Sub. Res. 522, A-05)

H-120.950 Change DEA Procedures in Partial Filling of Schedule II Prescriptions

Our AMA requests that the federal Drug Enforcement Administration change its partial filling of Schedule II Prescription regulation (21 CFR 1306.13) so that patients can acquire the balance of a prescription if, for whatever reason, only a portion of the supply was dispensed when the prescription was presented to a licensed pharmacy. (Res. 505, A-02)

H-120.951 Mandatory Acceptance of the Currently Utilized Physician Prescription Form by Pharmacy Benefit Plan Administration

Our AMA seeks legislation or regulation that would: (1) require that pharmacy benefits plans accept the currently utilized physician prescription forms for all initial prescriptions and renewals; and (2) ensure that a written, oral or electronically transmitted prescription that complies with state and federal law constitutes the entirety of the physician's responsibility in providing patient prescriptions. (Res. 516, A-02)

H-120.952 Restriction on Prescription Refills

Our AMA opposes restrictions on the legitimate, clinically appropriate refill of patient prescriptions including, but not limited to: (1) restricting refill hours to less than usual pharmacy hours; (2) restricting refills to limited pharmacies rather than all participating pharmacies; (3) restricting refills for chronic medications to a less than 90-day supply; and (4) restricting the date of refill. (Res. 512, A-01)

H-120.953 Isotretinoin

Our AMA reiterates to the Food and Drug Administration that it opposes a mandatory registry for physicians and patients for isotretinoin. (Res. 510, I-00)

H-120.955 Non-Physician Prescribing

(1) Our AMA:advocates that prescriptive authority include the responsibility to monitor the effects of the medication and to attend to problems associated with the use of the medication. This responsibility includes the liability for such actions. (2) AMA supports the development of methodologically valid research on the relative impact of non-physician prescribing on the quality of health care. (CMS Rep. 11, I-99)

H-120.956 Internet Prescribing

Our AMA will:
(1) develop principles describing appropriate use of the Internet in prescribing medications;
(2) support the use of the Internet as a mechanism to prescribe medications with appropriate safeguards to ensure that the standards for high quality medical care are fulfilled;
(3) work with state medical societies in urging state medical boards to ensure high quality medical care by investigating and, when appropriate, taking necessary action against physicians who fail to meet the local standards of medical care when issuing prescriptions through Internet web sites that dispense prescription medications;
(4) work with the Federation of State Medical Boards and others in endorsing or developing model state legislation to establish limitations on Internet prescribing;
(5) continue to work with the National Association of Boards of Pharmacy and support their "Verified Internet Pharmacy Practice Sites" program so that physicians and patients can easily identify legitimate Internet pharmacy practice sites;
(6) work with federal and state regulatory bodies to close down Internet web sites of companies that are illegally promoting and distributing (selling) prescription drug products in the United States; and.
(7) keep pace with changes in technology by continually updating standards of practice on the Internet. (BOT Rep. 35, A-99; Reaffirmed: BOT Rep. 3, I-04; Reaffirmed: Sub. Res. 522, A-05)

H-120.957 Prescription of Schedule II Medications by Fax and Electronic Data Transmission

Our AMA: (1) encourages the Drug Enforcement Administration to rewrite Section 1306 of Title 21 of the Code of Federal Regulations to accommodate encrypted electronic prescriptions for Schedule II controlled substances, as long as sufficient security measures are in place to ensure the confidentiality and integrity of the information. (2) Our AMA supports the concept that public key infrastructure (PKI) systems or other signature technologies designed to accommodate electronic prescriptions should be readily adaptable to current computer systems, and should satisfy the criteria of privacy and confidentiality, authentication, incorruptibility, and nonrepudiation. (3) Because sufficient concerns exist about privacy and confidentiality, authenticity, and other security measures, the AMA does not support the use of "hard copy" facsimile transmissions as the original written prescription for Schedule II controlled substances, except as currently allowed in Section 1306 of Title 21 of the Code of Federal Regulations (BOT Rep. 8, A-99; Reaffirmed in lieu of Res. 215, I-08)

H-120.958 Supporting Safe Medical Products as a Priority Public Health Initiative

Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names;
(2) continue participation in the National Patient Safety Foundation's efforts to advance the science of safety in the medication use process and likewise work with the National Coordinating Council for Medication Error Reporting and Prevention;
(3) support the FDA's Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events;
(4) vigorously work to support and encourage efforts to create and expeditiously implement a national machine-readable coding system for prescription medicine packaging in an effort to improve patient safety;
(5) participate in and report on the work of the Healthy People 2010 initiative in the area of safe medical products especially as it relates to existing AMA policy; and
(6) seek opportunities to work collaboratively within the Medicine-Public Health initiative
(H-440.991) and with the Food and Drug Administration (FDA), National Institutes of Health (NIH), United States Pharmacopoeia (USP) and Centers for Disease Control and Prevention (CDC) the Agency for Health Care Policy and Research (AHCPR) and the Centers for Medicare & Medicaid Services (CMS) to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety. (Res. 416, A-99; Appended: Res. 504, I-01)

H-120.959 DVA Non-Physician Prescribing Authority

Our AMA will continue to pursue appropriate regulatory, legislative and legal means to oppose any efforts to permit non-physician health care professionals to prescribe medications. (Sub. Res. 220, A-99; Reaffirmed: CMS Rep. 11, I-99)

H-120.960 Protection for Physicians Who Prescribe Pain Medication

Our AMA supports the following:
(1) the position that physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution. It is the policy of the AMA that state medical societies and boards of medicine develop or adopt mutually acceptable guidelines protecting physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain before seeking the implementation of legislation to provide that protection; (2) education of medical students and physicians to recognize addictive disorders in patients, minimize diversion of opioid preparations, and appropriately treat or refer patients with such disorders; and (3) the prevention and treatment of pain disorders through aggressive and appropriate means, including the continued education of doctors in the use of opioid preparations.

Our AMA opposes harassment of physicians by agents of the Drug Enforcement Administration in response to the appropriate prescribing of controlled substances for pain management. (BOT Rep. 1, I-97; Reaffirm: Res. 237, A-99; Appended: Res. 506, A-01; Appended: Sub. Res. 213, A-03)

H-120.962 National Mail Order Pharmacy Practices

1. The AMA insists that mail-order pharmacy companies respect the prescribing authority of physicians and dispense prescription medications only in the amounts prescribed; and recommends that mail order pharmacy companies charge only a reasonable and small shipping and handling fee per shipment in order not to encourage patients to request amounts of medications greater than those warranted by their physician's best judgment.

2. Our AMA opposes charging patients more than one co-pay for multiple prescriptions of the same or varying doses of a long-term medication within a 90-day period when evidence-based medicine dictates that less than 90-day prescriptions should be written during the initialization and dose stabilization of a newly prescribed long-term medication or during change in dosing of a long-term

medication currently being taken.

3. Our AMA will make traditional pharmacies, including national chains, mail-order pharmacies, appropriate insurance carriers, and pharmaceutical benefit management companies aware of its policy opposing the charging of patients more than one co-pay for multiple prescriptions of the same or varying doses of a long-term medication within a 90-day period when evidence-based medicine dictates that less than 90-day prescriptions should be written during the initialization and dose stabilization of a newly prescribed long-term medication or during change in dosing of a long-term medication currently being taken. (Sub. Res. 506, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Appended: Res. 121, A-07)

H-120.963 Epidemiology of Drug Errors

The AMA will continue its collaborations with the Food and Drug Administration and the US Pharmacopoeial Convention, Inc., along with its own ongoing initiatives, to identify and eliminate causes of medication errors. (Sub. Res. 519, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-120.965 Medication Errors

The AMA reaffirms its long-standing supportive efforts to curtail the problems of drug errors; and encourages physicians to add a brief notation of purpose (i.e., for cough, for constipation) on prescriptions, where appropriate, to avoid confusion on the part of either the pharmacists or the patients. (Res. 515, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-120.967 Dispensing of Computer Generated Drug Information

(1) The AMA continues to cooperate with the National Council on Patient Information and Education (NCPIE), USP, the FDA and others to establish standards for patient information. (2) The AMA continues to participate on the NCPIE to foster better medication use through improved communication between physicians and their patients, and the AMA encourages state and specialty medical societies to become members of NCPIE. (Res. 512, A-95)

H-120.968 Medication (Drug) Errors in Hospitals

(1) Our AMA encourages individual physicians to minimize medication errors by adhering to the following guidelines when prescribing medications:

(a) Physicians should stay abreast of the current state of knowledge regarding optimal prescribing through literature review, use of consultations with other physicians and pharmacists, participation in continuing medical education programs, and other means.
(b) Physicians should evaluate the patient's total status and review all existing drug therapy before prescribing new or additional medications (e.g., to ascertain possible antagonistic drug interactions).
(c) Physicians should evaluate and optimize patient response to drug therapy by appropriately monitoring clinical signs and symptoms and relevant laboratory data; follow-up and periodically reevaluate the need for continued drug therapy.
(d) Physicians should be familiar with the hospital's medication-ordering system, including the formulary system; the drug use review (DUR) program; allowable delegation of authority; procedures to alert nurses and others to new drug orders that need to be processed; standard medication administration times; and approved abbreviations.
(e) Written drug or prescription orders (including signatures) should be legible. Physicians with poor handwriting should print or type medication orders if direct order entry capabilities for computerized systems are unavailable.
(f) Medication orders should be complete and should include patient name; drug name (generic drug name or trademarked name if a specific product is required); route and site of administration; dosage form (if applicable); dose; strength; quantity; frequency of administration; and prescriber's name. In some cases, a dilution, rate, and time of administration should be specified. Physicians should review all drug orders for accuracy and legibility immediately after they have prescribed them.
(g) Medication orders should be clear and unambiguous. Physicians should: (i) write out instructions rather than use nonstandard or ambiguous abbreviations (e.g., write "daily" rather than "qd" which could be misinterpreted as "qid" or "od"); (ii) not use vague instructions, such as "take as directed"; (iii) specify exact dosage strengths (such as milligrams) rather than dosage form units (such as one vial) (an exception would be combination products, for which the number of dosage form units should be specified); (iv) prescribe by standard nomenclature, using the United States Adopted Names (USAN)-approved generic drug name, official name, or trademarked name (if a specific product is required) and avoid locally coined names, chemical names, unestablished abbreviated drug names (e.g., AZT), acronyms, and apothecary or chemical symbols; (v) always use a leading "0" to precede a decimal expression of less than one (e.g., 0.5 ml), but never use a terminal "0" (e.g., 5.0 ml); (vi) avoid the use of decimals when possible (e.g., prescribe 500 mg instead of 0.5 g); (vii) spell out the word "units" rather than writing "u"; (viii) and use the metric system. Instructions with respect to "hold" orders for medications should be clear.
(h) Verbal medication orders should be reserved only for those situations in which it is impossible or impractical for the prescriber to write the order or enter it in a computer. Verbal orders should be dictated slowly, clearly, and articulately to avoid confusion. The order should be read back to the prescriber by the recipient (e.g., nurse, pharmacist); when read back, the recipient should spell the drug name and avoid abbreviations when repeating the directions. A written copy of the verbal order should be placed in the patient's

medical record and later confirmed by the prescriber in accordance with applicable state regulations and hospital policies.

(2) Our AMA encourages the hospital medical staff to take a leadership role in their hospital, and in collaboration with pharmacy, nursing, administration, and others, to develop and improve organizational systems for monitoring, reviewing, and reporting medication errors and, after identification, to eliminate their cause and prevent their recurrence. (BOT Rep. 11, A-94; Reaffirmed by Sub. Res. 508, I-94; Reaffirmed and Modified: CSA Rep. 6, A-04)

H-120.969 Dispensing Controlled Substances to Long Term Care Patients

The AMA will work with the Drug Enforcement Administration to amend the Code of Federal Regulations to allow for pharmacy service providers to use appropriately authenticated medication orders from patients' charts in place of an original prescription for controlled substances for long term care patients. (Res. 204, A-94; Reaffirmed: BOT Rep. 29, A-04)

H-120.970 Increase in DEA Licensing Fees

The AMA will continue to uphold the principle that it will oppose any DEA physician registration fees that are unrelated to the amount needed to support and further DEA activities specifically related to physician activity. (Sub. Res. 232, A-93; Reaffirmed: Res. 222, A-94; Reaffirmed and Modified: BOT Rep. 29, A-04)

H-120.971 Emergency Department Administration of Schedule II Drugs Under Physician Order

The AMA, working with state medical societies, urges hospitals and emergency departments to develop criteria for dictating and accepting telephone orders for controlled substances. (Sub. Res. 501, A-93; Reaffirmed: CSA Rep. 8, A-03)

H-120.972 Confidentiality of Identification During Prescription Refills

Our AMA supports regulations that require information contained in mail service pharmacy prescriptions and refill slips to be in sealed envelopes that protect the confidentiality of the prescribing information. (Res. 503, A-93; Amended: CSA Rep. 8, A-03)

H-120.973 DEA, Diagnosis and ICD-9-CM Codes on Prescriptions

Our AMA, in order to protect patient confidentiality and to minimize administrative burdens on physicians, will (1) work to eliminate requirements by pharmacies, prescription services, and insurance plans to include such information as ICD-9-CM codes, DEA numbers, and diagnoses on prescriptions; and (2) inform physicians of their rights to withhold DEA numbers from prescriptions that do not legally require them. (Sub. Res. 518, A-93; Reaffirmation A-97; Reaffirmed by Sub. Res. 205, A-98; Reaffirmed: Res. 523, A-00; Amended: Res. 527, A-02)

H-120.975 Certifying Indigent Patients for Pharmaceutical Manufacturers' Free Drug Programs

Our AMA: (1) compliments the Pharmaceutical Research and Manufacturers of America (PhRMA) on its programs for indigent patients and continues to urge PhRMA and its member companies to develop a universal application process, eligibility criteria and form for all prescription drug patient-assistance programs to facilitate enrollment of patients and physicians in all the programs providing pharmaceuticals to indigent patients that are provided by pharmaceutical manufacturers; and, at a minimum, all member companies should participate in the enhanced version of PhRMA's web site, www.helpingpatients.org;

(2) encourages the PhRMA to provide information to physicians and hospital medical staffs about the members of PhRMA that provide pharmaceuticals to indigent patients;

(3) (a) urges drug companies, through the PhRMA, to accelerate the development of user-friendly and culturally sensitive uniform centralized policies and procedures for certifying indigent patients for free or discounted medications. The process should not require physician participation beyond providing the prescription and individual patients, once certified, should be able to obtain medications from the pharmacy of choice; and (b) encourages pharmaceutical manufacturers to expand their already generous free drug programs for the indigent;

(4) encourages physicians to facilitate the expansion of free drug programs for the indigent by declining to receive noneducational promotional materials from drug manufacturers and by urging that the funds otherwise spent on such materials be redirected to support expanded free drug programs for the indigent;

(5) will continue to meet with the PhRMA to develop more uniform, universally accepted, rapid mechanisms for physicians to request and obtain useful quantities of medications from American pharmaceutical companies for use by indigent patients; and

(6) opposes the practice of charging patients to apply for or gain access to pharmaceutical assistance programs. (Sub. Res. 105, I-92;

Sub. Res. 507, A-96; Appended: Sub. Res. 513, I-97; Reaffirmation I-98; Reaffirmation I-00; Reaffirmation A-01; Amended: Res. 513, A-02; Reaffirmed and Appended: Sub. Res. 705, I-03; Reaffimed and Modified: BOT Rep. 13, A-04; Reaffirmation I-04)

H-120.977 Drug Error Issues

The AMA urges its constituent organizations to encourage doctors to improve the legibility of handwritten orders for medications. (Sub. Res. 553, A-92; Reaffirmed: CSA Rep. 8, A-03)

H-120.978 Principles of Drug Utilization Review

Our AMA adopts the following Principles of Drug Utilization Review.
Principle 1: The primary emphasis of a DUR program must be to enhance quality of care for patients by assuring appropriate drug therapy. Characteristics: (a) While a desired therapeutic outcome should be cost-effective, the cost of drug therapy should be considered only after clinical and patient considerations are addressed; (b) Sufficient professional prerogatives should exist for individualized patient drug therapy.

Principle 2: Criteria and standards for DUR must be clinically relevant. Characteristics: (a) The criteria and standards should be derived through an evaluation of (i) the peer-reviewed clinical and scientific literature and compendia; (ii) relevant guidelines obtained from professional groups through consensus-derived processes; (iii) the experience of practitioners with expertise in drug therapy; (iv) drug therapy information supplied by pharmaceutical manufacturers; and (v) data and experience obtained from DUR program operations. (b) Criteria and standards should identify underutilization as well as overutilization and inappropriate utilization. (c) Criteria and standards should be validated prior to use.

Principle 3: Criteria and standards for DUR must be nonproprietary and must be developed and revised through an open professional consensus process. Characteristics: (a) The criteria and standards development and revision process should allow for and consider public comment in a timely manner before the criteria and standards are adopted. (b) The criteria and standards development and revision process should include broad-based involvement of physicians and pharmacists from a variety of practice settings. (c) The criteria and standards should be reviewed and revised in a timely manner. (d) If a nationally developed set of criteria and standards are to be used, there should be a provision at the state level for appropriate modification.

Principle 4: Interventions must focus on improving therapeutic outcomes. Characteristics: (a) Focused education to change professional or patient behavior should be the primary intervention strategy used to enhance drug therapy. (b) The degree of intervention should match the severity of the problem. (c) All retrospective DUR profiles/reports that are generated via computer screening should be subjected to subsequent review by a committee of peers prior to an intervention. (d) If potential fraud is detected by the DUR system, the primary intervention should be a referral to appropriate bodies (e.g., Surveillance Utilization Review Systems). (e) Online prospective DUR programs should deny services only in cases of patient ineligibility, coverage limitations, or obvious fraud. In other instances, decisions regarding appropriate drug therapy should remain the prerogative of practitioners.

Principle 5: Confidentiality of the relationship between patients and practitioners must be protected. Characteristic: The DUR program must assure the security of its database.

Principle 6: Principles of DUR must apply to the full range of DUR activities, including prospective, concurrent and retrospective drug use evaluation.

Principle 7: The DUR program operations must be structured to achieve the principles of DUR. Characteristics: (a) DUR programs should maximize physician and pharmacist involvement in their development, operation and evaluation. (b) DUR programs should have an explicit process for system evaluation (e.g., total program costs, validation). (c) DUR programs should have a positive impact on improving therapeutic outcomes and controlling overall health care costs. (d) DUR programs should minimize administrative burdens to patients and practitioners. (BOT Rep. PPP, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 6, A-03)

H-120.979 Involvement of State Medical Societies in Medicaid DUR Activities

Our AMA strongly encourages each state medical society to work with other interested parties within their state to ensure that Medicaid DUR is cemented in medical standards by assisting in the development of the state Medicaid DUR. (Res. 61, A-91; Modified: Sunset Report, I-01)

H-120.981 Drug Utilization Review

(1) Our AMA supports DUR programs provided: (a) primary emphasis is placed on high quality patient care through improved prescribing by physicians, dispensing by pharmacists, and medication compliance by patients; (b) physicians are actively involved in the development, implementation, and maintenance of the DUR programs; (c) criteria and standards for prescribing are developed by physician organizations and they are based on the peer-reviewed medical literature and the experiences of physicians with expertise in

drug therapy; (d) focused professional education is emphasized as the primary intervention strategy to improve physician prescribing, pharmacist dispensing, and patient compliance practices; and (e) the confidentiality relationship between physicians and their patients is maintained.

(2) Our AMA supports interacting with appropriate pharmacy organizations to develop guidelines for prospective (point-of-sale) DUR that will decrease the incidence of adverse events from drug therapy.

(3) Our AMA recognizes the right of government and private third party payers to include in DUR programs a component that addresses fraud and abuse, but reaffirms the right of physicians, who are so accused, to due process.

(4) Our AMA opposes DUR programs of government or private third party payers that focus only on cost containment and prevent physicians from prescribing the most appropriate drugs for individual patients. (BOT Rep. R, I-90; Modified: Sunset Report, I-00; Reaffirmed: CMS Rep. 6, A-03)

H-120.983 Prescription Mail Service

The AMA (1) urges the pharmaceutical industry to provide the same economic opportunity to individual pharmacies as given mail order pharmacies; and (2) endorses public education programs which emphasize the important contribution of the community pharmacist in providing good health care. (Res. 121, I-90; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed: CSA Rep. 8, A-05)

H-120.987 American Pharmacists Association

The AMA advocates (1) continued surveillance of mail-order prescriptions; (2) notification by the American Pharmacists Association (APhA) of its members that prescriptions should be refilled only on the physician's order; and (3) that the APhA advise its members to discontinue the practice of assuming a prescription may be refilled unless a form is returned stating that the prescription may not be refilled. (Res. 147, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

H-120.988 Patient Access to Treatments Prescribed by Their Physicians

The AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate "off-label" uses of drugs on their formulary. The AMA recommends the following:

Prescribing and Reimbursement for FDA-Approved Drugs and Devices for Unlabeled Uses

(1) Our AMA reaffirms the following policies: (a) A physician may lawfully use an FDA-approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion (Policy H-120.988); (b) When the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, irrespective of labeling, and should fulfill their obligation to their beneficiaries by covering such therapy (Policy H-120.988); and (c) Our AMA encourages the use of three compendia (AMA's Drug Evaluations*; United States Pharmacopeia-Drug Information, Volume I*; and American Hospital Formulary Service-Drug Information) and the peer-reviewed literature for determining the medical acceptability of unlabeled uses (Policy H-165.896, #15). (*These two compendia currently are being merged as the result of an alliance between the American Medical Association and the United States Pharmacopeia.)

Dissemination of Information about Unlabeled Uses of Drugs and Devices by Manufacturers

(2) Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about unlabeled uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.
(3) Our AMA supports the dissemination of independently derived scientific information about unlabeled uses by manufacturers to physicians, if the independent information is provided in its entirety, is not edited or altered by the manufacturer, and is clearly distinguished from manufacturer-sponsored materials. Dissemination of information by manufacturers to physicians about unlabeled uses can be supported under the following conditions:
(a) Reprints of independently derived articles from reputable, peer-reviewed journals that meet the following criteria: (i) The article should be peer reviewed and published in accordance with the regular peer review procedure of the journal in which it is published; (ii) The reprint should be from a peer-reviewed journal that both has an editorial board and utilizes experts to review and objectively select, reject, or provide comments about proposed articles; such experts should have demonstrated expertise in the subject of the article under review, and be independent from the journal; (iii) The journal is recognized to be of national scope and reputation, as defined by an advisory panel to the FDA; among its members, this advisory panel should have representatives from national medical

societies; (iv) The journal must be indexed in the Index Medicus of the National Library of Medicine; (v) The journal must have and adhere to a publicly stated policy of full disclosure of any conflicts of interest or biases for all authors or contributors; (vi) When the subject of the article is an unlabeled use, or the article contains other information that is different from approved labeling, the industry sponsor disseminating the reprint must disclose that the reprint includes information that has not been approved by the FDA and attach a copy of the FDA-approved professional labeling with the reprint; (vii) If financial support for the study and/or the author(s) was provided by the industry sponsor disseminating the article, and this is not already stated in the article, then this information should be clearly disclosed with the reprint.
(b) Reprints of monographs or chapters from the three compendia (AMA's Drug Evaluations; United States Pharmacopeia-Drug Information, Volume I; and American Hospital Formulary Service-Drug Information) named in federal statutes for determining the medical acceptability of unlabeled uses, provided: (i) The monograph or chapter is reprinted in its entirety by the publisher of the compendia, and the reprints are then sent to the requesting industry sponsor; (ii) The reprints are not altered in any way by the industry sponsor; (iii) The industry sponsor disseminating the reprint discloses that the reprint includes information that has not been approved by the FDA and attaches a copy of the FDA-approved professional labeling with the reprint.
(c) Complete textbooks that meet the following criteria: (i) The reference text should not have been written, edited, excerpted, or published specifically for, or at the request of, a drug, device, or biologic firm; when financial support is provided by a drug, device, or biologic firm, it should be disclosed clearly in the textbook; (ii) The content of the reference text should not have been edited or significantly influenced by a drug, device, or biologic firm, or agent thereof; (iii) The reference text should be generally available for sale in bookstores or other distribution channels where similar books are normally available and should not be distributed only or primarily through drug, device, or biologic firms; (iv) The reference text should not focus primarily on any particular drug(s), device(s), or biologic(s) of the disseminating company, nor should it have a significant focus on unapproved uses of drug(s), device(s), or biologic(s) marketed or under investigation by the firm supporting the dissemination of the text; (v) Specific product information (other than the approved package insert) should not be physically appended to the reference text.
(d) Manufacturers should report to the FDA and share with all physicians any proprietary information that a drug is ineffective or unsafe when used for a specific unlabeled indication.
(e) Continuing medical education (CME) activities: (i) The FDA should continue to support principles in the FDA Draft Policy Statement on Industry-Supported Scientific and Educational Activities (Fed. Reg. 1992;57:56412-56414), which acknowledges the importance of relying on the professional health-care communities, rather than the Agency, to monitor independent provider activities; and (ii) The FDA should continue a policy of regulatory deference for industry-supported CME activities conducted by organizations accredited by the Accreditation Council for Continuing Medical Education (ACCME), state medical societies, specialty societies, and the American Academy of Family Physicians (AAFP), that follow the Essentials and Standards of the ACCME and that may be certified for AMA PRA credit under the auspices of the American Medical Association Physician's Recognition Award program.
(4) Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an unlabeled use).Improving the Supplemental New Drug Application (SNDA) Process
(5) Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.
(6) Our AMA encourages the US Congress, the FDA, pharmaceutical manufacturers, the United States Pharmacopeia, patient organizations, and medical specialty societies to work together to ensure that Supplemental New Drug Applications (SNDAs) for new indications (efficacy supplements), including those for uses in special populations (e.g., pediatrics), are submitted and acted upon in a timely manner. Specific recommendations include:
(a) User fee legislation should be re-authorized to ensure that the FDA has the necessary resources to act on all efficacy supplements within 6 months of submission;
(b) The SNDA process should be streamlined as much as possible (e.g., basing review decisions on already published literature), without compromising the requirements for substantial evidence of efficacy and safety;
(c) Legislation should be enacted that provides extensions of marketing exclusivity for the product to manufacturers who submit and gain FDA approval of efficacy supplements, including mechanisms both to provide greater reward when the new indication is for a life-threatening disease (with limited or no alternatives), an orphan disease, or for a special population (e.g., pediatrics), and to prevent inappropriate use of the system by manufacturers (e.g., place a limit on total length of extended marketing exclusivity);
(d) For drugs no longer under patent and for which generic versions are available, the FDA, other governmental agencies (e.g., the National Institutes of Health), the pharmaceutical industry, the United States Pharmacopeia, patient organizations, and medical specialty societies should discuss and mutually agree on alternative mechanisms to ensure that efficacy supplements will be submitted to and acted upon by the FDA in a timely manner; and
(e) Pharmaceutical manufacturers are urged to seek FDA approval for pediatric uses through the FDA's 1994 regulation that allows approval of pediatric uses based on adult efficacy studies (where the course of the disease and the effects of the drug are sufficiently similar in both populations) and additional information for pediatric use, usually pharmacokinetic studies for determination of dosage (Fed. Reg. 1994:59:64240-64250).

Encouraging Clinical Research in Pediatrics

(7) Our AMA urges pharmaceutical manufacturers and the FDA to work with the American Academy of Pediatrics and experts in pediatric medicine to identify those investigational drugs that would have pediatric indications and set up a mechanism to ensure that necessary pediatric clinical studies are completed prior to submission of NDAs for approval of these drug products. Legislation

should be enacted that provides extensions of marketing exclusivity for the product to manufacturers who complete pediatric studies that lead to pediatric labeling (Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified by CSA Rep. 3, A-97; Reaffirmed and Modified by Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04; Reaffirmation I-07; Reaffirmed: Res. 819, I-07)

H-120.989 Mail Service Pharmacy

The AMA believes that: (1) MSP is an established alternative method of distributing drugs in the United States. (2) Controlled studies in the 1970s support the fact that MSPs are less vulnerable to drug diversion than retail pharmacies. Although numerous concerns about lack of safety and drug diversion have been expressed in trade publications and newsletters, documented controlled data regarding these concerns are minimal. There is no evidence of lack of safety in the peer-reviewed controlled-study literature. Presently, the practice of obtaining drugs from mail service pharmacies appears to be relatively safe. (3) Mail service pharmacy for prescription drugs is probably most appropriate for patients who have a well-established diagnosis, who have long-term chronic illnesses, whose disease is relatively stable and in whom the dose and dosage schedule is well regulated, who are isolated because of geographic or personal reasons, who have a drug history profile on record, who have been adequately informed about their medication, and who continue to see their physician regularly. Certainly, MSP is not best utilized for medications that are to be used acutely. Further, there must be assurance that generic substitution occur only by order of the prescribing physician. (4) Any purported price savings from the use of MSP is difficult to assess, since studies are generally limited to regional and limited patient populations. (5) Physicians have the responsibility to prescribe reasonable amounts of prescription medications based on the diagnosis and needs of their patients. Physicians must not be influenced by purely economic reasons, but they must take into account the patient's ability to pay and be aware of the guidelines recommended by particular health benefit programs for drugs. (BOT Rep. I, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-120.990 Physician Dispensing

Our AMA supports the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with AMA's ethical guidelines. (Sub. Res. 154, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 123, A-00)

H-120.991 Sample Medications

Our AMA (1) continues to support the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge;
(2) reiterates that samples of prescription drug products represent valuable benefits to the patients;
(3) continues to support the availability of drug samples directly to physicians through manufacturers' representatives and other means, with appropriate safeguards to prevent diversion; and
(4) endorses sample practices that: (a) preclude the sale, trade or offer to sell or trade prescription drug samples; (b) require samples of prescription drug products to be distributed only to licensed practitioners upon written request; and (c) require manufacturers and commercial distributors of samples of prescription drug products and their representatives providing such samples to licensed practitioners to: (i) handle and store samples of prescription drug products in a manner to maintain potency and assure security; (ii) account for the distribution of prescription drug samples by maintaining records of all drug samples distributed, destroyed or returned to the manufacturer or distributor; and (iii) report significant thefts or losses of prescription drug samples. (Sub. Res. 17, I-86; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed: Res. 516, A-01)

H-120.993 Physicians' Desk Reference

The AMA (1) believes that the Physicians' Desk Reference (PDR) is one of the many resources for a physician and does not establish the sole standard for appropriate use of drugs in the practice of medicine and often includes drug use that is not reflected in approved drug labeling; and (2) urges the publisher of the PDR to include an FDA statement in the publication regarding the use by physicians of approved drugs for purposes not in the labeling. (BOT Rep. N, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-120.996 Prescribing Eye Medications

Our AMA (1) reaffirms its policy that only physicians licensed to practice medicine and surgery are qualified to prescribe or apply eye medications; and (2) continues to urge that state medical societies oppose legislation or administrative attempts to give optometrists a license to prescribe or apply medications or to diagnose disease or injury or to diagnose the absence of disease or injury. (Sub. Res. 76, A-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation A-99)

H-120.997 Child-Protective Containers for Medications

Our AMA (1) supports pharmacists' dispensing medications in child-protective containers, (2) encourages the acceptance of such containers by parents, and (3) urges promotion of their widespread utilization by physicians and pharmacies. (Res. 26, A-70;

Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-120.999 Refilling of Prescriptions

The AMA supports pursuing through the proper state or federal enforcement agencies full compliance with the laws, and if no law applies, supports legislation to carry out the following criteria: (1) any prescription not labeled as to number of refills may not be refilled; and (2) any prescription labeled PRN or ad lib may not be refilled. (Res. 46, A-63; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-125.000 Drugs: Substitution
(See also: Drugs; Drugs: Advertising; Drugs: Cost; Drugs: Labeling and Packaging; Drugs: Prescribing and Dispensing)

H-125.981 Generic Medications

Our AMA encourages the Food and Drug Administration to reexamine the standards and criteria used for approving generic medications to ensure bioequivalence under various conditions and in relevant patient populations. (Sub. Res. 527, A-08; Reaffirmation I-08)

H-125.982 Medicare Part D Modifications

Our AMA will seek necessary federal legislative changes to:
a. have all pharmacy benefit programs participating in Medicare Part D offer at least one program that eliminates the coverage gap; and
b. require that all pharmacy benefit programs participating in Medicare Part D inform the enrollees of lower cost/generic alternatives for each prescribed medication. (Res. 130, A-07)

H-125.983 Changes in Drug Formularies and Copays

Our AMA opposes actions by insurance companies that would mandate changes in medications, except by the addition of new medications or the deletion of withdrawn medications, or increase co-pays for at least one year or the term of the contract, whichever is greater. (Res. 906, I-06)

H-125.984 Generic Drugs

Our AMA believes that: (1) Physicians should be free to use either the generic or brand name in prescribing drugs for their patients, and physicians should supplement medical judgments with cost considerations in making this choice.

(2) It should be recognized that generic drugs frequently can be less costly alternatives to brand-name products.

(3) Substitution with Food and Drug Administration (FDA) "B"-rated generic drug products (i.e., products with potential or known bioequivalence problems) should be prohibited by law, except when there is prior authorization from the prescribing physician.

(4) Physicians should report serious adverse events that may be related to generic substitution, including the name, dosage form, and the manufacturer, to the FDA's MedWatch program.

(5) The FDA, in conjunction with our AMA and the United States Pharmacopoeia, should explore ways to more effectively inform physicians about the bioequivalence of generic drugs, including decisional criteria used to determine the bioequivalence of individual products.

(6) The FDA should fund or conduct additional research in order to identify the optimum methodology to determine bioequivalence, including the concept of individual bioequivalence, between pharmaceutically equivalent drug products (i.e., products that contain the same active ingredient(s), are of the same dosage form, route of administration, and are identical in strength).

(7) The Congress should provide adequate resources to the FDA to continue to support an effective generic drug approval process. (CSA Rep. 6, A-02; Reaffirmed: CSAPH Rep. 2, A-07; Reaffirmation A-08)

H-125.985 Expanded Use of the AMA's Principles of a Sound Drug Formulary

Our AMA urges managed care organizations, pharmacy benefit managers, and others who design benefit packages and/or make pharmacy benefit decisions, to utilize the Principles of a Sound Drug Formulary System (as described in BOT Rep. 28, I-00) as they develop their pharmaceutical benefit plan(s) and that the Principles of a Sound Drug Formulary System be readily available on the AMA web site. (Res. 520, A-01; Amended: Res. 514, A-02; Reaffirmed: CSA Rep. 2, A-04; Reaffirmation I-04; Reaffirmed: Sub.

Res. 529, A-05; Reaffirmed in lieu of Res. 535, A-05; Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05; Reaffirmation A-06)

H-125.986 Pharmaceutical Benefits Management Companies

Our AMA: (1) encourages physicians to report to the Food and Drug Administration's (FDA) MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutic alternates;
(2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate;
(3) pursues Congressional action to end the inappropriate and unethical use of confidential patient information by pharmacy benefits management companies;
(4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients; and
(5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to ensure that they are based on sound science and represent safe and cost-effective medical care. (BOT Rep. 9, I-97; Appended: Res. 224, I-98; Appended: Res. 529, A-02; Reaffirmed: Res. 533; A-03; Reaffirmation I-08)

H-125.987 Prepaid Prescription Plans Medication Substitution

Policy of the AMA states that when managed care organizations or prepaid prescription plans attempt to substitute for a physician's prescription, this substitution may only be accomplished after either another physician or a registered pharmacist calls to obtain approval from the prescribing physician. (Res. 727, A-96; Reaffirmed: CMS Rep. 8, A-06)

H-125.989 Opposition to Payment for Prescription-Switching

The AMA: (1) denounces the practice of pharmacists recommending to patients that prescriptions be changed to products manufactured by companies which pay pharmacists upon completion of such prescription-switching; and (2) denounces the practice by companies of offering payments to pharmacists in exchange for recommending changes in prescriptions. (Sub. Res. 501, I-94; Reaffirmed: CSA Rep. 6, A-04)

H-125.990 Medicaid Payment for Over-The-Counter Drugs When They are the Drug of Choice

The AMA supports over-the-counter drug benefits under Medicaid that provide physician-prescribed medications to enrollees. Cost-conscious OTC drug programs should satisfy the criteria contained in Policy 110.997 for AMA support of programs designed to contain the rising costs of prescription drugs and follow AMA Policy 125.991 on development and implementation of drug formularies. (CMS Rep. 12, A-94; Reaffirmed: CMS Rep. 7, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-125.991 Drug Formularies and Therapeutic Interchange

It is the policy of the AMA:

(1) That the following terms be defined as indicated:
(a) Formulary: a compilation of drugs or drug products in a drug inventory list; open (unrestricted) formularies place no limits on which drugs are included whereas closed (restrictive) formularies allow only certain drugs on the list;
(b) Formulary system: a method whereby the medical staff of an institution, working through the pharmacy and therapeutics committee, evaluates, appraises, and selects from among the numerous available drug entities and drug products those that are considered most useful in patient care;
(c) Pharmacy & Therapeutics (P&T) Committee: an advisory committee of the medical staff that represents the official, organizational line of communication and liaison between the medical staff and the pharmacy department; its recommendations are subject to medical staff approval;
(d) Therapeutic alternates: drug products with different chemical structures but which are of the same pharmacological and/or therapeutic class, and usually can be expected to have similar therapeutic effects and adverse reaction profiles when administered to patients in therapeutically equivalent doses;
(e) Therapeutic interchange: authorized exchange of therapeutic alternates in accordance with previously established and approved written guidelines or protocols within a formulary system; and
(f) Therapeutic substitution: the act of dispensing a therapeutic alternate for the drug product prescribed without prior authorization of the prescriber.

(2) That our AMA reaffirms its opposition to therapeutic substitution (dispensing a therapeutic alternate without prior authorization) in any patient care setting.

(3) That drug formulary systems, including the practice of therapeutic interchange, are acceptable in inpatient hospital and other institutional settings that have an organized medical staff and a functioning Pharmacy and Therapeutics (P&T) Committee, provided they satisfy the following standards:

(a) The formulary system must:
(i) have the concurrence of the organized medical staff;
(ii) openly provide detailed methods and criteria for the selection and objective evaluation of all available pharmaceuticals;
(iii) have policies for the development, maintenance, approval and dissemination of the drug formulary and for continuous and comprehensive review of formulary drugs;
(iv) provide protocols for the procurement, storage, distribution, and safe use of formulary and non-formulary drug products;
(v) provide active surveillance mechanisms to regularly monitor both compliance with these standards and clinical outcomes where substitution has occurred, and to intercede where indicated;
(vi) have enough qualified medical staff, pharmacists, and other professionals to carry out these activities;
(vii)provide a mechanism to inform the prescriber in a timely manner of any substitutions, and that allows the prescriber to override the system when necessary for an individual patient without inappropriate administrative burden;
(viii) provide a mechanism to assure that patients/guardians are informed of any change from an existing outpatient prescription to a formulary substitute while hospitalized, and whether the prior medication or the substitute should be continued upon discharge from the hospital;
(ix) include policies that state that practitioners will not be penalized for prescribing non-formulary drug products that are medically necessary; and
(x) be in compliance with applicable state and federal statutes and/or state medical board requirements.

(b) The P&T Committee must:
(i) objectively evaluate the medical usefulness and cost of all available pharmaceuticals (reliance on practice guidelines developed by physician organizations is encouraged);
(ii) recommend for the formulary those drug products which are the most useful and cost-effective in patient care;
(iii) conduct drug utilization review (DUR) activities;
(iv) provide pharmaceutical information and education to the organization's (e.g., hospital) staff;
(v) analyze adverse results of drug therapy;
(vi) make recommendations to ensure safe drug use and storage; and
(vii) provide protocols for the timely procurement of non-formulary drug products when prescribed by a physician for the individualized care of a specific patient, when that decision is based on sound scientific evidence or expert medical judgment.

(c) The P&T Committee's recommendations must be approved by the medical staff;

(d) Within the drug formulary system, the P & T Committee shall recommend, and the medical staff must approve, all drugs that are subject to therapeutic interchange, as well as all processes or protocols for informing individual prescribing physicians; and

(e) The act of providing a therapeutic alternate that has not been recommended by the P&T Committee and approved by the medical staff is considered unauthorized therapeutic substitution and requires immediate prior consent by the prescriber; i.e., authorization for a new prescription.

(4) That drug formulary systems in any outpatient setting shall operate under a P&T Committee whose recommendations must have the approval of the medical staff or equivalent body, and must meet standards comparable to those listed above. In addition:

(a) That our AMA continues to insist that managed care and other health plans identify participating physicians as their "medical staff" and that they use such staff to oversee and approve plan formularies, as well as to oversee and participate on properly elected P&T Committees that develop and maintain plan formularies;
(b) That our AMA continues to insist that managed care and other health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated, that this process impose minimal administrative burdens, and that it include access to a formal appeals process for physicians and their patients; and
(c) That our AMA strongly recommends that the switching of therapeutic alternates in patients with chronic diseases who are stabilized on a drug therapy regimen be discouraged.

(5) That our AMA encourages mechanisms, such as incentive-based formularies with tiered co-pays, to allow greater choice and economic responsibility in drug selection, but urges managed care plans and other third party payers to not excessively shift costs to patients so they cannot afford necessary drug therapies. (BOT Rep. 45, I-93; Reaffirmed by Sub. Res. 501, A-95; Appended: BOT Rep. 7, I-99; Modified: Sub. Res. 524 and Reaffirmed: Res. 123, A-00; Reaffirmed: Res. 515, I-00; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: Res. 533, A-03; Modified: CMS Rep. 6, A-03; Modified: CSA Rep. 2, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 535, A-05; Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05; Reaffirmed: CMS Rep. 2, I-05; Reaffirmation A-06; Reaffirmation A-08)

H-125.993 Legislation Prohibiting Therapeutic Substitution

It is the policy of the AMA to (1) oppose the establishment of a system at the federal or state level premised on therapeutic interchangeability of prescription drugs and formularies, since it will inevitably interfere with the ability of the patient's physician to assure that the medication prescribed is dispensed to the patient; (2) encourage and assist all states in passing legislation prohibiting the practice of therapeutic substitution; and (3) provide education to physicians and the general public that therapeutic substitution is not equal to generic substitution and provide information about the potential dangers of therapeutic substitution. (Sub. Res. 161, A-90; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed: BOT Rep. 9, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-125.995 Therapeutic and Pharmaceutical Alternatives by Pharmacists

The AMA opposes legislative attempts at any level of government that would permit pharmacists, when presented with a prescription for a drug product, to: (1) dispense instead a drug product that is administered by the same route and which contains the same pharmaceutical moiety and strength, but which differs in the salt or dosage form (pharmaceutical alternatives); and (2) dispense a drug product containing a different pharmaceutical moiety but which is of the same therapeutic and/or pharmacological class (therapeutic substitution). Our AMA will work with state medical associations to ensure that state pharmacy laws and medical practice acts are properly enforced so that treating physician’s prescriptions cannot be overruled or substituted without prior physician approval. If this issue is not addressed in existing laws, our AMA will develop model legislation to assist state medical associations in this endeavor. (Res. 89, I-85; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CLRPD Rep. 2, I-95; Appended by Res. 501, A-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-125.999 Drug Substitutes

Our AMA (1) supports continued efforts to inform the public and the profession of the potential problems and risks should a physician's choice of therapeutic agents be delegated to non-physicians; and (2) asks that state medical associations provide scientific and economic reasons in support of this position to state legislatures considering enactment of laws on substitution of drug products other than those prescribed or agreed upon by an attending physician. (Sub. Res. 27, A-74; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation A-99)

H-130.000 Emergency Medical Services

H-130.941 Legal Issues Surrounding the Deployment and Utilization of Licensed Physicians in Response to Declared Disasters

Our AMA: (1) encourages physicians who are interested in volunteering during a disaster to register with their state’s Emergency System for Advance Registration of Volunteer Health Professionals program, local Medical Reserve Corps unit, or similar registration systems capable of verifying that practitioners are licensed and in good standing at the time of deployment; and (2) (a) supports the National Conference of Commissioners on Uniform State Laws (NCCUSL) Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) with the liability language of Alternative A; and (b) continues to advocate for civil liability protections for qualified physicians that provide care in a disaster who are not covered under the UEVHPA, but are covered in AMA model legislation titled "To Protect Physicians from Civil Liability Arising from Health Care Provided During a Disaster." (BOT Rep. 4, I-08)

H-130.942 Development of a Federal Public Health Disaster Intervention Team

1. Our AMA supports government efforts to: (a) coordinate and integrate federal medical and public health disaster response entities such as the Medical Reserve Corps, National Disaster Medical System, Public Health Services Commissioned Corps (PHSCC), as well as state-to-state sponsored Emergency Management Compact Systems, to strengthen health system infrastructure and surge capacity for catastrophic disasters (Incidents of National Significance) as defined by the Department of Homeland Security’s (DHS) National Response Plan (NRP); and (b) place all federal medical and public health disaster response assets (with the exception of the Department of Defense) under authority of the Secretary of the Department of Health and Human Services (DHHS) to prevent significant delays and ensure coordination during a catastrophic disaster (Incident of National Significance).

2. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will work with the DHHS, PHSCC, DHS, and other relevant government agencies to provide comprehensive disaster education and training for all federal medical and public health employees and volunteers through the National Disaster Life Support and other appropriate programs. Such training should address the medical and mental health needs of all populations, including children, the elderly, and other vulnerable groups.

3. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will monitor progress in strengthening federal disaster medical and public health response capacity for deployment anywhere in the nation on short notice, and report back as appropriate. (BOT Rep. 3, A-07)

H-130.943 Physician Identification in Emergencies

Our AMA, through the Center on Public Health Preparedness and Disaster Response, will continue to: (1) monitor the development of volunteer registration systems, such as Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP), as well as volunteer organizations, such as the Medical Reserve Corps (MRC), and report back as appropriate; and (2) support the development of laws and policies such as license reciprocity and civil liability protections that encourage physicians to volunteer services during disasters. (BOT Rep. 15, I-06; Reaffirmed: BOT Rep. 4, I-08)

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-130.945 Overcrowding and Hospital EMS Diversion

It is the policy of the AMA:

(1) that the overall capacity of the emergency health care system needs to be increased through facility and emergency services expansions that will reduce emergency department overcrowding and ambulance diversions; incentives for recruiting, hiring, and retaining more nurses; and making available additional hospital beds;

(2) to advocate for increased public awareness as to the severity of the emergency department crisis, as well as the development and distribution of patient-friendly educational materials and a physician outreach campaign to educate patients as to when it is appropriate to go to the emergency department;

(3) to support the establishment of local, multi-organizational task forces, with representation from hospital medical staffs, to devise local solutions to the problem of emergency department overcrowding, ambulance diversion, and physician on-call coverage, and encourage the exchange of information among these groups;

(4) that hospitals be encouraged to establish and use appropriate criteria to triage patients arriving at emergency departments so those with simpler medical needs can be redirected to other appropriate ambulatory facilities;

(5) that hospitals be encouraged to create nurse-staffed and physician-supervised telephone triage programs to assist patients by guiding them to the appropriate facility; and

(6) to work with the American Hospital Association and other appropriate organizations to encourage hospitals and their medical staffs to develop diversion policy that includes the criteria for diversion; monitor the frequency of diversion; identify the reasons for diversion; and develop plans to resolve and/or reduce emergency department overcrowding and the number of diversions. (CMS Rep. 1, A-02; Reaffirmed: BOT Rep. 3, I-02; Modified: BOT Rep. 15, I-04; Reaffirmation A-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-08)

H-130.946 AMA Leadership in the Medical Response to Terrorism and Other Disasters

Our AMA: (1) Condemns terrorism in all its forms and provide leadership in coordinating efforts to improve the medical and public health response to terrorism and other disasters.

(2) Will work collaboratively with the Federation in the development, dissemination, and evaluation of a national education and training initiative, called the National Disaster Life Support Program, to provide physicians, medical students, other health professionals, and other emergency responders with a fundamental understanding and working knowledge of their integrated roles and responsibilities in disaster management and response efforts.

(3) Will join in working with the Department of Homeland Security, the Department of Health and Human Services, the Department of Defense, the Federal Emergency Management Agency, and other appropriate federal agencies; state, local, and medical specialty societies; other health care associations; and private foundations to (a) ensure adequate resources, supplies, and training to enhance the medical and public health response to terrorism and other disasters; (b) develop a comprehensive strategy to assure surge capacity to address mass casualty care; (c) implement communications strategies to inform health care professionals and the public about a terrorist attack or other major disaster, including local information on available medical and mental health services; (d) convene local and regional workshops to share "best practices" and "lessons learned" from disaster planning and response activities; (e) organize annual symposia to share new scientific knowledge and information for enhancing the medical and public health response to terrorism and other disasters; and (f) develop joint educational programs to enhance clinical collaboration and increase physician knowledge of the diagnosis and treatment of depression, anxiety, and post traumatic stress disorders associated with exposure to disaster, tragedy, and trauma.

(4) Believes all physicians should (a) be alert to the occurrence of unexplained illness and death in the community; (b) be knowledgeable of disease surveillance and control capabilities for responding to unusual clusters of diseases, symptoms, or presentations; (c) be knowledgeable of procedures used to collect patient information for surveillance as well as the rationale and procedures for reporting patients and patient information; (d) be familiar with the clinical manifestations, diagnostic techniques, isolation precautions, decontamination protocols, and chemotherapy/prophylaxis of chemical, biological, and radioactive agents likely to be used in a terrorist attack; (e) utilize appropriate procedures to prevent exposure to themselves and others; (f) prescribe treatment plans that may include management of psychological and physical trauma; (g) understand the essentials of risk communication so that they can communicate clearly and nonthreateningly with patients, their families, and the media about issues such as exposure risks and potential preventive measures (e.g., smallpox vaccination); and (h) understand the role of the public health, emergency medical services, emergency management, and incident management systems in disaster response and the individual health professional's role in these systems.

(5) Believes that physicians and other health professionals who have direct involvement in a mass casualty event should be knowledgeable of public health interventions that must be considered following the onset of a disaster including: (a) quarantine and other movement restriction options; (b) mass immunization/chemoprophylaxis; (c) mass triage; (d) public education about preventing or reducing exposures; (e) environmental decontamination and sanitation; (f) public health laws; and (g) state and federal resources that contribute to emergency management and response at the local level.

(6) Believes that physicians and other health professionals should be knowledgeable of ethical and legal issues and disaster response. These include: (a) their professional responsibility to treat victims (including those with potentially contagious conditions); (b) their rights and responsibilities to protect themselves from harm; (c) issues surrounding their responsibilities and rights as volunteers, and (d) associated liability issues.

(7) Believes physicians and medical societies should participate directly with state, local,
and national public health, law enforcement, and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals, and practices in preparation for terrorism and other disasters.

(8) Urges Congress to appropriate funds to support research and development (a) to improve understanding of the epidemiology, pathogenesis, and treatment of diseases caused by potential bioweapon agents and the immune response to such agents; (b) for new and more effective vaccines, pharmaceuticals, and antidotes against biological and chemical weapons; (c) for enhancing the shelf life of existing vaccines, pharmaceuticals, and antidotes; and (d) for improving biological chemical, and radioactive agent detection and defense capabilities. (BOT Rep. 26, I-01; Reaffirmed: BOT Rep. 3, I-02; Modified: CSA Rep. 1, I-03)

H-130.947 Hospital Emergency Use

It is the policy of our AMA that, in order to protect the health and welfare of the public, all health plans should be required to cover emergency services regardless of whether the plan has a contractual arrangement with the hospital. (Sub. Res. 706, I-00; Reaffirmed: Res. 708, A-02)

H-130.948 On-Call Physicians

Our AMA: (1) advocates that physician on-call coverage for emergency departments be guided by the following principles:
(a) The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients.
(b) Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that are available for consultation and treatment of patients.
(c) The organization and function of on-call services should be determined through hospital policy and medical staff by-laws, and include methods for monitoring and assuring appropriate on-call performance.
(d) Hospital medical staff by-laws and emergency department policies regarding on-call physicians responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.
(e) Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage.
(f) Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care.
(g) Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained.
(h) The decision to operate or close an emergency department should be made jointly by the hospital and medical staff;

(2) supports the enforcement of existing laws and regulations that require physicians under contract with health plans to be adequately compensated for emergency services provided to the health plans' enrollees; and

(3) supports the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans' enrollees or be subject to significant fines similar to the civil monetary penalties that

can be imposed on hospitals and physicians for violation of EMTALA. (CMS Rep. 3, I-99; Reaffirmation A-00; Modified: Sub. Res. 217, I-00; Reaffirmation I-01; Reaffirmation A-07)

H-130.949 Organized Medicine's Role in the National Response to Terrorism

Our AMA: (1) and the Federation of Medicine will work with appropriate public health, law enforcement, hospital, and emergency response agencies and associations, as well as the pharmaceutical industry and media to develop coordinated plans and strategies that identify the specific needs, roles, contributions, and participation of organized medicine and individual physicians in disaster planning and emergency response to terrorist attacks and identify procedures for the rapid detection, early reporting, and medical management of affected individuals; and (2) urges medical schools and residency programs to develop curricula and training programs for medical students and residents regarding medical and public health aspects of biological and chemical terrorism, as well as community disaster planning and emergency response procedures in the event of such terrorism. (CSA Rep. 4, A-99; Reaffirmed: CSA Rep. 10, A-00)

H-130.950 Emergency Medical Treatment and Active Labor Act (EMTALA)

Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act (EMTALA) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under EMTALA;
(2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act (EMTALA) rules and regulations;
(3) urgently seeks return to the original congressional intent of EMTALA to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and.
(4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous EMTALA requirements. (Sub. Res. 214, A-97; Reaffirmation I-98; Reaffirmation A-99; Appended: Sub. Res. 235 and Reaffirmation A-00; Reaffirmation A-07)

H-130.951 Heat-Related Illness

The AMA recognizes the significant public health threat imposed by heat-related emergencies, and provides the following policy: (1) Physicians should identify patients at risk for extreme heat-related illness such as the elderly, children, individuals with physical or mental disabilities, alcoholics, the chronically ill, and the socially isolated. Patients, family members, friends, and caretakers should be counseled about prevention strategies to avoid such illness. Physicians should provide patients at risk with information about cooling centers and encourage their use during heat emergencies. (2) The AMA encourages patients at risk for heat-related illness to consider wearing appropriate medical identification. (CSA Rep. 10, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-130.952 Community-Wide Training In Basic Life Support and First Aid

Our AMA: (1) will collaborate with medical specialty societies and public health organizations to increase public awareness of and encourages education in (a) basic life support and first aid, and (b) effective interventions for reducing and preventing injuries and coronary heart disease; (2) urges state and local medical societies to participate in the development and promotion of community programs for adults, children, businesses, community groups, and public servants to increase awareness of the potential benefits of training in basic life support and first aid and to increase public knowledge, confidence, and motivation for responding to serious, or potentially serious illness and injury situations; and (3) encourages physicians to discuss with their patients: (a) how to recognize and respond to emergency situations; (b) proper utilization and activation of the local EMS system; (c) measures for reducing or eliminating potential risk factors for injuries and coronary heart disease; and (d) the availability and appropriateness of community programs in basic life support and first aid. (BOT Rep. 16, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-130.954 Non-Emergency Patient Transportation Systems

The AMA: (1) supports the education of physicians and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients. (Sub. Res. 812, I-93; Reaffirmed: CMS Rep. 10, A-03)

H-130.955 Patient Responsibility of On-Call Physicians

The AMA urges hospital medical staffs to have written policies and procedures in place to delineate clearly the patient follow-up responsibilities of staff members who serve in an on-call capacity to the hospital emergency department. (CMS Rep. F, I-92; Reaffirmed: CMS Rep. 10, A-03)

H-130.956 Screening for Alcohol and Other Drug Use in Trauma Patients

Our AMA (1) encourages hospital medical staffs to promote the performance of blood alcohol concentration (BAC) tests and urine

drug screens on hospitalized trauma patients; (2) urges physicians responsible for the care of hospitalized trauma patients to implement appropriate evaluation and treatment when there is a positive BAC, other positive drug screen result, or other source of suspicion of a potential substance misuse disorder; and (3) encourages relevant physician organizations to develop practice parameters to assist physicians in the diagnosis and management of substance misuse disorders. (BOT Rep. J, I-91; Reaffirmed: Sunset Report, I-01)

H-130.957 Emergency Transfer Responsibilities

Our AMA supports seeking amendments to Section 1867 of the Social Security Act, pertaining to patient transfer, to:

(1) require that the Office of the Inspector General (IG) request and receive the review of the Peer Review Organization (PRO) prior to imposing sanctions;

(2) make the PRO determination in alleged patient transfer violations binding upon the IG;

(3) expand the scope of PRO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks;

(4) restore the knowing standard of proof for physician violation;

(5) recognize appropriate referral of patients from emergency departments to physician offices;

(6) clarify ambiguous terms such as emergency medical transfer and stabilized transfer;

(7) clarify ambiguous provisions regarding the extent of services which must be provided in examining/treating a patient;

(8) clarify the appropriate role of the on-call specialist, including situations where the on-call specialist may be treating other patients; and

(9) clarify that a discharge from an emergency department is not a transfer within the meaning of the act. (Sub. Res. 78, A-91; Reaffirmation A-00)

H-130.958 International Emergency Network

It is the policy of the AMA not to become involved in establishing and maintaining an international emergency network. (BOT Rep. GG, A-91; Reaffirmed: Sunset Report, I-01)

H-130.959 Repeal of COBRA Anti-Physician Provisions

It is the policy of the AMA (1) to seek legal or legislative opportunities to clarify that Section 1867 of the Social Security Act applies only to inappropriate transfers from hospital emergency departments and not to issues of malpractice; and (2) to continue to seek appropriate modifications of Section 1867 of the Social Security Act to preclude liability for discharges from the hospital, including emergency department and outpatient facility. (Sub. Res. 145, I-90; Reaffirmed: Sunset Report, I-00)

H-130.960 Payment for Emergency Visits

It is the policy of the AMA to study the appropriate use of CPT modifiers for emergency services provided by physicians in their offices, and for services provided by physicians in their offices outside of normal practice hours, and to take appropriate steps to ensure proper payment for such physician services. (Sub. Res. 163, I-90; Reaffirmed: Res. 105, A-93; Reaffirmation A-00)

H-130.961 Refusal of Appropriate Patient Transfers

The AMA (1) continues to urge county medical societies to develop, with their local hospitals, protocols, and interhospital transfer agreements, and to urge state medical associations to assist their county societies as they develop such agreements; and (2) encourages county medical societies and local hospitals to review and utilize the AMA Principles for the Transfer of Emergency Patients and the American College of Emergency Physicians' Principles of Appropriate Patient Transfer as they develop local transfer arrangements. (BOT Rep. BB, A-90; Reaffirmation A-00)

H-130.962 Medicare Fee Disclosure for Emergency/Nonelective Procedures

It is the policy of the AMA to make a concerted effort to require CMS to stop requiring the fee disclosure rule for emergency/nonelective situations. (Res. 155, A-90; Reaffirmed: Sunset Report, I-00)

H-130.963 Criteria for Public Safety at Major Events

Our AMA has concluded that the planning and regulation of public safety at major events is best left to state and local public safety, police, and emergency medical services (EMS) officials, in conjunction with event promoters. State and county medical societies have an important role to play in such efforts. There is a clear need for local flexibility in planning and providing EMS for mass gatherings. Several event-specific variables, such as number of participants, type of crowd and event, design, and availability of community hospitals and local EMS system influence planning for and provision of EMS at mass gatherings. Thus, local, regional and state EMS agencies are the most appropriate groups to determine criteria for public safety at special events in their area of responsibility. In addition, the AMA believes that if it advocated and disseminated specific guidelines for EMS equipment and staffing at large public events, it might place an undue burden on local governments, event promoters, and insurers. (BOT Rep. D, A-90; Reaffirmed: Sunset Report, I-00)

H-130.964 Federal Patient Transfer Laws

(1) It is the policy of the AMA to do whatever is appropriate to modify the new regulations of Federal Patient Transfer so that (a) an appropriate reporting mechanism is developed for those physicians who were on-call and did not respond in a reasonable period of time to stabilize patients in an emergency setting and (b) it is not necessary to include the name and address of said physician in a transfer record to another facility. (2) The AMA urges physicians and component medical associations to collect and submit to the AMA reports on physician willingness to serve on Emergency Department on-call panels. (Res. 275, A-90; Reaffirmed: Sunset Report, I-00)

H-130.965 Refusal of Appropriate Patient Transfers

Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the basis of economics; (2) supports working with the American Hospital Association to develop model agreements for appropriate patient transfer; and (3) supports continued work by the AMA and the AHA on the problem of providing adequate financing for the care of these patients transferred. (Sub. Res. 155, I-89; Reaffirmed: Sunset Report and Reaffirmation A-00)

H-130.966 Federal Hospital Patient Transfer Amendments

Our AMA supports making every effort to eliminate both existing and proposed onerous federal hospital transfer laws and regulations which inhibit appropriate patient transfers. (Res. 182, I-89; Reaffirmed: Sunset Report and Reaffirmation A-00)

H-130.967 Action Regarding Illegal Aliens

Our AMA supports the legislative and regulatory changes that would require the federal government to provide reasonable payment for federally mandated medical screening examinations and further examination and treatment needed to stabilize a condition in patients presenting to hospital emergency departments, when payment from other public or private sources is not available. (BOT Rep. MM, A-89; Reaffirmed by BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07)

H-130.968 Confusion Between Inappropriate Patient Transfer and Appropriate Patient Transfer

Our AMA (1) believes that the use of the term "patient dumping" for inappropriate patient transfer is offensive and should be discontinued; and (2) supports efforts to educate physicians, the public, government officials, and the media and others regarding the difference between appropriate patient transfers, as defined in existing policy statements, and inappropriate patient transfers. (Sub. Res. 164, A-89; Reaffirmed: Sunset Report and Reaffirmation A-00)

H-130.970 Access to Emergency Services

Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services: (1) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part.

(2) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)

(3) All health plans should be prohibited from requiring prior authorization for emergency services.

(4) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.

(5) 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 an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

(6) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third party payer whether it is retrospectively determined that an emergency existed or not.

(7) States should be encouraged to enact legislation holding health plans and third party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.

(8) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.

(9) In instances in which no private or public third party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services. (CMS Rep. A, A-89; Modified by CMS Rep. 6, I-95; Reaffirmation A-97; Reaffirmed by Sub. Res. 707, A-98; Reaffirmed: Res. 705, A-99; Reaffirmed: CMS Rep. 3, I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 706, I-00; Amended: Res. 229, A-01; Reaffirmation and Reaffirmed: Res. 708, A-02)

H-130.971 Emerging Toxic Challenge

Our AMA (1) proclaims its continued endorsement of poison information programs as essential components of the nation's health care emergency response system; (2) supports assisting the Institute of Medicine and our nation's poison centers in undertaking pilot investigations to augment selected centers' capacities to respond to the broadened menu of toxic inquiries - particularly those concerning industrial, occupational and environmental hazards; and (3) supports federal legislation for pilot investigations to complement and augment the poison centers' existing operating budgets to permit the nation's poison network to better respond to those emerging toxic challenges. (Res. 154, A-89; Reaffirmed: Sunset Report, A-00)

H-130.972 Unfair CMS/OIG Review and Sanction Process for Hospital Emergency Room Care and Patient Transfers

Our AMA supports modification of inadequate procedures utilized by CMS and the OIG in decertifying hospitals for "noncompliance" with the Medicare Conditions of Participation, particularly as they are being applied to hospital emergency room care issues. (Res. 88, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00)

H-130.973 Federal Emergency Transfer/"Anti-Dumping" Law

Our AMA urges CMS to: (1) provide fair and equitable due process for physicians under investigation prior to assessing any penalty or otherwise taking adverse action; and (2) provide for several levels of peer reviewed corrective action, such as education, prior to imposing arbitrarily determined fines. (Res. 111, A-88; Modified: Sunset Report, I-98; Reaffirmation A-00)

H-130.975 The Emergency Department and the Medical Staff

The AMA believes that the decision to open, keep open, or terminate the emergency department, or other departments and services at a given hospital, should be a joint decision of the hospital governing board and its medical staff. (Res. 189, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-130.976 On-Site Emergency Care

(1) The AMA reaffirms its policy endorsing the concept of appropriate medical direction of all prehospital emergency medical services. (2) The following factors should be considered by prehospital personnel in making the decision either to provide extended care in the field or to evacuate the trauma victim rapidly: (a) the type, severity and anatomic location of the injury; (b) the proximity and capabilities of the receiving hospital; (c) the efficiency and skill of the paramedic team; and (d) the nature of the environment (e.g., rural or urban). (3) Because of the variability of these factors, no single methodology or standard can be applied to all accident situations. Trauma management differs markedly between locales, settings, and types of patients receiving care. For these reasons, physician supervision of prehospital services is essential to ensure that the critical decision to resuscitate in the field or to transfer the patient rapidly is made swiftly and correctly. (BOT Rep. N, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-130.977 Trauma Center Efficacy

The AMA supports the development of regional trauma care systems and trauma center designations. (BOT Rep. V, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-130.978 Billing Procedures for Emergency Care

(1) Our AMA urges physicians rendering emergency care to ensure that the services they provide are accurately and completely described and coded on the appropriate claim forms. (2) In the interest of high quality care, patients who seek medical attention on an emergency basis should have the benefit of an immediate evaluation of any indicated diagnostic studies. The physician who provides such evaluation is entitled to adequate compensation for his or her services. When such evaluations are provided as an integral part of and in conjunction with other routine services rendered by the emergency physician, ideally an inclusive charge, commensurate with the services provided, should be made. Where the carrier collapses or eliminates CPT-4 coding for payment purposes, the physician may be left with no realistic alternative other than to itemize. Such an itemized bill should not be higher than the amount which would be paid if the appropriate inclusive charge were recognized. The interpretation of diagnostic procedures by a consulting specialist, as a separate and independent service provided the emergency patient, is equally important to good patient care. Physicians who provide such interpretations are also entitled to adequate compensation for their services. (3) Our AMA encourages state and local organizations representing the specialty of emergency medicine to work with both private and public payers in their area to implement payment practices and coding procedures which assure that payment to physicians rendering emergency care adequately reflects the extent of services provided. (CMS Rep. J, I-86; Reaffirmed by Res. 118, I-95; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, I-01)

H-130.979 National Disaster Medical System

The AMA endorses the U.S. Department of Homeland Security's National Disaster Medical System, which was designed to fulfill three main objectives: (1) to provide medical assistance to a disaster area in the form of medical teams, supplies and equipment; (2) to evacuate patients who cannot be cared for in the affected area to designated locations elsewhere in the nation; and (3) to provide hospitalization in a national network of hospitals that have agreed to accept patients in the event of a national emergency. (BOT Rep. Q, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06)

H-130.981 The Heimlich Maneuver

(1) The AMA endorses the following recommendations of the National Conference CPR and Emergency Cardiac Care concerning the Heimlich maneuver: (a) the Heimlich maneuver is the preferred technique in most cases of adult and pediatric foreign body airway obstruction; (b) chest thrusts are preferred for markedly obese individuals and women in advanced stages of pregnancy; (c) a combination of chest thrusts and back blows is preferred for infants; and (d) the Heimlich maneuver should be used in near-drowning victims only when the rescuer suspects foreign body airway obstruction or when the victim fails to respond to mouth-to-mouth ventilation. (2) The AMA urges organizations that teach CPR to introduce these recommendations into their training programs. (CSA Rep. C, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-130.982 Transfer of Emergency Patients

Our AMA: (1) supports the following principles for the transfer of emergency patients: (a) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay; (b) an interfacility transfer of an unstabilized emergency patient should be undertaken only for appropriate medical purposes, i.e., when in the physician's judgment it is in the patient's best interest to receive needed medical service care at the receiving facility rather than the transferring facility; and (c) all interfacility transfers of emergency patients should be subject to the sound medical judgment and consent of both the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer; (2) urges county medical societies to develop, in conjunction with their local hospitals, protocols and interhospital transfer agreements addressing the issue of economically motivated transfers of emergency patients in their communities. At a minimum, these protocols and agreements should address the condition of the patients transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. The American College of Emergency Physicians' Guidelines for Transfer of Patients should be reviewed in the development of such community protocols and agreements; and (3) urges state medical associations to encourage and provide assistance to their county medical societies as they develop such protocols and interhopsital agreements with their local hospitals. (CMS Rep. H, A-86; Reaffirmed: BOT Rep. BB, A-90; Reaffirmed: CMS Rep. F, I-92; Reaffirmation A-00)

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-130.986 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-130.987 Emergency Medical Identification Aids

The AMA (1) urges worldwide use of the Emergency Medical Identification Symbol (Symbol); (2) urges that persons with special health problems wear a readily evident durable metal or plastic alerting device and that all persons carry a universal medical information card identifying family, friends and personal physicians; (3) urges that the Symbol be imprinted on alerting devices, on medical identification cards, and on emergency medical care educational material; and (4) encourages physicians to work individually with their patients in selecting an appropriate signal device and identification card. (BOT Rep. U, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed by CSA Rep. 10, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

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-130.990 Freestanding Emergency Medical Care

(1) The AMA is concerned that the use of the term "emergency" in the title or description of a medical practice or a hospital center without maintaining specific emergency capabilities is not in the public interest since needed critical emergency service may be delayed. (2) The AMA firmly believes that the optimal provision of emergency care requires prompt physical access to the immediate resources of the hospital and that a freestanding emergency center without such access may delay definitive care of critical emergencies. (3) The AMA endorses the following criteria to aid in determining if a full range of emergency services is being offered: hours of operation, staffing and medical direction, relationship to the local emergency medical services system, ancillary service and equipment, protocols, private physician referrals, medical records, and payment for services. (BOT Rep. L, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed and Modified: CMS Rep. 5, A-04)

H-130.992 Proposed Crisis Relocation and Shelter Plans

Patients must be treated regardless of how they are injured, and planning for treatment is an important part of good medicine. The AMA, therefore, is committed to working with the federal government to provide advice concerning development of sound medical planning for disasters and catastrophes of any and all magnitude. (BOT Rep. I, I-82; Reaffirmed: Res. 34, A-83; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-130.993 Use of Emergency Medical Information Aids

The AMA (1) endorses and encourages the use of effective medical information aids by which appropriate individual medical information can be brought to the attention of emergency personnel; and (2) supports continued review of existing medical information aids to determine appropriate steps to encourage greater use of those information aids which are considered effective. (Res. 57, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-130.994 AMA-US Department of Defense Cooperation

Our AMA supports increased exploration with the Department of Defense of possible ways in which the AMA and the Department of Defense may cooperate to assure the nation's medical preparedness in the event of a national emergency. (Res. 85, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

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)

H-130.996 Medical Disasters

Our AMA believes that the primary responsibility for patient care in disasters involving multiple casualties should remain with local emergency medical systems. If the local system requires augmentation of its medical resources, it has the responsibility of requesting this assistance in the manner that will best facilitate the optimum care of the injured. Other organizations which wish to complement the local emergency medical care system should do so by properly contacting, informing, and coordinating their efforts with the community's emergency medical services system. (BOT Rep. GG, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

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)

H-130.998 Special Amateur Radio Bands for Medical Emergencies

Our AMA supports the allocation of a special band of radio frequencies for emergency health care services. (Res. 93, A-71; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-130.999 Health System Security for Disasters

The AMA calls to the attention of the governors of the several states, and other officials, both state and local, under whose guidance the protection of the public is instituted, that the maintenance of medical treatment facilities and the care of all patients and hospital personnel in the event of a disaster is of prime basic importance, and that preliminary planning to provide such protection should be a part of every disaster program. (Res. 77, A-68; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CLRPD Rep. 1, A-08)

H-135.000 Environmental Health
(See also: Public Health; Radiation and Radiology)

H-135.938 Global Climate Change and Human Health

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change’s fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.

2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating

the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment. (CSAPH Rep. 3, I-08)

H-135.939 Green Initiatives and the Health Care Community

Our AMA supports: (1) responsible waste management policies, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5) community-wide adoption of "green" initiatives and activities by organizations, businesses, homes, schools, and government and health care entities. (CSAPH Rep. 1, I-08)

H-135.940 Toxic Disposable Consumer Products

Our AMA supports federal legislation to create standardized and easily recognizable sites for safe disposal and/or recycling of toxic substances and electronic waste materials in easily accessible locations (Res. 416, A-08)

H-135.941 Air Pollution and Public Health

Our AMA supports increased physician participation in regional and state decision-making regarding air pollution across the United States. (Res. 408, A-08)

H-135.942 Modern Chemicals Policies

Our AMA supports: (1) the restructuring of the Toxic Substances Control Act to serve as a vehicle to help federal and state agencies to assess efficiently the human and environmental health hazards of industrial chemicals and reduce the use of those of greatest concern; and (2) the Strategic Approach to International Chemicals (SAICM) process leading to the sound management of chemicals throughout their life-cycle so that, by 2020, chemicals are used and produced in ways that minimize adverse effects on human health and the environment. (Sub. Res. 404, A-08)

H-135.943 Expansion of Hazardous Waste Landfills Over Aquifers

Our AMA:

(1) recognizes that the expansion of hazardous waste landfills or the construction of new hazardous waste landfills over principal aquifers represents a potential health risk for the public water supply and is inconsistent with sound principles of public health policy, and therefore should be opposed;

(2) will advocate for the continued monitoring of groundwater sources, including principal aquifers, that may be contaminated by hazardous waste landfill or other landfill leachate; and

(3) supports efforts to improve hazardous waste treatment, recycling, and disposal methods in order to reduce the public health burden. (CSAPH Rep. 4, A-07)

H-135.944 Further Limit of Asbestos in the United States

Our AMA supports legislation further restricting the use of asbestos in the United States. (Res. 215, A-07)

H-135.945 Encouraging Alternatives to PVC/DEHP Products in Health

Our AMA: (1) encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) medical device products, especially those containing Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-effective, alternative products where available; and (2) urges expanded manufacturer development of safe, cost-effective alternative products to PVC medical device products, especially those containing DEHP. (BOT Action in response to referred for decision Res. 502, A-06)

H-135.946 Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)

Our AMA supports more stringent air quality standards for particulate matter than those proposed by the EPA Administrator. This position is supported by several medical specialty societies. (BOT Action in response to referred for decision Res. 720, I-05)

H-135.947 Guidance for Worldwide Conservation of Potable Water

Our AMA favors scientific and cultural development of a plan for worldwide potable water conservation. (Res. 406, A-04)

H-135.948 Toxicity of Computers and Electronics Waste

Our AMA (1) encourages its members and US health institutions to adopt purchasing or leasing contracts only with electronics manufacturers and distributors who are committed to safely handling the products at the end of life, meaning that they reuse and recycle to the greatest extent possible, do not export hazardous electronic waste to developing countries and safely dispose of the waste that can not be reused or recycled; (2) encourages its members and US health institutions to provide purchasing/leasing preferences to electronics manufacturers that minimize the use of toxic and hazardous constituents, use recycled content and design products that can be easily recycled in order to minimize the adverse public health impacts from electronic waste; and (3) supports policies that hold electronics manufacturers and distributors responsible for taking back their products at the end of life, with the objective of redesigning their products for longevity and reduction of harmful materials. (Res. 423, A-03)

H-135.949 Support of Clean Air and Power Plant Emissions Act

Our AMA supports federal legislation that meaningfully reduces the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide. (Res. 429, A-03; Reaffirmation I-07)

H-135.950 Support the Health Based Provisions of the Clean Air Act

Our AMA (1) opposes changes to the New Source Review program of the Clean Air Act; (2) urges the Administration, through the Environmental Protection Agency, to withdraw the proposed New Source Review regulations promulgated on December 31, 2002; and (3) opposes further legislation to weaken the existing provisions of the Clean Air Act. (Res. 417, A-03; Reaffirmation A-05)

H-135.951 Environmental Chemical and Disease Tracking and Reduction

Our AMA urges that the primary findings of the 2003 Centers for Disease Control and Prevention report on chemicals be widely disseminated to physicians and patients for education regarding the impact on public health; and urges the CDC to consider implementation of a program similar to the Environmental Health Tracking Network. (Res. 414, A-03)

H-135.952 Manganese in Gasoline

Our AMA: (1) urges the appropriate federal agencies and industries to support further research into health effects of manganese exposure from the use of methylcyclopentadienyl manganese tricarbonyl (MMT) in gasoline before it is introduced widely in the US gasoline supply. Research is especially needed to determine health effects of long-term low-dose exposures to MMT and its combustion products, particularly effects on vulnerable populations; (2) urges the appropriate government agencies to monitor the use of MMT by gasoline refiners and sellers and to make their findings available to the public; (3) urges appropriate federal agencies to fully inform physicians, other health care providers, and the public of any potential health effects of MMT; and (4) continues to monitor research and developments regarding potential health effects of MMT and its combustion products and that this report be updated as appropriate. (CSA Rep. 7, A-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-135.953 Expense of Biohazardous Waste Removal

(1)The AMA encourages the Environmental Protection Agency (EPA): (a) to explore the feasibility of establishing a national definition of biohazardous waste, emphasizing the origins and relative importance of wastes that can plausibly transmit infection compared with wastes that cannot, and (b) to monitor the sources of medical waste in environmental settings and develop guidelines applicable to all waste generators, including home health care sites, to reduce these sources of environmental pollution. (2)The AMA will work with appropriate governmental agencies and medical societies to educate physicians about the management of biohazardous

waste and advocate that these groups work collectively to attain cost savings in biohazardous waste management.(3) The AMA urges practicing physicians to develop a biohazardous waste management program that fulfills their county, state, and municipal regulations, and that considers the different health risks to employees and the general public. (CSA Rep. 4, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-135.954 Education and Prevention Programs Regarding Air Pollution Impact on Body Organs and Systems

The AMA will provide leadership and participate in a major air pollution education and prevention program carried out by the health care community, in cooperation with environmental organizations and business, to inform patients and the public of the negative health effects of indoor and outdoor air pollution on the organs and systems of the body. (Res. 404, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation I-06)

H-135.955 Human Health and the Protection of Biodiversity

The AMA urges physicians and health care professionals to become more aware of the importance of the protection of biological diversity and its relationship to human health, especially in terms of the development of drugs and biologicals to treat diseases that are derived from plants and animals and other elements of the natural world, and to work with environmental, educational, health care and scientific communities to educate the public about this matter. (Res. 403, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-135.956 Human and Environmental Health Impacts of Chlorinated Chemicals

The AMA: (1) encourages the Environmental Protection Agency to base its evaluations of the potential public health and environmental risks posed by exposure to an individual chlorinated organic compound, other industrial compound, or manufacturing process on reliable data specific to that compound or process; (2) encourages the chemical industry to increase knowledge of the environmental behavior, bioaccumulation potential, and toxicology of their products and by-products; and (3) supports the implementation of risk reduction practices by the chemical and manufacturing industries. (Sub. Res. 503, A-94; Reaffirmation I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-135.957 Moratorium on Methyl Tertiary Butyl Ether Use as an Oxygenated Fuel in Alaska

The AMA urges that a moratorium on the use of methyl tertiary butyl ether (MTBE) blended fuels be put into place until such time that scientific studies show that MTBE blended fuels are not harmful to health, and that no penalties or sanctions be imposed on Alaska during the moratorium. (Res. 423, A-94; Reaffirmed: CSA Rep. 6, A-04)

H-135.959 Eliminating Lead, Mercury and Benzene from Common Household Products

Our AMA: (1) supports the development of standards to achieve non-hazardous levels of exposure to lead, mercury, or benzene arising from common household or workplace products; (2) encourages efforts to minimize or eliminate mercury use in hospitals and other health care facilities; and (3) will work in coalitions with appropriate federal agencies and health care organizations to educate physicians and other health care professionals about suitable alternatives to the use of mercury and mercury-containing devices and the appropriate disposal of mercury and mercury-containing devices (Sub. Res. 418, I-92; Appended: Sub. Res. 410, A-00; Reaffirmation I-00; Reaffirmed A-03)

H-135.960 Endorsement of the Concept of Recyclable and Biodegradable Packing, Including Pharmaceutical Packaging

The AMA strongly endorses the use of recycled, recyclable and biodegradable materials for the packaging of pharmaceutical products, medical supplies and equipment, provided that such packaging does not adversely impact product stability. (Res. 404, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-135.961 Risks of a High-Level Radioactive Waste Repository

The AMA (1) urges the U.S. Department of Energy and the state of Nevada to invite representatives of the Nevada State Medical Association to serve as members or consultants to the advisory committees or boards concerned with planning for and characterizing the site of a high-level radioactive waste repository; (2) strongly encourages the U.S. Nuclear Regulatory Commission and the Nuclear Waste Technical Review Board of the National Research Council to include representatives of the appropriate state medical societies/associations, the AMA, and appropriate medical specialty groups with expertise in the field to advise and/or act as consultants to those entities; (3) urges the U.S. Congress to continue the process it has set in place to characterize a site for a high-level radioactive waste repository; and (4) will continue to study the issue of high-level radioactive waste disposal through its Council on Scientific Affairs to ensure the decision-making process is based on scientific facts. (BOT Rep. A, I-92; Amended: CSA Rep. 8, A-03)

H-135.962 Management of Waste Associated with Health Care Delivery

The AMA will work with appropriate organizations toward a more rational definition of contaminated waste associated with the delivery of medical care and a more rational policy for disposal of that waste. (Sub. Res. 522, A-92; Reaffirmed: CSA Rep. 8, A-03

H-135.963 Recyclable and Reusable Utensils

Our AMA makes a commitment to use only reusable and recyclable utensils to the extent possible and encourages its constituent societies to do likewise. (Res. 608, I-91; Reaffirmed: Sunset Report, I-01)

H-135.964 Radioactive Waste Storage

It is the policy of the AMA to coordinate medical support for any task force which may be convened to insure coordination among federal, state and local governments, and all potentially involved medical facilities to assure the safe transportation and disposal of radioactive wastes. (Res. 428, I-91; Reaffirmed: Sunset Report, I-01)

H-135.966 Low-Level Radioactive Wastes

Our AMA (1) reiterates its endorsement of the process now in place for dealing with the disposal of low-level radioactive wastes, which involves the formation of compacts among the 50 states and the construction of regional facilities, and (2) encourages physicians to support and assist state agencies and others responsible for planning the safe disposal of low-level radioactive wastes. (BOT Rep. O, A-91; Reaffirmed: Sunset Report, I-01)

H-135.967 Disposable Diapers

Our AMA encourages consumer education on the health and environmental consequences of the use, cleansing and disposal of various types of diapers consistent with Policy H-135.972. (Res. 3, I-90; Reaffirmed: Sunset Report, I-00)

H-135.968 Support for the Improvement of the Health Environment in Developing Countries

It is the policy of the AMA to (1) support the concept of debt-for-development swaps; and (2) encourage Congress to continue the promotion of measures to improve child survival and development through long-term health and environmental programs in less developed countries. (BOT Rep. V, A-90; Reaffirmed: Sunset Report, I-00)

H-135.969 Environmental Health Programs

Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees. (Res. 124, A-90; Reaffirmed: Sunset Report, I-00)

H-135.971 Low-Level Radioactive Waste Disposal Facility

Our AMA urges the Nuclear Regulatory Commission that any site for the disposal of low-level radioactive waste be rejected unless all applicable statutes and regulations are fully satisfied. (Res. 162, A-90; Reaffirmed: Sunset Report, I-00)

H-135.972 Environmental Preservation

It is the policy of the AMA to support state society environmental activities by (1) acting as an information clearinghouse by providing state societies access to significant environmental information as it becomes available, including the dissemination of data regarding health risks received from the states;

(2) identifying areas of concern and encouraging productive research designed to provide authoritative data regarding health risks of environmental pollutants;

(3) encouraging continued and expanded efforts by the CSA to prepare focused environmental studies, where these studies can be decisive in the public consideration of such problems;

(4) maintaining a global perspective on environmental problems;

(5) considering preparation of public service announcements or other materials appropriate for public/patient education; and

(6) encouraging state and component societies that have not already done so to create environmental committees. (Res. 52, A-90;

Reaffirmed: Sunset Report, I-00)

H-135.973 Stewardship of the Environment

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients;
(2) encourages the medical community to cooperate in reducing or recycling waste;
(3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner;
(4) supports enhancing the role of physicians and other scientists in environmental education;
(5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention;
(6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes;
(7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation;
(8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment;
(9) encourages educational programs for worldwide family planning and control of population growth;
(10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy;
(11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.
(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment;
(13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives;
(14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues;
(15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS);
(16) encourages expanded funding for environmental research by the federal government; and
(17) encourages family planning through national and international support. (CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04)

H-135.975 Recycling in the Medical Community

Our AMA encourages (1) the medical community to initiate appropriate material recycling programs to show its commitment to improving the environment; (2) the medical community to use recyclable products in lieu of substances shown to be deleterious to the environment; and (3) AMNews and other publications to publicize model recycling programs. (Sub. Res. 169, I-89; Reaffirmed: Sunset Report, A-00)

H-135.976 Electromagnetic Pulse (EMP) and its Effects

Our AMA (1) encourages the development of low-cost devices and technology applicable to medical, electronic, and other equipment which will increase its resistance to EMP and other severe electromagnetic phenomena; and (2) supports the recommendations of the National Security Telecommunications Advisory Committee's task force on electromagnetic pulse and urges that these recommendations be adapted to the medical sector and public. These recommendations are: (a) the federal government should designate a single entity to provide information regarding EMP; (b) the information on EMP technology and EMP-resisting systems should be provided in unclassified form; a handbook should be developed on EMP mitigation techniques by the government in cooperation with industry; (c) industry and government should attempt to develop less costly methods to limit the effects of EMP in buildings; and (d) standards and specifications should be developed for EMP-resistant equipment to be used in the private sector. (BOT Rep. P, A-89; Reaffirmed: Sunset Report, A-00)

H-135.977 Global Climate Change - The "Greenhouse Effect"

Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting;

(2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;

(3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity;

(4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and

(5) encourages humanitarian measures to limit the burgeoning increase in world population. (CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00)

H-135.978 National Beverage Container Reuse and Recycling Program

Our AMA supports and encourages passage of federal legislation that would (1) prohibit the sale of carbonated soft drinks, beer, wine coolers, mineral water or soda water in beverage containers unless such a container carried a refund or "deposit" value of not less than five cents to be paid by the consumer at time of purchase; and (2) require beverage retailers and distributors to refund that deposit when the containers are returned, thus creating a self-sustaining recycling network. (Res. 150, A-89; Reaffirmed: Sunset Report, A-00)

H-135.979 Clean Air

Our AMA supports cooperative efforts with the Administration, Congress, national, state and local medical societies, and other organizations to achieve a comprehensive national policy and program to address the adverse health effects from environmental pollution factors, including air and water pollution, toxic substances, the "greenhouse effect," stratospheric ozone depletion and other contaminants. (Sub. Res. 43, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-06; Reaffirmation I-07)

H-135.981 Medical Perspective on Nuclear Power

The AMA supports the following statements on the health and safety aspects of electricity production and nuclear power: (1) Need for electricity - Adequate capacity to generate electricity is necessary for people's health and well-being and for the progress of society. Adequate capacity relates to both the supply and the conservation of electricity.
(2) Energy conservation - Emphasis in the U.S. on the conservation of energy and on the more efficient use of energy should continue and accelerate.
(3) Safety in generating electricity - During recent decades in the U.S. the principal methods of generating electricity have been made increasingly safe and environmentally benign.
(4) Safety of nuclear power - Generating electricity with nuclear power is a safe method in the U.S., both absolutely and in comparison with alternative methods.
(5) Safety features of nuclear power reactors - Power reactors in the U.S. are designed and constructed to prevent unintended releases of ionizing radiation, and those safety features have proved effective in actual operation.
(6) Radiation exposures of workers - Exposures of workers to ionizing radiation in U.S. nuclear power plants have diminished and are extremely low.
(7) Disposal of radioactive wastes - The nation should continue efforts to reach a national goal for all states to make arrangements for the disposal of low-level radioactive wastes generated within their borders. All methods of generating electricity involve the production of wastes requiring disposal.
(8) Role of Physicians - Physicians, as members of a profession concerned with the ill and with risks to the healthy, should know where information and guidance are available on how to treat persons injured by ionizing radiation. They should also recognize that they have a broader responsibility to respond to the real and perceived health needs, as well as the anxiety and fear, of the public following a radiation emergency. Physicians also have a societal obligation to contribute to efforts to improve public understanding of the benefits and risks of nuclear power compared with alternate ways to generate electricity.
(9) AMA role - The AMA supports continued monitoring and reporting as appropriate on activities, technologies and aspects of society affecting the public's health, such as nuclear power, and keeping physicians apprised of important technologic developments with implications for providing medical care and for their roles as responsible professionals. (CSA Rep. G, I-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

H-135.982 Low Level Radioactive Wastes

(1) Many activities of society giving rise to low-level radioactive wastes are useful; such activities include diagnosis and treatment of disease, research in science and medicine, and industrial uses such as generating electricity, detecting metal fatigue and discovering oil. (2) The rules and recommendations for radiation protection promulgated by the U.S. Nuclear Regulatory Commission, the U.S. Environmental Protection Agency, the National Council on Radiation Protection and Measurements, and the International Commission on Radiological Protection assure that disposal facilities for low-level radioactive wastes will be built and operated in a manner that protects the safety of workers and the public. (3) Physicians should inform their patients and help inform the public about the many beneficial uses of radioactive materials and about the measures and standards that are in place to reduce unnecessary exposures to these materials. (4) Physicians should minimize the diagnostic and therapeutic exposures of patients to ionizing radiation in accord with good medical practice. (CSA Rep. A, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-135.984 Federal Clean Air Legislation

The AMA urges the enactment of comprehensive clear ambient air legislation which will lessen risks to human health. (Res. 142, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-07)

H-135.985 Environmental Protection and Safety in Federal Facilities

The AMA urges physicians to contribute to the solution of environmental problems by serving as knowledgeable and concerned consultants to environmental, radiation, and public health protection agencies of state and local governments. (BOT Rep. T, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-135.989 Low Level Radioactive Waste Disposal

The AMA (1) believes that each state should be responsible for providing capacity within or outside the state for disposal of commercial, non-military low level radioactive waste generated within its border; and (2) urges expeditious Environmental Protection Agency action to ensure capacity for disposal of low level radioactive waste. (Res. 48, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-135.991 Clean Air

(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.

(2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.

(3) The AMA endorses a more effective hazardous pollutant program to allow for efficient control of serious health hazards posed by airborne toxic pollutants.

(4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.

(5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health. (BOT Rep. R, A-82; Reaffirmed: CLRPD Rep. A, I-92; Amended: CSA Rep. 8, A-03; Reaffirmation I-06)

H-135.992 Acid Precipitation

Our AMA encourages further scientific studies to determine the effects of acid precipitation on the population of the U.S. and Canada in order that the maximum impact of health professionals may be brought to bear toward the solution of this problem. (Res. 66, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-135.993 Transportation and Storage of Hazardous Materials

Our AMA requests governmental agencies to develop adequate systems, which include instruction for detoxification or neutralization in event of emergencies, for continuous monitoring of transportation and storage of hazardous materials. (Sub. Res. 42, I-74; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-135.994 Mirex - Carcinogen in Mice

Our AMA opposes use of pesticides with cumulative carcinogenic effects in government-funded projects for eradication of insect pests when instituted without consideration of ecological consequence. (Res 54, I-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-135.995 Ecology

Our AMA urges establishment of educational programs on ecology in schools, colleges, and communities, including emphasis on human ecology. (Res. 27, I-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-135.996 Pollution Control and Environmental Health

Our AMA supports (1) continuing its efforts to alert the American people to health hazards of environmental pollution and the need for expanded research and control measures in this area; and (2) further expansion and intensification of its present activities in pollution control and improvement of environmental health. (Sub. Res. 40, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-135.997 Promoting Environmental Health

Our AMA urges more active involvement in solving and preventing environmental health problems. (Res. 55, I-69; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed in lieu of Res. 417, A-04)

H-135.998 AMA Position on Air Pollution

Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.

(2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community.

(3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.

(4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control. (BOT Rep. L, A-65; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06)

H-135.999 Federal Programs

The AMA believes that the problem of air pollution is best minimized through the cooperative and coordinated efforts of government, industry and the public. Current progress in the control of air pollution can be attributed primarily to such cooperative undertakings. The Association further believes that the federal government should play a significant role in these continuing efforts. This may be done by federal grants for (1) the development of research activity and (2) the encouragement of local programs for the prevention and control of air pollutants. (BOT Rep. M, A-63; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06; Reaffirmation I-07)

H-140.000 Ethics
(See also the *Current Opinions* of the AMA Council on Ethical and Judicial Affairs.)

H-140.861 Physicians' Self-Referral

Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships—including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices—are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:

(1) Ensure that referrals are based on objective, medically relevant criteria.

(2) Ensure that the arrangement:

(a) is structured to enhance access to appropriate, high quality health care services or products;

(b) within the constraints of applicable law:

(i) does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;

(ii) does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and

(iii) adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.

(3) Take steps to mitigate conflicts of interest, including:

(a) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;

(b) establishing mechanisms for utilization review to monitor referral practices; and

(c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.

(4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral (CEJA Rep. 1, I-08)

H-140.862 Expedited Partner Therapy

Expedited Partner Therapy (EPT) is the practice of treating the sex partners of patients with sexually transmitted diseases via patient-delivered partner therapy without the partner receiving a medical evaluation or professional prevention counseling. While this practice is presently recommended by the Centers for Disease Control and Prevention for use in very limited circumstances (for gonorrhea or chlamydial infection in heterosexual men and women), EPT may be recommended for additional applications in the future.

Although EPT has been demonstrated to be effective at reducing the burden of certain diseases, it also has ethical implications. EPT potentially abrogates the standard informed consent process, compromises continuity of care for patients' partners, encroaches upon the privacy of patients and their partners, increases the possibility of harm by a medical or allergic reaction, leaves other diseases or complications undiagnosed, and may violate state practice laws. The following guidelines are offered for use in establishing whether EPT is appropriate:

(1) Physicians should determine the need for EPT by engaging in open discussions with patients to ascertain their partners' abilities to access medical services. Only if the physician reasonably believes that a patient's partner(s) will be unwilling or unable to seek treatment within the context of a traditional patient-physician relationship should the use of EPT be considered.

(2) Prior to initiating EPT, physicians are advised to seek the guidance of public health officials, as well as determine the legal status of EPT in their state.

(3) If the physician chooses to initiate EPT, he or she must provide patients with appropriate instructions regarding EPT and its accompanying medications and answers to any questions that they may have.

(4) Physicians must provide patients with educational material to share with their partners that encourages the partners to consult a physician as a preferred alternative to EPT, and that discloses the risk of potential adverse drug reactions and the possibility of dangerous interactions between the patient-delivered therapy and other medications that the partner may be taking. The partner should also be informed that he or she may be affected by other STDs that may be left untreated by the delivered medicine.

(5) The treating physician should also make reasonable efforts to refer a patient's partner(s) to appropriate health care professionals. (CEJA Rep. 6, A-08)

H-140.863 Sedation to Unconsciousness in End-of-Life Care

The duty to relieve pain and suffering is central to the physician's role as healer and is an obligation physicians have to their patients. Palliative sedation to unconsciousness is the administration of sedative medication to the point of unconsciousness in a terminally ill patient. It is an intervention of last resort to reduce severe, refractory pain or other distressing clinical symptoms that do not respond to aggressive symptom-specific palliation. It is an accepted and appropriate component of end-of-life care under specific, relatively rare circumstances. When symptoms cannot be diminished through all other means of palliation, including symptom-specific treatments, it is the ethical obligation of a physician to offer palliative sedation to unconsciousness as an option for the relief of intractable symptoms. When considering the use of palliative sedation, the following ethical guidelines are recommended:

(1) Patients may be offered palliative sedation to unconsciousness when they are in the final stages of terminal illness. The rationale for all palliative care measures should be documented in the medical record.

(2) Palliative sedation to unconsciousness may be considered for those terminally ill patients whose clinical symptoms have been unresponsive to aggressive, symptom-specific treatments.

(3) Physicians should ensure that the patient and/or the patient's surrogate have given informed consent for palliative sedation to unconsciousness.

(4) Physicians should consult with a multidisciplinary team, if available, including an expert in the field of palliative care, to ensure that symptom-specific treatments have been sufficiently employed and that palliative sedation to unconsciousness is now the most appropriate course of treatment.

(5) Physicians should discuss with their patients considering palliative sedation the care plan relative to degree and length (intermittent or constant) of sedation, and the specific expectations for continuing, withdrawing or withholding future life-sustaining treatments.

(6) Once palliative sedation is begun, a process must be implemented to monitor for appropriate care.

(7) Palliative sedation is not an appropriate response to suffering that is primarily existential, defined as the experience of agony and distress that may arise from such issues as death anxiety, isolation and loss of control. Existential suffering is better addressed by other interventions. For example, palliative sedation is not the way to address suffering created by social isolation and loneliness; such suffering should be addressed by providing the patient with needed social support.

(8) Palliative sedation must never be used to intentionally cause a patient's death. (CEJA Rep. 5, A-08)

H-140.864 Peers as Patients

The opportunity to care for a fellow physician is a privilege and may represent a gratifying experience and serve as a show of respect or competence. In emergencies or isolated or rural settings when options for care by other physicians are limited or where there is no other qualified physician available, physicians should not hesitate to treat peers. There are, however, a number of ethical considerations to weigh before undertaking the care of a colleague.

(1) Physicians who provide care to a peer should be alerted to the possibility that their professional relationship with the patient may affect their ability to exercise objective professional judgment and make unbiased treatment recommendations. They must also recognize that the physician-patient may be reluctant to disclose sensitive information or permit an intimate examination.

(2) Physicians providing care to a professional colleague have an obligation to respect informational and physical privacy of physician-patients as they would for any patient. Treating physicians should consider, and possibly discuss with the physician-patient, how to respond appropriately to the inquiries about the physician-patient's medical care from other physicians or medical staff. Treating physicians should also recognize that special measures may be required to ensure that the physician-patient's physical privacy is respected.

(3) Physicians providing care to a colleague should respect the physician-patient's right to participate in informed decision making. Treating physicians should make no assumptions about the physician-patient's knowledge about her or his medical condition and should provide information to enable the physician-patient to make voluntary, fully informed decisions about care.

(4) Physicians in training and medical students face unique challenges when asked to provide or participate in care for peers given the circumstances of their roles in medical schools and residency programs. Except in emergency situations or when other care is not available, physicians in training should not be required to care for fellow trainees, faculty members, or attending physicians if they are reluctant to do so. (CEJA Rep. 4, A-08)

H-140.865 Pediatric Decision-Making

Medical decision-making for pediatric patients should be based on the child's best interest, which is determined by weighing many factors, including effectiveness of appropriate medical therapies, the patient's psychological and emotional welfare, and the family situation. When there is legitimate inability to reach consensus about what is in the best interest of the child, the wishes of the parents should generally receive preference.

Physicians treating pediatric patients generally must obtain informed consent from a parent or a legal guardian. Certain classes of children, such as emancipated or mature minors, may provide consent to their own medical care.

Physicians should give pediatric patients the opportunity to participate in decision-making at a developmentally appropriate level. The

physician should seek the patient's assent, or agreement, by explaining the medical condition, its clinical implications, and the treatment plan. If the patient does not or cannot assent, physicians should still explain the plan of care and tell him or her what to expect, without deception. In the case of an adolescent patient who has decision-making capacity, the physician should encourage the patient's active participation in decision-making. The use of force such as with using physical restraints to carry out a medical intervention in adolescent patients who do not assent should be a last resort.

Parents and physicians may disagree about the course of action that best serves the pediatric patient's interests. When disagreements occur, institutional policies for timely conflict resolution should be followed, including consultation with an ethics committee, pastoral service, or other counseling resource. If a health care facility does not have policies for resolving conflicts in a timely manner, physicians should encourage their development. Physicians should treat reversible life-threatening conditions regardless of any persistent disagreement. Resolution of disagreements in the courts should be pursued only as a last resort. (CEJA Rep. 8, I-07)

H-140.872 Physician Pay-for-Performance Programs

Physician pay-for-performance (PFP) compensation arrangements should be designed to improve health care quality and patient safety by linking remuneration to measures of individual, group, or organizational performance. To uphold their ethical obligations, physicians who are involved with PFP programs must take appropriate measures to promote patients' well-being.

(1) Physicians who are involved in the design or implementation of PFP programs should advocate for:
(a) incentives that are intended to promote health care quality and patient safety, and are not primarily intended to contain costs;
(b) program flexibility that allows physicians to accommodate the varying needs of individual patients;
(c) adjustment of performance measures by risk and case-mix in order to avoid discouraging the treatment of high-risk individuals and populations;
(d) processes to make practice guidelines and explanations of their intended purposes and the clinical findings upon which they are based available to participating physicians.

(2) Practicing physicians who participate in PFP programs while providing medical services to patients should:
(a) maintain primary responsibility to their patients and provide competent medical care, regardless of financial incentives;
(b) support access to care for all people and avoid selectively treating healthier patients for the purpose of bolstering their individual or group performance outcomes;
(c) be aware of evidence-based practice guidelines and the findings upon which they are based;
(d) always provide care that considers patients' individual needs and preferences, even if that care conflicts with applicable practice guidelines;
(e) not participate in PFP programs that incorporate incentives that conflict with physicians' professional values or otherwise compromise physicians' abilities to advocate for the interests of individual patients. (CEJA Rep. 3, I-05; Reaffirmation A-06; Reaffirmation I-06)

H-140.873 The Use of Quarantine and Isolation as Public Health Interventions

Quarantine and isolation to protect the population's health potentially conflict with the individual rights of liberty and self-determination. The medical profession, in collaboration with public health colleagues, must take an active role in ensuring that those interventions are based on science and are applied according to certain ethical considerations.

(1) To this end, the medical profession should:
(a) seek an appropriate balance of public needs and individual restraints so that quarantine and isolation use the least restrictive measures available that will minimize negative effects on the community through disease control while providing protections for individual rights;
(b) help ensure that quarantine and isolation are based upon valid science and do not arbitrarily target socioeconomic, racial, or ethnic groups;
(c) advocate for the highest possible level of confidentiality of personal health information whenever clinical information is transmitted in the context of public health reporting;
(d) advocate for access to public health services to ensure timely detection of risks and prevent undue delays in the implementation of quarantine and isolation;
(e) help to educate patients and the public about quarantine and isolation through the development of educational materials and participation in educational programs;
(f) advocate for the availability of protective and preventive measures for physicians and others caring for patients with communicable diseases.

(2) Individual physicians should participate in the implementation of appropriate quarantine and isolation measures as part of their obligation to provide medical care during epidemics (see Opinion E-9.067, "Physician Obligation in Disaster Preparedness and Response"). In doing so, advocacy for their individual patients' best interests remains paramount (see Opinion E-10.015, "The Patient-Physician Relationship"). Accordingly, physicians should:

(a) encourage patients to adhere voluntarily to scientifically grounded quarantine and isolation measures by educating them about the nature of the threat to public health, the potential harm that it poses to the patient and others, and the personal and public benefits to be derived from quarantine or isolation. If the patient fails to comply voluntarily with such measures, the physician should support mandatory quarantine and isolation for the non-compliant patient;
(b) comply with mandatory reporting requirements and inform patients of such reports;
(c) minimize the risk of transmitting infectious diseases from physician to patient and ensure that they remain available to provide necessary medical services by using appropriate protective and preventive measures, seeking medical evaluation and treatment if they suspect themselves to be infected, and adhering to mandated public health measures.

(3) Frontline physicians have an increased ethical obligation to avail themselves of safe and effective protective and preventive measures (for example, influenza vaccine). (CEJA Rep. 1, I-05; Reaffirmed in lieu of Res. 813, I-06)

H-140.874 Opposition to Legislation that Presumes to Prescribe Patients' Preferences for Artificial Hydration and Nutrition

Our AMA opposes legislation that would presume to prescribe the patient's preferences for artificial hydration and nutrition in situations where the patient lacks decision-making capacity and an advance directive or living will. (Res. 209, A-05)

H-140.896 Moratorium on Capital Punishment

Our AMA: (1) does not take a position on capital punishment; and (2) urges appropriate legislative and legal authorities to continue to implement changes in the system of administration of capital punishment, if used at all, and to promote its fair and impartial administration in accordance with basic requirements of due process. (Sub. Res. 8, A-01; Reaffirmation A-04; Reaffirmation A-07)

H-140.898 Medical Profession Opposition to Physician Participation in Execution

Our AMA strongly reaffirms its opposition to physician participation in execution. (Res. 10, A-02; Reaffirmation A-04)

H-140.900 A Declaration of Professional Responsibility

Our AMA adopts the Declaration of Professional Responsibility

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE'S SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to: (1) Respect human life and the dignity of every individual.

(2) Refrain from supporting or committing crimes against humanity and condemn any such acts.

(3) Treat the sick and injured with competence and compassion and without prejudice.

(4) Apply our knowledge and skills when needed, though doing so may put us at risk.

(5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.

(6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering

and contribute to human well-being.

(7) Educate the public and polity about present and future threats to the health of humanity.

(8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.

(9) Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor. (CEJA Rep. 5, I-01; Reaffirmation A-07)

H-140.901 Equity in Health Care for Domestic Partnerships

Our AMA supports legal recognition of domestic partners for hospital visitation rights and as the primary medical care decision maker in the absence of an alternative health care proxy designee. (Res. 101, I-01)

H-140.910 Preservation of National Bioethics Advisory Commission

Our AMA endorses the creation by the federal government of a permanent national Bioethics Commission charged with a mission similar to that of the current National Bioethics Advisory Commission and the responsibility to examine the many ethical issues arising from new technology and research. (Res. 9, I-00)

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)

H-140.912 Genetic Information and the Criminal Justice System

The release of genetic information from a physician's records without the consent of the patient constitutes a breach of confidentiality. Opinion 5.05, "Confidentiality," acknowledges that law and overriding social considerations may permit physicians to disclose confidential information in limited circumstances. However, such circumstances present ethical challenges. The following guidelines are intended to aid physicians in considering the ethical basis for the release of genetic information to the criminal justice system.

(1) Physicians should release a patient's genetic information only with the patient's consent or in compliance with a warrant or other order of a court of law. The circumstances in which law enforcement may seek a suspect's genetic information from the suspect's physician depend on whether any specific suspect has been identified, and if the suspect is in custody.
(a) If law enforcement personnel have identified a suspect and the suspect cannot be located to provide a genetic sample, physicians should release clinical genetic information only when a warrant or court order mandates such a release.
(b) When law enforcement personnel have identified a suspect, and the suspect has been located but refuses to provide a sample or is deceased (but his or her body is available), physicians should not be required to release genetic information as in these circumstances a court can authorize collection of a sample from the suspect or from postmortem tissue.
(c) Searching clinical and research databases of genetic information, or extracting and analyzing DNA from clinical or research tissue repositories, should not be conducted for the mere possibility that there is a match to a suspect's DNA unless there is a warrant or court order to do so.

(2) When genetic information is provided to the judicial system, physicians should provide the minimum amount of information necessary for the explicit identification procedure being performed. Other elements of the medical record, or the results of any genetic testing or genetic diagnosis, should not be released without the patient's consent or further warrant or order of the court.

(3) It is unethical for any genetic information obtained from a physician for identification purposes to be used subsequently for other purposes, such as research, unless appropriate ethical guidelines are followed and the informed consent of the individual is obtained (or the legally appropriate surrogate if the individual is incompetent or deceased, in compliance with Opinion 5.051, "Confidentiality of Medical Information Postmortem").

(4) Databases that contain only the genetic identifiers from the specific loci that are typically used for identification purposes do not present the same ethical concerns that are presented by databases which contain genotypic or phenotypic information. Physicians participating in the creation of genetic databases for the exclusive use of the criminal justice system should ensure that the database is not used inappropriately for purposes other than identification.

(5) In general, requiring that the genetic sample be destroyed or returned after the analysis necessary for identification is performed affords protection against inappropriate uses.

(6) When the criminal justice system seeks genetic information for the purposes of identifying a deceased victim, the above relevant

guidelines also apply. (CEJA Rep. 6, I-00)

H-140.919 Doctor/Patient/Health Plan Communications

Our AMA adopts as policy that: (1) the fundamental relationship between physicians and their patients should not be disrupted by direct communications from health plans to patients regarding individual clinical matters; (2) any health plan communications to patients promoting improved outcomes through evidence-based approaches (e.g., promotion of preventive measures or disease management programs) should be designed to reinforce the primacy of the patient-physician relationship, and be sensitive to confidentiality issues and patients' concerns about their health status; and (3) in cases where a health plan directly communicates with a patient, a copy of that communication should be sent to the patient's primary physician. (Res. 701, I-99)

H-140.920 Socioeconomic Factors Influencing the Patient-Physician Relationship

Our AMA continues to monitor infringements on the patient-physician relationship and respond with policy development and advocacy initiatives that are both timely and appropriate. (CMS Rep. 7, I-99)

H-140.921 Preserving the Traditional Patient-Physician Relationship

Our AMA reaffirms the traditional medical ethical principles expressed in CEJA Opinions 4.07, 8.02, 8.03, 8.12, and 8.13. (Sub. Res. 2, I-99)

H-140.926 Policy for Physician Entrepreneur Activity

Members of the AMA shall not: (1) coerce their patients to purchase medications, vitamins, nutritional supplements or medical devices from the physician's practice; and (2) recruit their patients to participate in marketing programs in which the physician personally benefits, financially or otherwise, from the efforts of their patients. (Res. 7 , A-99)

H-140.938 Professional Courtesy

The AMA reaffirms a physician's right (consistent with Council on Ethical and Judicial Affairs Opinion E-6.13) to provide professional courtesy. (Sub. Res. 4, I-97; Reaffirmation I-98; Reaffirmed: Res. 5, I-02; Reaffirmed: CEJA Rep. 2, A-04)

H-140.945 Code Status Requirement for Nursing Home Residents

The AMA opposes any legislative or regulatory attempts that would allow a nursing home facility to require that a patient consent to a DNR order as a condition of admission unless that facility is limited to palliative care. The AMA urges other medical agencies and associations to oppose any legislative or regulatory attempts that would allow a nursing home facility to require that a patient consent to a DNR order as a condition of admission unless that facility is limited to palliative care. (Res. 236, I-97; Reaffirmed: CEJA Rep. 7, A-07)

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)

H-140.949 Physician-Assisted Suicide

The AMA will (1) initiate an educational campaign to make palliative treatment and care directions based on values-based advance care planning the standard of care for meeting the needs of patients at the end of life; and (2) will work with local, state, and specialty medical societies to develop programs to: facilitate referrals to physicians qualified to provide necessary palliative and other care for patients seeking help in meeting their physiological and psychological needs at the end of life; and establish a faculty of physicians with expertise in end-of-life care who can provide consultations for other physicians in caring for patients at the end of life. (BOT Rep. 59, A-96; Reaffirm: Res. 237, A-99)

H-140.950 Physician Participation in Capital Punishment

Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed: Our AMA endorses the following: (1) Physician participation in evaluations of a prisoner's competence to be executed is ethical only when certain safeguards are in place. A physician can render a medical opinion regarding competency which should be merely one aspect of the information taken into account by the ultimate decision maker, a role that legally should be assumed by a judge or hearing officer. Prisoners' rights

to due process at the competency hearings should be carefully observed.
(2) When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner to restore competence unless a commutation order is issued before treatment begins.
(3) If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. It will not always be easy to distinguish these situations from treatment for the purpose of restoring the prisoner's competence, and in particular, to determine when treatment initiated to reduce suffering should be stopped. However, these is no alternative at this time other than to rely upon the treating physician to exercise judgment in deciding when and to what extent treatment is necessary to reduce extreme suffering. The cumulative experience of physicians applying these principles over time may lead to future refinements.
Treatment should be provided in a properly-secured, general medical or psychiatric facility, not in a cell block. The task of re-evaluating the prisoner's competence to be executed should be performed by an independent physician examiner.
(4) Given the ethical conflicts involved, no physician, even if employed by the state, should be compelled to participate in the process of establishing a prisoner's competence to be executed if such activity is contrary to the physician's personal beliefs. Similarly, physicians who would prefer not to be involved with treatment of an incompetent, condemned prisoner should be excused or permitted to transfer care of the prisoner to another physician. (CEJA Rep. 6, A-95; Reaffirmation A-04)

H-140.951 Professionalism and Medical Ethics

The AMA reaffirms that the medical profession is solely responsible for establishing and maintaining standards of professional medical ethics and that the state cannot legislate ethical standards or excuse physicians from their ethical obligations; and urges all physicians and other appropriate health professional organizations to make their views known to their state legislatures and governors. (Res. 4, A-95; Reaffirmed: CEJA Rep. 2, A-05)

H-140.952 Physician Assisted Suicide

It is the policy of the AMA that: (1) Physician assisted suicide is fundamentally inconsistent with the physician's professional role.
(2) It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.
(3) Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease.
(4) Requests for physician assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated.
(5) Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations. (CEJA Rep. 8, I-93; Reaffirmed by BOT Rep. 59, A-96; Reaffirm: Res. 237, A-99)

H-140.963 Secrecy and Physician Participation in State Executions

The AMA opposes any and all attempts either in state laws or in rules and regulations that seek to enable or require physician participation in legal executions and/or which protect from disclosure the identity of physicians participating or performing direct or ancillary functions in an execution. (Res. 6, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmation A-04)

H-140.964 Enforcement of Code of Ethics

It is the policy of the AMA (1) to make appropriate education and enforcement of its ethical guidelines a priority and (2) with the input and consent of the Federation, to begin a process to coordinate the Federation, including specialty societies and hospital medical staffs, in joint efforts to better communicate and enforce ethical standards. (BOT Rep. BBB, I-91; Reaffirmed: Sunset Report, I-01)

H-140.966 Decisions Near the End of Life

Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

(3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.

(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.

(5) Our AMA supports continued research into and education concerning pain management. (CEJA Rep. B, A-91; Reaffirmed by BOT Rep. 59, A-96; Reaffirmation A-97; Appended: Sub. Res. 514, I-00)

H-140.967 Conflicts of Interest

Our AMA calls on state and county medical societies to seek out and to respond to complaints of significant violations of the Council on Ethical and Judicial Affairs' guidelines, and it reminds those societies of the AMA's pledge to stand behind and to provide financial support for any society enforcing in good faith and under approved disciplinary procedures AMA's code of ethics. (CEJA Rep. G, A-91; Modified: Sunset Report, I-01)

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)

H-140.970 Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients

The AMA believes that: (1) Advance directives (living wills and durable powers of attorney for health care) are the best insurance for individuals that their interests will be promoted in the event that they become incompetent. Generally, it is most effective if the individual designates a proxy decisionmaker and discusses with the proxy his or her values regarding decisions about life support.
(2) Without an advance directive that designates a proxy, the patient's family should become the surrogate decisionmaker. Family includes persons with whom the patient is closely associated. In the case when there is no person closely associated with the patient, but there are persons who both care about the patient and have some relevant knowledge of the patient, such relations should be involved in the decision-making process, and may be appropriate surrogates.
(3) It is the responsibility of physicians to provide all relevant medical information and to explain to surrogate decisionmakers that decisions should be based on substituted judgment (what the patient would have decided) when there is evidence of patients' preferences and values. If there is not adequate evidence of preferences and values, the decision should be based on the best interests of the patient (what outcome would most likely promote the patient's well-being).
(4) Institutional ethics committees should be established for the purpose of facilitating sound decisionmaking. These ethics committees should be structured so that a diversity of perspectives, including those from outside medicine, are represented.
(5) The surrogate's decision should almost always be accepted by the physician. However, there are four situations that may require either institutional or judicial review and/or intervention in the decision-making process. These situations are when: (a) there is no available family willing to be the patient's surrogate decisionmaker; (b) there is a dispute among family members and there is no decisionmaker designated in an advance directive; (c) a health care provider believes that the family's decision is clearly not what the patient would have decided if competent; and (d) a health care provider believes that the decision is not a decision that could reasonably be judged to be in the patient's best interests. Decisions based on a conflict of interest generally would not be in the patient's best interest. In these four cases, the guidelines outlined in the report should be followed. In particular, when there are disputes among family members or between family and health care providers, the use of ethics committees specifically designed to facilitate sound decisionmaking is recommended before resorting to the courts.
(6) Judicial review for decisions about life-sustaining treatment should be a last resort. It is strongly encouraged that when judicial review is necessary, in nonemergency situations, the courts should determine who is to make treatment decisions, including appointing a guardian, rather than making treatment decisions.
(7) When a permanently unconscious patient was never competent or had not left any evidence of previous preferences or values, since there is no objective way to ascertain what would be in the best interests of the patient, the surrogate's decision should not be challenged as long as the decision is based on the decisionmaker's true concern for what would be best for the patient.
(8) In the case of seriously ill or handicapped newborns, present and future interests of the infant must be considered. Due to the complexities involved in deciding about life support for seriously ill newborns, physicians should specifically discuss with parents the risks and uncertainties involved. When possible, parents should be given time to adjust to the shock of the situation and absorb the medical information presented to them before making decisions about life-sustaining treatment. In addition, counseling services and

an opportunity to talk with couples who have had to make similar decisions should be available to the parents.
(9) Due to the complexity of decisions for permanently unconscious patients and newborns, an ethics committee should be available, whenever possible, to facilitate the surrogate's decisionmaking.
(10) Hospitals and other health care facilities should establish protocols regarding assessment of decisionmaking capacity, informing patients about advance directives, identifying surrogate decisionmakers, the use of advance directives, substituted judgment and best interests in decisionmaking, and the procedures for challenging the decision of a surrogate. These protocols should be in accordance with the CEJA preceding guidelines. (CEJA Rep. D, A-91; Reaffirmed: Res. 3, A-99; Reaffirmed: Res. 209, A-05; Reaffirmed: BOT Rep. 9, A-08)

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)

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)

H-140.978 Financial Incentives to Limit Care - Ethical Implications for HMOs and IPAs

(1) Physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward, or the avoidance of financial penalties
(2) Patients must have the necessary information to make informed decisions about their care. Physicians therefore have an ethical obligation to assure the disclosure of medically appropriate treatment alternatives, regardless of cost.
(3) Physicians must assure that any agreement or understanding (explicit or implicit) restricting referral or treatment options is disclosed to patients.
(4) Physicians must assure disclosure of any financial inducements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or that may tend to limit patients' overall access to care.
(5) Physicians may satisfy their disclosure obligations by assuring that the managed care plan makes adequate disclosure to patients enrolled in the plan. Physicians in groups, health care delivery systems or closed hospital departments may satisfy their disclosure obligations by assuring that the group, health care delivery system or hospital, respectively, makes adequate disclosure to patients of that practice setting.
(6) Physicians should promote an effective program of peer review to monitor and evaluate the quality and appropriateness of the patient care services provided within their practice setting. (CEJA Rep. B, A-90; Reaffirmed: Sub. Res. 702, I-94; Reaffirmation A-00; Reaffirmed in lieu of Res. 901, I-05; Modified: BOT Rep. 38, A-06; Reaffirmation A-07)

H-140.983 Hospital Medical Staff and Joint Ventures Oversight Committees

Our AMA (1) encourages medical staffs of hospitals to promote the ethical operation of joint ventures involving physicians through existing medical staff oversight committees (including committees responsible for quality assurance, utilization review, credentialing and continuing medical education) or a new joint venture oversight committee, and recommends that such promotion be coordinated by the executive committee of the medical staff; and (2) encourages the ethical operation of health care joint ventures involving physicians through an organizational structure developed to generally promote the ethical opinions and reports of CEJA. That structure should involve county grievance committees, councils or committees of state medical associations responsible for ethics, and state medical boards. (BOT Rep. FF, A-89; Reaffirmed: Sunset Report, A-00)

H-140.984 Physicians' Involvement in Commercial Ventures

Our AMA opposes an across-the-board ban on self-referrals because of benefits to patients including increased access and competition, but proposes a list of standards to ensure ethical and acceptable financial arrangements:

(1) Opportunity to Invest - The opportunity to invest in the medical or health care facility established by a health care service(s) (HCS) financial arrangement should be open to all individuals who are financially able and interested in the investment. This would include non-physicians. The only exception allowed would be for a sole community health care provider where ownership could be limited to potential referring physicians or their immediate family due to a lack of other individuals who have sufficient capital and interest to establish the facility.

(2) Real Investment at Risk - Each investor should be undertaking a real financial risk similar to that which might occur in any other

similar commercial investment. A referring physician should not be allowed to become involved in the HCS investment without incurring a real financial risk. The ability of a physician to refer patients must not be considered "capital" to become an investor in the facility. Each investor in the medical facility must be at risk by virtue of a binding commitment to capitalize the venture, such as a commitment to contribute money, property or services.

(3) Patient Referral Requirement - No investor in the medical facility can be required or coerced in any manner to refer patients to the facility. No investor can be required to divest his or her investment for failure to refer patients. No investor can be required to divest because he or she moves from the area or ceases practicing medicine.

(4) Distribution of Profit or Equity - Distribution should be based generally on the amount contributed to capital. Remuneration or profit distribution may not be related to patient referrals.

(5) Disclosure of Ownership Interest - A physician or other health care professional or provider with an ownership interest in a medical or other health care facility or service to which the physician refers patients must disclose to the patients this ownership interest. A general disclosure can be made in a manner which is appropriate to his or her practice situation.

(6) Request for Care - Each patient of a physician with an ownership interest (or whose immediate family member has an interest) must be provided with a physician's request for ancillary care to enable the patient to select a facility for such care. However, in accordance with the physician's ethical responsibility to provide the best care for the patient, the physician must be free to recommend what in the physician's judgment is the most appropriate facility, including his or her own facility.

(7) Notification of Ownership Interest to Payer - If the physician (or immediate family member) has an ownership interest in a medical or health care facility or service to which he or she refers patients who are Medicare beneficiaries, this physician should identify the ownership interest on the Medicare claim form. If the Medicare carrier detects a pattern suggesting inappropriate utilization, the matter could be referred to the PRO for follow-up pursuant to the existing PRO review process. Such PRO review would have to be conducted in a uniformly fair, open-minded manner.

(8) Internal Utilization Review Program - Each medical facility with referring physician owners (or immediate family members) must have an internal utilization review program to monitor referrals by such physicians. Regular reports from this internal program should be made available to the Medicare carrier on request.

(9) Compliance with Standards - Failure to comply with any one individual standard or compliance with all the standards, in and of itself, would not be sufficient to find that the arrangement is illegal. The entire arrangement needs to be examined to determine whether it is merely a sham arrangement to conceal a kickback scheme or whether it is "legal." Failure to comply with standards would subject the HCS investment arrangement to further scrutiny. (BOT Rep. ZZ, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 201, I-00; Reaffirmation A-02; Reaffirmation I-04)

H-140.989 Informed Consent and Decision-Making in Health Care

(1) Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.

(2) Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the patient.

(3) A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.

(4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or others.

(5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.

(6) A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.

(7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 408, A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07)

H-140.996 Reaffirmation of Professionalism

Our AMA believes that the primary mission of the physician is to use his best efforts and skill in the care of his patients and to be mindful of those forces in society that would erode fundamental ethical medical practice. The AMA House of Delegates, Board of Trustees, staff, and membership rededicate themselves to professionalism such that it permeates all activities and is the defining characteristic of the AMA's identity. (Res. 129, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Appended by Rep. of the Ad Hoc Committee to Study the Sunbeam Matter, A-98; Reaffirmed: CEJA Rep. 11, A-08)

H-140.997 Patient Advocacy

Our AMA believes that physicians are the primary patient advocates, are not rationers of medical care, and will continue to utilize diagnostic and therapeutic measures and facilities in the best interest of the individual patient. (Res. 146, A-84; Reaffirmed: BOT Rep. I-93-25; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CEJA Rep. 2, A-04; Reaffirmation A-05)

H-140.999 Our AMA and Bioethics

Our AMA requests official representation on any federal advisory committee or commission dealing with ethical issues of interest to medicine. (Res. 39, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CEJA Rep. 2, A-04)

H-145.000 Firearms: Safety and Regulation

H-145.978 Gun Safety

Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed. (Res. 425, I-98; Reaffirmed: Res. 409, A-00)

H-145.979 Prevention of Unintentional Shooting Deaths Among Children

Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law. (Res. 204, I-98)

H-145.982 Prevention of Ocular Injuries from BB and Air Guns

The AMA encourages businesses that sell BB and air guns to make appropriate and safe protective eye wear available and encourages its use to their customers and to distribute educational materials on the safe use of non-powder guns. (Res. 416, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-145.983 School Violence

The AMA encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property. (Sub. Res. 402, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-145.984 Data on Firearm Deaths and Injuries

The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System. (Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04)

H-145.985 Ban on Handguns and Automatic Repeating Weapons

It is the policy of the AMA to: (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions

should include but not be limited to:
(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 18;
(c) the imposition of significant licensing fees for firearms dealers;
(d) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
(e) mandatory destruction of any weapons obtained in local buy-back programs.

(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.

(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls. (BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-145.987 Funding for Hunter Safety Education Programs and Wildlife Restoration

The AMA supports continuation of using at least a portion of excise tax funds collected on a variety of firearms and ammunition for hunter safety education programs and wildlife restoration. (Sub. Res. 234, I-93; Reaffirmed: CLRPD Rep. 5, A-03)

H-145.988 AMA Campaign to Reduce Firearm Deaths

The AMA, as part of its campaign against violence, will publicize information to educate the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home. (Res. 410, A-93; Reaffirmed: CLRPD Rep. 5, A-03)

H-145.989 Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns

It is the policy of the AMA to encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the safe use of as well as the dangers inherent in the unsafe use of nonpowder (gas-loaded/spring-loaded) guns and incorporate these into ongoing initiatives. (Res. 423, I-91; Modified: Sunset Report, I-01)

H-145.990 Prevention of Firearm Accidents in Children

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms;(2) encourages state medical societies to work with other organizations to increase public education about firearm safety; and (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children. (Res. 165, I-89; Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00)

H-145.991 Gun Control

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country. (Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07)

H-145.992 Waiting Period Before Gun Purchase

The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S. (Res. 171, A-89; Reaffirmed: BOT Rep.50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07)

H-145.993 Restriction of Assault Weapons

Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon. (Sub. Res. 264, A-89; Reaffirmed: BOT Rep. 50, I-93; Amended: Res.215, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07)

H-145.994 Control of Non-Detectable Firearms

The AMA supports a ban on the manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices. (Sub. Res. 79, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-145.995 Ban Realistic Toy Guns

The AMA supports (1) working with civic groups and other interested parties to ban the production, sale, and distribution of realistic toy guns; and (2) taking a public stand on banning realistic toy guns by various public appeal methods. (Sub. Res. 140, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-145.996 Handgun Availability

The AMA (1) advocates a waiting period and background check for all handgun purchasers; (2) encourages legislation that enforces a waiting period and background check for all handgun purchasers; and (3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices. (Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-145.997 Firearms as a Public Health Problem in the United States - Injuries and Death

Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms; and
(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention. (CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07)

H-145.999 Gun Regulation

Our AMA supports stricter enforcement of present federal and state gun control legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm. (Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07)

H-150.000 Foods and Nutrition

H-150.941 Banning the Use of Artificial Trans Fats in Restaurants and Bakeries in the United States

Our AMA supports state and federal legislation that bans the use of artificial trans fats in restaurants and bakeries in the United States. (Res. 210, I-08)

H-150.942 Rating System for Processed Foods

Our AMA supports the concept of a simplified, uniform nutrition rating system to be used in addition to the current food label. (Res. 407, A-08)

H-150.943 Reducing Trans Fats

Our AMA encourages and promotes the reduction of trans fats in the American diet in order to maintain good health and lower the incidence of coronary artery disease and will issue a statement that when trans fats are removed from foods, healthier fats or oils should be substituted. (Res. 430, A-07)

H-150.944 Combating Obesity and Health Disparities

Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their

constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of products low in fat and cholesterol. (Res. 413, A-07)

H-150.945 Nutrition Labeling and Nutritionally Improved Menu Offerings in Fast-Food and Other Chain Restaurants

Our AMA:
1. supports federal, state, and local policies to require fast-food and other chain restaurants with 10 or more units (smaller, neighborhood restaurants could be exempt) to provide consumers with nutrition information on menus and menu boards;
2. recommends that nutrition information in fast-food and other chain restaurants include calorie, fat, saturated fat and trans fat, and sodium labeling on printed menus, and, at a minimum, calories on menu boards, since they have limited space, and that all nutrition information be conspicuous and easily legible;
3. urges federal, state, and local health agencies, health organizations, and physicians and other health professionals to educate people how to use the nutrition information provided in restaurants to make healthier food choices for themselves and their families; and
4. urges restaurants to improve the nutritional quality of their menu offerings--for example, by reducing caloric content; offering smaller portions; offering more fruits, vegetables, and whole-grain items; using less sodium; using cooking fats lower in saturated and trans fats; and using less added sugars/sweeteners. (Res. 419, A-07)

H-150.946 Advertising for Herbal Supplements

It is AMA policy that the naming, packaging, and advertising of dietary supplement products be such that they cannot be confused with pharmaceutical products. (Sub. Res. 504, A-05)

H-150.947 Mercury and Fish Consumption: Medical and Public Health Issues

AMA policy is that:
(1) Women who might become pregnant, are pregnant, or who are nursing should follow federal, state or local advisories on fish consumption. Because some types of fish are known to have much lower than average levels of methylmercury and can be safely consumed more often and in larger amounts, women should also seek specific consumption recommendations from those authorities regarding locally caught or sold fish.
(2) Physicians should (a) assist in educating patients about the relative mercury content of fish and shellfish products; (b) make patients aware of the advice contained in both national and regional consumer fish consumption advisories; and (c) have sample materials available, or direct patients to where they can access information on national and regional fish consumption advisories.
(3) Testing of the mercury content of fish should be continued by appropriate agencies; results should be publicly accessible and reported in a consumer-friendly format.
(4) Given the limitations of national consumer fish consumption advisories, the Food and Drug Administration should consider the advisability of requiring that fish consumption advisories and results related to mercury testing be posted where fish, including canned tuna, are sold. (CSA Rep. 13, A-04; Modified: Res. 538, A-05)

H-150.948 Increasing Customer Awareness of Nutrition Information and Ingredient Lists in Restaurants

Our AMA supports and seeks federal legislation or rules requiring (1) restaurants that have menu items common to multiple locations to provide standard nutrition labels for all applicable items, available for public viewing; and (2) all school and work cafeterias and restaurants to have ingredient lists for all menu items, available for public viewing. (Sub. Res. 411, A-04; Reaffirmation A-07)

H-150.949 Healthy Food Options in Hospitals

Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on hospital premises. (Res. 410, A-04)

H-150.950 Regulation of Meat Plants that Process Wild Game

Our AMA asks the United States Department of Agriculture, the Food and Drug Administration, and the Department of Health and Human Services to (1) investigate potential cross-contamination of commercial meat products and wild game in facilities that process both wild game and commercial meats; and (2) develop methods to ensure that facilities and equipment used to process wild game and commercial meat products do not allow cross-contamination of either with a particular focus on the potential transmission of prion-related and other diseases with long incubation periods (Sub. Res. 401, A-03; Reaffirmed: CSA Rep. 3, A-05)

H-150.951 Dietary Supplements Containing Ephedra Alkaloids

Our AMA continues to advocate for the removal of dietary supplement products containing ephedra alkaloids from the market in the United States. (BOT Rep. 25, A-03)

H-150.952 Point-of-Sale Warning Signs Regarding Consumption of Raw Shellfish

Our AMA advocates regulations requiring point-of-sale warnings concerning foodborne illness wherever raw, unpasteurized shellfish is purchased or served for consumption. (Res. 406, I-99)

H-150.953 Obesity as a Major Public Health Program

Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;
(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;
(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;
(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;
(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;
(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;
(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and
(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity. (CSA Rep. 6, A-99)

H-150.954 Dietary Supplements and Herbal Remedies

(1) Our AMA will work with the FDA to educate physicians and the public about FDA's MedWatch program and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.

(2) Our AMA continues to urge Congress to modify the Dietary Supplement Health and Education Act to require that (a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy; (b) meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling; (c) meet FDA postmarketing requirements to report adverse events, including drug interactions; and (d) pursue the development and enactment of legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement.

(3) Our AMA work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements.

(4) That the product labeling of dietary supplements and herbal remedies contain the following disclaimer as a minimum requirement: "This product has not been evaluated by the Food and Drug Administration and is not intended to diagnose, mitigate, treat, cure, or prevent disease." This product may have significant adverse side effects and/or interactions with medications and other dietary supplements; therefore it is important that you inform your doctor that you are using this product.

(5) That in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.

(6) Our AMA continue its efforts to educate patients and physicians about the possible ramifications associated with the use of dietary supplements and herbal remedies. (Res. 513, I-98; Reaffirmed: Res. 515, A-99; Amended: Res. 501 & Reaffirmation I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 516, I-00; Modified: Sub. Res. 516, I-00; Reaffirmed: Sub. Res. 518, A-04; Reaffirmed: Sub. Res. 504, A-05; Reaffirmation A-05; Reaffirmed in lieu of Res. 520, A-05)

H-150.959 Risk of Transmission of Bovine Spongiform Encephalopathy to Humans in the United States

The AMA: (1) supports the current FDA guidance/regulations regarding the treatment of products from bovine sources destined for

human utilization, and the treatment of blood products from potential Creutzfeld-Jakob disease (CJD) donors;
(2) recommends the FDA and the United States Department of Agriculture (USDA) continue to aggressively enforce regulations in place to prevent the occurrence/transmission of bovine spongiform encephalopathy (BSE) in the United States;
(3) recommends the FDA, USDA, and Department of Health and Human Services continue to evaluate scientific data on transmissible spongiform encephalopathies (TSEs) and incorporate this information into their guidance and regulations;
(4) recognizes that the public may be concerned about BSE risks; therefore, the AMA recommends that physicians become knowledgeable about BSE so that they can appropriately advise their patients about routes and risks of BSE transmission, especially that the consumption of brain and spinal cord from infected animals would carry the highest risk of transmission to humans, and that persons who are travelling abroad should refrain from consuming brain and spinal cord from cattle unless they know that the countries in which they are traveling are free of BSE;
(5) recommends increased surveillance of new CJD cases as they arise in order to monitor for the possible appearance of new variant Creutzfeldt-Jakob disease (nv-CJD) via: (a) Referral of all deaths due to suspected CJD to an appropriately qualified pathologist for autopsy, with the submission of autopsy reports of confirmed cases to the Prion Disease Pathology Surveillance Center at Case Western Reserve University, which is collaborating with the CDC. (b) Reporting of the diagnosis of CJD on the death certificate in all cases and the strengthening of the current system enabling health authorities to obtain clinical or pathologic data on the CJD cases of greatest public health concern. (c) Prompt notification of any case of new variant Creutzfeldt-Jakob disease to both the appropriate state health department and the CDC; and
(6) recommends that well-controlled research be performed in the following areas: (a) Elucidation of the mechanism of disease of TSEs; (b) Elucidation of the infectivity, dose requirements, and clearance of the disease agent to provide more data for adequate risk analyses of disease transmission; (c) The risk of transmission via blood and blood products; (d) Alternatives to the use of bovine-derived products in drug manufacture and other biologic industries; (e) Antemortem diagnosis of BSE and nv-CJD and the detection and inactivation of the disease agent in blood supplies. (CSA Rep. 6, A-98; Reaffirmed: CSA Rep. 3, A-05)

H-150.960 Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools

The AMA supports the position that primary and secondary schools should replace foods in vending machines and snack bars, which are of low nutritional value and are high in fat, salt and/or sugar, with healthier food choices which contribute to the nutritional needs of the students. (Res. 405, A-94; Reaffirmation A-04; Reaffirmed in lieu of Res. 407, A-04; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07)

H-150.961 Irradiation of Food

It is the policy of the AMA to: (1) affirm food irradiation as a safe and effective process that increases the safety of food when applied according to governing regulations; (2) consider the value of food irradiation to be diminished unless it is incorporated into a comprehensive food safety program based on good manufacturing practices and proper food handling, processing, storage, and preparation techniques; (3) encourage the FDA and the U.S. Department of Agriculture to continue the requirement that all irradiated fruits, vegetables, meats, and seafood carry the international logo that has become recognized as indicating that the food has been subjected to gamma irradiation; and (4) affirm the principle that the demonstration of safety requires evidence of a reasonable certainty that no harm will result but does not require proof beyond any possible doubt (i.e., "zero" risk does not exist). (CSA Rep. 4, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-150.962 Quality of School Lunch Program

The AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines. (Sub. Res. 507, A-93; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-07)

H-150.964 Availability of Heart-Healthy and Health-Promoting Foods at AMA Functions

The AMA and its constituent medical societies strive to make heart-healthy and other health-promoting foods available as options at all functions. (Res. 406, I-92; Reaffirmed: CLRPD Rep. 5, A-03)

H-150.965 Eating Disorders

The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as is obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for interventional counseling; and (4) participates in this effort by consulting with appropriate specialty societies and by assisting in the dissemination of appropriate educational and counseling materials pertaining to unhealthy eating, dieting, and weight restrictive behaviors. (Res. 417, A-92; Appended by Res. 503, A-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

H-150.966 FDA Regulations Regarding the Inclusion of Added L-Glutamic Acid Content on Food Labels

Until such time as L-glutamic acid in any form has been shown to pose a significant public health hazard or until biological non-equivalence of monosodium glutamate and L-glutamate has been demonstrated, the AMA supports the exclusion of L-glutamic acid released from hydrolyzed protein from food product labeling requirements. (CSA Rep. D, A-92; Reaffirmed: CSA Rep. 8, A-03)

H-150.967 Food Safety - Federal Inspection Programs

Our AMA encourages the FDA and the U.S. Department of Agriculture to continue their efforts to assure the safety of the food supply. Inspection of meat, poultry, and seafood should be viewed as one component of an overall program for improving food safety. (CSA Rep. L, I-91; Reaffirmed: Sunset Report, I-01)

H-150.969 Commercial Weight-Loss Systems and Programs

It is the policy of the AMA to (1) continue to cooperate with appropriate state and/or federal agencies in their investigation and regulation of weight-loss systems and programs that are engaged in the illegal practice of medicine and/or that pose a health hazard to persons to whom they sell their services; (2) continue to provide scientific information to physicians and the public to assist them in evaluating weight-reduction practices and/or programs; and (3) encourage review of hospital-based weight-loss programs by medical staff. (CSA Rep. A, A-91; Reaffirmed: Sunset Report, I-01)

H-150.971 Food Labeling and Advertising

Our AMA believes that there is a need for clear, concise and uniform labeling on food products and supports the following aspects of food labeling:
(1) Required nutrition labeling for all food products that includes a declaration of carbohydrates, protein, total fat, total saturated and polyunsaturated fatty acids, cholesterol, sodium and potassium content, and number of calories per serving.

(2) Use of and/or ingredient labeling to declare the source of fats and oils. Knowledge of the degree of saturation is more important than knowing the source of oils in food products. It is not uncommon for manufacturers to use blends of different oils or to hydrogenate oils to achieve specific functional effects in foods. For example, vegetable oils that are primarily unsaturated may be modified by hydrogenation to more saturated forms that bring about desired taste, texture, or baking characteristics. This recommendation is therefore contingent upon nutrition labeling with saturated fat content.

(3) The FDA's proposed rule on food labeling that requires quantitative information be provided on both fatty acid and cholesterol content if either one is declared on the label, as an interim step.

(4) Warning statements on food labels are not appropriate for ingredients that have been established as safe for the general population. Moreover, the FDA has not defined descriptors for foods that are relatively higher in calories, sodium, fat, cholesterol, or sugar than other foods because there are no established scientific data indicating the level at which any of these substances or calories would become harmful in an individual food.

(5) Our AMA commends the FTC for its past and current efforts and encourages the Commission to monitor misleading food advertising claims more closely, particularly those related to low sodium or cholesterol, and health claims.

(6) Our AMA supports the timely approval of the Food and Drug Administration’s proposed amendment of its regulations on nutrition labeling to require that the amount of trans fatty acids present in a food be included in the amount and percent daily value, and that definitions for "trans fat free" and "reduced trans fat" be set. (BOT Rep. C, A-90; Reaffirmed: Sunset Report, I-00; Appended: Res. 501, A-02; Reaffirmation A-04; Reaffirmed in lieu of Res. 407, A-04)

H-150.973 AMA Support for Cholesterol Screening

Our AMA supports collaborating with organizations involved in nutrition education to promote physician awareness of the impact of diet on cholesterol levels. (Res. 258, A-89; Reaffirmed: Sunset Report, A-00)

H-150.975 Dangerous Health and Diet Books

The AMA supports study of effective and appropriate ways in which to educate physicians and the American public about the dangers of various diets and health fads. (Res. 181, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-150.979 Fast Food

The AMA encourages fast food restaurants to reduce the saturated fat content of their foods, as well as to offer low fat alternatives to

highly saturated fat foods. (Sub. Res. 123, A-86; Amended by Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-150.980 Milk and Human Health

The AMA reaffirms its policy that all milk sold for human consumption should be required to be pasteurized. (Sub. Res. 67, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-150.986 Labeling of Soft Drink Sweeteners

The AMA believes that all sweetening agents used in soft drinks should be clearly labeled on the containers. (Sub. Res. 37, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04)

H-150.988 Caffeine Labeling

The AMA (1) supports a continued review of the safety of dietary caffeine intake; (2) supports continued efforts to disseminate information to the public and physicians on the caffeine content of food and beverages; and (3) will work with the FDA to ensure that, when caffeine is added to a product, the label reflects this in prominent letters and the amount of caffeine in the product be written on the label. (CSA Rep. E, I-83; CLRPD Rep. 1, I-93; Modified by Res. 523, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-150.989 Weight Loss Clinics

The AMA encourages any person considering participation in a weight loss program to first consult his or her regular attending physician, or any other independent physician, for a physical examination and an objective professional evaluation of the proposed weight loss program as it relates to the individual's physical condition. (Res. 59, A-83; CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-150.990 Sodium in Processed Foods

Our AMA (1) encourages physicians to reinforce the profession's public education programs when counseling their patients; and (2) supports the efforts of food industries to achieve useful reductions in the sodium content of processed food, without compromising their safety or nutritive values. (CSA Rep. G, A-82; Amended: CLRPD Rep. A, I-92; Reaffirmed: Res. 408, A-01)

H-150.992 Nutritive Quality of Processed Foods

(1) The nutritional quality of foods and beverages can be enhanced by the addition of specific nutrients. In the United States, the Recommended Dietary Allowances provide a goal for good nutrition and form a basis for quantitative considerations when improvement of the nutritive quality of foods is deemed desirable.

(2) Addition of nutrients is accomplished through the techniques of restoration and fortification. Restoration of nutrients to conventional processed food helps assure that levels present in the food are similar to nutrient levels present in the original product and is a method used to prevent nutritional inadequacies in the population. Fortification is the addition of nutrients that initially were not present in the food or were present in nutritionally insignificant amounts. It is a technique that can be used when intervention is necessary to correct a demonstrated deficiency in an identified segment of the population.

(3) Important guidelines for both restoration and fortification include considerations of stability and bioavailability of the nutrient to be added as well as reasonable cost. Guidelines for restoration require that the product be an important source of the nutrient to be restored. Guidelines for sound fortification policies require knowledge of national dietary patterns and of the nutritional status of the population. Thus, an urgent need exists for thorough and current analyses of variations in dietary patterns and nutritional status in the United States.

(4) Many formulated foods have easily identifiable dietary counterparts that can serve as guides for decisions on the addition of nutrients in conformance with the guidelines established in this statement. When foods have no easily identifiable counterpart, the nutrient density concept can serve as a reasonable guide for nutrient additions. (CSA Rep. E, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-150.993 Medical Education in Nutrition

The AMA recommends that instruction on nutrition be included in the curriculum of medical schools in the United States. (Sub. Res. 82, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: CME Rep. 3, I-97; Reaffirmed: CME Rep. 2, A-07)

H-150.994 Food Safety and the Food, Drug, and Cosmetic Act (Delaney Clause)

Our AMA supports the development of alternative proposals to substitute for the Delaney Clause of the Food, Drug, and Cosmetic Act and supports advising Congress that (1) the current Food, Drug, and Cosmetic Act limits the ability of regulatory agencies to exercise judgment and thereby make comparative risk or risk/benefit assessments for food additives as a part of the decision-making process; (2) the Food, Drug, and Cosmetic Act should be amended to require consideration of the concept of alternative risks before requiring the banning of substances suspected of being carcinogenic; and (3) eligibility of a substance for consideration by the regulatory agency as an acceptable food substance should be based upon the best scientific data available on the usefulness, function, uniqueness, health need for, and potential risk of the substance. (CSA Rep. A, I-79; Reaffirmed: CLRPD B, I-89; Reaffirmed: Sunset Report, A-00)

H-150.995 Basic Courses in Nutrition

Our AMA encourages effective education in nutrition at the undergraduate, graduate, and postgraduate levels. (Sub. Res. 116, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-150.996 Nutrition Courses in Medicine

Our AMA recommends the teaching of adequate nutrition courses in elementary and high schools and that the LCME work toward enhancement of the teaching of nutrition in medical schools. (Sub. Res. 66, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-150.997 Excess Sodium in the Diet

Our AMA supports continued use of its publications to inform the public of foods containing high sodium levels, and the relationship of sodium intake to the potential development and control of hypertension. (Sub. Res. 22, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 408, A-01)

H-150.998 Delaney Amendment (Food Additives)

Our AMA supports the passage of legislation that would amend the Food Additive Act to require evidence based upon scientifically reproducible studies of the association of food additives with an increased incidence of cancer in animals or humans at dosage levels related to the amounts calculated as normal daily consumption for humans before removal of an additive from the market. (Sub. Res. 4, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-155.000 Health Care Costs
(See also: Drugs: Cost; Health Care Delivery; Health Care Reform; Managed Care)

H-155.959 Legislation to Reduce Administrative Waste in Health Insurance by Accurate Reporting of Medical Expense Ratios

AMA policy is that private health plans should be required to report data related to administrative costs, expenses and rate setting to appropriate state regulatory bodies to allow for the calculation of medical expense ratios to be consistent on the state level. (Res. 727, A-08)

H-155.960 Strategies to Address Rising Health Care Costs

Our AMA:

(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;

(2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease; (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and
(d) promote "value-based decision-making" at all levels;

(3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;

(4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-

effectiveness information to physicians and other health care decision-makers;

(5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;

(6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;

(7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are reduced for maintenance medications used to treat chronic medical conditions, particularly when non-compliance poses a high risk of adverse clinical outcome and/or high medical costs. Consideration should be given to tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and

(8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care. (CMS Rep. 8, A-07; Reaffirmed: CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 828, I-08)

H-155.961 Transparency of Employer Sponsored Health Insurance

Our AMA encourages employers to inform employees as frequently as possible, preferably with each payment period (pay stub) but at least annually, of the total cost of health insurance benefits paid on their behalf by the employer in the form of health insurance premiums, direct payments for services and deposits into health savings accounts. (Res. 127, A-07)

H-155.962 Maximum Allowable Cost of Prescription Medications

Our AMA opposes the use of price controls in any segment of the health care industry, and continues to promote market-based strategies to achieve access to and affordability of health care goods and services. (CMS Rep. 2, A-07)

H-155.963 Health System Expenditures

1. Our AMA supports the development and adoption of a consistent format for estimating and publicly reporting health care administrative costs, in order to facilitate unbiased comparisons across insurers, and from different sources. The format would:

(a) Report all government expenditures for the administration of Medicare, Medicaid, and other public programs, including those incurred but not currently reported by the Centers for Medicare and Medicaid Services (CMS) and state Medicaid agencies (e.g., staff salaries, building costs, promotion of benefits to beneficiaries);

(b) Report all government expenditures for administration of Medicare, Medicaid, and other public programs that are incurred by all government entities, including agencies other than the CMS and state Medicaid agencies (e.g., Inspector General audits, Social Security Administration revenue collection);

(c) Identify and report those overhead expenditures that can be defined as either administrative or non-administrative (e.g., profits and retained earnings);

(d) Identify and report those overhead expenditures that arise from legislative or regulatory requirements (e.g., compliance expenses, premium taxes);

(e) Express administrative expenditures in the following metrics: dollars per-member-per-month, dollars per claim, percentage of total expenditures, and percentage of total claims payments.

(f) Serve as a model and template for private health plan reporting of administrative costs at the state level and to national databases.

2. Our AMA supports efforts to educate the medical profession and the public about health care costs, including administrative costs and the costs of defensive medicine. (CMS Rep. 1, A-06; Reaffirmation A-07; Res. 727, A-08; Reaffirmation I-08)

H-155.965 Health Care Rationing

The AMA defines "health care rationing" as follows: "a process of allocating health care resources that results in limitations or denials of medical services." (BOT Rep. 38, I-93; Reaffirmed: CMS Rep. 7, A-05)

H-155.966 Controlling Cost of Medical Care

The AMA urges the American Hospital Association and all hospitals to encourage the administrators and medical directors to provide to the members of the medical staffs, housestaff and medical students the charges for tests, procedures, medications and durable medical equipment in such a fashion as to emphasize cost and quality consciousness and to maximize the education of those who order these items as to their costs to the patient, to the hospital and to society in general. (Sub. Res. 75, I-81; Reaffirmed: CLRPD Rep. F, I-91; Res. 801, A-93; CMS Rep. 12, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation A-08)

H-155.970 Cost-Cutting Decisions by Third Party Payers

Our AMA strongly opposes, and will take appropriate action as necessary to restrict, third party payer cost-containment strategies that jeopardize patient health and the quality of care. (Sub. Res. 709, I-92; Reaffirmed: Res. 720, A-02; Reaffirmation A-05; Reaffirmation I-06)

H-155.974 Excessive Regulatory Costs

Our AMA will: (1) support actively seeking reduction in regulatory requirements such as record review, length-of-stay review, insurance requirements and form completion, and diagnosis coding for physicians and hospitals,

(2) vigorously oppose future regulatory requirements for physicians and hospitals that are not compensated;

(3) seek through appropriate legislative channels support for an Economic Impact Statement requirement for all legislation and regulation affecting the delivery of medical care and that the increased cost be reflected in the RBRVS value; and

(4) advocate that all governmental health care cost containment activities must simultaneously evaluate and report the total costs associated with their activities, and that government, federal, state and local, join the medical profession and hospitals in their efforts to contain the cost of health care, by reducing the number of regulations, reports, and forms. (Res. 125, A-79; Reaffirmed: CLRPD Rep. B, I-89; Res. 54, I-90; Res. 147, I-90; Res. 135, A-92; CMS Rep. 12, A-95; Reaffirmation A-00; Reaffirmed: BOT Rep. 25, I-01; Reaffirmation A-02)

H-155.976 Administrative Costs and Access to Health Care

Our American Medical Association supports accurate calculations of the administrative costs of government programs (Medicare, Medicaid, TRICARE, etc.) and private health insurance plans. It is the policy of the AMA:

(1) to begin immediately to seek comprehensive reforms to reduce the administrative inefficiencies, burdens and expenses involved in paying for health care services and to urge that proposals to increase access to health care also address the need to reduce administrative costs and burdens;

(2) that state and county medical societies and national medical specialty societies be urged to utilize the joint Guidelines for Health Benefits Administration in discussions with health care payers directed toward improving the efficiency of utilization management programs and minimizing the administrative burdens they impose on physicians and hospitals;

(3) that the AMA strongly encourage further study of the cost-effectiveness of all types of utilization management systems and programs and report further results of such study to the Federation as they become available;

(4) that state medical societies be urged to work for enactment of the AMA model state legislation governing: (a) clarity and readability of contract language and uniform policy provisions; (b) liability of review entities for injury to beneficiaries; (c) physician involvement in the review process; and (d) confidentiality of medical information requested by review entities; and

(5) that this information be conveyed to the American public through appropriate mechanisms. (Res. 202, A-90; CMS Rep. A, A-90; Reaffirmed: BOT Rep. 40, I-93; CMS Rep. 12, A-95; Appended: Res. 715, I-02; Reaffirmation A-07; Reaffirmed in lieu of Res. 828, I-08)

H-155.978 Correcting Misinformation on Health Care Costs and Spending

It is the policy of the AMA to continue to use press releases, press conferences, and appropriate paid advertising to inform the public of the reasonableness of health care costs and their increases, with such information to include (a) the similarity of increases in medical and non-medical costs when increases in population served and intensity of service are considered, and (b) the importance of healthy lifestyle choices. (Sub. Res. 18, A-90; Res. 56, A-91; CMS Rep. O, A-92; Reaffirmed in lieu of Res. 811, I-93; CMS Rep. 12, A-95; Reaffirmed and Modified: CMS Rep. 7, A-05)

H-155.979 Future Health Care Costs

It is the policy of the AMA to study projections of future health care costs and assist society in prioritizing services. (Res. 33, A-90; Modified: Sunset Report, I-00)

H-155.980 Patient and Public Education about Cost of Care

The AMA, as a part of its program to strengthen the US health care system, supports (1) intensifying its efforts to better understand patient concerns regarding fees and other costs of health care in all settings, including the cost of medication, and supports attempts to relieve these concerns; and (2) conducting a public education program that clearly identifies the elements of medical care expenditures and those factors that lead to unwarranted, unavoidable or unproductive expenses not subject to physician control (e.g., an aging population, high health insurance administrative costs, inappropriate applications of technology and unneeded hospital beds). (Res. 153, I-89; Sub. Res. 42, I-89; Reaffirmed in lieu of Res. 811, I-93; CMS Rep. 12, A-95; Reaffirmed: CMS Rep. 7, A-05)

H-155.985 Fairness in Cost Containment

Our AMA (1) supports continued efforts, at all appropriate opportunities and as one of its highest priorities, to seek remedies eliminating any discriminatory treatment against physicians;
(2) supports continued and intensified efforts to promote voluntary health care cost containment without compromising quality of care;
(3) believes that any cost containment recommendations or activities adopted by the AMA should be applied equally to federal and state hospitals, facilities and medical programs and government administrative mechanisms;
(4) urges a similar commitment to cost containment I governmental health care facilities; and
(5) urges government to acknowledge and minimize the adverse impact that governmental controls have on health care cost. Our AMA supports and will seek (a) legislation to require that medical programs administered by all federal government agencies, exclusive of military health care systems, make publicly available annually, and publish separately, their medical care costs and their administrative costs; and (b) legislation to require that federal agencies, exclusive of military health care systems, provide a fiscal impact report on any proposed new program or modifications to present programs, clearly demonstrating how the cost of care will be reduced or the quality improved, and the expected effect of such new or altered programs on the providers of the services. (Res. 61, A-78; Res. 29. A-78; Res. 53, A-80; BOT Rep. QQ, I-86; Reaffirmed: CLRPD Rep. C, A-89;Reaffirmed: CLRPD Rep. B, I-90; CMS Rep. 12, A-95; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation A-02)

H-155.988 Public Health and Safety Awareness

The AMA believes that attention to personal health and safety can dramatically improve well-being and reduce health care costs. (Res. 42, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CMS Rep. 5, A-04)

H-155.993 Increases in the Costs of Medical Care

Our AMA recognizes that medical and health care costs have increased in part because of the increased demand for services as a result of third party payment, the number of regulations generated by federal and state agencies, professional liability insurance premiums, and because of deficit spending by the federal government. (Res. 103, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-155.994 Sharing of Diagnostic Findings

The AMA (1) urges all physicians, when admitting patients to hospitals, to send pertinent abstracts of the patients' medical records, including histories and diagnostic procedures, so that the hospital physicians sharing in the care of those patients can practice more cost-effective and better medical care; (2) urges the hospital to return all information on in-hospital care to the attending physician upon patient discharge; and (3) encourages providers, working at the local level, to develop mechanisms for the sharing of diagnostic findings for a given patient in order to avoid duplication of expensive diagnostic tests and procedures. (BOT Rep. A, NCCMC Rec. 26, A-78; Sub. Res. 115, I-78; Reaffirmed: CLRPD Rep. C, A-89; CMS Rep. 12, A-95; Reaffirmed: CMS Rep. 7, A-05)

H-155.998 Voluntary Health Care Cost Containment

(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature.
(2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient.
(3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including housestaff officers, on all aspects of hospital charges, including specific medical tests, procedures, and all ancillary services.

(4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum.
(5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care.
(6) The AMA, assisted by the American Hospital Association, should inform physicians of the actual costs of the services they order for patients and join with their patients in decisions regarding the most cost effective use of health care resources; and should form a coalition with the AHA and third party payers for the purpose of enabling physicians and patients to make cost effective choices for quality medical services.
(7) All physicians, practicing solo or in groups, independently or in professional association, should review their professional charges and operating overhead with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs.
(8) The AMA, as a part of the public communications activities of the Campaign to Strengthen the U.S. Health Care System and other appropriate communications efforts, should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care. (Res. 34, A-78; Reaffirmed: CLRPD Rep. C, A-89; Res. 100, I-89; Res. 822, A-93; Reaffirmed: BOT Rep. 40, I-93; CMS Rep. 12, A-95; Reaffirmed: Res. 808, I-02)

H-160.000 Health Care Delivery
(See also: Health Care Reform; Health Insurance; Health Maintenance Organizations; Preferred Provider Arrangements)

H-160.919 Principles of the Patient-Centered Medical Home

Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows:

Principles

Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician Directed Medical Practice - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole Person Orientation - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

Evidence-based medicine and clinical decision-support tools guide decision making.

Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

It should support adoption and use of health information technology for quality improvement.

It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

It should recognize case mix differences in the patient population being treated within the practice.

It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

It should allow for additional payments for achieving measurable and continuous quality improvements. (Res. 804, I-08)

H-160.920 Financial Impact of Immigration on the American Health System

Our AMA supports legislative and regulatory changes to require the federal government to make reasonable payments to physicians for the federally mandated care they provide to patients, regardless of the immigration status of the patient. (CMS Rep. 3, A-07)

H-160.921 Store-Based Health Clinics

1. It is AMA policy that any individual, company, or other entity that establishes and/or operates store-based health clinics should adhere to the following principles:
a. Store-based health clinics must have a well-defined and limited scope of clinical services, consistent with state scope of practice laws.
b. Store-based health clinics must use standardized medical protocols derived from evidence-based practice guidelines to insure patient safety and quality of care.
c. Store-based health clinics must establish arrangements by which their health care practitioners have direct access to and supervision by MD/DOs, as consistent with state laws.
d. Store-based health clinics must establish protocols for ensuring continuity of care with practicing physicians within the local community.
e. Store-based health clinics must establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic.
f. Store-based health clinics must clearly inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as the limitation in the types of illnesses that can be diagnosed and treated.
g. Store-based health clinics must establish appropriate sanitation and hygienic guidelines and facilities to insure the safety of patients.
h. Store-based health clinics should be encouraged to use electronic health records as a means of communicating patient information and facilitating continuity of care.
i. Store-based health clinics should encourage patients to establish care with a primary care physician to ensure continuity of care.

2. Our AMA will continue to monitor the effects of store-based health clinics on the health care marketplace, and report back to the House of Delegates.

3. Health insurers and other third-party payers should be prohibited from waiving and/or lowering co-payments only for patients that receive services at store-based health clinics. (CMS Rep. 7, A-06; CMS Rep. 5, A-07)

H-160.922 Physician and Health Plan Provision of Uncompensated Care

The AMA: (1) continues to urge physicians to share in the provision of uncompensated care to the uninsured indigent.
(2) opposes any health plan-originated prohibition or discouragement of the provision of any uncompensated care by the plan's employed or participating physicians, in the absence of any external legislative or regulatory prohibition of such pro bono activities.
(3) supports legislation prohibiting health plan-originated attempts to prohibit the provision of any uncompensated care by the plan's employed or participating physicians.
(4) encourages physicians to contract wherever possible only with those health care delivery or financing plans that contribute in some way to care of the uninsured indigent and/or other community health needs, and that allow individual participating physicians to provide uncompensated care.
(5) encourages all health care delivery or financing plans that control the source of covered services and the amount of payment for such services, including plans owned or sponsored by physicians, to contribute to the care of the uninsured indigent or to other community health needs through such means as: (a) Offering direct plan enrollment to individuals and families lacking group coverage and/or offering special coverages or premium subsidies for older, lower-income, and/or less healthy populations; (b) Provision of preventive or basic care services to disadvantaged populations at reduced or no charge; (c) Health education programs for the community at large; and (d) Provision of professional staff services, training, equipment and/or other assistance to public health clinics, community health centers or other care resources serving the disadvantaged.
(6) encourages organizations and entities that accredit or develop and apply performance measures for health plans to consider inclusion of recognition for such contributions in their evaluation criteria.
(7) urges state medical societies to collect information on, recognize, and publicize the pro bono activities of health plans.
(8) encourages state medical societies to support development of state assistance with malpractice premiums, caps on liability, or immunity from liability for services provided to uninsured indigent patients.
(9) continues to support state legislation requiring diversion of assets to charitable causes by non-profit health plans converting to for-profit status. (CMS Rep. 4, A-96; Renumbered: CMS Rep. 7, I-05)

H-160.923 Offsetting the Costs of Providing Uncompensated Care

Our AMA:

(1) supports the transitional redistribution of public funds currently spent on uncompensated care provided by institutions for use in subsidizing private health insurance coverage for the uninsured;

(2) supports the use of innovative federal- or state-based projects that are not budget neutral, such as the Texas Designated Trauma Facility and Emergency Medical Services Account, for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and

(3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians. (CMS Rep. 8, A-05; Reaffirmation A-07)

H-160.924 Use of Language Interpreters in the Context of the Patient-Physician Relationship

AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care;

(2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive;

(3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid LEP patients' involvement in meaningful decisions about their care; and

(4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements. (BOT Rep. 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07)

H-160.925 Repeal of Office of Civil Rights Guidance Requiring Physicians to Pay for Translation Services

Our AMA strongly opposes and shall work to repeal the unfunded mandate imposed by the Department of Health and Human Services' Office of Civil Rights on physicians to pay for translation services for non-English speaking Medicare and Medicaid patients. (Sub. Res. 805, A-02)

H-160.926 Sharpening the Focus on Men's Health

Our AMA shall promote the idea that health care for men differs in many ways from the health care of women and encourage research and medical education to address the reasons for why men have a shorter life span, ways to engage men in their health care, and methods to improve access to care for men. (Res. 404, A-02)

H-160.927 Coerced Employment of Physicians

Our AMA urges individual physicians or physician groups that believe they are being coerced into specific employment arrangements to contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel. (CMS Rep. 4, A-99; Reaffirmation A-05)

H-160.928 Drug Initiation or Modification by Pharmacists

Our AMA opposes pharmacists being given the authority to initiate or modify prescription drug treatment except on a case by case basis at the specific direction of a physician. (Res. 509, A-99)

H-160.929 Anesthesiology is the Practice of Medicine

It is the policy of the AMA that anesthesiology is the practice of medicine. Our AMA seeks legislation to establish the principle in federal and state law and regulation that anesthesia care requires the personal performance or supervision by an appropriately licensed and credentialed doctor of medicine, osteopathy, or dentistry. (Sub. Res. 216, I-98)

H-160.930 Home Health Care

Our AMA takes the position that the attending physician should provide all initial orders for patient care (to include medication, lab and ancillary services) and request an evaluation of unique home environmental concerns by an appropriately qualified home care registered nurse with recommendations for additional forms of care for the physician's approval. This nursing assessment should include as a minimum a recommended plan of care, supplies or DME needs, frequency of visits by nurses, aides or other ancillary personnel, and shall be returned to the attending physician for approval. (Res. 812, A-98; Reaffirmed: CMS Rep. 4, A-08)

H-160.931 Health Literacy

Our AMA: (1) recognizes that limited patient literacy is a barrier to effective medical diagnosis and treatment;
(2) encourages the development of literacy appropriate, culturally diverse health-related patient education materials for distribution in the outpatient and inpatient setting;
(3) will work with members of the Federation and other relevant medical and nonmedical organizations to make the health care community aware that approximately one fourth of the adult population has limited literacy and difficulty understanding both oral and written health care information;
(4) encourages the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with patients who have limited literacy skills;
(5) encourages all third party payers to compensate physicians for formal patient education programs directed at individuals with limited literacy skills;
(6) encourages the US Department of Education to include questions regarding health status, health behaviors, and difficulties communicating with health care professionals in the National Adult Literacy Survey of 2002; and
(7) encourages the allocation of federal and private funds for research on health literacy. (CSA Rep. 1, A-98; Appended: Res. 415, I-99)

H-160.932 Asthma Control

The AMA: (1) encourages physicians to make appropriate use of evidence-based guidelines, including those contained in Expert Panel Report III: Guidelines for the Diagnosis and Management of Asthma released by the National Heart, Lung and Blood Institute; (2) encourages physicians to provide self-management education tailored to the literacy level of the patient by teaching and reinforcing appropriate self-monitoring, the use of a written asthma action plan, taking medication correctly, and avoiding environmental factors that worsen asthma; and (3) encourages physicians to incorporate the four components of care (assessment and monitoring; education; control of environmental factors and comorbid conditions; and appropriate medication selection and use). (CSA Rep. 4, A-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

H-160.935 Policy on Phone Counseling

The AMA recommends the following statements on phone counseling: (1) Medical phone counseling services must appoint a physician director. Such services are not absolved of that responsibility by a disclaimer to the callers. A physician director must be ultimately responsible for the telephone triaging of patients in a given system. (2) A physician director must be responsible for: (a) Providing and updating protocols and algorithms for phone counseling by non-physicians. (b) Identifying high-risk patients who must

be directly and immediately referred to physicians at all times. (c) Supervision and review of second-level triage provided by advanced nurse practitioners and physician assistants. (d) Ensuring permanent records of all calls received. (e) Maintaining accountability for the patient until a referral has been effected with an accepting physician. (3) Urges quality assurance programs be developed by national accrediting agencies that address issues raised by phone counseling centers. (BOT Rep. 2, A-97; Reaffirmed: CMS Rep. 9, A-07)

H-160.936 Comprehensive Physical Examinations by Appropriate Practitioners

AMA policy supports the position that performance of comprehensive physical examinations to diagnose medical conditions be limited to licensed MDs/DOs or those practitioners who are directly supervised by licensed MDs/DOs; and the AMA will actively work with state medical societies and medical specialty associations, both in the courts and in the legislative and regulatory spheres, to oppose any proposed or adopted law or policy that would inappropriately expand the scope of practice of practitioners other than MDs/DOs. (Sub. Res. 210, I-96; Reaffirmed: BOT Rep. 34, A-06)

H-160.937 The Promotion of Quality Telemedicine

(1) The AMA adopts the following principles for the supervision of nonphysician providers and technicians when telemedicine is used:

(a) The physician is responsible for, and retains the authority for, the safety and quality of services provided to patients by nonphysician providers through telemedicine.
(b) Physician supervision (e.g. regarding protocols, conferencing, and medical record review) is required when nonphysician providers or technicians deliver services via telemedicine in all settings and circumstances.
(c) Physicians should visit the sites where patients receive services from nonphysician providers or technicians through telemedicine, and must be knowledgeable regarding the competence and qualifications of the nonphysician providers utilized.
(d) The supervising physician should have the capability to immediately contact nonphysician providers or technicians delivering, as well as patients receiving, services via telemedicine in any setting.
(e) Nonphysician providers who deliver services via telemedicine should do so according to the applicable nonphysician practice acts in the state where the patient receives such services.
(f) The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services.
(g) Mechanisms for the regular reporting, recording, and supervision of patient care delivered through telemedicine must be arranged and maintained between the supervising physician, nonphysician providers, and technicians.
(h) The physician is responsible for providing and updating patient care protocols for all levels of telemedicine involving nonphysician providers or technicians.

(2) The AMA urges those who design or utilize telemedicine systems to make prudent and reasonable use of those technologies necessary to apply current or future confidentiality and privacy principles and requirements to telemedicine interactions.

(3) The AMA emphasizes to physicians their responsibility to ensure that their legal and ethical requirements with respect to patient confidentiality and data integrity are not compromised by the use of any particular telemedicine modality.

(4) The AMA advocates that continuing medical education conducted using telemedicine adhere to the standards of the AMA's Physician Recognition Award and the Essentials and Standards of the Accreditation Council for Continuing Medical Education. (CME/CMS Rep., I-96; Reaffirmed: CMS Rep. 8, A-06)

H-160.938 Disease-Specific Self-Management Programs

The AMA: (1) will work with invited medical groups to promote the physician-led team approach to disease-specific patient care as providing the highest quality of patient care; (2) insists that evidence-based disease -specific (eg, diabetes and asthma) education services and self-management training be initiated and continued under the direction of a physician; (3) believes all changes of care or medications by members of the team should be supervised by a physician; (4) will seek to have physician-directed benefits of evidence-based disease-specific education and self-management training provided to the beneficiaries of Medicare, Medicaid, other publicly supported programs, and all other payers; and (5) believes that status reports and all changes made by the disease-specific self-management team be transmitted in a timely fashion to the primary care physician, if the primary care physician is not the supervisor of the management team. (Sub. Res. 515, I-96; Amended by CSA Rep. 4, A-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-160.940 Free Clinic Support

The AMA supports organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics. (Sub. Res. 113, I-96; Reaffirmed: BOT 17, A-04)

H-160.942 Evidence-Based Principles of Discharge and Discharge Criteria

(1) The AMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process by following the principle that the needs of patients must be matched to settings with the ability to meet those needs.

(2) The AMA calls on physicians, specialty societies, insurers, and other involved parties to join in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients and that are flexible to meet advances in medical and surgical therapies and adapt to local and regional variations in health care settings and services.

(3) The AMA encourages incorporation of discharge criteria into practice parameters, clinical guidelines, and critical pathways that involve hospitalization.

(4) The AMA promotes the local development, adaption and implementation of discharge criteria.

(5) The AMA promotes training in the use of discharge criteria to assist in planning for patient care at all levels of medical education. Use of discharge criteria will improve understanding of the pathophysiology of disease processes, the continuum of care and therapeutic interventions, the use of health care resources and alternative sites of care, the importance of patient education, safety, outcomes measurements, and collaboration with allied health professionals.

(6) The AMA encourages research in the following areas: clinical outcomes after care in different health care settings; the utilization of resources in different care settings; the actual costs of care from onset of illness to recovery; and reliable and valid ways of assessing the discharge needs of patients.

(7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process:
(a) As tools for planning patients' transition from one care setting to another and for determining whether patients are ready for the transition, discharge criteria are intended to match patients' care needs to the setting in which their needs can best be met.
(b) Discharge criteria consist of, but are not limited to: (i) Objective and subjective assessments of physiologic and symptomatic stability that are matched to the ability of the discharge setting to monitor and provide care. (ii) The patient's care needs that are matched with the patient's, family's, or caregiving staff's independent understanding, willingness, and demonstrated performance prior to discharge of processes and procedures of self care, patient care, or care of dependents. (iii) The patient's functional status and impairments that are matched with the ability of the care givers and setting to adequately supplement the patients' function. (iv) The needs for medical follow-up that are matched with the likelihood that the patient will participate in the follow-up. Follow-up is time-, setting-, and service-dependent. Special considerations must be taken to ensure follow-up in vulnerable populations whose access to health care is limited.
(c) The discharge process includes, but is not limited to: (i) Planning: Planning for transition/discharge must be based on a comprehensive assessment of the patient's physiological, psychological, social, and functional needs. The discharge planning process should begin early in the course of treatment for illness or injury (prehospitalization for elective cases) with involvement of patient, family and physician from the beginning. (ii) Teamwork: Discharge planning can best be done with a team consisting of the patient, the family, the physician with primary responsibility for continuing care of the patient, and other appropriate health care professionals as needed. (iii) Contingency Plans/Access to Medical Care: Contingency plans for unexpected adverse events must be in place before transition to settings with more limited resources. Patients and caregivers must be aware of signs and symptoms to report and have a clearly defined pathway to get information directly to the physician, and to receive instructions from the physician in a timely fashion. (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, he or she is responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred. (v) Communication: Transfer of all pertinent information about the patient (such as the history and physical, record of course of treatment in hospital, laboratory tests, medication lists, advanced directives, functional, psychological, social, and other assessments), and the discharge summary should be completed before or at the time of transfer of the patient to another setting. Patients should not be accepted by the new setting without a copy of this patient information and complete instructions for continued care. (8) The AMA supports the position that the care of the patient treated and discharged from a treating facility is done through mutual consent of the patient and the physician; and (9) Policy programs by Congress regarding patient discharge timing for specific types of treatment or procedures be discouraged. (CSA Rep. 4, A-96; Reaffirmation I-96; Modified by Res. 216, A-97; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 1, A-08)

H-160.943 Definition of "Principal Care"

The AMA defines "principal care" as follows: Principal care is ongoing preventive, diagnostic, curative, counseling, or rehabilitative care, provided or coordinated by a physician, that is focused on a specific organ system or disease/condition. Principal care may be provided concurrently with or apart from primary care. The AMA supports Principal Care by taking steps to maintain access to quality Principal Care physicians who by their training, continuing education, experience and peer review have the expertise and knowledge to deliver contemporary and effective Principal Care in the management of acute or chronic diseases or conditions. (CMS Rep. 3, A-96; Sub. Res. 726, A-97; Reaffirmed: CMS Rep. 9, A-07)

H-160.944 Defining "Observation Care"

(1) The AMA will work with third party payers to establish a uniform definition of "observation care," including the following: (a) The patient should be designated as under "observation care" if the physician's intent for hospital stay is less than 24 hours. If the physician's intent and expectation is for a hospital stay of greater than 24 hours, then the stay should be considered inpatient. The use of 24 hours as a threshold for observation is a guideline. It is not unusual for observation to extend to a few hours beyond 24 hours or for patients to be admitted to inpatient status before 24 hours. (b) Patients classified as under "observation care" require hospital level-of-care. (c) The patient should be registered as under "observation care" after initial physician evaluation of the patient's signs and symptoms and appropriate testing. Post day surgical patients should be registered as under "observation care" if, after a normal recovery period, they continue to require hospital level-of-care as determined by a physician.
(2) The AMA will establish policy on "observation care" and develop model legislation to ensure that: (a) After initial approval of inpatient admission by insurers, there should be no retrospective reassignment to "observation care" status by insurers unless the original information given to insurers is incorrect. (b) Insurers should provide 60 days prior notice to providers of changes to "observation care" criteria or the application of those criteria with opportunity for comment. There should be no implementation of criteria or changes without first following these protocols. (c) Insurers' "observation care" policies should include an administrative appeal process to deal with all utilization and technical denials within a 60 day time frame for final resolution. An expedited appeal process should be available for patients in the admission process, allowing for a decision within 24 hours. (d) Insurers and HMOs should provide clearly written educational materials on "observation care" to subscribers highlighting differences between inpatient and "observation care" benefits and patient appeal procedures. (Res. 808, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: BOT Action in response to referred for decision Res. 715, I-07)

H-160.945 Subacute Care Standards for Physicians

AMA guidelines for physicians' responsibilities in subacute care include:
(1) Physicians are responsible to their patients for delivery of care in all subacute care settings, 24 hours a day, 7 days a week.
(2) Patients who might benefit from subacute care should be admitted to and discharged under the orders of the physician who is responsible for the continuous medical management needed to meet the patient's needs and safety and maintaining quality of care.
(3) Physicians are responsible for coordinating care for their patients with other physicians including medical directors, primary care physicians, and appropriate specialists, to optimize the quality of care in subacute settings.
(4) Physicians are responsible for supervision and coordination of the medical care for their patients and providing leadership for all other health care providers in subacute care.
(5) Physicians should guide procedures for their patients performed within integrated practices and direct other health care providers, consistent with federal and state regulations.
(6) Physicians are responsible for: (a) Fulfilling their roles and identifying the medical skills needed to deliver care in subacute facilities and for creating and developing continuing medical education to meet the special needs of patients in subacute care. (b) Identifying and appropriately utilizing subacute care facilities in their communities. (c) Oversight of physician credentialing in subacute settings (d) Promoting medical staff organization and by-laws that may be needed to support peer evaluations. (e) Planning care of their patients with acute and chronic conditions in subacute care, as well as pursuing efforts to restore and maintain functions for quality of life.
(7) Subacute units and/or programs need physician medical directors to assure quality of medical care, provide peer group liaisons, and coordinate and supervise patients and families input and needs.
(8) Physicians provide a plan of care for medically necessary visits after completing an initial assessment within 24 hours of admission that identifies the medical services expected during subacute care.
(9) Attending physicians should: (a) make an on-site visit to review the interdisciplinary care plan within seventy two hours of admission. (b) Determine the number of medically necessary follow up visits; these may occur daily but never less often than weekly. (c) Document active involvement of physicians in interdisciplinary care and all major components of the patient care plan including completing a progress note for each patient visit.
(10) Physicians should implement these guidelines through organized medical staff by-laws in subacute settings to assure quality patient care. (BOT Rep. 21, I-95; Reaffirmed: CMS Rep. 7, A-05)

H-160.946 The Criminalization of Health Care Decisionmaking

The AMA opposes the attempted criminalization of health care decisionmaking especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decisionmaking,

including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decisionmaking. (Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07)

H-160.947 Physician Assistants and Nurse Practitioners

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety.):(1) The physician is responsible for managing the health care of patients in all settings.

(2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.

(3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.

(4) The physician is responsible for the supervision of the physician assistant in all settings.

(5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.

(6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.

(7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.

(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.

(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.

(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care. (BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03)

H-160.949 Practicing Medicine by Non-Physicians

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;

(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;

(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; and

(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine. (Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00)

H-160.950 Guidelines for Integrated Practice of Physician and Nurse Practitioner

Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only I their entirety

when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.

(2) The physician is responsible for managing the health care of patients in all practice settings.

(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.

(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.

(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.

(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.

(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.

(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.

(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.

(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.

(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns. (CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240 and Reaffirmation A-00)

H-160.951 Access to Primary Care Services

The AMA (1) will work to assure that a patient's access to primary and principal care services provided by a physician is not limited by the specialty or subspecialty designation of the physician, but should be determined by the training, competence, and experience of the physician to provide primary or principal care services; (2) urges health plans to allow physicians with the appropriate qualifications to elect to provide primary, specialty and subspecialty care services, and to pay these physicians appropriately for the provision of such services; (3) encourages all health insurance programs, indemnity programs, HMOs and federally funded health insurance programs, such as Medicare and Medicaid, to list Med-Peds physicians who request dual listings, to include them as both adult and pediatric clinicians, and (4) urges physicians, prior to electing to provide both primary and specialty care services under a specified health plan contract, to consider the possible economic and profiling consequences of such actions. (CMS Rep. 6 - I-94; CMS Rep. 2, A-96; CMS Rep. 3, A-96; Reaffirmed: Sub. Res. 717, I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Appended: Res. 706, I-97; Reaffirmed: Res. 220, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-160.952 Access to Specialty Care

The AMA: (1) continues to encourage primary care and other medical specialty organizations to collaborate in developing guidelines to delineate the clinical circumstances under which treatment by primary care physicians, referral for initial or ongoing specialist care, and direct patient self-referral to other specialists are appropriate, timely, and cost-effective; (2) encourages the medical specialty organizations that develop referral guidelines to document the impact of the guidelines on the quality, accessibility, timeliness, and cost-effectiveness of care; and (3) urges all health plans that control access to services through a primary care case manager to cover direct access to and services by a specialist other than the case manager without financial penalty when that access is in conformance with such collaboratively developed guidelines. (CMS Rep. 1, A-94; Reaffirmed and Modified: CMS Rep. 7, A-05)

H-160.953 Free Clinics

The AMA: (1) encourages the establishment of free clinics as an immediate partial solution to providing access to health care for indigent and underserved populations; (2) will explore the potential for a partnership with state and county medical societies to establish a jointly-sponsored free clinic pilot program to provide health services and information to indigent and underserved populations; and (3) will develop strategies that will allow the AMA, along with one or more state or county medical societies, to join in partnership with private sector liability insurers and government - especially at the state, county, and local levels - to establish

programs that will have appropriate levels of government pay professional liability premiums or indemnify physicians who deliver free services in free clinics or otherwise provide free care to the indigent. (BOT Rep. 27-A-94; Reaffirmed: BOT 17, A-04)

H-160.954 Criminalization of Medical Judgment

(1) Our AMA continues to take all reasonable and necessary steps to insure that medical decision-making, exercised in good faith, does not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties. (Sub. Res. 223, I-93; Reaffirmed: Res. 227, I-98; Reaffirmed: Res. 237, A-99; Reaffirmed and Appended: Sub. Res. 215, I-99)

H-160.955 Legislation to Expand Rural Health Clinics to Urban Areas

Our AMA (1) will pursue legislation to provide for modification of the Rural Health Clinic Services Act to allow similar services in urban areas, including the Act's current provision requiring physician supervision of care; (2) will continue to develop a health agenda for the provision of health care in underserved urban areas which addresses the availability and quality of services and the role of physician extenders; and (3) will support separate urban and rural funding so that rural and urban health clinics are not forced to compete for funding allocations. (BOT Rep. KK, A-93; Reaffirmation A-01)

H-160.956 Federal Funding for Safety Net Care for Undocumented Aliens

Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens. (Sub. Res. 207, A-93; Reaffirmed BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07)

H-160.959 Health Care Access for the Inner-City Poor

(1) Our AMA reaffirms the following statement from Policy 140.975: "Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care."

(2) Our AMA will pursue the following initiatives to improve access to health care in the innercity: (a) Encourage the development of a congressional innercity coalition, modeled after the Rural Health Care Coalition, to move an inner-city legislative health care agenda through Congress. (b) Urge Congress to consider appropriate AMA-supported provisions from the rural health legislative agenda for application to health care services in the innercity as well; specifically those related to: (i) extension of Medicare and Medicaid bonuses to physicians practicing in medical service areas in the innercity where the poverty rate exceeds a certain threshold; (ii) expanded private and federal funding of state-of-the-art medical equipment; (iii) limited exemption for innercity physicians from federal or state antitrust or other limitations prohibiting physicians from more effectively pooling their resources and otherwise working together; (iv) tax credits for physicians practicing in underserved inner-city areas to help make up practice-related income differentials for choosing to practice in those areas; and (v) loan forgiveness for practice in underserved areas. (c) Consider the development or support of additional legislation to implement such incentives for practice in the innercity as: (i) financial assistance with start-up costs; and (ii) assistance with property and casualty insurance costs. (d) To supplement overall efforts at tort reform, continue to pursue innovative approaches for relief of professional liability costs for inner-city physicians such as: (i) payment of malpractice damages by a state or local government agency; and (ii) assistance in reducing physician costs for professional liability insurance through payment of premiums or discounts on such premiums by a government agency. (e) Encourage appropriate funding from public and private sources for inner-city hospitals. (f) Encourage additional funding of community health resources through federal and private grants.

(3) Our AMA urges medical schools to identify, expand, and publicize the roles they play in educating students to serve the innercity poor. These included but are not limited to: (a) Recruiting more students likely to practice in the innercity; (b) Developing incentives for medical students to choose to practice in the innercity; (c) Providing exposure during undergraduate and graduate medical education to innercity practice and practice role models; and (d) Working cooperatively with community groups to develop model health care training sites in the innercity.

(4) Our AMA will encourage and where appropriate assist physicians and their local medical societies to work with teaching institutions, local health department, and community organizations in developing innovative service and financing mechanisms for delivering care in the innercity.

(5) Our AMA supports the further development of innovative, multidisciplinary approaches to delivering health care in the innercity, including use of a wide variety of health professionals under proper physician (i.e., MD/DO) supervision on a part-time or consultant basis and expanded use of physician assistants, nurse practitioners, nurse midwives, nutritionists, social workers, community outreach personnel, and lay workers.

(6) Our AMA will work to reduce the professional and personal isolation of physicians working in the innercity by encouraging: (a)

Increased outreach activities and supportive interaction with such physicians by area medical schools; (b) Increased availability and use of telecommunications and on-site consultant visits from such teaching centers; (c) Practitioner linkages with the surrounding community through local customs and language training for health professionals where appropriate and the use of lay advisory committees for community clinics; and (d) Local government measures to enhance personal safety.

(7) Our AMA will stimulate more effective ways in which health education and preventive health services can be more effectively provided to and utilized by the inner-city underserved. Such services may include: (a) Immunizations; (b) Nutritional guidance; (c) Family planning; (d) Programs for prevention of sexually transmitted diseases; (e) Substance abuse programs; (f) Programs on domestic violence; (g) Education in healthy lifestyles; and (h) Parenting assistance and education.

(8) Our AMA encourages efforts to address the transportation problems that interfere with access to health care for underserved populations.

(9) Our AMA will study innovative approaches to assure patient access to prescription drugs.

(10) Our AMA will identify and publicize models of successful health care delivery for underserved populations as examples for other medical schools, physicians, and community groups.

(11) Our AMA will sponsor a national conference on access to health care for the inner-city poor.

(12) Our AMA will study and develop a plan for provision and retention of generalist physicians for service to the innercity poor. (CMS/CME Rep., I-92; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation A-01)

H-160.960 Corporate Ownership of Established Private Medical Practices

When a private medical practice is purchased by corporate entities, patients going to that practice shall be informed of this ownership arrangement by the corporate entities and/or by the physician. (Res. 3, I-92; Modified by CMS Rep. 1, A-95; Reaffirmed: CMS Rep. 7, A-05)

H-160.961 Caring for the Poor

(1) Each physician has an obligation to share in providing care to the indigent. The measure of what constitutes an appropriate contribution may vary with circumstances such as community characteristics, geographic location, the nature of the physician's practice and specialty, and other conditions. All physicians should work to ensure that the needs of the poor in their communities are met. Caring for the poor should become a normal part of the physician's overall service to patients. In the poorest communities, it may not be possible to meet the needs of the indigent for physicians' services by relying solely on local physicians. The local physicians should be able to turn for assistance to their colleagues in prosperous communities, particularly those in close proximity. Physicians are meeting their obligation, and are encouraged to continue to do so, in a number of ways such as: by seeing indigent patients in their offices at no cost or at reduced cost, by serving at freestanding or hospital clinics that treat the poor, and by participating in government programs that deliver health care to the poor. Physicians can also volunteer their services at weekend clinics for the poor and at shelters for battered women or the homeless. In addition to meeting their obligation to care for the indigent, physicians can devote their energy, knowledge and prestige to designing and lobbying at all levels for better programs to provide care for the poor.

(2) State, local, and specialty medical societies should help physicians meet their obligations to provide care to the indigent. By working together through their professional organizations, physicians can provide more effective services and reach more patients. Many societies have developed innovative programs and clinics to coordinate care for the indigent by physicians. These efforts can serve as a model for other societies as they assist their members in responding to the needs of the poor. (CEJA Rep. C, I-92; Reaffirmed by CMS Rep. 2, A-98; Reaffirmed: CMS Rep. 4, A-08)

H-160.963 Community-Based Treatment Centers

It is the policy of the AMA (1) to communicate to state and county medical societies its support of community-based treatment centers for substance abuse, emotional disorders and developmental disabilities; (2) to make available to state and county medical societies model liability legislation and scientific reports dealing with community-based services; and (3) to alert American Medical Television and American Medical News to this policy and to explore the possibility of enhancing physician and public knowledge regarding community-based treatment centers. (BOT Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-160.964 "900" Telephone Number Medical Delivery Systems

It is the policy of the AMA to take appropriate measures to ensure that the American public is adequately protected in the delivering of "900" telephone number medical services. (Res. 13, I-91; Reaffirmed: Sunset Report, I-01)

H-160.965 Voluntary Medical Care for the Indigent

Our AMA: (1) urges that all jurisdictions provide physicians with protection from liability for uncompensated care for the indigent; and (2) encourages county medical societies to study the nature and extent of medical care needed for the indigent in their counties. (Sub. Res. 105, I-90; Modified: Sunset Report, I-00)

H-160.966 Market Forces on Medical Practice

It is the policy of the AMA that (1) the ratcheting down of physician payment rates will not produce appreciable reductions in the rate of health care cost increase, since payment for physicians' services constitutes only about one-fifth of spending for health care; however, it may well reduce access to care as more physicians leave the area, retire, or in other ways change their practices;

(2) at the same time, physician-directed peer review mechanisms must take the lead in fostering appropriate utilization of services and encouraging less hospital-intensive patterns of care where indicated;

(3) the capture of a dominant or controlling share of the private health insurance market by any one payer can ultimately result in payer control of physicians' total remuneration; such control should be resisted through all legislative means available;

(4) physicians must continue to initiate and publicize voluntary programs to accept assignment and/or other special arrangements for lower-income Medicare beneficiaries as a deterrent to legislation mandating assignment or banning balance billing for all Medicare enrollees regardless of economic status; and

(5) it is equally incumbent on those developing state legislative and regulatory proposals to seek the advice of the health care professionals who will be affected by such proposals at the outset; without such input, the state will risk alienating those who provide the care and jeopardizing the health of its residents. (CMS Rep. I, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation I-03; Reaffirmed in lieu of Res. 105, A-04; Reaffirmation A-06)

H-160.968 Medical Access Facilities

Our AMA: (1) supports studying the concept of medical access (or "assistance") facilities in light of information that such facilities would not require appropriate physician involvement; and (2) opposes any federal or state legislation providing further funding of any demonstration projects of medical access facilities until such AMA studies can be completed. (Sub. Res. 30, I-89; Reaffirmed: Sunset Report, A-00)

H-160.969 Tax Deduction for Care Provided the Indigent

Our AMA does not believe that it should seek a special income tax deduction for providing medical care to the indigent. (BOT Rep. N, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed in lieu of Res. 141, A-07)

H-160.970 Indigent Health Care

Our AMA reaffirms its commitment that every citizen of this nation have access to medical care when needed. (CMS Rep. N, A-89; Reaffirmed: Sunset Report, A-00)

H-160.971 Uncompensated Care

Our AMA supports (1) communicating to the public the problem of uncompensated care and the ever increasing regulations involving such care as well as the detrimental effect that uncompensated care has on the availability of necessary health care services to many citizens; and (2) publicizing the programs currently instituted to address uncompensated care and pursuing additional solutions for dealing with the problem of uncompensated care. (Res. 165, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CMS Rep. 8, A-05)

H-160.972 Physician Representation on State and National Health Care Advisory Bodies

The AMA urges Congress, and others who select members of state and national health advisory bodies, to increase the proportion of physicians in active clinical practice serving on these bodies, with selected members being recommended by state or national medical associations. (Sub. Res. 110, A-88; Reaffirmed: Sunset Report, I-98)

H-160.975 Planning and Delivery of Health Care Services

(1) Planning agencies should utilize policies, educational programs and incentives to develop and maintain individual lifestyles that promote good health. The planning process should identify incentives for the providers and participants in the health care system to

encourage the development and introduction of innovative and cost-effective health care services. Government at all levels, as a provider, purchaser and consumer of health services, should play an integral role in the planning process, including the provision of adequate funding and ensuring that government policies and/or regulations facilitate and do not unduly restrict the planning process. The authority to impose sanctions on those who take actions that are inconsistent with developed plans should be separated from the planning process. Funding for the planning process should be developed by the participants.

(2) The planning process should seek to ensure the availability and the coordination of a continuum of supportive health care services for special populations in senior citizen centers, day care and home care programs, supervised life-care centers, nursing homes, hospitals, hospices, and rehabilitation facilities.

(3) Decisions concerning the use of health care services, including the selection of a health care provider or delivery mechanism, should be made by the individual.

(4) Both the public and private sectors should be encouraged to donate resources to improve access to health care services. Where appropriate, incentives should be provided for those in the private sector who give care to those who otherwise would not have access to such care. In addition, existing short-comings in the current public system for providing access need to be addressed.

(5) Health care facilities should have or should establish review bodies (such as hospital ethics committees) to resolve conflicts over access to scarce health care technologies. In the event that a conflict over delivery of scarce health care technologies cannot be mediated satisfactorily, individuals should be able to seek redress through appropriate appeal mechanisms. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-160.978 The Mentally Ill Homeless

(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population. (BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-160.983 Satellite and Commercial Medical Clinics

The AMA believes that (1) in principle, self-regulatory measures are preferable to mandatory state regulation as a mechanism to ensure quality of care in freestanding emergency and urgent care facilities; and (2) recently initiated self-regulatory programs applicable to freestanding facilities should be given ample opportunity to demonstrate their effectiveness in practice. (BOT Rep. GG, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CMS Rep. 5, A-04)

H-160.987 Access to Medical Care

The AMA reaffirms the dedication of physicians to serving those in need of medical care and their commitment to the principle that no one shall be denied necessary medical care because of inability to pay for that care. (Sub. Res. 88, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 1, I-02)

H-160.988 Health Care Coalitions

The AMA (1) supports health care coalitions that include strong physician participation so that primary emphasis is given to the quality, availability and access to medical care; and (2) encourages physicians in the clinical practice of medicine to take an active role in the development and activities of health care coalitions in their respective areas. (Sub. Res. 49, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CMS Rep. 10, A-03)

H-160.990 Discontinuance of the Term "Medical Malpractice" and "Health Care"

The AMA believes that (1) representatives and publications of the Association should use precise language when discussing socioeconomic matters of concern to medicine, to the extent feasible and to the best of each individual's abilities; (2) the

representatives and publications should strive to avoid the use of terms such as "health care," "health care costs," "health care providers" and "malpractice"; instead, when possible, other more specific existing terminology should be used to address the exact issue to be discussed; and (3) misleading or confusing terms should not be used in AMA news releases, testimony and publications. (Sub. Res. 35, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CMS Rep. 10, A-03)

H-160.991 Health Care Needs of the Homosexual Population

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of sexual orientation and behavior enhances the ability to render optimal patient care in health as well as in illness. In the case of the homosexual patient this is especially true, since unrecognized homosexuality by the physician or the patient's reluctance to report his or her sexual orientation and behavior can lead to failure to screen, diagnose, or treat important medical problems. With the help of the gay and lesbian community and through a cooperative effort between physician and the homosexual patient effective progress can be made in treating the medical needs of this particular segment of the population; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of homosexuality and the need to take an adequate sexual history; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of their homosexual patients; (iii) encouraging the development of educational programs for homosexuals to acquaint them with the diseases for which they are at risk; (iv) encouraging physicians to seek out local or national experts in the health care needs of gay men and lesbians so that all physicians will achieve a better understanding of the medical needs of this population; and (v) working with the gay and lesbian community to offer physicians the opportunity to better understand the medical needs of homosexual and bisexual patients; and (c) opposes, the use of "reparative" or "conversion" therapy that is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her homosexual orientation.

2. Our AMA will (a) educate physicians regarding: (i) the need for women who have sex exclusively with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (b) support our partner medical organizations in educating women who have sex exclusively with women on the need for regular cancer screening exams, the risk for sexually transmitted infections, and the appropriate safe sex techniques to avoid that risk.

3. Our AMA will use the results of the survey being conducted in collaboration with the Gay and Lesbian Medical Association to serve as a needs assessment in developing such tools and online continuing medical education (CME) programs with the goal of increasing physician competency on gay, lesbian, bisexual, and transgender health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to physicians to enable the provision of high quality and culturally competent care to gay men and lesbians. (CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08)

H-160.998 Health Care

The AMA believes that the medical profession will see to it that every person receives the best available medical care regardless of his ability to pay, and it further believes that the profession will render that care according to the system it believes is in the public interest; and that it will not be a willing party to implementing any system which we believe to be detrimental to the public welfare. (Bauer Amendment, A-61; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-160.999 Statements on the Medical Profession

Whether definitely stated or not, it is the position of the AMA that all conditions or principles adopted by the Association concerning the position of the medical profession, in any form of medical practice, are set forth primarily in order to maintain such standards as are essential to the maintenance of the best medical care and the protection of the health of all members of the community. (1934 Annual Session; Reaffirmed: CLRPD Rep. B, A-87; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CLRPD Rep. 2, A-06)

H-165.000 Health Care/System Reform
(See also: Health Care Costs; Health Care Delivery; Health Insurance)

H-165.840 Preventive Medical Care Coverage for All

Our AMA advocates for (1) health care reform that includes evidence-based prevention insurance coverage for all; (2) evidence-based prevention in all appropriate venues, such as primary care practices, specialty practices, workplaces and the community. (Res. 827, I-08)

H-165.841 Comprehensive Health System Reform

Our AMA supports the overall goal of ensuring that every American has access to affordable high quality health care coverage and will work with interested members of Congress to seek legislation consistent with AMA policy. (Sub. Res. 924, I-07)

H-165.842 Health Insurance Coverage of High-Risk Patients

Our AMA: (1) supports the principle that health insurance coverage of high-risk patients be subsidized through direct risk-based subsidies such as high-risk pools, risk adjustment, and reinsurance, rather than through indirect methods that rely heavily on market regulation; and (2) supports state-based demonstration projects to subsidize coverage of high-risk patients through mechanisms such as high-risk pools, risk adjustment, reinsurance, and other risk-based subsidies. (CMS Rep. 2, I-07)

H-165.843 Trends in Employer-Sponsored Health Insurance

Our AMA encourages employers to:
a) promote greater individual choice and ownership of plans;
b) enhance employee education regarding how to choose health plans that meet their needs;
c) offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
d) support increased fairness and uniformity in the health insurance market; and
e) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care.
(CMS Rep. 4, I-07)

H-165.844 Educating the American People About Health System Reform

Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system. (Res. 717, I-07)

H-165.845 State Efforts to Expand Coverage to the Uninsured

Our AMA supports the following principles to guide in the evaluation of state health system reform proposals:

1. Health insurance coverage for state residents should be universal, continuous, and portable. Coverage should be mandatory only if health insurance subsidies are available for those living below a defined poverty level.

2. The health care system should emphasize patient choice of plans and health benefits, including mental health, which should be value-based. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as references when considering if a given plan would provide meaningful coverage.

3. The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable.

4. The administration and governance system should be simple, transparent, accountable, and efficient and effective in order to reduce administrative costs and maximize funding for patient care.

5. Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations. (CMS Rep. 3, I-07)

H-165.846 Adequacy of Health Insurance Coverage Options

Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:

1. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.

2. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.

3. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.

4. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services. (CMS Rep. 7, A-07; Reaffirmation I-07)

H-165.847 Comprehensive Health System Reform

1. Comprehensive health system reform, which achieves access to quality health care for all Americans while improving the physician practice environment, is of the highest priority for our AMA.

2. Our AMA recognizes that as our health care delivery system evolves, direct and meaningful physician input is essential and must be present at every level of debate. (Res. 613, A-06; Reaffirmation I-07; Res. 107, A-08)

H-165.848 Individual Responsibility To Obtain Health Insurance

1. Our AMA will support a requirement that individuals and families earning greater than 500% of the federal poverty level obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance.

2. Upon implementation of a system of refundable, advanceable tax credits inversely related to income or other subsidies to obtain health care coverage, our AMA will support a requirement that individuals and families earning less than 500% of the federal poverty level obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance. (CMS Rep. 3, A-06; Modified: CMS Rep. 8, A-08)

H-165.849 Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans

Our AMA opposes health plan requirements that require physicians to bill patients for out-of-pocket payments and do not allow physicians to collect these payments in a more efficient manner, such as collecting at point-of-service, establishing systems of electronic transfers from a patient's account, or offering cash discounts for expedited payment, particularly for patients enrolled in health savings accounts (HSAs), health reimbursement arrangements (HRAs), and other consumer-directed health care plans. (CMS Rep. 3, I-05)

H-165.851 Options for Implementing and Financing Tax Credits for Individually Selected and Owned Health Insurance

Our AMA supports (1) implementation of individual tax credits for the purchase of health insurance for specific target populations such as low-income workers, low-income individuals, children, the chronically ill, and those living within geographic areas that are pilot testing tax credits; and (2) incremental steps toward financing individual tax credits for the purchase of health insurance, including but not limited to capping the tax exclusion for employment-based health insurance. (CMS Rep. 4, I-04; Reaffirmed in lieu of Res. 105, A-06)

H-165.852 Health Savings Accounts

It is the policy of the AMA that:

(1) high-deductible health insurance plans issued to families in conjunction with Health Savings Accounts (HSAs) be allowed to apply lower, per-person deductibles to individual family members with the permitted levels for per-person deductibles being the same as permitted levels for individual deductibles, and with the annual HSA account contribution limit being determined by the full family deductible or the dollar-limit for family policies;

(2) contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families;

(3) advocacy of HSAs continues to be incorporated prominently in its campaign for health insurance market reform;

(4) activities to educate patients about the advantages and opportunities of HSAs be enhanced;

(5) efforts by companies to develop, package, and market innovative products built around HSAs continue to be monitored and encouraged;

(6) HSAs continue to be promoted and offered to AMA physicians through its own medical insurance programs; and

(7) legislation promoting the establishment and use of HSAs and allowing the tax-free use of such accounts for health care expenses,

including health and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. (CMS Rep. 11 - I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 5 and 7, I-99; CMS Rep. 10, I-99; Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed Res. 109 & Reaffirmation A-01; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation A-02; CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; CMS Rep. 6, A-04; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07)

H-165.854 Health Reimbursement Arrangements

It is the policy of the AMA: (1) to support Health Reimbursement Arrangements (HRAs) as one mechanism for empowering patients to have greater control over their health care decision-making; and (2) that employers offering HRAs be encouraged to consider: (a) making HRAs into real (rather than notional) accounts; (b) allowing rollover of all unspent HRA balances annually; and (c) making unspent HRA balances available to employees upon their retirement or departure from the company. (CMS Rep. 3, I-03; Modified: CMS Rep. 3, I-05)

H-165.855 Medical Care for Patients with Low Incomes

It is the policy of our AMA that: (1) the medical care portion of the Medicaid program should be financed with federally issued tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, to allow acute care patients to purchase coverage individually and through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP), with varying cost-sharing obligations based on income and eligibility under the current Medicaid program as described below:

(a) Individuals who would otherwise qualify for mandatory Medicaid eligibility groups should receive tax credits that are large enough to enable them to purchase coverage with no cost-sharing obligations.
(b) Individuals who would otherwise qualify in an optional Medicaid eligibility group should receive tax credits that are large enough to enable them to purchase coverage with limited cost-sharing.

(2) individuals who do not qualify for Medicaid, and have resources that are insufficient to purchase health insurance, should receive federally issued tax credits that are large enough to enable them to cover a substantial portion of coverage, with moderate cost-sharing.

(3) in order to assure continuity of care, there should be a seamless mechanism to quickly reassess the eligibility group and amount of tax credit with changes in income and family.

(4) tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area until the next enrollment opportunity.

(5) to support the development of a safety net mechanism to allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care.

(6) state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available as either a mandatory or optional services under Medicaid, but are not medical benefits per se.

(7) as individuals in the acute care population transition into chronic care needs, they should be eligible for sufficient additional subsidization to allow them to maintain their current coverage.

(8) our AMA encourages the development of pilot projects, including children, incorporating the above recommendations. (CMS Rep. 1, I-03; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation I-07)

H-165.856 Health Insurance Market Regulation

Our AMA supports the following principles for health insurance market regulation:

(1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan;

(2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection;

(3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general

tax revenues rather than through strict community rating or premium surcharges;

(4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium;

(5) Insured individuals should be protected by guaranteed renewability;

(6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices;

(7) Guaranteed issue regulations should be rescinded;

(8) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage; and

(9) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically:

(a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed;
(b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and
(c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.
(CMS Rep. 7, A-03; Reaffirmed: CMS Rep. 6, A-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 2, I-07)

H-165.861 Use of Federal Surpluses for Uninsured Americans

AMA policy is that a portion of any increases in federal health care benefit spending be used to provide refundable, advanceable tax credits inversely related to income, for the purchase of health insurance to uninsured Americans, and that this be communicated to the President of the United States and to the Congress. (Res. 129, A-01; Modified: CMS Rep. 10, A-02; Modified: CMS Rep. 8, A-08)

H-165.862 Evolving Internet-Based Health Insurance Marts

Our AMA endorses the concept and use of Internet-based health insurance marts and health benefits systems as mechanisms for employers and individuals to select and purchase health insurance. (CMS Rep. 5, A-01)

H-165.863 Flexible Spending Accounts (FSAs)

Along with other efforts to liberalize the Health Savings Account rules, our AMA places a top priority on allowing employees to roll-over any unexpended funds in a Flexible Spending Account into a Health Savings Account. In addition, our AMA seeks federal legislation to rescind Internal Revenue Service tax regulations requiring annual forfeiture of unspent funds in employer provided flexible spending accounts. (Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 5 and 7, I-99; Appended by Res. 220, A-00; Reaffirmation I-00; Res. 120, A-01; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05)

H-165.865 Principles for Structuring a Health Insurance Tax Credit

(1) AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles: (a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided. (b) Tax credits should be refundable. (c) The size of tax credits should be inversely related to income. (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people. (e) The size of tax credits should be capped in any given year. (f) Tax credits should be fixed-dollar amounts for a given income and family structure. (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums. (h) Tax credits for families should be contingent on each member of the family having health insurance. (i)Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account, and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-income persons who could not afford the monthly out-of-pocket premium costs.

(2) It is the policy of our AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code.

(3) Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance. (CMS Rep. 4, A-00; CMS Rep. 5, A-00; Reaffirmation I-00; Reaffirmation A-02; Reaffirmation I-03; CMS Rep. 2, A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08)

H-165.866 All Americans Must Have Health Insurance

Our AMA strongly affirms and calls upon all of the state medical societies and all other national physician specialty organizations to strongly affirm the joint statement, "All Americans Must Have Health Insurance." (The Statement was developed in 1999 by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Emergency Physicians, the American College of Obstetricians and Gynocologists, the American College of Physicians-American Society of Internal Medicine, the American College of Surgeons, and the American Medical Association. The Statement was further endorsed by other physician specialty organizations.) (Res. 118, A-00)

H-165.877 Increasing Coverage for Children

Our AMA:

(1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant women;

(2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;

(3) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children in accordance with AMA Policy 165.920[2] the AMA recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs;

(4) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18;

(5) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23;

(6) seeks to have introduced or support federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families;

(7) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package;

(8) advocates that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits that meet the standards of the AMA standard benefit package;

(9) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage;

(10) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage;

(11) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group;

(12) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; and

(13) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in identifying and encouraging enrollment in Medicaid of the estimated three million children currently eligible for but not covered under this program. (Sub. Res. 208, A-97; CMS Rep. 7, A-97; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, I-99;

Reaffirmed: Res. 238 and Reaffirmation A-00; Reaffirmation A-02; Reaffirmation A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-08)

H-165.881 Expanding Choice in the Private Sector

Our AMA will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice, and expanded individual selection and ownership of health insurance where plans are truly accountable to patients. (BOT Rep. 23, A-97; Reaffirmed BOT Rep. 6, A-98; Reaffirmation A-02)

H-165.882 Improving Access for the Uninsured and Underinsured

Our AMA:

(1) Will assist state medical associations and local medical societies to work with states and the insurance industry to design value-based private group and individual health insurance policies. Such policies should cover with low cost-sharing those services adjudged to have the greatest health benefit, should be affordable, and should be equivalent to or an improvement over the Medicaid coverage in that state, so as to provide a continuum of gradually enhanced coverage.

(2) Supports federal legislation to encourage the formation of small employer and other voluntary choice cooperatives by exempting insurance plans offered by such cooperatives from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws, while safeguarding state and federal patient protection laws. Any support for such small employer and voluntary purchasing cooperatives shall be strictly contingent upon safeguarding state and federal patient protections. For purposes of such legislation, small employers should be defined in terms of the number of lives insured, not the total number employed.

(3) Through appropriate channels, encourages unions, trade associations, health insurance purchasing cooperatives, farm bureaus, fraternal organizations, chambers of commerce, churches and religious groups, ethnic coalitions, and similar groups to serve as voluntary choice cooperatives for both children and the general uninsured population, with emphasis on formation of such pools by organizations which are national or regional in scope.

(4) Supports continued study of all approaches to providing health services for the uninsured and cooperation with business groups to develop approaches that are best suited to the needs of small employers.

(5) Encourages physicians, through their local county medical societies, to explore ways to work within their communities to address the expanding problem of inadequate access to care for the uninsured and underinsured and openly communicate with one another to share information about successful programs. (CMS Rep. C, I-86; BOT Rep. JJ, A-89; Reaffirmed: Sub. Res. 110, A-94; Reaffirmed: CMS Rep. 6, I-96; CMS Rep. 7, A-97; Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, I-99; Reaffirmed: Res. 238 and Reaffirmation A-00; Modified: BOT Rep. 17, I-00; Reaffirmation A-02; Res. 102, A-05; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 8, A-08)

H-165.887 Development of Health Care Priorities

Our AMA supports efforts to move patients in public programs into the private sector, through the implementation of vouchers or other mechanisms, thereby enabling individual patients to participate in the prioritization of their health care services; and encourages state governments that are investigating the prioritization of health care services provided under Medicaid programs to consider other potential allocation methodologies including variable levels of funding tied to relative health benefit, beneficiary income, or other factors, for such services. (CMS Rep. 2, I-95; Reaffirmed and Modified: CMS Rep. 7, A-05; Reaffirmed in lieu of Res. 105, A-06)

H-165.888 Evaluating Health System Reform Proposals

Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

(1) Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.

(2) Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.

(3) All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform

proposal and what the impact will be.

(4) All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.

(5) Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.

(6) Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.

(7) All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.

(8) True health reform is impossible without true tort reform. (Res. 118, I-91; Res. 102, I-92; BOT Rep. NN, I-92; BOT Rep. S, A-93; Reaffirmed: Res. 135, A-93; Reaffirmed: BOT Reps. 25 and 40, I-93; Reaffirmed in lieu of Res. 714, I-93; Res. 130, I-93; Res. 316, I-93; Sub. Res. 718, I-93; Reaffirmed: CMS Rep. 5, I-93; Res. 124, A-94; Reaffirmed by BOT Rep.1- I-94; CEJA Rep. 3, A-95; Reaffirmed: BOT Rep. 34, I-95; Reaffirmation A-00; Reaffirmation A-01; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, A-03; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmed with change in title: CEJA Rep. 2, A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation I-07; Reaffirmed in lieu of Res. 113, A-08)

H-165.904 Universal Health Coverage

Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans (Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07)

H-165.916 Government Controlled Medicine

Our AMA strongly reaffirms its unwavering opposition against the encroachment of government in the practice of medicine as well as any attempts to covertly change the American health care system to a government program with the subsequent loss of precious personal freedoms, including the right of physicians and patients to contract privately for health care without government interference. (Res. 141, I-93; Reaffirmed: Sub. Res. 132, A-94; Reaffirmation A-97; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation I-07)

H-165.920 Individual Health Insurance

Our AMA:

(1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;

(2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;

(3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:
(a) Continue to support equal tax treatment for payment of health insurane coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;
(b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the

employee's insurance directly;
(c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and
(d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;

(4) will identify any further means through which universal coverage and access can be achieved;

(5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;

(6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;

(7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;

(8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;

(9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;

(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;

(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;

(12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;

(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and

(14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured. (BOT Rep. 41, I-93; CMS Rep. 11, I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Res. 212, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Reaffirmation I-98; Res. 105 & 108, A-99; Reaffirmation A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmed CMS Rep. 5, A-02; Reaffirmation A-03; Reaffirmed: CMS Rep. 1 and 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 3, A-06; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation A-07; Appended and Modified: CMS Rep. 5, A-08; Modified: CMS Rep. 8, A-08)

H-165.969 Federation and Physician Unity on Health System Reform

The AMA renews its call to the Federation, including state and specialty societies, to work together in a professional and collegial fashion to forge consensus in health system reform. (Res. 139, I-92; Reaffirmed: CMS Rep. 10, A-03; Consolidated: CMS Rep. 7, I-05)

H-165.985 Opposition to Nationalized Health Care

Our AMA reaffirms the following statement of principles as a positive articulation of the Association's opposition to socialized or nationalized health care:
(1) Free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations or promotion.
(2) Freedom of patients to select and to change their physician or medical care plan, including those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services. (Reaffirmed: BOT Rep. I-93-25; Reaffirmed: CMS Rep. I-93-5)
(3) Full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.
(4) Freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, to participate or not participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service.
(5) Inclusion in all methods of medical care payment of mechanisms to foster increased cost awareness by both providers and recipients of service, which could include patient cost sharing in an amount which does not preclude access to needed care, deferral by physicians of a specified portion of fee income, and voluntary professionally directed peer review.
(6) The use of tax incentives to encourage provision of specified adequate benefits, including catastrophic expense protection, in health benefit plans.
(7) The expansion of adequate health insurance coverage to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing providers of uncompensated care, and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level.
(8) Replacing the present Medicare program with a system developed by the AMA of pre-funded vouchers to older persons to purchase health insurance with comprehensive benefits, including catastrophic coverage.
(9) Development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately prefunded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family caregiving. (BOT Rep. U, I-88; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: Sub. Res. 110, A-94; Reaffirmed: CMS Rep. 7, I-97; Reaffirmed by CMS Rep. 9, A-98; Reaffirmed: CMS Rep. 4, A-99; Reaffirmation I-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08)

H-165.995 Coverage of the Uninsured Through State Risk Pooling

Our AMA supports:

(1) the establishment in each state of a risk pooling program, in which all health care underwriting entities in the state participate, to provide adequate health insurance coverage at a premium slightly higher than the standard group rate to (a) those who are unable to obtain such coverage because of medical considerations, and (b) those with medically standard risks who could afford, but presently lack, access to such group coverage;

(2) the amendment of the federal tax code to require employers to purchase group health insurance coverage from an entity participating in the state risk pool or, if self-insured, to participate in the risk pool if such a pool is available, in order to deduct the cost of their coverage as a business expense;

(3) legislation to allow individuals to "buy in" to state employee purchasing pools or the Federal Employee Health Benefits Program (FEHBP); and

(4) using state tax revenues as an alternative source for defraying excess pool costs. (CMS Rep. J, I-85; CMS Rep. A, I-87; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: Res. 241, A-93; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed by CMS Rep. 6, I-96; Reaffirmation A-99; Reaffirmation I-00; Appended: CMS Rep. 10, A-02; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-03; Reaffirmation I-03; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 8, A-08)

H-165.997 Prioritization of Health Care Services

(1) Our AMA urges the medical profession to develop and pursue an initiative for improvement in the systems design for medical and health care plans. (2) Our AMA opposes rationing of health and medical care services. (3) In developing its initiative to contribute responsibly to improvements in the systems design of health and medical care plans, our AMA urges the medical profession to support efforts to evaluate all mechanisms for financing, provision of care and reimbursement in light of their impact on access to care, quality of care and affordability. (4) Our AMA will develop additional clinically based criteria by which benefits desirable under both private and publicly funded health plans can be identified, and will use these criteria in further refining AMA policy in this area. (5) These criteria will be used to evaluate any benefit package developed by any source. (6) Our AMA continues to support the allocation of health services through a decentralized working of the market, coupled with incentives for effective individual choices, as the preferred alternative to centralized prioritization of services or decisions about coverage for such services. (7) Our AMA urges that

physicians work to assist society, including legislatures, whenever discussion regarding prioritization of resources take place. (8) Our AMA will assist medical societies in those states considering or undertaking prioritization to develop processes and criteria for such prioritization that best serve the needs of patients. (9) Our AMA will study and take the lead in stimulating discussion among all concerned sectors of society about the implications of limited and limiting health care resources, current experimental programs for centralized allocation, and the processes and criteria to be used in any such allocation. (10) Our AMA will continue to assign a high priority to the problem of the medically uninsured and underinsured and continue working toward national consensus on providing access to adequate health care coverage for all Americans. (Res. 88, A-84; BOT Rep. EE, I-92; CLRPD Rep. 3 - I-94; Appended: Sub. Res. 109, I-98; Reaffirmed: Res. 808, I-02; Reaffirmed: CMS Rep. 5, A-04; Consolidated: CMS Rep. 7, I-05)

H-170.000 Health Education

H-170.963 Reward-Based Incentive Programs for Healthy Lifestyles

Our AMA:

(1) Supports an integrated approach to encouraging the adoption of healthy lifestyles, involving coordinated efforts by physicians, other health care providers, insurers, employers, unions, and government.

(2) Policy is that reward-based incentive programs that are developed to promote healthy lifestyles should be guided by the following principles:
(a) Incentive programs should be designed with input from physicians.
(b) Incentive programs should reward behaviors, not health status.
(c) Programs should be designed to assess and address risk factors as well as current health status.
(d) Program participation should allow for at least some level of individual assessment and feedback.
(e) Confidentiality of program participants must be maintained, possibly through use of a third-party vendor to track individual participation.
(f) Incentives should be integrated into an ongoing risk-reduction and behavior change program to encourage and support long-term changes in habits and behaviors.
(g) To the extent possible, efforts should be made to ensure that other policies, resources, and activities support and facilitate participation in healthy behaviors. (Joint CMS and CSAPH Rep., A-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 9, A-07)

H-170.964 Drug Education in Schools

Our AMA supports scientifically-based drug education in schools and commends those school districts that have suspended factually inaccurate approaches. (Res. 418, A-05)

H-170.965 Education on Condom Use

Our AMA:

(1) Supports joining with appropriate medical and public health organizations and federal agencies in endorsing the use of condoms in reducing the risk of HIV/AIDS and other sexually transmissible diseases among the population;

(2) Encourages the production of condom education materials that meet standards of accuracy, completeness, social appropriateness, clarity, and simplicity;

(3) Supports cooperating with other medical societies, the public health community, government agencies, and the media to develop standards for public service announcements regarding condom use in prevention of HIV/AIDS and other sexually transmissible diseases;

(4) In cooperation with state, county, and specialty medical societies, encourages physicians to educate their patients about the role of condom use in reducing the risk of sexually transmissible diseases, including HIV disease. While such counseling may not be appropriate for all patients, physicians should be encouraged to provide this information to any patient who may benefit from being more aware of the risks of sexually transmissible diseases; and

(5) In collaboration with appropriate specialty medical societies, supports exploring with condom manufacturers the development of a condom-education kit to train physicians to educate patients on condom use. (CSA Rep. 4, A-03)

H-170.966 Human Sexuality Education

Our AMA encourages physicians to assist parents in providing human sexuality education to children and adolescents. (CSA Rep. 4, A-03)

H-170.967 Rehabilitative Programs, Mental Health, and Educational Services for Girls in the Juvenile Detention System

Our AMA supports comprehensive health education for female delinquents, including information on responsible sexual behavior, the prevention of sexually transmissible diseases and HIV/AIDS, and also supports the availability of intervention programs for girls who have been victimized (Res. 411, A-03)

H-170.968 Sexuality Education, Abstinence, and Distribution of Condoms in Schools

Our AMA:

(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;

(2) Urges schools to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (c) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (d) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (e) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (f) are part of an overall health education program;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;

(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;

(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and

(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy. (CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04)

H-170.969 Teaching Preventive Self-Examinations to High School Students

The AMA supports the development of comprehensive high school health curricula in conjunction with local medical societies and health departments. This curriculum should include instruction in appropriate self-examinations of the skin, breasts, testes and other systems. (Sub. Res. 406, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

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-170.972 Role of Physicians in Improving Adolescent Health

The AMA reaffirms its advocacy for programs that encourage teen health and supports the involvement of medical students, residents, and other physicians in educational efforts to enhance teen health. (Res. 431, A-94; Reaffirmed and Modified: CSA Rep. 6, A-04)

H-170.977 Comprehensive Health Education

(1) Educational testing to confirm understanding of health education information should be encouraged. (2) The AMA accepts the CDC guidelines on comprehensive health education. The CDC defines its concept of comprehensive school health education as follows: (a) a documented, planned, and sequential program of health education for students in grades kindergarten through 12; (b) a curriculum that addresses and integrates education about a range of categorical health problems and issues (e.g., human immunodeficiency virus (HIV) infection, drug abuse, drinking and driving, emotional health, environmental pollution) at developmentally appropriate ages; (c) activities to help young people develop the skills they will need to avoid: (i) behaviors that result in unintentional and intentional injuries; (ii) drug and alcohol abuse; (iii) tobacco use; (iv) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies; (v) imprudent dietary patterns; and (vi) inadequate physical activity; (d) instruction provided for a prescribed amount of time at each grade level; (e) management and coordination in each school by an education professional trained to implement the program; (f) instruction from teachers who have been trained to teach the subject; (g) involvement of parents, health professionals, and other concerned community members; and (h) periodic evaluations, updating, and improvement. (BOT Rep. X, A-92; Modified: CME Rep. 2, A-03; Reaffirmation A-04)

H-170.980 Health Education

It is the policy of the AMA (1) to urge all state medical societies to urge their respective state departments of education to: implement model health education curricula, act as clearinghouses for data on curriculum development, work with local school districts to implement health education programs and to seek funding for these programs; and (2) that the health education programs contain provisions for educator training and development of local community health advisory committees. (Sub. Res. 417, I-91; Reaffirmed: Sunset Report, I-01)

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)

H-170.984 Healthy Living Behaviors

Our AMA encourages all state medical associations to become involved in the promotion of healthy living behaviors for children and youth through quality physical and wellness activities, and encourages all physicians to provide advocacy by working with parents, schools and community organizations to develop programs and services for the children and youth population. (Res. 129, I-89; Reaffirmed: CLRPD Rep. 2, I-99; Reaffirmation I-07)

H-170.985 Science Education

The AMA (1) supports working with other concerned organizations and agencies to identify ways to improve science education and science literacy in the nation, and to increase interest in science and education on the part of the nation's youth. (Res. 2, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

H-170.986 Health Information and Education

(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted.
(2) Employers should provide and employees should participate in programs on health awareness, safety and the use of health care benefit packages.
(3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite.
(4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse.
(5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities.
(6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care.
(7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the

health care delivery system to their patients and to the local community.
(8) Information on health and health care should be presented in an accurate and objective manner.
(9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.
(10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.
(11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs.
(12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services.
(13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-07)

H-170.988 Health Education Legislation

The AMA (1) reaffirms current policy which supports the establishment of a comprehensive health education program in the elementary and secondary schools; and (2) encourages state and specialty medical societies to consider the introduction of such model legislation in their state legislatures. (Sub. Res. 13, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-170.989 Health Fairs

The AMA (1) urges that the emphasis of health fairs be primarily educational and informative; and (2) encourages the sponsors of health fairs and similar single-purpose screening programs to emphasize the importance of the establishment of a personal doctor-patient relationship (Sub. Res. 7, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-170.990 Radioactive Substance Education in Public Schools

The AMA supports teaching fundamental aspects of exposure to ionizing radiation as part of the health education provided in secondary schools. (Res. 94, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed and Modified: CSA Rep. 8, A-05)

H-170.991 Information on Products and Services

The AMA strongly urges firms advising purchasers to seek medical advice regarding use of any product or service to include the name, address and telephone number of a responsible contact from whom information can be readily accessible to physicians on request (e.g., toll-free access or prompt delivery of printed matter about the product or service). (Res. 113, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CLRPD Rep. 1, A-05)

H-170.992 Alcohol and Drug Abuse Education

Our AMA: (1) supports continued encouragement for increased educational programs relating to use and abuse of alcohol, marijuana and controlled substances; (2) supports the implementation of alcohol and marijuana education in comprehensive health education curricula, kindergarten through grade twelve; and (3) encourages state medical societies to work with the appropriate agencies to develop a state-funded educational campaign to counteract pressures on young people to use alcohol. (Sub. Res. 63, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation and Reaffirmed: Sunset Report, I-00; Appended: Res. 415, I-01)

H-170.993 Health Education

Our AMA supports increased Association activity in the promotion of health education in kindergarten through grade 12 and the physician's office in the following ways: (1) Encourage and assist physicians on patient education/information programs for their offices. (2) Encourage physicians to support comprehensive health education programs in kindergarten through grade 12. (Res. 117, A-80; Reaffirmed: CLRPD Rep. B, I-90; Modified: Sunset Report, I-00)

H-170.995 Healthful Lifestyles

The AMA believes that consumers should be encouraged and assisted to learn healthful practices by: (1) educating and motivating the consumers to adopt more healthful lifestyles; (2) exploring methods of utilizing public communication more effectively in health education efforts directed towards motivating consumers to adopt healthful lifestyles; (3) encouraging consumers, in appropriate risk

groups, to utilize professional preventive health care services which would permit the early detection and treatment, or the prevention, of illness; and physicians demonstrating these practices through personal examples of health lifestyles. (BOT Rep. A, NCCMC Rec. 48, A-78; Reaffirmed: CLRPD Rep. C, A-89; Res. 402, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: BOT Rep. 8, I-06)

H-170.996 Establishing Active Liaison with Schools and Colleges

Our AMA encourages state and local societies to establish liaison relationships with schools to provide appropriate assistance in health education, particularly personal hygiene, drug abuse, smoking, venereal disease, quackery, and the role of the physician in maintaining good health. (Res. 72, A-71; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-170.997 School Health Committees

Our AMA encourages state medical associations to request state departments of education and local school districts to appoint school health committees of which at least one member would be a physician. (Res. 20, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-170.999 Health Instruction and Physical Education in Schools

The AMA reaffirms its long-standing and fundamental belief that health education should be an integral and basic part of school and college curriculums, and encourages state and local medical societies to work with the appropriate health education officers and agencies in their communities to achieve this end. (BOT Res., A-60; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-07)

H-175.000 Health Fraud

H-175.972 Plea Bargaining and Immunity from Prosecution

Our AMA opposes the use of harassment and coercive plea bargaining by prosecutors to pressure physicians. (Res. 205, A-05)

H-175.973 Medicare Investigation Search and Seizure Process

(1) It is the policy of our AMA that: (1) no duly authorized law enforcement or legal agency conduct any unannounced search of physicians' offices or seizure of records without observance of appropriate legal procedures;

(2) should unannounced search and seizure procedures be warranted in emergency situations based on clear and immediate threats to the lives or physical well-being of patients or the general public, such searches/seizures be conducted within the following parameters: (a) the search and/or seizure shall be conducted in a non-threatening and thoroughly professional manner; (b) the search and/or seizure shall not disrupt patient care; (c) the search and/or seizure shall be conducted in a manner to avoid publicity injurious to a physician's practice and professional reputation until all facts are known and culpability, if any, can be proven;

(3) When an episode occurs whereby a governmental agency disrupts the daily activities of a physician's office in the process of investigating alleged fraud and abuse activities, that such episodes be reported to the Division of Private Sector Advocacy for tracking purposes and to assist the involved/affected physician(s); and.

(4) If abusive practices of the investigative agency are noted, the AMA will inform the Department of Justice of those tactics. (Res. 205, I-01)

H-175.974 E&M Documentation Code Guidelines

Moved to Coding and Nomenclature as H-70.934 (Sub. Res. 813, I-99)

H-175.975 Clarification and Consolidation of Fraud Investigation Units

Our AMA encourages the federal government to: (1) simplify and consolidate the Medicaid fraud efforts of the many federal agencies currently investigating fraud; and (2) clearly define what healthcare fraud and/or abuse issues must be dealt with on a federal versus state level. (Res. 206, I-99)

H-175.976 Physician Protections in Fraud Data Bank Program

Our AMA will take all necessary actions to oppose and rescind the Health Care Integrity and Protection Data Bank. If not possible to repeal the establishment of the data bank, the AMA should take steps to protect the legal due process rights of practitioners. (Sub. Res. 803, A-99; Reaffirmation I-07)

H-175.977 Disruptive Visits to Medical Offices by Government Investigators and Agents

Our AMA: (1) supports legislation and/or other appropriate means to ensure that State and Federal investigators, and/or agents, give a physician written notice prior to a visit to a medical office, so that such visit may be scheduled upon mutual agreement at a time when patients are not present in the medical office; (2) in any circumstances which lawfully permit a visit to a medical office without notice, such as a search warrant, arrest warrant or subpoena, investigators and/or agents should be required to initially identify themselves to appropriate medical staff in a quiet and confidential way that allows the physician an opportunity to comply in a manner that is least disruptive and threatening to the patients in the medical office; and (3) encourages physicians to report incidents of inappropriate intrusions into their medical offices to the AMA's Office of the General Counsel and consider development of a hotline for implementation. (Res. 211, A-99; Reaffirmation I-01)

H-175.978 E&M Guidelines and AMA Position

Moved to Coding and Nomenclature as H-70.933 (Res. 804, I-98; Amended: Res. 831 and Reaffirmed: Res. 836, A-99; Reaffirmed: BOT Rep. 6, A-00)

H-175.979 Medicare "Fraud and Abuse" Update

Our AMA seeks congressional intervention to halt abusive practices by the federal government and refocus enforcement activities on traditional definitions of fraud rather than inadvertent billing errors. (BOT Rep. 34, I-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation I-01)

H-175.980 Anti-Kickback Implications of Ambulance Restocking

Our AMA: (1) supports federal legislation to create a safe harbor under the anti-kickback statute for ambulance restocking by hospitals, such as H.R. 3247, the "Community Safety Act of 1998;" and (2) urges the Office of the HHS Inspector General to change its position, as expressed in two existing advisory opinions, that hospital restocking of ambulances on a gratis basis may constitute a violation of the anti-kickback statute. (BOT Rep. 17, I-98)

H-175.981 Delay of the Implementation of E&M Codes

(1) Our AMA stands firmly committed to eradicate true fraud and abuse from within the Medicare system. Furthermore, the AMA calls upon the DOJ, OIG, and CMS to establish truly effective working relationships where the AMA can effectively assist in identifying, policing, and deterring true fraud and abuse.

(2) Physicians must be protected from allegations of fraud and abuse and criminal and civil penalties and/or sanctions due to differences in interpretation and or inadvertent errors in coding of the E&M documentation guidelines by public or private payers or law enforcement agencies.

(3) The burden of proof for proving fraud and abuse should rest with the government at all times.

(4) Congressional action should be sought to enact a "knowing and willful" standard in the law for civil fraud and abuse penalties as it already applies to criminal fraud and abuse penalties with regard to coding and billing errors and insufficient documentation.

(5) Physicians must be accorded the same due process protections under the Medicare audit system or Department of Justice investigations, that are afforded all US citizens. (Sub. Res. 801, A-98; Reaffirmed: Res. 804, I-98; Reaffirmed: BOT Rep. 6, A-00; Reaffirmation I-01)

H-175.982 Due Process for Physicians

It is the policy of the AMA to review current legislation governing fraud and abuse investigations and propose additional legislation and/or regulations as necessary and be prepared to take legal action in order to assure physicians due process in the conduct of fraud and abuse investigations.

Our AMA requests the United States Department of Justice to establish a specific procedure for audit of a physician's office records which includes, but is not limited to, the following: (1) Patient care in the physician's office must not be interrupted during the course of the audit;

(2) Patient ingress and egress must not be hindered during the course of an audit;

(3) Normal telephonic communication must not be interrupted during the course of an audit; and

(4) Normal routine of physician's care of patients in hospital or at home must not be interrupted. AMA policy is to pursue legislative, regulatory or other avenues to eliminate fines for inadvertent Medicare billing errors. (Sub. Res. 229, I-97; Reaffirmation A-99; Reaffirmation I-00; Reaffirmation I-01; Reaffirmed: Res. 12, A-06; Reaffirmation I-07)

H-175.983 Health Care Fraud and Abuse

The AMA believes that physicians should make no intentional misrepresentations to increase the level of payment they receive or to secure non-covered health benefits for their patients. The AMA encourages: (1) federal agencies and private sector research organizations to sponsor studies that will allow for a more accurate understanding of the actual nature and scope of health care fraud and abuse in the United States, and (2) state medical associations and county medical societies to pursue the development of physician committees charged with assisting in a comprehensive response to health care fraud and abuse in their communities, and provide assistance in the development of such committees.

The AMA will work toward the achievement of appropriate legal immunity for physicians who report fraud and abuse, and for continued antitrust protection for physician participation on physician peer review committees. (CEJA/CMS Rep., I-97; Reaffirmation A-99)

H-175.984 Health Care Fraud and Abuse Update

AMA policy is that: (1) our AMA leadership intensify efforts to urge federal policy makers to apply traditional definitions of fraud and abuse which focus on intentional acts of misconduct and activities inconsistent with accepted medical practice;
(2) our AMA continue to work with federal law enforcement officials to improve the ability to root out intentional schemes to defraud public programs;
(3) our AMA work with federal policymakers to balance payment integrity objectives with reasonable documentation and other administrative requirements;
(4) our AMA develop model compliance plans and educational materials to assist physicians in conforming to the latest laws and regulations; and
(5) our AMA continue to work in a coalition of other health care organizations to lobby for restrictions on the use of the False Claims Act. (BOT Rep. 25, I-97; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation I-00)

H-175.985 Kennedy-Kassebaum: Fraud and Abuse

Our AMA: (1) will work to alleviate the oppressive, burdensome effects on physicians of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

(2) opposes efforts to repeal provisions in Health Insurance Portability and Accountability Act of 1996 (HIPAA) that would alter the standard of proof in criminal and civil fraud cases or that would eliminate the ability of physicians to obtain advisory opinions regarding anti-kickback issues; and thoroughly evaluate and oppose other fraud and abuse proposals that are inappropriately punitive to physicians;

(3) will ensure that any proposed criminal fraud and abuse proposals retain the current intent standard of "willfully and knowingly" to be actionable fraud; and that the AMA oppose any effort to lower this evidentiary standard;

(4) will vigorously oppose efforts by the Department of Justice to punish and harass physicians for unintentional errors in Medicare claims submissions and the legitimate exercise of professional judgment in determining medically necessary services;

(5) continues its efforts to educate the entire Federation about the AMA’s successful amendment of the Health Insurance Portability and Accountability Act (also commonly referred to as the Kassebaum-Kennedy bill) which resulted in language being added so that physicians cannot be prosecuted or fined for inadvertent billing errors, absent an intent to "knowingly and willfully" defraud;

(6) educates the public and government officials about the distinction under the law, between inadvertent billing errors and fraud and abuse; and

(7) responds vigorously to any public statements that fail to distinguish between inadvertent billing errors and fraud and abuse. (Sub. Res. 222, A-97; Appended: Res. 202, I-98; Reaffirmation A-99; Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02)

H-175.986 Bounty Hunter Provision of the Health Insurance Portability and Accountability Act of 1996

The AMA will work toward amending the Health Insurance Portability and Accountability Act of 1996 by imposing civil monetary penalties for fraudulently and falsely reporting physician fraud or abuse. (Res. 222, I-96; Reaffirmed: BOT Rep. 34, A-06)

H-175.987 All-Payer Health Care Fraud and Abuse Enforcement Program

Our AMA: (1) opposes an All-Payer Health Care Fraud and Abuse Enforcement Program described in the Health Security Act of 1993 as it specifically applies to the seizure of property as a punitive measure in health care fraud cases; (2) supports efforts to clearly define health care fraud and establish an intergovernmental commission to investigate the nature, magnitude and costs involved in health care fraud and abuse; and (3) will pursue enactment of laws that ensure the equal application of due process rights to physicians in health care fraud prosecution. (Res. 215, A-94; Reaffirmation A-99; Reaffirmation I-00; Reaffirmation I-00; Reaffirmation I-01)

H-175.988 Thermography Update

(1) In view of the lack of sufficient proof of effectiveness, it is the policy of the AMA that the use of thermography for diagnostic purposes cannot be recommended at this time. It should be noted that research protocols using thermography are continuing and data derived from these studies will require careful evaluation.
(2) The AMA will continue to monitor the published literature on thermography, with periodic reports as appropriate.
(3) The AMA affirms the principle that proponents of a test, procedure, or treatment should bear the burden of proving that it is safe and effective for the proposed purpose through well-designed and well-controlled clinical trials. The results of these trials should be critically reviewed, preferably through reports submitted to peer-reviewed journals. (CSA Rep. C, A-93; Reaffirmed: CSA Rep. 8, A-03)

H-175.989 Health Care Fraud Legislation

Our AMA: (1) should continue to scrutinize current and future key legislation regarding health care fraud and abuse;

(2) should use all appropriate resources available to ensure that any proposed sanctions, penalties, or sentences be commensurate with the offense committed, especially regarding the imposition of criminal penalties in measures that fail even to define the boundaries of a "health care offense" or to establish the requisite intent necessary for conviction;

(3) should work with appropriate federal agencies and congressional committees in studying the extent to which health care fraud pervades the current environment;

(4) should continue to support legislative measures such as HR 5120, which would establish a national commission to investigate the nature, magnitude, and cost of health care fraud and abuse;

(5) should conduct surveys and research in order to develop data on possible abuses in the system;

(6) should continue to support the Principles of Medical Ethics concerning fraud by encouraging physicians to accept the responsibility to expose those engaged in fraud and deception;

(7) should continue to pursue recent initiatives, including providing assistance to the FBI in a cooperative endeavor as it attempts to identify and prosecute health care fraud, and continue ongoing efforts with the FTC to remove the current legal barriers to professional self-regulatory activity that would assist in the elimination of fraud and abuse;

(8) should pursue legislative efforts to enact a program that would award grants to medical societies for the creation of programs specifically targeted at fraud and abuse; and

(9) continue to make the relief of oppressive and overzealous application of fraud and abuse regulations a high priority and take whatever action is necessary to challenge improprieties in the application of fraud and abuse laws against physicians. (BOT Rep. Z, I-92; Reaffirmed: Sub. Res. 232, A-96; Reaffirmation A-99; Appended: Sub. Res. 244, A-00; Reaffirmed: Res. 201, I-00; Reaffirmation I-00; Reaffirmation A-02)

H-175.992 Deceptive Health Care Advertising

Our AMA (1) encourages and assists all physicians and medical societies to monitor and report to the appropriate state and federal agencies any health care advertising for which there is a reasonable, good-faith basis for believing that said advertising is false and/or deceptive in a material fact, together with the basis for such belief; and (2) encourages medical societies to keep the Association advised as to their actions relating to medical advertising. (Sub. Res. 102, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BOT Rep. 13, I-01)

H-175.993 Fraudulent Health Practices

The AMA favors providing information and educational materials to the public and the profession on fraudulent health practices. (Sub. Res. 62, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CLRPD Rep. 2, A-06)

H-175.994 Chelation Therapy

(1) There is no scientific documentation that the use of chelation therapy is effective in the treatment of cardiovascular disease, atherosclerosis, rheumatoid arthritis, and cancer. (2) If chelation therapy is to be considered a useful medical treatment for anything other than heavy metal poisoning, hypercalcemia or digitalis toxicity, it is the responsibility of its proponents to conduct properly controlled scientific studies, to adhere to FDA guidelines for drug investigation, and to disseminate study results in the usually accepted channels. (Sub. Res. 66, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04)

H-175.995 Hair Analysis - A Potential for Medical Abuse

The AMA opposes chemical analysis of the hair as a determinant of the need for medical therapy and supports informing the American public and appropriate governmental agencies of this unproven practice and its potential for health care fraud. (Sub. Res. 67, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04)

H-175.997 Chelation Therapy

The AMA believes that chelation therapy for atherosclerosis is an experimental process without proven efficacy. (Res. 57, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-175.998 Evaluation of Iridology

Our AMA believes that iridology, the study of the iris of the human eye, has not yet been established as having any merit as a diagnostic technique. (CSA Rep. F, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-180.000 Health Insurance
(See also: Health Care Delivery; Health Care Reform; Health Insurance: Benefits and Coverage; Health Insurance: Claim Forms and Claims Processing; Health Maintenance Organizations; Managed Care; Medical Review; Medicare; Physician Payment; Preferred Provider Arrangements)

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)

H-180.952 Physician Penalties for Out-of-Network Services

Our AMA vehemently opposes any penalties implemented by insurance companies against physicians when patients independently choose to obtain out-of-network services. (Res. 702, A-07)

H-180.953 Decreased Insurance Premiums for Nonsmokers

Our AMA:

(1) encourages insurance companies to review and make public their current actuarial experience with respect to smokers and nonsmokers and to consider ways of making available to nonsmokers, at reduced rates, policies for accident, auto, life, homeowners, fire, and health insurance; and

(2) supports the concept of health insurance contracts with lower premiums for nonsmokers, reflecting their decreased need for medical services and serving as a financial incentive for smokers (tobacco users) to discontinue this destructive habit. (CSA Rep. 3, A-04)

H-180.954 Privacy of Physician Medical Information

It is the policy of the AMA that a physician’s personal medical history is private and should remain confidential. Only information regarding current health status should be required for credentialing purposes. (BOT Rep. 7, I-02)

H-180.955 Deductibles Should Be Prorated to Make Them Equitable for Enrollees

Our AMA seeks legislation, regulation or other appropriate relief to require insurers to prorate annual deductibles to the date of contract enrollment. (Res. 235, A-01)

H-180.956 Physician Privileges Application - Timely Review by Managed Care

Our AMA policy is that:(1) final acceptance of residents who otherwise are approved by a health plan should be contingent upon the receipt of a letter from their program director stating that their training has been satisfactorily completed; (2) health plans which require board certification should allow the completing resident to be included in their plan after showing evidence of having completed the required training and of working towards fulfilling the requirements in the time frame established by their respective Board for completion of certification; and (3) Medicare, Medicaid, and managed care organizations should (a) make final physician credentialing determinations within 45 calendar days of receipt of a completed application; (b) grant provisional credentialing pending a final credentialing decision if the credentialing process exceeds 45 calendar days; and (c) retroactively compensate physicians for services rendered from the date of their credentialing. (Res. 708, A-01; Modified Sub. Res. 701, I-01; Reaffirmed: Res. 809, I-02; Reaffirmation A-05)

H-180.957 Health Savings Account

Our AMA will pursue activities to inform physicians and the public about the value and availability of Health Savings Accounts, including using the AMA Web Site as a key information medium for this purpose. (Res. 606, I-98; Reaffirmation A-99; Reaffirmation A-02; Reaffirmation I-03)

H-180.958 Coverage of Prescription Contraceptives by Insurance

Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives. (Res. 221, A-98; Reaffirmation A-04)

H-180.960 Insurance Company Medical Test Disclosures

AMA policy is that insurance companies must inform insurance applicants of any abnormal results that are found during an insurance health evaluation; that insurance companies should inform an applicant that if he or she receives information concerning an evaluation that has an abnormal result, he or she should send the results to his or her physician for further consultation; and that all insurance applicants should be made aware that all health information obtained from insurance evaluations is available upon an applicant's request. (Res. 208, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-180.961 Defining Levels of Health Insurance Coverage

Our AMA strongly encourages the National Association of Insurance Commissioners to develop standards and a uniform disclosure format applicable to health plans and policies offered in the general insurance market, taking into consideration the benefit definitions and disclosure format used by plans participating in the Federal Employees Health Benefits Plan program; and supports the enactment of federal and/or state legislation requiring the use by health plans of standardized uniform disclosure formats that have had appropriate input by medical organizations. (CMS Rep. 9, A-97; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation I-07)

H-180.963 Volume Discrimination Against Physicians

The AMA recommends that volume indicators should be applied only to those treatments where outcomes have been shown by valid statistical methods to be significantly influenced by frequency of performance; and affirms that volume indicators should not be used as the sole criteria for credentialing and reimbursement and that, when volume indicators are used, allowances should be made for physicians starting practice. (Sub. Res. 101, A-96; Reaffirmed: CMS Rep. 8, A-06)

H-180.964 Health Care Coverage of Young Adults Under Their Parents' Family Policies

Our AMA encourages the health insurance industry, employers and health plans to make available to young adults who do not have health insurance extended family health expense coverage to age 28 that conforms to the following characteristics: (1) The option to extend coverage under the parents' family policy or plan from the usual cut-off age to age 28 should be available for a specified initial enrollment period beyond the usual cut-off age under the plan.

(2) Enrollment in the family coverage other than during this initial period should be available without a preexisting condition limitation to those individuals (to age 28) seeking the coverage because of loss of previous insurance protection within a specified time after loss of the previous protection, and should be available with a preexisting condition limitation to those seeking the coverage for other reasons at any time.

(3) Status as a full-time student should not be a requirement for extension of or first-time enrollment in the parents' coverage.

(4) To the extent that premiums for such a plan are higher, the extended coverage should be made available as a separate extra-cost rider. (CMS Rep. 1, I-95; Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-02)

H-180.965 Income Tax Credits or Deductions as Compensation for Treating Medically Uninsured or Underinsured

The AMA will not pursue efforts to have federal laws changed to provide tax deductions or credits for the provision of care to the medically uninsured and underinsured. (BOT Rep. 49, I-93; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed in lieu of Res. 141, A-07)

H-180.966 Unfair Denial of Reimbursement

Our AMA will urge the United Mine Workers of America and other third party payers, as appropriate, not to exclude non-board certified physicians from participation in their programs or health benefit plans, without regard to individual training, experience and current competence. (Res. 707, A-93; Reaffirmation A-00)

H-180.967 Economic Credentialing by Insurance Companies

The AMA protests economic credentialing by third party payers in which economic factors are placed above quality of care factors. (Res. 817, I-92; Reaffirmed by Rules & Credentials Cmt., A-96; Modified and reaffirmed: CMS Rep. 8, A-06; Reaffirmation A-07)

H-180.968 Third Party Payer Credentialing

It is the policy of the AMA that third party payers should not exclude non-board certified physicians as a class from participation in their programs, without regard to individual training, experience, and current competence. (Sub. Res. 811, I-92; Reaffirmed by Sub. Res. 704, I-94; Reaffirmed by Sub. Res. 701, I-95; Reaffirmed by CME Rep. 5, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-180.970 Expanded State/Federal Regulation Oversight of Multiple Employer Welfare Arrangements

The AMA supports appropriate federal and state initiatives to regulate and oversee health care plans provided through multiple employer welfare arrangements. (Sub. Res. 204, I-92; Reaffirmed: BOT Rep. 28, A-03)

H-180.972 Increased Third Party Payer Accountability

The AMA will include in its legislative and/or public relations programs the goal of putting an end to inflammatory language contained in third party payer notifications to patients. (Res. 235, A-92; Reaffirmed: Sub. Res. 106, I-98; Reaffirmation I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-180.973 The "Hassle Factor"

Our AMA will greatly intensify its efforts (including support of HR 2695) to reduce the burden of government and third party regulation on medical practice and its intrusion into the physician-patient relationship and doctor patient time. (Res. 276, A-92; Reaffirmation A-00; Reaffirmation A-01; Modified: CLRPD Rep. 1, A-03; Reaffirmation I-07)

H-180.975 Insurance Industry Antitrust Exemption

It is the policy of the AMA (1) to continue efforts to have the insurance industry be more responsive to the concerns of physicians, including collective negotiations with physicians and their representatives regarding delivery of medical care;

(2) to continue efforts to have the insurance industry be more responsive to the concerns of physicians and their representatives regarding reasonable requests for appropriate information and data;

(3) to analyze proposed amendments to the McCarran-Ferguson Act to determine whether they will increase physicians' ability to deal with insurance companies, or increase appropriate scrutiny of insurance industry practices by the courts; and

(4) to continue to monitor closely and support appropriate legislation to accomplish the above objectives. (BOT Rep. DD, I-91; Reaffirmed: Res. 213, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08)

H-180.978 Access to Affordable Health Care Insurance through Deregulation of State Mandated Benefits

Our AMA (1) through its coalition with business and industry and its state federation, supports giving priority attention to a partial and rational deregulation of the insurance industry in order to expand access to affordable health care coverage; and

(2) reaffirms its commitment to private health care insurance using pluralistic, free enterprise mechanisms rather than government mandated and controlled programs. (Res. 129, A-89; Reaffirmed: CLRPD Rep. 2, I-99)

H-180.980 Sexual Orientation and/or Gender Identity as Health Insurance Criteria

The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity. (Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97; Reaffirmed: CMS Rep. 9, A-07; Modified: BOT Rep. 11, A-07)

H-180.981 Rating or Rejection of Applicants for Health Policies

(1) The AMA encourages state medical societies to urge state insurance commissioners to require the following: (a) that when an insurance company rates or rejects any applicant for a health policy, the insurance company must explain in writing in terms understandable to the patient the reason(s) for rating or rejection within 21 days; and (b) that in the case of a rating or rejection of an applicant for a health policy, the applicant, after having been informed of the reason(s) for such action, shall have 21 days to submit further information and to protest such action, and that such rating or rejection shall not be reported to the Medical Information Bureau until such information is reviewed. (2) In those instances where the insurance commissioner lacks the necessary authority or fails to implement the goals set out above on a regulatory basis, the AMA urges state medical associations to pursue legislation to accomplish the intent of the resolution, with appropriate review of the relevant provisions of the National Association of Insurance Commissioners Model Act. (CMS Rep. I, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-180.988 Federal Policy Favoring HMOs

Our AMA supports legislation amending the current federal law so that employers must offer multiple options for health care benefits to employees or to their union representatives, including the traditional fee-for-service coverage option, if a health care benefit is provided. (Sub. Res. 43, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmation A-00)

H-180.995 Government Subsidies to HMOs

Our AMA (1) reaffirms its stand against special and preferential subsidies to one form of health and medical care, and urges the federal government to refrain from such preferential grants and subsidies; and (2) protests the use of tax monies to promote HMOs over other forms of heath care. (Res. 59, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-180.997 Blue Cross/Blue Shield

Our AMA (1) reaffirms its policy that the AMA in its relationships with commercial carriers, mutual insurance companies - including Blue Cross and Blue Shield Plans - is to avoid any conduct which implies or give preferential competitive advantages; and (2) recommends this policy be continued. (BOT Rep. V, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-180.998 Regulation of Insurance Carriers and Health Plans

Our AMA believes that organizations financing health care services (e. g., insurance companies, Blue Cross, Blue Shield, HMOs, health and welfare trusts) should be certified at the state level on the basis of financial soundness, and plans should be routinely monitored by the same agency to guard against misrepresentation of costs or benefits. All carriers in a given regulatory jurisdiction should be subject to the same standards. (BOT Rep. A, NCCMC Rec. 7, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03)

H-185.000 Health Insurance: Benefits and Coverage
(See also: Health Care Delivery; Health Care Reform; Health Insurance; Health Insurance: Claim Forms and Claims Processing; Health Maintenance Organizations; Managed Care; Medical Review; Medicare; Mental Health; Physician Payment; Preferred Provider Arrangements)

H-185.948 Health Insurance for Children

Our AMA supports requiring all children to have adequate health insurance as a strategic priority. (Res. 610, I-08)

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

Our AMA will:
(1) 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;

(2) 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;
(3) educate physicians about the HAC-POA law and its implications for patient care, coding requirements and payment;
(4) 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;
(5) 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;
(6) 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
(7) 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. (BOT Rep. 17, A-08)

H-185.950 Removing Financial Barriers to Care for Transgender Patients

Our AMA supports public and private health insurance coverage for treatment of gender identity disorder as recommended by the patient's physician. (Res. 122; A-08)

H-185.951 Home Anti-Coagulation Monitoring

1. Our AMA encourages all third party payers to extend coverage and reimbursement for home monitors and supplies for home self-monitoring of anti-coagulation for all medically appropriate conditions.

2. Our AMA (a) supports the appropriate use of home self-monitoring of oral anticoagulation therapy and (b) will continue to monitor safety and effectiveness data, in particular cost-effectiveness data, specific to the United States on home management of oral anticoagulation therapy. (Res. 825, I-05; Modified and Reaffirmed: CSAPH Rep. 9, A-07)

H-185.952 Elimination of Lifetime Maximums of Health Insurance Benefits

It is the policy of our AMA that employers and health insurers should eliminate the lifetime maximums of health insurance benefits. (CMS Rep. 2, I-05)

H-185.953 Health Insurance Coverage of Specialty Pharmaceuticals

Our AMA supports complete transparency of health care coverage policies related to specialty pharmaceuticals, including co-payment or co-insurance levels and how these levels are determined. (CMS Rep. 2, I-05)

H-185.954 Coverage for Certain Types of Well Care Examinations by Health Insurers

Our AMA: (1) will continue to facilitate the education of the American public and physicians as to the benefits of clinical preventive services, such as mammography screening and periodic physical examinations; (2) will continue to evaluate on a regular basis the benefits and cost-effectiveness of clinical preventive services guidelines; and (3) urges all health insurers to make available for purchase a wide variety of group and individual health insurance policies that provide coverage for a range of clinical preventive services. (Sub. Res. 108, A-97; Modified: CMS Rep. 7, A-00; Reaffirmed: CMS Rep. 3, A-02; Renumbered: CMS Rep. 7, I-05)

H-185.955 Pap Smears as a Clinical Laboratory Test

The AMA: (1) advocates that it is imperative that Pap smear screening have sufficient payment levels to support the technology and personnel costs required to provide the service, and (2) seeks legislative and regulatory change in the Medicare payment policy for Pap smears so that payment for the technical component of the service is adequate to cover the cost of providing the service, and that pathologists are reimbursed for interpretation of abnormal Pap smears based on the RBRVS. (CMS Rep. 6, I-97; Renumbered: CMS Rep. 7, I-05)

H-185.956 Health Plan Coverage for Over-the-Counter Drugs

Our AMA: (1) opposes mandated health plan coverage for over-the-counter (OTC) pharmaceuticals, including those that had previously been available only with a prescription; (2) encourages health insurers and health plans to cover medically necessary OTC drugs for which no prescription alternative exists; and (3) continues to support efforts to study the effects of converting medically necessary drugs from prescription to over-the-counter status on the costs and access to such medications. (CMS Rep. 1, I-98; Renumbered: CMS Rep. 7, I-05)

H-185.957 Coverage for Strabismus Surgery

Our AMA supports legislation that requires all third party payers that cover surgical benefits to cover all strabismus surgery where medically indicated. (Res. 234, A-01; Renumbered: CMS Rep. 7, I-05)

H-185.958 Equity in Health Care for Domestic Partnerships

Our AMA: (1) encourages the development of domestic partner health care benefits in the public and private sector; and (2) supports equity of pre-tax health care benefits for domestic partnerships. (Res. 101, I-01; Renumbered: CMS Rep. 7, I-05)

H-185.959 Health Care Benefit Discrepancies for Small Employers Under COBRA

Our AMA: (1) supports the principle that small employers who provide their employees with a group health insurance benefit, and who can afford to do so, should be encouraged to provide continuation coverage for their former employees, ideally consistent with the 18 months of coverage under COBRA; and (2) encourages small employers to establish individual Medical Savings Accounts for their employees. (CMS Rep. 3, A-03, Renumbered: CMS Rep. 7, I-05)

H-185.960 Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans

Our AMA supports health plan coverage for the full range of colorectal cancer screening tests. (Res. 726, I-04; Reaffirmation I-07)

H-185.961 Health Plan Coverage of Prescription Drugs

It is the policy of our AMA that third party payers should not establish a higher cost-sharing requirement exclusively for prescription drugs approved for coverage under a medical exceptions process (CMS Rep. 6, A-03)

H-185.962 Payment for Advanced Technologies

Our AMA vigorously opposes actions by medical insurers to deny payment for services simply on the basis of the size of medical equipment. (Res. 126, A-03)

H-185.963 Insurance Coverage for Adults with Childhood Diseases

Our AMA: (1) will work with the Federation and other interested parties to encourage federal and state governmental agencies to develop a comprehensive population profile of adults with congenital and/or childhood diseases, their health care service needs, and their level of health insurance coverage;
(2) will work with the Federation and other interested parties to encourage federal and state governmental agencies to identify any barriers of access to primary and specialty health care services;
(3) urges public and private third party payers to increase access to health insurance products for adults with congenital and/or childhood diseases that are designed for the unique needs of this population; and
(4) emphasizes that any health insurance product designed for adults with congenital and/or childhood diseases include the availability of specialized treatment options, medical services, medical equipment and pharmaceuticals, as well as the accessibility of an adequate number of physicians specializing in the care of this unique population. (CMS Rep. 2, I-99)

H-185.964 Status Report on the Uninsured

Our AMA opposes new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations. (CMS Rep. 2, A-99)

H-185.965 Insurance Coverage of Screening Examinations

Our AMA adopts the policy that patients seeking covered screening examinations (e.g., mammogram) should be able to receive insurance reimbursement for such periodic examinations performed within an appropriately flexible interval (i.e., once annually, rather than having to wait precisely 365 days). (Res. 128, A-99)

H-185.966 Physician-Performed Microscopy

Our AMA informs managed care plans that physician-performed microscopy should be reimbursed under insurance plans if it is not included in the capitation rate. (Res. 115, A-98; Reaffirmed: CMS Rep. 4, A-08)

H-185.967 Coverage of Children's Deformities, Disfigurement and Congenital Defects

The AMA declares: (1) that treatment of a minor child's congenital or developmental deformity or disorder due to trauma or malignant disease should be covered by all insurers; (2) that such coverage shall include treatment which, in the opinion of the treating physician, is medically necessary to return the patient to a more normal appearance (even if the procedure does not materially affect the function of the body part being treated); and (3) that such insurability should be portable, i.e., not denied as a pre-existing condition if the patient's insurance coverage changes before treatment has been either initiated or completed. (Sub. Res. 119, I-97; Reaffirmed, A-03; Reaffirmation A-05; Reaffirmation A-08)

H-185.969 Insurance Coverage for Immunizations

Our AMA endorses laws requiring insurance companies to provide coverage for immunization schedules endorsed by the Advisory Committee on Immunization Practices, American Academy of Family Physicians, and American Academy of Pediatrics, with no co-pays or deductibles. (Res. 430, A-97; Reaffirmation A-01; Reaffirmation A-08)

H-185.970 Coverage of Hepatitis B Immunization by Health Insurers

The AMA believes all health insurers, including government, private and commercial insurers, should cover Hepatitis B immunizations, without co-pays or deductibles. (Res. 411, A-97; Reaffirmed: CSA Rep. 18, A-99)

H-185.971 Health Insurance Policy Information

The AMA urges that health insurance policies explicitly and specifically list exclusions from coverage in order that these are apparent and comparable. (Sub. Res. 106, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-185.972 Genetic Information and Insurance Coverage

AMA believes: (1) Health insurance providers should be prohibited from using genetic information, or an individual's request for genetic services, to deny or limit any health benefit coverage or establish eligibility, continuation, enrollment or contribution requirements.
(2) Health insurance providers should be prohibited from establishing differential rates or premium payments based on genetic information or an individual's request for genetic services.
(3) Health insurance providers should be prohibited from requesting or requiring collection or disclosure of genetic information.
(4) Health insurance providers and other holders of genetic information should be prohibited from releasing genetic information without express prior written authorization of the individual. Written authorization should be required for each disclosure and include to whom the disclosure would be made. (BOT Rep. 15, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-185.973 Simple, Honest Summary Statement

Our AMA will pursue the position that every health plan should include in its marketing and policies a bold type front page that explicitly details any limitations in choice of primary care physicians, access to a specialist and method of physician reimbursement. (Sub. Res. 115, A-96; Reaffirmation A-97; Modified and Reaffirmed: CMS Rep. 9, A-07)

H-185.974 Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs

Our AMA supports parity of coverage for mental illness, alcoholism and substance use. (Res. 212, A-96; Reaffirmation A-97; Reaffirmed: Res. 215, I-98; Reaffirmation A-99; Reaffirmed: BOT Action in response to referred for decision Res. 612, I-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 9, A-01; Reaffirmation A-02; Reaffirmation I-03; Modified: CMS Rep. 2, A-08)

H-185.975 Requiring Third Party Reimbursement Methodology be Published for Physicians

Our AMA:

(1) urges all third party payers and self-insured plans to publish their payment policies, rules, and fee schedules;

(2) pursues all appropriate means to make publication of payment policies and fee schedules a requirement for third party payers and self-insured plans;

(3) will develop model state and federal legislation that would require that all third party payers and self-insured plans publish all payment schedule updates, and changes at least 60 days before such changes in payment schedules are enacted, and that all participating physicians be notified of such changes at least 60 days before changes in payment schedules are enacted.

(4) seeks legislation that would mandate that insurers make available their complete payment schedules, coding policies and utilization review protocols to physicians prior to signing a contract and at least 60 days prior to any changes being made in these policies;

(5) works with the National Association of Insurance Commissioners, develop model state legislation, as well developing national legislation affecting those entities that are subject to ERISA rules; and explore the possibility of adding payer publication of payment policies and fee schedules to the Patient Protection Act; and

(6) supports the following requirements: (a) that all payers make available a copy of the executed contract to physicians within three business days of the request; (b) that all health plan EOBs contain documentation regarding the precise contract used for determining the reimbursement rate; (c) that once a year, all contracts must be made available for physician review at no cost; (d) that no contract may be changed without the physician's prior written authorization; and (e) that when a contract is terminated pursuant to the terms of the contract, the contract may not be used by any other payer. (Sub. Res. 805, I-95; Appended: Res. 117, A-98; Reaffirmation A-99; Appended: Res. 219, and Reaffirmed: CMS Rep. 6, A-00; Reaffirmation I-01; Reaffirmed and Appended: Res. 704, A-03; Reaffirmation I-04; Reaffirmation A-08; Reaffirmation I-08)

H-185.976 Insurance Discrimination Against Victims of Domestic Violence

Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence. (Res. 814, I-94; Appended: Res. 419, I-00)

H-185.977 Milliman and Robertson Guidelines

Our AMA will use its influence to stop the inappropriate application of the Milliman and Robertson Guidelines to clinical situations; and will offer its support amicus in any appropriate court action which centers upon adherence to the Milliman and Robertson Guidelines. (Res. 710, A-94; Reaffirmed: Sub. Res. 709, I-97; Reaffirmed: Res. 820, A-00)

H-185.979 Allocation of Health Services

The AMA will: (1) work with payer organizations and managed care plans and support legislation as necessary to develop and encourage adherence to a standard format across plans for disclosure of relevant plan information to prospective enrollees;

(2) expand its consumer information program to develop guides to assist individuals in understanding health insurance offerings and restrictions so that they can make informed decisions in selecting plans best suited to meet individual and family needs and circumstances;

(3) utilize all appropriate consumer health information channels to encourage the development by individuals and families of personal health records containing information on family and medical histories and problems, care received, medications, immunizations, allergies, and other relevant medical information and to explore the feasibility of developing sample formats for such personal health records; and

(4) encourage and facilitate the development and distribution to physicians for use in their offices of brochures and other appropriate materials that would address such issues as advance directives, health promotions, alternative medical care and other health care information that might be sought by patients and/or their families. (BOT Rep. I-93-22; Reaffirmation A-97; Reaffirmed: CMS Rep. 9, A-07)

H-185.981 Third Party Responsibility for Payment

Our AMA (1) will develop, with the assistance of the Blue Cross and Blue Shield Association, the Group Health Association of America, the Health Insurance Association of America, and other relevant health care organizations, guidelines for a standardized system of verifying eligibility for health benefits; (2) will assume a leadership role with these organizations in the development of guidelines for a standardized system of verifying eligibility for health benefits; and (3) following the development of such guidelines, will work with major insurers and managed care plans to promote the development of a standardized, national health benefits verification system based on the guidelines, which would include an obligation on the part of the insurer or managed care plan to pay physicians for any services rendered to patients whose eligibility for benefits have been verified erroneously. (Sub. Res. 721, A-92; Reaffirmed: Sub. Res. 828, A-99; Reaffirmation A-00)

H-185.982 "Catastrophic Only" Health Insurance

Our AMA: (1) recognizes that there are proportionally large administrative costs associated with the health insurance payment of small health care claims and (2) supports the study of "Catastrophic Only" health insurance. (Res. 121, A-92; Reaffirmation A-02)

H-185.983 Patient's Out-of-Pocket Contributions to Private Health Insurance

(1) The AMA takes the position that the practice of basing copayments on a different basis than the third party reimbursement should be condemned. (2) If physicians learn that their patients' copayments are being computed on a different basis than the third party's reimbursement, they should inform their patients and, when appropriate, help them make fully informed, cost-conscious alternative choices about their insurance coverage. (3) If physicians suspect that copayments are being set unfairly, they should bring these matters to the attention of the state insurance commissioner or other state regulator and ask for assistance from their state medical society. (BOT Rep. D, A-92; Reaffirmed: CMS Rep. 10, A-03)

H-185.984 Toll-Free 24-Hour Insurance Information

(1) It is the policy of the AMA to initiate and support efforts to require that health insurance providers and third party administrators maintain a toll-free 24 hour-a-day telephone line, or other confidential electronic means, to provide information about specific coverage and benefits available to any patient presenting for medical care.

(2) Our AMA supports a requirement that health insurers provide physicians with toll-free telephone access to adequate personnel who can discuss and respond to questions regarding patient covered services within 24 hours.

(3) Our AMA seeks legislation to rquire that, where a plan does not provide toll-free, 24 hour access to verify patient coverage eligibility, the patient's identification card from the plan with be deemed valid.

(4) Our AMA continues its efforts to seek reinstatement by CMS of toll-free telephone lines for transmission of electronic claims.

(5) The toll-free lines for questions and claims submission be available on a 24-hour basis.

(6) The toll-free lines are not reinstated, our AMA seeks enactment of legislation requiring CMS provision of toll-free telephone lines. (Res. 76, A-91; Res. 707, A-97; Reaffirmed and Appended: Sub. Res. 114, I-98; Reaffirmed: Sub. Res. 828, A-99; Reaffirmation A-00)

H-185.985 Internal Guidelines Used by Third Party Payers to Determine Coverage

Our AMA calls upon all third party payers and appropriate federal regulatory agencies to make all guidelines related to patient coverage a matter of public information and easily obtainable by both patients and physicians. (Res. 126, A-91; Modified: Sunset Report, I-01)

H-185.986 Nondiscrimination in Health Care Benefits

Our AMA reaffirms its opposition to discriminatory benefit limitations, copayments or deductibles for the treatment of psychiatric illness under existing health care plans, and opposes discrimination in any proposed plans for national health care coverage or universal access for the people who are uninsured. (Res. 58, A-91; Reaffirmation A-97; Reaffirmation A-00)

H-185.987 Prayer Fees Reimbursed As Medical Expenses

It is the policy of the AMA to: (1) publicize the position that prayer as therapy should not delay access to traditional medical care; (2) urge third party payers to consider reimbursement for prayer as therapy by any third party as inappropriate; and (3) inform the federal government that fees for prayer as therapy should not be considered as a medically deductible expense. (Res. 118, I-90; Reaffirmed: Sunset Report, I-00)

H-185.988 High Cost Health Benefits Management

The AMA has adopted the following guidelines concerning the structure and function of high-cost benefits management programs:

(1) Benefits management entities should be licensed and liable for unfavorable outcomes attributable to decisions by benefits managers and/or peer reviewing physicians that interfere with appropriate clinical judgment of the treating physicians. Physicians should document such interference.

(2) In selecting patients for benefits management, the manager should review and utilize the patient's medical record as the primary source of information on which to base a selection decision.

(3) Benefits managers should work with hospital discharge planners to educate patients regarding the benefits management process.

(4) Benefits managers should have the same level of responsibility for preserving patient confidentiality that is expected of physicians

and other health professionals.

(5) To minimize liability risks, high-cost benefits management programs should (a) utilize, in close coordination with treating physicians, written protocols or guidelines established by physicians for the development of treatment plans and referrals; (b) document all treatment recommendations, decisions, and their rationales; (c) clarify contract provisions for all parties concerned; and (d) secure written agreements to contract exceptions concerning benefits.

(6) Innovation concerning and evaluation of different compensation methods for benefits management services - hourly charges, capitation, or incorporation into the overall premium structure - should be encouraged to allow accumulation of more definitive data on the advantages and disadvantages of each.

(7) Currently, evidence that benefits management programs achieve their stated goals is largely anecdotal. A uniform method of assessing the extent to which such goals are met - one that monitors both quality and cost - should be developed and implemented. This system should be incorporated as an integral part of every benefits management program. (CMS Rep. D, A-90; Reaffirmed: Sunset Report, I-00)

H-185.989 Continuity of Insurance Coverage

Our AMA opposes any attempt by life or health insurers to cancel, reduce, refuse to renew, or increase the individual's premium for coverage under either individual or group policies based on an illness occurring during the time insurance is in force. (CMS Rep. J, A-89; Reaffirmed: Sub. Res. 828, A-99)

H-185.990 Infertility Insurance Coverage

The AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility. (Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-185.991 Uniform Definition of Experimental Procedures and Therapies

The AMA supports working with the Health Insurance Association of America, the Blue Cross and Blue Shield Association, and other appropriate parties and federal agencies to develop uniform definitions for investigational or experimental therapies and procedures, so that methodologies can be established so that all who inquire may learn the status of a therapy or procedure. (Res. 143, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-185.993 Third Party Encumbrances

The AMA urges public and private payers and consumer organizations to increase their educational efforts directed toward patients and subscribers regarding conditions for coverage of durable medical equipment. (CMS Rep. J, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmation A-08)

H-185.996 Utilization in Appropriate Settings

Our AMA (1) believes that private and government insurance benefit packages should be adjusted to provide balanced coverage of alternative services and settings in the provision of health care; and (2) encourages physicians and health insurance and prepayment plans to study jointly how insurance benefit packages can be used to stimulate more innovative and effective use of care settings without restricting needed local flexibility in determining what setting is best for each patient. (CMS Rep. C, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-185.997 Insurance Coverage for Complete Maternity Care

Our AMA (1) reaffirms its policy of encouraging health insurance coverage for care of the newborn from the moment of birth;

(2) urges the health insurance industry and government to include in their plans, which provide maternity benefits, coverage for normal obstetrical care, and all obstetrical complications including necessary intrauterine evaluation and care of the unborn infant;

(3) urges the health insurance industry to offer such plans on the broadest possible basis; and

(4) urges the health insurance industry to make available, on an optional basis, coverage for treatment associated with voluntary control of reproduction. (BOT Rep. M, CMS Rep. J, I-74; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-185.998 Exclusion of First 14 Days of Life in Health Insurance

Our AMA recommends eradication from health insurance policies of exclusionary clauses affecting children, such as the "first 14 days." (Sub. Res. 153, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-185.999 Multiple Coverage in Voluntary Health Insurance

(1) Over-insurance can arise when an individual is insured under two or more policies of health insurance. When the reimbursement from this multiple coverage exceeds the expenses against which the individual has insured himself, a profit may result. Over-insurance thus encourages wasteful use of the public's health care dollar. (2) A solution to this problem can be accomplished by the use of contract language and the application of coordination of benefits provisions which operate to enable persons covered under two or more group programs to be fully reimbursed for their expenses of insured services without receiving more in total benefits than the amount of such expenses. (3) Therefore, the AMA encourages the health insurance companies and prepayment plans to adopt policy provisions and mechanisms based upon the preceding principles which would control the adverse effects of over-insurance. (CMS Rep. F, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-190.000 Health Insurance: Claim Forms and Claims Processing
(See also: Health Insurance; Health Insurance: Benefits and Coverage; Health Maintenance Organizations; Managed Care; Medical Review; Medicare: Carrier Review; Physician Payment; Preferred Provider Arrangements)

H-190.959 Physician Reimbursement by Health Insurance and Managed Care Companies

(1) Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days.
(2) When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim.
(3) Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment. (Sub. Res. 713, A-02; Modified: Res. 714, A-03; Reaffirmation I-04)

H-190.960 HIPAA Law and Regulations

Our AMA believes that inadvertent disclosures of protected health information should not lead to the imposition of criminal sanctions. (Sub. Res. 207, A-02)

H-190.961 Repeal of Federally Mandated Uniform Medical Identifiers

Our AMA: (1) actively supports legislation that would repeal the unique patient medical health identifier mandated by the Health Insurance Portability and Accountability Act of 1996; and (2) urges all state medical societies to ask each of their congressional delegations to declare themselves publicly on this matter. (Res. 207, I-01)

H-190.962 Automatic Claims Processing by Medicare Contractors

Our AMA seeks to have Medicare supplement insurers be required to accept transmissions from Medicare contractors as a claim for benefits without the need for patients or physicians to submit additional claims. (Res. 104, I-01)

H-190.963 Identity Fraud

Our AMA policy is to discourage the use of Social Security numbers to identify insureds, patients, and physicians, except in those situations where the use of these numbers is required by law and/or regulation. (Res. 805, A-01; Reaffirmed: Res. 804, A-02)

H-190.964 Electronic Claims

Our AMA policy is that ALL third party payers: (1) acknowledge receipt of each electronic claim received within 24 hours; and (2) accept or reject each electronic claim within 10 business days. (Res. 707, A-01; Reaffirmation I-04)

H-190.965 Claims Denial and Payment Delays

Our AMA policy is that insurers should not deny payment on lost claims discovered beyond the required filing date when the physician has proof that the electronic or paper claim was filed in a timely manner. (Res. 705, A-01; Reaffirmation I-04)

H-190.966 AMA Assistance with HIPAA

Our AMA: (1) make it a priority to keep its members informed of the impact HIPAA regulations have on the practice of medicine and

the cost to physicians; and (2) encourages physician participation in appropriate national organizations involved in the implementation of HIPAA regulations such as the Strategic National Implementation Process (SNIP) as organized by the Workgroup on Electronic Data Interchange (WEDI). (Sub. Res. 806, I-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02)

H-190.967 Time Restrictions on Submitting Medicaid Claims

Our AMA advocates for a change in regulations of the CMS to require any insurer administering Medicaid claims to accept claims up to one year after the date of service. (Res. 107, A-00)

H-190.968 Timely Medicare Patient Eligibility Information

Our AMA strongly encourages Medicare to: (1) move immediately to provide physicians with timely Medicare patient eligibility information; and (2) change its entire claims processing system from a batch processing system to a real-time processing system. (Res. 106, A-99; Reaffirmation I-04)

H-190.969 Delay in Payments Due to Disputes in Coordination of Benefits

Our AMA:

(1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;

(2) includes the "birthday rule" and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims;

(3) urges state medical associations to advocate for the inclusion of the "employer first rule" and "birthday rule" in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits;

(4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays;

(5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation;

(6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and

(7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services. (CMS Rep. 8, I-98; Reaffirmation I-04)

H-190.970 Status Report on the National Uniform Claim Committee and Electronic Data Interchange

The AMA advocates the following principles to improve the accuracy of claims and encounter-based measurement systems:

(1) the development and implementation of uniform core data content standards (e.g., National Uniform Claim Committee (NUCC) data set);

(2) the use of standards that are continually modified and uniformly implemented;

(3) the development of measures and techniques that are universal and applied to the entire health care system;

(4) the use of standardized terminology and code sets (e.g., CPT) for the collection of data for administrative, clinical, and research purposes; and

(5) the development and integration of strategies for collecting and blending claims data with other data sources (e.g., measuring the performance of physicians on a variety of parameters in a way that permits comparison with a peer group). (CMS Rep. 2, I-97; Reaffirmation I-04)

H-190.971 Physicians' Right to Receive Billing and Remittance Information

AMA policy is that all physicians are entitled to receive detailed itemized billing and remittance information for medical services they provide, and that our AMA develop strategies to assist physicians who are denied such information. (Sub. Res. 711, I-97; Reaffirmation I-04; Reaffirmation A-07)

H-190.972 Strategy for Eliminating Delayed Payments to Physicians by Third Party Payers

It is the policy of our AMA that delayed payments to physicians and hospitals without justification by third party payers should be prohibited by law. (BOT Rep. 13, I-97; Reaffirmation I-04)

H-190.973 Uniform Physician and Physician Group Identifiers

The AMA strongly urges that all private payers accept the National Provider Identifier as the sole physician and physician group identifier on all claims. (Res. 818, A-97; Modified and Reaffirmed: CMS Rep. 9, A-07)

H-190.975 Universality of CMS 1500 Form

The AMA will undertake the task of asking individual carriers and/or their representative organizations to maintain the universal contents and acceptance of specific data in the CMS 1500 Form so that it will remain as a truly universal form for the patient-doctor claim form. (Res. 107, I-96; Reaffirmed: Res. 139, A-99; Reaffirmation I-04)

H-190.978 National Clearinghouse for Health Care Claims

Our AMA: (1) adopts the following policy principles to encourage greater use of electronic data interchange (EDI) by physicians and improve the efficiency of electronic claims processing: (a) public and private payers who do not currently do so should cover the processing costs of physician electronic claims and remittance advice; (b) vendors, claims clearinghouses, and payers should offer physicians a full complement of EDI transactions (e.g., claims submission; remittance advice; and eligibility, coverage and benefit inquiry); (c) vendors, clearinghouses, and payers should adopt American National Standards Institute (ANSI) Accredited Standard's Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim; (d) all clearinghouses should act as all-payer clearinghouses (i.e., accept claims intended for all public and private payers); (e) practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products; (f) states should be encouraged to adopt AMA model legislation concerning turnaround time for "clean" paper and electronic claims; and (g) federal legislation should call for the acceptance of the Medicare National Standard Format (NSF) and ANSI ASC X12N standards for electronic transactions and NUCC recommendations on a uniform data set for a physician claim. This legislation should also require that (i) any resulting conversions, including maintenance and technical updates, be fully clarified to physicians and their office staffs by vendors, billing agencies or health insurers through educational demonstrations and (ii) that all costs for such services based on the NSF and ANSI formats, including educational efforts be fully explained to physicians and/or their office staffs during negotiations for such contracted services;

(2) continues to encourage physicians to develop electronic data interchange (EDI) capabilities and to contract with vendors and payers who accept American National Standards Institute (ANSI) standards and who provide electronic remittance advice as well as claims processing;

(3) continues to explore EDI-related business opportunities;

(4) continues to facilitate the rapid development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange electronically claims and eligibility information and remittance advice with payers and others in a manner that protects confidentiality of medical information and to assist physicians in the transition to electronic data interchange;

(5) continues its leadership roles in the NUCC and WEDI; and.

(6) through its participation in the National Uniform Claim Committee, will work with third party payers to determine the reasons for claims rejection and advocate methods to improve the efficiency of electronic claims approval. (BOT Rep. 9, A-96; Amended: CMS Rep. 11, I-96; Appended: Sub. Res. 702, A-00)

H-190.979 Insurance Company Filing Deadlines

Our AMA will work with the insurance industry so that where there is a specified filing deadline for services, this deadline is reset when insurance companies contend that they have either not received a filed claim or require additional supporting documentation. (Sub. Res. 110, A-96; Reaffirmed: Res. 705, A-01; Reaffirmation I-04)

H-190.980 Electronic Data Interchange and Telemedicine: Update

Our AMA will continue to help create a uniform data set for electronic claims transmission to public and private payers, through its leadership of the National Uniform Claim Committee, a committee chaired by the AMA that is comprised of key parties affected by health care electronic data interchange. (CMS Rep. 8, I-95; Reaffirmation I-01; Reaffirmation A-02)

H-190.981 Required Timely Reimbursements by all Health Insurers

Our AMA will prepare and/or seek sponsorship of legislation calling for all health insurance entities and third party payers--inclusive of not-for-profit organizations and health maintenance organizations--to pay for "clean" claims when filed electronically within 14 days and paper claims within 30 days, with interest accruing thereafter. These time periods should be considered ceilings, not floors or fixed differentials between paper and electronic claims. (Sub. Res. 112, A-95; Modified: BOT Rep. 17, I-00; Reaffirmation A-02; Reaffirmed: Res. 815, I-02; Reaffirmation I-04)

H-190.983 Submission of Electronic Claims Through Electronic Data Interchange

The AMA: (1) will take a leadership role in representing the interests of the medical profession in all major efforts to develop and implement EDI technologies related to electronic claims submission, claims payment, and the development of EDI standards that will affect the clinical, business, scientific, and educational components of medicine;
(2) supports aggressive time tables for implementation of EDI as long as the implementation is voluntary, and as long as all payers are required to receive standard electronic claims and provide electronic reconciliation prior to physicians being required to transmit electronic claims;
(3) supports the acceptance of the ANSI 837 standard as a uniform, but not exclusive, standard for those physicians who wish to bill electronically; and
(4) will continue to monitor the cost effectiveness of EDI participation with respect to rural physicians. (CMS Rep. 1, I-93; Reaffirmation A-04)

H-190.986 Medical Insurance Overhead Costs

(1) The AMA, through participation with CMS on the National Uniform Claim Committee, will reexamine the paper Uniform Claim Form (CMS 1500) to address any documented shortcomings caused by recent changes in claims processing technology and inappropriate uses of the CMS 1500 by third party payers. (2) The AMA urges the National Uniform Claim Committee to address problems resulting from the wide variations in electronic claims processing formats and to work toward greater uniformity of such formats. (3) The AMA will continue to participate actively in efforts such as those of the Workgroup on Electronic Data Interchange to help assure that proposals and recommendations are implemented in a way that will facilitate appropriate standardization in electronic data interchange while preserving the flexibility needed for special situations. (4) The AMA will seek, insofar as practical, to involve members who are in active practice in the discussions of the National Uniform Claim Committee, American National Standards Institute, and other groups directed toward improvement and standardization of claims processing methodology and formats. (CMS Rep. E, I-92; Reaffirmed and Modified: CMS Rep. 10, A-03)

H-190.988 Medicare Claims Processing Accuracy

Our AMA will: (1) continue efforts to assure that Medicare carriers accurately process claims; (2) continue to pursue legislation to require local physician input on the adequacy of carrier performance; (3) continue to pursue legislation to allow individual physicians to request and receive an administrative law hearing to challenge carrier performance of administrative and other policy requirements; and (4) take other appropriate actions that will result in penalties for carriers that process claims inaccurately. (BOT Rep. C, A-92; Reaffirmed: Res. 712, A-02)

H-190.990 New, Revised CMS-1500 Claim Form

Our AMA supports working with CMS to assure that with any future revisions to the CMS-1500 Claim Form be field tested by practicing physicians and their staffs and by the vendors who provide the form to providers prior to its mandated use. (Res. 821, I-91; Modified: Sunset Report, I-01)

H-190.991 Excessive Requests for Information from Insurance Carriers and Delays in Processing Insurance Claims

It is the policy of our AMA (1) to continue to oppose excessive and unnecessary requests for additional information and unexplained delays in processing and payment by third party insurance carriers where a completed standard claim form for reimbursement has been submitted, and (2) that state medical societies should pursue existing AMA model legislation to require the payment of claims with interest where clean claims are not paid on a timely basis. (Sub. Res. 69, A-91; Modified: Sunset Report, I-01; Reaffirmation I-04)

H-190.992 Electronic Claims Submission

It is the policy of the AMA to: (1) support, assist and encourage the use of electronic data interchange (EDI) and electronic media claims (EMC) by physicians; (2) support and continue its involvement in the development of uniform EMC format and technical requirements; (3) continue to support the elimination of the Medicare 14-day payment delay regulation following Medicare carrier receipt of a claim; and (4) oppose the establishment, at this time, of any time tables or plans for mandatory EMC or EDI use by physicians. (BOT Rep. W, A-90; Amended: CMS Rep. 1, I-93; Modified: Sunset Report, I-00; Reaffirmation A-04)

H-190.994 Misleading Explanation of Benefits Language by Insurance Carriers

The AMA (1) opposes the inaccurate and/or misleading use of the terms "usual, customary or reasonable" by insurance carriers in their communications with patients (Reaffirmed: Reference Committee A, in lieu of Res. 121, A-93); (2) urges the health insurance industry to develop and utilize explanation of benefits language which is less misleading or inflammatory, while still consistent with applicable state and federal laws; and (3) encourages state and local medical societies to continue to bring to the attention of local insurance carriers instances of language in carrier communications which lead patients to believe that physicians' charges are "unreasonable." (Res. 137, A-88; Reaffirmed: Res. 117, A-93; Reaffirmation I-98; Reaffirmation A-99)

H-195.000 Health Maintenance Organizations
(See also: Health Care Delivery; Health Care Reform; Health Insurance; Health Insurance: Benefits and Coverage; Health Insurance: Claim Forms and Claims Processing; Managed Care; Preferred Provider Arrangements)

H-195.990 HMO Guarantee Fund

Our AMA urges enactment of state and/or federal legislation that would require HMOs, as part of their enabling requirements, to develop a "guarantee fund" that would be used to pay for legitimate claims rendered for patient care before HMO insolvency has been declared. (Sub. Res. 105, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 115, A-02)

H-195.991 "Truth in HMOs"

The AMA supports passage of federal legislation which would require HMOs to: (1) provide patients with a brochure describing the HMO, including limitations of coverage, professional qualifications of personnel providing service, and grievance procedures; (2) provide ample notice to beneficiaries participating in the HMO of any premium changes; and (3) notify enrollees when contracts with participating hospitals or clinics are canceled or interrupted and the options for alternative health care. (Res. 116, I-87; Reaffirmed: Sub. Res. 114, I-95; Reaffirmed: Sub. Res. 710, A-98)

H-195.993 Oversight of Medicare Managed Care Plans

The AMA supports maintaining liaison with CMS and the Office of Management and Budget to monitor the implementation of the regulations for review of HMOs and competitive medical plans participating in the Medicare program. (Res. 174, A-87; Reaffirmed: Sunset Report, I-97; Modified and Reaffirmed: CMS Rep. 9, A-07)

H-195.994 Mandatory HMO Enrollment

The AMA opposes an employer's mandatory enrollment in an HMO for employees. (Res. 171, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-200.000 Health Workforce
(See also: Allied Health Professions; Nurses and Nursing; Minorities)

H-200.951 Strategies for Enhancing Diversity in the Physician Workforce

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

H-200.952 Diversity in Medical Education

Our AMA: (1) commends the Institute of Medicine for its report, "In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (2) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish

that goal. (Res. 305, A-06)

H-200.953 The Physician Workforce: Recommendations for Policy Implementation

AMA policy is that there is now a shortage of physicians, at least in some regions and specialties, and that evidence exists for additional shortages in the future. (CME Rep. 8, A-05; Reaffirmation I-06)

H-200.954 US Physician Shortage

Our AMA: (1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;

(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties; and

(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US. (Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08)

H-200.955 Revisions to AMA Policy on the Physician Workforce

It is AMA policy that: (1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.
(2) Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.
(3) The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.
(4) In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.
(5) There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.
(6) There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.
(7) Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career. (CME Rep. 2, I-03; Reaffirmation I-06; Reaffirmation I-07)

H-200.956 Appropriations for Increasing Number of Primary Care Physicians

Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747. (Res. 814, I-03; Reaffirmation I-08)

H-200.957 Proper Notification and Education Regarding Healthcare Professional Shortage Areas by Medicare Carrier

Our AMA shall educate member physicians regarding Medicare Part B carriers' responsibility to notify all physicians that if they practice in a Healthcare Professional Shortage Area, they are eligible for incentive payments under Centers for Medicare & Medicaid Services guidelines, and they may be eligible to file amended claims under the incentive payment program retroactively for up to twelve months. (Res. 103, I-99)

H-200.959 Support for the Funding of the National Health Service Corps

The AMA supports the continuation of funding to the National Health Service Corps at least at the level originally appropriated in 1995. (Res. 241, A-95; Reaffirmed: CME Rep. 2, I-00)

H-200.964 Encouragement of Physician Participation in Project USA

The AMA will work with state medical societies and appropriate professional specialty organizations to encourage physician participation in Project USA. (Res. 604, A-94; Reaffirmed: CLRPD 1, A-04)

H-200.966 Federal Financial Incentives and Medical Student Career Choice

To further expand policy the AMA has adopted the following:

Federal financial assistance programs aimed at stimulating interest in primary care should have the following characteristics:
(1) Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
(2) There should be an analysis of outcome data for federal financial assistance programs, to determine if they are having the desired effects and a study of the impact of these programs on disadvantaged and underrepresented groups of students. (CME Rep. 6, A-94; Reaffirmed: CME Rep. 2, A-05; Modified: CME Rep. 13, A-06; Reaffirmation I-08)

H-200.969 Definition of Primary Care

(1) The AMA rejects the definition of primary care as stated in the March 1996 report of the Institute of Medicine as "the provision of integrated accessible health care services by clinicians." The AMA believes that primary care consists of the provision of a broad range of personal medical care (preventive, diagnostic, palliative, therapeutic, curative, counseling and rehabilitative) in a manner that is accessible, comprehensive and coordinated by a licensed MD/DO physician over time. Care may be provided to an age-specific or gender-specific group of patients, as long as the care of the individual patient meets the above criteria.
(2) The AMA encourages the efforts to define what constitutes primary care services. Data should be collected on which specialties currently provide these services, and how these services are integrated into the practice of physicians. Such data are essential to determine future physician workforce needs in primary care.
(3) The AMA encourages that training programs for physicians who will practice primary care include appropriate educational experiences to introduce physicians to the required knowledge and skills, as well as to the types of services and the modes of practice that characterize primary care.
(4) Where case management or coordination might limit access to appropriate medical care, patients should have the freedom to see a physician appropriate for the services they need, regardless of specialty. Above all, the best interests of the patient must be paramount. (BOT Rep. 12, A-94; Reaffirmed CMS Rep. 3, A-96; BOT Rep. 19, A-97; Amended: Res. 317, I-97; Reaffirmed: Res. 220, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-200.970 Designation of Health Professional Shortage Areas

Our AMA: (1) will continue to urge CMS to extend the 10% Medicare payment bonus for physicians practicing in Health Professional Shortage Areas (HPSAs) to Medicaid payments and to modify the regulations governing HPSA designations to allow a grace period of five years for areas exceeding the allowable provider-to-population ratio, during which such areas would receive no additional resources but would continue to receive the 10% bonus and other existing resources linked to designation;
(2) will work with the PHS to determine the appropriate percentage threshold of poverty which would quality a county for HPSA designation;
(3) recommends to the PHS that it revise the criteria in the federal regulations related to the designation of HPSAs as originally published in the November 1980 Federal Register;
(4) recommends to the PHS that it review the process by which HPSA boundaries are drawn to avoid the potential for "gerrymandering";
(5) urges the PHS and CMS to publish annually a Notice of Proposed Rulemaking (NPRM) in the Federal Register so that the public is notified and may comment on any proposed changes to HPSA and medically underserved areas (MUA) designations;
(6) urges CMS and the PHS to require states to provide for notification at the community/local level regarding changes in HPSA and MUA designation;
(7) urges CMS and the PHS to update the status of MUAs concurrently with HPSAs;
(8) urges CMS to revise its cost-based reimbursement accounting methodology so as not to pay independent rural health clinics any less than the amounts paid to provider-based clinics in the same geographic area;
(9) urges CMS and the PHS to allow for rural health clinic (RHC) designated status if a physician outside a HPSA or MUA can demonstrate that a significant percentage of the clinic's patients reside in a relevant HPSA or MUA, as is the case for federally qualified health clinics (FQHCs);
(10) urges CMS and the PHS jointly to: (a) review and establish guidelines for designating HPSAs and Medically Underserved Areas (MUAs), and (b) develop priorities for establishment of rural health clinics in HPSAs and MUAs; and
(11) strongly encourages state medical associations that are invited to comment on proposed changes in HPSA and Medically Underserved Area designations to continue to solicit input on such changes from the local medical societies affected. (CMS Rep. 7-A-94; CMS Rep. 9, A-96; Reaffirmation A-01)

H-200.972 Primary Care Physicians in the Inner City

Our AMA should pursue the following plan to improve the recruitment and retention of physicians in the inner city:
(1) Encourage the creation and pilot-testing of school-based, church-based, and community-based urban "family" health clinics, with an emphasis on health education, prevention, primary care, and prenatal care.
(2) Encourage the affiliation of these family health clinics with urban medical schools and teaching hospitals.
(3) Promote medical student rotations through the various inner-city neighborhood family health clinics, with financial assistance to the clinics to compensate their teaching efforts.
(4) Encourage medical schools and teaching hospitals to integrate third- and fourth-year undergraduate medical education and

residency training into these teams.
(5) Advocate the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.
(6) Study the concept of having medical schools with active outreach programs in the inner city offer additional training to physicians from nonprimary care specialties who are interested in achieving specific primary care competencies.
(7) Consider expanding opportunities for practicing physicians in other specialties to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family practice, internal medicine, pediatrics, etc. These may be developed so that they are part-time, thereby allowing physicians enrolling in these programs to practice concurrently.
(8) Encourage the AMA Senior Physicians Services Group to consider the use in underserved urban settings of retired physicians, with appropriate mechanisms to ensure their competence.
(9) Urge urban hospitals and medical societies to develop opportunities for physicians to work part-time to staff urban health clinics.
(10) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who serve the inner-city poor.
(11) Urge medical schools to seek out those students whose profiles indicate a likelihood of practicing in underserved urban areas, while establishing strict guidelines to preclude discrimination.
(12) Encourage medical school outreach activities into secondary schools, colleges, and universities to stimulate students with these profiles to apply to medical school.
(13) Encourage medical schools to continue to change their curriculum to put more emphasis on primary care.
(14) Urge state medical associations to support the development of methods to improve physician compensation for serving this population, such as Medicaid case management programs in their respective states.
(15) Urge urban hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to fill gaps in urban care.
(16) Urge CMS to explore the use of video and computer capabilities to improve access to and support for urban primary care practices in underserved settings.
(17) Urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
(18) Continue to urge measures to enhance payment for primary care in the inner city. (CMS Rep. I-93-2; Reaffirmation A-01; Reaffirmation I-03; Modified: CME Rep. 13, A-06)

H-200.973 Increasing the Availability of Primary Care Physicians

It is the policy of the AMA that:
(1) Each medical school should reexamine its institutional goals and objectives, including the extent of its commitment to primary care. Those schools recognizing a commitment related to primary care should make this an explicit part of the mission, and set institutional priorities accordingly.
(2) The admission process should be sensitive to the institution's mission. Those schools with missions that include primary care should consider those predictor variables known to be associated with choice of these specialties.
(3) Through early recruitment and outreach activities, attempts should be made to increase the pool of applicants likely to practice primary care.
(4) Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective.
(5) All four years of the curriculum in every medical school should provide experiences in primary care for all students. These experiences should feature increasing levels of student responsibility and use of ambulatory and community settings.
(6) The visibility of primary care faculty members should be enhanced within the medical school and positive attitudes toward primary care among all faculty members should be encouraged.
(7) Medical schools should provide career counseling related to the choice of a primary care specialty.
(8) The curriculum in primary care residency programs and the sites used for training should be consistent with the objective of training generalist physicians.
(9) There should be increased financial incentives for physicians practicing primary care.
(10) Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, and enhanced efforts to eliminate "hassle" and unnecessary paper work should be undertaken.
(11) There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
(12) States should be encouraged to provide positive incentives--such as scholarship or loan repayment programs, relief of professional liability burdens and reduction of duplicative administrative responsibilities--to support medical students' choice of a primary care specialty. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools. (CME Rep. N, A-93; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 13, A-06; Reaffirmed: CME Rep. 1, I-08; Reaffirmation I-08)

H-200.975 Availability, Distribution and Need for Family Physicians

The AMA will continue to recommend specific strategies to increase the availability of primary care physicians, which may include curricular modification, financing mechanisms for medical education and research, financial aid options, and modifications of the practice environment. (Sub. Res. 306, I-92; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 2, I-03; Reaffirmation I-08)

H-200.977 Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians

It is the policy of the AMA, with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians, improved recruitment of medical school graduates and training a sufficient number of primary care physicians to meet projected national needs. (Res. 306, I-91; Reaffirmed: BOT Rep. GG, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmation I-08)

H-200.978 Loan Repayment Programs for Primary Care Careers

The AMA will (1) work with federal and state governments to develop incentive programs, such as loan repayment, to encourage practice in underserved areas, (2) engage in research to identify all factors which deter students and physicians from choosing and remaining in primary care disciplines and (3) use this information to support and implement AMA policy to enhance primary care as a career choice. (BOT Rep. EEE, A-91; Reaffirmed: BOT Rep. GG, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmation I-06; Reaffirmed: CME Rep. 1, I-08)

H-200.982 Significant Problem of Access to Health Care in Rural and Urban Underserved Areas

Our AMA encourages state legislatures and the Congress of the United States to recognize this significant problem and to develop rapidly incentives to make practice in rural and urban underserved areas more attractive to primary care physicians in order to provide access to necessary medical services in these areas. (Sub. Res. 35, I-90; Reaffirmed: BOT Rep. GG, I-92; Reaffirmation A-01; Modified: CME Rep. 2, I-03)

H-200.983 Health Manpower

It is the policy of the AMA to (1) use its influence to convince the Administration and Congress of the continuing need for federal support for the education and training of primary care physicians, including reauthorization of federal programs under Title VII to help meet manpower requirements for primary care physicians; and (2) use its influence to encourage federal funding to promote educational and training opportunities for primary care and increase the field strength of the NHSC in medically underserved urban and rural areas. (Res. 112, I-90; Reaffirmed: BOT Rep. GG, I-92; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 7, A-05)

H-200.984 National Health Service Corps Reauthorization

It is the policy of the AMA: (1) to support legislative efforts to revitalize and reauthorize the NHSC; and (2) to undertake efforts to assure that such legislation include increased funding for recruitment and retention efforts and adequate funding for both the loan repayment and scholarship programs. (Res. 120, A-90; Reaffirmed: Sunset Report and CME Rep. 2, I-00)

H-200.985 Increasing Support for Service in America's Inner Cities Through the National Health Service Corps

Our AMA (1) urges the U.S. Public Health Service to earmark a certain percentage of repayment opportunities for the National Health Service Corps (NHSC) loans and scholarships for underserved inner-city facilities; and (2) supports increased funding for NHSC. (Res. 78, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-01)

H-200.987 Supply and Distribution of Health Professionals

(1) Licensure, certification and accreditation should not be used for the purpose of regulating the supply of health professionals.

(2) Health professions' curricula should emphasize the needs of underserved populations, including the poor, minorities, the chronically ill and disabled, and the geographically isolated. Decisions regarding the financing of health professions education should be based in part on the data and analyses of the national consortium on the supply and distribution of health professionals. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmation A-01; Modified: CME Rep. 2, I-03)

H-200.989 National Health Service Corps

The AMA believes that since a sufficient need for physician manpower is expected to continue to exist in certain areas of the U.S., continuation of assistance from the NHSC is justified. As long as this need continues, the AMA does not think it would be appropriate to deprive residents of certain areas of the U.S. of necessary medical services by diverting NHSC physicians to other countries. (CMS Rep. F, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, I-00)

H-200.991 Difficulties in the Fulfillment of National Health Service Corps Contractual Obligations

(1) The AMA strongly urges the NHSC to provide intensive and frequent counseling to NHSC scholars as they enter and then proceed

through the NHSC program. Through such briefings, as well as frequent written communications, the NHSC Administration should emphasize: (a) the dynamic nature of the HMSA Placement Opportunity List and the possibility of changes in placement options at any time; (b) the extent of any financial commitments that a scholar may have to incur to develop a Private Practice Option opportunity; and (c) the future possibilities of obtaining a Private Practice Option and/or a federal placement. (2) The AMA urges the NHSC to make particular effort to minimize, to the degree possible, the imposition of changes in assignment options during the last year of the obligee's education, so as to avoid disruption of personal and family plans. (CMS Rep. D, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CMS Rep. 7, A-05)

H-200.992 Designation of Areas of Medical Need

The AMA urges the federal government to: (1) consolidate the federal designation process for identifying areas of medical need; (2) coordinate the federal designation process with state agencies to obviate duplicative activities; and (3) ask for state and local medical society approval of said designated underserved areas. (Res. 24, A-82; Amended: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

H-200.994 Health Workforce

The AMA endorses the following principle on health manpower: Both physicians and allied health professionals have legal and ethical responsibilities for patient care, even though ultimate responsibility for the individual patient's medical care rests with the physician. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency. (BOT Rep. C, I-81; Reaffirmed: Sunset Report, I-98; Modified: CME Rep. 2, I-03)

H-200.995 Federally Funded Clinic Programs

Our AMA supports the following policy statements regarding federally funded clinics: (1) Physician services should be available in underserved areas and should be provided in a manner which ensures continuity of patient care, integration with the existing health system, and retention of the health providers.
(2) Physicians should be sensitive and responsive to indicators of need for additional health personnel or accessibility of health care. Through their component medical society, physicians should seek involvement in the designation process for Health Manpower Shortage Areas and Medically Underserved Areas. The medical community and local residents are in an excellent position to ascertain the need for additional health providers in the community, and to support appropriate decisions in that regard.
(3) Where need is clearly identified, through a federal designation process or other means, the local medical community should explore alternatives for responding appropriately to meet the need.
(4) Where physicians have responded appropriately to needs identified through the designation process, the component medical society should work with the local planning groups to remove the area's designation, so that federal resources are not called on to duplicate services.
(5) Where identified needs cannot be met by the local medical community, and all local public and private financial assistance options are determined to be inadequate, federal assistance should be sought. In such cases, the local medical community should assume the responsibility of working with the agency applying for federal funds to facilitate the placement of health personnel with long range service potential.
(6) Where inappropriate designations were made leading to capacity which exceeds the need, the patient volume is likely to be low, and the unit costs excessive. In such situations, constructive consultation between the local medical community and the federally funded clinic program should explore options for a resolution of the problem. (Res. 125, A-81; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01)

H-200.997 Primary Care

The AMA believes that there should be a sufficient supply of primary care physicians - family physicians, general internists, general pediatricians, and obstetricians/gynecologists. In order to achieve this objective: (1) Voluntary efforts to develop and expand both undergraduate and graduate programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for family practice should be encouraged. (2) Federal support, without coercive terms, should be available to institutions needing financial support for the expansion of resources for both undergraduate and graduate programs designed to increase the number of primary care physicians. (3) It is the policy of the AMA, with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians and improved recruitment of medical school graduates into primary care specialties. (CME Rep. C, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: BOT Rep. GG, I-92; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 2, I-03; Reaffirmation I-08)

H-200.998 Tax Credit to Disadvantaged Area Medical Practices

Our AMA actively supports national and state legislation which would grant income tax credits to medical practices established in

disadvantaged communities and in areas of critical physician need. (Res. 35, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-06)

H-205.000 Health Planning
(See also: Health Care Delivery)

H-205.991 Development of Health Care Priorities

The AMA advocates the philosophy of citizen and physician involvement in the development of health care priorities such as was used in the development of the Oregon Health Plan. (Res. 128, A-94; Reaffirmed: CMS Rep. 5, A-04)

H-205.992 Supply and Distribution of Health Care Facilities

(1) Local communities or regions should exercise the responsibility for assessing their needs with respect to the type, size, scope, and location of health care facilities. State governments should ensure that needs of the underserved are being met satisfactorily without wasteful duplication. (2) The role of the federal government in planning the supply and distribution of health care facilities should be limited to providing planning incentives and resources to states and communities for their activities. (3) It is the responsibility of the governing body of health care facilities to ensure that their primary goal is to serve community need. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-205.993 Licensure of Health Care Facilities

(1) Omnibus and uniform principles that incorporate minimum standards should be developed to be used by states as a basis for their individual facility licensing acts. (2) All nonfederal health care facilities should be subject to licensure by the state in which they operate. State governments should provide adequate staffing and funding to support the implementation and enforcement of licensure laws. The federal government should ensure that its health care facilities meet the licensure requirements of the states in which they operate, or comparable federal standards. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-205.994 Definition of Health Care Facilities

(1) A health care facility should be defined as "a formally organized and legally constituted entity that arranges or contracts for the provision of health care and shares public accountability for the quality, accessibility, and costs of such care with the health professionals who provide or direct the care." (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-205.995 Voluntary Health Planning

Our AMA opposes federally-mandated health planning programs and advocates the principles of voluntary, locally based health planning. (CMS Rep. A, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed and Modified: CMS Rep. 7, A-05)

H-205.997 AMA Statement on Voluntary Health Planning

Our AMA believes that the following principles should be considered in the creation and implementation of a program of voluntary community health planning: (1) Health planning should be the primary function of a collaborative group of community organizations and interested individuals. While a variety of structural modalities may be considered to implement this function, the most common is the creation of an eleemosynary organization by the community to be served. However structured and financed, this "health planning organization" should be created from the mandate of the community to address health needs and priorities in a structured fashion and should be legally incorporated to perform this function.

(2) The planning organization must be representative of the community and have the active support and participation of the community to be served, including but not limited to physicians. The proper mix of the participants should be determined by the community served and should be responsive to the priorities of the community.

(3) As an entity representing the community-at-large, the planning organization should exhibit the following characteristics: thoroughness, objectivity, integrity, sensitivity to the interests of the community; understanding of health care delivery systems and financing; and accountability to the community served.

(4) The planning organization should assume an active positive role in assessing community health and medical needs and should serve as the community's advocate in meeting those needs. The recommendations of the organization should be advisory and the responsibility for implementing those recommendations should rest with the institutions and entities most directly involved.

(5) The organization should serve in an informational and educational role to the community-at-large on such issues as community

health status, health care financing, health care costs, and the availability of local health resources. Periodic reports should be provided to the community on these and other significant health care issues.

(6) The size and scope of the geographic area to be served is best determined by the community residents based on analysis of such factors as population density, service area of health care institutions and practitioners, geographic and transportation considerations, and should not be arbitrarily defined by existing political boundaries. Regional considerations involving two or more such local planning areas may be best coordinated through a consortium of the local planning organizations as appropriate.

(7) The planning organization should function under a constitution and bylaws which, at a minimum, set forth: (a) the major objectives of the organization; (b) a locally accepted process for the election, selection and/or appointment of members to the governing body; (c) a mechanism to preserve account-ability to the community-at-large for the recommendations and actions of the organization, recognizing the accepted principles of confidentiality; and (d) a mechanism for ongoing evaluation of all aspects of the organization's services to the community.

(8) Decisions regarding the employment of professional consultants and/or staff are properly those of the governing body of the local organization based on the scope of its activities and financial viability.

(9) There should be a substantial commitment from the community-at-large to supporting and financing the operation of the planning organization. This commitment may be expressed through donations of public funds, private funds and general solicitation. Donations of time and expertise may be quite substantive and should be recognized equivalently as community contributions.

(10) Government may provide supplemental funding in support of local health planning activities directed toward meeting locally determined goals and objectives. Such supplemental financial assistance from government sources should not diminish or replace the financial or other substantive support of the community. Such supplemental funding should not be accepted without careful consideration of the obligations which may accompany it and a commitment to achieve sufficiency as early as possible.

(11) The planning organization should encourage and promote the development of positive incentives to attain the objectives identified by the community and should not have regulatory authority or responsibilities.

(12) The protection of the public welfare is properly a concern of government and activities to protect the public may be implemented in a variety of ways. However, local voluntary health planning is a creative process and, therefore, should not include the use of regulatory sanctions.

(13) Exemption from the antitrust laws should be sought for actions taken to implement recommendations of the planning organization, in furtherance of the objectives identified and approved by the community through the planning process.

(14) Our AMA should encourage the use of Healthy People 2010 for purposes of voluntary health planning. (CMS Rep. A, A-81; Reaffirmed: Sunset Report, I-98; Modified: Sub. Res. 226 and Reaffirmation A-00)

H-205.998 Regionalization of Medical Services

The AMA opposes mandatory regionalization of medical services. (Sub. Res. 62, A-80; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-205.999 Cost Effectiveness of State Certificate of Need Programs

Our AMA believes that there is little evidence to suggest that Certificate of Need programs are effective in restraining health care costs or in limiting capital investment. In the absence of such evidence, the AMA reaffirms current policy opposing the extension of certificate of need to private physicians' offices. (CMS Rep. D, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-210.000 Home Health Services
(See also: Medicare)

H-210.979 Physician Responsibility for Nursing Agencies

With respect to the provision of post-acute and long-term care (i.e., post-hospital care for sub-acute and chronic illnesses in a variety of health care settings, such as home health agencies and skilled nursing facilities).

(1) It is the policy of the AMA that: (a) Physicians should continue to be responsible only for those services that they directly order and not for practices that are inconsistent with the physician’s certification. (b) Physicians should continue to have to meet the "willfully and knowingly" intent standard for fraud and abuse penalties to apply. (c) Post-acute and long-term care agencies and

facilities should continue to be held accountable for practices that are inconsistent with the physician's certification. (d) Post-acute and long-term care agencies and facilities should only include services on the certification form that require a physician to determine the medical necessity of those services and whether those services should be part of the patient's plan of care. (e) Post-acute and long-term care agencies and facilities and/or the institutions affiliated with them should avoid pressuring physicians to certify the services that they provide

(2) Our AMA continues to strongly oppose any efforts by federal regulators or legislators to expand the role and responsibility of physicians for the billing practices of post-acute and long-term care (i.e., post-hospital care for sub-acute and chronic illnesses in a variety of health care settings, such as home health agencies and skilled nursing facilities) agencies and facilities. (CMS Rep. 1, A-00)

H-210.980 Physicians and Family Caregivers: Shared Responsibility

Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden;
(2) continues to support health policies that facilitate and encourage health care in the home;
(3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care; and
(4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders. (Res. 308, I-98; Reaffirmation A-02)

H-210.981 On-Site Physician Home Health Care

The AMA: (1) recognizes that timely access to physician care for the frail, chronically ill or disabled patient is a goal that can only be met by an increase in physician house calls to this vulnerable, underserved population.
(2) strongly supports the role of interdisciplinary teams in providing direct care in the patient's own home, but recognizes that physician oversight of that care from a distance must sometimes be supplemented by on-site physician care through house calls.
(3) advocates that the physician who collaborates in a patient's plan of care for home health services should see that patient on a periodic basis.
(4) recognizes the value of the house call in establishing and enhancing the physician-patient and physician-family relationship and rapport, in assessing the effects of the social, functional and physical environment on the patient's illness, and in incorporating the knowledge gained into subsequent health care decisions.
(5) believes that physician on-site care through house calls is important when there is a change in condition that cannot be diagnosed over the telephone with the assistance of allied health personnel in the home and assisted transportation to the physician's office is costly, difficult to arrange, or excessively tiring and painful for the patient.
(6) recognizes the importance of improving communication systems to integrate the activities of the disparate health professionals delivering home care to the same patient. Frequent and comprehensive communication between all team members is crucial to quality care, must be part of every care plan, and can occur via telephone, FAX, e-mail, videotelemedicine and in person.
(7) recognizes the importance of removing economic, institutional and regulatory barriers to physician house calls.
(8) supports the requirement for a medical director for all home health agencies, comparable to the statutory requirements for medical directors for nursing homes and hospice.
(9) recommends that all specialty societies address the effect of dehospitalization on the patients that they care for and examine how their specialty is preparing its residents in-training to provide quality care in the home.
(10) encourages appropriate specialty societies to continue to develop educational programs for practicing physicians interested in expanding their involvement in home care.
(11) urges CMS to clarify and make more accessible to physicians information on standards for utilization of home health services, such as functional status and severity of illness.
(12) urges CMS, in its efforts to redefine homebound, to consider the adoption of criteria and methods that will strengthen the physician's role in authorizing home health services, as well as how such criteria and methods can be implemented to reduce the paperwork burden on physicians. (CSA Rep. 9, I-96; Reaffirmed and Appended:CMS Rep. 4, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 4, A-08)

H-210.982 Home Health Nursing Costs

The AMA will work with appropriate regulatory agencies to clearly display home health agency summary reports to physicians an itemized statement of the allowable charges for services rendered by the home health agency (including aides, physical therapy, etc.) to the patient since care was initiated or since the last summary report was received. (Sub. Res. 111, A-96; Reaffirmed by Res. 122, A-97; Reaffirmed: CMS Rep. 9, A-07)

H-210.984 Conflicts of Interest

Update on Home Care: The AMA has adopted the following:

The AMA continues to urge third party payers to allow for remuneration consistent with the services rendered by physicians involved in treating patients at home. (CEJA Rep. I-93-5; Reaffirmation A-02; Modified and Reaffirmed CEJA Rep. 1, A-03)

H-210.985 Medicare Policy on Telephone Consultations for Home Health Patients

The AMA (1) reaffirms policy concerning a physician's right to charge a Medicare patient, if the physician chooses to do so, for medically necessary telephone consultations; and (2) supports the physician's option to bill for medically necessary telephone and other consultations with health care personnel attendant to the provision of home health care services. (Sub. Res. 205, I-92; Reaffirmed: CMS Rep. 10, A-03)

H-210.986 Physicians and Family Caregivers - A Model for Partnership

Our AMA (1) encourages residency review committees and residency program directors to consider physician needs for training in evaluation of caregivers. Emphasis at both the undergraduate and graduate level is needed on the development of the physician's interpersonal skills to better facilitate assessment and management of caregiver stress and burden;
(2) supports health policies that facilitate and encourage home health care. Current regulatory and financing mechanisms favor institutionalization, often penalizing families attempting to provide lower cost, higher quality-of-life care;
(3) reaffirms support for reimbursement for physician time spent in education and counseling of caregivers and/or home care personnel involved in patient care; and
(4) supports research that identifies the types of education and support services that most effectively enhance the activities and reduce the burdens of caregivers. Further research is also needed on the role of physicians and others in supporting the family caregiver. (CSA Rep. I, I-91; Reaffirmed: Sunset Report, I-01)

H-210.987 Home Intravenous Therapy

Our AMA supports continuing to pursue modification in Medicare coverage policy to provide payment for home intravenous therapy services when monitored properly to ensure that the procedures are safe for home use and provided with physician case management or supervision. Our AMA will review the cost effectiveness of home intravenous therapy as an alternative to inpatient service. The AMA urges that reasonable payment for physician management services related to home intravenous therapy be included in any such program. (BOT Rep. B, A-91; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation A-04)

H-210.988 Medicare - Home Health Services

Our AMA petitions Congress and CMS to authorize adequate reimbursement for home health care case management by physicians under the Medicare program. (Res. 63, A-91; Reaffirmed by Res. 122, A-97; Reaffirmation A-97; Reaffirmation A-02)

H-210.989 Medicare Physician Reimbursement for Home Health Visits

It is the policy of the AMA: (1) to urge Congress and CMS to adjust reimbursement for physician home visits so that the payment made to physicians is consistent with the services involved in treating patients at home; and (2) that physician reimbursement should appropriately reflect the relative differences in the training and skill of physicians and other home health care providers. (Res. 109, A-91; Reaffirmation A-97: Reaffirmation I-99; Reaffirmation A-02)

H-210.990 Medicare Reimbursement for Homebound Patients

Our AMA continues its efforts to persuade CMS to recognize and fairly reimburse legitimate physician case management services for patients receiving home health care services. (Res. 211, A-91; Reaffirmed by Res. 122, A-97; Reaffirmation A-97; Reaffirmation A-02)

H-210.991 The Education of Physicians in Home Health Care

It is the policy of the AMA that: (1) faculties of the schools of medicine be encouraged to teach the science and art of home health care as part of the regular undergraduate curriculum;

(2) graduate programs in the fields of family practice, general internal medicine, pediatrics, obstetrics, general surgery, orthopedics, physiatry, and psychiatry be encouraged to incorporate training in home health care practice;

(3) the concept of home health care as part of the continuity of patient care, rather than as an alternative care mode, be promoted to physicians and other health care professionals;

(4) assessment for home health care be incorporated in all hospital discharge planning;

(5) our AMA develop programs to increase physician awareness of and skill in the practice of home health care;

(6) our AMA foster physician participation (and itself be represented) at all present and future home health care organizational planning initiatives (e.g., JCAHO, ASTM, FDA, etc.);

(7) our AMA encourage a leadership role for physicians as active team participants in home health care issues such as quality standards, public policy, utilization, and reimbursement issues, etc.; and

(8) our AMA recognize the responsibility of the physician who is involved in home health care and recommend appropriate reimbursement for those health care services. (Joint CSA/CME Rep., A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-02)

H-210.992 Tax Deduction for Individuals Rendering Home Care to Family Members with a Long-term Illness

The AMA supports legislation to provide a federal tax deduction and/or additional appropriate incentives for individuals rendering home care to family members with a long-term illness. (Res. 28, A-88; Reaffirmed: Sunset Report, I-98)

H-210.993 Physician Reimbursement in Home Health Care Management

Our AMA supports development of a method (such as a CPT code) for identifying services for reimbursement of physicians who are managing the care of homebound patients through a home health care agency. (Res. 78, A-88; Reaffirmed by BOT Rep. 3, A-95; Reaffirmation A-97; Reaffirmation A-02)

H-210.994 Home Health Care

Our AMA (1) reaffirms its support of home health care as an alternative to hospital, nursing home, or institutional care;
(2) encourages physicians to take a more active role in the provision of home health care;
(3) supports modifications in Medicare regulations for home health care, so that those regulations include appropriate standardized definitions and instructions to fiscal intermediaries;
(4) supports improving patient accessibility to home health services by seeking modifications in the Medicare regulations to provide coverage for the care of homebound patients by qualified individuals working under the supervision of the patient's attending physician; and
(5) supports continued monitoring of the adequacy of the home health care system to meet the accessibility needs of homebound patients. (BOT Rep. EE, A-87; Reaffirmed by Res. 122, A-97; Reaffirmed: Sunset Report, I-97; Reaffirmed by Res. 129, A-98; Reaffirmed: CMS Rep. 4, A-08)

H-210.995 Home Health Care

The AMA (1) supports the concept of home health care as an alternative to hospital, nursing home, or other institutional care and as part of a total medical care plan; and (2) believes that home health care is an effective benefit to many patients. (BOT Rep. HH, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-210.996 Providing Cost Estimate with Home Health Care Order Authorization

The AMA urges physicians to request home health care providers to provide a cost estimate with the physician authorization form, when the form is sent to the physician for his/her signature. (Res. 63, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Res. 122, A-97; Reaffirmed: CMS Rep. 9, A-07)

H-210.997 Physician Reimbursement for Home Health Care

Our AMA urges third party payers to allow for remuneration consistent with the services rendered by physicians involved in treating patients at home. (Res. 49, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmation A-97; Reaffirmation I-99; Reaffirmation A-02)

H-210.998 Home Health Service Abuse

Our AMA (1) calls upon the nation's physicians to write or carefully review all initial and renewal orders for post-acute and long-term care (i.e., post-hospital care for sub-acute and chronic illnesses in a variety of health care settings, such as home health agencies and skilled nursing facilities) services, and to approve only those that are medically indicated; (2) urges physicians to report to appropriate payment agencies and regulatory authorities cases of abusive practices post-acute and long-term care providers; and (3) urges physicians not to authorize the provision post-acute or long-term care to any patient with whom he or she is not professionally involved in providing care. (Res. 35, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: Res. 122, A-97; Reaffirmation A-97; Modified: CMS Rep. 1, A-00)

H-215.000 Hospitals
(See Also: Emergency Medical Services; Health Planning; Hospitals: Accreditation Standards; Hospitals: Medical Staff; Hospitals: Medical Staff - Credentialing and Privileges; Hospitals: Medical Staff - Organization; Hospitals: Reimbursement)

H-215.964 Patient Identification Wrist Bands

Our AMA (1) supports the concept of uniform patient identification wrist bands at all hospitals and other health care facilities where wrist bands are used, and (2) encourages the adoption of uniquely colored patient identification wrist bands for specific patient information, such as, patient's name, allergies and those with identified greater fall risk. (Res. 727, A-07)

H-215.965 Hospital Visitation Privileges for GLBT Patients

Our AMA encourages all hospitals to add to their rules and regulations, and to their Patient's Bill of Rights, language permitting same sex couples and their dependent children the same hospital visitation privileges offered to married couples. (Res. 733, A-06)

H-215.966 Evaluating Advertising

1. AMA policy is that organizations conferring titles/awards/rankings on hospitals should adopt the following criteria:
a. Significant physician involvement in selection of criteria and methodology.
b. Significant physician involvement in screening potential award winners.
c. Significant physician involvement in on-site hospital review (if part of the ranking/title/award process).
d. Significant physician involvement in the judging process and final selection of award winners.
e. Evidenced based performance measures for selection.
f. Public transparency and substantive information regarding all aspects including the leadership involved in the criteria, methodology, selection process.
g. Disclosure of any conflicts of interest (BOT Rep. 8, A-06)

H-215.967 For-Profit Conversions of Health Care Organizations

The AMA adopts as policy the following principles regarding the for-profit conversion of not-for-profit health care organizations: (1) Representatives of state government (e.g. state attorney general, state insurance commissioner) should oversee all for-profit conversions of health care organizations;
(2) Public notice and subsequent public hearings should be required prior to the approval of a for profit-conversion;
(3) The health care organization converting to for-profit status should be required to obtain an independent appraisal of its assets prior to the conversion. This appraisal should be made available to the representatives of state government (e.g., state attorney general, state insurance commissioner) overseeing the for-profit conversion;
(4) For-profit conversions should be structured to prohibit private inurement from officers, directors and key employees of the converting health care organization, as well as private benefit from other individuals;
(5) If the establishment of a charitable foundation is required as part of the for-profit conversion, the mission of the foundation, as well as its proposed program agenda, should be determined and offered for public comment prior to the completion of the conversion;
(6) The mission of a charitable foundation resulting from a for-profit conversion should closely reflect the original mission of the not-for-profit health care organization;
(7) A designated proportion of the members serving on the board of directors of a charitable foundation should be new, independent members not previously affiliated with the converting organization, who are selected based on their experience relative to the mission of the foundation;
(8) The level of compensation received by members serving on the board of directors of a charitable foundation should be consistent with that received by board members of similar types and sizes of foundations;
(9) Representatives of state government (e.g., state attorney general, state insurance commissioner) should approve the mission and governance of any charitable foundation established as a result of for-profit conversions;
(10) Once a charitable foundation has been established as a result of a for-profit conversion, ongoing community liaison with the foundation should occur on a regular basis (e.g., community advisory committees, periodic public reports); and
(11) There should be meaningful physician presence on the board of directors of a charitable foundation formed as a result of the conversion of a not-for-profit health care organization to a for-profit organization (CMS Rep. 8, A-97; Renumbered: CMS Rep. 7, I-05)

H-215.968 Specialty Hospitals and Impact on Health Care

Our AMA supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care. (BOT Rep. 15, I-04)

H-215.969 Hospital Merger Study

It is the policy of the AMA that, in the event of a hospital merger, acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues: (1) medical staff representation on the board of directors;
(2) clinical services to be offered by the institutions;
(3) process for approving and amending medical staff bylaws;
(4) selection of the medical staff officers, medical executive committee, and clinical department chairs;
(5) credentialing and recredentialing of physicians and limited licensed providers;
(6) quality improvement;
(7) utilization and peer review activities;
(8) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges;
(9) conflict resolution mechanisms;
(10) the role, if any, of medical directors and physicians in joint ventures;
(11) control of medical staff funds;
(12) successor-in-interest rights; and
(13) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals. (CMS Rep. 4, I-01)

H-215.970 The Effects of Closing Safety Net Hospitals

It is the policy of our AMA that the current reporting mechanism should be modified to monitor accurately the provision of care by hospitals to economically disadvantaged patients so that polices and programs targeted to support the safety net and the populations these hospitals serve can be reviewed for effectiveness. (CMS Rep. 3, I-01; Reaffirmed: BOT Rep. 15, I-04)

H-215.971 Standardization of Emergency Paging Nomenclature

Our AMA urges the development of standardized emergency paging nomenclature for hospitals. (Sub. Res. 805, A-00)

H-215.972 Use of Wireless Radio-Frequency Devices in Hospitals

Our AMA encourages: (1) collaborative efforts of the Food and Drug Administration, American Hospital Association, American Society for Healthcare Engineering, Association for the Advancement of Medical Instrumentation, Emergency Care Research Institute, and other appropriate organizations to develop consistent guidelines for the use of wireless radio-frequency transmitters (e.g., cellular telephones, two-way radios) in hospitals and standards for medical equipment and device manufacturers to ensure electromagnetic compatibility between radio-frequency transmitters and medical devices; and that our AMA work with these organizations to increase awareness among physicians and patients about electromagnetic compatibility and electromagnetic interference in hospital environments;

(2) hospital administrators to work with their clinical/biomedical engineering staff, safety committees, and other appropriate personnel to adopt and implement informed policies and procedures for (a) managing the use of wireless radio-frequency sources in the hospital, particularly in critical patient care areas; (b) educating staff, patients, and visitors about risks of electromagnetic interference (EMI); (c) reporting actual or suspected EMI problems; and (d) testing medical devices for susceptibility to EMI when electromagnetic compatibility information is lacking;

(3) medical device and electronic product manufacturers to design and test their products in conformance with current electromagnetic immunity standards and inform users about possible symptoms of electromagnetic interference (EMI). If a possibility of EMI problems affecting medical devices exists, steps should be taken to ensure that all sources of electromagnetic energy are kept at sufficient distance; and

(4) physicians to become knowledgeable about electromagnetic compatibility and electromagnetic interference (EMI), recognize EMI as a potential problem in hospital environments, and report suspected EMI problems to the Food and Drug Administration MedWatch program or appropriate hospital personnel. (CSA Rep. 4, A-00)

H-215.973 Emergent Care Adjacent to Hospitals

The AMA will urge hospitals and their medical staffs to review their policy that pertains to the administration of care to critically ill patients who present adjacent to hospitals without ambulance assistance. (Sub. Res. 859, A-98; Reaffirmed: CMS Rep. 4, A-08)

H-215.974 Not-For-Profit Boards

Our AMA seeks by whatever appropriate means available to change IRS requirements to allow more than 50% of a not-for-profit health care entity and/or hospital Board to be interested parties who are MDs or DOs. (Res. 222, A-98)

H-215.975 Uniform Standards for Not-For-Profit and For-Profit Hospitals

The AMA supports the concept that all hospitals be held to the same standards of care, community service, professional education and commitment to their respective communities. (Res. 705, A-96; Reaffirmed: CMS Rep. 8, A-06)

H-215.976 Public Hospitals and Their Contribution to Public Health

Our AMA recognizes the public hospital as a component in the public health infrastructure of many communities as well as a source and base for organized preventive outreach services; and together with its specialty, state and local medical societies, our AMA seeks to make public authorities more aware of the public health and the clinical contributions of public hospitals and, therefore, the necessity for adequate financial support during the current health care transition. (Substitute Res. 412, I-95; Reaffirmed: CMS Rep. 3, I-01)

H-215.977 Guns in Hospitals

The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention:

(1) Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted.

(2) The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs.

(3) Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.

(4) Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included.

(5) Policies should undergo periodic reassessment and evaluation.

(6) Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital. (BOT Rep. 23, I-94; Reaffirmation I-03; Reaffirmed: CSA Rep. 6, A-04)

H-215.978 Guns in Hospitals

Our AMA: (1) supports the efforts of the International Association for Healthcare Security and Safety, the AHA, and the JCAHO to develop guidelines or standards regarding hospital security issues and recognizes these groups' collective expertise in this area. As standards are developed, the AMA will ensure that physicians are advised; (2) encourages physicians to work with their hospital safety committees to address the security issues within particular hospitals and also encourages physicians to become aware of and familiar with their own institution's policies and procedures; and (3) urges that hospital safety committees include physicians and that emergency departments be recognized as high risk environments for violence. (BOT Rep. 16, A-94; Reaffirmation I-99; Reaffirmation I-03)

H-215.979 Unilateral Imposition of Employee Status on Physicians by Hospitals

The AMA strongly opposes hospitals' unilateral coercion of any physician or physician group, hospital based or otherwise, to enter into an employment or contractual relationship essentially making the physicians or physician group employees of the hospitals. (Sub. Res. 819, I-92; Modified by CLRPD Rep. 1, I-95; Reaffirmed: CMS Rep. 4, A-99)

H-215.981 Hospital Employed Physicians

Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine. (Res. 247, A-91; Reaffirmed: Sunset Report, I-01)

H-215.982 Translator Services in Hospitals

Our AMA encourages hospitals that serve populations with a significant number of non-English speaking patients to provide trained translator services. (BOT Rep. D, A-91; Reaffirmed: Sunset Report, I-01)

H-215.983 Distribution of Drug Samples in the in-Hospital Setting

In the interest of patient safety, the hospital pharmacy should be responsible for the procurement, distribution, and control of all drugs, including any samples used in the institution. The AMA believes that existing Joint Commission standards that advocate the elimination of sample distribution, but provide for a means for the control of samples when they are used, are appropriate. The hospital pharmacy should serve as the central point of distribution for record-keeping purposes. Without this control, the AMA is concerned that there would be substantially decreased ability to account for where drug samples are distributed throughout the hospital and to whom they have been given. (BOT Rep. N, I-90; Reaffirmed: Sunset Report, I-00)

H-215.984 Duplicate Bureaucratic Regulations

Our AMA encourages the identification of duplicate regulatory activities and inspection in hospitals and nursing homes so that these matters may be brought to the attention of legislators, governors and regulatory agencies. It is AMA policy that such information be made available nationally via the AMA and the AHA in an attempt to eliminate duplicate bureaucratic bodies and unnecessary regulations. (Res. 53, I-90; Reaffirmed: Sunset Report, I-00)

H-215.985 Child Care in Hospitals

Our AMA: (1) strongly encourages hospitals to establish and support child care facilities; (2) encourages that priority be given to children of those in training and that services be structured to take their needs into consideration; (3) supports informing the AHA, hospital medical staffs, and residency program directors of these policies; and (4) supports studying the elements of quality child care and availability of child care on a 24-hour basis. (BOT Rep. J, I-90; Reaffirmed: Sunset Report, I-00)

H-215.987 Elimination of Hospital Medical Library

It is the policy of the AMA (1) through appropriate councils, to review current trends in scientific journal publishing and pricing and lend its support to efforts which will maintain Health Sciences Libraries at a level which ensures adequate learning resources for the present and future; and (2) to oppose the decision to eliminate the requirement that hospitals maintain a medical library to be eligible for federal funding. (Sub. Res. 24, A-90; Reaffirmed: Sunset Report, I-00)

H-215.991 Medicare Hospital Inspection and Certification Process

Our AMA (1) opposes hospital Medicare decertification based on state survey agency inspections which do not include review by practicing physicians and due process protection prior to any adverse determination; (2) urges the AHA to join in its request to CMS to provide sufficient notice, including a comment period, on interpretive guidelines utilized in inspections, so that appropriate medical disciplines may adequately review and comment on the guidelines; and (3) supports CMS modification and improvement of the inspection process so that practicing physicians are included in the reviews, and so that due process protections are provided prior to the notice of decertification. (Res. 113, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-215.992 Hospital Security

Our AMA supports efforts by physicians and other hospital staff to encourage all hospitals to institute and/or maintain appropriate and adequate security measures, such as general identification, patrols, visual monitoring systems and metal detectors, in order to protect staff and patients. (Sub. Res. 187, A-87; Modified by CLRPD Rep. 1, I-95; Reaffirmed: CLRPD Rep. 1, A-05)

H-215.993 Medical Society-Governing Body (Trustee) Liaison Program

Our AMA (1) encourages state medical associations to maintain this activity to assure ongoing communication with hospital governing bodies; and (2) encourages state medical associations to draw upon all sources, including national level activities, to enhance their own direct communication with hospital governing bodies. (BOT Rep. O, A-87; Modified by CLRPD Rep. 1, I-95; Reaffirmed: CLRPD Rep. 1, A-05)

H-215.994 Subrogation by Hospitals

Our AMA urges hospitals to insist that contracts for hospital professional liability insurance require that the carrier obtain the consent of the policy holder prior to initiating legal action against a physician in the name of the hospital. (Res. 2, I-81; Reaffirmed: CLRPD

Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-215.995 Hospital Admission Histories and Physicals

Our AMA believes that the best interests of hospitalized patients are served when admission history and physical exams are performed by a physician, recognizing that portions of the histories and physical exams may be delegated by the physician to others whose credentials are accepted by the medical staff. (I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-215.996 Compensation for Service on Government Mandated and Funded Hospital Committees

Our AMA believes that federal or third party funds provided for reimbursement of physicians serving on mandated hospital review committees should not be diverted by the hospital for other purposes. (CMS Rep. H, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-215.999 Denial of Hospital Service Resultant from Labor Discord

Our AMA encourages hospitals to take all reasonable measures to resolve labor disputes expeditiously so that citizens of the community are not deprived of essential medical service. (Sub. Res. 45, I-75; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-220.000 Hospitals: Accreditation Standards
(See also: Hospitals; Hospitals: Medical Staff; Hospitals: Medical Staff - Credentialing and Privileges; Hospitals: Medical Staff - Organization; Hospitals: Reimbursement)

H-220.931 Evidence-Based Value of Joint Commission Standards and Measures

Our AMA asks The Joint Commission that all present and future standards and performance measures set forth by The Joint Commission be supported by the best available evidence. (Res. 523, A-03; Reaffirmation A-05; Modified in lieu of Res. 511, A-07)

H-220.932 Life Safety Code

Our AMA urges CMS to adopt the most current "Life Safety Code" as expeditiously as possible. (Res. 827, A-99)

H-220.933 Critical Relevancy of Medical Staff in JCAHO Standards

Our AMA will instruct its Commissioners to the JCAHO to seek incorporation into accreditation guidelines requirements (a) that the bylaws of the governing bodies of hospitals provide a process by which the medical staff can appeal to the governing body any decisions made by the hospital administration and/or governing body which has an adverse effect on the quality of care rendered to patients and (b) that the medical staff bylaws of the hospital also provide a process for making such an appeal. (Sub. Res. 818, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-220.934 Conflicting Accreditation Standards Among Various Accreditors

Our AMA will work: (1) with the Joint Commission on Accreditation of Healthcare Organizations, the Centers for Medicare & Medicaid Services, state legislatures and regulating agencies, and other appropriate accrediting organizations, to ensure that there are no conflicts among the standards and their interpretation; (2) to ensure that accreditation remain in the private sector, and not become a function of government. (Res. 808, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-220.937 Activities of the Joint Commission on Accreditation of Healthcare Organizations

Policy of the AMA is: (1) that geographic disparities or differences in patient populations may warrant multiple organized, self-governing medical staffs within a single hospital corporation. Such medical staffs shall have all the usual rights, privileges, and responsibilities of a medical staff organization. Each medical staff shall develop and adopt bylaws and rules and regulations to establish a framework for self-governance of medical activities and accountability to the governing body.

(2) that hospital medical staffs should be actively involved in at least the following activities at the onset of and during a merger, acquisition, consolidation, or affiliation: (a) defining the role and structure of the medical staff(s), (b) development and approval of medical staff bylaws, rules, policies, and regulations, (c) defining and approving credentialing processes, (d) quality improvement, peer and utilization review activities, (e) decisions regarding clinical services to be offered by the institutions, and (f) all decisions pertaining to the delivery of and access to medical services.

(3) that the AMA Commissioners to the JCAHO will advocate development of JCAHO standards for assuring that, where geographic

disparities and differences in patient populations justify a relationship of more than one medical staff to a single governing body, a mechanism exists for representation of each medical staff and coordination between the medical staffs in their interactions with the governing body. (BOT Rep. 27, I-96; Modified: CMS Rep. 7, I-00)

H-220.938 JCAHO Adherence to its Own Standards

The AMA Board of Trustees directs its Commissioners to the JCAHO to strongly advocate that the JCAHO consistently enforce its standards regarding unilateral amendment of medical staff bylaws, and that hospitals found to have made unilateral changes to medical staff bylaws be cited for a serious (Type 1) violation of JCAHO standards which may lead to loss of accreditation if the violation is not rectified within a specified timeframe. (Sub. Res. 816, A-96; Reaffirmed: CLRPD Rep. 2, A-06)

H-220.939 Activities of the Joint Commission on Accreditation of Healthcare Organizations

1. Our AMA supports continued active AMA participation as a corporate member of the JCAHO.

2. Pursuant to Policy 220.949 (AMA Policy Database), our AMA:
(a) Advocates accountability through voluntary, professionally directed quality assurance mechanisms as part of every system of health care delivery;
(b) Monitors the effects of JCAHO standards, surveys, and other activities on the quality, cost, and outcomes of care;
(c) Retains its current role in the JCAHO and continue to evaluate that role on a regular basis; and
(d) Continues to investigate additional methods to facilitate participation in voluntary accreditation mechanisms.

3. Our AMA establishes the following goals for AMA participation in the JCAHO:
(a) To assist the JCAHO to define its mission, long-term goals, and role in the accreditation arena;
(b) To assure continued physician involvement in medical decision-making by advocating a requirement for integrated medical delivery systems to have organized medical staffs;
(c) To advocate the improvement of the quality and consistency of the JCAHO accreditation process, surveyors, and survey reports;
(d) To urge consideration of cost implications when revising JCAHO standards, developing and implementing other activities, and increasing the costs of surveys;
(e) To work toward minimal revision of JCAHO standards, unless there is a clear need to change them to improve patient care or outcome, once the proposed medical staff standards for the 1996 AMH are finalized;
(f) To urge the JCAHO to focus on its accreditation activities and to provide accountability to the public for health services through private sector accreditation activities; and
(g) To work toward JCAHO recognition as an accreditation body for integrated health care networks. (BOT Rep. 33, A-95; Reaffirmed: BOT Rep. 9, I-04)

H-220.940 Changing Joint Commission on Accreditation of Healthcare Organization Standards and Agenda for Change

The AMA will instruct its Commissioners to the JCAHO to: (1) convey to the JCAHO that the changes in the "Accreditation Manual for Hospitals," scoring guidelines, intent statements, and aggregation rules or decisions rules should preserve the quality assurance of medical care as the function of the hospital medical staff as stated in Policy 220.956;
(2) work to maintain the structural standards and Medical Staff Chapter in the "Accreditation Manual for Hospitals" as stated in Policy 220.960;
(3) work to assure that the Joint Commission physician surveyors review all medical staff activities subject to JCAHO evaluation during the accreditation process. (Res. 826, I-93; Amended: CSA Rep. 8, A-03)

H-220.942 Joint Commission Accreditation of Provider Networks

The AMA will: (1) request the JCAHO to revise the standards of the Joint Commission on provider networks to delineate physician responsibility for the quality of patient care that is substantially equivalent to the medical staff standards of the "Accreditation Manual for Hospitals"; and (2) request the AMA Commissioners to the JCAHO to actively promote the necessity for a medical staff chapter in the new Joint Commission "Accreditation Manual for Provider Networks." (Res. 819, I-93; Reaffirmed: CSA Rep. 8, A-03)

H-220.943 Medical Staff Self-Governance

The AMA Commissioners to the JCAHO should attempt to have a provision incorporated in the JCAHO Accreditation Manual that states that the voting members of the medical executive committee must have been elected by the membership of the medical staff or by a subset thereof (such as a department). (Res. 825, I-93; Reaffirmed: CSA Rep. 8, A-03)

H-220.945 Economic Credentialing

The AMA will work to amend JCAHO Standard MS.2.4.1.3 to add "that economic credentialing shall not be a part of the

appointment/reappointment process to the medical staff"; and will develop and widely circulate prototype hospital medical staff bylaws dealing specifically with the issue of economic credentialing. (Sub. Res. 832, A-93; Reaffirmed: CSA Rep. 8, A-03)

H-220.946 Unreasonable Burden of Joint Commission on Accreditation of Healthcare Organizations Standards and Surveys

The AMA requests the JCAHO to study and consider the ability of small hospitals, particularly in rural areas, to bear the burden of the increasing demands on staff and financial resources in the implementation of the current and proposed standards; and urges the JCAHO to eliminate standards that increase health care costs without demonstrably improving the quality of care. (Res. 834, A-93; Reaffirmed: CSA Rep. 8, A-03)

H-220.949 JCAHO

The AMA (1) will closely monitor the effects of JCAHO standards, surveys, and other activities on the quality, cost, and outcomes of patient care, as the Agenda for Change is implemented; and (2) will maintain its current role in the JCAHO and will continue to evaluate that role on a regular basis; (BOT Rep I, A-92; Amended: CSA Rep. 8, A-03)

H-220.950 Medical Staff Involvement in Development of a "Plan of Correction"

Our AMA (1) adopts the policy that a hospital medical staff must be appropriately involved in the development of a "Plan of Correction" and that such involvement be consistent with existing medical staff bylaws, rules and regulations; (2) encourages hospital medical staffs to amend their bylaws, if necessary, to establish a procedure to ensure appropriate medical staff input into the development of a "Plan of Correction"; and (3) urges the JCAHO to work to ensure that these principles are part of the Joint Commission's survey process. (Res. 810, I-91; Reaffirmed: Sunset Report, I-01)

H-220.951 Medical Staff Membership

The AMA (1) requests the JCAHO to require that conditions for hospital medical staff membership be based only on the physician's professional training, experience, qualifications, and adherence to medical staff bylaws; and (2) will work toward protecting the due process rights of physicians when medical staff privileges are terminated without appropriate due process as described by the medical staff bylaws. (Res. 721, I-91; Reaffirmed by Res. 802, I-94; Reaffirmed: CLRPD 1, A-04; Reaffirmation A-05)

H-220.952 JCAHO Accreditation Manual for Hospitals

The AMA (1) will work for the retention of important structural provisions in future revisions of the Accreditation Manual for Hospitals; and (2) will continue to work to preserve the appropriate medical staff role in quality medical care activities. (BOT Rep. H, I-91; Modified by CLRPD Rep. 1, I-95; Reaffirmed: CLRPD Rep. 1, A-05)

H-220.953 A Quality Improvement Program Directed Toward the Administrative and Governing Bodies of Health Care Organizations

Our AMA authorizes its Commissioners to the JCAHO to seek incorporation of the following concepts into accreditation guidelines for health care organizations: (1) establish accreditation guidelines with greater emphasis on the assessment of the effect that actions and decisions of the administrative and governing bodies of health care organizations have on the quality of patient care;
(2) establish the requirement that management efforts must be made in concert with those of physicians, nurses and other health care professionals pursuant to the needs of the patients served by these professionals and the prevailing standards of practice;

(3) establish the requirement of assessing major processes in the health care organization with the goal of continuous improvement rather than intensely focusing on individual persons or services;

(4) establish the requirement that risk management processes be established that will emphasize prevention of problems rather than policies that call for taking action only after a problem has arisen;

(5) establish accountability of the management and governance elements of a health care organization to its professional staff of physicians and nurses; and

(6) require that the bylaws of the governing body provide a process through which the medical staff could appeal any decision made by the administration and/or the governing body which has an adverse effect on the quality of care rendered to patients, require that medical staff bylaws provide a process by which the need for such an appeal is identified, and provide a process for making the appeal. (Res. 822, I-91; Reaffirmed: Sunset Report, I-01)

H-220.955 Definition of Hospital Leadership - JCAHO

Our AMA urges the JCAHO to change the definition of leaders of the organization from elected and/or appointed . . . to elected and appointed leaders of the medical staff and the clinical departments. (Sub. Res. 142, A-91; Reaffirmed: Sunset Report, I-01)

H-220.956 To Preserve the Quality Assurance of Medical Care as the Function of the Hospital Medical Staff

Our AMA requests (1) clarification of the new JCAHO Standards on Quality Assessment and Improvement to assure that Medical Care Review on Quality Assurance remain the functions of the duly established hospital medical staff, and (2) that the new standards of the Joint Commission maintain a clear distinction between (a) the medical staff committees entrusted with review and monitoring of medical care and (b) the hospital-wide committees composed of the medical staff representatives, the administration, nursing and all appropriate departments or services to deal with infection control, physical plant, food service, transportation, communication, and central supply (the administrative part of the care of the patient). (Res. 145, A-91; Reaffirmed: Sunset Report, I-01)

H-220.958 Professional and Technical Advisory Committees of the JCAHO

Our AMA encourages its Trustees who serve as Commissioners to the JCAHO (1) to retain the professional and technical advisory committees as the key advisory committees to the members of the Standards and Survey Procedures Committee and Board of Commissioners of the JCAHO; and (2) to oppose proposals to restructure the professional and technical advisory committees that weaken the ability of professional organizations to provide input into the standards setting activities of the JCAHO. (Res. 152, I-90; Reaffirmed: Sunset Report, I-00)

H-220.959 Compliance with JCAHO Accreditation Standards

The AMA Commissioners to the JCAHO oppose the accreditation of hospitals that do not adhere to JCAHO standards prohibiting unilateral amendment of medical staff bylaws by either the governing body or the medical staff. (Sub. Res. 184, I-90; Reaffirmed: Sub. Res. 808, A-94; Reaffirmed: CLRPD 1, A-04)

H-220.960 Joint Commission's Accreditation Manual for Hospitals

Our AMA requests its trustees who serve as Commissioners to JCAHO to support retention of important structural standards in the Accreditation Manual for Hospitals, including, but not limited to, standards requiring that medical staff operate as a self-governing entity - as defined in medical staff bylaws; that physician directors of hospital departments be board certified or possess equivalent qualifications; and that board certification is an excellent benchmark for the delineation of clinical privileges; and that any changes to the Accreditation Manual for Hospitals occur only after a full, thorough and deliberative process, including a full field review of all proposed changes to the Accreditation Manual for Hospitals. (Res. 153, I-90; Reaffirmed: Sunset Report, I-00)

H-220.961 Hospital Boards of Trustees

Our AMA urges the JCAHO to require that at least one voting member on a hospital's board of trustees be a member of that hospital's medical staff, in active practice at that hospital and elected by the medical staff. (Res. 159, A-90; Reaffirmed: Sunset Report, I-00)

H-220.962 Selection of Medical Staff Officers

Our AMA urges the JCAHO to change the accreditation standards to require that all medical staff bylaws and hospital governing documents recognize the inherent authority of the medical staff to elect and seat its medical staff officers and provide that such elections of officers are not subject to hospital governing body approval, affirmance or concurrence. (Res. 278, A-90; Reaffirmed: Sunset Report, I-00)

H-220.963 Medical Staff Selection of Clinical Chiefs

Our AMA supports amendment of JCAHO Medical Staff Standard MS 3.9 by addition of the words "and selection," so as to read: "Responsibilities and selection of department chairmen are specified in the medical staff bylaws, rules and regulations..." (BOT Rep. B, A-89; Reaffirmed: Sunset Report, A-00)

H-220.966 Future Directions of the JCAHO

The AMA urges the JCAHO, in any standards revision process, to make efforts to reduce burdensome and expensive administrative requirements imposed on health care providers that do not directly affect the quality of patient care. (Sub. Res. 49, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-220.971 Joint Commission Medical Staff Standard on the Amendment of Bylaws

The AMA formally expresses its support for maintaining JCAHO Medical Staff Standard 2.1, which establishes that neither the

medical staff nor the hospital governing body may unilaterally amend the medical staff bylaws. (Res. 102, I-87; Reaffirmed: Sunset Report, I-97; Modified and Reaffirmed: CLRPD Rep. 2, A-07)

H-220.972 Medical Staff Participation in the Joint Commission Site Surveys

The AMA (1) supports working with the Joint Commission to ensure that appropriate members of the medical staff, along with their designated support personnel, represent the medical staff during the Joint Commission site survey; and (2) urges that, in addition to physician members of the medical staff, both the medical staff-designated support personnel and appropriate administrative staff participate during the survey of Joint Commission standards for which each has a responsibility (e.g., quality assurance). (Sub. Res. 9, I-87; Reaffirmed: Sunset Report, I-97; Modified and Reaffirmed: CLRPD Rep. 2, A-07)

H-220.975 Medical Staff Comment on JCAHO "Field Review of Proposed Standards"

The AMA believes that all "Field Review of Proposed Standards" that are sent to hospitals should be sent simultaneously to the medical staff of said hospital, with their comments to be returned directly to the Joint Commission for its consideration. (Sub. Res. 128, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CLRPD Rep. 2, A-06)

H-220.976 Bylaws Approval Time Limit

The AMA supports including a standard in the JCAHO Accreditation Manual for Hospitals requiring that initial medical staff bylaws and subsequent amendments be approved or disapproved by the hospital governing body within a reasonable period of time specified in the medical staff bylaws and, if the governing body fails to act within the time specified, the proposed changes should be deemed adopted. (Sub. Res. 2, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CLRPD Rep. 2, A-06)

H-220.977 Chief Executive Officer at Medical Staff Executive Session

The AMA reaffirms its support for amending JCAHO Medical Staff Standard 1.40, Element of Performance 2, to read as follows: "That the Chief Executive Officer of the hospital or his or her designee may be invited to attend meetings of the Executive Committee of the medical staff." (Res. 138, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed and Modified: CLRPD Rep. 2, A-06)

H-220.978 Hospital Medical Staff Representation on the Hospital Governing Body

The AMA supports amending the governing body chapter of the JCAHO "Accreditation Manual for Hospitals" to provide for representation at all meetings of the governing body, with vote by one or more medical staff members nominated and elected by the medical staff, consistent with applicable state law. (Sub. Res. 1, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CLRPD Rep. 2, A-06)

H-220.980 Credentialing Procedure

The AMA encourages the JCAHO to continue to monitor medical staff credentialing procedures to include clearly delineated authority to an elected physician of the medical staff for access, review and judgment over contents, to ensure that the individual medical staff member's credentials file contains only well documented and appropriate data and does not include information that is immaterial, misleading or of questionable value. (BOT Rep. C, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CLRPD Rep. 1, A-05)

H-220.983 JCAHO Standard IV Should Not Tie Clinical Privilege Termination to Contract

The AMA does not believe the JCAHO standards should dictate specific provisions of individual contracts between physicians and hospitals that are mutually agreeable to the parties. (BOT Rep. C, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CLRPD 1, A-04)

H-220.988 Hospital Admitting Privileges

(1) The AMA supports incorporation into Joint Commission standards the concept that individuals granted the privilege to admit patients to inpatient services may or may not be members of the medical staff. (2) The AMA believes that any revisions of JCAHO language should reaffirm that the medical staff retains responsibility for clinical privileges and patient care standards for all practitioners admitting to the facility. (Res. 12, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CLRPD 1, A-04)

H-220.989 Physician Credentialing

The AMA encourages the JCAHO to develop standards that permit hospital medical staffs to establish educational needs as one of the criteria for medical staff privileges in teaching hospitals, to assure an appropriate number and variety of patients for educational purposes. (Sub. Res. 82, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-220.990 Principles for Revision of the Medical Staff Section of the Joint Commission on Accreditation of Healthcare Organizations "Accreditation Manual for Hospitals"

The AMA supports adherence to the following principles as the basis for any revision of the Medical Staff Section of the "Accreditation Manual for Hospitals": (1) continued use of the term "Medical Staff" in the title of the chapter and throughout the Manual; (2) deletion of any specific reference to limited licensed practitioners without precluding such practitioners from having hospital privileges consonant with their training, experience and current competence, if approved by the normal credentialing process; (3) consideration of qualified limited licensed practitioners in accordance with state law, and when approved by the executive committee of the medical staff, by the governing board, and when their services are appropriate to the goals and missions of that hospital, taking into account the training, experience and current clinical competence of the practitioners; (4) provision that the executive committee of the medical staff is composed of members selected by the medical staff, or appointed in accordance with the hospital bylaws. All members of the active medical staff, as defined in the Medical Staff Bylaws, are eligible for membership on the executive committee, and a majority of the executive committee members must be fully licensed physician members (Doctors of Medicine or Doctors of Osteopathy) of the active medical staff in the hospital; (5) assurance that the medical care of all patients remains under the supervision and direction of qualified, fully licensed physicians (Doctors of Medicine or Doctors of Osteopathy); and (6) assurance that the continued high quality of care, credentialing of physicians and other licensed practitioners, and effective quality assurance programs remain under the supervision and direction of fully licensed physicians. (Sub. Res. 116, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CLRPD Rep. 1, A-05)

H-220.991 AMA Policy on Hospital Accreditation

The AMA (1) believes that the objective of hospital accreditation should be primarily to evaluate the quality of patient care, to provide recommendations for remedying deficiencies and improving the quality of patient care, and to withhold accreditation from those institutions which do not meet an acceptable standard of patient care; (2) opposes accreditation requirements which impose rigid, uniform, mandatory administrative procedures, methods of operation, nomenclature, or forms of organization for the hospital, its governing board, attending staff and committees; and (3) recognizes that excellence in patient care is more easily attainable when the accreditation process is flexible and is concerned with evaluating the quality of hospital service and not the administrative procedures or form of organization used to provide patient care. (Res. 13, A-82; Reaffirmed: I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CMS Rep. 10, A-03)

H-220.992 Joint Commission on Accreditation of Hospitals

Our AMA believes there is a need to (1) ensure that all present and future JCAHO standards positively impact the safety, quality and excellence of patient care and to eliminate standards and requirements that fail to meet these criteria; (2) ensure that professional time can be directed to cost effective patient care rather than to unnecessary, irrelevant and repetitious administrative and compliance activities; and (3) ensure that hospital and medical staffs are afforded due process to protect against arbitrary and inflexible interpretations of standards by on-site evaluators and JCAHO personnel. (Res. 81, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-220.993 Joint Commission on Accreditation of Hospitals

(1) Our AMA supports the initiation of meetings with the appropriate policy-making bodies of the other four corporate members to discuss its concerns relative to JCAHO, to emphasize its desire to return the primary focus of the JCAHO to the quality and excellence of patient care, and to explore methods of improving the voluntary accreditation process of the JCAHO

(2) Our AMA believes that the future environment will create a demand from the public for reliable and credible quality processes, and that this same environment will create demands from the hospitals for a streamlined and efficient accreditation that is flexible, comprehensive, non-duplicative and less costly. To meet these demands, the AMA supports: (a) a complete review of the "Optimal Achievable Standards" philosophy, currently in effect at the JCAHO, to determine if this approach is appropriate for the hospital of the future; (b) the rewriting of standards to eliminate significant portions that are ambiguous and subject either to misinterpretation or various interpretations by the JCAHO surveyors and hospitals, and to allow more flexibility in the implementation of the standards by the individual hospital and medical staff; (c) for the immediate future, placing the major emphasis on improving the quality of the survey and accreditation process in the short term acute care hospital; (d) reconsideration of the desirability of continuing to survey long term care facilities that are not hospital related, both from the standpoint of finances and the ability to produce a quality product; (e) exploration of methods of streamlining the accreditation process by considering: (i) the feasibility of contracting with a management firm to perform the accreditation process, (ii) the feasibility of extending the present term of accreditation from two years to three or four years with interim written reports to be submitted by the hospital, and (iii) other alternative methods of accreditation; and (f) an evaluation of the appropriateness of continuing to include life safety codes in JCAHO standards for hospital accreditation. (BOT Rep. MM, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-220.995 JCAHO Guidelines Impact Statement

Our AMA recommends that when guidelines, rules and specific recommendations to hospitals and other medical facilities are originated by accreditation, certification or regulatory agencies, they include a proof of impact statement to include (1) actual or estimated costs of implementation (as a total cost or cost per bed). Included in the costs should be estimates of volunteer medical staff time required to implement the policy; (2) a brief statement of the expected benefit, goal or improvement in health care or reduction in health care costs; (3) a brief outline of the data tending to prove that the guidelines and rules will actually and significantly improve patient care, not have an adverse impact, and will accomplish the intended goal stated in the benefit statement; and (4) cost estimates of implementation and ongoing compliance, for small, medium, and large hospitals, and/or other health care facilities. (Res. 37, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed in lieu of Res. 816, I-93; Amended: Sub. Res. 805, I-01)

H-220.996 Private Patients and the Responsibility of the Attending Physician in a Teaching Hospital Setting

Our AMA opposes mandatory delegation of diagnosis and treatment of private patients primarily to housestaff physicians in teaching hospitals and recommends that (1) refusal to delegate care of private patients to housestaff not be grounds for reduction or termination of privileges; (2) the patient's own private physician be responsible for his care; and (3) JCAHO assure that accreditation standards maintain the right of free choice by patients to have care provided by his own physician. (Sub. Res. 131, A-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-220.997 Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Our AMA calls for continued encouragement of all state medical associations to cooperate with JCAHO to the fullest extent in evaluating medical staff activities. (Sub. Res. 29, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-220.998 Education and Control of Therapeutic and Diagnostic Drug Usage

Our AMA supports (1) increased JCAHO educational programs on drug usage; (2) encouragement of hospital committees to review reactions and maintain drug usage surveillance; and (3) evaluation and dissemination of the findings of such review committees in order to assure maximum use of the educational materials derived. (Res. 3, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-225.000 Hospitals: Medical Staff
(See also: Hospitals; Hospitals: Accreditation Standards; Hospitals: Medical Staff - Credentialing and Privileges; Hospitals: Medical Staff - Organization; Hospitals: Reimbursement)

H-225.956 Behaviors That Undermine Safety

1. Our AMA adopted the following policies:

A. **The Medical Staff**

The medical staff shall develop and implement its own code of conduct in the medical staff bylaws which includes, but not be limited to the following provisions:

1. The medical staff in consultation with independent medical staff legal counsel defines what constitutes disruptive behavior;
2. The medical staff defines the behavior and its nexus to quality medical care;
3. The medical staff provides a mechanism whereby instances of possible alleged disruptive behavior are recorded;
4. The medical staff develops a process whereby the physician accused of disruptive behavior is notified at the time of the event and provided an opportunity to respond within the confines of the organized medical staff;
5. The medical staff, in consultation with independent medical staff legal counsel, develops bylaw language that allows for freedom of expression by physicians when describing flaws within the hospital;
6. The medical staff, in consultation with independent medical staff legal counsel, develops bylaws language that protects from retribution physicians who speak about quality concerns;
7. The medical staff establishes a process to investigate and assess, in a timely fashion, reports of alleged disruptive behavior;
8. The medical staff develops corrective actions that are commensurate with the reported behavior;
9. The medical staff bylaws contain procedural safeguards that protect due process;
10. The medical staff code of conduct shall identify, by position, which members or committee will be involved in the various stages of the process for reviewing reports, informing physicians and monitoring conduct; and
11. The medical staff shall develop processes for the protection of confidentiality.

B. **The Hospital**

1. The hospital must also have a code of conduct, applicable to members of the board, management and all employees;
2. The hospital must have policy that defines alleged disruptive and inappropriate behaviors for its constituents placed in the employee manual and administrative policy manual; and
3. The hospital and the medical staff must provide a mechanism to review episodes of alleged disruptive behavior to ascertain if the system of medical delivery in the hospital is responsible for some of the so-called disruptive behavior.

2. Our AMA Commissioners to the Joint Commission will urgently convey to The Joint Commission that a one-year moratorium on The Joint Commission Standard LD.03.01.01 is necessary to provide a feasible time frame for the medical staff to bring the medical staff bylaws into compliance with the Standard. (Res. 6, I-08)

H-225.957 Principles for Strengthening the Physician-Hospital Relationship

The following twelve principles are AMA policy:

PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

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, and working continuously to improve patient care and outcomes, 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.

2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.

3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.

4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.

5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.

6. The organized medical staff has inherent rights of self governance, which include but are not limited to:

a) Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the organized medical staff.

b) Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.

c) Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.

d) Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.

e) Establishing within the medical staff bylaws: 1) the qualifications for holding office, 2) the procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee, and 3) the qualifications for election and/or appointment to committees, department and other leadership positions.

f) Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.

g) Retaining and being represented by legal counsel at the option and expense of the organized medical staff.

h) Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.

i) Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.

j) The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.

k) Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.

l) Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.

m) Enforcing the organized medical staff bylaws, regulations and policies and procedures.

n) Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.

7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.

8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.

9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.

10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.

11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.

12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-

defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body. (Res. 828, I-07)

H-225.958 Blue Cross of California Quality of Care Allegations

Our AMA insists that all insurance plan inquiries regarding quality of care and peer review issues be evaluated through objective due process and peer review; and supports a position stating that all future peer review and quality of care issues between insurance companies and medical staffs be brought to an objective and neutral peer review body. (Res. 851, I-03)

H-225.959 Medical Staff Testing

Our AMA: (1) establish policy that, in the absence of statutory and/or regulatory requirements, hospital medical staffs should determine those tests and/or immunization that are required for medical staff members, and delineate under what circumstances such tests or immunizations should be administered; and (2) encourages medical staffs to regularly review and update their bylaws and workplace policies to ensure that they reflect current laws, regulations, health care policy, and evidence-based medicine. (Sub. Res. 801, I-01)

H-225.960 Voluntary Use of Hospitalists and Required Consent

It is the policy of our AMA that the use of a hospitalist physician as the physician of record during a hospitalization must be voluntary and the assignment of responsibility to the hospitalist physician must be based on the consent of the patient's personal physician and the patient. (CME Rep. 2, A-99; Reaffirmation I-99; Reaffirmed: Res. 812, A-02; Reaffirmed with change in title: BOT Rep. 15, A-05; Reaffirmed in lieu of Res. 734, A-05)

H-225.961 Medical Staff Development Plans

1. All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria related to appointment/reappointment to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used .inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, gender identity or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of .patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals.

2. The AMA communicates the medical staff development plan principles to the President and Chair of the Board of the American Hospital Association and recommend that state and local medical associations establish a dialogue regarding medical staff development plans with their state hospital association. BOT Rep. 14, A-98; Modified: BOT Rep. 11, A-07)

H-225.962 Medical Staff Membership Category for Physicians Providing Telemedicine

The AMA recommends that organized medical staffs, as part of their responsibility for the quality of professional services provided by individuals with clinical privileges, identify to the governing body of the hospital/medical care organization those clinical services that can be provided by telemedicine; and recommends that organized medical staffs (a) amend the medical staff bylaws to allow physicians providing telemedicine to be granted and maintain medical staff membership if they meet other obligations of such membership and (b) incorporate Policy 160.937, regarding their responsibility for supervision of non-physician providers and technicians delivering services via telemedicine, in the medical staff bylaws or rules and regulations. (BOT Rep. 3, A-97; Reaffirmed: CLRPD Rep. 2, A-07)

H-225.963 Unilateral Imposition of Medical Staff Development Plans and Economic Credentialing Controlled by the Hospital

The AMA, if requested directly or by a constituent medical society, will provide assistance to the medical staff in resolving a dispute over medical staff development plans or economic credentialing controlled by the hospital, if appropriate. (Res. 823, A-97; Reaffirmed: CLRPD Rep. 2, A-07)

H-225.964 Hospital Employed/Contracted Physicians Reimbursement

AMA policy states that: (1) all hospital employed/contracted physicians be prospectively involved if the hospital negotiates for them for capitation and global billing contracts; (2) hospital employed/contracted physicians be informed about the actual payment amount allocated to the physician component of the total hospital payment received by the contractual arrangement; and (3) all potential hospital/contracted physicians request a bona fide hospital plan which delineates the actual payment amount allocated to the employed or contracted physicians. (Sub. Res. 723, I-96; Reaffirmed: Res. 812, A-02)

H-225.965 Activities of the Joint Commission on Accreditation of Healthcare Organizations and a Single Signature to Document the Validity of the Contents of the Medical Record

The AMA supports the authentication of the following important entries in the medical record, history and physical examinations, operative procedures, consultations, and discharge summaries. Unless otherwise specified by the hospital or medical staff bylaws, or as required by law or regulation, a single signature may document the validity of other entries in the medical record. (BOT Rep. 58, A-96; Reaffirmed: CLRPD Rep. 2, A-06)

H-225.966 American Hospital Association Management Advisory on No-Cause Drug Testing of the Medical Staff

The AMA establishes the primacy of medical staff authority in substance abuse policy and procedures covering any pre-employment, credentialing, or other phases of physician evaluation. (CSA Rep. 2, I-95; Reaffirmed and Modified: CSA Rep. 8, A-05)

H-225.967 American Hospital Association Management Advisory on No-Cause Drug Testing of the Medical Staff

(1) Policy of the AMA states that medical staff must be involved in the development of the institution's substance abuse policy, including: (a) selection of analytical methods to ensure scientific validity of the test results, (b) determination of measures to maintain confidentiality of the test results, (c) in for-cause post-incident/injury testing, definition of standards for determining whether cause exists and which incidents and/or injuries will result in testing, and (d) development of mechanisms to address the physical and mental health of medical staff members. (2) The AMA believes all drug and alcohol testing must be performed only with substantive and procedural due process safeguards in place. (CSA Rep. 2, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-225.968 Standard Admitting Orders

It is the policy of the AMA that any standard admitting orders are the responsibility of and should be developed and approved by the medical staff. (Sub. Res. 815, I-93; Reaffirmed: CSA Rep. 8, A-03)

H-225.969 Disputes Between Medical Supervisors and Trainees

The AMA has adopted the following guidelines with regard to disputes between medical supervisors and trainees:
(1) Clear policies for handling complaints from medical students, resident physicians, or other staff should be established, as outlined in the recommendations of the AMA's Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures and Council on Ethical and Judicial Affairs (CEJA) Opinion 9.031; "Reporting Impaired, Incompetent or Unethical Colleagues." Grievance Committees or other mechanisms for handling complaints should provide for participation by peers of the medical student or resident physician complainant.
(2) Policies for handling complaints should include adequate provisions for protecting the confidentiality of complainants when possible. Retaliatory or punitive actions against those who raise complaints are unethical and are a legitimate cause for filing a grievance with the appropriate institutional committee.
(3) Mechanisms for adjudicating disputes requiring immediate resolution should be in place. Disputes requiring immediate resolution are defined as those involving serious errors in clinical or ethical judgment, or physician impairment, that result in a threat of imminent harm to the patient or to others. Third party mediators of such disputes may include the chief of staff or the involved service, the chief resident, a designated member of the institutional grievance committee, or, in large institutions, an institutional ombudsperson largely outside of the established hospital staff hierarchy.
(4) In accordance with item 3, medical students, resident physicians, and other staff should refuse to participate in patient care ordered by their supervisors in those rare cases in which the orders reflect serious errors in clinical or ethical judgment, or physician impairment, that result in a threat of imminent harm to the patient. In these rare cases, the complainant may withdraw from the care ordered by the supervisor, provided that withdrawal does not itself threaten the patient's immediate welfare. In any event, it is essential that the student, resident physician, or staff member communicate his or her concerns to the physician issuing the orders and,

if necessary, to the appropriate persons for mediating disputes requiring immediate resolution, as defined in item 3 above. Retaliatory or punitive actions against complainants are unethical and are a legitimate cause for filing a grievance with the appropriate institutional committee.
(5) Access to employment and evaluation files should be carefully monitored to remove the possibility of inappropriate alteration or tampering. Resident physicians should be permitted access to their employment files and also the right to copy the contents thereof, within the provisions of applicable federal and state laws. (CEJA Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-225.970 Full Participation for All Members of Hospital Medical Staff

The AMA opposes efforts by hospital administrations or governing boards to abrogate the voting rights of the physicians who serve on the medical executive committee. The AMA will communicate to its members its strong concern about hospital administrations' or governing boards' efforts to limit the participation of any physician who serves on the medical executive committee in the self-governing medical staff. (Res. 805, A-93; Reaffirmed: CMS Rep. 10, A-03)

H-225.971 Credentialing and the Quality of Care

It is the policy of the AMA: (1) that the hospital medical staff be recognized within the hospital as the entity with the overall responsibility for the quality of medical care;

(2) that hospital medical staff bylaws reaffirm the JCAHO standard that medical staffs have "overall responsibility for the quality of the professional services provided by individuals with clinical privileges";

(3) that each hospital's quality assurance, quality improvement, and other quality-related activities be coordinated with the hospital medical staff's overall responsibility for quality of medical care;

(4) that the hospital governing body, management, and medical staff should jointly establish the purpose, duties, and responsibilities of the hospital administrative personnel involved in quality assurance and other quality-related activities; establish the qualifications for these positions; and provide a mechanism for medical staff participation in the selection, evaluation, and credentialing of these individuals;

(5) that the hospital administrative personnel performing quality assurance and other quality activities related to patient care report to and be accountable to the medical staff committee responsible for quality improvement activities;

(6) that the purpose, duties, responsibilities, and reporting relationships of the hospital administrative personnel performing quality assurance and other quality-related activities be included in the medical staff and hospital corporate bylaws;

(7) that the general processes and policies related to patient care and used in a hospital quality assurance system and other quality-related activities should be developed, approved, and controlled by the hospital medical staff; and

(8) that any physician hired or retained by a hospital to be involved solely in medical staff quality of care issues be credentialed by the medical staff prior to employment in the hospital. (BOT Rep. T, I-92; Reaffirmed: CMS Rep. 10, A-03)

H-225.972 AMA Sponsored Leadership Training for Hospital Medical Staff Officers and Committee Chairs

It is the policy of the AMA (1) to offer, both regionally and locally, extensive training and skill development for emerging medical staff leaders to assure that they can effectively perform the duties and responsibilities associated with medical staff self-governance; and (2) that training and skill development programs for medical staff leaders be as financially self-supporting as feasible. (Res. 808, I-91; Reaffirmed: Sunset Report, I-01)

H-225.973 Financial Arrangements Between Hospitals and Physicians

Our AMA: (1) opposes financial arrangements between hospitals and physicians that are unrelated to professional services, or to the time, skill, education and professional expertise of the physician;

(2) opposes any requirement which states that fee-for-services payments to physicians must be shared with the hospital in exchange for clinical privileges;

(3) opposes financial arrangements between hospitals and physicians that (a) either require physicians to compensate hospitals in excess of the fair market value of the services and resources that hospitals provide to physicians, (b) require physicians to compensate hospitals even at fair market value for hospital provided services that they neither require nor request, or (c) require physicians to accept compensation at less than the fair market value for the services that physicians provide to hospitals;

(4) opposes financial arrangements between hospitals and pathologists that force pathologists to accept no or token payment for the medical direction and supervision of hospital-based clinical laboratories; and

(5) urges state medical associations, HHS, the AHA and other hospital organizations to take actions to eliminate financial arrangements between hospitals and physicians that are in conflict with the anti-kickback statute of the Social Security Act, as well as with AMA policy. (CMS Rep. C, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed and Appended: CMS Rep. 2, I-02)

H-225.975 Compensation for the Medical Staff for Committee Work

(1) Organized medical staffs and their members have an obligation to carry out professional responsibilities through the efficient operation of medical staff committees.

(2) Physicians participating in patient care review committee activities which place an extraordinary demand on their time should be compensated.

(3) Government and other third party inpatient care review requirements that are not the traditional responsibility of the organized hospital medical staff should be appropriately funded by the hospital.

(4) If the hospital compensates the medical staff leaders directly, the medical staff should be involved in their nomination and election. If other physicians are retained by the hospital to assist the medical staff in fulfilling their responsibilities, the medical staff should be involved in the credentialing of those physicians. Each medical staff should discuss possible funding alternatives with the hospital governing body and should determine how funds will be used to support medical staff activities. (BOT Rep. MM, I-90; Reaffirmed: Sunset Report, I-00)

H-225.977 Liability Coverage for Physician Members of Hospital Committees

Our AMA believes that every physician who serves as medical staff president, head of a medical staff department, a member of a medical staff peer review or quality review committee or acts in any hospital and/or medical staff administrative capacity, absent malice, should be fully indemnified and held harmless by the hospital. (Res. 183, I-89; Reaffirmed: Sunset Report, A-00)

H-225.979 Hospital Medical Staff Relationships - Dispute Resolution

Our AMA supports the following principles that may assist in dispute resolution: (1) Hospitals should establish a committee consisting of an equal number of board of trustees/directors and medical staff representatives, such as a joint conference committee, to address conflicts and attempt to resolve them as they arise. An outside facilitator or mediator might be used to frame the issues objectively and impartially and identify the reasons communications between the hospital governing board or management and the organized medical staff were not open or effective.

(2) County and state medical societies that have not done so are encouraged to meet with their county and state hospital association or council counterparts to consider the feasibility of establishing a service that could be made available at the request of the chairman of a hospital governing board and the chief of the medical staff to assist in resolving any dispute between the two that could not be resolved within the institution. The representatives of each could serve as a fact-finding body and make recommendations on how the dispute or impasse might be resolved without the need to resort to litigation or generate adverse publicity for the parties.

(3) Any mechanism or services available to assist individual hospital governing boards and management to resolve disputes with the hospital medical staff should be publicized and widely disseminated. If the service involves identification of experienced facilitators or mediators, their availability should also be publicized.

(4) Any mechanism or service made available for hospital dispute resolution at the county or state level must have the capability of having individuals who can engage in fact finding at the particular hospital in which the dispute arose. The county/state association, with appropriate input from the AMA, when requested, makes a decision on the type of assistance that is appropriate for that particular hospital dispute based on existing policies.

(5) The use of alternative dispute resolution mechanisms available at the local level to resolve hospital governing board and management and hospital medical staff disputes should be encouraged and fostered in programs and publications of the AMA. (BOT II, A-89; Reaffirmed: Sunset Report, A-00)

H-225.980 Hospital Medical Staff Section Representation on State Governing Boards

Our AMA encourages state medical associations to consider providing representation from the state hospital medical staff section on state medical associations' governing boards and encourages those states that have not yet established state-level hospital medical staff sections to do so. (Res. 3, I-88; Reaffirmed: Res. 303 and Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-225.982 Hospitals' Contractual Relationships with Health Plans

In those situations where a hospital has entered into agreements with one or more delivery systems without consulting its medical staff, or when there are not enough physicians on that medical staff who have contracted with delivery systems, AMA recommends that the medical staff work with the hospital to make the hospital aware of the benefits of consulting with the medical staff about these arrangements. The AMA also recommends that the medical staff offer suggestions that will help to resolve the problems faced by physicians who have not contracted with delivery systems but are obligated to treat patients of delivery systems. (BOT Rep. CC, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-225.983 Physician Representation on Hospital Governing Boards

(1) It is the policy of the AMA that physicians who are members of the medical staff shall be eligible for, and should be included in, full membership on hospital governing bodies and their action committees in the same manner as are other knowledgeable and effective individuals. Other physicians also should be considered eligible for membership on the governing body. The hospital medical staff should have the right of representation at all meetings of the governing body by medical staff members elected by the medical staff having the right of attendance, voice and, if appropriate, vote. Compensation to medical staff members for service to the hospital should not preclude the physician’s membership on the hospital governing board. (2) Hospital conflict of interest policies should include physician medical staff members of hospital governing boards. (Sub. Res. 820, I-92; Reaffirmed: CMS Rep. 10, A-03; Modified: Res. 714, A-04)

H-225.984 Hospital Corporate Bylaws

The AMA encourages hospital medical executive committees to: (1) regularly examine the hospital/corporate bylaws, rules and regulations for any conflicts with the medical staff bylaws, rules and regulations or practices; (2) request that their hospital board of trustees/directors notify them of any proposed or impending changes in the hospital/corporate bylaws; and (3) advise members/applicants of the medical staff of the effect of these hospital/corporate bylaws, rules and regulations. (Res. 3, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmation A-05; Reaffirmation A-06)

H-225.985 Medical Staff Review of Quality of Care Issues Prior to Exclusive Contract

The AMA believes that the medical staff should review and make recommendations to the governing body related to exclusive contract arrangements, prior to any decision being made, in the following situations: (1) the decision to execute an exclusive contract in a previously open department or service; (2) the decision to renew or otherwise modify an exclusive contract in a particular department or service; (3) the decision to terminate an exclusive contract in a particular department or service; and (4) prior to termination of the contract the medical staff should hold a hearing, as defined by the medical staff and hospital to permit interested parties to express their views on the hospital's proposed action. (Res. 182, A-87; Res. 806, A-93; Reaffirmed: CMS Rep. 10, A-03)

H-225.986 Physician Economic Incentive Program

The AMA: (1) opposes physician economic incentives that conflict with patients' welfare; and (2) believe the physician must remain the patient's advocate in the patient's relationship with the hospital. (Res. 3, A-86; Reaffirmed by CMS Rep. 1, A-95; Modified by CLRPD Rep. 1, I-95; Modified by Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-225.987 Reporting of Incidents

The AMA believes that (1) all hospital reports mandated by state agencies or outside authorities involving individual physician care of patients should be reviewed by an appropriate medical staff committee prior to reporting; (2) hospital medical staffs should be given a reasonable period of time to evaluate any reports pertaining to a physician's care of patients; and (3) the organized medical staff should seek the assurance of the state agency or outside authority that the report will remain strictly confidential. (Res. 120, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CLRPD Rep. 1, A-05)

H-225.988 Hospital-Medical Staff Joint Ventures

The AMA believes it is vital for physicians to appraise responsibly the benefits and risks of specific hospital medical staff joint venture activities in light of their individual circumstances and the advice of knowledgeable and independent financial advisors and legal counsel. (BOT Rep. C, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CLRPD Rep. 1, A-05)

H-225.989 AMA Opposes Forcing Medical Staffs to Repay Hill-Burton Obligations of Free Medical Care

The AMA (1) opposes attempts to create new and arbitrary requirements for hospital compliance with the Hill-Burton Act by shifting responsibility for these requirements to hospital medical staffs; (2) believes that a hospital's Hill-Burton Act obligations should be

satisfied in a manner that does not interfere with the professional rights of its medical staff; and (3) endorses exploration of means to assure equal access to medical care for the people of the U.S. (Res. 8, I-79; Reaffirmed: Res. 99, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CLRPD 1, A-04)

H-225.991 Communication and Cooperation Between Hospital Management and Medical Staff

The AMA encourages hospitals to make known to physicians the diagnostic codes which are recorded by medical records and business departments so the accuracy of these diagnoses can be confirmed. (Sub. Res. 86, A-84; CLRPD Rep. 3 - I-94; Reaffirmed: CLRPD 1, A-04)

H-225.992 Right to Relevant Information

(1) The AMA advocates "timely notice" and "opportunity to rebut" any adverse entry in the medical staff member's credential file, believes that any health care organization file on a physician should be opened to him or her for inspection, and supports inclusion of these provisions in hospital medical staff bylaws.

(2) Triggers that initiate a peer review within a health care facility should be valid, transparent and available to all member physicians and should be uniformly applied to all cases and physicians.

(3) A physician accused of an infraction of medical staff bylaws, rules, regulations, policies or procedures and faced with potential peer review action shall be promptly notified that an investigation is being conducted and shall be given an opportunity to respond.

(4) All relevant information pertaining to a potential peer review action should be obtained promptly from the subject physician and other relevant sources. Relevant information includes, but is not limited to, pre-event factors, names of other health professionals involved in the care of the patient, and the contributing environmental factors of the health care facility/system.

(5) All material information obtained by the peer review committee regarding the subject of the peer review should be made available to the physician under review in a timely manner prior to the hearing.

(6) The investigating individual or body shall interview the practitioner, unless the practitioner waives his/her right to be heard, to evaluate the potential charges and explore alternative courses of action before proceeding to the formal peer review process. (Res. 121, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Modified by Sub. Res. 801, A-94; Reaffirmed: CLRPD 1, A-04; Amended with change in title: BOT Action in response to referred for decision BOT Rep. 23, A-05)

H-225.993 Medical Staff Policy Determination

The AMA believes that only fully licensed physicians on the medical staff should establish overall medical staff standards and policy for quality medical care, where consistent with local, state and federal laws. (Res. 115, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CMS Rep. 7, A-05)

H-225.994 Hospital Advertising in Printed and Broadcast Media

In order to prevent medical misinformation, the AMA encourages medical staff participation in hospital administration decisions regarding marketing and advertising. (Res. 118, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CLRPD Rep. 1, A-05)

H-225.995 Duplication in Hospital Liability and Physicians' Professional Liability Insurance

Our AMA reaffirms existing policy that (1) Each physician should be free to determine whether to carry liability coverage as well as the amount of such coverage. Likewise, it is the responsibility of the hospital governing board to determine the extent to which the hospital should protect its assets by purchasing liability insurance; and (2) Regardless of the type of insurance coverage or protection plan hospitals and physicians on the organized staff have, the AMA encourages medical staffs and hospitals to work toward the establishment of effective risk management programs. (Res. 60, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Modified: Res. 813, I-02; Reaffirmation A-04)

H-225.996 Computer-Based Hospital and Order System

The AMA supports the concept of early involvement and participation by the hospital medical staff in decisions as to installation of a hospital information system and in the development of policies governing the use of such a system in the institution. (CMS Rep. F, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: BOT Rep. R, A-93; Reaffirmed: CMS Rep. 10, A-03)

H-225.997 Physician-Hospital Relationships

(1) Physicians and hospital authorities have a mutual responsibility to cooperate and work together in effectively maintaining patient care.

(2) Although final authority for granting, denial, termination, or limitation of hospital staff privileges is vested in the governing board of the hospital, it is expected that the judgment of the organized medical staff will be relied upon in the evaluation of the professional competence, education, experience, and qualifications of all physicians, including the hospital-associated medical specialists.

(3) Physicians having contractual or financial arrangements with hospitals should be members of the organized medical staff and responsible to it. They should be subject to the bylaws of the medical staff and conduct their professional activities according to the standards, rules and regulations adopted by it.

(4) Hospital-associated medical specialists, as well as all members of the medical staff, are expected to contribute a reasonable amount of their time, without compensation, to participation in hospital staff committee activities for the purpose of improving patient care; providing continuing education for the benefit of the medical staff; and assisting in the training of physicians and allied health personnel. Physicians who provide teaching or other services in excess of those ordinarily expected of members of the attending staff are entitled to reasonable compensation therefore.

(5) Hospitals are entitled to recover their reimbursable expenses, determined in accordance with recognized standard hospital cost-accounting principles, from the operation of departments in which hospital-associated medical specialists perform personally or supervise or direct the services provided patients.

(6) The form of the contractual or financial arrangement between hospitals and hospital-associated physicians depends upon the facts and practical considerations existing in each situation. No single form of contractual or financial arrangement can be feasible for all of the arrangements that may be entered into between hospitals and hospital-associated physicians. The essential consideration is that whatever the arrangement, it is fair to the parties, promotes the interests of patients and supports the provision of high quality care and services. Arrangements should be avoided that are unrelated to the professional services, or time expended or to the skill, education, and professional expertise of the physician, and that result in disproportionate earnings.

(7) Hospital-associated medical specialists are entitled to charge (a) for the services they provide in accordance with the same standards of equity and fairness that apply to the charges of other physicians, and (b) for supervision of personnel under their direction.

(8) There should be no duplication of charges to the patient where services are not actually provided by both the physician and the hospital. Each party should receive the compensation reasonably and equitably owing for services for which each is primarily responsible. Only one of the parties is entitled to the reasonable costs of assuring the accuracy and reliability of the procedures performed in such departments.

(9) Both hospitals and hospital-associated medical specialists have an obligation to serve the needs of patients and the medical staff. The primary responsibility for determining the services needed adequately to care for the needs of individual patients should be that of the attending physician subject to review by his peers. (BOT Rep. R, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-05)

H-225.998 Hospitals and Liability Insurance

Our AMA believes that (1) liability insurance should remain the independent responsibility of physicians and hospitals; and (2) medical staffs and hospitals should work toward establishment of effective risk management programs. (BOT Rep. L, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-04)

H-230.000 Hospitals: Medical Staff - Credentialing and Privileges
(See also: Hospitals; Hospitals: Accreditation Standards; Hospitals: Medical Staff; Hospitals: Medical Staff - Organization; Hospitals: Reimbursement)

H-230.955 Clarification of Medical Staff Rights in Granting Clinical Staff Privileges

Our AMA: (1) policy is that medical staffs may establish any method of granting clinical privileges that complies with Joint Commission on Accreditation of Healthcare Organizations standard MS.4.20; and (2) requests that its Commissioners to JCAHO ask JCAHO to notify all hospitals and medical staffs that there can be multiple ways to comply with JCAHO standards. (Res. 729, A-05)

H-230.956 Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records

1. AMA policy regarding the appropriate disposition of physician credentialing records following the closure of hospitals, ambulatory

surgery facilities, nursing homes and other health care facilities, where in accordance with state law and regulations is as follows:

A. Governing Body to Make Arrangements: The governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility shall be responsible for making arrangements for the disposition of physician credentialing records or CME information upon the closing of a facility.
B. Transfer to New or Succeeding Custodian: Such a facility shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information. In the alternative, the facility shall seek to make arrangements with a reputable commercial storage firm. The new or succeeding custodian shall be obligated to treat these records as confidential.
C. Documentation of Physician Credentials: The governing body shall make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.
D. Maintenance and Retention: Physician credentialing information and CME information transferred from a closed facility to another hospital, other entity, or commercial storage firm shall be maintained in a secure manner intended to protect the confidentiality of the records.
E. Access and Fees: The new custodian of the records shall provide access at a reasonable cost and in a reasonable manner that maintains the confidential status of the records.

2. Our AMA advocates for the implementation of this policy with the American Hospital Association. (Res. 808, I-04)

H-230.957 Access to Hospital Records

Our AMA will support legislation guaranteeing that physicians engaged in staff privileges disputes have free and full access to all medical records related to those disputes so they can adequately defend themselves. (Res. 527, A-04; Reaffirmation A-05)

H-230.958 Economic Loyalty Criteria for Medical Staff Privileges

Our AMA strongly opposes the implementation of economic loyalty criteria. (Res. 804, I-00; Reaffirmation A-05)

H-230.959 Ultrasound and Biopsy of the Thyroid

Our AMA adopts the position that only appropriately trained and credentialed physicians (M.D. and D.O.) and appropriately trained and certified ultrasound technologists perform ultrasound examinations of the thyroid and that only appropriately trained and credentialed physicians evaluate and interpret ultrasound examinations and perform ultrasound-guided biopsies of the thyroid. (Sub. Res. 818, I-99)

H-230.960 Privileging for Ultrasound Imaging

(1) AMA affirms that ultrasound imaging is within the scope of practice of appropriately trained physicians;

(2) AMA policy on ultrasound acknowledges that broad and diverse use and application of ultrasound imaging technologies exist in medical practice;

(3) AMA policy on ultrasound imaging affirms that privileging of the physician to perform ultrasound imaging procedures in a hospital setting should be a function of hospital medical staffs and should be specifically delineated on the Department's Delineation of Privileges form; and

(4) AMA policy on ultrasound imaging states that each hospital medical staff should review and approve criteria for granting ultrasound privileges based upon background and training for the use of ultrasound technology and strongly recommends that these criteria are in accordance with recommended training and education standards developed by each physician's respective specialty. (Res. 802, I-99; Reaffirmed: Sub. Res. 108, A-00)

H-230.961 Credentialing of Physicians by CMS

Our AMA vigorously opposes: (1) efforts by the CMS to impose specific requirements for any specific area of medical practice that dictate credentialing, privileging, and continuing medical education requirements which are better left to hospital medical staffs and medical licensing boards; and (2) any efforts by CMS to usurp the prerogative of hospital medical staffs, medical licensing boards, or appropriate medical organizations to credential, privilege, and define continuing medical education requirements for physicians. (Sub. Res. 140, A-99)

H-230.962 Subspecialists Functioning as Primary Care Physicians

It is the policy of the AMA that clinical privileges in primary care be granted to physicians that have demonstrated capability through education, training, experience and current competence, and that the practice of managed care organizations to arbitrarily deny primary care privileges to physicians because of subspecialty or second specialty training be opposed by the AMA. (Res. 307, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-230.963 Limitations of Membership on Multiple Hospital Medical Staffs

Our AMA: (1) supports the principle that a hospital may not limit a physician's participation or medical staff privileges at the hospital based in whole or in part on the physician's membership or participation at a different hospital or hospital system or on the medical staff membership or participation of a partner, associate or employee of the physician at a different hospital or hospital system; (2) opposes hospitals placing limitations on medical staff privileges or participation at a hospital based in whole or in part on the physician's membership or participation at a different hospital or hospital system or on the medical staff membership or participation of a partner, associate or employee of the physician at a different hospital or hospital system; and (3) opposes hospitals placing limitations on medical staff privileges or participation at a hospital based in whole or in part on the physician (or a partner, associate or employee of the physician) having a financial relationship with another hospital/health system. (Res. 823, I-97; Appended Res. 814, I-00; Reaffirmation A-05; Reaffirmed: CMS Rep. 2, A-06)

H-230.964 Physician Credentialing and Privileging

The AMA supports the following general guidelines:

I. PREAMBLE The practice of medicine is dynamic and continues to evolve. Additional training may be required to integrate techniques or procedures that are new to the individual physician. The purpose of this document is to provide unifying guidelines for institutions/organizations offering continuing medical education programs and to provide information about training in new procedures for which the physician will request new or expanded privileges. These guidelines are not intended to document competency in a specific procedure.

II. INTRODUCTION Continuing advances in the medical sciences and technology have resulted in the development of an array of new technical procedures in patient care, including minimal access surgical procedures. This phenomenon has not only increased the necessity for rapid dissemination of information and instruction regarding the new technologies and procedures but it has triggered a growing number of requests for new or expanded clinical privileges. To ensure safe and effective patient care and to provide assistance to those charged with granting new or expanded clinical privileges, the medical community recognizes the critical need to have appropriate educational standards for training leading to the acquisition of new clinical skills. This training should be accessible, without discrimination, to all physicians in every specialty, who have the appropriate education, training, experience, and documented competence. Moreover, to maintain proficiency in interventional techniques and to enhance technical expertise, an ongoing commitment to continuing medical education is crucial.

III. GENERAL GUIDELINES FOR INSTITUTIONS/ORGANIZATIONS The general guidelines, which have been established by the American Medical Association in collaboration with participating medical specialty societies, should be followed by institutions/organizations sponsoring continuing medical education clinical skills training activities regardless of specialty. The skills training activities must be sponsored by an organization accredited by the ACCME or a state medical society, or be approved for Prescribed Credit by the American Academy of Family Physicians for family physicians. Further, any individual skills training activity must demonstrate that it is in substantial compliance with the general guidelines applicable to all clinical skills training activities and the special guidelines, developed by and applicable to clinical skills training activities within a particular medical specialty for physicians in that specialty. The educational activities that meet these guidelines will be listed in a national registry maintained by the AMA in coordination with the appropriate national medical specialty society. The instruction may take place in either (a) a formal learning activity, i.e., course, or (b) a defined clinical preceptorship. Many times both modalities will be used. Ideally, formal learning and a preceptorship will be followed by observation of the practitioner in his/her own setting. These general guidelines provide practical guidelines to educators in designing clinical skills training activities. They also provide guidance to faculty in evaluating and assessing individual skills acquisition. The process could be useful to credentialing bodies, as one factor in determining whether or not a physician completing a given activity should be granted specific privileges.
IlIa. Educational Components. The provider will have a mission of providing procedural learning activities for physicians. The teaching of skills acquisition may be through 1) specific formal courses, 2) a clinical preceptorship, or both.

1. Formal Courses
1a. Learning objectives. There must be a stated set of objectives for each educational activity. These should conform to accepted practice as defined by the specialty/ subspecialty societies. The skills objectives to be taught must be defined as tasks, successful completion of which can be objectively assessed.
1b. Site/Operations. The site of the educational activity must be physically adequate to meet the stated objectives and to provide appropriate facilities for the number of participants enrolled,
1c. Qualifications of faculty. The director of the educational activity and the faculty must be knowledgeable in educational methodology, have the appropriate qualifications, and necessary clinical and/or laboratory expertise to teach the subject matter of the

course. These qualifications must meet institutional and specialty/ subspecialty society specifications.
There must be an appropriate ratio of clinical faculty to trainees in order to assure that the course objectives are met and to enable documentation of the learner's achievement of these objectives.
The director of the educational activity, under the guidance of the sponsoring organization, has the responsibility for setting objectives, curriculum development, faculty and staff appointment, and development of evaluation criteria. The director of the educational activity must disclose directly to the trainees, in advance, any relationships with industry.
1d. Qualifications of trainees. The trainees must have background knowledge, basic skills, and clinical experience relevant to the tasks to be learned. The trainees may be required to provide documentation of the above. If appropriate, the trainees may be pre-tested to demonstrate eligibility.
1e. Curriculum. There must be a written curriculum which should include a list of skills to be acquired, definitions of skill levels and a defined method of progressing from one skill level to the next. Supplemental resource materials (e.g., a bibliography, reprints, videos) must be included or referenced in a syllabus given to all trainees.
An educational activity must contain didactic instruction, supported by published or peer-reviewed data in the following areas as they apply to the stated objectives:
*R = required information **D = desired information
- Patient selection (R)
- Indications and contraindications (R)
- Historical considerations (D)
- Instrumentation (R)
- Techniques/adjunctive techniques (R)
- Cost considerations/cost effectiveness (R)
- Content validity (R)
- Management of complications (R)
- Documentation methodology (R)
- Pre- and post-procedure care (R)
- Follow-up policies (R)
- Analysis of outcomes (R)
- Current research (D)

Appropriate components of a skills laboratory may include, but are not limited to:
- Reading material and syllabi
- Didactic sessions
- Inanimate model practice
- Animate laboratory instruction and practice
- Equipment familiarity
- Video, CD ROM, and audio tape instruction/practice
- Procedure observation
- Simulator/virtual reality models
- Interactive computer programs
- Self-assessment exercises

1f. Duration of training. The length of the formal educational activity or course should be proportionate to the complexity of the skills to be learned, in order for the trainee to demonstrate the achievement of the defined objectives, and to provide familiarity with the patients and diseases requiring evaluation.
1g. Documentation. The director of the educational activity must provide each trainee with a written summary verifying his/her successful achievement of the defined objectives and specifying the method of measuring that achievement (e.g., passing a post-test). This information may be provided, upon written request, to a credentials committee of a health care organization.

2. Preceptorship in a Clinical Setting
2a. Learning objectives. The clinical preceptorship must have stated objectives. The objectives must include a program outline and a proposed list of tasks and skills to be addressed during the training period.
2b. Site/Operations. The preceptorship site must have a sufficient patient population and facilities to adequately educate the trainee. The preceptorship must be sponsored by an accredited health care organization or a recognized national medical society with a CME accreditation program.
2c. Qualifications of preceptor. The physician preceptor must be appropriately privileged and have documentable clinical experience in the procedure(s) and/or technique(s) in the particular, field of expertise.
The preceptor has the responsibility of setting objectives, developing curriculum, overseeing instruction and practice of skills, demonstrating technique and clinical procedures, and evaluating the trainee under the overall responsibility of the sponsoring organization.
The preceptor must disclose directly to the preceptee, in advance, any relationship with industry.
The preceptor must have primary responsibility for the care of the patient and is obliged to supervise not only procedures in which the trainee participated but also the appropriate periprocedure care.

There must be written evidence of informed consent by the patient, which allows a trainee to be involved in his/her care. As an alternative, evidence of institutional review board research approval must be on file which conforms with the institution's policies and protocols dealing with human research involving patient procedures.
2d. Qualifications of trainee/preceptee. The trainee must have background knowledge, basic skills, and clinical experience relevant to the tasks to be learned. The trainees may be required to provide documentation of the above.
In addition, the trainee must have a current and valid license to practice medicine, or meet local requirements for waiver of licensure. The trainee should be able to provide evidence of current liability coverage, hold current clinical privileges in an accredited health care institution, and should have completed an accredited residency training program. Alternatively, the trainee could provide verifiable evidence of equivalent training and/or board certification.
2e. Curriculum. Preceptorship training must be rigorous and based on clinical experiences. Training should include didactic and technical components and may be supplemented with teaching tools at the preceptor's discretion.
Most importantly, a preceptorship should include an appropriate number of opportunities for the trainee to both assist and serve as primary operator in the designated procedure and/or technique.
2f. Duration of preceptorship. Training should be proportionate to the complexity of the skills to be taught in order for the preceptee to demonstrate the achievement of the defined objectives, as well as to provide familiarity with the patients and diseases requiring evaluation.
2g. Documentation. The preceptor must document in writing both qualitative and quantitative descriptions of the trainee's experiences. This should include the skills acquired and the number of procedures in which the trainee assisted or served as primary operator.
Documentation stating that the procedures were satisfactorily performed must be provided to the preceptee. This information may be provided, upon written request, to a credentials committee of a health care organization. A log of activities kept by the trainee and reviewed by the preceptor and/or credentialing body could assist in the privileging process-
Sponsoring institutions must maintain permanent records of preceptees in order to make these available to appropriate authority bodies on request- A certificate of appropriate continuing medical education credit may be provided by the sponsoring organization, if appropriate.
2h. Indemnity. It is the dual responsibility of the preceptor and the trainee to secure appropriate authorization from the host institution and, if necessary, to secure appropriate indemnity coverage.

IIIb. Quality Assurance. Health care institutions awarding new or expanded privileges to physicians on the basis of such newly acquired skills must establish a program providing on-going review of the physician's performance, as part of their overall quality assurance program.

IIIc. Overall Program Assessment. Every provider of the above described educational activities must regularly evaluate the degree to which its goals are being met as well as evaluate its overall outcomes and be prepared to report these to the appropriate organizations (e.g., AMA, medical specialty societies, and the ACCME). Such evaluations should be systematically documented to ensure that the educational activity is preparing qualified practitioners (e.g., number of procedures performed by each preceptee in the year following the preceptorship, percent complications, etc.). The assessment process must include evaluation of courses and faculty by trainees.

IV. SPECIFIC GUIDELINES (to be developed, in collaboration with specialty/ subspecialty societies) (CME Rep. 7, I-95; Reaffirmed and Modified: CME Rep. 2, A-05)

H-230.965 Immunity from Retaliation Against Medical Staff Representatives by Hospital Administrators

The AMA condemns any action taken by administrators or governing bodies of hospitals or other health care delivery systems who act in an administrative capacity to reduce or withdraw or otherwise prevent a physician from exercising professional privileges because of medical staff advocacy activities unrelated to professional competence, conduct or ethics. (Sub. Res. 813, I-96; Reaffirmed: CLRPD Rep. 2, A-06)

H-230.966 Physician Appeals Mechanism for Denial of Academic Appointment

Hospital governing boards and hospital medical staffs through their Bylaws must remain responsible for medical staff selection. In situations in which hospital medical staff privileges are granted by contract on the condition of an academic appointment, the physician must be made aware of and agree to the linkage. Under those circumstances when a physician may lose an academic appointment after full and fair due process, no further action is required for revocation of hospital medical staff privileges. (CME Rep. 8, A-96; Reaffirmed: CME Rep. 2, A-06)

H-230.968 Practice Limitations

The AMA supports model hospital medical staff bylaws requiring the same due process in limiting professional practice for economic or contractual reasons as is followed for quality reasons; and will clarify that practice limitations based on economic or contractual reasons are not reportable to the National Practitioner Data Bank. (Res. 803, I-95; Reaffirmed by BOT Rep. 14, A-98; Reaffirmed: CMS Rep. 4, A-08)

H-230.969 Strengthening Medical Staff Bylaws

The AMA: (1) supports the physicians in their appeal of the Austin vs. Mercy case; (2) will study the feasibility of assisting states in developing legislation to mandate that hospital medical staff bylaws be viewed as contracts; and (3) will study the feasibility of introducing federal legislation to mandate that medical staff bylaws be viewed as a contract. (Sub. Res. 810, A-95; Reaffirmed: CLRPD Rep. 1, A-05)

H-230.970 Proper Notification of a Physician Regarding Possible Loss of Medical Staff Membership or Privileges

Except in the instance of summary suspension, hospital notification of possible loss of medical staff membership and/or privileges must be sent by certified mail, return receipt requested, or its equivalent. (Res. 802, I-94; Reaffirmed: CLRPD 1, A-04)

H-230.971 Economic Credentialing

The AMA: (1) will pursue incorporation of language into JCAHO standard MS.2.4.1.3 to state, "Economic criteria unrelated to quality of care or professional competency should not be used in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges";
(2) will seek to have the following incorporated into the "Score 1" description of the scoring guideline for JCAHO Standard MS.2.4.1.3, "The medical staff bylaws include language stating that any criteria used in the credentialing process are directly related to the quality of patient care";
(3) The AMA will work with the JCAHO to assure, through the survey process, that any criteria used in the credentialing process are directly related to the quality of patient care. (BOT Rep. 15, I-93; Reaffirmed: CLRPD Rep. 1, A-05)

H-230.972 Physician Credentialing and Privileging

The AMA: (1) reaffirms the position that clinical procedures be performed only by physicians with appropriate education, training, experience and demonstrated current competence; (2) supports the position that physicians be assessed on the basis of their education, training, experience and documented competence; (3) in coordination with national medical specialty societies, will pursue the development and application of appropriate guidelines for continuing medical education that is directed toward procedural competence; (4) in collaboration with national medical specialty societies, will organize a national conference to delineate principles for credentialing physicians to perform specific clinical procedures; and (5) in coordination with national medical specialty societies, will develop a process to evaluate educational programs that educate physicians to perform new procedures or procedures which are new for that physician. (CME Rep. 8, I-93; Reaffirmation A-05; Reaffirmed: CLRPD Rep. 1, A-05)

H-230.975 Economic Credentialing

The AMA (1) adopts the following definition of economic credentialing: economic credentialing is defined as the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges;
(2) strongly opposes the practice of economic credentialing;
(3) believes that physicians should continue to work with their hospital boards and administrators to develop appropriate educational uses of physician hospital utilization and related financial data and that any such data collected be reviewed by professional peers and shared with the individual physicians from whom it was collected;
(4) believes that physicians should attempt to assure provision in their hospital medical staff bylaws of an appropriate role for the medical staff in decisions to grant or maintain exclusive contracts or to close medical staff departments;
(5) will communicate its policy and concerns on economic credentialing on a continuing basis to the American Hospital Association, Federation of American Health Systems, and other appropriate organizations;
(6) encourages state medical societies to review their respective state statutes with regard to economic credentialing and, as appropriate, to seek modifications therein;
(7) will explore the development of draft model legislation that would acknowledge the role of the medical staff in the hospital medical staff credentialing process and assure various elements of medical staff self-governance; and
(8) will study and address the issues posed by the use of economic credentialing in other health care settings and delivery systems. (CMS Rep. B, I-91; Reaffirmed by BOT Rep. 14, A-98; Reaffirmation A-07)

H-230.976 Economic Credentialing

The AMA opposes the use of economic criteria not related to quality to determine an individual physician's qualifications for the granting or renewal of medical staff membership or privileges. (Res. 2, A-91; Reaffirmed: CME Rep. 8, I-93; Reaffirmed by BOT Rep. 14, A-98; Reaffirmation A-07)

H-230.978 Physician Assignment

It is the policy of the AMA (1) to oppose any hospital policy which would require physicians to become Medicare participating physicians or which would coerce or require physicians to accept Medicare assignment as a condition of medical staff membership; (2) to educate medical staffs about this policy; and (3) to work with the AHA to inform hospitals of this policy. (Res. 266, A-90; Reaffirmed: Sunset Report, I-00)

H-230.979 Medical Staff Credentialing Verification

Our AMA encourages specialty boards, residency programs and medical schools organizations, hospitals and other sources of primary data to charge only actual cost for the verification of the status of their graduates and staff members. (Res. 37, A-90; Reaffirmed: Sunset Report, I-00)

H-230.980 Physicians' DRG Profiles

Our AMA opposes the use of diagnosis related group (DRG) profiles as a means of credentialing and/or sanctioning physicians. (Res. 21, A-89; Reaffirmed: Sunset Report, A-00)

H-230.982 Clinical Privileges - Model Medical Staff Bylaws

Our AMA supports the following policy concerning clinical privileges: (1) Clinical privileges are defined as the right of a medical staff member to provide specific patient care services in a manner consistent with licensure, education and expertise.

(2) Privileges are conferred by the hospital governing body upon recommendation of the medical staff and shall include access to those hospital resources essential to the full exercise of such privileges.

(3) The hospital governing body may abridge one's privileges, only upon recommendation of the medical staff, for reasons related to professional competence, adherence to appropriate standards of medical care, health status, or other parameters agreed upon by the medical staff. Procedures described in the medical staff bylaws must be followed.

(4) A member providing clinical services at a hospital shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be hospital specific, within the scope of any state license, certificate or other legal credential authorizing practice and consistent with any restrictions thereon, and shall be subject to the rules and regulations of the medical staff (including the clinical department). (Sub. Res. 62, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CLRPD Rep. 2, A-07)

H-230.983 Credentials Files for Members of Hospital Medical Staffs

The AMA urges medical staffs (1) to establish and incorporate into their medical staff bylaws policies covering the management and maintenance of credentials files; and (2) to develop credentials files policies which are suited to the specific conditions prevailing at each individual hospital. (BOT Rep. G, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CLRPD Rep. 2, A-07)

H-230.984 Peer Review of the Performance of Hospital Medical Staff Physicians

The AMA (1) encourages state and local medical associations to establish procedures and committees for monitoring, upon the request of the medical staff, the effectiveness of hospital medical staff peer review; and (2) supports working with the AHA and other appropriate organizations to devise methods to encourage the development of such programs. (CMS Rep. E, I-86; Reaffirmed: I-87; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-230.985 Medical Staff Privileges

The AMA believes that if, under the principle of self-governance, a medical staff determines that productivity, as it has a direct relationship to quality of care, is a reasonable criterion to use in its consideration of reappointment, it should be permitted to do so. However, the AMA does not believe that economic productivity should be a factor in medical staff reappointment. (BOT Rep. T, I-86; Reaffirmed: BOT Rep. 15, I-93; Reaffirmed: CLRPD Rep. 1, A-05)

H-230.986 JCAHO Recognition of Specialty Boards Recognized by American Board of Medical Specialties and AMA and AOA

The AMA believes that medical staffs should have flexibility in determining which, if any, specialty board certification will be used as a criterion to delineate clinical privileges. (BOT Rep. XX, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CLRPD Rep. 2, A-06; Reaffirmed: CME Rep. 7, A-07)

H-230.987 Hospital Decisions to Grant Exclusive Contracts

The AMA supports the concept that individual medical staff members who have been granted clinical privileges are entitled to full due process in any attempt to abridge those privileges by granting of exclusive contracts by the hospital governing body. (Res. 119, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CLRPD Rep. 1, A-05)

H-230.988 Guidelines for Maintenance and Exchange of Credentialing Information

The AMA supports the development of guidelines for the maintenance and exchange of credentialing information and encourages all health care facilities, including the military, the Veterans Administration and the Public Health Service, to comply with such guidelines. (Sub. Res. 20, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed with change in title: CLRPD Rep. 1, A-05)

H-230.989 Patient Protection and Clinical Privileges

Concerning the granting of staff and clinical privileges in hospitals and other health care facilities, the AMA believes: (1) the best interests of patients should be the predominant consideration;

(2) the accordance and delineation of privileges should be determined on an individual basis, commensurate with an applicant's education, training, experience, and demonstrated current competence. In implementing these criteria, each facility should formulate and apply reasonable, nondiscriminatory standards for the evaluation of an applicant's credentials, free of anti-competitive intent or purpose;

(3) differences among health care practitioners in their clinical privileges are acceptable to the extent that each has a scientific basis. However, the same standards of performance should be applied to limited practitioners who offer the kinds of services that can be performed by limited licensed health care practitioners or physicians; and

(4) health care facilities that grant privileges to limited licensed practitioners should provide that patients admitted by limited licensed practitioners undergo a prompt medical evaluation by a qualified physician; that patients admitted for inpatient care have a history taken and a comprehensive physical examination performed by a physician who has such privileges; and that each patient's general medical condition is the responsibility of a qualified physician member of the medical staff. (Sub. Res. 36, A-84; Reaffirmed: CME Rep.8, I-93; Reaffirmed: Res. 802, I-99)

H-230.992 Hospital Admitting Privileges

The AMA believes that hospital admitting privileges should be granted in accordance with state law and in accordance with criteria for standards of medical care established by the individual hospital medical staff. (Sub. Res. 45, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CLRPD Rep. 1, A-05)

H-230.993 Physician Credentialing

The AMA recommends that hospital medical staffs adopt bylaws which enable them to retain the prerogative and responsibility, as granted by the hospital governing body, for credentialing all physicians and other licensees who apply for clinical privileges, including those who seek to enter into contractual arrangements with hospitals. (Sub. Res. 143, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CLRPD Rep. 1, A-05)

H-230.994 Encouragement of Open Hospital Medical Staffs

The AMA reaffirms its support for the principle of open staff privileges for physicians, based on training, experience and demonstrated competence. (Sub. Res. 16, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 8, I-93; Reaffirmed by BOT Rep. 14, A-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-230.995 Medical Liability Insurance Coverage as Mandatory Requirement for Hospital Staff Appointment

(1) Each hospital medical staff should determine for itself whether or not it will require professional liability insurance coverage as a condition for membership on the hospital medical staff. (2) Our AMA also believes that, if equity demands that voluntary staff members should have insurance coverage so that the burden of financial loss would not fall entirely upon the hospital, then salaried hospital physicians should likewise be covered by adequate insurance or protected financially through self-insurance mechanisms established by the hospital, so that the burden would not fall unfairly upon the members of the voluntary medical staff. (BOT Rep. T, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 11, A-03; Reaffirmation A-04)

H-230.997 Recertification and Hospital or Health Plan Network Privileges

(1) The fact that a board certified practitioner fails to undergo the recertification examination shall not be adequate reason to modify or withhold hospital privileges or health plan network status from a physician. (2) Modification or withholding of hospital privileges or health plan network status shall be purely on the basis of assessment of performance. (Res. 26, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00) (Res. 26, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: Res. 727, A-06)

H-230.998 Hospital Privileges

Our AMA believes that clinical departments of family practice should be established where appropriate with duties comparable to any other specialty department of the medical staff. (Res. 35, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-235.000 Hospitals: Medical Staff - Organization
(See also: Hospitals; Hospitals: Accreditation Standards; Hospitals: Medical Staff; Hospitals: Medical Staff - Credentialing and Privileges; Hospitals: Reimbursement)

H-235.964 Preservation of Medical Staff Self-Governance

Our AMA strongly supports: (1) the medical staff of San Buenaventura Hospital in Ventura, California, in its fight to preserve medical staff self-governance; and (2) any hospital medical staff whose rights of self-governance are being threatened by the hospital administration or the governing body. (Sub. Res. 614, A-03)

H-235.965 Physician Involvement in Hospital or Health Care Corporate Compliance Committees Concerning Fraud and Abuse

It is the policy of our AMA that physician members of hospital medical staffs, who are not employed by that hospital in management positions, have involvement in development of, and representation on, institutional committees involving hospital or health care corporate compliance and ethics concerning fraud and abuse. (Res. 805, I-00)

H-235.966 CMS Regulation to Eliminate the Critical Role of the Hospital Medical Staff

Our AMA: (1) opposes the CMS proposed regulation to eliminate 42 C.F.R. 482.22 Conditions of Participation: Medical Staff; (2) supports the position that the medical staff is the uniquely qualified organization to report to the governing body on all aspects of hospital operations impacting patient care; (3) adopts and implements a strategic plan to assure that CMS does not eliminate 42 C.F.R. 482.12 Condition of Participation: Governing Body which states the requirement that a medical staff be accountable to the governing body for the quality of patient care provided to patients; such strategic plan to include, but not be limited to, education of CMS about the critical role of the hospital medical staff and specific Federal legislation; and (4) if unable to prevent the elimination of 42 C.F.R. 482.22 Conditions of Participation: Medical Staff, then AMA will cause legislation to be introduced to restore the original intent of 42 C.F.R. 482.22. (Res. 819, I-98)

H-235.967 Medical Staff Legal Counsel and Conflict of Interest

There is an inherent conflict of interest when an attorney represents the hospital and the organized medical staff. Organized medical staffs should require that the following disclosures be made prior to retaining separate legal counsel to avoid any real or perceived conflicts of interest on the counsel's part and to assure his or her loyalty: (1) whether the lawyer or the firm in which he or she is associated or employed has ever represented the hospital as a client and received payment from the hospital or another party on behalf of the hospital for the legal services provided; (2) whether the hospital has paid legal fees to the lawyer or the law firm with which he or she is associated or employed for legal opinions or advice on matters pending before the hospital governing board and/or hospital administration; and (3) whether the lawyer or the firm with which he or she is associated or employed has represented or provided legal opinions and advice to other hospitals in the community or to a local or state hospital association. (Res. 803, I-98; Modified: BOT Rep. 3, A-99)

H-235.968 Physician Review of Medical Staff Activities

The AMA recommends that hospital medical staffs have a policy that would allow minutes of medical staff committees, except minutes concerning peer review or corrective action information, be made available for review by medical staff members in the medical staff office; and recommends that the medical executive committee approve all reports, policies and recommendations from medical staff clinical departments and committees and have a process to distribute significant changes to the members of the medical staff. (BOT Rep. 10, A-96; Reaffirmed: CLRPD Rep. 2, A-06)

H-235.969 Responsibility for Infection Control

AMA policy states that: (1) the hospital medical staff should have a multidisciplinary committee to oversee the surveillance,

prevention and control of infection; (2) the infection control committee should report to the hospital medical staff executive committee; and (3) the medical staff's role, responsibility and authority in the infection control activities should be included in the medical staff bylaws. (Sub. Res. 802, A-95; Reaffirmed: CSA Rep. 8, A-05)

H-235.970 Conflict of Interest Issues in the Medical Staff

Policy of the AMA states that: Candidates for election or appointment to medical staff offices, department or committee chairs, or the medical executive committee, should disclose in writing to the medical staff, prior to the date of election or appointment, any personal, professional or financial affiliations or responsibilities on behalf of the medical staff; and encourages hospital medical staffs to incorporate a "disclosure of interest" provision in their medical staff bylaws based on this policy statement. (Sub. Res. 801, A-95; Reaffirmed: CLRPD Rep. 1, A-05)

H-235.971 Amending Medical Staff Bylaws

The AMA provides the assistance of its legal staff to hospital medical staffs and county and state medical associations when a hospital board of directors unilaterally changes, amends, or substitutes medical staff bylaws, or denies seats to duly-elected medical staff officers. (Sub. Res. 808, A-94; Reaffirmed: CLRPD 1, A-04)

H-235.972 Proxy Voting at Medical Staff Meetings

It is the policy of the AMA that proxy voting prior to or at medical staff meetings should not be permitted in medical staff bylaws. (Res. 814, I-93; Reaffirmed: CMS Rep. 10, A-03)

H-235.973 Resident Medical Staffs in US Training Hospitals

The AMA will work with the AMA Resident and Fellow Section, the AMA Organized Medical Staff Section, state resident and fellow sections, state medical societies, and state and national medical staff services organizations toward the goal of establishing Resident and Fellow Organizations in all U.S. training hospitals. (Res. 835, A-93; Modified: CME Rep. 2, A-03)

H-235.974 Autonomy of the Hospital Medical Staff

Our AMA (1) believes strongly in the autonomy of the hospital medical staff and does not support automatic inclusion of the medical staff in hospital personnel policies and programs; (2) believes hospital medical staffs should develop personnel policies and programs for members of the hospital medical staff and incorporate these policies in the medical staff bylaws or rules and regulations; and (3) understands that there are physicians who are not members of the medical staff but who are employees of the hospital and their participation in hospital programs should be dictated by their employment agreements. (Res. 832, I-91; Reaffirmed: Sunset Report, I-01)

H-235.976 Medical Staff Bylaws and Medical Staff Autonomy

Our AMA reaffirms that (1) medical staff bylaws are a contract between the organized medical staff and the hospital; and (2) application for medical staff appointment and clinical privileges should provide that each member of the medical staff, as well as the hospital, is bound by the terms of the medical staff bylaws, and the terms of the medical staff bylaws should be incorporated by reference into the application. (Res. 8, A-91; Modified: Sunset Report, I-01; Reaffirmed: BOT Rep. 9, I-04)

H-235.977 Medical Staff Committees to Assist Impaired or Distressed Physicians

Our AMA recognizes the importance of early recognition of impaired or distressed physicians, and encourages hospital medical staffs to have provisions in their bylaws for a mechanism to address the physical and mental health of their medical staff and housestaff members. (Sub. Res. 67, A-89; Reaffirmed: BOT Rep. 17 and Sunset Report, A-00)

H-235.980 Hospital Medical Staff Self-Governance

(1) Our AMA: supports essentials of self-governance for hospital medical staffs which, at a minimum include the right to: (a) initiation, development and adoption of medical staff bylaws, rules and regulations; (b) approval or disapproval of amendments to the medical staff bylaws, rules and regulations; (c) selection and removal of medical staff officers; (d) establishment and enforcement of criteria and standards for medical staff membership; (e) establishment and maintenance of patient care standards; (f) accessibility to and use of independent legal counsel; (g) credentialing and delineation of clinical privileges; (h) medical staff control of its funds; and (i) successor-in-interest rights.

(2) Our AMA opposes any attempts to reengineer or otherwise amend medical staff bylaws or split the bylaws into a variety of separate and unincorporated manuals or policies, thereby eliminating the control and approval rights of the medical staff as required

by the principles of medical staff self-governance.

(3) Our AMA will ask its Commissioners to the Joint Commission on Accreditation of Healthcare Organizations to require that JCAHO medical staff standards require the following components to be an integral part of the medical staff bylaws, and not separate "governance documents," requiring approval by the entire medical staff. The medical staff is responsible for the following:
(a) Application, reapplication, credentialing and privileging standards;
(b) Fair hearing and appeal process;
(c) Selection, election and removal of medical staff officers;
(d) Clinical criteria and standards which manage quality assurance, utilization review;
(e) Structure of the medical staff organization;
(f) Rules and regulations that affect the entire medical staff.

(4) Our AMA recognizes that hospital non-compliance with JCAHO Standard MS 1.20 will be treated in the same way as hospital non-compliance with any other standard. (Sub. Res. 201, A-89; Reaffirmed: Sub. Res. 808, A-94; Reaffirmed, Amended, and Appended: Sub. Res. 817, I-01; Reaffirmation A-05; Appended: Res. 730, A-05)

H-235.981 The Role of the Hospital Medical Director

Our AMA supports the following guidelines regarding the role of the hospital medical director: (1) The hospital governing body, management, and medical staff should jointly determine if there is a need to employ a medical director; establish the purpose, duties, and responsibilities of this position; establish the qualifications for this position; and provide a mechanism for medical staff input into the selection, evaluation, and termination of the hospital medical director.

(2) The purpose, duties, and responsibilities of the medical director should be included in the medical staff and hospital corporate bylaws.

(3) The organized medical staff should maintain overall responsibility for the quality of the professional services provided by individuals with clinical privileges and should have the responsibility of reporting to the governing body.

(4) The chief elected officer of the medical staff should represent the medical staff to the administration, governing body, and external agencies.

(5) Government regulations which would mandate a hospital medical director who would have authority over the medical staff should be opposed.

(6) The hospital medical director shall be a physician. (BOT Rep. O, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed in lieu of Res. 732, A-05)

H-235.983 AMA Response to Hospital Governing Bodies in Challenging Medical Staff Self-Governance

The AMA (1) reaffirms its policy in support of medical staff self-governance, including the process of electing and seating officers of the staff in accordance with medical staff bylaws, and its policy in opposition to improper interference by the governing body in that process; and (2) supports working with state hospital medical staff sections, state medical societies, and individual medical staffs to support medical staff self-governance in appropriate situations. (Sub. Res. 124, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmation A-05)

H-235.984 Hospital Medical Directors Designated as the Representative of the Medical Staff

The AMA (1) supports working with state medical associations to oppose the enactment of any governmental regulations which would mandate that every hospital governing body appoint a medical director who would have authority over the medical staff; and (2) urges that the duly elected officer of the medical staff be recognized as its representative. (Sub. Res. 120, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CLRPD Rep. 2, A-07)

H-235.985 Medical Executive Committee Composition

The AMA's policy states that the medical staff shall govern itself by the bylaws, rules and regulations which define the Medical Staff Executive Committee, whose members are selected in accordance with criteria and standards established by the medical staff, consistent with applicable state law. (Res. 142, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CLRPD Rep. 2, A-06)

H-235.987 Right of Committees of Medical Staffs to Meet in Executive Sessions

The AMA (1) supports the right of any hospital medical staff committee to meet in executive session, with only voting members of the

medical staff present, in order to permit open and free discussion of issues such as peer review and to maintain confidentiality; and (2) encourages individual medical staffs to incorporate provisions in their bylaws to affirm this right. (Res. 182, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CLRPD 1, A-04)

H-235.988 Non-Physicians Voting on the Medical Staff

The AMA opposes any regulation that would mandate voting privileges for non-physician members of medical staffs. (Sub. Res. 181, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CLRPD 1, A-04)

H-235.989 Medical Staff Bylaws

The AMA believes that (1) the medical staff bylaws, rules and regulations should be initiated and adopted by the medical staff and should establish a framework of self-government; (2) the medical staff should govern itself by these bylaws, rules and regulations which should: (a) be approved by the governing body, whose approval should not be unreasonably withheld; (b) be reviewed and revised as necessary to reflect current medical staff practices, and (c) define the Executive Committee of the medical staff, whose members are selected in accordance with criteria and standards established by the medical staff; and (3) the medical staff should have authority to approve or disapprove all amendments to medical staff bylaws, rules and regulations. (Res. 177, A-84; Reaffirmed: Sub. Res. 808, A-94; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CLRPD 1, A-04; Reaffirmation A-05)

H-235.990 Organized Self-Governing Medical Staff

With respect to the responsibilities and functions of the hospital, its governing board and the medical staff, the AMA believes that: (1) the hospital has corporate responsibility for maintaining the necessary facilities, a safe environment, and a mechanism for the prudent selection of those who treat patients within the institution; (2) the governing board is responsible for the operation and management of the hospital and fulfilling its corporate responsibilities; (3) the organized medical staff and its members have a contractual obligation, entered into with the hospital, to carry out their professional medical responsibilities through the efficient operation of medical staff committees; the objective selection of professionally qualified members of the organized medical staff and disciplinary functions relating to their competent performance; and functioning as a self-governing body in promoting quality patient care within the hospital; and (4) members of the organized medical staff may likewise deal collectively, as an entity, with the hospital and its governing board with respect to professional matters involving their own interests, as distinguished from the functions the organized medical staff performs on behalf of the hospital. (BOT Rep. PP, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CLRPD 1, A-04)

H-235.991 Medical Staff Bylaws

Our AMA encourages individual hospital medical staffs to develop bylaw provisions affirming the binding effect of the bylaw provisions on both the governing body and the medical staff, where consistent with applicable state law. The medical staff bylaws also should contain a successor-in-interest provision to protect medical staffs from a hospital ignoring the medical staff bylaws, and establishing new medical staff bylaws to apply post-merger, acquisition, affiliation, or consolidation. (BOT Rep. M, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Modified: CMS Rep. 7, I-00)

H-235.992 Legal Counsel for Medical Staffs

(1) Organized medical staffs have a right to independent legal counsel. Our AMA strongly recommends that hospital medical staffs retain their own attorneys so that the medical staff will have access to its own legal advocates for guidance and to ensure the integrity, both legally and organizationally, of the self-governing medical staff. Since the medical staff bylaws establish a binding contract between the organized medical staff and the hospital, it is critical for the medical staff's legal counsel to draft the medical staff bylaws and amendments to the bylaws. (2) Medical staff legal counsel should have an understanding of medical staff structure, responsibilities, and functions, and be knowledgeable about health law, antitrust law, hospital accreditation standards, and applicable federal and state laws and regulations. (Res. 59, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Modified: BOT Rep. 3, A-99)

H-235.993 Representation of the Medical Staff on All Committees of the Governing Board and Administration of American Hospitals

The AMA supports (1) medical staff representation on all committees of the governing board and administration of American hospitals; and (2) hospital administration representation on administrative committees of the medical staff. (Sub. Res. 50, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CLRPD Rep. 1, A-05)

H-235.996 Bylaws and Rules and Regulations - No Incorporation by Reference

The AMA encourages medical staffs to develop their own bylaws, rules and regulations and not to incorporate other documents by reference. (Sub. Res. 148, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CLRPD Rep. 1, A-05)

H-235.999 All Physicians Employed by Hospitals Required to be on Staff

The AMA believes that physicians having contractual or financial arrangements with hospitals should be members of the organized medical staff and responsible to it, should be subject to the bylaws of the medical staff, and should conduct their professional activities according to the standards, rules and regulations adopted by it. (BOT Rep. R, Rec. 3, A-77; Reaffirmed: I-81; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-240.000 Hospitals: Reimbursement
(See also: Hospitals; Hospitals: Accreditation Standards; Hospitals: Medical Staff; Hospitals: Medical Staff - Credentialing and Privileges; Hospitals: Medical Staff - Organization)

H-240.961 Definition of a Hospital Day

Our AMA defines a Hospital Day as a 24-hour period that begins at the hour of admission. (Res. 715, A-04)

H-240.962 New DRG for Severe Sepsis

Our AMA will explicitly recognize that severe sepsis is a clinically coherent condition associated with a high mortality deserving of its own Diagnostic Related Group (DRG). (Res. 133, A-04)

H-240.963 The Effects of Closing Safety Net Hospitals

It is the policy of our AMA that Medicare and Medicaid subsidies and contracts related to the care of economically disadvantaged patients should be sufficiently allocated to hospitals on the basis of their service to this population in order to prevent the loss of services provided by these facilities. (CMS Rep. 3, I-01; Reaffirmed: BOT Rep. 15, I-04)

H-240.964 AMA Support of Federal Funding for Public Hospitals

Our AMA (1) recognizes the special mission of public hospitals and supports short-term federal financial assistance for such hospitals until national or state health system reform is implemented; and (2) advocates as part of a national reform initiative that studies be carried out to evaluate whether special consideration for public hospitals is justified in the form of national or state financial assistance, or other reform financing mechanisms, including assistance in privatization and legal restructuring, and if so, it should be implemented. (BOT Rep. MM, A-93; Reaffirmed: CMS Rep. 3, I-01; Reaffirmed: BOT Rep. 15, I-04)

H-240.966 Reimbursement to Physicians and Hospitals for Government Mandated Services

(1) It is the policy of the AMA that government mandated services imposed on physicians and hospitals that are peripheral to the direct medical care of patients be recognized as additional practice cost expense.
(2) Our AMA will accelerate its plans to develop quantitative information on the actual costs of regulations.
(3) Our AMA strongly urges Congress that the RBRVS and DRG formulas take into account these additional expenses incurred by physicians and hospitals when complying with governmentally mandated regulations and ensure that reimbursement increases are adequate to cover the costs of providing these services.
(4) Our AMA will advocate to the CMS and Congress that an equitable adjustment to the Medicare physician fee schedule (or another appropriate mechanism deemed appropriate by CMS or Congress) be developed to provide fair compensation to offset the additional professional and practice expenses required to comply with the Emergency Medical Treatment and Labor Act. (Sub. Res. 810, I-92; Appended by CMS 10, A-98; Reaffirmation I-98; Reaffirmation A-02; Reaffirmation I-07)

H-240.967 Defining Hospital Inpatient and Outpatient Stays

Our AMA (1) encourages hospitals and hospital medical staffs, CMS, private payers, and other concerned groups to adopt and use the definition of a hospital day as a 24-hour period beginning at the hour of admission, for purposes of quality assurance, utilization review, payment policy, and research; and (2) urges CMS to instruct fiscal intermediaries to define the "outpatient hold" (observation) period for Medicare beneficiaries as beginning at the time the patient is first seen by an attending physician or that physician's designee. (CMS Rep. M, A-92; Reaffirmed: Sub. Res. 709, I-97; Reaffirmed: Res. 709, A-00)

H-240.969 Medicare Social Admissions

It is the policy of the AMA to (1) support the establishment of a new 72-hour DRG that can be assigned as appropriate to Medicare patients, with a payment amount that reflects the less intensive use of resources needed for care of such patients; and (2) continue to pursue appropriate action to allow all acute care hospitals to designate a range of their beds, based on community need, for the provision of skilled nursing facility or intermediate care facility care. (CMS Rep. E, A-90; Reaffirmed: Sunset Report, I-00)

H-240.970 Reimbursement to Rural Hospitals for Patients Returning from Tertiary Care Centers

(1) When it is in the best interest of their patients, physicians and hospitals should be encouraged to transfer patients back to hospitals in their home communities. (2) The AMA supports any needed revisions in Medicare regulations that would allow appropriate reimbursement for patients returning to their home community hospitals from tertiary care centers. (Sub. Res. 240, A-90; Reaffirmed: Sunset Report, I-00)

H-240.971 Elimination of DRG Differentials Between Urban and Rural Medical Care

Our AMA (1) supports elimination of Medicare reimbursement differentials between urban and rural medical care; and (2) supports efforts to inform the Congress of the impact of such programs on the rural population. (Res. 107, A-89; Reaffirmed: Sunset Report, A-00)

H-240.975 Realistic DRG Reimbursement

The AMA encourages CMS to develop a better and faster means of upgrading the DRG based reimbursement system to reflect medical advances. (Sub. Res. 53, A-88; Modified: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-240.977 Hospital Swing Beds

The AMA supports legislation and/or regulations which would allow all acute care hospitals to designate a specific number of their hospital beds as "swing beds," which could then be used as skilled nursing beds, as appropriate, for certain patients requiring the use of such services. (Res. 10, A-88; Reaffirmed: Sunset Report, I-98)

H-240.978 Medicare's Ambulance Service Regulations

The AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to facilities other than the closest based upon the physician's judgment. (Res. 37, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-240.979 Intrusion by Hospitals into the Private Practice of Medicine

The AMA urges private third party payers to implement coverage policies that do not unfairly discriminate between hospital-owned and independently-owned outpatient facilities with respect to payment of "facility" costs. (CMS Rep. H, I-87; Modified: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-240.985 Position Statement on the Federal DRG Program

The AMA (1) encourages and supports the testing of innovative medical reimbursement systems; (2) endorses for general application only those medical reimbursement systems that have been appropriately and adequately tested and found to promote quality of care as well as to be cost-effective; and (3) supports continued monitoring of the program and the development of constructive recommendations, including changes in the prospective pricing system, when appropriate to assure the high quality of care to patients. (Sub. Res. 151, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed and Modified: CMS Rep. 7, A-05)

H-240.993 Discontinuance of Federal Funding for Ambulatory Care Centers

The AMA strongly urges more aggressive implementation by HHS of existing provisions in federal legislation calling for equity of reimbursement between services provided by hospitals on an outpatient basis and similar services in physicians' offices. (CMS Rep. B, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmation I-98; Reaffirmation I-03; Reaffirmation I-07)

H-240.994 Diagnosis Related Groups

The AMA urges that governmental agencies responsible for reimbursing hospitals under Medicare and Medicaid pay their fair share of the cost of hospital care, fully reimbursing for expenditures on a beneficiary's behalf regardless of whether the system is based on prospective rate setting or cost reimbursement. (Sub. Res. 71, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmation A-00)

H-240.995 Diagnostic Related Groups

The AMA (1) supports input by hospital medical staffs into the DRG process to insure that quality of care is not compromised; and (2) supports the concept that the individual hospital medical staff's responsibility is to ensure appropriate quality of care for patients. (Res. 58, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CMS Rep. 7, A-05)

H-240.996 Cost Shifting

Our AMA (1) continues to oppose changes in the Medicare and Medicaid hospital reimbursement systems that result in cost shifting to private patients; and (2) supports continued efforts to widely publicize the deleterious effects on the private sector of such cost shifts in efforts to save dollars for federal programs. (Res. 6, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmation A-00)

H-240.997 Patient Signatures for Medicare Payment

Our AMA endorses a proposal to permit all physicians to use the patient signature on hospital records in completing any claim form accepted by CMS for Medicare payment for inpatient hospital care. (Res. 15, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-240.998 Preferential Hospital Rates

Our AMA (1) opposes hospital charge/cost arrangements granting unwarranted advantage to any group of patients; and (2) urges all health care payers, government and private, to pay their equitable share of costs incurred by hospitals and other facilities consistent with a reasonable definition of full financial requirements. (Res. 21, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-04)

H-240.999 Relationship of Hospital Costs and Hospital Charges

Our AMA urges hospitals: (1) to adopt pricing policies which will more specifically relate the charge for a given item or service to the actual cost of that item or service, including an adequate profit margin;

(2) to inform the medical staff and the public of the rationale for charges which cannot be strictly related to costs;

(3) to inform medical staffs as quickly as possible of any changes in prices; and

(4) to standardize their nomenclature for services, and to group these services in the general service charge or room rate consistently from one hospital to another so as to simplify comparison. (CMS Rep. H, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

H-245.000 Infant Health
(See also: Children and Youth; Pregnancy; Preventive Medicine; Public Health)

H-245.971 Home Deliveries

Our AMA: (1) supports the recent American College of Obstetricians and Gynecologists (ACOG) statement that "the safest setting for labor, delivery, and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the American Academy of Pediatrics (AAP) and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers"; and (2) supports state legislation that helps ensure safe deliveries and healthy babies by acknowledging that the safest setting for labor, delivery and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the AAP and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers. (Res. 205, A-08)

H-245.972 Breast Milk Banking

Our AMA encourages breast milk banking (Res. 443, A-07)

H-245.973 Standardization of Newborn Screening Programs

Our AMA: (1) recognizes the need for uniform minimum newborn screening (NBS) recommendations; and (2) encourages continued research and discussions on the potential benefits and harms of NBS for certain diseases. (CSAPH Rep. 9, A-06)

H-245.976 Hyponatremic Seizures Among Infants Fed with Commercial Bottled Drinking Water

The AMA supports educational efforts targeted toward encouraging appropriate parental behavior in order to prevent routine replacement of breast milk or infant formula with dilute aqueous solutions (including tap water). (CSA Rep. 2, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-245.977 Sudden Infant Death Syndrome

The AMA encourages the education of parents, physicians and all other health care professionals involved in newborn care regarding methods to eliminate known Sudden Infant Death Syndrome (SIDS) risk factors, such as prone sleeping, soft bedding and parental smoking. (Res. 414, A-95; Reaffirmed: CSA Rep. 8, A-05)

H-245.978 Impact of 24-Hour Postpartum Stay on Infant and Maternal Health

(1) The AMA is concerned about the trend toward increasingly brief perinatal hospital stays as a routine practice in the absence of adequate data to demonstrate the practice is safe.
(2) Policy of the AMA is that in the absence of definitive empirical data, perinatal discharge of mothers and infants should be determined by the clinical judgment of attending physicians and not by economic considerations. This decision should be made based on the criteria of medical stability, delivery of adequate predischarge education, need for neonatal screening, and determination that adequate feeding is occurring, and with consideration of the mother's social and emotional needs and preferences. A plan should be in place for psychosocial and medical follow-up, as outlined in the Guidelines for Perinatal Care developed by the AAP and ACOG.
(3) The AMA should encourage well-designed experimental studies to identify safe neonatal practices with regard to the hospital discharge of mothers and infants.
(4) The AMA supports the collaborative efforts of the Maternal and Child Health Bureau and other concerned national organizations to examine more thoroughly the issue of appropriate medical care during the perinatal period. (CSA Rep. 5, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06)

H-245.979 Opposition to Proposed Budget Cuts in WIC and Head Start

The AMA opposes reductions in funding for WIC and Head Start and other programs that significantly impact child and infant health and education. (Res. 246, I-94; Reaffirmed: BOT Rep. 29, A-04)

H-245.981 Vitamin K Prophylaxis in Newborn Infants

The AMA recommends that state medical societies urge state health departments to amend their health codes to specify that every neonate should receive a single dose of 0.5-1 mg of natural vitamin K oxide (phytonadione), preferably parenterally, within one hour of birth to prevent vitamin K dependent hemorrhagic disease and coagulation disorders; and will become a vigilant advocate in a continuing way on the routine use of vitamin K prophylaxis for the newborn. (Res. 514, A-94; Reaffirmed: CSA Rep. 6, A-04)

H-245.982 AMA Support for Breastfeeding

(1) Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2005 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.

(2) Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottlefeeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician. (CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07)

H-245.983 Baby Walkers

The AMA strengthens its policy on baby walkers by urging the Consumer Product Safety Commission to ban infant walkers as a

mechanical hazard. (Res. 403, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-245.984 Treatment Decisions for Seriously Ill Newborns

Physicians should play an active role in advocating for changes in the Child Abuse Prevention Act as well as state laws that require physicians to violate the ethical guidelines stated in E-2.215 (Treatment Decisions for Seriously Ill Newborns). (CEJA Rep. I, A-92; Modified and Reaffirmed: CEJA Rep. 1, A-03)

H-245.985 Mandatory Labeling for Waterbeds and Beanbag Furniture

The AMA petitions the Consumer Product Safety Commission to require waterbed manufacturers and manufacturers of similar type furnishings to affix a permanent label and to distribute warning materials on each waterbed and other furnishings sold concerning the risks of leaving an infant or handicapped child, who lacks the ability to roll over, unattended on a waterbed or beanbag. (Res. 414, A-92; Reaffirmed: CSA Rep. 8, A-03)

H-245.986 Infant Mortality in the United States

It is the policy of the AMA: (1) to work with the World Health Organization toward the development of standardized international methodology for collecting infant mortality data, which will include collecting information regarding racial/ethnic background in order to document the needs of infants, children, and adolescents of subpopulations of society, and will improve the basis on which international comparisons are made; (2) to continue to work to increase public awareness of the flaws in comparisons of infant mortality data between countries, as well as of the problems that contribute to infant mortality in the United States; (3) to continue to address the problems that contribute to infant mortality within its ongoing health of the public activities. In particular, the special needs of adolescents and the problem of teen pregnancy should continue to be addressed by the adolescent health initiative; and (4) to be particularly aware of the special health access needs of pregnant women and infants, especially racial and ethnic minority group populations, in its advocacy on behalf of its patients. (BOT Rep. U, I-91; Modified by BOT Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-07)

H-245.987 International Infant Mortality Data

The AMA (1) supports taking actions that would influence the World Health Organization to adopt a standard methodology for collecting infant mortality data. Such standardized data would permit more accurate comparison of the U.S. infant mortality rate with that of other countries; and (2) supports taking steps to make the public aware that baseline data differences exist in comparison studies, so that information presented for political purposes may be misleading. (BOT Rep. HH, A-91; Reaffirmed by BOT Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-245.988 Cardiopulmonary Resuscitation Training for Expectant and New Parents

Our AMA encourages CPR training (such as the American Heart Association/American Academy of Pediatrics Pediatric Basic Life Support Course) for new and expectant parents at childbirth preparation classes, prenatal clinics and sites of well-baby pediatric visits. (Res. 5, I-90; Reaffirmed: Sunset Report, I-00)

H-245.989 Adequate Funding of the WIC Program

Our AMA urges the U.S. Congress to investigate recent increases in the cost of infant formula, as well as insure that WIC programs receive adequate funds to provide infant formula and foods for eligible children. (Res. 269, A-90; Reaffirmed: Sunset Report, I-00)

H-245.990 Infant Walkers

Our AMA recommends that physicians counsel parents on the risk of injury that can occur from the use of infant walkers and inform parents that these devices do not either promote bipedal ambulation or offer a substitute for careful parental supervision. (BOT Rep. B, A-90; Reaffirmed: Sunset Report, I-00)

H-245.992 Perinatal and Infant Mortality Reviews

Our AMA join with ACOG and the American Academy of Pediatrics in calling for a national effort to provide guidance for local perinatal and infant mortality reviews, to stimulate implementation of these reviews at state and local levels, and to encourage state and county medical societies to support these efforts locally. (Res. 119, A-90; Reaffirmed: Sunset Report, I-00)

H-245.994 Inclusion of Overseas Beneficiaries in WIC

The AMA supports the inclusion of Department of Defense dependents overseas, who are eligible under the US Department of

Agriculture criteria, in the WIC program. (Sub. Res. 25, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-245.998 Infant Mortality Statistics

The AMA (1) requests that all countries use a standard form of reporting births in their country and the deaths that result per 1,000 live births based on rules and regulations set up by the World Health Organization; and (2) supports publicizing that the medical profession is vitally concerned with infant mortality rates and pledges to continue its efforts to decrease the infant mortality rates in the US to the lowest rate possible. (Res. 7, I-71; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed by BOT Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-245.999 Centralized Community and Regionalized Perinatal Intensive Care

Our AMA (1) urges development on the local level of centralized community or regionalized newborn intensive care units; and (2) encourages (a) training programs necessary to staff regional facilities, (b) allocation of facilities and equipment within communities and development of guidelines, (c) continuing research into etiologic factors responsible for the high-risk infant, and (d) continuing evaluation. (BOT Rep. J, A-71; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-250.000 International Health
(See also: Foods & Nutrition)

H-250.986 AMA and Public Health in Developing Countries

Our AMA will adhere to a focused strategy that channels and leverages our reach into the global health community, primarily through participation in the World Medical Association and the World Health Organization. (BOT Rep. 5, A-07)

H-250.987 Duty-Free Medical Equipment and Supplies Donated to Foreign Countries

Our AMA will seek, through the federal government, a process to allow for duty-free donations of medical equipment and supplies, which are intended to reach medically-underserved areas and not be used for profit, to foreign countries. (Res. 229, A-04)

H-250.988 Low Cost Drugs to Poor Countries During Times of Pandemic Health Crises

Our AMA: (1) encourages pharmaceutical companies to provide low cost medications to countries during times of pandemic health crises; and (2) shall work with the World Health Organization (WHO), UNAID, and similar organizations that provide comprehensive assistance, including health care, to poor countries in an effort to improve public health and national stability. (Res. 402, A-02)

H-250.989 Screening Nonimmigrant Visitors to the United States for Tuberculosis

Our AMA: (1) recognizes the need for global cooperative efforts to control TB and encourage the establishment of well-supported TB-control programs, especially in countries with a high incidence of TB, founded on the principles of the World Health Organization's Directly Observed Treatment -- Short-course, or DOTS program; and (2) urges Congress to provide adequate funding for the CDC and other public health agencies in order to facilitate global cooperative efforts to control TB. (CSA Rep. 1, I-99)

H-250.990 Interamerican College of Physicians and Surgeons

Our AMA will find ways to collaborate with the Interamerican College of Physicians and Surgeons to achieve a more healthy, prosperous and understanding community within the Americas. (Res. 604, I-99)

H-250.991 Support of the AMA Mission in International Medicine

The AMA will include the International Medical Graduates Section as a resource for international medical initiatives. (Res. 608, A-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-250.992 World Health Organization

The AMA: (1) continues to support the World Health Organization as an institution; (2) advocates full funding as understood by the United States Government for the World Health Organization; (3) will participate in coalitions with other interested organizations to lend its support and expertise to assist the World Health Organization; and (4) encourages the World Medical Association to develop a cooperative work plan with the World Health Organization as expeditiously as possible. (BOT Rep. 31, A-96; Reaffirmed: CLRPD Rep. 2, A-06)

H-250.993 Overseas Medical Education Developed by US Medical Associations

The AMA will: (1) continue to focus its international activities on and through organizations that are multinational in scope; (2) encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the world; and (3) encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world. (CME Rep. 6, I-93; Reaffirmed: CME Rep. 2, A-05)

H-250.995 International Medical Records

It is the policy of the AMA to work with the U.S.-Mexico Border Health Commission, the U.S. Public Health Service, the Mexican Medical Society, regional medical societies, and appropriate specialty societies to foster the development and use of international perinatal and pediatric care records for children who may receive medical care in both the United States and Mexico. (Sub. Res. 510, I-92; Reaffirmed: CMS Rep. 10, A-03)

H-250.996 Enhancing Young Physicians' Effectiveness in International Health

It is the policy of the AMA to work with national medical specialty societies and other organizations in preparing materials which guide young physicians in the development of skills necessary for effectively promoting the health of poor populations both in the United States and abroad. (Res. 407, I-91; Reaffirmed: Sunset Report, I-01)

H-250.998 International Health Care Delivery

The AMA supports the activities of the World Medical Association (WMA) to improve health care in developing countries and supports WMA commendation of those countries that demonstrate exemplary efforts to improve health care delivery to their populations. (Sub. Res. 102, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CLRPD Rep. 1, A-05)

H-250.999 World Health Organization

Our AMA supports the position of the U.S. government to preserve the integrity of the World Health Organization (WHO) and opposes any attempts to politicize the WHO. (Res. 56, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

H-255.000 International Medical Graduates
(See also: Medical Education; Medical Education - Graduate; Licensure and Discipline)

H-255.970 Employment of Non-Certified IMGs

Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure; and

(2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs. (Res. 309, A-03)

H-255.971 J-1 Visas and Waivers

It is the policy of the AMA to: (1) support the Conrad-30 program, a program authorizing states to place 30 physicians annually in either Health Professional Shortage Areas or Medically Underserved Areas, as one of several strategies to help alleviate physician shortages in underserved areas; and (2) recognize that the security interests of the U.S. are of utmost importance and thorough background checks must be conducted on all visa applicants. (BOT Rep. 11, I-02)

H-255.974 Preservation of Opportunities for US Graduates and International Medical Graduates Already Legally Present in the US

In the event of reductions in the resident workforce, the AMA will advocate for a mechanism of resident selection which promotes the maintenance of resident physician training opportunities for all qualified graduates of United States Liaison Committee on Medical Education and American Osteopathic Association accredited institutions; and the AMA adopts the position that it will be an advocate for IMGs already legally present in this country. (Res. 324, A-97; Reaffirmed: CME Rep. 10, A-99)

H-255.975 J-1 Exchange Visitor Program (J-1 Visa)

Policy of the AMA states: the purpose of the physician J-1 Visa Exchange Program is to ameliorate physician specialty shortages in other countries; and the AMA will work to correct the problems of inconsistency, lack of accountability, and non-compliance in the administration of the physician J-1 Visa Exchange Program. (CME Rep. 2, A-97; Modified and Reaffirmed: CME Rep. 2, A-07)

H-255.976 Speech Tests for International Medical Graduates

The AMA encourages state licensing boards to accept ECFMG certification in satisfaction of requirements for demonstrating English language competence. (CME Rep. B, A-93; Reaffirmed: CME Rep. 2, A-03)

H-255.977 International Medical Graduates Participation in Medical Societies

Our AMA encourages the federation of state, county, and specialty medical societies to identify qualified and interested international medical graduates to be invited, appointed and elected to committees and leadership positions within the House of Medicine. (Res. 217, A-91; Reaffirmed: Sunset Report, I-01; Modified: Res. 616, A-06)

H-255.978 Unfair Discrimination Against International Medical Graduates

It is the policy of the AMA to take appropriate action, legal or legislative, against implementation of Section 4752(d) of the OBRA of 1990 that requires international medical graduates, in order to obtain a Medicaid UPlN number, to have held a license in one or more states continuously since 1958, or pass the Foreign Medical Graduate Examination in Medical Sciences (FMGEMS), or pass the Educational Commission for Foreign Medical Graduates (ECFMG) Examination, or be certified by ECFMG. (Res. 123, I-90; Reaffirmation A-00)

H-255.980 Foreign Medical Graduate Examination in Medical Sciences Scores not Sole Criteria for Residency Selection

The AMA (1) urges that the United States Medical Licensing Examination (USMLE) scores not be used as the sole criteria for selecting interns and residents; and (2) recommends that residency programs consider all of the candidates' attributes and qualifications during the selection process. (3) Our AMA reaffirms policy that residency appointments should be made solely on the basis of the individual applicant's merit and qualifications. (Res. 143, A-90; Appended Res. 303, I-98; Modified and Reaffirmed: CME Rep. 2, A-08)

H-255.982 Equality in Licensure and Reciprocity

Our AMA (1) reaffirms its policy that it is inappropriate to discriminate against any physician because of national origin or geographical location of medical education; (2) continues to recognize the right and responsibility of states and territories to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdiction; and (3) supports the development and distribution of model legislation to encourage states to amend their Medical Practice Acts to provide that graduates of foreign medical schools shall meet the same requirements for licensure by endorsement as graduates of accredited U.S. and Canadian schools. (Res. 69, A-89; Rescinded: Sunset Report, A-00; Restored: CME Rep. 3, A-02; Reaffirmed: CME Rep. 7, A-04; Reaffirmed in lieu of Res. 320, A-04; Reaffirmed in Lieu of Res. 325, A-08)

H-255.983 Graduates of Non-United States Medical Schools

The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character. (Sub. Res. 45, A-88; Reaffirmed by Res. 311, A-96; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 1, I-03; Reaffirmed: CME Rep. 7, A-04; Reaffirmed: Sub. Res. 314, A-04)

H-255.984 IMG Participation

The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater participation of international medical graduates in leadership positions at all levels of organized medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among International medical graduates. (Sub. Res. 20, I-87; Reaffirmed: CLRPD Rep. 3, I-97; Modified: Res. 616, A-06)

H-255.985 Graduates of Foreign Health Professional Schools

(1) Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States' programs. Agencies recognized to license or certify health professionals in the United States should have mechanisms to evaluate the entry-level competence of graduates of foreign health professional programs. The level of competence and the means used to assess it should be the same or equivalent to those required of graduates of U.S. accredited programs. (2) All health care facilities, including governmental facilities, should adhere to the same or equivalent licensing and credentialing requirements in their employment practices. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 320 and Res. 305, A-03; Reaffirmed: CME Rep. 1, I-03)

H-255.986 Foreign Medical Graduates in Residency Programs

The AMA continues to support the position that those foreign medical graduates who plan to return to their country of origin have the opportunity to obtain graduate medical education in the U.S. (Res. 114, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06)

H-255.987 Foreign Medical Graduates

Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background. (Res. 56, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmation A-00)

H-255.988 Report of the Ad Hoc Committee on Foreign Medical Graduates

(1) The AMA reaffirms its support of current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
(2) The AMA continues to support current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
(3) The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
(4) The AMA continues to support cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
(5) The AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools.
(6) The AMA continues to support working with the ECFMG and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.
(7) The AMA strongly supports the policy that the core clinical curriculum of a foreign medical school should be provided by that school and that U.S. hospitals should not provide substitute core clinical experience for students attending a foreign medical school.
(8) The AMA continues to support working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
(9) The AMA, in cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
(10) The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
(11) Special consideration should be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
(12) The AMA reaffirms its existing policy supporting the use of accreditation standards to enhance the quality of patient care and medical education. Also the AMA opposes the use of such standards for purposes of regulating physician manpower.
(13) AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. In particular, these AMA representatives should emphasize that AMA policy does not prohibit the appointment of qualified graduates of foreign medical schools to residency training programs.
(14) The AMA strongly reaffirms existing policy urging the U. S. licensing authorities to focus on the individual academic and personal achievements when evaluating IMGs for the purposes of licensure. More effective methods for evaluating the quality of the undergraduate medical education of IMGs should be pursued and, when available, the results should be a part of the determination of eligibility for licensure.
(15) The AMA reaffirms its support for the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
(16) The AMA supports continued monitoring of the effectiveness of the Fifth Pathway program, including to the degree possible any measurable impact of the program on enrollments in Caribbean and Central American medical schools.
(17) The AMA reaffirms and supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
(18) The AMA reaffirms its support of the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine.
(19) The AMA encourages the constituent medical societies to support qualified IMGs for nominations to AMA committees and councils.
(20) The AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
(21) The AMA is committed to using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians.
(22) The AMA supports demonstrating its interests in issues related to IMGs by publicizing its many relevant resources to all physicians, especially to nonmember IMGs.
(23) The AMA supports expansion of its efforts to prepare and disseminate information about requirements for admission to

accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
(24) The AMA continues to recognize the common aims and goals of all physicians, particularly those practicing in the U.S., and supports making every effort to include all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
(25) The AMA is committed to identifying and publicizing resources within the AMA that will respond to inquiries from IMGs.
(26) The AMA is committed to providing leadership to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
(27) The AMA urges institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
(28) The AMA is committed to informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S. (BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03)

H-255.989 A Program for Exchange Visitor Physicians

(1) It is the AMA's policy to separate the issues involved in the support of alien physicians participating in exchange visitor physician programs for purposes of education, training and/or research followed by return to their native lands from the issues involving U.S. citizens who are graduates of foreign medical schools and alien physician graduates of foreign medical schools who seek permanent residence in the United States. (2) The AMA urges government and private funding of the physician exchange visitor program under the auspices of an appropriate organization that will: consider the range and type of medical education and health care needs of those foreign nations sending exchange visitor physicians; the means to evaluate the level of knowledge and needs of prospective participants in graduate medical education programs; and identify truly outstanding public health, geographic medicine, basic medical science, and clinical training programs to answer the needs of the visitor's native land. (Res. 107, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

H-255.991 Education for Foreign Physicians

After reviewing the past and present status of medical education for physicians of other countries, the AMA adopts the following statement: (1) Medical education in the U.S., consistent with available resources, should recognize and respond to the unique needs of foreign physicians and the environment in which they practice.
(2) A first priority for the improvement of medical education in all countries should be directed toward the development of opportunities for medical education at all levels, undergraduate, graduate, remedial, and continuing, within the system of medical education existing in the individual foreign nation or region.
(3) U.S. physicians, when resources are available, should be encouraged to contribute to medical education conducted in other countries at the undergraduate, graduate, remedial and continuing levels.
(4) The accredited residency program directed toward practice within the U.S. is an educational modality which should be limited to foreign physicians who can be expected to apply what they have learned in the U.S. to the education or practice needs of their own country.
(5) Recognition should be afforded graduate programs, tailored to the individual needs of the foreign physicians not involving significant responsibility for the care of patients, and thus obviating the need for foreign physicians, otherwise qualified, to pass the Visa Qualifying Examination.
(6) Opportunities for exchange visitor programs of all types pertaining to the improvement of medical education should be compiled and made available to both foreign physicians and U.S. physicians who may have an interest in participating in such programs.
(7) Since continuing medical education is of universal importance, efforts to make educational materials available on an even wider basis, such as the foreign language editions of JAMA, deserve commendation. (CME Rep. C, I-85; Modified by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

H-255.992 Discrimination Against Physicians

Our AMA: (1) believes that the quality of a physician's medical education is an appropriate consideration in the recruitment and licensure of physicians and discrimination against physicians on the basis of the country in which they completed their medical education is inappropriate; and (2) affirms that the residency application process should be free of discrimination, including discrimination arising from the electronic submission of applications. (Sub. Res. 44, A-85; Reaffirmed: CLRPD Rep. 2, I-95; Appended: Sub. Res. 305 and Reaffirmation A-00)

H-255.993 Evaluation of Foreign Medical Schools

The AMA continues to support the efforts of appropriate organizations to gather information that will assist state licensing authorities in evaluating foreign medical schools. (Sub. Res. 56, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-255.994 Physician Exemption from Medical School Standards and Performance Evaluation Requirements

(1) The AMA recommends to medical licensing boards that those physicians who are foreign medical graduates currently duly licensed by any licensing jurisdiction in the U.S. should not be denied endorsement of their licenses, or denied admission to reexamination when this is required by law, solely because they are unable to provide documentation of graduation from a school meeting "equivalent standards and performance evaluation requirements" to those of programs accredited by the Liaison Committee on Medical Education. (2) The AMA encourages licensing boards, in reviewing applications for licensure endorsement, to take into account a physician's ethical standards and his or her having practiced medicine of an acceptable quality. (Sub. Res. 108, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-255.995 International Medical Graduates

The AMA believes that reduced requirements for licensure should not be applied under any circumstances to graduates of foreign medical schools. (Res. 23, A-82; Reaffirmed: CLRPD Rep. A, I-92; Modified: CME Rep. 5, A-04)

H-255.997 Fifth Pathway

Our AMA supports the principle that any existing or proposed alternative programs conducted by U.S. medical schools to facilitate entry of U.S. citizens studying in foreign medical schools into U.S. programs should assure that those who complete such programs are reasonably comparable to the school's regularly enrolled and graduated students. (CME Rep. D, A-81; Reaffirmed: CLRPD Rep. F, I-91; Modified: Sunset Report, I-01)

H-255.998 Foreign Medical Graduates

Our AMA supports the following principles, based on recommendations of the Ad Hoc Committee on Foreign Medical Graduates (FMGs): Our AMA supports the practice of U.S. teaching hospitals and foreign medical educational institutions entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine. (CME Rep. F, A-81; Reaffirmed: CLRPD Rep. F, I-91; Modified: Sunset Report, I-01)

H-255.999 Final Report of the Ad Hoc Committee on Foreign Medical Graduate Affairs

Our AMA (1) For the next three years, supports actively seeking qualified foreign medical graduates for nomination or appointment to councils of the AMA
.
(2) Supports the development of a special effort to recruit FMGs to AMA membership.

(3) Encourages state medical societies to make an effort to include qualified foreign-trained physicians among their nominees for medical licensing boards.

(4) Supports considering appointing a qualified FMG as one of its representatives to the ECFMG Board of Trustees.

(5) Encourages state, county and specialty medical organizations to make a special effort to encourage membership and participation by FMGs.

(6) Continues its policy that U.S. medical schools offer admission with advanced standing, within the capabilities determined by each institution, to foreign medical students who satisfy the requirements of the institution for matriculation.

(7) Continues the policy that U.S. medical schools, within the capabilities determined by each school, sponsor one year of supervised clinical experience for foreign medical students in accordance with the criteria established for such programs by the Council on Medical Education ("Fifth Pathway"). Supports the idea of a study recently authorized by the House of Delegates to evaluate the effectiveness of these programs.

(8) Continues to provide U.S. students who are considering attendance at a foreign
medical school with information enabling them to assess the difficulties and consequences associated with matriculation in a foreign medical school.

(9) Encourages medical schools to develop special programs for foreign physicians entering the United States as exchange visitors. These programs should be designed to meet the needs of the nations from which the physicians come, as well as the needs of the physicians.

(10) Commends and supports the American specialty boards for their interest in evaluating oral examinations and in developing techniques aimed at enhancing the reliability and validity of oral examinations.

(11) Commends and supports the Federation of State Boards, its several member boards and the ECFMG in their willingness to adjust their administrative procedures in processing FMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.

(12) Regularly appoint an AMA member, who is an international medical graduate, as one of its representatives to the Educational Commission for Foreign Medical Graduates Board of Trustees. (BOT Rep. G, I-79; Reaffirmed: CLRPD Rep. C, A-90; Appended: Res. 304, A-00)

H-260.000 Laboratories
(See also: Physician Payment: Medicare; Quality of Care)

H-260.964 Reimbursement for Clinical Lab Work

Our AMA supports the concept that a professional fee should be paid directly to the appropriate physician for clinical laboratory work, regardless of payer source. (Res. 107, I-01; Reaffirmed: CMS Rep. 2, I-06)

H-260.965 Reporting Clinical Test Results

(1) It is the policy of the AMA that, in the best interest of patient safety laboratories should provide a written report of all critical results to the physician, regardless of the test or tests that the physician requested, and that a physician order should not be required for written release of this information. (2) Our AMA supports modifying the Clinical Laboratory Improvement Amendments of 1988 to require laboratories to provide a written report of all critical results to the physician, regardless of the test or tests that the physician requested, and that a physician order should not be required for written release of this information. (CMS Rep. 2, A-00)

H-260.966 CLIA Physician Office Laboratory Inspections

The AMA will seek and support legislation which would amend Section 353 of the Public Health Service Act to exempt physicians' office laboratories, except for those which perform a pap smear (Papanicolaou's Smear) analysis, from the clinical laboratories requirements of that section; and if this is not possible, the AMA will seek legislation or modification in the Centers for Medicare & Medicaid Services regulations which would allow physicians' office laboratories which do not do cytology, which have no significant deficiencies on inspection thus triggering a "revisit," which have satisfactory proficiency testing performances, which have no complaints against the lab and which have not undergone any significant changes (i.e., new director), be allowed to perform a self-assessment study called the Alternative Quality Assessment Survey (AQAS) in lieu of the biannual on-site inspection. (Res. 212, A-97; Reaffirmed: BOT Rep. 33, A-07)

H-260.968 Standardized Drug Testing

The AMA recommends that all forensic drug testing analysis be performed by laboratories accredited by the National Laboratory Certification Program or the College of American Pathologists; and urges the adoption of guidelines for forensic drug testing, which include guidance on proper techniques for selection of individuals to be tested, proper collection of specimens, appropriate laboratory techniques, and review of all results by medical review officers. (Res. 408, A-94; Reaffirmed: CSA Rep. 6, A-04)

H-260.970 Repeal of CLIA

The AMA establishes as primary policy the repeal of CLIA 88 and will continue to work to achieve changes that markedly reduce or eliminate the obstacles experienced by physicians and public health departments under CLIA. (Sub. Res. 234, A-93; Reaffirmed: Res. 230, I-97; Reaffirmation I-99)

H-260.971 CLIA Improvements

The AMA will continue to support eliminating the full weight of regulatory requirements through the development of an expanded and modified free-standing physician testing category that would allow a physician or physician-supervised personnel to perform tests necessary for the treatment of the physician's patients. (Sub. Res. 235, A-93; Reaffirmation I-99)

H-260.972 SI Units of Measure

It is the policy of the AMA for its scientific publications to use both SI and conventional terminology whenever laboratory data are included in these publications. (Res. 504, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-260.973 Cost and Benefits of CLIA '88 and Other Health Regulations

The AMA demands from the government any proven evidence, research, study or any data concerning CLIA '88: (a) showing that this law was actually necessary, and (b) indicating in a quantitative way how any potential benefits of this law outweigh this addition to the already overburdened cost of health care. (Res. 245, I-92; Reaffirmed: BOT Rep. 28, A-03)

H-260.975 Repeal of CLIA

The AMA (1) will work through appropriate regulatory, legislative or judicial channels for changes in CLIA '88 or elimination of those portions of the CLIA '88 regulations that do not improve patient care; and (2) will continue to work to achieve changes that markedly reduce or eliminate the obstacles experienced by physicians under CLIA '88, with the understanding that should this not be successful, the Association shall move to seek legislative repeal of CLIA '88. (Sub. Res. 237, I-92; Reaffirmed: BOT Rep. 28, A-03)

H-260.977 Commission on Office Laboratory Accreditation

The AMA, with state medical and national medical specialty societies, will (1) take immediate action to cause CMS to publish the "deeming" regulations under CLIA '88;

(2) take immediate action to assure that applications for deemed status under CLIA '88 are processed expeditiously and that potential accrediting organizations capable of complying with the regulations are granted deemed status as quickly as possible;

(3) take immediate action to cause CMS to delay sending bills for laboratory certification fees until at least 60 days have passed from the time that at least one alternative private sector accrediting body has been granted deemed status; and

(4) publicize information about the Commission on Office Laboratory Accreditation (COLA) and encourage that all physicians seek clinical laboratory accreditation through COLA in lieu of federal or other government certification. (Sub. Res. 264, A-92; Reaffirmation I-99; Reaffirmed: BOT Rep. 28, A-03)

H-260.978 Salary Equity for Laboratory Personnel

It is the policy of the AMA to promote adequate compensation for medical technologists, cytotechnologists and other medical laboratory personnel and to promote increased funding for their educational programs. (Sub. Res. 39, A-91; Reaffirmed: Sunset Report, I-01)

H-260.980 Clinical Laboratory Improvement Act of 1988

It is the policy of the AMA to (1) continue and intensify its efforts to seek appropriate and reasonable modifications in the proposed rules for implementation of the CLIA 88;

(2) communicate to Congress and to CMS the positive contribution of physician office laboratory testing to high quality, cost effective care so that through administrative revision of the regulations, clarification of Congressional intent and, if necessary, additional legislation, the negative impact of these proposed regulations on patient care and access can be eliminated;

(3) continue to work with Congress, CMS, the Commission on Laboratory Assessment, and other medical and laboratory groups for the purposes of making the regulations for physicians' office laboratories reasonable, based on scientific data, and responsive to the goal of improving access to quality services to patients;

(4) protest the reported high costs being considered for certification of laboratories and the limited number of laboratory categories proposed;

(5) encourage all components of the federation to express to CMS and members of Congress their concerns about the effect of the proposed rules on access and cost of laboratory services; and

(6) protest the very limited list of waivered tests. (Sub. Res. 46, A-90; Reaffirmed: Sunset Report, I-00)

H-260.982 Regulation of Clinical Laboratories

Our AMA supports working with medical specialty societies and national medical specialty organizations and CMS to assure that regulations which are promulgated by CMS reflect accurately the intent of Congress and set reasonable requirements and appropriate fees that will allow the continuing operation of physician office laboratories. (Res. 87, I-89; Reaffirmed: Sunset Report, A-00)

H-260.983 Repeal of Assignment of Physician-Office Laboratory Services

Our AMA urges Congress to delete the requirement of mandatory assignment for physician-office laboratory services. (Res. 24, I-89; Reaffirmed: Sunset Report, A-00)

H-260.984 Quality of Cytotechnology

Our AMA supports working with pathologists and cytotechnology training programs to publicize the importance of this career, and supports making working conditions and reimbursement commensurate with this most important segment of the health care system. (Res. 108, A-89; Reaffirmed: Sunset Report, A-00)

H-260.996 Progress in Adoption of SI Units

(1) Our AMA recognizes the benefits of the application of uniform units of measure throughout the world.

(2) Our AMA interprets both mass concentration and molecular (molar) concentration units to be SI Units.

(3) Conversion to molecular (molar) units should not be automatic: analytes should be considered on an individual basis. A single unit is to be preferred for each analyte.

(4) The chosen mass or molar units should be applied as uniformly as possible to closely related analytes such as the concentration of drugs in biological specimens.

(5) The decision to recommend a change from units in current use should be based on an evaluation of the impact of the change on medical care, balancing potential advantage with expected cost and confusion caused by the change.

(6) Present units of pressure (mm Hg) should be retained in medicine at this time.

(7) Recommendations on the introduction of SI into American medicine, such as the substitution of the kilojoule for the kilocalorie, should be developed from the broadest possible base with involvement of appropriate parties and a concomitant extensive education program.

(8) All recommendations regarding unit changes in medicine should be coordinated through the AMA, which serves as secretariat to the Biomedical Sector Committee of the American National Metric Council.

(9) Following acceptance of a demonstrated need for a change in units, the change should be widely implemented as expeditiously as possible.

(10) No system of units can be expected to remain static. Evolutionary modification in the SI can be expected to occur as improvements are achieved in measurement science and medical knowledge. (CSA Rep. E, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-260.997 Adoption of International System of (SI) Units

Regarding the use of SI Units in clinical chemistry, the AMA recommends that: (1) the use of mass concentration units (wgt/vol) be retained by medical laboratories until it is shown that a change to mole concentrations will improve patient care (diagnosis, treatment or follow-up), or prove a significant advantage with respect to laboratory measurement technique; and (2) no abrupt changes in the current use of mass concentrations, or in milliequivalent units for certain electrolytes, be undertaken until an overall plan and schedule has been agreed upon by representative medically oriented groups and appropriate councils of the AMA. (CSA Rep. E, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-260.998 Laboratory Services Contracted by a Physician

Our AMA believes that: (1) laboratories should bill and collect from patients or third party payers for laboratory services; (2) attending physicians are entitled to fair compensation for professional services rendered; and (3) bills for laboratory services performed by attending physicians should show the location where services were rendered and a description of such services. (Sub. Res. 71, A-69; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CMS Rep. 2, I-06)

H-265.000 Legal Medicine
(See also: Crime; Prisons)

H-265.990 Expert Witness Affirmation

AMA policy is that all physicians, serving as expert witnesses in medical liability litigation, voluntarily sign an expert witness affirmation explicitly stating that they will adhere to the AMA's principles guiding expert witness testimony. (Res. 7, A-04)

H-265.992 Expert Witness Testimony

Our AMA: (1) encourages each state medical society to work with its state licensing board toward the development of effective disciplinary measures for physicians who provide fraudulent testimony;

(2) provides legal and advocacy support to those medical and specialty organizations who seek to devise programs designed to discipline physicians for unprofessional conduct relative to expert witness testimony;

(3) continues to study and work with interested organizations to address the inherent difficulties in conducting the peer review of physicians who provide expert witness testimony;

(4) continues to educate physicians about ethical guidelines and professional responsibility regarding the provision of expert witness testimony;

(5) encourages each state medical society to work with its state licensing board to grant any out-of-state expert witness physician a temporary license at a nominal fee or at no cost for the express purpose of expert testimony on a per case basis, such that the expert witness is subject to the peer review process.

(6) encourages each state medical society to assist its state licensing board in the peer review process of expert witnesses by providing an expert witness committee program similar to the one in the state of Florida;

(7) works with the Federation of State Medical Boards to address problems regarding out-of-state expert witnesses; and

(8) acts as a clearinghouse for advice and support as the state medical associations develop their own expert witness committee programs. (BOT Rep. 18, I-98; Reaffirmed: Res. 221, A-99; Reaffirmation A-00; Reaffirmed: Res. 16, A-03; Reaffirmed: BOT Rep. 8, I-04)

H-265.993 Peer Review of Medical Expert Witness Testimony

AMA policy is that: (1) the giving of medico-legal testimony by a physician expert witness be considered the practice of medicine, and (2) all medico-legal expert witness testimony given by a physician should be subject to peer review. (Res. 221, I-97; Reaffirmed: BOT Rep. 18, I-98; Reaffirmation A-99; Reaffirmation A-00)

H-265.994 Expert Witness Testimony

(1) Regarding expert witnesses in clinical matters, as a matter of public interest the AMA encourages its members to serve as impartial expert witnesses.

(2) Our AMA is on record that it will not tolerate false testimony by physicians and will assist state, county and specialty medical societies to discipline physicians who testify falsely by reporting its findings to the appropriate licensing authority.

(3) Existing policy regarding the competency of expert witnesses and their fee arrangements (BOT Rep. SS, A-89) is reaffirmed, as follows:

(a) The AMA believes that the minimum statutory requirements for qualification as an expert witness in medical liability issues should reflect the following: (i) that the witness be required to have comparable education, training, and occupational experience in the same field as the defendant or specialty expertise in the disease process or procedure performed in the case; (ii) that the occupational experience include active medical practice or teaching experience in the same field as the defendant; (iii) that the active medical practice or teaching experience must have been within five years of the date of the occurrence giving rise to the claim; and (iv) that the witness be certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association or by a board with equivalent standards.

(b) The AMA opposes payment of contingent fees for all types of medicolegal consultations, including management services provided by firms engaged in locating physician consultants. Where necessary, the AMA supports state legislation making it illegal for

medicolegal consulting firms to take a contingent fee in personal injury litigation. Such arrangements threaten the integrity and the compensation goals of the civil justice system. Like the individual expert witness, the role of the medicolegal consulting firm which locates and supplies experts should be one of limited service to the judicial process. Contingent fee arrangements are plainly inconsistent with the scope of this responsibility.

(c) The AMA supports the right to cross examine physician expert witnesses on the following issues: (i) the amount of compensation received for the expert's consultation and testimony; (ii) the frequency of the physician's expert witness activities; (iii) the proportion of the physician's professional time devoted to and income derived from such activities; and (iv) the frequency with which he or she testified for either plaintiffs or defendants. The AMA supports laws consistent with its model legislation on expert witness testimony. (Sub. Res. 223, A-92; Appended: Sub. Res. 211, I-97; Reaffirmation A-99; Modified: BOT Rep. 8, I-04; Reaffirmed: Res. 2, I-05)

H-265.995 Guidelines for Expert Witness

The AMA supports (1) continued study of the various state and specialty society expert witness guidelines that are available, and (2) again disseminating its model state legislation establishing expert witness guidelines and working with the American Bar Association to achieve passage of the guidelines embodied therein. (Sub. Res. 98, A-91; Reaffirmation A-99; Reaffirmation A-00)

H-265.997 AMA-ABA Statement on Interprofessional Relations for Physicians and Attorneys

The AMA supports the following statement of interprofessional relations for physicians and attorneys, developed, jointly by the AMA and the American Bar Association. Its purpose is to promote the public welfare, improve the practical working relationships of the two professions, and facilitate the administration of justice.
(1) Medical Reports: Physicians, upon proper authorization, should promptly furnish the attorney with a complete medical report, and should realize that delays in providing medical information may prejudice the opportunity of the patient either to settle his claim or suit, delay the trial of a case, or cause additional expense or the loss of important testimony. The attorney should give the physician reasonable notice of the need for a report and clearly specify the medical information which he seeks.
(2) Conferences: It is the duty of each profession to present fairly and adequately the medical information involved in legal controversies. To that end the practice of discussion in advance of the trial between the physician and the attorney is encouraged and recommended. Such discussion should be had in all instances unless it is mutually agreed that it is unnecessary. Conferences should be held at a time and place mutually convenient to the parties. The attorney and the physician should fully disclose and discuss the medical information involved in the controversy.
(3) Subpoena for Medical Witness: Because of conditions in a particular case or jurisdiction or because of the necessity for protecting himself or his client, the attorney is sometimes required to subpoena the physician as a witness. Although the physician should not take offense at being subpoenaed, the attorney should not cause the subpoena to be issued without prior notification to the physician. The duty of the physician is the same as that of any other person to respond to judicial process.
(4) Arrangements for Court Appearances: While it is recognized that the conduct of the business of the courts cannot depend upon the convenience of litigants, lawyers or witnesses, arrangements can and should be made for the attendance of the physician as a witness which take into consideration the professional demands upon his time. Such arrangements contemplate reasonable notice to the physician of the intention to call him as a witness and to advise him by telephone after the trial has commenced of the approximate time of his required attendance. The attorney should make every effort to conserve the time of the physician.
(5) Physician Called as Witness: The attorney and the physician should treat one another with dignity and respect in the courtroom. The physician should testify solely as to the medical facts in the case and should frankly state his medical opinion. He should never be an advocate and should realize that his testimony is intended to enlighten rather than to impress or prejudice the court or the jury. It is improper for the attorney to abuse a medical witness or to seek to influence his medical opinion. Established rules of evidence afford ample opportunity to test the qualifications, competence, and credibility of a medical witness, and it is always improper and unnecessary for the attorney to embarrass or harass the physician.
(6) Fees for Services of Physician Relative to Litigation: The physician is entitled to reasonable compensation for time spent in conferences, preparation of medical reports, and for court or other appearances. These are proper and necessary items of expense in litigation involving medical questions.
(7) Payment of Medical Fees: The attorney should do everything possible to assure payment for services rendered by the physician for himself or his client. When the physician has not been fully paid, the attorney should request permission of the patient to pay the physician from any recovery which the attorney may receive in behalf of the patient. (BOT Rep. II, I-81; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-265.998 Guidelines for Due Process

While it is not possible to develop universal guidelines for due process, voluntary utilization of the following general guidelines for due process, adapted in each instance to suit the circumstances and conditions of the health care organization and within the requirements of the applicable laws of the jurisdiction, should assist in providing the type of hearing which the law in each jurisdiction requires:
(1) The physician should be provided with a statement, or a specific listing, of the charges made against him or her.
(2) The physician is entitled to adequate notice of the right to a hearing and a reasonable opportunity of no less than 30 days to prepare

for the hearing.
(3) It is the duty and responsibility of the hearing officer to conduct a fair, objective, expeditious and independent hearing pursuant to established rules.
(4) The rules of procedure should clearly define the extent to which attorneys may participate in the hearing.
(5) The physician against whom the charges are made should have the opportunity to be present at the hearing and hear all of the evidence against him or her.
(6) The physician is entitled to the opportunity to present a defense to the charges against him or her.
(7) To the extent feasible, the hearing panel should evaluate the issues and evidence presented related to the proposed corrective action while blinded to the patient outcome.
(8) The hearing panel should render a decision based on the evidence produced at the hearing.
(9) The hearing panel should include in its decision the conclusions reached and actions recommended and, as an important focus if feasible, remedial steps for the physician and for the health care facility itself. When feasible, the hearing panel should include terms that permit measurement and validation of the completed remediation process.
(10) The hearing panel should endeavor to state its findings, the clinical basis and support for its findings, its recommendations, and actions as clearly as possible.
(11) Within 10 days of the receipt of the hearing panel's decision, the physician, medical executive committee or health care organization, if it brought the correction action, has the right to request an appellate review. The written request for an appellate review shall include an identification of the grounds for appeal and a clear and concise statement of the facts and/or evidence in support of the appeal. The grounds for an appeal of the decision shall be: (a) substantial non-compliance with the procedures required in the medical staff bylaws; or (b) the decision is against the manifest weight of the evidence. If an appellate review is to be conducted, the appeal board shall schedule the appellate review and provide notice to the physician, medical executive committee and the health care organization. The MEC shall appoint an appeal board consisting of members of the medical staff who did not sit on the original hearing panel, or, at the request of the MEC, the governing body or at least three members thereof may sit as the appeal board. The appeal board shall consider the record of the hearing before the hearing panel. If the appeal board determines that significant relevant evidence, which could bare on the outcome of the proceeding, was not entertained by the hearing panel, it may refer the matter back to the hearing panel for further deliberation or, at the appeal board's discretion, it may receive and consider the new evidence. Similarly, if the appeals board determines that there was not substantial compliance with the hearing procedures in the medical staff bylaws, the appeal board may refer the matter back to the hearing body or, at the appeal board's discretion, it may convene additional hearings to correct any defect in the process. Upon completion of the appeal board's deliberations, the appeal board shall present its recommendation(s) to the governing body as to whether the recommendations(s) of the hearing body should be affirmed, modified, or reversed.
(12) In any hearing, the interest of patients and the public must be protected. (BOT Rep. II, A-80; Reaffirmed: Sunset Report, I-98; Amended: BOT Action in response to referred for decision BOT Rep. 23, A-05; Reaffirmed: Res. 12, A-06)

H-265.999 Legal Reports on Physician-Hospital Relationships

The AMA supports the continuation of its current pattern of publishing periodic reports and bulletins that update laws and court decisions pertaining to physician-hospital relations as well as all other aspects of medical practice and health care. (Sub. Res. 104, A-72; Reaffirmed: Sunset Report, I-98)

H-270.000 Legislation and Regulation

H-270.957 FTC Identification Theft Prevention Programs

Our AMA is commended for its efforts to eliminate physicians under the definition of "creditors" as currently interpreted by the Federal Trade Commission (FTC) in its rules implementing the Fair and Accurate Credit Transaction Act of 2003, and will continue its vigorous advocacy opposing the FTC's efforts to include physicians as creditors under the FACTA 2003. (Res. 222, I-08)

H-270.958 Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners

1. It is AMA policy that state medical boards shall have authority to regulate the practice of medicine by all persons within a state notwithstanding claims to the contrary by nonphysician practitioner state regulatory boards or other such entities.

2. Our AMA will work with interested Federation partners: (a) in pursuing legislation that requires all health care practitioners to disclose the license under which they are practicing and, therefore, prevent deceptive practices such as nonphysician healthcare practitioners presenting themselves as physicians or "doctors"; (b) on a campaign to identify and have elected or appointed to state medical boards physicians (MDs or DOs) who are committed to asserting and exercising the state medical board's full authority to regulate the practice of medicine by all persons within a state notwithstanding efforts by nonphysician practitioner state regulatory boards or other such entities that seek to unilaterally redefine their scope of practice into areas that are true medical practice. (BOT Action in response to referred for decision Res. 902, I-06)

H-270.959 AMA Stance on the Interference of the Government in the Practice of Medicine

Our AMA opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations. (Res. 523, A-06)

H-270.960 Inappropriate Legislative Mandates of eGFR Calculations

Our AMA supports the position that (1) the estimated Glomerular Filtration Rate Calculation (eGFR) calculation, when appropriate and feasible, is a clinically useful calculation that should be promoted in the medical community in a scientific manner as a calculation that does NOT require state legislation or state law that would create an inflexible, politically-based mandate for the practice of medicine that, in general, can be deleterious to patient care; and (2) legislation mandating the eGFR calculation improperly and detrimentally prescribes medical decision-making to the extent that it deprives a physician of the ability to make appropriate, patient-specific clinical judgments regarding the performance of the calculation. (Res. 525, A-06)

H-270.961 Medical Care Must Stay Confidential

Our AMA will strongly oppose any federal legislation requiring physicians to establish the immigration status of their patients. (Res. 214, A-04)

H-270.962 Unfunded Mandates

Our AMA vigorously opposes any unfunded mandates on physicians. (Res. 217, A-03)

H-270.963 Organ Donation

Our AMA urges the Centers for Medicare & Medicaid Services and other federal and state organizations with authority over healthcare advanced directives to add a health care directive regarding organ donation to the Advance Directive Form. (Res. 2, A-02; Reaffirmed: CSA Rep. 4, I-02)

H-270.964 Fraud Compliance and Compliance Plans

Our AMA express its strong objections to the OIG for its unwarranted punitive attitude and the financial and administrative burden to physician practices and seeks modification to the final version of the "Office of Inspector General's Compliance Program Guidance for Individual and Small Group Physician Practices" so that it is not burdensome nor costly to medical practices (with respect to physician, staff, administrative, and financial resources) and focuses on education rather than criminal punishment. (BOT Rep. 29, A-01)

H-270.965 Physician-Assisted Suicide

Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer. (Sub. Res, 5, I-98; Reaffirmed: CEJA Rep. 11, A-08)

H-270.966 Disclosure of Addiction Treatment History in Public Housing Applications

The AMA opposes Section 301-d (the Grams Amendment of the Public Housing Reform and Responsibility Act of 1997), which authorizes public housing agencies to require that housing applicants consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance, and seeks its removal. (Res. 245, A-97; Reaffirmed: BOT Rep. 33, A-07)

H-270.968 Preservation of Political Advocacy by Nonprofit Organizations

The AMA continues to oppose a federal initiative that would impose restrictions on advocacy activities of federal grantees that preclude them from both utilizing private funds for advocacy activities as well as delivering government-funded services. (Res. 216, A-96; Reaffirmed: BOT Rep. 34, A-06)

H-270.972 Protecting Raw Material Suppliers from Product Liability Litigation

The AMA supports legislation which protects raw material suppliers from product liability litigation so long as the materials they supply conform to medical device manufacturer specifications. (Res. 221, I-94; Reaffirmed: BOT Rep. 29, A-04)

H-270.974 Acupuncture

It is the policy of the AMA that nonphysician boards should not regulate the clinical practice of medicine. (CME Rep. M, A-93; Modified: CME Rep. 2, A-03)

H-270.975 Cost Effectiveness of Legislation Regulating Medicine

The AMA will seek legislation to require a cost effectiveness study, including evaluation of the effects on the delivery of high quality patient care services, before congressional passage of any future legislation regulating the medical profession. (Res. 235, I-92; Reaffirmation A-00)

H-270.977 FDA Intrusion into the Practice of Medicine

The AMA strongly opposes the FDA's intrusion into the practice of medicine by making decisions for individual care and mandated informed consent documents written without the input of specialists in the related field of medicine. (Res. 544, A-92; Reaffirmed: BOT Rep. 28, A-03)

H-270.978 Legislation to Establish United States-Mexico Health and Environment Commission

It is the policy of the AMA to draft and introduce legislation in 1992 to enact the establishment of a United States-Mexico Health and Environment Commission. (Res. 224, I-91; Modified: Sunset Report, I-01)

H-270.980 Independent Health Policy Advisory Council

Our AMA believes that yet another national health advisory body would be redundant and that the AMA should not sponsor legislation at the national level that would provide for an independent health policy advisory council. (BOT Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-270.981 IRS Pension Regulations Sections 1.414(m) and (n)

It is the policy of the AMA (1) to use all appropriate resources, including legal action if necessary, to seek changes in the proposed Internal Revenue Service regulations, Sections 1.414(m)(5) and 1.414(n), regarding pension and profit sharing plans;

(2) to seek to inform and educate physicians about the effects of the proposed Internal Revenue Service regulations, Sections l.414(m)(5) and 1.414(n);

(3) to seek a delay in the effective date of proposed IRS regulations Section 1.414 (n); (4) that if IRS regulations, Sections l.414(m)(5) and 1.414(n), are adopted that they only be applied prospectively; and

(4) that, if necessary, the AMA seek legislative redress of proposed regulations, Sections 1.414(m)(5) and 1.414(n). (Sub. Res. 255, A-90; Reaffirmed: Sunset Report, I-00)

H-270.982 Truth in Advertising Standards for Managed Health Care Plans

It is the policy of the AMA to seek legislation which would provide that managed health care plans meet high standards of truth in advertising and legal safeguards to assure high quality medical care is not compromised by deceptive marketing activities, unsubstantiated claims, bogus quality assurance activities, disruptive referral requirements, and unreasonable precertification and concurrent review practices. (Res. 220, A-90; Reaffirmed: Sunset Report, I-00)

H-270.984 Change in Bankruptcy Code

The AMA supports the passage of an amendment to Section 523(a)(8) of the Bankruptcy Code, which would substitute the word "organization" for the word "institution." (Res. 45, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BOT Rep. 33, A-07)

H-270.987 Tax Law Changes

The AMA supports: (1) correction of inequities in the Tax Reform Act of 1986, including (a) the excise penalty tax on excess retirement distribution; (b) the excise tax on excess retirement accumulation; (c) the requirement of 10-year plan participation; and (d) the requirement of plan participation by the specified percentage of all employees; and (2) re-establishment of IRA rules as under the previous law. (Sub. Res. 138, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BOT Rep. 33, A-07)

H-270.992 Remedial Antitrust Legislation

Our AMA supports legislation that would require courts reviewing antitrust cases involving the sale or delivery of health services to

consider whether the activities are directed, authorized or encouraged by the federal or state government, whether the activity is intended to maintain or improve the quality of health care in the public interest, and whether the activity is intended to control costs in the public interest. (BOT Rep. Q, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmation I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-04)

H-270.995 Federal Regulations and Cost Controls

Our AMA requests the federal government to refrain from implementing further regulations and health care systems without supportive evidence of positive impact upon quality of care and cost containment, or positive impact upon quality of care alone. (Sub. Res. 58, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report and Reaffirmation A-00; Reaffirmation A-02)

H-270.997 Legal Restrictions on Sexual Behavior Between Consenting Adults

Our AMA supports in principle repeal of laws which classify as criminal any form of noncommercial sexual conduct between consenting adults in private, saving only those portions of the law which protect minors, public decorum, or the mentally incompetent. (BOT Rep. I, A-75; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-270.999 Legislation Making the Federal Register Give Fairer and More Reasonable Notice of the Promulgation of Regulations Which Will Have the Force of Law

Our AMA (1) is concerned over the lack of opportunity to develop and submit appropriate comments on proposed regulations, especially in the Federal Register, without adequate notice; and (2) supports (a) taking appropriate action to obtain greater advance notice and opportunity to comment on proposed regulations; (b) consideration of appropriate means to make available for the profession information concerning significant proposals of the various federal agencies on health matters; and (c) development of mechanisms to provide for more effective relief from the implementation of regulations harmful to sound medical practice should comments adverse to such regulations be ignored. (Sub. Res. 152, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-275.000 Licensure and Discipline
(See also: International Medical Graduates; National Practitioner Data Bank)

H-275.925 Protection of the Titles "Doctor," "Resident" and "Residency"

Our AMA: (1) will advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; and (2) supports state legislation that would make it a felony to misrepresent oneself as a physician (MD/DO). (Sub. Res. 232, A-08)

H-275.926 Maintaining Medical Specialty Board Certification Standard

1. Our AMA opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.

2. Our AMA will communicate its concerns about the misleading use of the term "board certification" by the National Board of Public Health Examiners and others to the specialty and service societies in the federation, the Association of Schools of Public Health, the American Board of Medical Specialties, the Accreditation Council for Graduate Medical Education, the National Board of Medical Examiners, and the Institute of Medicine.

3. Our AMA will continue to work with other medical organizations to educate the profession and the public about the board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination. (Res. 318, A-07)

H-275.927 Medicare/ Medicaid Exclusion: Amendment of Definition of Conviction in Health Insurance Portability and Accountability Act

1. It is AMA policy that a recovering physician who is convicted of a felony for an offense which relates to the "unlawful manufacture, distribution, prescription or dispensing of a controlled substance," and in order to resolve criminal charges arising from personal substance abuse, has entered into a first offender, deferred adjudication or other such arrangement (42 USC § 1320a-7[i]), should not be excluded from the Medicare and Medicaid programs for a mandatory five years.

2. Our AMA seeks legislation either to (a) delete this first offender, deferred adjudication definition of "conviction" from the statute,

or (b) seek to exempt recovering providers from its application. (BOT Action in response to referred for decision Res. 215, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-275.928 Arbitrary Exclusion of International Medical Schools Which Impacts Physician Licensure

Our AMA opposes the practice by state medical boards of creating arbitrary and non criterion-based lists of approved or unapproved international medical schools. (Res. 310, A-05)

H-275.929 Additions to United States Medical Licensure Examination and Comprehensive Osteopathic Medical Licensure Examination

Our AMA opposes additions to the United States Medical Licensing Examination and Comprehensive Osteopathic Medical Licensure Examination that lack predictive validity for future performance as a physician. (Res. 308, A-04)

H-275.930 Opposition to Clinical Skills Examinations for Physician Medical Relicensure

Our AMA: (1) opposes clinical skills examinations for the purpose of physician medical relicensure; (2) reaffirms its support for continuous quality improvement of practicing physicians, and supports research into methods to improve clinical practice, including practice guidelines; and (3) continues to support the implementation of quality improvement through local professional, non-governmental oversight. (Res. 307, A-04)

H-275.931 Representation on Medical Specialty Boards

Our AMA encourages each medical and surgical specialty board recognized by the American Board of Medical Specialties and the AMA to assure a diverse representation on its Board, including physicians who are in private, community-based practice. (Res. 311, A-03)

H-275.932 Internal Medicine Board Certification Report--Interim Report

Our AMA opposes the use of recertification or Maintenance of Certification (MOC) as a condition of employment, licensure or reimbursement. (CME Rep. 7, A-02)

H-275.933 Specialty Board Recertification Requirements for Employment

Our AMA opposes specialty board recertification as a sole condition of employment. (Res. 303, I-01; Reaffirmed: CME Rep. 7, A-07)

H-275.934 Alternatives to the Federation of State Medical Boards Recommendations on Licensure

Our AMA adopts the following principles:(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Parts 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Part 1 of COMLEX. There should be provision made for students who have not completed Step 2 of the USMLE or Part 2 of the COMLEX to do so during the first year of residency training.

(2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content.

(3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Part 1 of COMLEX.

(4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians.

(5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements.

(6) There should be no reporting of actions against medical students to state medical licensing boards.

(7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills.

(8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants. (CME Rep. 8, A-99; Reaffirmed: CME Rep. 4, I-01)

H-275.935 Licensure of IMGs

Our AMA asks the Federation of State Medical Boards to ask all the state licensing boards to adopt a uniform standard governing the allowed number of administrations of the licensure examinations. (Res. 314, A-99)

H-275.936 Mechanisms to Measure Physician Competency

Our AMA (1) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (2) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency. (Res. 320, I-98; Amended: Res. 817, A-99; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07)

H-275.937 Patient/Physician Relationship and Medical Licensing Boards

(1) Our AMA encourages all state medical societies to advocate for inclusion of the following policy in their state medical licensing board regulations: Without regard to whether an act or failure to act is entirely determined by a physician, or is the result of a contractual or other relationship with a health care entity, the relationship between a physician and a patient must be based on trust and must be considered inviolable. Included among the elements of such a relationship of trust are: (a) Open and honest communication between the physician and the patient, including disclosure of all information necessary for the patient to be an informed participant in his or her care.(b)- Commitment of the physician to be an advocate for the patient and for what is best for the patient, without regard to the physician's personal interests. (c) Provision by the physician of that care which is necessary and appropriate for the condition of the patient and neither more nor less.(d)- Avoidance of any conflict of interest or inappropriate relationships outside of the therapeutic relationship.
(2) The relationship between a physician and a patient is fundamental and is not to be constrained or adversely affected by any considerations other than what is best for the patient. The existence of other considerations, including financial or contractual concerns, is and must be secondary to the fundamental relationship.
(3) Any act or failure by a physician that violates the trust upon which the relationship is based may place the physician at risk of being found in violation of the Medical Practice Act.
(4) The following statement reflects the policy of the (name of state) Board of Medical Examiners regarding the physicians it licenses.
(5) A (name of state) physician has both medical-legal and ethical obligations to his or her patients. These are well established in both law and professional tradition. Some models of medical practice may result in an inappropriate restriction of the physician's ability to practice quality medicine. This may create negative consequences for the public. It is incumbent that physicians take those actions they consider necessary to assure that medical practice models do not adversely affect the care that they render to their patients. (BOT Rep. 30, I-98; Reaffirmed: CME Rep. 2, A-08)

H-275.938 USMLE Part III and Licensure

Our AMA will lobby the Federation of State Medical Boards to discourage states from linking mandatory application for licensure with application to take the USMLE Part III. (Res. 325, A-98; Reaffirmed: CME Rep. 2, A-08)

H-275.939 Internet Gambling

Our AMA: (1) informs physicians and patients of the dangers of addiction associated with Internet gambling; (2) supports the prohibition of government-sponsored Internet gambling; and (3) in collaboration with appropriate specialty societies, pursues other avenues to prohibit the availability of Internet gambling to children. (Res. 217, A-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-275.940 Physician Impairment

The AMA adopts the policy that, except in the case of summary suspension necessary to protect patients from imminent harm, no adverse action be taken against the privileges of a physician by a hospital, managed care organization or insurer based on a claim of physician impairment without a suitable due process hearing in accordance with medical staff bylaws to determine the facts related to the allegations of impairment and, where appropriate, a careful clinical evaluation of the physician. (Res. 701, I-97; Reaffirmed: CME

Rep. 2, A-07)

H-275.941 Out-of-State Residents in Training and State Licensing Board Requirements for Temporary Licenses

The AMA will work with the Federation of State Medical Boards (FSMB) to facilitate a timely process so that residents in a training program can meet the licensure requirements to avail themselves of opportunities for educational experiences in states other than that of their primary program location. (Sub. Res. 301, A-97; Reaffirmed: CME Rep. 2, A-07)

H-275.942 AMA Physician Profiles

The AMA will give advance notice to the Federation of major changes in physician-profiling operations; and the AMA will respect and collaborate with those Federation units which operate physician credentialing services. (Res. 622, A-96; Reaffirmed: CLRPD Rep. 2, A-06)

H-275.943 Public Education about Physician Qualifications

The AMA will continue to develop programs to educate the public about the differences in education and professional standards between physicians and non-physician health care providers. (Res. 623, A-96; Reaffirmation A-99)

H-275.944 Board Certification and Discrimination

(1) Where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes, the AMA oppose discrimination that may occur against physicians involved in the board certification process including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination. (2) Our AMA reaffirms and communicates its policy of opposition to discrimination against member physicians based solely on lack of American Board of Medical Specialties or equivalent American Osteopathic Board certification. (3) Our AMA continues to advocate for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not. (Sub. Res. 701, I-95; Appended: Res. 314, I-98; Appended: Sub. Res. 301, I-99; Reaffirmed: Sub. Res. 722, A-00; Reaffirmed: CME Rep. 7, A-07)

H-275.945 Self-Incriminating Questions on Applications for Licensure and Specialty Boards

The AMA will: (1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information; (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and (3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked. (BOT Rep. 1, I-933; CME Rep. 10 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-275.949 Discrimination Against Physicians Under Supervision of Their Medical Examining Board

The AMA opposes the exclusion of otherwise capable physicians from employment, business opportunity, insurance coverage, specialty board certification or recertification, and other benefits, solely because the physician is either presently, or has been in the past, under the supervision of a medical licensing board in a program of rehabilitation. (Sub. Res. 3, A-92; Reaffirmed: BOT Rep. 18, I-93; Reaffirmed: CME Rep. 2, A-05)

H-275.950 Board Certification

Our AMA (1) reaffirms its opposition to the use of board certification as a requirement for licensure or reimbursement; and (2) seeks an amendment to the new Medicaid rules that would delete the use of board certification as a requirement for reimbursement and would address the exclusion of internal medicine, emergency medicine, and other specialties. (Res. 143, A-92; ; Reaffirmed by Res. 108, A-98; Reaffirmation A-00)

H-275.951 Mandatory Acceptance of Patient's Group Plan

It is the policy of the AMA that the sole purpose of medical licensure is to assure the competence of physicians to practice medicine. (Sub. Res. 111, I-91; Modified: Sunset Report, I-01)

H-275.952 Reporting Impaired, Incompetent or Unethical Colleagues

Physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues. Physicians should be familiar with the reporting requirements of their own state and comply accordingly.

(1) Physicians should work to assure that state laws provide immunity to those who report impaired, incompetent, or unethical colleagues.

(2) Principles of due process must be observed in the conduct of all disciplinary matters involving physician participants at all levels. However, the confidentiality of the reporting physician should be maintained to the greatest extent possible within the constraints of due process, in order to minimize potential professional recriminations.

(3) The medical profession as a whole must correct the misperception that physicians are not adequately protecting the public from incompetent, impaired or unethical physicians by better communicating its efforts and initiatives at maintaining high ethical standards and quality assurance. (CEJA Rep. A, I-91; Reaffirmed: BOT Rep. 17, I-99; Modified and Reaffirmed: CEJA Rep. 1, A-03; Reaffirmation I-03)

H-275.953 The Grading Policy for Medical Licensure Examinations

(1) The AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection. (2) The AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students. (CME Rep. G, I-90; Reaffirmed by Res. 310, A-98; Reaffirmed: CME Rep. 3, A-04)

H-275.955 Physician Licensure Legislation

Our AMA (1) reaffirms its policies opposing discrimination against physicians on the basis of being a graduate of a foreign medical school and supports state and territory responsibility for admitting physicians to practice; and (2) reaffirms earlier policy urging licensing jurisdictions to adopt laws and rules facilitating the movement of physicians between states, to move toward uniformity in requirements for the endorsement of licenses to practice medicine, and to base endorsement of medical licenses on an assessment of competence rather than on passing a written examination of cognitive knowledge. (CME Rep. B, A-90; Reaffirmation A-00)

H-275.956 Demonstration of Clinical Competence

It is the policy of the AMA to (1) support continued efforts to develop and validate methods for assessment of clinical skills; (2) continue its participation in the development and testing of methods for clinical skills assessment; and (3) recognize that clinical skills assessment is best performed using a rigorous and consistent examination administered by medical schools and should not be used for licensure of graduates of Liaison Committee on Medical Education (LCME)- and American Osteopathic Association (AOA)-accredited medical schools or of Educational Commission for Foreign Medical Graduates (ECFMG)-certified physicians. (CME Rep. E, A-90; Reaffirmed: CME Rep. 5, A-99; Modified: Sub. Res. 821, I-02; Modified: CME Rep. 1, I-03)

H-275.957 Changing the Grading Policy for Medical Licensure Examinations

Our AMA is concerned about the potential for inappropriate use of numerical scores of licensing examinations, particularly as a significant criterion in appointment to residency training programs. Past studies show some residency programs inappropriately use USMLE examination scores in screening their applicants. Our AMA supports the development of mechanisms to ensure confidentiality of the results of licensure exams, and that these results are used only in an appropriate fashion. (BOT Rep. GGG, A-90; Reaffirmed: Sunset Report, I-00)

H-275.958 Discouraging the Use of Licensing Exams for Internal Promotion in Medical Schools

It is the policy of the AMA to use its representatives on key national medical education committees to encourage the discontinuation of the use of the USMLE Step 1 Exam as a requirement for the promotion of medical students to the clinical phase. (Res. 289, A-90; Reaffirmed: Sunset Report, I-00)

H-275.959 Cognitive Exams

It is the policy of the AMA to oppose the use of cognitive exams as the major means of evaluating a physician's clinical competence. (Sub. Res. 205, A-90; Modified: Sunset Report, I-00)

H-275.960 Postgraduate Training Requirements for Obtaining Permanent Medical Licensure

Our AMA continues to oppose lengthy residency training requirements for licensure. (CME Rep. A, I-89; Reaffirmed: Sunset Report, A-00)

H-275.962 Proposed Single Examination for Licensure

Our AMA: (1) endorses the concept of a single examination for medical licensure;

(2) urges the NBME and the FSMB to place responsibility for developing Steps I and II of the new single examination for licensure with the faculty of U.S. medical schools working through the NBME;

(3) continues its vigorous support of the LCME and its accreditation of medical schools and supports monitoring the impact of a single examination on the effectiveness of the LCME;

(4) urges the NBME and the FSMB to establish a high standard for passing the examination,

(5) strongly recommends and supports actively pursuing efforts to assure that the standard for passing be criterion-based; that is, that passing the examination indicate a degree of knowledge acceptable for practicing medicine; and

(6) urges that appointing graduates of LCME accredited medical schools to accredited residency training not be dependent on their passing Steps I and II or the single examination for licensure. (CME Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

H-275.963 Mandatory Medicare Assignment or Determination of Fee Levels

Our AMA supports federal legislation that would prohibit states from enacting legislation to require that acceptance of Medicare assignment or the Medicare allowance of reimbursement be a condition of medical licensure, or used in determinations of unprofessional conduct, or made effectively mandatory in any other fashion. (Sub Res. 75, A-89; Reaffirmed: Sunset Report, A-00)

H-275.964 Impaired Physicians Practice Act

Our AMA encourages state medical societies that do not have effectively functioning impaired physicians programs to improve their programs and to urge their states to adopt the AMA 1985 Model Impaired Physician Treatment Act, as necessary. (Sub. Res. 7, A-89; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-97; Reaffirmed: BOT Rep. 17 and Sunset Report, A-00)

H-275.965 Health Care Quality Improvement Act of 1986 Amendments

The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists. (Res. 203, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05)

H-275.967 Licensure by Endorsement

The AMA opposes national legislation which would mandate licensing reciprocity by all state licensing authorities. (Res. 42, A-88; Reaffirmed: Sunset Report, I-98)

H-275.968 Recredentialing of Physicians

The AMA vigorously opposes any state or other government agency plan for mandated recredentialing of physicians for the purpose of relicensure or reregistration. (Res. 201, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)

H-275.970 Licensure Confidentiality

The AMA (1) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (2) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (4) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (5) encourages state licensing boards to require that, if an applicant has had psychiatric treatment, the physician who has

provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine. (CME Rep. B, A-88; Reaffirmed: BOT Rep. 1, I-933; CME Rep. 10 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-275.972 Annual Report of Disciplinary Actions from the Federation of State Medical Boards

The AMA supports the Federation of State Medical Boards' efforts to assure that organizations that use the Federation's copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards. (Sub. Res. 126, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)

H-275.973 State Control of Qualifications for Medical Licensure

(1) The AMA firmly opposes the imposition of federally mandated restrictions on the ability of individual states to determine the qualifications of physician candidates for licensure by endorsement. (2) The AMA actively opposes the enactment of any legislation introduced in Congress that promotes these objectives. (Res. 84, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)

H-275.975 Qualifications of Health Professionals

(1) Private certifying organizations should be encouraged to continue certification programs for all health professionals and to communicate to the public the qualifications and standards they require for certification. Decisions concerning recertification should be made by the certifying organizations. (2) Working with state licensing and certifying boards, health care professions should use the results of quality assurance activities to ensure that substandard practitioner behavior is dealt with in a professional and timely manner. Licensure and disciplinary boards, in cooperation with their respective professional and occupational associations, should be encouraged to work to identify "deficient" health care professionals. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)

H-275.976 Boundaries of Practice for Health Professionals

(1) The health professional who coordinates an individual's health care has an ethical responsibility to ensure that the services required by an individual patient are provided by a professional whose basic competence and current performance are suited to render those services safely and effectively. In addition, patients also have a responsibility for maintaining coordination and continuity of their own health care. (2) As a supplement to strengthen state licensure of health professionals, standard-setting and self-regulatory competency assurance programs should be conducted by health professions associations, certifying and accrediting agencies, and health care facilities. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97

H-275.977 Verifying Physicians' Credentials

The AMA endorses the use of pluralistic approaches to the verification and validation of physicians' credentials. The AMA will seek legislation that managed care companies be required to request credentialing information in a uniform standardized format which all groups involved in credentialing would accept. (Sub. Res. 91, A-87; Amended by Res. 736, A-97; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)

H-275.978 Medical Licensure

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;
(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;
(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;
(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;
(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;
(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);
(7) urges licensing boards to maintain strict confidentiality of reported information;

(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;
(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;
(10) urges all physicians to participate in continuing medical education as a professional obligation;
(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;
(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;
(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;
(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;
(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;
(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;
(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;
(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;
(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;
(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement; and
(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement. (CME Rep. A, A-87; Modified: Sunset Report, I-97; Reaffirmation A-04)

H-275.979 Medicare Reporting of Adverse Incidents in Hospitals to State Agencies

The AMA opposes the sharing of information generated through the Medicare utilization process or other institutional review with state licensure bodies until hospital quality assurance committees have been notified and given a reasonable time to respond. (Res. 118, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06)

H-275.980 Funding of State Medical Boards

(1) The AMA urges state medical associations to recommend to their respective state legislatures that all fees and charges collected by the state licensing/disciplinary board(s), or on its behalf, be specifically designated for use of the board(s) in fulfilling its duties under the state's medical practice act. (2) When such funds are inadequate to support such activities, state general funds should be used to support the board's effective fulfillment of its duties mandated by the state's medical practice act. (Sub. Res. 23, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06)

H-275.981 Education in the Professional Discipline Process

The AMA (1) urges all state medical associations to recommend that each medical school in its state invite members of the state agency in charge of professional medical conduct to lecture on the topic of professional discipline; and (2) urges each state medical association to recommend that each hospital in its state with a training program invite a member of the state agency in charge of professional medical conduct to disseminate to its housestaff information on the workings of the professional discipline agency. (Res. 8, I-86; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)

H-275.984 Legislative Action

The AMA (1) vigorously opposes legislation which mandates that, as a condition of licensure, physicians who treat Medicare beneficiaries must agree to charge or collect from Medicare beneficiaries no more than the Medicare allowed amount; (2) strongly affirms the policy that medical licensure should be determined by educational qualifications, professional competence, ethics and other appropriate factors necessary to assure professional character and fitness to practice; and (3) opposes any law that compels either

acceptance of Medicare assignment or acceptance of the Medicare allowed amount as payment in full as a condition of state licensure. (Sub. Res. 117, I-85; Modified by CLRPD Rep. 2, I-95; Reaffirmed: BOT Rep. 12, A-05)

H-275.985 Graduate Medical Education Requirement for Medical Licensure

The AMA reaffirms its policy that all applicants for full and unrestricted licensure should be required to provide evidence of satisfactory completion of at least one year of an accredited program of graduate medical education in the US. (CME Rep. E, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

H-275.988 Identifying Persons with Illegally Obtained Medical Degrees

The AMA supports appropriate efforts of private and governmental agencies in identification of persons possessing illegally obtained medical degrees. (Res. 43, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-275.990 Clinical Diagnostic Electromyography

The AMA urges appropriate state boards of medical examiners, certification boards, and others to consider the following statement when dealing with the performance of clinical diagnostic electromyography: "Clinical diagnostic electromyographic examinations involving the selection of the muscles to be studied, modifying the examination as the data unfold, inserting the needle electrodes, recording of and interpreting the data thereby obtained, describing the findings, and the rendering of a diagnostic opinion based upon an integration of the clinical history, physical examination features, other pertinent clinical data and the electromyographic findings, should be performed only by a fully licensed physician qualified by reason of education, training, and experience in these procedures." (Res. 62, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-275.993 Examinations for Medical Licensure

Our AMA affirms its recommendation that medical school faculties continue to exercise the responsibilities inherent in their positions for the evaluation of students and residents, respectively. (CME Rep. B, I-81; Reaffirmed: CLRPD Rep. F, I-91; Modified: Sunset Report, I-01)

H-275.994 Physician Participation in Third Party Payer Programs

The AMA opposes state laws making a physician's licensure contingent upon his providing services to Medicaid beneficiaries or any other specific category of patients should be opposed. (CMS Rep. N, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed by Res. 108, A-98)

H-275.995 Physician Membership on State Boards of Medicine

Rather than developing a model Medical Practice Act, our AMA supports providing continued assistance in the drafting of Medical Practice Act provisions by working individually with each state medical association desiring such assistance. (BOT Rep. Q, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-275.996 Physician Competence

Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base. (CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07)

H-275.997 Licensure by Specialty

Experience with licensure by specialty is too limited to determine what the long-range effects will be in the provision of timely, safe and comprehensive medical care. However, the AMA does not consider licensure by specialty to be desirable even in unusual cases. (CME Rep. F, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-275.998 Physician Competence

Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent.

(2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent.

(3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been successful.

(4) State governments to provide to their state medical licensing boards resources adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine.

(5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent.

(6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.) (CME Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03)

H-275.999 Electromyoneurographic Procedures

(1) The term "electromyography" rather than "electromyoneurography" should be used in all communications regarding this subject.
(2) The AMA urges state boards of medical examiners to investigate and take appropriate action whenever cases involving the performance of clinical electromyographic examinations by unqualified persons contrary to the state medical practice act are brought to their attention. (CMS Rep. F, A-77; Reaffirmed: CLRPD Rep. C, A-89; Amended by Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06)

H-280.000 Long-Term Care
(See also: Aging; Ethics; Medicare; Physician Payment: Medicare)

H-280.951 Quality of Care in Nursing Homes Nursing Staffing Level

Our AMA will support the policy that staffing levels in nursing homes should appropriately address: (1) the acuity of the patient population; (2) the functional level of the patient and the services provided; (3) the existence of shortages for certain types of staff in some geographic locations and temporary shortages due to events such as employee illness or termination; and (4) the quality, education, and training of staff. (Sub. Res. 109, A-06)

H-280.952 CMS Interim Final Rule on the Use of Seclusion and Restraints

Our AMA uses the following principles in establishing policy regarding restraints and seclusion:
(1) the patient has the right to be free of restraints and seclusion unless medically necessary.
(2) the least restrictive means be considered first.
(3) the use of restraints and seclusion is a medical decision and should not be dictated by government agencies.
(4) when a physician is not physically present a properly trained and authorized health care professional may institute seclusion and restraints when this is clinically appropriate. In such cases the physician shall be contacted immediately. The patient must be examined by a physician within a period of time that meets an acceptable clinical standard. (Sub. Res. 101, I-99)

H-280.953 Physicians Visits Under Medicare Skilled Nursing Facility Prospective Payment System

Our AMA will: (1) work with the CMS and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to ensure that physician visits to nursing homes and skilled nursing facilities be based on the physician's determination of appropriate care for each patient; (2) work with CMS to ensure that its Medicare carriers implement these policies in a uniform way; and (3) advocate that physician assessments necessary to comply with both the prospective payment system (PPS) as well as JCAHO requirements be recognized and reimbursed. (Sub. Res. 807, A-99; Reaffirmation A-06)

H-280.954 Nursing Home Drug Therapy Surveyor Guidelines

Our AMA: (1) expresses its significant concerns to CMS about the inappropriate nature of the Drug Therapy Surveyor Guidelines; (2) adopts the policy that the continued interference in the practice of medicine by third party payers that compromises the appropriate care of patients is highly inappropriate and must cease; and (3) in collaboration with the Federation, work with CMS to ensure that any surveyor guidelines for medication use in long term care facilities are accurate and up-to-date with current medical practice. (Sub. Res. 806, A-99)

H-280.955 Surveys in Nursing Facilities

Our AMA will: (1) advocate that nursing home surveyors have at least one year of actual work experience in long term care;
(2) work with the CMS and state survey offices to instruct surveyors that pre-survey meetings with any nursing facility staff or family members are prejudicial and inappropriate;
(3) argue that both state and federal survey processes not interfere with the daily operations of a facility or any resident's medical care;
(4) support and encourage efforts directed toward more standardization and professionalism of the survey process with elimination of variability from region to region, state to state, and surveyor to surveyor; and
(5) urge the CMS to adopt a standardized Survey Policy and Procedure Manual for surveys in Nursing Facilities. (Res. 805, A-99)

H-280.956 Medicare Prospective Payment System for Skilled Nursing Facilities

Our AMA: (1) advocates for the prospective payment systems being developed by CMS for skilled nursing facilities and home health agencies accurately reflect the costs of care for patients with multiple comorbidities and high medical complexity; and (2) advocates that CMS, the Medicare Payment Advisory Commission, and the Congress monitor the effects of the home health interim payment system and the new prospective payment systems on quality of care and patient access to medically necessary services. (Sub. Res. 108, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-280.957 Continuity of Care in Nursing Homes

Our AMA: (1) establishes policy that as long as the physician complies with applicable state and federal laws and regulations, medical directors in nursing homes should be strongly discouraged from taking over the routine medical care of a physician’s patient without the request of the patient, the patient’s family, or the patient’s physician; and (2) encourages the American Medical Directors Association to incorporate this policy into its model nursing home medical practice agreement. (Sub. Res. 725, A-98; Reaffirmation A-07)

H-280.958 Pain Control in Long-Term Care

Our AMA will work: (1) to promulgate clinical practice guidelines for pain control in long term care settings and support educational efforts and research in pain management in long term care; and (2) to reduce regulatory barriers to adequate pain control at the federal and state levels for long term care patients. (Res. 715. A-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-280.959 Recycling of Nursing Home Drugs

Our AMA supports the return and reuse of medications to the dispensing pharmacy to reduce waste associated with unused medications in long-term care facilities (LTCFs) and to offer substantial savings to the health care system, provided the following conditions are satisfied: (1) The returned medications are not controlled substances. (2) The medications are dispensed in tamper-evident packaging and returned with packaging intact (e.g., unit dose, unused injectable vials and ampules). (3) In the professional judgment of the pharmacist, the medications meet all federal and state standards for product integrity. (4) Policies and procedures are followed for the appropriate storage and handling of medications at the LTCF and for the transfer, receipt, and security of medications returned to the dispensing pharmacy. (5) A system is in place to track re-stocking and reuse to allow medications to be recalled if required. (6) A mechanism (reasonable for both the payer and the dispensing LTC pharmacy) is in place for billing only the number of doses used or crediting the number of doses returned, regardless of payer source. (CSA Rep. 2, I-97; Reaffirmed: BOT Rep. 33, A-07; Modified and Reaffirmed: CSAPH Rep. 3, A-07)

H-280.961 Use of Restraints for Patients in Nursing Homes

Our AMA: (1) recommends further research to support or refute the findings that physical restraints in nursing homes tend to be more harmful than beneficial;

(2) supports the position that there must be compelling reasons to justify the use of restraints and urge CMS to expand the OBRA Requirements of Participation for Long-Term Care Nursing Facilities to include specific examples and definitions of what constitutes "medical necessity" for which restraint use is justified;

(3) encourages widespread dissemination of information and educational initiatives for the public as well as health care professionals on the risks and uncertain benefits of restraints;

(4) encourages physicians to communicate the consequences, risks, and potential benefits of restraint use with family members of residents who ask for restraints;

(5) encourage research to determine precisely when the use of restraints results in improved outcomes;

(6) encourages the long-term evaluation of effects of the restraint regulation on the health and well-being of nursing home residents; and

(7) continues to oppose the implementation of the CMS Interim Final Rule that requires face-to-face assessment of every patient within one-hour of the initiation of seclusion and restraint for behavior management. (CSA Rep. 4, A-97; Reaffirmation I-98; Appended: Sub. Res. 818, A-00)

H-280.962 Dehydration

Evaluation and Management in Older Adults: The policy of the AMA is that undergraduate, graduate and continuing education programs for physicians and allied health professionals be encouraged to teach the science of dehydration in older adults; and that assessment of hydration status and potential for dehydration be incorporated when appropriate in hospital discharge planning, home health agency and nursing home assessments. The AMA:
(1) encourages development of programs to increase physician awareness and skills in the evaluation of dehydration in long-term care residents and older adults living in the community setting;
(2) encourages a leadership role for physicians as active team participants in long-term care facilities regarding quality assurance programs assessing the hydration status of residents and recommend appropriate reimbursement for those services;
(3) encourages development of programs to increase awareness of the potential problem of dehydration in community residents;
(4) encourages community nursing facilities that do not provide daily clinical laboratory services to make them available for residents so that necessary data on patient status can be provided promptly, even on a STAT basis. The ready availability of laboratory services could present unnecessary hospitalizations; and
(5) encourages the expansion of research efforts in this area. (CSA Rep. 1, A-94; Reaffirmation A-04)

H-280.963 Drug Regimen Review in Long Term Care Settings

The AMA: (1) supports physician involvement in drug utilization review in long term care settings and encourages CMS to recognize that the evaluation and management services of the medical director (MD/DO) of the long term care facility can reduce drug expenditures, fraud and overutilization while assuring quality medical care; (2) encourages CMS to conduct well-designed research into medication uses in nursing facilities and the clinical outcomes of drug therapy; and (3) will work closely with the American Medical Directors Association and other appropriate organizations to improve outcomes of drug therapy in nursing homes and to encourage CMS to review the issue of appropriate professional resources needed to provide optimal prescription use in nursing facilities. (Res. 105, A-94; Reaffirmed and Appended by Res. 502, A-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-280.964 Medicare Certified Beds in Nursing Facilities

The AMA will work with CMS to eliminate any unnecessary requirements for designating by location Medicare Certified beds within a nursing facility, thus allowing each facility to flexibly apply the certified status to any appropriate bed within the facility. (Res. 104, A-94; Reaffirmed: CMS Rep. 5, A-04)

H-280.967 Nurse Practitioner Reimbursement in Nursing Facilities

Our AMA encourages state medical associations to carefully evaluate the relevant practice acts in their jurisdictions and to identify any modifications needed to allow the most effective use of nurse practitioners and physician assistants in improving care in nursing homes and long-term care facilities while assuring appropriate physician direction and supervision of such practitioners. (BOT Rep. H, A-93; Reaffirmed: Res. 240 and Reaffirmation A-00)

H-280.968 Do Not Hospitalize Orders

Our AMA (1) acknowledges that do-not-hospitalize orders in the nursing home situation, when based on the resident's (or his or her family's) informed consent, provide an appropriate means of promoting patient autonomy and carrying out the expressed level of treatment goals and wishes of the resident; and (2) strongly encourages physicians to familiarize themselves with do-not-hospitalize orders and supports all efforts to educate the public about such orders. (BOT Rep. NN, A-93; Reaffirmed: Sub. Res. 514, I-00)

H-280.969 Reducing Administrative Burdens of OBRA '87

Our AMA will continue to work with CMS and other appropriate federal agencies in an effort to simplify the requirements and to reduce the administrative burdens imposed on physicians, other health professionals and long-term care facilities in implementing the provisions of OBRA-87 related to nursing home reform, including the elimination of the unnecessary and expensive regulations mandated by the Preadmission Screening and Annual Record Review, and the simplification of the Minimum Data Set requirement for long-term care facilities. (Res. 231, A-93; CMS Rep. 3, A-94; Res. 821, A-93; CMS Rep. 11, I-95; Reaffirmed: CSA Rep. 3, I-98; Reaffirmation A-01)

H-280.974 Medically Necessary Nursing Facility Visits

Our AMA (1) defines a "medically necessary" visit to a Medicare/Medicaid resident in a nursing facility as any physician visit necessary to complete comprehensive nursing facility assessments and other assessments that are required as a condition of Medicare or state statute, as well as those visits that respond to a patient's development of a significant complication or a significant new problem which requires the creation of a new medical plan of care or visits that respond to the reported possibility of a change in patient condition;

(2) supports the concepts embodied in the CPT Evaluation and Management codes for Nursing Facility services, including the concept that counseling and/or coordination of care that are provided consistent with the patient and/or family's needs be recognized as medically appropriate and necessary;

(3) will monitor the use of the CPT codes for Nursing Facility Services and Medicare's determination of medical necessity to determine if revisions to the definitions of medical necessity are necessary;

(4) supports eliminating the Medicare established arbitrary visit frequency parameters (inclusive of multiple same day visits where quality of care and severity of condition necessitates such encounters);

(5) supports eliminating required documentation for obtaining such payments which place a significant burden on physician endeavors to provide quality care;

(6) urges carrier refrainment from references to bona fide multiple patient visits on the same day as "gang visits," which unjustly impugn the quality of medical care provided;

(7) supports establishment of a moratorium by CMS on any carrier collection of past "overpayments" for such multiple visits, and

(8) will use whatever means necessary to achieve these objectives. (Sub. Res. 805, A-92; Res. 148, A-91; CMS Rep. 11, I-95; Reaffirmed: CMS Rep. 7, A-05)

H-280.977 Direct Admission of Medicare Patients to Skilled Nursing Facilities

Our AMA supports regulatory change and any necessary legislation which would delete the 3-day prior hospitalization requirement for provision of skilled nursing facility benefits under Medicare, so as to allow coverage for direct admission of Medicare patients to a skilled nursing facility whether or not they have been discharged from an acute care hospital within the last 30 days. (Res. 33, A-91; Res. 48, I-81; Reaffirmed: CLRPD Rep. F, I-91; CMS Rep. 11, I-95; Reaffirmation A-97; Reaffirmation I-00; Reaffirmed: Res. 730, A-06)

H-280.979 Adequate Physician Reimbursement for Long-Term Care

Our AMA supports: (1) continuing discussion with CMS to improve Medicare reimbursement to physicians for primary care services, specifically including nursing home and home care medical services;
(2) continued efforts to work with the Federation to educate federal and state legislative bodies about the issues of quality from the perspective of attending physicians and medical directors and express AMA's commitment to quality care in the nursing home;
(3) efforts to work with legislative and administrative bodies to assure adequate payment for routine visits and visits for acute condition changes including the initial assessment and ongoing monitoring of care until the condition is resolved; and
(4) assisting attending physicians and medical directors in the development of quality assurance guidelines and methods appropriate to the nursing home setting. (Res. 110, I-88; Res. 94, A-89; Res. 152, A-91; CMS Rep. 11, I-95; Reaffirmed: Sunset Report, I-98; Reaffirmation A-02; Reaffirmation A-06)

H-280.984 LTC Facility Regulations

The AMA will (1) strive to see that enhanced quality of care results from regulations proposed for long-term care facilities; (2) attempt to ensure that appropriate and necessary physician involvement be maintained for patients in long-term care environments; (3) urge HHS to seek consultation and advice from the AMA in developing rules and regulations that affect medical care in the long-term care facility setting; (4) support cooperative efforts with appropriate groups for the purpose of developing mutually supported positions regarding medical care regulations in long-term care facilities; (5) support efforts to monitor federal and state legislation and regulations which affect physicians involved in long-term care, and to provide testimony and information about appropriate medical management of long-term care facility patients to regulatory and/or licensing bodies; and (6) support actions to establish better understanding and cooperation among federal health agencies as they formulate long-term care facility inspection regulations. (Res. 89, I-89; Sub. Res. 168, A-89; Sub. Res. 109, I-87; CMS Rep. 11, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06)

H-280.991 Policy Directions for the Financing of Long-Term Care

The AMA believes that programs to finance long-term care should: (1) assure access to needed services when personal resources are inadequate to finance care; (2) protect personal autonomy and responsibility in the selection of LTC service providers; (3) prevent impoverishment of the individual or family in the face of extended or catastrophic service costs; (4) cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual; (5) coordinate benefits across different LTC financing program; (6) provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the poverty level; (7) provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the poverty level; (8) encourage private sector LTC coverage through an asset protection program; equivalent to the amount of private LTC coverage purchased; (9) create tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and expenses; and (10) authorize a tax deduction or credit to encourage family care giving. Consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to: (a) provide an environment within their states that permit innovative LTC financing and delivery arrangements, and (b) assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high quality care. The AMA continues to evaluate and support additional health system reform legislative initiatives that could increase states' flexibility to design and implement long-term care delivery and financing programs. The AMA will also encourage and support the legislative and funding changes needed to enable more accurate and disaggregated collection and reporting of data on health care spending by type of service, so as to enable more informed decisions as to those social components of long-term care that should not be covered by public or private health care financing mechanisms. (BOT Rep. O, A-88; BOT Rep. X, I-88; Reaffirmed: CMS Rep. 3, A-94; BOT Rep. S, I-87; Reaffirmed: CMS Rep. 3-A-94; CMS Rep. 11, I-95; Reaffirmation A-04; Modified: CMS Rep. 6, I-05)

H-280.995 Medicare Coverage of "Skilled Nursing Care"

The AMA encourages CMS to (1) clarify the Medicare definitions of "skilled nursing care" and "custodial care"; (2) identify and implement appropriate measures to assure greater consistency in the administrative interpretation of rules governing coverage of nursing home care; and (3) better explain to beneficiaries the exclusion for custodial care services. (Res. 6, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: BOT Rep. 12, A-05)

H-280.998 Resident Medical Training in Nursing Homes for Geriatric Patients

Our AMA endorses the concept of affiliation between nursing home facilities for geriatric patients and resident training programs for the development of clinical experience in such facilities where feasible. (Sub. Res. 12, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-280.999 Physician Involvement in Long-Term Care

The AMA will emphasize in its communications to the medical profession, medical educators, and other professional groups concerned with long-term care the importance of increased physician understanding, supervision of, and involvement in care of the chronically ill and disabled of all ages in all care settings. The AMA believes that physicians have a central role in assuring that all residents of nursing facilities receive thorough assessments and that medical plans of care are instituted or revised to enhance or maintain the resident's physical and psychosocial functioning. The AMA endorses the following "Guidelines for Physicians Attending Patients in Long-Term Care Facilities":
(1) Each licensed physician admitting patients to the long-term care facility should observe its patient care policies, including those governing the provision of physician services, if they do not conflict with accepted and established methods of care. The final decision on admitting privileges to the facility rests with the governing body.
(2) Each physician seeking to admit a patient should obtain the administrator's consent.
(3) It is important that each physician admitting patients provide such information as may be necessary to assure the protection of other patients and the facility's administration from those patients who are or may become a source of danger.
(4) Each attending physician should designate an alternate physician or should advise his physician exchange of who may be called to see his patients for regular or emergency care when the attending physician is not available. In the event that neither the attending physician nor the designated alternate physician is available to examine and treat a patient requiring immediate attention, the medical director shall have the authority to call another physician for appropriate treatment or treat the patient himself.
(5) Prior to or upon admission of a patient, it would be desirable for the attending physician to perform a physical examination of his patient and provide the facility with an admitting diagnosis, statement of patient's functional status, and orders for diet, medication and initial treatment. Other patient information required by the facility may be provided at the time of admission or as soon as practical thereafter and should include a family history, past medical history, report of current medical findings, and a statement of rehabilitation potential and prognosis. The physician should also make arrangements for furnishing the facility with appropriate laboratory, x-ray, and consultation reports.

(6) Each attending physician is responsible for planning the medical care of his patient. Upon admission of his patient, the physician should make a medical evaluation of his patient's immediate and long-term care needs. This should include information about medications, treatments, rehabilitative services, diets, precautions related to activities undertaken by the patient, and plans for continuing care and, when appropriate, discharge. In developing this plan, it may be necessary for the attending physician to consult with the patient and/or the patient's family. The attending physician should review this plan at least annually and make revisions when appropriate. The plan may be reviewed by the medical director so that he may ensure consistency with the facility's policies.
(7) The facility should inform each attending physician of the availability of social, psychological and other non-medical aspects of care for his patient so that he may assure himself that such care is compatible with the medical condition of the patient.
(8) The attending physician should be aware of the need for the medical director, in fulfilling his required duties, to review the records of patients in the facility and, on occasion, actually contact the patient and/or family.
(9) It is desirable for the attending physician to consult with the medical director and/or administrator when, in the judgment of either, there is a question as to the appropriate placement or the advisability of transfer of any patient originally admitted by the attending physician.
(10) Where possible, the physician should reserve the right to seek consultation. As part of the treatment plan, this should be discussed with the patient. The facility's administrative personnel, medical director, and other involved personnel, should not independently request consultation without prior approval of the attending physician.
(11) The attending physician should visit his patient on a schedule determined by the patient's medical needs, and which is consistent with any state or federal regulations applicable, and this schedule should be documented in the patient's record. The attending physician may review his schedule of visits for each patient in conjunction with an annual reevaluation of the patient's health status.
(12) During each visit, the attending physician should see his patient, sign all written changes in orders and enter a progress note in the patient's record indicating that the patient has been visited. It should be the duty of the charge nurse to call the attention of the attending physician to orders requiring renewal. Except as specifically indicated below, treatment orders should not be permitted to expire without notification to the attending physician.
(13) The attending physician should give all orders for treatment in writing. An order may be considered in writing if it is dictated to a licensed nurse, signed and dated by the nurse, and countersigned by the physician at the time of his next visit to the facility or by other acceptable arrangements.
(14) The attending physician and the charge nurse should review the patient's medications and other treatment orders at time of visits. If there are no changes in the orders, the physician need only write that the orders be continued. However, this privilege of a simple note may be limited by facility policy.
(15) Patients should be discharged only on orders of the attending physician, except that in an emergency situation the medical director may order a transfer to a hospital. After discharge, the attending physician should furnish the necessary information on the transfer form, and should complete and sign the patient's records, as soon as practical. If the patient is to be transferred, the attending physician may, except in an emergency, furnish the necessary information on the transfer form.
(16) The attending physician should recognize that all orders for narcotics, sedatives and hypnotics, anticoagulants, and antibiotics will be automatically controlled by institution policy unless the order specifies the number of doses to be administered and the duration of time is specified.
(17) The attending physician should be aware that the pharmacist may review the drug regimen of each patient at least monthly and report his comments to the medical director and administrator. In those instances where the medical director and the pharmacist question the appropriateness of the drug regimen, the question should be brought to the attention of the attending physician.
(18) It would be desirable for each attending physician to prepare and maintain a complete medical record for each patient.
(19) It would be desirable for each attending physician to participate in developing and maintaining an appropriate quality assurance program for the facility. Such participation may extend to medical care evaluation studies and periodic assessments and evaluation of patient care.
(20) The attending physician should recognize that all records are the property of the facility and may not be removed without permission. In case of readmission of a patient, all previous records should be available for the use of the attending physician. This should apply whether the patient is attended by the same or by another physician.
(21) The attending physician should have free access to all medical records of all patients in the facility for bona fide study and research, consistent with preserving the confidentiality of information concerning individual patients and physicians. Physicians formerly having patients in the facility should be permitted free access to information from the medical records of their patients covering all periods during which the physician attended such patients.
(22) The attending physician may attend an annual meeting, if appropriate, at which the medical director, the administrator and the committees functioning in the facility shall make appropriate reports. Each attending physician should have the opportunity to make recommendations concerning the facility's staff, services and resources. (CMS Rep. H, I-77; Reaffirmed: CLRPD Rep. C, A-89; CMS Rep. 3, A-94; Sub. Res. 805, A-92; CMS Rep. 11, I-95; Reaffirmed: CMS Rep. 7, A-05)

H-285.000 Managed Care
(See also: Health Care Costs; Health Care Delivery; Health Care Reform; Health Insurance; Health Maintenance Organizations; Medical Review; Preferred Provider Arrangements)

H-285.913 Medicare Advantage Policies

Our AMA will:

1. pursue legislation requiring that any Medicare Advantage policy sold to a Medicare patient must include a seven-day waiting period that allows for cancellation without penalty;

2. pursue legislation to require that Medicare Advantage policies carry a separate distinct page, which the patient must sign, including the statement, "THIS COVERAGE IS NOT TRADITIONAL MEDICARE. YOU HAVE CHOSEN TO CANCEL YOUR TRADITIONAL MEDICARE COVERAGE; NOT ALL PHYSICIANS, HOSPITALS AND LABORATORIES ACCEPT THIS NEW MEDICARE ADVANTAGE POLICY AND YOU MAY PERMANENTLY LOSE THE ABILITY TO PURCHASE MEDIGAP SECONDARY INSURANCE" (or equivalent statement) and specifying the time period before they can resume their traditional Medicare coverage; and

3. petition the Centers for Medicare and Medicaid Services to implement the patient's signature page in a Medicare Advantage policy. (Res. 907, I-07; Reaffirmation A-08)

H-285.914 Patient Access to Specialty Care in Managed Care Systems

Our AMA: (1) will take all appropriate action to require all health plans or sponsors of such plans that restrict a patient's choice of physicians, hospitals, or surgical pathology and cytopathology services, to offer, at the time of enrollment and at least for a continuous one-month period annually thereafter, an optional and affordable "point-of-service-type" feature so that patients who choose such plans may elect to self-refer to physicians, hospitals, or surgical pathology and cytopathology services outside of the plan at additional cost to themselves;

(2) urges managed care plans to provide patients, on an ongoing basis, with the right to select a new primary physician from the panel of physicians contracting with that managed care plan, and appeal to the plan when the patient is dissatisfied with his/her present primary physician;

(3) encourages medical specialty societies, through the Specialty and Service Society, the Practice Parameters Partnership, and other appropriate channels, to conduct further research to define the circumstances better when patient self-referrals to specialists of their choice are appropriate and cost-effective;

(4) opposes any governmental incentives or mandates that would favor managed care, the gatekeeper concept, and restrictions upon patient self-referral in the absence of any research to demonstrate conclusively the cost-effectiveness of such a system;

(5) will study the impact on access to specialty care if the government mandates the use of "gatekeepers" in health system reform, and the AMA will take appropriate action based on the results of its study; and

(6) encourages all components of organized medicine to minimize the use of the term "gatekeeper" when making any reference to primary care physicians or to their role. (CMS Rep. I-93-5; CMS Rep. 5, A-95; Reaffirmed by CMS Rep. 5, I-95; Reaffirmed by Ref. Cmt. G, A-96; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 706, I-96; Amended by Res. 707, I-96; Reaffirmed and Amended by Sub. Res. 701, A-98; Reaffirmation I-98; Amended: Res. 709, A-99; Reaffirmation A-00; Renumbered: CMS Rep. 7, I-05)

H-285.915 AMA Policy on ERISA

Our AMA will seek, through amendment of the ERISA statute, through enactment of separate federal patient protection legislation, through enactment of similar state patient protection legislation that is uniform across states, and through targeted elimination of the ERISA preemption of self-insured health benefits plans from state regulation, to require that such self-insured plans: (1) Ensure that plan enrollees have access to all needed health care services;

(2) Clearly disclose to present and prospective enrollees any provisions restricting patient access to or choice of physicians, or imposing financial incentives concerning the provision of services on such physicians;

(3) Be regulated in regard to plan policies and practices regarding utilization management, claims submission and review, and appeals and grievance procedures;

(4) Conduct scientifically based and physician-directed quality assurance programs;

(5) Be legally accountable for harm to patients resulting from negligent utilization management policies or patient treatment decisions through all available means, including proportionate or comparative liability, depending on state liability rules;

(6) Participate proportionately in state high-risk insurance pools that are financed through participation by carriers in that jurisdiction;

(7) Be prohibited from indemnifying beneficiaries against actions brought by physicians or other providers to recover charges in excess of the amounts allowed by the plan, in the absence of any provider contractual agreement to accept those amounts as full payment;

(8) Inform beneficiaries of any discounted payment arrangements secured by the plan, and base beneficiary coinsurance and deductibles on these discounted amounts when providers have agreed to accept these discounted amounts as full payment;

(9) Be subject to breach of contract actions by providers against their administrators; and

(10) Adopt coordination of benefits provisions applying to enrollees covered under two or more plans. (CMS Rep. 6, I-96; Reaffirmation A-97; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed by Sub. Res. 202, A-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmed: Res. 238, A-00; Renumbered: CMS Rep. 7, I-05)

H-285.916 Accuracy in Managed Care Organizations' Physician Listings

Our AMA: (1) policy is that a managed care company should be required to accurately list participating physicians and to include a physician's subspecialty interest, office location(s), and any practice restrictions that the physician may specify; and (2) encourages state attorneys general to prosecute managed care organizations that practice deceptive actions regarding physician listings. (Res. 727, A-05; Reaffirmation A-07)

H-285.917 Stop Trial by Health Insurers

1. Our AMA opposes (a) any health insurer's efforts to make determinations regarding whether or not a physician has made a medical mistake; and (b) the practice of health plans using adverse event reporting data for purposes other than quality improvement and learning, as it could shift the focus of such reporting from improving patient safety to fostering a punitive environment.

2. Our AMA will (a) inform all health insurance companies that they are not the appropriate entity for determining medical mistakes; and (b) encourage physicians to be aware of contractual provisions that would allow insurers to deny payment in the event of a medical mistake. (Res. 804, I-04)

H-285.918 Mandatory Subspecialty Consultation

Our AMA: (1) opposes the unilateral actions of hospitals and health care organizations to mandate specialty consultation for a patient with a specific disease state, when the mandate specifically denies the physician providing care the ability to determine medical necessity of the consultation and/or the consultation is not requested by the patient, and (2) discourages physicians from requesting hospital medical staff oversight committees, health plans and managed care organizations to mandate specialty consultations when the physician or physician group would gain financially from the mandatory consultation due to increased revenues from consultation billing, unless the consultation is required by law or regulation. (Res. 538, A-04)

H-285.919 Medical Care "Carve-Outs"

It is the policy of the AMA that the term "carve-out" be defined as follows: A financial arrangement for the provision and/or management of a clinically defined subset of a health plan's benefits, which is separate from the financial arrangement for the provision and/or management of most or all of the plans' other health benefits. (CMS Rep. 7, A-02)

H-285.920 Criteria for Level of Care Status

(1) Our AMA support the development and use of level of care guidelines that meet the following criteria: (a) Level of care guidelines should function as guidelines only, and should not be used as requirements for all instances and cases. That is, level of care guidelines must allow for appropriate physician autonomy in making responsible medical decisions;
(b) Level of care guidelines should acknowledge the complexity of care for each patient under the particular set of clinical circumstances;
(c) Level of care guidelines should apply to all facility support systems so that patients are not assigned a level of care that slows or stalls their treatment;
(d) Level of care guidelines should be developed under the direction of actively practicing physicians;
(e) Level of care guidelines should be developed based on individual patient severity of illness and intensity of service;
(f) Level of care guidelines should be validated through standard data quality control checks and professional advisory consensus;
(g) Level of care guidelines should be reviewed and updated; and
(h) Level of care guidelines should allow for a timely appeal process.

(2) It is the policy of the AMA that private sector accrediting organizations, where applicable, should adopt standards that are consistent with AMA criteria for the development and use of level of care status guidelines. (CMS Rep. 5, I-01)

H-285.921 Managed Behavioral Health Organizations (MBHOs)

It is the policy of our AMA that, when requested, Managed Behavioral Health Organizations (MBHOs) should share their written disease management protocols with primary care and other treating physicians. .When a patient is receiving treatment for mental illness and/or chemical dependency through an MBHO, with the patient's permission and in accordance with relevant legal requirements, the primary care physician should be notified immediately; and, if requested, be kept apprised of the patient's treatment (including all medications prescribed) and progress, so that the primary care and other treating physicians can coordinate the patient's health care needs in optimal fashion. (Res. 702, I-01)

H-285.922 Anti-"Carve-Out"

Our AMA opposes carve-outs when used as a tool to deny necessary and appropriate care, reduce the likelihood that care will be sought, to intimidate patients or referring physicians from initiating needed referrals, or to create additional burdens to either patients or physicians. (Sub. Res. 709, A-01; Reaffirmed: CMS 7, A-02)

H-285.923 Elimination of Mental Health and Chemical Dependency Carve-Outs

Our AMA opposes and will work to eliminate mental health and chemical dependency carve-outs. (Sub. Res. 702, I-00; Reaffirmed: CMS 7, A-02)

H-285.924 Managed Care Contract Deadline

It is the policy of our AMA that health plans: (1) should not include the name of a physician in their marketing materials and directory of participating physicians without the prior written consent of that physician;
(2) must promptly remove the physician's name from marketing materials and directory of participating physicians upon termination of that physician's contract with the plan;
(3) should provide patients with their current directory of participating physicians through multiple media, including, but not limited to, the Internet; and
(4) should continue to cover services provided by physicians who involuntarily leave a plan, for reasons other than loss of/restrictions on their medical license/certification or fraud, until a new printed directory is distributed. (Sub. Res. 703, I-00; Modified: CMS Rep. 8, A-02; Reaffirmation A-07)

H-285.925 Mental Health "Carve-Outs"

It is the policy of the AMA that: (1) mental health carve-out programs should adequately provide for the appropriate diagnosis, evaluation, and treatment of medical comorbidities; and (2) where a cap on the number of mental health visits is imposed by a health plan, re-certification for additional visits should be granted upon request by the treating psychiatrist, or other health care professional, without additional personal information from the patient. (CMS Rep. 6, I-00)

H-285.926 Clinical and Professional Impacts of Cost Containment Efforts

Our AMA encourages the Agency for Healthcare Research and Quality to study the effects of cost containment activities on clinical outcomes and patient safety. (Res. 714, I-99)

H-285.927 Denied and Down-Coded Days

Our AMA: (1) seeks legislation to eliminate the utilization of retrospectively denied (so-called "carve-out days") and down-coded days by managed care organizations, and will disseminate information regarding this practice to physicians and their respective hospitals across the country in order to warn them and to help them fight the existence of denied and down-coded days which can be deleterious to patients' care; and (2) alerts state medical societies to the problem of rampant and random utilization of retrospectively denied days by managed care organizations, and urges state medical societies to alert their respective attorneys-general and state insurance commissioners. (Res. 716, I-99)

H-285.928 Health Plan and Fiscal Intermediary Insolvency Protection Measures

(1) It is the policy of the AMA that health plans should be legally responsible to pay directly for physician services in the event of an insolvency of fiscal intermediaries like groups, independent practice associations, and physician practice management companies. (2) Our AMA continues to advocate at the state level for protective measures for patients and physicians who are adversely affected by health insurers and their fiscal intermediaries that declare insolvency, to include: (a) actuarially sound capitation rates and administrative costs; (b) submission of timely financial information by health plans to independent practice associations and medical groups; and (c) the establishment of financial and monetary standards for health plans, as well as for independent practice

associations, and groups that assume financial risk unrelated to direct provision of patient care. (Res. 717, I-99; Reaffirmed: Res. 711, A-03)

H-285.929 Patient Notification of Physician Contract Termination

Our AMA encourages medical groups and other corporate entities, such as physician practice management corporations and limited liability corporations, to include in the contract language governing notification of patients regarding termination of a physician's contract, wording which is in compliance with Council on Ethical and Judicial Affairs Opinion 7.03 and/or model language developed by state medical societies. (Res. 707, I-99)

H-285.930 Pharmacy Benefit Risk-Sharing by Physicians

Our AMA: (1) opposes the imposition of mandatory pharmacy benefit risk-sharing on physicians and physician groups by health plans and other third party payers; and (2) urges physicians and physician groups to seek actuarial, contracting, and legal advice prior to entering into any voluntary agreement to accept or share pharmacy risk. (CMS Rep. 12, I-99)

H-285.931 The Critical Role of Physicians in Health Plans and Integrated Delivery Systems

Our AMA adopts the following organizational principles for physician involvement in health plans and integrated delivery systems (IDS):

(1) Practicing physicians participating in a health plan/IDS must:
(a) be involved in the selection and removal of their leaders who are involved in governance or who serve on a council of advisors to the governing body or management;
(b) be involved in the development of credentialing criteria, utilization management criteria, clinical practice guidelines, medical review criteria, and continuous quality improvement, and their leaders must be involved in the approval of these processes;
(c)be accountable to their peers for professional decisions based on accepted standards of care and evidence-based medicine;
(d) be involved in development of criteria used by the health plan in determining medical necessity and coverage decisions; and
(e) have access to a due process system.
(2) Representatives of the practicing physicians in a health plan/IDS must be the decision-makers in the credentialing and recredentialing process.
(3) To maximize the opportunity for clinical integration and improvement in patient care, all of the specialties participating in a clinical process must be involved in the development of clinical practice guidelines and disease management protocols.
(4) A health plan/IDS has the right to make coverage decisions, but practicing physicians participating in the health plan/IDS must be able to discuss treatment alternatives with their patients to enable them to make informed decisions.
(5) Practicing physicians and patients of a health plan/IDS should have access to a timely, expeditious internal appeals process. Physicians serving on an appeals panel should be practicing participants of the health plan/IDS, and they must have experience in the care under dispute. If the internal appeal is denied, a plan member should be able to appeal the medical necessity determination or coverage decision to an independent review organization.
(6) The quality assessment process and peer review protections must extend to all sites of care, e.g., hospital, office, long-term care and home health care.
(7) Representatives of the practicing physicians of a health plan/IDS must be involved in the design of the data collection systems and interpretation of the data so produced, to ensure that the information will be beneficial to physicians in their daily practice. All practicing physicians should receive appropriate, periodic, and comparative performance and utilization data.
(8) To maximize the opportunity for improvement, practicing physicians who are involved in continuous quality improvement activities must have access to skilled resource people and information management systems that provide information on clinical performance, patient satisfaction, and health status. There must be physician/manager teams to identify, improve and document cost/quality relationships that demonstrate value.
(9) Physician representatives/leaders must communicate key policies and procedures to the practicing physicians who participate in the health plan/IDS. Participating physicians must have an identified process to access their physician representative.
(10) Consideration should be given to compensating physician leaders/representatives involved in governance and management for their time away from practice.

Our AMA aggressively advocates to private health care accreditation organizations the incorporation of the organizational principles for physician involvement into their standards for health plans, networks and integrated delivery systems. (Res. 706, I-98; Reaffirmation A-99; Reaffirmation A-07)

H-285.933 Financial Liability Encountered in Referrals for Alternative Care

The AMA supports legislation that managed care organizations that offer alternative medicine as a covered service not require referral by the primary care physician for that service, and that the primary care physician not be held at risk financially for the costs of those provided alternative medical services. (Res. 702, A-98; Reaffirmed: BOT Rep. 36, A-02)

H-285.934 Physician Recredentialing by Managed Care Plans

That the AMA adopt the following policy statements concerning recredentialing by managed care plans: (1) Recredentialing of a physician or physician group by a managed care plan should not be triggered by a change of practice location within the plan's contractually defined service area, by a change in practice by a currently credentialed physician to a different group that is also currently credentialed, or to solo practice, or by a change in staff size of the physician group. Any significant resulting change in the number, type, quality or costs of services provided in the practice should be addressed first through physician-directed quality assurance and utilization management mechanisms established in the plan. (2) Recredentialing of a physician or physician group by a managed care plan should not be required when two or more such plans merge. (3) Recredentialing or reconsideration of plan participation for a physician or physician group may legitimately be precipitated by a relocation of the practice outside of the plan's service area. (CMS Rep. 8, A-98; Reaffirmed: CMS Rep. 4, A-08)

H-285.935 Patient Rights During Health Plan Sales

The AMA advocates that when a "sale of covered lives" takes place due to the sale or merging of health plans, that the health plan emerging from such transactions be required to abide by the original health plan contract with the patient, especially those contract provisions that address health benefits coverage and access to physicians. (Sub. Res. 701, A-98; Reaffirmed: CMS Rep. 4, A-08)

H-285.937 Surgical Pathology in Managed Care

Our AMA will develop model legislative and regulatory language for states to insure that managed care plans: (1) which require surgical pathology specimens to be sent to specified laboratories, provide a list of qualified surgical pathologists and surgical pathology subspecialists associated with those laboratories to whom physicians may refer surgical pathology specimens or slides for consultation; and (2) allow clinicians in the plans access to qualified surgical pathologists and surgical pathology subspecialists for covered pathology services, when the plans do not have contracts with a specific laboratory or laboratories for such services or when the plan's contracted laboratory or laboratories cannot provide the appropriate surgical pathology services. (Res. 716, A-98; Reaffirmation A-99)

H-285.938 AMA Establishment of a Nationwide Federation of Physician Networks

Our AMA will: (1) disseminate general information to national medical specialty societies, state medical associations, county medical societies, and interested physician members regarding opportunities for physicians to form networks to directly contract with self-funded employers; (2) act as a clearinghouse for information and expertise directed at providing assistance in the development of local and regional physician networks; and (3) serve as a facilitator and convener of meetings among existing physician networks interested in pursuing interstate and/or national contracts with self-funded employers. (CMS Rep. 13, A-98; Modified and Reaffirmed: CMS Rep. 4, A-08)

H-285.939 Managed Care Medical Director Liability

AMA policy is that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine. (1) Our AMA seeks to include in federal and state patient protection legislation a provision subjecting medical directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions; (2) that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services; and (3) that our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability. (Sub. Res. 202, A-98; Appended: Res. 201, I-98; Reaffirmation A-99; Reaffirmed: BOT Rep. 18, I-00; Reaffirmation A-07)

H-285.940 Denials of Payment for Necessary Services Because of Lack of Authorization

Our AMA seeks the elimination of clauses in managed care contracts that allow plans to refuse to pay for provision of covered services for the sole reason that required notification of these services was not reported in a timely manner. (Sub. Res. 722, I-97; Reaffirmation A-02)

H-285.941 Managed Care Consensus Bill

The AMA continues to support the enactment of comprehensive legislation that addresses the wide range of patient protection and physician fairness issues, such as disclosure of health plan information to enrollees and prospective enrollees, utilization review and grievance procedures, due process in physician selective contracting decisions, and physician involvement in health plan medical policies. (Sub. Res. 716, I-97; Reaffirmation A-99; Reaffirmation A-06)

H-285.943 Payment for Managed Care Administrative Services

Our AMA: (1) opposes managed care contract provisions that prohibit physician payment for the provision of administrative services; (2) encourages physicians entering into: (a) capitated arrangements with managed care plans to seek the inclusion of a separate capitation rate (per member per month payment) for the provision of administrative services, and (b) fee-for-service arrangements with managed care plans to seek a separate case management fee or higher level of payment to account for the provision of administrative services; and (3) supports the concept of a time-based charge for administrative duties (such as phone precertification, utilization review activities, formulary review, etc.), to be assessed to the various insurers. (CMS Rep. 13, I-97; Appended: Res. 806, I-99; Reaffirmation A-04; Reaffirmation I-08)

H-285.944 Disease Management and Demand Management

The AMA strongly encourages health insurance plans and managed care organizations that provide disease management to involve the patient's current primary or principal care physician in the disease management process as much as possible, and to minimize arrangements that may impair the continuity of a patient's care across different settings. The AMA supports the development of disease management systems and demand management through telephone triage programs that adhere to the following principles, and encourages any public or private entities that evaluate such programs for purposes of certification or accreditation to utilize these principles in conducting their evaluation:

Disease Management and Demand Management
(1) The primary goals of both disease management and demand management should be as follows: (a) to improve outcomes by the provision of timely and appropriate preventive, therapeutic and restorative services. Cost savings and care efficiencies resulting from such services are a secondary but legitimate objective. (b) To promote cooperation between primary care and specialty care physicians to provide a continuum of care for specific health care needs.
(2) Both disease management and demand management should continue to place major emphasis on educating and empowering patients to more successfully manage their own health and intelligently use care resources.
(3) Both the clinical practice guidelines utilized in disease management and the referral algorithms or protocols used in telephone triage should be developed by physicians knowledgeable in dealing with the conditions addressed, and should be updated regularly.

Disease Management
(4) The decision to participate or not participate in a disease management program should always be the prerogative of the patient, who should be fully informed of any plan coverage conditions attendant on such decisions.
(5) Physicians should be able to deviate from disease management practice guidelines without incurring sanctions or jeopardizing coverage for services, when in their judgment such deviation is indicated by the medical needs or desires of individual patients.
(6) Attention to the performance of physicians in disease management programs should be triggered by concern with a physician's overall practice patterns rather than by deviation from practice guidelines in a single case. Emphasis in remedial activities should be on helping the practitioner to correct any overall performance problems identified by peer review, rather than on sanctions.
(7) Non-physicians who function as care coordinators in disease management programs should be certified or licensed as physician assistants or nurse practitioners, or have at least a comparable level of training.
(8) The overall authority for decisions to use or not use specialized care and ancillary or supportive services or products for patients enrolled in a disease management program should rest with the primary or principal care physician providing care in the program.
(9) The primary or principal care physician in a disease management program should strive to assure effective collaboration among the different programs and personnel needed for care of patients with comorbidities, and should be routinely informed by such personnel of the services they provide.
(10) Physicians who provide care in disease management programs should be fully licensed to practice medicine in the jurisdiction of the program's location, and should be professionally and legally accountable for any adverse patient events resulting from that care.
(11) In disease management programs conducted by drug manufacturers, the choice of pharmaceuticals used in program formularies and for care of individual patients should not be restricted to those of the sponsoring manufacturer, but should be based on the clinical judgment of participating physicians and validated outcome studies.

Demand Management Through Telephone Triage
(12) Payment for emergency or other covered services by a health plan should not be conditioned on prior use of the plan's telephone triage center by an enrollee seeking such services, or on adherence by the enrollee to triage center recommendations. Enrollees eligible to use or accessing the triage center should be informed of this policy, and of their right to have immediate access to a physician if desired.
(13) Telephone counseling and triage centers should routinely compile outcome information on all calls handled, and should modify their operating policies and referral protocols as needed to enhance the effectiveness of the service.
(14) Telephone triage centers should routinely inform primary or principal care physicians of the disposition of all calls received from their patients.
(15) Telephone counseling and triage should be performed by health professionals with a level of knowledge and training no less than that of a registered nurse.
(16) Qualified physicians should be readily accessible for consultation and second-level triage to the nurses or other health professionals providing telephone counseling or triage.
(17) Physicians performing second level triage for telephone triage centers should be compensated for such services by the center or

sponsoring health plan.
(18) Compensation for individuals performing telephone counseling and triage should not be based on the number or the disposition of calls handled.
(19) Organizations that provide telephone triage services should provide such services 24 hours a day on a year-round basis and calls should be handled as expeditiously as possible. (CMS Rep. 3, I-97; Reaffirmed by Sub. Res. 707, A-98; Reaffirmation A-99; Reaffirmed: CSA Rep. 11, A-04)

H-285.945 Establishment of Liability of Managed Care Organizations

Our AMA supports changes in federal law to prohibit the exemption from liability of managed care organizations, including ERISA plans, for damages resulting from their policies, procedures, or administrative actions taken in relation to patient care. (Sub. Res. 220, I-97; Reaffirmation A-99; Reaffirmed: BOT Rep. 18, I-00)

H-285.946 Fair Physician Contracts

Our AMA will develop national (state) standards and model legislation for fair managed care/physician contracts, thereby requiring full disclosure in plain English of important information, including but not limited to: (1) disclosure of reimbursement amounts, conversion factors for the RBRVS system or other formulas if applicable, global follow-up times, multiple procedure reimbursement policies, and all other payment policies;

(2) which proprietary "correct coding" CPT bundling program is employed;

(3) grievance and appeal mechanisms;

(4) conditions under which a contract can be terminated by a physician or health plan;

(5) patient confidentiality protections;

(6) policies on patient referrals and physician use of consultants;

(7) a current listing by name and specialty of the physicians participating in the plan; and

(8) a current listing by name of the ancillary service providers participating in the plan. (Res. 727, A-97; Amended by CMS Rep. 3, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-08)

H-285.947 Retroactive Assignment of Patients by Managed Care Entities

(1) Our AMA opposes the practice of "retroactive or late assignment" of patients by managed care entities, noting that "retroactive or last assignment" includes: (a) the practice of failing to require enrollees in a capitated plan to select a responsible physician(s) at the time of enrollment; (b) the practice of failing to inform the responsible physician(s) of the enrollment of the patient and the assignment of responsibility until the patient has sought care; and (c) the practice of failing to pay the responsible physician the capitated rate until after the patient has sought care. (2) Our AMA will develop and disseminate model legislation that would eliminate "retroactive or late assignment" by requiring capitated plans to require enrollees to select a responsible physician at the time of enrollment, and requiring capitated plans to pay the responsible physician the monthly capitated rate from the date of patient enrollment in the plan. (Sub. Res. 719, A-97; Reaffirmation I-01)

H-285.950 Managed Care Organizations' Use of Physicians to Provide Second Opinions to Physicians Providing Emergency Services

The AMA adopts the following principles to guide the use by managed care plans of physicians employed or contracted with to specifically provide second opinions to physicians providing emergency services. The AMA encourages managed care plans to follow these guidelines when employing or contracting with physicians to provide second opinions to physicians providing emergency services.

(1) All managed care plans shall disclose to their enrollees and prospective enrollees any plan requirements or the existence of contractual arrangements whereby physicians are required to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities.

(2) The required use of physicians to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall not impede the immediate diagnosis and therapy of acute cardiac, trauma, and other critical patient situations for which delay may result in death or an increase in severity of illness.

(3) Any physician with a contractual arrangement to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall be licensed to practice medicine and actively practicing emergency medicine in the same state in which the second opinion is provided.

(4) Any physician with a contractual arrangement to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall have active staff privileges in any facility in which the second opinion is provided.

(5) To the degree possible, patients presenting at an emergency department or facility should be involved in the decisions regarding the treatment, referral, and follow-up care for their condition.

(6) In the event of disagreements over second opinions, final decisions regarding the treatment, referral, and follow-up care provided to patients presenting at emergency departments or facilities shall be made by the attending emergency physician or other appropriate physicians on staff at the facility. (CMS Rep. 1, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-285.951 Financial Incentives Utilized in the Management of Medical Care

Our AMA believes that the use of financial incentives in the management of medical care should be guided by the following principles:
(1) Patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
(2) Physicians should have the right to enter into whatever contractual arrangements with health care systems, plans, groups or hospital departments they deem desirable and necessary, but they should be aware of the potential for some types of systems, plans, group and hospital departments to create conflicts of interest, due to the use of financial incentives in the management of medical care.
(3) Financial incentives should enhance the provision of high quality, cost-effective medical care.
(4) Financial incentives should not result in the withholding of appropriate medical services or in the denial of patient access to such services.
(5) Any financial incentives that may induce a limitation of the medical services offered to patients, as well as treatment or referral options, should be fully disclosed by health plans to enrollees and prospective enrollees, and by health care groups, systems or closed hospital departments to patients and prospective patients.
(6) Physicians should disclose any financial incentives that may induce a limitation of the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options. Physicians may satisfy their disclosure obligations by assuring that the health plans with which they contract provide such disclosure to enrollees and prospective enrollees. Physicians may also satisfy their disclosure obligations by assuring that the health care group, system or hospital department with which they are affiliated provide such disclosure to patients seeking treatment.
(7) Financial incentives should not be based on the performance of physicians over short periods of time, nor should they be linked with individual treatment decisions over periods of time insufficient to identify patterns of care.
(8) Financial incentives generally should be based on the performance of groups of physicians rather than individual physicians. However, within a physician group, individual physician financial incentives may be related to quality of care, productivity, utilization of services, and overall performance of the physician group.
(9) The appropriateness and structure of a specific financial incentive should take into account a variety of factors such as the use and level of "stop-loss" insurance, and the adequacy of the base payments (not at-risk payments) to physicians and physician groups. The purpose of assessing the appropriateness of financial incentives is to avoid placing a physician or physician group at excessive risk which may induce the rationing of care.
(10) Physicians should consult with legal counsel prior to agreeing to any health plan contract or agreeing to join a group, delivery system or hospital department that uses financial incentives in a manner that could inappropriately influence their clinical judgment.
(11) Physicians agreeing to health plan contracts that contain financial incentives should seek the inclusion of provisions allowing for an independent annual audit to assure that the distribution of incentive payments is in keeping with the terms of the contract.
(12) Physicians should consider obtaining their own accountants when financial incentives are included in health plan contracts, to assure proper auditing and distribution of incentive payments.
(13) Physicians, other health care professionals, third party payers and health care delivery settings through their payment policies, should continue to encourage use of the most cost-effective care setting in which medical services can be provided safely with no detriment to quality. (CMS Rep. 3, I-96; Reaffirmed by CMS Rep. 15, A-98; Reaffirmation A-99; Reaffirmed: CMS Rep. 12, I-99; Reaffirmation A-00; Reaffirmation A-01; Reaffirmed in lieu of Res. 901, I-05; Modified: BOT Rep. 38, A-06)

H-285.952 Amendments to Managed Care Contracts

It is policy of the AMA that: (1) participating physicians be allowed a minimum of 60 days to review amendments to managed care contracts;

(2) patients should have the opportunity for continued transitional care from physicians and hospitals whose contracts with health plans have terminated for reasons other than loss of/restrictions on their license/certification or fraud. Patients eligible for transitional

care should specifically include, but not be limited to those who are: undergoing a course of treatment for a serious or complex condition, undergoing a course of institutional or inpatient care, undergoing non-elective surgery, pregnant, or are terminally ill at the time that they receive notice of the termination. Transitional care should be provided at the physicians' and hospitals' discretion, and should continue for an appropriate length of time. Physicians and hospitals also should continue to receive payment for the services provided during this transitional period.

(3) when a participating physician leaves a managed care plan, patients of the physician be informed, in a timely manner, of the departure by the physician and/or the managed care plan, and, if applicable, of their right to elect continued transitional care from that physician;

(4) when a participating physician voluntarily leaves a managed care plan, patients of the physician be informed of the departure by the physician and/or the managed care plan;

(5) the AMA opposes managed care plan mandating that physician to notify all his/her patients;

(6) the AMA opposes the preapproval of physician-developed notification letters by managed care plans required if a participating physician who is voluntarily leaving the plan chooses to inform his/her patient of the departure; and

(7) managed care contracts not hold participating physicians financially liable for medical services delivered to a patient who electively chooses or mistakenly receives medical services from a "non-plan" physician. (Sub. Res. 708, I-96; Appended and Modified: CMS Rep. 8, A-02)

H-285.953 Managed Care Organizations - Credentialing

Policy of the AMA states that hospital medical staff privileges not be required for physician participation in managed care contract panels, that managed care entities should have an effective, physician directed peer review mechanism to fairly evaluate their participating physician. The AMA urges physicians without hospital privileges to ensure that appropriate coverage arrangements are made for the hospital care of their patients. (Sub. Res. 701, I-96; Reaffirmed and Appended by Sub. Res. 717, A-98; Reaffirmed: CMS Rep. 4, A-08)

H-285.954 Physician Decision-Making in Health Care Systems

AMA policy states: (1) That certain professional decisions critical to high quality patient care should always be the ultimate responsibility of the physician regardless of the practice setting, whether it be a health care plan, group practice, integrated or non-integrated delivery system or hospital closed department, whether in primary care or another specialty, either unilaterally or with consultation from the plan, group, delivery system or hospital. Such decisions include, but are not limited to, the following: (a) What diagnostic tests are appropriate. (b) When and to whom physician referral is indicated. (c) When and with whom consultation is indicated. (d) When non-emergency hospitalization is indicated. (e) When hospitalization from the emergency department is indicated. (f) Choice of service sites for specific services (office, outpatient department, home care, etc.). (g) Hospital length of stay. (h) Frequency/length of office/outpatient visits or care. (i) Use of out-of formulary medications. (j) When and what surgery is indicated. (k) When termination of extraordinary/heroic care is indicated. (l) Recommendations to patients for other treatment options, including non-covered care. (m) Scheduling on-call coverage. (n) Terminating a patient-physician relationship. (o) Whether to work with, and what responsibilities should be delegated to, a mid-level practitioner. (p) Determination of the most appropriate treatment methodology. (2) The AMA encourages state medical associations to consider development and wide dissemination of guidelines for the extent of practicing physician involvement in plan, group, system or hospital department medical decisions and policies. Such guidelines should be relevant to their jurisdiction, allow for variation in plan, group, system or hospital department sponsorship and structure, and optimize patient care. (3) The AMA encourages organizations and entities that accredit or develop and apply performance measures for health plans, groups, systems or hospital departments to consider inclusion of plan, group, system or hospital department compliance with any applicable state medical association or medical staff-developed decision-making guidelines in their evaluation criteria. (4) The AMA encourages physicians in integrated health plans and systems to have a functioning medical staff structure in place. (CMS Rep. 5, I-96; Amended by CMS Rep. 12, A-97; Reaffirmation A-97; Reaffirmed by CMS Rep. 3, A-98; Reaffirmation A-99; Reaffirmed: Res. 538, A-04; Modified: BOT Rep. 38, A-06)

H-285.956 Mental Health "Carve-Outs"

Our AMA is opposed to mental health carve-outs. However, in order to protect the large number of patients currently covered by carve-out arrangements, the AMA advocates that all managed care plans that provide or arrange for behavioral health care adhere to the following principles, and that any public or private entities that evaluate such plans for the purposes of certification or accreditation utilize these principles in conducting their evaluations: (1) Plans should assist participating primary care physicians to recognize and diagnose the behavioral disorders commonly seen in primary care practice.
(2) Plans should reimburse qualified participating physicians in primary care and other non-psychiatric physician specialties for the behavioral health services provided to plan enrollees.

(3) Plans should utilize practice guidelines developed by physicians in the appropriate specialties, with local adaptation by plan physicians as appropriate, to identify the clinical circumstances under which treatment by the primary care physician, direct referral to psychiatrists or other addiction medicine physicians, and referral back to the primary care physician for care of behavioral disorders is indicated, and should pay for all physician care provided in conformance with such guidelines. In the absence of such guidelines, direct referral by the primary care physician to the psychiatrist or other addiction medicine physician should be allowed when deemed necessary by the referring physician.
(4) Plans should foster continuing and timely collaboration and communication between primary care physicians and psychiatrists in the care of patients with medical and psychiatric comorbidities.
(5) Plans should encourage a disease management approach to care of behavioral health problems.
(6) Participating health professionals should be able to appeal plan-imposed treatment restrictions on behalf of individual enrollees receiving behavioral health services, and should be afforded full due process in any resulting plan attempts at termination or restriction of contractual arrangements.

(7) Plans using case managers and screeners to authorize access to behavioral health benefits should restrict performance of this function to appropriately trained and supervised health professionals who have the relevant and age group specific psychiatric or addiction medicine training, and not to lay individuals, and in order to protect the patient's privacy and confidentiality of patient medical records should elicit only the patient information necessary to confirm the need for behavioral health care.

(8) Plans assuming risk for behavioral health care should consider "soft" capitation or other risk/reward-sharing mechanisms so as to reduce financial incentives for undertreatment.

(9) Plans should conduct ongoing assessment of patient outcomes and satisfaction, and should utilize findings to both modify and improve plan policies when indicated and improve practitioner performance through educational feedback. (CMS Rep. 2, A-96; Modified: CMS Rep. 6, I-00; Reaffirmed: CMS Rep. 9, A-01; Reaffirmed Res. 702, I-01; Reaffirmation A-02)

H-285.957 Use of Risk-Adjustment Mechanisms for Physician Compensation Under Capitation Contracts

The AMA will work with the American Academy of Pediatrics and other medical organizations in urging state Medicaid programs and other third party payers to assure the inclusion of risk adjustment mechanisms in capitation rates paid to physicians providing care to chronically ill children and adults enrolled in managed care plans. (Sub. Res. 128, A-96; Reaffirmed: CMS Rep. 8, A-06)

H-285.959 Gag Clauses

The AMA will continue to support any and all legislation to ban "gag clauses" from physician contracts. (Res. 726, A-96; Reaffirmation A-97)

H-285.960 Incorporation of Organized Medical Staff in Managed Care Accreditation Standards

The AMA will establish, as a very high priority, the inclusion of an organized medical staff as a requirement for accreditation by private organizations of managed care plans, integrated delivery systems/networks, provider-sponsored organizations and other organizations delivering health care. (Sub. Res. 801, A-96; Reaffirmation A-97; Reaffirmed: CLRPD Rep. 2, A-07)

H-285.962 Anti-Psychiatry Practices of Certain Health Maintenance Organizations and Managed Care Organizations

Our AMA opposes managed care organization (MCO) requirements that a patient determined by his or her physician to be in need of specific treatment, including psychiatric treatment, be interviewed by an unqualified employee of the MCO prior to approval of the treatment. (Sub. Res. 702, I-95; Reaffirmation A-00)

H-285.964 Admitting Officer and Hospitalist Programs

AMA policy states that: (1) managed care plan enrollees and prospective enrollees should receive prior notification regarding the implementation and use of "admitting officer" or "hospitalist" programs; (2) participation in "admitting officer" or "hospitalist programs" developed and implemented by managed care or other health care organizations should be at the voluntary discretion of the patient and the patient's physician; (3) hospitalist programs when initiated by a hospital or managed care organization should be developed consistent with AMA policy on medical staff bylaws and implemented with the formal approval of the organized medical staff by at least the same notification and voting threshold required to approve a bylaws change to assure that the principles and structure of the autonomous and self-governing medical staff are retained; (4) Hospitals and other health care organizations should not compel physicians by contractual obligation to assign their patients to "Hospitalists" and that no punitive measure should be imposed on physicians or patients who decline participation in "hospitalists programs"; and (5) AMA opposes any hospitalist model that disrupts the patient/physician relationship or the continuity of patient care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants. (Sub. Res. 714, I-95; Amended by CMS Rep. 4, A-98; Reaffirmed: Res. 819, A-99; Reaffirmation I-99; Reaffirmed: Res. 812, A-02; Reaffirmed: BOT Rep. 15, A-05; Reaffirmed in lieu of Res. 734, A-05; Modified:

Res. 731, A-07)

H-285.965 Managed Care Cost Containment Involving Prescription Drugs

(1) Physicians who participate in managed care plans should maintain awareness of plan decisions about drug selection by staying informed about pharmacy and therapeutics (P&T) committee actions and by ongoing personal review of formulary composition. P&T committee members should include independent physician representatives. Mechanisms should be established for ongoing peer review of formulary policy. Physicians who perceive inappropriate influence on formulary development from pharmaceutical industry consolidation should notify the proper regulatory authorities.

(2) Physicians should be particularly vigilant to ensure that formulary decisions adequately reflect the needs of individual patients and that individual needs are not unfairly sacrificed by decisions based on the needs of the average patient. Physicians are ethically required to advocate for additions to the formulary when they think patients would benefit materially and for exceptions to the formulary on a case-by-case basis when justified by the health care needs of particular patients. Mechanisms to appeal formulary exclusions should be established. Other cost-containment mechanisms, including prescription caps and prior authorization, should not unduly burden physicians or patients in accessing optimal drug therapy.

(3) Limits should be placed on the extent to which managed care plans use incentives or pressures to lower prescription drug costs. Financial incentives are permissible when they promote cost-effectiveness, not when they require withholding medically necessary care. Physicians must not be made to feel that they jeopardize their compensation or participation in a managed care plan if they prescribe drugs that are necessary for their patients but that may also be costly. There should be limits on the magnitude of financial incentives, incentives should be calculated according to the practices of a sizable group of physicians rather than on an individual basis, and incentives based on quality of care rather than cost of care should be used. Physician penalties for non-compliance with a managed care formulary in the form of deductions from withholds or direct charges are inappropriate and unduly coercive. Prescriptions should not be changed without physicians having a change to discuss the change with the patient.

(4) Managed care plans should develop and implement educational programs on cost-effective prescribing practices. Such initiatives are preferable to financial incentives or pressures by HMOs or hospitals, which can be ethically problematic.

(5) Patients must fully understand the methods used by their managed care plans to limit prescription drug costs. During enrollment, the plan must disclose the existence of formularies, the provisions for cases in which the physician prescribes a drug that is not included in the formulary and the incentives or other mechanisms used to encourage physicians to consider costs when prescribing drugs. In addition, plans should disclose any relationships with pharmaceutical benefit management companies or pharmaceutical companies that could influence the composition of the formulary. If physicians exhaust all avenues to secure a formulary exception for a significantly advantageous drug, they are still obligated to disclose the option of the more beneficial, more costly drug to the patient, so that the patient can decide whether to pay out-of-pocket.

(6) Research should be conducted to assess the impact of formulary constraints and other approaches to containing prescription drug costs on patient welfare.

(7) Our AMA urges pharmacists to contact the prescribing physician if a prescription written by the physician violates the managed care drug formulary under which the patient is covered, so that the physician has an opportunity to prescribe an alternative drug, which may be on the formulary.

(8) When pharmacists, insurance companies, or pharmaceutical benefit management companies communicate directly with physicians or patients regarding prescriptions, the reason for the intervention should be clearly identified as being either educational or economic in nature.

(9) Our AMA will develop model legislation which prohibits managed care entities, and other insurers, from retaliating against a physician by disciplining, or withholding otherwise allowable payment because they have prescribed drugs to patients which are not on the insurer’s formulary, or have appealed a plan’s denial of coverage for the prescribed drug.

(10) Our AMA urges health plans including managed care organizations to provide physicians and patients with their medication formularies through multiple media, including Internet posting.

(11) In the case where Internet posting of the formulary is not available and the formulary is changed, coverage should be maintained until a new formulary is distributed.

(12) For physicians who do not have electronic access, hard copies must be available. (CEJA Rep. 2, A-95; Res. 734, A-97; Appended by Res. 524 and Sub. Res.714, A-98; Reaffimed: Res. 511, A-99; Modified: Res. 501, Reaffirmed: Res. 123 and 524, A-00; Modified: Res. 509, I-00; Reaffirmed: CMS Rep. 6, A-03; Reaffirmation I-04; Reaffirmed: Sub. Res. 529, A-05; Reaffirmation A-08)

H-285.967 Distribution of Premiums Collected by Managed Care Companies

The AMA develop and support appropriate legislation to require managed care plans to publish, on an annual basis, relevant operating and financial information. (Sub. Res. 702, A-95; Reaffirmation I-96; Reaffirmation A-06; Reaffirmed: CMS Rep. 8, A-06)

H-285.969 Managed Care Education

The AMA will continue to emphasize professionalism, patient and physician autonomy, patient and physician rights, and practical assistance to physicians as key principles to guide AMA advocacy efforts related to managed care. (Sub. Res. 707, A-95; Reaffirmed: CMS Rep. 7, A-05)

H-285.970 Physician Office Review by Third Party Payers

The AMA supports development of standardized criteria to be used in managed care contracts for reviewing physicians' office and medical records in order to avoid multiple review. (Res. 719, A-95; Reaffirmed: CMS Rep. 7, A-05)

H-285.971 Population Based Practices in Managed Care Systems

The AMA recommends to all managed care plans that they: (1) develop population based programs for prevention, health risk assessments, and health's status improvement; (2) adopt a process to measure clinical quality provided to patients and demonstrate how quality in their system of care is improving; (3) develop programs which assure that communicable and environmentally induced health problems are followed up by physicians within the plan in cooperation with competent health department personnel; and (4) manage these programs in concert with established standards of preventive medicine and public health. (Sub. Resolution 718, I-94; Reaffirmation I-96; Reaffirmed: CMS Rep. 8, A-06)

H-285.972 Post-Operative Services Under Managed Care

AMA policy states that managed care plans should not limit or abrogate the surgeon's professional duty to care for the patient until recovered from the operation or other surgical care. (Res. 722, I-94; Reaffirmed: CMS Rep. 5, A-04)

H-285.973 Access to Specialists and Subspecialists in Managed Care Plans

Our AMA: (1) advocates that all managed care plans be required to provide appropriate access, when geographically available, to representatives of all medical and surgical specialties and subspecialties; and (2) advocates that health plans not restrict appropriate referrals to medical and surgical subspecialists, including those specialties that are age group specific. (Sub. Resolution 707, I-94; Reaffirmed: CMS Rep. 3, A-96; Reaffirmed: CMS Rep. 3, A-98; Reaffirmation A-00)

H-285.974 Residents Working with Managed Care Programs

The AMA encourages managed care plans to allow residents to care for patients under faculty supervision in the inpatient and outpatient setting. (Sub. Res. 706, I-94; Reaffirmed: CMS Rep. 5, A-04)

H-285.975 Consensus Opinions

Policy of the AMA is that all managed care programs must provide, or offer reimbursement for acquisition of, sufficient opinions necessary to reach a conclusion regarding the management of a given medical condition. (Res. 708, I-94; Reaffirmed: CMS Rep. 5, A-04)

H-285.979 Managed Care Insurance Company Credentialing

The AMA: (1) supports the development and utilization by all health insurance plans and managed care organizations of both a uniform application form and a reapplication form;
(2) will work with the centralized credentialing collection services established by state and county medical societies to implement the acceptance of uniform application and reapplication forms;
(3) urges managed care organizations to recredential participating physicians no more frequently than every two years;
(4) urges hospitals, managed care organizations and insurance companies to utilize state and county central credentialing services, where available, for purposes of credentialing plan physician applicants, and will identify all state and county central credentialing services and make this information available to all interested parties including hospital and managed care/physician credentialing committees;
(5) supports state and county medical society initiatives to promulgate a uniform reappointment cycle for hospitals and managed care plans; and

(6) opposes any legislative or regulatory initiative to mandate accreditation for CVOs by the NCQA or any other agency until a fair, equitable, reasonable and appropriately inclusive process for such accreditation exists. (Sub. Res. 703, A-94; Amended in lieu of Res. 705, I-94; Amended by Res. 716, I-96; Reaffirmed: Res. 809, I-02)

H-285.981 Fair Market Practices

Our AMA: (1) continues to advocate for the enactment of state and federal laws and regulations that would provide for patient protection and physician fairness, including

(a) permitting physicians to negotiate individually and collectively with managed care organizations on the terms and conditions of physician participation in a managed care organization's health benefits plans;
(b) providing for formal input by practicing physicians in the development and refinement of the medical policies of a managed care organization, especially those policies related to physician credentialing, performance review, and utilization review;
(c) requiring managed care organizations to disclose all participation requirements and selective contracting criteria to applying physicians;
(d) requiring managed care organizations to provide due process to physicians in all adverse selective contracting decisions;
(e) providing enrollees and participating physicians with the opportunity to complete a "report card" at regular intervals for appropriate dissemination regarding the quality of service rendered by the managed care organization; and

(2) continues to encourage all state medical associations and national medical specialty societies to advocate vigorous support of the Patient Protection Act. (Sub. Res. 704, A-94; Res. 716, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: Sub. Res. 718, 722, and Reaffirmation I-96; Reaffirmed by CMS Rep. 3, A-98; Reaffirmation A-06; Reaffirmation A-07)

H-285.983 Organized Medical Staffs in Medical Delivery Systems

The AMA supports expanding the concept of physician governance of medical delivery systems by recommending that: (1) Medical delivery systems establish self-governing medical staffs similar, if not identical, to those in hospitals; (2) The principles of self-governance should include, but not be limited to: (a) the development of medical staff bylaws which cannot be unilaterally changed by the governing board of a medical delivery system; (b) physician election of representatives to the governing board and other appropriate committees of medical delivery systems including credentialing, privileging, quality assurance and utilization review committees; (c) due process protections for physicians credentialed by a medical delivery system; and (d) full indemnification by medical delivery systems of physicians who, in good faith, serve as members of credentialing, quality assurance and utilization review committees of medical delivery systems; and (3) Policy of the AMA is that the establishment of guidelines, review of decisions, and the adjudication of patient care quality issues in managed care plans must be performed by participating practicing physicians. (Res. 706, A-94; CMS Rep. 4, I-95; Amended by BOT Rep. 14, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-285.984 Any Willing Provider Provisions and Laws

Our AMA: (1) acknowledges that health care plans or networks may develop and use criteria to determine the number, geographic distribution, and specialties of physicians needed;

(2) will advocate strongly that managed care organizations and third party payers be required to disclose to physicians applying to the plan the selection criteria used to select, retain, or exclude a physician from a managed care plan, including the criteria used to determine the number, geographic distribution, and specialties of physicians needed;

(3) will advocate strongly that those health care plans or networks that use criteria to determine the number, geographic distribution, and specialties of physicians needed be required to report to the public, on a regular basis, the impact that the use of such criteria has on the quality, access, cost, and choice of health care services provided to patients enrolled in such plans or networks;

(4) will advocate in those cases in which economic issues may be used for consideration of sanction or dismissal, the physician participating in the plan should have the right to receive profile information and education, in a due process manner, before action of any kind is taken;

(5) opposes any federal effort to preempt state "any willing provider" laws; and

(6) will continue to advocate its "Legislative Specifications for Federal Regulation of Managed Care Plans." (BOT Rep. I-93-25; Reaffirmed: Sub. Res. 110 and 702, A-94; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed: Sub. Res. 704, A-01)

H-285.985 Discrimination Against Physicians by Health Care Plans

Our AMA: (1) will develop draft federal and model state legislation requiring managed care plans and third party payers to disclose to physicians and the public, the selection criteria used to select, retain, or exclude a physician from a managed care or other provider

plans;

(2) will request an advisory opinion from the Department of Justice on the application of the Americans with Disabilities Act of 1990 to selective contracting decisions made by managed care plans or other provider plans;

(3) will support passage of federal legislation to clarify the Americans With Disabilities Act to assure that coverage for interpreters for the hearing impaired be provided for by all health benefit plans. Such legislation should also clarify that physicians practicing in an office setting should not incur the costs for qualified interpreters or auxiliary aids for patients with hearing loss unless the medical judgment of the treating physician reasonably supports such a need;

(4) encourages state medical associations and national medical specialty societies to provide appropriate assistance to physicians at the local level who believe they may be treated unfairly by managed care plans, particularly with respect to selective contracting and credentialing decisions that may be due, in part, to a physician's history of substance abuse; and

(5) urges managed care plans and third party payers to refer questions of physician substance abuse to state medical associations and/or county medical societies for review and recommendation as appropriate. (BOT Rep. 18, I-93; Appended by BOT Rep. 28, A-98; Reaffirmation A-99; Reaffirmation A-00)

H-285.986 Standardization of Managed Care Office Safety Standards

The AMA: (1) opposes duplicative efforts by managed care organizations to develop physician office safety standards that have already been implemented by federal and/or state regulation; and (2) urges the Joint Commission on Accreditation of Health Care Organizations, the National Committee on Quality Assurance, the Accreditation Association for Ambulatory Health Care, and other relevant accreditation organizations to seek greater simplification and standardization of such office review efforts as a means of reducing health care costs and unnecessary burdensome paperwork for physicians and their employees. (Sub. Res. 702, I-93; Reaffirmed: Res. 817, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-285.987 Guidelines for Qualifications of Managed Care Medical Directors

The AMA has adopted the following "Guidelines for Qualifications of Medical Directors of Managed Care Organizations":
To the greatest extent possible, physicians who are employed as medical directors of managed care organizations shall:
(1) hold an unlimited current license to practice medicine in one of the states served by the managed care organization, and where that Medical Director will be making clinical decisions or be involved in peer review that Medical Director should have a current license in each applicable state;
(2) meet credentialing requirements equivalent to those met by plan providers;
(3) be familiar with local medical practices and standards in the plan's service area;
(4) be knowledgeable concerning the applicable accreditation or "program approval" standards for preferred provider organizations and health maintenance organizations;
(5) possess good interpersonal and communications skills;
(6) demonstrate knowledge of risk management standards;
(7) be experienced in and capable of overseeing the commonly used processes and techniques of peer review, quality assurance, and utilization management;
(8) demonstrate knowledge of due process procedures for resolving issues between the participating physicians and the health plan administration, including those related to medical decision-making and utilization review;
(9) be able to establish fair and effective grievance resolution mechanisms for enrollees;
(10) be able to review, advise, and take action on questionable hospital admissions, medically unnecessary days, and all other medical care cost issues; and
(11) be willing to interact with physicians on denied authorizations.
The AMA strongly encourages managed care organizations and payer groups to utilize these guidelines in their recruitment and retention of medical directors. (CMS Rep. 6, I-93; Reaffirmed: CMS Rep. 7, A-05)

H-285.988 Vertical Divestiture in the Health Care System

It is the policy of the AMA: (1) to continue to oppose organizational structures that may lead to nonphysician control of medical decision-making; (2) that hospital-physician business arrangements must be based on mutual respect and shared incentives; hospital programs should be developed that provide medical staff physicians with incentives to render high quality medical care in an effective and efficient manner and leave physicians in control of the clinical aspects of that care; and (3) to encourage individual physicians and hospital medical staff to remain alert to, and oppose, efforts by hospitals or insurers to obtain control of medical practices through the employment of physicians. (CMS Rep. 1, I-931; Reaffirmed by CMS Rep. 1, A-95; Reaffirmed: CMS Rep. 7, A-05)

H-285.989 AMA Opposition to Requiring Physician Participation in Health Maintenance Organizations in Order to Join Preferred Provider Organization Panel

Our AMA will seek legislative action to prohibit tying a physician's membership in a managed care panel (e.g., a PPO) to that physician's participation in any other managed care panel (e.g., an HMO). (Res. 109, I-93; Reaffirmation I-99; Reaffirmation A-00)

H-285.990 Managing Managed Care

The AMA will continue to provide educational information on changes in the health care delivery system, how the changes will affect practicing physicians, and identify practice option and/or organizational models, including the pros and cons of each alternative, to assist physicians in making informed choices about how they will practice in the future. (Res. 723, A-93; Reaffirmed: CMS Rep. 10, A-03)

H-285.991 Qualifications and Credentialing of Physicians Involved in Managed Care

(1) AMA policy on selective contracting is as follows: (a) Health plans or networks should provide public notice within their geographic service areas when applications for participation are being accepted.

(b) Physicians should have the right to apply to any health care plan or network in which they desire to participate and to have that application approved if it meets physician-developed objective criteria that are available to both applicants and enrollees and are based on professional qualifications, competence and quality of care.

(c) Selective contracting decisions made by any health delivery or financing system should be based on an evaluation of multiple criteria related to professional competency, quality of care, and the appropriateness by which medical services are provided. In general, no single criterion should provide the sole basis for selecting, retaining, or excluding a physician from a health delivery or financing system.

(d) Prior to initiation of actions leading to termination or nonrenewal of a physician's participation contract for any reason the physician shall be given notice specifying the grounds for termination or nonrenewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities, except in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine.

(2) The qualifications, responsibilities, and duties of physicians employed as medical directors of managed care plans should be developed on an individual basis by the plan concerned. Physicians who participate in the plan, or the plan's medical staff, if one is so designated, should participate in developing such qualifications, responsibilities, and duties. (CMS Rep. B, A-93; BOT Rep. I-93-25; Reaffirmed: Sub. Res. 704, I-94; Reaffirmed: Sub. Res. 701, I-95; Reaffirmed by Rules & Credentials Cmt., A-96 Reaffirmed: CMS Rep. 3, I-97; Reaffirmed by Res. 108, A-98; Reaffirmation A-01)

H-285.992 Exclusion of Physicians by Managed Care Health Plans

The AMA will seek federal legislation and/or support the efforts of state medical societies to seek state legislation which would prohibit health care plans that have attained a certain percentage of patient enrollment or market power from denying a physician the right to enter into a contractual agreement with the health care plan if the physician is qualified and is willing to meet the terms and conditions established in that contractual agreement. (Res. 724, A-93; Reaffirmed: BOT Rep. 28, A-03)

H-285.994 Managed Care

The AMA (1) will develop resources to assist physicians practicing in managed care plans with the design and implementation of peer review processes to assess and assure the quality of care provided in these plans; (2) similarly urges all physicians and physician groups to continue and expand efforts to document and assure the quality of care they provide in their own practices, especially in this increasingly competitive environment; (3) urges managed care plans, hospitals, review entities, third party administrators and any other organizations that are compiling information on physician performance to share that information with the practitioners concerned prior to public release and, if these organizations do not implement this policy, the AMA will develop model state legislation to require such disclosure; and (4) will continue to collect and analyze information as to the impact of managed care systems on quality of care and use the findings as the basis for developing further policy and proposals in this area. (CMS Rep. A, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-06)

H-285.995 Managed Care - Policy and Initiatives

(1) All "hold harmless" clauses in managed care contracts should be explicitly identified as such. Our AMA urges physicians to consult with legal counsel prior to contracting with a managed care entity to prevent the imposition of unfair liability upon the physician. Our AMA will develop model state legislation to prohibit "hold harmless" clauses in managed care contracts and

encourages state medical societies to pursue such legislation.

(2) Our AMA will continue to advocate strongly to Congress, the Department of Justice, and the Federal Trade Commission the need for changes in relevant antitrust laws to allow physicians and physician organizations to form bargaining groups to engage in group negotiations with managed care plans.

(3) Our AMA will continue to advocate strongly and refine further, as appropriate, the managed care provisions contained in Health Access America.

(4) Our AMA will support, and pursue an active role in, the development of national managed care and utilization review standards.

(5) Our AMA will support, and pursue an active role in, the creation of a national managed care/utilization review accrediting or certifying process when acceptable national standards are developed.

(6) Our AMA extends Policy 340.928 to managed care programs so that such programs make available to physicians under review the identities and credentials of the physician reviewers.

(7) Our AMA reaffirms the portion of its existing model state legislation that calls for certain elements of utilization review to be defined as the practice of medicine.

(8) Our AMA reaffirms its policy that payers be liable for harm resulting from the results of any review decisions. (BOT Rep. MM, I-92; Reaffirmed: BOT Rep. I-93-25; Reaffirmed by Res. 725, A-95; Reaffirmed by BOT Rep. 12, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation I-96; Reaffirmation A-97; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-04; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-08)

H-285.996 Due Process in the Managed Care Environment

The AMA adopts the policy that all managed care contracts should expressly require the managed care plan to provide meaningful due process protections, in order to prevent wrongful and arbitrary contract terminations that leave the physician without means of redress. (Res. 725, A-92; Reaffirmed: BOT Rep. I-93-25; Reaffirmed by Rules & Credentials Cmt., A-96; Modified by CMS Rep. 3, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-285.997 Managed Care

(1) Those health delivery or financing systems that contract with selected physicians to furnish care should utilize selection criteria based primarily on professional competence and quality of care. Any economic criteria used in such selective contracting should have a demonstrated positive relationship to the quality and appropriateness of care and to professional competency. (2) Health plans that contract with selected providers should have an established mechanism by which any provider willing to abide by terms of the plan contract could appeal a decision to deny the provider's application for participation in the plan. (CMS Rep. C, A-92; CMS Rep. B, A-93; Reaffirmed: BOT Rep. I-93-25; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06)

H-285.998 Managed Care

(1) Introduction The needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing.

(2) Definition "Managed care" is defined as those processes or techniques used by any entity that delivers, administers, and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization, or costs and prices or outcomes of such services provided to a defined enrollee population.

(3) Techniques Managed care techniques currently employed include any or all of the following: (a) prior, concurrent, or retrospective review of the quality, medical necessity, and/or appropriateness of services or the site of services; (b) controlled access to and/or coordination of services by a case manager; (c) efforts to identify treatment alternatives and to modify benefits for patients with high cost conditions; (d) provision of services through a network of contracting providers, selected and deselected on the basis of standards related to cost-effectiveness, quality, geographic location, specialty, and/or other criteria; (e) enrollee financial incentives and disincentives to use such providers, or specific service sites; and (f) acceptance by participating providers of financial risk for some or all of the contractually obligated services, or of discounted fees.

(4) Case Management Health plans using the preferred provider concept should not use coverage arrangements which impair the continuity of a patient's care across different treatment settings.

With the increased specialization of modern health care, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by professional preparation to assume this leadership role. The primary goal of high-cost case management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care.
Any health plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations.

(5) Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed.
A physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field.
A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions.
All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan.

All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient.
When inordinate amounts of time or effort are involved in providing case management services required by a third party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage."

Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring prior authorization are recommended by the physicians.
In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process. (Joint CMS/CLRPD Rep. I-91; Reaffirmed: CMS Rep. I-93-5; Reaffirmed: Res. 716, A-95; Modified: CMS Rep. 3, I-96; Modified: CMS Rep. 4, I-96; Reaffirmation A-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed: CMS Rep. 9, A-98; Reaffirmed: Sub. Res. 707, A-98; Reaffirmed: CMS Rep. 13, I-98; Reaffirmed: Res. 717, A-99; Reaffirmation A-00; Reaffirmation A-02; Reaffirmation I-04; Reaffirmed in lieu of Res. 839, I-08)

H-290.000 Medicaid and State Children's Health Insurance Programs
(See also: Health Care Reform; Medicare)

H-290.970 Federal Legislation on Access to Community-Based Services for People with Disabilities

Our AMA strongly supports reform of the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396) to provide services in the most appropriate settings based upon the individual's needs, and to provide equal access to community-based attendant services and supports. (Res. 917, I-07)

H-290.971 Expanding Enrollment for the State Children’s Health Insurance Program (SCHIP)

Our AMA continues to support:
a. health insurance coverage of all children as a strategic priority;
b. efforts to expand coverage to uninsured children who are eligible for the State Children's Health Insurance Program (SCHIP) and Medicaid through improved and streamlined enrollment mechanisms;
c. the reauthorization of SCHIP in 2007; and
d. supports the use of enrollment information for participation in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and/or the federal school lunch assistance program as documentation for SCHIP eligibility in order to allow families to avoid duplication and the cumbersome process of re-documenting income for child health coverage. (Res. 118, A-07; CMS Rep. 1, A-07)

H-290.972 Health Savings Accounts in the Medicaid Program

1. Our AMA encourages state medical associations to assist in the design, monitoring, and evaluation of state Health Opportunity Account (HOA) demonstrations.

2. It is the policy of our AMA that states offering Medicaid beneficiaries HOAs or similar coverage modeled after Health Savings Accounts (HSAs) should adhere to the following principles:
(a) Make beneficiary participation voluntary;
(b) Provide first-dollar coverage of preventive services regardless of whether the beneficiary has met the deductible;
(c) Offer positive incentives to reward healthy behavior and offset beneficiary cost-sharing, provided that such incentives do not result in punitive cuts in standard benefits or increased cost-sharing to enrollees who are unable to achieve improvements in personal behavior affecting their health;
(d) Set deductibles at 100% of account contributions, but no higher;
(e) Allow payments to non-Medicaid providers by beneficiaries to count toward deductibles and out-of-pocket spending limits;
(f) Allow the deductible limits for families to be the lower of either the individual or family combined deductible;
(g) Ensure that enrollees are protected by standard Medicaid maximum out-of-pocket spending limits;
(h) Provide outreach, information, and decision-support that is readily accessible through a variety of formats (e.g., written, telephone, online), and in multiple languages;
(i) Encourage HOA enrollees to establish a medical home, in order to assure provision of preventive care services, coordination of care and continuity of care;
(j) Prohibit use of HOA funds for non-medical purposes, but consider allowing HOA balances of enrollees who lose Medicaid coverage to be used to purchase private insurance, including the employee share of premium for employer-sponsored coverage;
(k) Monitor the impact on utilization and beneficiary financial burden;
(l) Test broadening of eligibility to include currently ineligible beneficiary groups; and
(m) Ensure that physicians and other providers of health care services have access to up-to-date information verifying beneficiary enrollment and covered benefits, and are paid at point-of-service, or are allowed to use their standard billing procedures to obtain payment from the insurer or account custodian. (CMS Rep. 1, I-06)

H-290.973 Medicaid Citizenship Documentation Interim Final Rule

Our AMA strongly urges the Centers for Medicare and Medicaid Services to amend 42 CFR 435.407 (a) to specify that the state Medicaid agency's record of payment for the birth of an individual in a US hospital is satisfactory documentary evidence of both identity and citizenship. (Res. 702, I-06)

H-290.974 Status Report on the Medicaid Program

1. It is the policy of our AMA that in the absence of private sector reforms that would enable persons with low-incomes to purchase health insurance, our AMA supports eligibility expansions of public sector programs, such as Medicaid and the Children's Health Insurance Program, with the goal of improving access to health care coverage to otherwise uninsured groups.

2. Our AMA advocates that any tax treatment applied to health insurance for the purpose of encouraging individual ownership also apply to long-term care insurance.

3. Our AMA urges Congress and the Administration to develop proposals and enact solutions to address the pending growth of long-term care needs of the American population. (CMS Rep. 5, I-99; Reaffirmed: CMS Rep. 5, I-04, Renumbered: CMS Rep. 7, I-05)

H-290.975 State and Federal Medicaid Physician Advisory Bodies

Our AMA: (1) supports the creation of state Medicaid Physician Advisory Commissions that would advise states on payment policies, utilization of services, and other relevant policies impacting physicians and patients; and (2) reaffirms support for a federal Medicaid Physician Advisory Committee to advise the Centers for Medicare & Medicaid Services (CMS) and Congress on policies impacting physicians and patients related to the Medicaid program. (BOT Rep. 13, I-02)

H-290.976 Enhanced SCHIP Enrollment, Outreach, and Reimbursement

(1) It is the policy of our AMA that prior to or concomitant with states' expansion of State Children's Health Insurance Programs to adult coverage, our American Medical Association urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds. (2) Our AMA affirms its commitment to advocating for reasonable SCHIP and Medicaid reimbursement for its medical providers, defined as at minimum 100% of RBRVS Medicare allowable. (Res. 103, I-01; Reaffirmation A-07)

H-290.977 Medicaid Sterilization Services Without Time Constraints

Our AMA will pursue an action to amend federal Medicaid law and regulations to remove the time restrictions on informed consent, and thereby allow all patients, over the age of 21 and legally competent, to choose sterilization services. (Res. 226, A-01)

H-290.978 Medicare/Medicaid Dual Eligible Reimbursement

Our AMA seeks the repeal of Section 4714 of the Balanced Budget Act of 1997 and restore the requirement that states pay the deductible, copayment and coinsurance amounts for Medicare/Medicaid dual-eligible patients. (Res. 231, A-00)

H-290.979 Strategies for Increasing Access and Expanding Health Insurance Coverage

Our AMA continues to develop and advocate policy in response to the needs of public sector "safety net" programs, particularly Medicaid and the Children's Health Insurance Program. (BOT Rep. 2, I-99; Reaffirmation A-05)

H-290.980 Status Report on the Medicaid Program

Our AMA continues to advocate for appropriate payment to physicians under the Medicaid program. (CMS Rep. 5, I-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 1, A-05; Reaffirmed in lieu of Res. 124, A-08)

H-290.981 Out-of-State Medicaid Patients

The AMA encourages the CMS to propose regulations that prohibit state Medicaid programs from requiring physicians and other providers to be credentialed in the patient's state of residency, as long as the physician or provider is credentialed where the care is rendered (Res. 136, A-98)

H-290.982 Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;

(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.

(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;

(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;

(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;

(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;

(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to

administrative barriers or lack of understanding of the programs;

(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;

(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;

(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;

(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;

(12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;

(13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;

(14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;

(15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;

(16) supports efforts to assess the needs of mentally retarded individuals and, as appropriate, shift them from institutional care in the direction of community living;

(17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;

(18) urges CMS to require states to use its simplified four-page combination Medicaid / Children’s Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and

(19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations. (BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08)

H-290.983 Support of Health Care to Legal Immigrants

Our AMA opposes federal and state legislation denying or restricting legal immigrants Medicaid and immunizations. (Res. 211, A-97; Reaffirmation A-02)

H-290.984 Mandatory Enrollment of Medicare-Medicaid Patients in Managed Care Plans

The AMA, in keeping with its support for free market competition among all modes of health care delivery and financing, strongly opposes mandatory enrollment of Medicare and/or Medicaid patients in managed care plans. (Sub. Res. 711, A-97; Reaffirmation A-04; Reaffirmation I-04)

H-290.985 Monitoring Medicaid Managed Care

As managed care plans increasingly become the source of care for Medicaid beneficiaries, the AMA advocates the same policies for the conduct of Medicaid managed care that the AMA advocates for private sector managed care plans. In addition, the AMA advocates that the following criteria be used in federal and/or state oversight and evaluation of managed care plans serving Medicaid beneficiaries, and insists upon their use by the Federation in monitoring the implementation of managed care for Medicaid beneficiaries:

(1) Adequate and timely public disclosure of pending implementation of managed care under a state program, so as to allow meaningful public comment.

(2) Phased implementation to ensure availability of an adequate, sufficiently capitalized managed care infrastructure and an orderly transition for beneficiaries and providers.

(3) Geographic dispersion and accessibility of participating physicians and other providers.

(4) Education of beneficiaries regarding appropriate use of services, including the emergency department.

(5) Availability of off-hours, walk-in primary care.

(6) Coverage for clinically effective preventive services.

(7) Responsiveness to cultural, language and transportation barriers to access.

(8) In programs where more than one plan is available, beneficiary freedom to choose his/her plan, enforcement of standards for marketing/enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers.

(9) Beneficiary freedom to choose and retain a given primary physician within the plan, and to request a change in physicians when dissatisfied.

(10) Significant participating physician involvement and influence in plan medical policies, including development and conduct of quality assurance, credentialing and utilization review programs.

(11) Ability of plan participating physicians to determine how many beneficiaries and the type of medical problems they will care for under the program.

(12) Adequate identification of plan beneficiaries and plan treatment restrictions to out-of-plan physicians and other providers.

(13) Intensive case management for high utilizers and realistic financial disincentives for beneficiary misuse of services.

(14) Treatment authorization requirements and referral protocols that promote continuity rather than fragment the process of care.

(15) Preservation of private right of action for physicians and other providers and beneficiaries.

(16) Ongoing evaluation and public reporting of patient outcomes, patient satisfaction and service utilization.

(17) Full disclosure of plan physician and other provider selection criteria, and concerted efforts to qualify and enroll traditional community physicians and other existing providers in the plan.

(18) Absence of gag rules.

(19) Fairness in procedures for selection and deselection.

(20) Realistic payment levels based on costs of care and predicted utilization levels.

(21) Payment arrangements that do not expose practitioners to excessive financial risk for their own or referral services, and that tie any financial incentives to performance of the physician group over significant time periods rather than to individual treatment

decisions.

(22) Our AMA urges CMS to direct those state Medicaid agencies with Medicaid managed care programs to disseminate data and other relevant information to the state medical associations in their respective states on a timely and regular basis. (CMS Rep. 5 A-96; Reaffirmed and Appended: Sub. Res. 704, I-97; Reaffirmation A-00; Reaffirmation I-04)

H-290.986 Medicaid and Efforts to Assure it Maintains its Role as a Safety Net

The AMA supports the position that the Medicaid program maintain its role as a safety net for the nation's most vulnerable populations. (Sub. Res. 204, A-96; Reaffirmation A-05; Reaffirmation A-07)

H-290.987 Medicaid Waivers for Managed Care Demonstration Projects

(1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program consistent with the processes described in the September 27, 1994 Federal Register notice published by HHS, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education.

(2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package. (BOT Rep. 24, A-95; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-04)

H-290.988 Monitoring of State Medicaid DUR Programs

The AMA will continue to monitor the progress, quality and problems associated with the Omnibus Budget Reconciliation Act of 1990 mandated state Medicaid Drug Use Review (DUR) programs and assure that DUR programs focus on the quality of patient care and use appropriate scientifically-based criteria to evaluate individual patient therapy and the effectiveness of physician and pharmacist activities. (Res. 526, I-92; Reaffirmed: BOT Rep. 28, A-03)

H-290.989 Access to Care by Medicaid Patients

Our AMA (1) requests CMS to improve Medicaid patients' access to care by considering physicians' costs in its determinations regarding the cost effectiveness of Medicaid third party liability requirement; (2) will work with CMS and/or Congress to allow state Medicaid agencies to waive the requirement that physicians pursue third party payments prior to seeking payment from Medicaid; and (3) supports federal legislation to establish MEDICAID-PAC (Medicaid Physician Advisory Commission) to advise the CMS and Congress on policies impacting physicians and patients related to state Medicaid programs. (Res. 225, I-92; Appended: Res. 201, A-00)

H-290.993 Coverage of Drugs by Medicaid

Our AMA (1) urges CMS to develop meaningful guidelines for state Medicaid agencies to pay for drugs necessary to treat life-threatening and other serious medical conditions, even if such drugs are manufactured/distributed by non-rebating firms, and (2) asks CMS to grant states reasonable autonomy in decisions to cover these medically necessary drugs without retroactive economic penalty. (Res. 195, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmation I-07)

H-290.995 Case Management System for Outpatient Clinics

The AMA has adopted the following policy: (1) That states be given the authority to establish primary care case management programs for populations whose medical care is provided through Medicaid or other public welfare funding: (a) on a voluntary basis with incentives provided toward a prudent choice of care source; and (b) on a mandatory basis only for those recipients in a given area who have been identified as overutilizers or misutilizers of services; and (2) that comparative analyses of these programs be undertaken to determine their relative effectiveness regarding patient access, quality of and satisfaction with care, and cost reduction. (CMS Rep. A, I-90; Reaffirmed by Res. 731, A-95; Reaffirmed: CMS Rep. 7, A-05)

H-290.996 Oregon Senate Bill 27 Federal Waiver

Our AMA supports the necessary Congressional or federal administrative waivers so that the innovative program proposed in Oregon State Senate Bill 27 and related legislation be implemented and its effectiveness assessed periodically. (Res. 47, A-90; Reaffirmed:

Sunset Report, I-00)

H-290.997 Medicaid - Towards Reforming the Program

Our AMA believes that greater equity should be provided in the Medicaid program, through adoption of the following principles:

(1) the creation of basic national standards of uniform eligibility for all persons below poverty level income (adjusted by state per capita income factors);

(2) the creation of basic national standards of uniform minimum adequate benefits;

(3) the elimination of the existing categorical requirements;

(4) the creation of adequate payment levels to assure broad access to care; and

(5) establishment of national standards that result in uniform eligibility, benefits and adequate payment mechanisms for services across jurisdictions. (BOT Rep. UU, A-88; Reaffirmed: CMS Rep. G, A-93; Reaffirmation I-96; Reaffirmation A-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00; Reaffirmation A-05)

H-295.000 Medical Education
(See Also: Medical Education: Continuing; Medical Education: Financing and Support; Medical Education: Graduate; Minorities)

H-295.869 Student Loan Empowerment

Our AMA supports a requirement that medical schools inform students of all government loan opportunities along with private loans, and requires disclosure of reasons that preferred lenders were chosen. (Res. 307, A-08)

H-295.870 Medical School Language Electives in Medical School Curriculum

Our AMA strongly encourages all Liaison Committee on Medical Education- and American Osteopathic Association-accredited US medical schools to offer medical second languages to their students as electives. (Res. 304, A-07)

H-295.871 Initiative to Transform Medical Education: Strategies for Medical Education Reform

Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role. (CME Rep. 13, A-07)

H-295.872 Expansion of Student Health Services

1. It is AMA policy that medical students should have timely access to needed preventive and therapeutic medical and mental health services at sites in reasonable proximity to where their education is occurring.

2. Our AMA will encourage the Liaison Committee on Medical Education to develop an annotation to its standard on medical student access to preventive and therapeutic health services that includes a specification of the following:
a. Medical students should have timely access to needed preventive and therapeutic medical and mental health services at sites in reasonable proximity to where their education is occurring.
b. Medical students should have information about where and how to access health services at all locations where training occurs.
c. Medical schools should have policies that permit students to be excused from class or clinical activities to seek needed care. (CME Rep. 10, A-07)

H-295.873 Eliminating Benefits Waiting Periods for Residents and Fellows

Our AMA:
(1) supports the elimination of benefits waiting periods imposed by employers of resident and fellow physicians-in-training;
(2) will strongly encourage the Accreditation Council for Graduate Medical Education (ACGME) to require programs to make insurance for health care, dental care, vision care, life, and disability available to their resident and fellow physicians on the trainees' first date of employment and to aggressively enforce this requirement; and
(3) will work with the ACGME and with the Liaison Committee on Medical Education (LCME) to develop policies that provide continuous hospital, health, and disability insurance coverage during a traditional transition from medical school into graduate medical education. (BOT Action in response to referred for decision Res. 318, A-06)

H-295.874 Educating Medical Students for Cultural Competence: What do we know?

Our AMA:

(1) Supports efforts designed to integrate cultural competence training across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care.

(2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence.

(3) Supports medical schools in their efforts to evaluate the effectiveness of their cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence.

(4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of cultural competence in the undergraduate medical school curriculum.

(5) Recommends studying the integration of cultural competence training in graduate and continuing medical education and publicizing successful models. (CME Rep. 11, A-06)

H-295.875 Palliative Care and End-of-Life Care

Our AMA:
1. Reaffirms the Council on Medical Education's support of palliative medicine as a medical subspecialty with certification recognized by the American Board of Medical Specialties, and also encourages the inclusion of palliative medicine in the core curriculum of undergraduate and graduate medical education.
2. Encourages the training of all allied health workers in the use of palliative care techniques and interdisciplinary team care.
3. Will continue its efforts in producing and distributing clinical CME programs on pain management and end-of-life care. (BOT Rep. 5, A-06)

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-295.877 Medical Treatment of Prisoners of War and Detainees

Our AMA encourages medical schools to include ethics training on the issue of medical treatment of prisoners of war and detainees. (Sub. Res. 10, A-05)

H-295.878 Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education

Our AMA:

(1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care-without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age;

(2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; and

(3) encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to include Lesbian, Gay, Bisexual, and Transgender health issues in the cultural competency curriculum for medical education. (Res. 323, A-05)

H-295.879 Improving Sexual History Curriculum in the Medical School

Our AMA (1) encourages all medical schools to train medical students to be able to take a thorough and nonjudgmental sexual history in a manner that is sensitive to the personal attitudes and behaviors of patients in order to decrease anxiety and personal difficulty with sexual aspects of health care; and (2) supports the creation of a national public service announcement that encourages patients to discuss concerns related to sexual health with their physician and reinforces its commitment to helping patients maintain sexual health and well-being. (Res. 314, A-05)

H-295.880 Service Learning in Medical Education

Our AMA will support the concept of service learning as a key component in medical school and residency curricula, and that these experiences should include student and resident collaboration with a community partner to improve the health of the population. (Res. 321, A-04)

H-295.881 Clinical Skills Assessment Exam

Our American Medical Association opposes the implementation of the Clinical Skills Assessment Exam as part of the United States Medical Licensing Examination by any means, including possible legal action. (Res. 304, A-03)

H-295.882 Proposed Consolidation of Liaison Committee on Medical Education

(1) Our AMA reaffirms its ongoing commitment to excellence in medical education and its continuing responsibility for accreditation of undergraduate medical education.

(2) Any proposed changes in the role of the AMA in the organization or structure of the LCME should be considered matters of AMA policy. (CME Rep. 7, A-03)

H-295.883 Comprehensive Reform at the Interface of Medical Education and Health Care

Our AMA expresses its commitment to ensuring the quality of undergraduate, graduate, and continuing medical education. (CME Rep. 6, A-02; Reaffirmed: CME Rep. 3, A-06)

H-295.884 Better Assisting our Patients with Near End of Life Decisions

Our AMA encourages: (1) the American Association of Medical Colleges and residency program directors to make "Decisions Near the End of Life" an integral part of American undergraduate and graduate medical education; and (2) primary care and psychiatric medicine through their specialty societies to develop joint continuing medical education programs on "Decisions Near the End of Life" open to colleagues from all specialties. (Res. 4, A-02)

H-295.886 Progress in Medical Education: Evaluation of Medical Students' and Resident Physicians' Professional Behavior

AMA policy is that the educational programs for medical students and resident physicians must include an evaluation of professional behavior, carried out at regular intervals and employing methods shown to be valuable in adding to the information that can be obtained from observational reports. An ideal system would utilize multiple evaluation formats and would build upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident physicians aimed at improving their performance and for summative decisions about progression in training. (CME Rep. 3, I-00)

H-295.887 Clinical Skills Assessment During Medical School

Our AMA encourages medical schools that do not already do so to implement valid and reliable methods to evaluate medical students' clinical skills. (CMS Rep. 7, I-99)

H-295.888 Progress in Medical Education: the Medical School Admission Process

Our AMA encourages: (1) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (2) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (3) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges. (CME Rep. 8, I-99)

H-295.889 Color Blindness

Our AMA will encourage medical schools to be aware of students with color blindness and its effect on their medical studies. (Sub. Res, 303, A-99)

H-295.890 Medical Education and Training in Women's Health

Our AMA: (1) encourages the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women's health/gender-based biology that have been developed for use in the medical school curriculum. Medical schools should include attention to women's health throughout the basic science and clinical phases of the curriculum;
(2) does not support the designation of women's health as a distinct new specialty;
(3) that each specialty should define objectives for residency training in women's health, based on the nature of practice and the characteristics of the patient population served;
(4) that surveys of undergraduate and graduate medical education, conducted by the AMA and other groups, should periodically collect data on the inclusion of women's health in medical school and residency training;
(5) encourages the development of a curriculum inventory and database in women's health for use by medical schools and residency programs;
(6) encourages physicians to include continuing education in women's health/gender based biology as part of their continuing professional development; and
(7) encourages its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, and the various Residency Review Committees to promote attention to women's health in accreditation standards. (Jt. Rep. CME and CSA, A-99)

H-295.891 Governance of the National Resident Matching Program

Our AMA will encourage the National Resident Matching Program to structure its governance board so as to include designated seats for direct representation of residency directors and the medical school deans of students. (Res. 302, A-99)

H-295.892 Potential Implications of Attending Non-LCME/AOA Accredited Medical Education Programs

Our AMA encourages efforts to educate all prospective medical students about the potential implications of attending any non-Liaison Committee on Medical Education/American Osteopathic Association accredited medical education program. (Res. 322, I-98; Reaffirmed: CME Rep. 2, A-08)

H-295.893 Voting Rights for AMA-MSS NBME Representatives

Our AMA will: (1) petition the National Board of Medical Examiners (NBME) to add AMA student representation to the National Board, the governing and voting body of the NBME; and (2) work with the NBME to ensure that the AMA-MSS, through its Governing Council, is given appropriate advance notice of any major upcoming votes. (Res. 323, I-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CME Rep. 10, A-08)

H-295.894 Medical Education on Sleep and Sleep Disorders

Our AMA supports diagnosis and management of sleep and sleep disorders as an essential and integral component of medical education. (Res. 310 , I-98; Reaffirmed: CME Rep. 2, A-08)

H-295.895 Progress in Medical Education: Structuring the Fourth Year of Medical School

It is the policy of the AMA that: (1) Trends toward increasing structure in the fourth year of medical school should be balanced by the need to preserve opportunities for students to engage in elective clinical and other educationally appropriate experiences.
(2) The third and fourth years as a continuum should provide students with a broad clinical education that prepares them for entry into residency training.
(3) There should be a comprehensive assessment of clinical skills administered at a time when the results can be used to plan each student's fourth-year program, so as to remedy deficiencies and broaden clinical knowledge.
(4) Medical schools should develop policies and procedures to ensure that medical students receive counseling to assist them in their choice of electives.
(5) Adequate and timely career counseling should be available at all medical schools.
(6) The ability of medical students to choose electives based on interest or perceived academic need should not be compromised by the residency selection process. The American Medical Association should work with the Association of American Medical Colleges, medical schools, and residency program directors groups to discourage the practice of excessive audition electives.
(7) Our AMA should continue to work with relevant groups to study the transition from the third and fourth years of medical school to residency training, with the goal of ensuring that a continuum exists in the acquisition of clinical knowledge and skills. (CME Rep.

1, I-98; Reaffirmed: CME Rep. 9, A-07)

H-295.896 Conscience Clause: Final Report

Principles to guide exemption of medical students from activities based on conscience include the following:

(1) Medical schools should address the various types of conflicts that could arise between a physician's individual conscience and patient wishes or health care institution policies as part of regular curricular discussions of ethical and professional issues.
(2) Medical schools should have mechanisms in place that permit students to be excused from activities that violate the students' religious or ethical beliefs. Schools should define and regularly review what general types of activities a student may exempt as a matter of conscience, and what curricular alternatives are required for students who exempt each type of activity.
(3) Prospective students should be informed prior to matriculation of the school's policies related to exemption from activities based on conscience.
(4) There should be formal written policies that govern the granting of an exemption, including the procedures to obtain an exemption and the mechanism to deal with matters of conscience that are not covered in formal policies.
(5) Policies related to exemption based on conscience should be applied consistently.
(6) Students should be required to learn the basic content or principles underlying procedures or activities that they exempt. Any exceptions to this principle should be explicitly described by the school.
(7) Patient care should not be compromised in permitting students to be excused from participating in a given activity. (CME Rep .9, I-98; Reaffirmed: CEJA Rep. 11, A-08)

H-295.897 Enhancing the Cultural Competence of Physicians

The AMA will: (1) continue to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula;

(2) continue research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys and focus groups at regularly scheduled meetings;

(3) form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of resources on cultural competencies for physicians and maintaining it and related resources in an electronic database;

(4) assist physicians in obtaining information about and/or training in culturally effective health care through development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM; and

(5) seek external funding to develop a five-year program for promoting cultural competence in and through the education of physicians, including a critical review and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of American Indian Physicians,) the American Medical Women's Association, the American Public Health Association, the American Academy of Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice. (CME Rep. 5, A-98; Reaffirmed: Res. 221, A-07)

H-295.900 Creating an Effective Environment for Medical Student Education

The AMA encourages the development of a model student orientation program that includes workshops that address health awareness for students and standards of behavior for teachers and learners. (CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, A-08)

H-295.901 Restrictive Covenants in Residency and Fellowship Training Programs

Our AMA adopts as policy and publicizes to all teaching institutions the Current Opinion that it is unethical for a teaching institution to seek a non-competition guarantee in return for fulfilling its educational obligations. Physicians-in-training should not be asked to sign covenants not-to-compete as a condition of their entry into any residency or fellowship program. (Sub. Res. 305, I-97; Reaffirmed: CME Rep. 2, A-07)

H-295.902 Alternative Medicine

(1) AMA policy states that courses offered by medical schools on alternative medicine should present the scientific view of unconventional theories, treatments, and practice as well as the potential therapeutic utility, safety, and efficacy of these modalities.

(2) Our AMA will work with members of the Federation to convey physicians' and patients' concerns and questions about alternative care to the NIH Office of Alternative Medicine and work with them and other appropriate bodies to address those concerns and questions. (CSA Rep. 12, A-97; Appended by Res. 525, A-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-295.903 Opposition to Legislation that Directs the Content of Medical School Curriculum

The AMA opposes efforts from all levels of government to dictate the content of medical school curricula either directly or as a condition for receipt of funding. (Res. 322, A-97; Reaffirmed: CME Rep. 2, A-07)

H-295.904 Commitment to Honor Resident Contracts

The AMA adopts the following language as policy: In the event of a residency program reduction or closure, institutions should make every effort possible to allow residents already in the program to complete their education and, should honor the provisions of their existing contracts. (Res. 314, A-97; Reaffirmed: CME Rep. 2, A-07)

H-295.905 Promoting Culturally Competent Health Care

The AMA encourages medical schools to offer electives in culturally competent health care with the goal of increasing awareness and acceptance of cultural differences between patient and provider. (Res. 306, A-97; Reaffirmed: CME Rep. 2, A-07)

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)

H-295.907 Managed Care and Graduate Medical Education

The American Medical Association will encourage AMA representatives to Residency Review Committees and to the Accreditation Council for Graduate Medical Education to request that these bodies review the impact of the changing health care environment on the feasibility of meeting accreditation standards related to patient volume, number of procedures to be performed, residency program size, and the requirement for the presence of residency programs in other disciplines. (CME Rep. 7, A-97; Modified: CME Rep. 7, A-05)

H-295.908 Protection of Medical Students in the Event of Medical School Closure or Reduction in Enrollment

The AMA will continue to monitor medical school closures, mergers, and changes in ownership. In the case of medical school closure or decreases in class size that affect enrolled students, the AMA will provide appropriate assistance, where feasible, so that medical students will experience an orderly transition. (CME Rep. 4, A-97; Reaffirmed: CME Rep. 2, A-07)

H-295.910 Restrictive Covenants During Training

The AMA strongly urges residency and fellowship training programs that utilize restrictive covenants to provide written intent to impose such restrictions in advance of the interview process. (Res. 6, I-96; Reaffirmed: CME Rep. 2, A-06)

H-295.911 Medical Student Education on Termination of Pregnancy Issues

The AMA encourages education on termination of pregnancy issues so that medical students receive a satisfactory knowledge of the medical, ethical, legal and psychological principles associated with termination of pregnancy, although observation of, attendance at, or any direct or indirect participation in an abortion should not be required. (Res. 304, I-96; Reaffirmed: CME Rep. 2, A-06)

H-295.912 Education of Medical Students and Residents about Domestic Violence Screening

The AMA will continue its support for the education of medical students and residents on domestic violence by advocating that medical schools and graduate medical education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient. (Res. 303, I-96; Reaffirmed: CME Rep. 2, A-06)

H-295.913 Hepatitis Vaccinations

The AMA will pursue various avenues to assure that all medical students be vaccinated for Hepatitis B at the beginning of their first year of study, or upon entering a residency training program, unless evidence of immunity can be demonstrated. (Sub. Res. 228, A-96; Reaffirmed: CME Rep. 2, A-06)

H-295.914 Instruction in Managed Care

The AMA will communicate with medical school deans and residency program directors urging the inclusion in their curricula of appropriate instruction regarding the concept, implementation and impact of managed care on the practice of medicine. (Res. 309, A-96; Reaffirmed by CME Rep. 5, A-97; Reaffirmed: CME Rep. 2, A-07)

H-295.915 Residency Program Responsibility for Resident Education

The AMA affirms that the basic skills and competencies for the practice of medicine and its specialties must be determined solely by the medical profession. (Res. 313, A-96; Reaffirmed: CME Rep. 2, A-06)

H-295.916 Improving Medical School/Community Practice

(1) Medical schools should be encouraged to include community physicians who serve as volunteer faculty in medical school activities and in committees and other decision-making bodies related to the student educational program, such as the curriculum committee and the admission committee, and in search committees for medical school deans and department chairs.
(2) County/state medical societies should be encouraged to include medical school administrators and faculty members in committees and other society activities, and to consider creating a seat for medical school deans in the state society house of delegates.
(3) There should be mechanisms established at local or state levels to address tensions arising between the academic and practice communities, such as problems associated with the granting of faculty appointment or hospital staff privileges.
(4) The AMA Medical School Visitation Program should be widely publicized and medical schools who have not yet participated should be encouraged to do so. Periodic re-visits should be encouraged.
(5) Medical schools and other academic continuing medical education providers should work with community physicians to develop continuing education programs that address local needs.
(6) Community physician groups and schools of medicine should be encouraged to communicate during the initial stages of discussions about the formation of patient care networks. (BOT Rep. 20, A-96; Reaffirmed: CME Rep. 2, A-06)

H-295.917 Protection of Medical Students in the Event of Medical School Closure or Reduction in Enrollment

The AMA will develop a plan of action to assist and protect medical students in the event of reduction in enrollment or closure of medical schools. (Sub. Res. 310, A-96; Modified and reaffirmed: CME Rep. 2, A-06)

H-295.918 Strengthening Education in Geriatrics

The AMA supports education in geriatric medicine, with defined curriculum content, goals, and objectives; and encourages enhanced training in residency programs for patient care of the elderly and that the leadership of specialty societies and continuing medical education centers encourage joint educational activities in geriatrics-related topics. (Res. 306, A-95; Reaffirmed: CME Rep. 2, A-05)

H-295.919 Advanced Cardiac Life Support Training

Our AMA: (1) strongly supports the teaching of advanced cardiac life support and basic life support beginning in medical school and continuing during residency training; and (2) encourages medical schools to include the following areas related to airway management as part of the required curriculum: (a) airway anatomy and function; (b) basic life support and advanced cardiac life support, and (c) airway management and intubation in the unconscious patient; and (3) will monitor the teaching in medical schools related to airway management in the unconscious patient. (Sub. Res. 309, A-95; Reaffirmed and Appended: CME Rep. 3, I-99)

H-295.920 Academic Freedom

The AMA supports the opportunity for residents to learn procedures for termination of pregnancy and opposes efforts by other persons or organizations to interfere with or restrict the availability of this training. (Res. 301, A-95; Reaffirmed: CME Rep. 2, A-05)

H-295.921 Federal Intervention in the Setting of Educational Standards

The AMA strongly opposes federal intervention, through legislative restrictions, that would limit the authority of professional accrediting bodies to design and implement appropriate educational standards for the training of physicians. The AMA strongly opposes infringements and mandates on medical school curricular requirements through state and federal legislative efforts, and also recommends that state medical societies should carefully monitor such activities and notify the AMA when such intrusions take place. (Res. 323, A-95; Appended: CME Rep. 4, I-97; Reaffirmed: CME Rep. 2, A-07)

H-295.922 Establishing Essential Requirements for Medical Education in Substance Abuse

AMA policy states that alcohol and other drug abuse education needs to be an integral part of medical education; and that the AMA supports the development of programs to train medical students in the identification, treatment, and prevention of alcoholism and other chemical dependencies. Our AMA: (1) asks all residency review committees to review their training requirements in the treatment and management of substance abuse and addicition and to make recommendations for strengthening this provision as needed; and (2) encourages the development of specialty-specific needs assessment to determine whether targeted educational activities in substance abuse would be useful in their overall program of continuing medical education (Res. 303, I-94; Reaffirmed and Appended: CME Rep. 10, I-98; Reaffirmed: CME Rep. 11, A-07)

H-295.923 Medical Training and Termination of Pregnancy

The AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services and about the medical and public health importance of access to safe termination of pregnancy. (Res. 315, I-94; Reaffirmed: CME Rep. 2, A-04)

H-295.924 Future Directions for Socioeconomic Education

The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum;
(2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings, at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which "socioeconomic" subjects are covered in the medical curriculum. (CME Rep. 1-I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

H-295.925 Restriction of Medical Staff Appointments

AMA policy states that nonsalaried faculty members of medical schools be able to hold concurrent appointments at more than one medical school as long as the individual physician agrees to carry out all responsibilities assigned by each medical school. (Sub. Res. 812, A-94; Reaffirmed: CME Rep. 2, A-04)

H-295.926 Support for Development of Continuing Education Programs for Primary Care Physicians in Non-Academic Settings

The AMA: (1) supports development, where appropriate, of programs of education for medical students and faculty in non-academic settings, making use of telecommunications; (2) encourages that medical schools provide faculty development programs that are designated for AMA PRA Category 1 credit; and (3) encourages that teaching continue to be accepted for AMA PRA Category 2 credit. (CME Rep. 3, A-94; Reaffirmed: CME Rep. 2, A-05)

H-295.927 Medical Student Health and Well-Being

The AMA encourages the Association of American Medical Colleges, Liaison Committee on Medical Education, medical schools, and teaching hospitals to address issues related to the health and well-being of medical students, with particular attention to issues such as HIV infection that may have long-term implications for health, disability and medical practice, and consider the feasibility of financial assistance for students with disabilities. (BOT Rep. 1, I-934; Modified with Title Change: CSA Rep. 4, A-03)

H-295.929 Faculty/Staff Appointments at More Than One Medical School

The AMA encourages medical schools that currently do not permit volunteer faculty members to hold appointments at more than one medical school to review this policy, to ensure that it is in the best interests of medical education and program integrity. (CME Rep. 3, I-93; Reaffirmed: CME Rep. 2, A-05)

H-295.931 Pesticide-Herbicide Toxicity Instruction

The AMA encourages education in pesticide and herbicide toxicity to be provided at all levels of medical education. (Res. 304, A-93; Reaffirmed: CME Rep. 2, A-03)

H-295.933 Medical School Affiliations With VA Medical Centers

The AMA will work to ensure that the successful relationships between VA academic medical centers and the nation's medical

schools are maintained. (Sub. Res. 313, A-93; Modified: CME Rep. 2, A-03)

H-295.934 Physician Training in Health Care Management and Administration

The AMA encourages the development of programs for physician education in health care administration and management. (Sub. Res. 311, A-93; Reaffirmed: CME Rep. 2, A-03)

H-295.937 Medical Students Infected with Bloodborne Pathogens

A medical student who becomes infected with human immunodeficiency virus (HIV) or other bloodborne infectious diseases should not be prevented from completing their course of study and receiving their MD/DO degree based solely on their seropositivity. (Res. 413, I-92; Reaffirmed: CME Rep. 2, A-03; Modified with Title Change: CSA Rep. 4, A-03)

H-295.938 Medical Education Accreditation

The AMA charges its representatives to medical education accrediting bodies to ensure that program accreditation not be used to address specialty distribution of physicians. (Res. 322, I-92; Reaffirmed: CME Rep. 2, A-03)

H-295.939 OSHA Regulations for Students

The AMA, working in conjunction with its Medical School Section, encourages all health care related educational institutions to apply existing Occupational Safety and Health Administration Blood Borne Pathogen Standards equally to employees and students. (Sub. Res. 229, I-92; Reaffirmed: CME Rep. 2, A-03)

H-295.940 Recruiting Students of Medicine at the Elementary and High School Levels

The AMA will work with state and local medical societies to encourage teachers at primary and secondary schools to alert their students to the potential for professional and personal satisfaction from service to others through a career in medicine. (Res. 319, A-92; Reaffirmed: CME Rep. 2, A-03)

H-295.941 Policies for the Admission of Students from Underserved Areas to Medical Schools

The AMA encourages all U.S. medical schools to develop admissions procedures that will facilitate the admission of students from underserved areas to medical schools, without compromising current admission standards. (Res. 302, A-92; Reaffirmed: CME Rep. 2, A-03)

H-295.942 Providing Dental and Vision Insurance to Medical Students and Resident Physicians

The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students;

(2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans;

(3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance;

(4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting.

(5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance. (BOT Rep. W, I-91;

Reaffirmed: BOT Rep. 14, I-93; Appended: Res. 311, I-98; Modified: Res. 306, A-04)

H-295.943 Issues Regarding Patient and/or Donor Transports by Resident Physicians and Medical Students

Our AMA (1) urges medical schools not to require medical students to participate in the air or ground transport of patients or organs during required clinical rotations; and (2) encourages all teaching institutions where medical students or resident physicians participate (compulsorily or voluntarily) in the air or ground transport of patients or organs (a) to notify prospective students and residents of all program requirements related to transports; (b) to include accident, disability, and life insurance as part of an available package for participating medical students and resident physicians, and to provide such insurance where participation is mandatory; (c) to include in the educational curriculum formal training on general and safety issues pertaining to emergency transport before students or residents participate in such activity; and (d) to adhere to the Association of Air Medical Services (AAMS) Minimum Quality Standards and Safety Guidelines for transport. (CME Rep. E, I-91; Reaffirmed: Sunset Report, I-01)

H-295.947 Legislative Threats to the Voluntary Accreditation Process

It is the policy of the AMA to strongly oppose legislation which would: (1) dismantle national accrediting agencies and which would substitute state standards for a uniform level of national standards in medical education; and (2) limit professional participation in the setting and evaluation of quality standards in medical education. (Res. 225, I-91; Modified: Sunset Report, I-01)

H-295.948 Health and Disability Insurance for Medical Students

The AMA (1) takes the position that all medical schools and residency programs provide insurance policy options that include a reasonable definition of "sickness" or "disability" that includes HIV infection, and require enrollment in such health and disability insurance plans for all their medical students and residents, and (2) encourages other health professions to provide similar health and disability insurance policies for their students. (BOT Rep. Q, A-91; Amended: BOT Rep. J, I-92; Reaffirmed: CME Rep. 2, A-03)

H-295.949 Encouraging Community Based Medical Education

Our AMA recognizes and acknowledges the vital role of practicing physicians in community hospitals in medical student and resident teaching. (Res. 44, A-91; Modified: Sunset Report, I-01)

H-295.953 Medical Student Legislative Awareness

The AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students. (Res. 14, A-91; Reaffirmed: Sunset Report, I-01)

H-295.955 Teacher-Learner Relationship In Medical Education

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR
The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment,

inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients. (BOT Rep. ZZ, I-90; Reaffirmed by CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, I-99; Modified: BOT Rep. 11, A-07)

H-295.956 Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers

Our AMA encourages the Bureau of Health Manpower to establish a series of grants for innovative pilot programs that change the current approaches to medical education at the undergraduate/graduate level in the primary care area which can be evaluated for their effectiveness in increasing the number of students choosing primary care careers. (Res. 173, I-90; Reaffirmed: Sunset Report, I-00)

H-295.957 Use of Animals in Medical Education

Our AMA has adopted the following guidelines on the use of animals in medical school curricula and continuing medical education courses: (1) Where appropriate, medical school faculty should consider using non-animal models in education activities; when animals are used in the curriculum, education goals should be clearly stipulated.

(2) Each medical school should disseminate a policy statement to students before matriculation regarding their participation in educational experiences involving animals.

(3) All educational experiences involving animals should have the approval of the institutional Animal Care and Use Committee.

(4) Involved faculty should discuss with students the learning objectives of any educational experience that utilizes animals, and faculty should remain available throughout the laboratory exercise for advice and guidance on the conduct of the educational experience.

(5) All educational experiences involving animals should be carried out in a humane manner without inflicting pain on the animal. This includes the appropriate use of anesthetic and analgesic drugs.

(6) At the conclusion of study, animals should be euthanized in the manner described by the American Veterinary Medical Association. (CSA Rep. A, I-90; Reaffirmed: Sunset Report, I-00)

H-295.959 Departments of Family Practice in all LCME Approved Medical Schools

Our AMA urges the LCME to strongly encourage every medical school without a Department of Family Practice to develop one. (Res. 59, I-90; Reaffirmed: Sunset Report, I-00)

H-295.960 Broadly Based Clinical Experience and Clinical Proficiency Standards

It is the policy of the AMA: (1) to direct its representatives on the LCME to continue to monitor the educational content of the final

year of educational programs accredited by the LCME so that the standards, and their application to accredited programs, will provide a broad clinical experience; and (2) to reaffirm existing policy that the first year of graduate medical education should provide the resident physician with a broad clinical experience. (CME Rep. H, A-90; Reaffirmed: Sunset Report, I-00)

H-295.961 Medicolegal, Political, Ethical and Economic Medical School Course

(1) The AMA urge every medical school and residency program to teach the legal, political, ethical and economic issues which will affect physicians. (2) The AMA will work with state and county medical societies to identify and provide speakers, information sources, etc., to assist with the courses. (3) An assessment of professional and ethical behavior, such as exemplified in the AMA Principles of Medical Ethics, should be included in internal evaluations during medical school and residency training, and also in evaluations utilized for licensure and certification. (4) The Speaker of the HOD shall determine the most appropriate way for assembled physicians at the opening sessions of the AMA House of Delegates Annual and Interim Meetings to renew their commitment to the standards of conduct which define the essentials of honorable behavior for the physician, by reaffirming or reciting the seven Principles of Medical Ethics which constitute current AMA policy. (5) There should be attention to subject matter related to ethics and to the doctor-patient relationship at all levels of medical education: undergraduate, graduate, and continuing. Role modeling should be a key element in helping medical students and resident physicians to develop and maintain professionalism and high ethical standards. (6) There should be exploration of the feasibility of improving an assessment of ethical qualities in the admissions process to medical school. (7) Our AMA pledges support to the concept that professional attitudes, values, and behaviors should form an integral part of medical education across the continuum of undergraduate, graduate, and continuing medical education. (Res. 189, A-90; Modified by CME Rep. 1, I-95; Appended: Res. 318, I-98; Reaffirmed: CME Rep. 2, A-08)

H-295.964 Enforcement of AMA Policy on Sexual Exploitation and Harassment

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

H-295.965 Medical Student Abuse

It is the policy of the AMA that the AMA, in cooperation with other appropriate agencies such as the LCME and the AAMC, define medical student abuse, study the pervasiveness of medical student abuse in U.S. medical schools and develop model guidelines to address abuse. (Res. 290, A-90; Modified: Sunset Report, I-00)

H-295.966 Medical School Honor Codes

Our AMA urges the LCME to facilitate the development of honor codes by medical schools. (CME Rep. D, A-90; Reaffirmed: Sunset Report, I-00)

H-295.968 Training Physicians for the 21st Century

Our AMA approves the concept of undertaking focused studies of medical education, with the participation of other appropriate organizations, at such time as adequate funding can be obtained. (CME Rep. D, I-89; Reaffirmed: Sunset Report, A-00)

H-295.969 Nondiscrimination Toward Medical School and Residency Applicants

Our AMA urges (1) the Liaison Committee on Medical Education to amend the Standards for Accreditation of Medical Education Programs Leading to the MD Degree, Part 2, Medical Students, Admissions to read: "In addition, there must be no discrimination on the basis of sex, age, race, creed, national origin, gender identity, or sexual orientation"; and (2) the Accreditation Council for Graduate Medical Education to amend the "General Essentials of Accredited Residencies, Eligibility and Selection of Residents" to read: "There must be no discrimination on the basis of sex, age, race, creed, national origin, gender identity or sexual orientation." (Res. 12, A-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 11, A-07)

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

The AMA believes that: (1) all medical training programs should develop and implement a policy that addresses sexual harassment and exploitation in the medical education environment; (2) such policies should include a discussion distinguishing consensual relationships from harassment; (3) such policies should contain a grievance procedure, including a mechanism to assure that the rights of all parties to due process are rigorously observed; and (4) information regarding that institution's policies pertaining to sexual

harassment and grievance procedures must be readily available to all parties. (CEJA Rep. B, A-89; Res. 301, I-94; Reaffirmed: CME Rep. 3, A-03)

H-295.972 Education Regarding Prescribing Controlled Substances

The AMA (1) encourages physicians, hospital medical staff organizations, resident physicians, and medical students to participate in education programs to ensure proper prescribing and dispensing of controlled substances; and (2) encourages regulatory agencies, state medical societies, and state medical boards to recognize the value of participation in such educational programs as an alternative to imposing disciplinary sanctions on well-intentioned physicians. (Sub. Res. 76, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)

H-295.974 Regulation of Medical Student Educational Opportunities

The AMA (1) reaffirms its support for the LCME standard for accreditation of undergraduate medical education programs that the curriculum be designed to instill in its graduates the knowledge and skills fundamental to the practice of medicine; and (2) opposes legislation or other efforts by state or federal regulatory agencies to define standards which limit educational opportunities in the training process of future physicians. (Res. 142, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)

H-295.975 Educating Competent and Caring Health Professionals

(1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in which they teach include as an objective the education of practitioners who are both competent and compassionate.
(2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants' extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities.
(3) Faculty of programs of education for the health professions must continue to emphasis than they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced.
(4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education should promote an interdisciplinary experience for their students. (BOT Rep. NN, A-87; Modified: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)

H-295.977 Socioeconomic Education for Medical Students

The AMA favors (1) continued monitoring of U.S. medical school curricula and (2) providing encouragement and assistance to medical school administrators to include or maintain material on health care economics in medical school curricula. (CME Rep. B, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

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-295.980 Clinical Training in STD for Medical Students/Physicians in Training

The AMA urges medical schools to provide supervised training in sexually transmitted diseases for all medical students and physicians in training. (Sub. Res. 88, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

H-295.981 Geriatric Medicine

Our AMA reaffirms its support for: (1) the incorporation of geriatric medicine into the curricula of medical school departments and its encouragement for further education and research on the problems of aging and health care of the aged at the medical school, graduate and continuing medical education levels; and (2) increased training in geriatric pharmacotherapy at the medical student and residency level for all relevant specialties and encourages the Accreditation Council for Graduate Medical Education and the appropriate Residency Review Committees to find ways to incorporate geriatric pharmacotherapy into their current programs. (Res. 137, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Appended: CSA Rep. 5, A-02)

H-295.983 Extramural Clerkships and Early Career Decisions

The AMA (1) recognizes the essential role of the medical school faculty in the determination of the core clinical education of medical students; and (2) opposes resident recruitment practices which would interfere with scheduled core clinical clerkships at the student's medical school. (Res. 77, I-84; CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-295.984 Family Medicine as a Fundamental Subject in Medical Schools

The AMA recommends that U.S. medical schools include family medicine as a clinical subject. (Res. 14, I-84; Reaffirmed: CMS Rep. L, A-93; Reaffirmed: CME Rep. 2, A-03)

H-295.985 Humanism in Graduate Medical Education

The AMA encourages medical schools and teaching hospitals to strengthen educational programs for undergraduates and resident physicians in recognizing and meeting the emotional needs of patients and their families. (Sub. Res. 154, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04)

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-295.988 Alcohol and Substance Abuse Education of Medical Students and Residents

In cooperation with other organizations, the AMA supports the education of medical students and residents in the prevention and treatment of alcoholism and substance abuse in our nation's youth. (Sub. Res. 100, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 11, A-07)

H-295.989 Computer and Information Systems in Medical Education

The AMA believes that, within the limits of its resources, including both finances and skilled personnel, each medical school should determine the methodology for, and the extent of the incorporation of, computer-based technology in its educational program. (CME Rep. B, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-295.992 Medical Student Education Concerning Physician Impairment

The AMA (1) supports the teaching of the prevention of physician impairment to medical students and residents; and (2) encourages state medical society physician impairment committees and institutions offering medical education to address student and resident problems with substance abuse. (Sub. Res. 80, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

H-295.993 Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs

Our AMA: (1) recognizes the need for (a) appropriate mechanisms to include medical students and resident physicians in existing medical society impaired physician programs; and (b) these programs to include activities to prevent impairment; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available medical school impairment treatment programs and that schools ensure that these services are provided confidentially. (Sub. Res. 84, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed and appended: CME Rep. 4, I-98; Reaffirmed: CME Rep. 2, A-08)

H-295.995 Recommendations for Future Directions for Medical Education

The AMA supports the following recommendations relating to the future directions for medical education:

(1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.
(2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.
(3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.
(4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.
(5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.
(6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.
(7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.
(8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.
(9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.
(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.
(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.
(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.
(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.
(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.
(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.
(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.
(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.
(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.
(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of

the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.
(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.
(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.
(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.
(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.
(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.
(25) Specialty boards should consider having members of the public participate in appropriate board activities.
(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.
(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.
(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.
(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.
(30) U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various jurisdictions, prerequisites for entry into graduate medical education programs, and other factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME.
(31) Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine.
(32) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.
(33) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.
(34) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.
(35) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.
(36) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.
(CME Rep. B, A-82; Amended: CLRPD Rep. A, I-92; Res. 331, I-95; Reaffirmed by Res. 322, A-97; Reaffirmation I-03; Modified: CME Rep. 7, A-05; Modified: CME Rep. 2, I-05)

H-295.996 Psychological Testing Without Informed Consent

Our AMA urges medical schools to (1) undertake student psychological or personality tests only after review and approval of the research proposal in customary fashion by the institutional committee responsible for human research and to obtain written consent in such a manner that the student who does not wish to participate does not feel embarrassed or threatened; and (2) maintain records of such studies in the most strict and secure manner so that their use is confined to the purpose(s) for which consent was obtained. The

results of such tests on individual students should not be incorporated into the individual's school file nor used for any purpose which could be misconstrued as possibly affecting the individual's professional career. (CME Rep. B, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-295.998 Due Process

(1) Our AMA reaffirms its 1974 approval of the policy adopted by the Liaison Committee on Medical Education, which states: "A medical school should develop and publicize to its faculty and students a clear definition of its procedures for the evaluation, advancement, and graduation of students. Principles of fairness and 'due process' must apply when considering actions of the faculty or administration which will adversely affect the student to deprive him of his valuable rights."

(2) In addition, to clarify and protect the rights of medical students, the AMA recommends that: (a) Each school develop and publish in its catalog, student handbook or similar publication the institutional policies and procedures both for evaluation of academic performance (promotion, graduation, dismissal, probation, remedial work, and the like) and for nonacademic disciplinary decisions. (b) These policies and procedures should define the responsible bodies and their function and membership, provide for timely progressive verbal and written notification to the student that his/her academic/nonacademic performance is in question, and provide an opportunity for the student to learn why it has been questioned. (c) These policies and procedures should also ensure that when a student has been notified of recommendations by the responsible committee for nonadvancement or dismissal, he/she has adequate notice and the opportunity to appear before the decision-making body to respond to the data submitted and introduce his/her own data. (d) The student should be allowed to be accompanied by a student or faculty advisor. (e) The policies and procedures should include an appeal mechanism within the medical school. (f) The student should be allowed to continue in the academic program during the proceedings unless extraordinary circumstances exist, such as physical threat to others. (CME Rep. D, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

H-295.999 Medical Student Support Groups

(1) Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty.

(2) Our AMA supports making these alternatives available to students at the earliest possible point in their medical education. (Res. 164, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: CME Rep. 4, I-98; Reaffirmed: CME Rep. 2, A-08)

H-300.000 Medical Education: Continuing
(See Also: Medical Education; Medical Education: Financing and Support; Medical Education: Graduate)

H-300.946 Inappropriate Use of Social Security Numbers in CME Accreditation

Our AMA opposes the use of Social Security numbers as: (1) a requirement to obtain continuing medical education credit and strongly encourage the use of the AMA Medical Education number for such educational activities; and (2) file identifiers by providers of continuing medical education, certification boards and similar entities, suggesting instead the use of the AMA Medical Education number where such a unique identifier is required and applicable. (Res. 306, A-00; Appended Res. 301, A-01)

H-300.948 Continuing Medical Education Activities for Procedural Skills

The AMA encourages the ACCME to require sponsors of courses in new procedures to provide documentation for physician attendees, using the following four levels of achievement: Level 1: Verification of attendance, Level 2: Verification of satisfactory completion of course objectives, Level 3: Verification of "proctor readiness", and Level 4: Verification of physician competence to perform the procedure. (CME Rep. 12, A-97; Reaffirmed: CME Rep. 2, A-07)

H-300.949 The Ecology of Medical Education: Physician Self-Directed Learning and Continuing Medical Education

The AMA: (1) encourages medical schools and residency programs to define and educate the trainee on principles of self-directed learning, including self-assessment and how to use these principles to achieve continuing professional development; (2) supports efforts of the ACCME to develop ethical guidelines for the providers of CME, recognizing the unique needs of those funding CME and their potential to influence the direction of CME; and (3) will seek support for a national study of the future directions of continuing medical education so that effective strategies and policies are developed for maintaining and improving the competence of physicians in caring for patients. (CME Rep. 10, A-97; Reaffirmed: CME Rep. 2, A-07)

H-300.951 Credit for Reading Medical Journals

The AMA continues to support appropriate credit for medical journal study and make every effort to simplify the process by which this is accomplished. (Res. 315, I-96; Reaffirmed: CME Rep. 2, A-06)

H-300.952 Dissemination of Information Regarding CME Activities

The AMA will continue to support the current system of Continuing Medical Education accreditation in which the Accreditation Council for Continuing Medical Education accredits sponsors whose mission and intended audience are on a regional or national level and state medical societies accredit sponsors whose mission and intended audience are physicians within state and contiguous states, following the guidelines enunciated by the ACCME. (CME Rep. 7, I-96; Reaffirmed: CME Rep. 2, A-06)

H-300.953 Content-Specific CME Mandated for Licensure

(1) The AMA, state medical societies, specialty societies, and other medical organizations should reaffirm that the medical profession alone has the responsibility for setting standards and determining curricula in continuing medical education. (2) State medical societies should establish avenues of communication with groups concerned with medical issues, so that these groups know that they have a place to go for discussion of issues and responding to problems. (3) State medical societies should periodically invite the various medical groups from within the state to discuss issues and priorities. (4) State medical societies in states which already have a content-specific CME requirement should consider appropriate ways of rescinding or amending the mandate. (CME Rep. 6, A-96; Reaffirmed: CME Rep. 2, A-06)

H-300.954 Reduced Fees for Retired Physicians to Attend Continuing Medical Education Courses

Our AMA encourages all providers of continuing medical education to consider a reduced fee policy for retired physicians. (Res. 319, A-96; Reaffirmation I-01; Reaffirmed: BOT Rep. 17, A-04)

H-300.955 Restructuring of Continuing Medical Education Credits

The AMA encourages state licensing boards with CME reporting requirements to allow AMA Physician's Recognition Award Category 1 and Category 2 continuing medical education credit toward reregistration of the license to practice medicine; and all state licensing boards be urged to accept a current and valid AMA Physician's Recognition Award as evidence of completion of these requirements. (CME Rep. 7, A-96; Reaffirmed: CME Rep. 2, A-06)

H-300.956 Practice Management Training

The AMA continues to develop and encourage the use by medical schools and residency programs of curricula on medical practice management and the efficient and economical use of time and resources. (Res. 308, A-94; Reaffirmed: CME Rep. 2, A-04)

H-300.957 Promoting Primary Care Services Through Continuing Medical Education

The AMA urges accredited continuing medical education sponsors to promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services. (Res. 311, A-94; Reaffirmed: CME Rep. 2, A-04)

H-300.958 Support for Continuing Medical Education

The AMA: (1) supports the concept of lifelong learning by recognizing the importance of continuing medical education as an integral part of medical education, along with undergraduate and graduate medical education;
(2) encourages physicians to maintain and advance their clinical competence and keep up with changes in health care delivery brought about by health system reform;
(3) assists and supports the expansion and enhancement of funding resources for continuing medical education on a local, regional, and national basis through foundations, private industry, health care organizations and appropriate government agencies;
(4) encourages U.S. medical schools to integrate continuing medical education into the continuum of undergraduate and graduate medical education;
(5) supports and assists medical schools, teaching institutions, and other health-related organizations in developing and facilitating implementation of health policy that supports research in continuing medical education, relevant to the needs of practicing physicians; and
(6) supports efforts to facilitate and speed development of computer-based interactive and distance learning technologies to support learning needs of practicing physicians regardless of their geographic location. (Sub. Res. 310, A-94; Reaffirmed by CME Rep. 10, A-97; Reaffirmed: CME Rep. 2, A-07; Reaffirmed: CME Rep. 3, A-08)

H-300.959 Physician Participation in the AMA Physician's Recognition Award

It is policy that: (1) the AMA, state medical societies, and specialty societies in the AMA House of Delegates publicize and promote physician participation in the AMA Physician's Recognition Award; and (2) that all physicians participate in the AMA Physician's Recognition Award as a visible demonstration of their commitment to continuing medical education. (CME Rep. 1, I-93; Reaffirmed with change in title: CME Rep. 2, A-05)

H-300.960 Promoting Physician Access to Quality Continuing Medical Education Programs

The AMA will instruct its representatives to the ACCME to advocate: (1) an extensive review and evaluation of the ACCME accreditation review process and criteria, including procedures for training and oversight of accreditation survey team members to assure review quality and continuity; (2) the development of specific documentation criteria which will be expected of accredited institutions and clearly communicate these to the accredited institutions; (3) the emphasis on physician access to quality continuing medical education programming rather than deterring providers with an over-emphasis on unnecessary bureaucratic detail; and (4) that the accreditation process be conducted as a mentoring and constructive process, as well as a quality assurance process. (Res. 313, I-93; Reaffirmed: CME Rep. 2, A-03)

H-300.962 Recognition of Those Who Practice Addiction Medicine

It is the policy of the AMA to: (1) encourage all physicians, particularly those in primary care fields, to undertake education in treatment of substance abuse; (2) direct its representatives to appropriate Residency Review Committees (RRCs) to ask the committees on which they serve to consider requiring instruction in the recognition and management of substance abuse. Those RRCs that already require such instruction should consider greater emphasis for this subject. (3) encourage treatment of substance abuse as a subject for continuing medical education; and (4) affirm that many physicians in fields other than psychiatry have graduate education and experience appropriate for the treatment of substance abuse, and for utilization review, and for other evaluation of such treatment, and should be entitled to compensation. (CME Rep. I-93-5; Reaffirmed: CME Rep. 10, I-98; Reaffirmed: CME Rep. 11, A-07)

H-300.964 Medical Ethics and Continuing Medical Education

The AMA encourages accredited continuing medical education sponsors to plan and conduct programs and conferences emphasizing ethical principles in medical decision making. (Res. 323, I-92; Reaffirmed: CME Rep. 2, A-03)

H-300.965 The FDA and Continuing Medical Education Supported by Industry

The AMA commends the activities of all parties, including the Food and Drug Administration (FDA), who have worked diligently through the Task Force on CME Provider-Industry Collaboration in CME, to develop guidelines and clear concepts of independence for activities supported by commercial companies. The AMA will continue to monitor the implementation of FDA policies in accredited CME activities. (Sub. Res. 307, I-92; Reaffirmed: CME Rep. 2, A-03)

H-300.966 Continuing Medical Education for Physicians in the Hospital Setting

It is the policy of the AMA that the continuing medical educational programs offered physicians in the hospital setting be the responsibility of the hospital medical staff and directed by the medical staff as defined in the hospital bylaws. (Res. 318, A-92; Reaffirmed: CME Rep. 2, A-03)

H-300.968 Protocol for Recognition of State Medical Society Accreditation Programs

The AMA (1) reaffirms that proposed changes in the Protocol for the Recognition of State Medical Societies to Accredit Intrastate Continuing Medical Education Sponsors, including Guidelines for the Interpretation of the Criteria, be considered matters subject to the review and approval of the ACCME, in accordance with ACCME Bylaws; (2) urges the ACCME Committee for Review and Recognition of State Medical Societies (CRR) to take into consideration the demographic diversity, geographic differences, and varying resources of states when evaluating state medical society accreditation processes; and (3) urges the ACCME and CRR to develop reasonable alternate mechanisms (without lowering essential standards) for creating accreditable CME programs in those states and portions of states designated by the federal government as "rural" and whose resources may vary significantly from the norm. (CME Rep. A, A-92; Reaffirmed: CME Rep. 2, A-03)

H-300.969 Uniform Standards for Continuing Medical Education

The AMA (1) will continue its efforts to develop uniform standards for continuing medical education; and (2) will solicit input from all state medical associations, medical licensure boards, and national specialty organizations concerning the development of the most appropriate uniform standards for continuing medical education. (Res. 313, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed in lieu of Res. 901, I-05)

H-300.973 Promoting Quality Assurance, Peer Review, and Continuing Medical Education

Our AMA: (1) reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and continuing medical education activities; (2) to encourage hospitals and other organizations in which quality assurance, peer review, and continuing medical education activities are conducted to provide recognition to physicians who participate voluntarily; (3) to increase its efforts to make physicians aware that participation in the voluntary quality assurance and peer review functions of their hospital medical staffs and other organizations provides credit toward the AMA's Physicians' Recognition Award; and (4) to continue to study additional incentives for physicians to participate in voluntary quality assurance, peer review, and continuing medical education activities. (BOT Rep. SS, I-91; Reaffirmed: Sunset Report, I-01)

H-300.974 Unification of Continuing Education Credits

Our AMA (1) forwards this report to the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the California Medical Association, and other interested parties for their deliberation, with a request for specific action, if needed, to endorse these standards: (a) a common definition of continuing medical education; (b) use of merged terminology for similar CME activities; and (c) recognition of only those CME programs which meet the ACCME "Guidelines for Commercial Support of CME," and follow the AMA Ethical Opinion on "Gifts to Physicians"; and (2) accepts AAFP prescribed credit hours and ACOG cognate credit hours for formal learning, as equivalent to AMA PRA category 1. (CME Rep. C, I-91; Reaffirmed: Sunset Report, I-01)

H-300.975 Fraudulent/Legitimate Continuing Medical Education Activities

Our AMA supports the development and publication of guidelines to assist physicians in identifying continuing medical education of high quality, responsive to their needs, and supports the promulgation of ethical principles regarding the responsibilities of physicians to participate in continuing medical education programs which they claim for continuing medical education recognition, credit or other purposes. (Sub. Res. 64, A-91; Reaffirmed: Sunset Report, I-01)

H-300.976 Unification of Education Credits

It is the policy of the AMA to develop, in cooperation with national specialty organizations and state medical associations, uniform nationwide standards for continuing medical education hours recognized by all medical associations and specialty societies. (Res. 102, I-90; Reaffirmed: Sunset Report, I-00)

H-300.977 Revisions to the Physician's Recognition Award

Our AMA has adopted the following changes in the Physician's Recognition Award:

(1) to accept recertification by an AMA-recognized specialty board in satisfaction of requirements for a three-year PRA certificate;

(2) to allow credit for international conferences when these have been approved by the AMA prior to the event; and

(3) to allow credit for teaching to be reported for AMA PRA Category 2 credit toward the award. (CME Rep. D, I-90; Reaffirmed: Sunset Report, I-00; Modified and reaffirmed: CME Rep. 2, A-06)

H-300.978 Continuing Medical Education Credits for Attendance at AMA Leadership Conferences

It is the policy of the AMA to design programs in the AMA Leadership Conference to meet the Essentials of Accreditation of the ACCME so that the Conference offers the maximum number of sessions which qualify for continuing medical education credit. (Sub. Res. 95, I-90; Reaffirmed: Sunset Report, I-00)

H-300.979 National Accreditation of Continuing Medical Education Providers

Our AMA urges the ACCME to reduce its arbitrary and unfair distinction between national and intrastate providers of continuing medical education, while retaining the authority of state medical associations as intrastate accreditors. (Res. 188, A-89; Reaffirmed: Sunset Report, A-00)

H-300.980 Focused Continuing Education Programs for Enhanced Clinical Competence

(1) The AMA encourages state and, where appropriate, local medical societies to respond to the needs of physicians who have been identified as requiring focused continuing medical education. (2) The AMA encourages state and county medical societies to cooperate with organizations and agencies concerned with physician competence, such as state licensing boards, and to assist in

providing opportunities for physicians to participate in focused continuing education programs. (3) The AMA supports the collection and dissemination of information on focused continuing medical education programs that have been developed or are in the process of development. (CME Rep. C, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)

H-300.982 Maintaining Competence of Health Professionals

(1) Health professionals are individually responsible for maintaining their competence and for participating in continuing education; all health professionals should be engaged in self-selected programs of continuing education. In the absence of other financial support, individual health professionals should be responsible for the cost of their own continuing education. (2) Professional schools and health professions organizations should develop additional continuing education self-assessment programs, should prepare guides to continuing education programs to be taken by practitioners throughout their careers, and should make efforts to ensure that acceptable programs of continuing education are available to practitioners. (3) Health professions organizations and faculty of programs of health professions education should develop standards of competence. Such standards should be reviewed and revised periodically. (4) When reliable and cost-effective means of assessing continuing competence are developed, they should be required for continued practice. (5) Patient relations and ethics are appropriate subjects for continuing education; educational providers should increase the offering in these fields. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BOT Rep. 17, A-04)

H-300.983 Community Hospital Continuing Medical Education

The AMA believes that quality, patient-centered, cost-effective continuing medical education is important for hospital medical staffs, and that the cooperative efforts of hospitals, state and county medical societies, and academic medical centers contribute to achieving this goal. (CME Rep. D, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

H-300.984 Abuses of the Continuing Medical Education System

The AMA urges accredited providers of continuing medical education to accept the responsibility for careful compliance with the "ACCME's Essential Areas and Elements" in order to prevent abuses of the continuing medical education system. (CME Rep. C, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed and Modified: CME Rep. 2, A-05)

H-300.988 Restoring Integrity to Continuing Medical Education

The AMA (1) supports retention of the definitions of continuing medical education in the Physicians' Recognition Award ("Continuing medical education is composed of any education or training which serves to maintain, develop or increase the knowledge, interpretive and reasoning proficiencies, applicable technical skills, professional performance standards or ability for interpersonal relationships that a physician uses to provide the service needed by patients or the public.") and revised ACCME Essentials ("Continuing medical education consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public."); (2) urges members of the medical profession to be attentive to the distinction between continuing medical education and continuing education which is not related directly to their professional activities; (3) believes that accredited sponsors should designate as continuing medical education only those continuing education activities which meet the definition of continuing medical education in the revised ACCME Essentials; (4) encourages the ACCME and state medical associations on the state level to weigh seriously, in considering the sponsor's continued accreditation, instances where an accredited sponsor identifies non-continuing medical education activities as continuing medical education; and (5) encourages state medical boards to accept for credit continuing education which relates directly to the professional activities of physicians, although each state with mandatory continuing medical education for reregistration of license has the prerogative of defining the continuing education it will accept for credit. (CME Rep. A, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

H-300.992 National Accreditation of AMA as Provider of Continuing Medical Education

Our AMA assigns to the CME the responsibility to be the unit of the AMA to become accredited for continuing medical education. (BOT Rep. NN, A-81; CLRPD Rep. F, I-91; Modified: Sunset Report, I-01)

H-300.994 Support of Voluntary Continuing Medical Education

Our AMA supports individual physician responsibility for self-education. (Res. 138, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-300.996 Reaffirmation of Support for Continuing Medical Education

Our AMA supports investing funds in effective self-instructional educational programs that are within the budget and are potentially

self-supportive. (Sub. Res. 122, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

H-300.997 "Medical Education" Travel

Our AMA (1) deplores excessive charges for continuing medical education programs which exploit physicians or distort the real purposes of education programs; (2) encourages state society accrediting agencies to consider the impact of the cost of the accreditation process on program charges; and (3) supports making a concentrated effort to acquaint physicians with programs that will help them meet their particular educational needs at a reasonable cost. (Sub. Res. 84, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

H-300.998 Continuing Medical Education

Our AMA continues to encourage physicians to voluntarily participate in continuing medical education. (Sub. Res. 13, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

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)

H-305.000 Medical Education: Financing and Support
(See Also: Medical Education; Medical Education: Continuing; Medical Education: Graduate)

H-305.927 Payment Cuts to Teaching Programs

Our AMA opposes payment cuts to any teaching program on the basis that the attending physician is concurrently or sequentially supervising more than one resident, fellow or student. (Sub. Res. 719, I-07)

H-305.928 Proposed Revisions to AMA Policy on Medical Student Debt

1. Our AMA will make reducing medical student debt a high priority for legislative and other action and will collaborate with other organizations to study how costs to students of medical education can be reduced.
2. Our AMA supports stable funding for medical schools to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue and should oppose mid-year and retroactive tuition increases.
3. Financial aid opportunities, including scholarship and loan repayment programs, should be available so that individuals are not denied an opportunity to pursue medical education because of financial constraints.
4. A sufficient breadth of financial aid opportunities should be available so that student specialty choice is not constrained based on the need for financial assistance.
5. Our AMA supports the creation of new and the expansion of existing medical education financial assistance programs from the federal government, the states, and the private sector.
6. Medical schools should have programs in place to assist students to limit their debt. This includes making scholarship support available, counseling students about financial aid availability, and providing comprehensive debt management/financial planning counseling.
7. Our AMA supports legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit the full deductibility of interest on student loans.
8. Medical students should not be forced to jeopardize their education by the need to seek employment. Any decision on the part of the medical student to seek employment should take into account his/her academic situation. Medical schools should have policies and procedures in place that allow for flexible scheduling in the case that medical students encounter financial difficulties that can be remedied only by employment. Medical schools should consider creating opportunities for paid employment for medical students.
9. Financial obligations, such as repayment of loans, and service obligations made in exchange for financial assistance, should be fulfilled. There should be mechanisms to assist physicians who are experiencing hardship in meeting these obligations. (CME Rep. 13, A-06; Reaffirmation I-06; Reaffirmation I-07; Reaffirmation I-08)

H-305.929 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs

It is AMA policy that:

(1) Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.

(2) Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.

(3) Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.

(4) Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.

(5) All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.

(6) Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.

(7) Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.

(8) Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.

(9) New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties. (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmed: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08)

H-305.930 Residents' Salaries

Our AMA supports appropriate increases in resident salaries. (Res. 307, A-05)

H-305.931 State Support of Public Medical School Education

Our AMA (1) opposes any legislation that would require graduates of public medical schools to agree to practice in a particular locale as a condition of matriculation; and (2) strongly endorses and supports voluntary programs involving loan repayment, discounted tuition, or a tuition waiver for medical students who voluntarily agree to practice in particular locales or underserved areas. (Res. 708, I-04)

H-305.932 State and Local Advocacy on Medical Student Debt

Our AMA: (1) opposes the charging of broad and ill-defined student fees by medical schools, such as but not limited to professional fees, encouraging in their place fees that are earmarked for specific and well-defined purposes; (2) encourages medical schools to use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; and (3) encourages medical schools to cooperate with undergraduate institutions to establish collaborative debt counseling for entering first-year medical students. (Res. 847, I-03)

H-305.934 Medical School Tuition Increases

Our American Medical Association opposes the imposition of mid-year and retroactive tuition increases at both public and private medical schools. (CME Rep. 2, I-02; Reaffirmed: CME Rep. 3, I-03)

H-305.935 Policy Options for Support of Graduate Medical Education

Our AMA adopts the following principles:

GRADUATE MEDICAL EDUCATION POSITIONS

(1) Planning for the number of residency positions should take into account the contributions to patient care made by other health professions and occupations, considering that other health professions and occupations do not substitute for physicians.

(2) Explicit immunity from antitrust constraints should be provided to private professional groups, to allow participation in the national debate on the physician workforce.

(3) Program quality, based on an assessment of educational program outcomes under the leadership of the Accreditation Council for Graduate Medical Education and its Residency Review Committees, should be a factor in the allocation of funded residency positions.

(4) Transitional funds should be provided to teaching institutions that lose residents as a result of cuts in the number of funded positions. (CME Rep. 10, A-99; Reaffirmed: CME Rep. 2, A-00; Modified: CME Rep. 2, I-03; Modified: CME Rep. 7, A-05; Reaffirmation I-07)

H-305.938 Use of Social Security Numbers in Student Loan Accounts

Our AMA will work with student loan servicers and other associated agencies to end the use of Social Security Numbers as account numbers. (Res. 302, I-98; Reaffirmed: CME Rep. 2, A-08)

H-305.940 Tax Exemption for Federal Medical Profession Scholarships

Our AMA plans to work with the American Association of Medical Colleges in support of federal legislation that will assure that the direct medical school expense portion of the National Health Service Corps Scholarship program, the Armed Forces Health Professions Scholarship program and all other federally funded health profession scholarships is not taxable. (Res. 225, I-97; Reaffirmation A-01)

H-305.941 Recognizing Dependent Care Expenses in Determining Medical Education Financial Aid

AMA policy is to pursue changes to federal legislation or regulation, and specifically to the Higher Education Act, to change the cost of attendance definition for medical education to include costs for food, shelter, clothing and health care for all dependents, and for dependent care. (Res. 205, I-97; Reaffirmed: CME Rep. 2, A-07)

H-305.942 The Ecology of Medical Education: The Infrastructure for Clinical Education

The AMA recommends the following to ensure that access to appropriate clinical facilities and faculty to carry out clinical education is maintained: (1) That each medical school and residency program identify the specific resources needed to support the clinical education of trainees, and should develop an explicit plan to obtain and maintain these resources. This planning should include identification of the types of clinical facilities and the number and specialty distribution of full-time and volunteer clinical faculty members needed. (2) That affiliated health care institutions and volunteer faculty members be included in medical school and residency program resource planning for clinical education when appropriate. (3) That medical school planning for clinical network development include consideration of the impact on the education program for medical students and resident physicians. (4) That accrediting bodies for undergraduate and graduate medical education be encouraged to adopt accreditation standards that require notification of changes in clinical affiliations, in order to ensure that changes in the affiliation status of hospitals or other clinical sites do not adversely affect the education of medical students and resident physicians. (CME Rep. 13, A-97; Modified: CME Rep. 2, I-05)

H-305.948 Direct Loan Consolidation Program

The AMA supports the Individual Education Account/Direct Loan Consolidation Program. (Res. 312, I-95; Reaffirmed: CME Rep. 2, A-05)

H-305.950 Fairness in Publication of Names of Loan Defaulters

The AMA opposes the selective publication of names of defaulters on federally funded student loans. (Res. 309, A-94; Reaffirmed: CME Rep. 2, A-04)

H-305.954 Repayment of Medical School Loans

Our AMA will further develop and more aggressively publicize a low interest and extended payment loan program for young physician members of the AMA to assist them in retiring their educational debts. (CME Rep. O, A-93; Appended: Res. 610, I-98; Modified: CME Rep. 13, A-06)

H-305.955 Cost of Medical School and Educational Loan Interest

Our AMA encourages legislation to restore the tax deductibility of student loan interest. (Res. 305, I-92; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01)

H-305.961 Student Loan Deferment

It is the policy of the AMA (1) to undertake an immediate major campaign to prevent further erosion of Higher Education Act provisions regarding student loan deferment and forbearance for physicians in training; (2) to seek the direct assistance of all appropriate organizations, including state and local medical societies and auxiliaries, national medical specialty societies, medical school deans and faculty, residency training program directors, and housestaff associations to galvanize support to maintain at least the current loan deferment and forbearance allowances for physicians in training; (3) to continue efforts to persuade Congress to extend deferment of repayment of educational program loans until the completion of residency training and to allow up to ten years of forbearance of such educational loans; and (4) to provide as soon as possible all factual information, such as medical student default rates, mean and median levels of student loans and average resident incomes to assist component societies in effective legislative efforts. (Sub. Res. 230, I-91; Reaffirmed: CME Rep. 2, I-00)

H-305.962 Taxation of Federal Student Aid

Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA). (Res. 210, I-91; Reaffirmed: Sunset Report, I-01)

H-305.965 Student Loans

Our AMA: (1) reaffirms its support of legislation that would defer the repayment of loans for education until the completion of residency training; and (2) lobby before the next federal budget for deferment of medical student loans for the full initial residency period. (Sub. Res. 203, A-90; Appended Res. 306, I-99; Reaffirmation A-01; Reaffirmation I-06)

H-305.968 Medicare Direct and Indirect Medical Education Costs

1996 Consensus Statement on Physician Workforce

During the past few years, studies of the physician workforce have produced compelling evidence that the United States is on the verge of a serious oversupply of physicians. The attendant consequences of physician oversupply - the underemployment and unemployment of physicians are highly undesirable from the perspective of both the society at large and the individual physicians who are affected. Given this, the current rate of physician supply (the number of physicians entering the workforce each year) is clearly excessive.

The rate of physician supply is determined primarily by the number of U.S. and non-U.S. medical school graduates who enter the country's graduate medical education (GME) system each year. In recent years, the number of non-U.S. medical school graduates (international medical graduates/IMGs) entering GME in the United States has approximated 40 percent of the number of U.S. medical school graduates. To decrease the rate of physician supply, limits must be placed on the number of medical school graduates entering GME. Since the federal government currently plays a major role in financing GME and is responsible for establishing immigration laws that affect IMG participation in GME in this country, it is imperative that the federal government partner with the medical education community to achieve this goal.

Limiting the number of medical school graduates entering GME each year has important implications for the medical students and medical school graduates who may wish to pursue GME in this country, for hospitals that sponsor GME and are dependent on resident physicians to provide patient care services, and for patients who receive those services. Given these considerations, the associations that are party to this consensus statement offer the following recommendations to guide the administration and members of Congress in their deliberations of potential policy solutions to the problem of physician oversupply.

Recommendations

The number of entry level positions in the country's GME system should be aligned more closely with the number of graduates of accredited U.S. medical schools. This realignment should be achieved primarily by limiting federal funding of GME positions. Since in the United States all physicians must complete a period of GME before being licensed to practice medicine, the number of funded positions should be sufficient to allow all MD and DO graduates of accredited U. S medical schools an opportunity to enroll in an accredited GME program.

The United States should continue to provide GME opportunities for foreign born physicians who have graduated from non-U.S. medical schools. These physicians should participate in GME under the J-1 Exchange Visitor Program. Their training should not be financed from Medicare funds currently dedicated for the support of GME, or from any national all payer GME fund that might be established in the future. It is important that these physicians return to their country of origin after completing GME in this country. To ensure this, the government should eliminate all waiver programs that allow these physicians to remain in the United States if they agree to accept a practice position in a state or federally designated medically underserved area. As noted below, the government

should attempt to meet the needs of these communities by expanding existing (for example, the National Health Services Corps) or establishing new programs designed to recruit U.S. graduates to these practice positions.

It is likely that many traditionally underserved communities will continue to have an inadequate number of physicians, particularly generalist physicians, to meet the needs of the population. Given the existence of physician oversupply, it is clear that this problem will not be solved by increasing the supply of physicians. At present, there is no federal program that provides funds explicitly for the purpose of establishing new medical schools or expanding the enrollment of existing schools and no federal program should be established for this purpose. The communities that are traditionally underserved are characterized by location - rural or inner city - or by the race and ethnicity of the population. To increase the likelihood that U.S. medical school graduates will establish practices in these communities, federal funds should be provided to encourage and support medical school efforts to expand the opportunities students have to gain experience in rural and inner city communities so that they will have an appreciation of the needs and challenges of practice in these communities. Historically, minority physicians have been more likely than non-minority physicians to establish practices in communities with minority populations. Given this, medical schools should be supported and encouraged in their efforts to increase the diversity of their student bodies so that they will be able to graduate an increasing number of minority physicians. To complement medical school efforts to increase the number of their graduates who might establish practices in traditionally underserved communities, federal incentives should be provided to encourage students to pursue careers as generalist physicians and to establish practices in these communities.

Teaching hospitals that lose resident physicians as a direct result of the reduction in the number of entry level positions in the GME system should receive transitional funds to assist them in establishing alternative methods of delivering services that formerly involved resident physicians. This is particularly critical for those institutions that have traditionally used resident physicians to provide services to the poor.

There are a number of reasons why teaching hospitals incur higher costs than non-teaching hospitals in providing patient rare - the complex nature of the patients cared for in these institutions, the participation of health professions students in the delivery of care, the development and deployment of new diagnostic and therapeutic technologies, and the conduct of concurrent clinical research activities. Historically, these costs have been funded through special types of reimbursement (most notably, the Medicare Indirect Medical Education Adjustment) and higher payment levels for patient care services. Given changes occurring in the financing of health care services, a stable source of funding for these activities must be established.

A national physician workforce advisory body should be established to monitor and periodically assess the adequacy of the size and specialty composition of the physician workforce in the context of the changing needs of the evolving health care delivery system and evolving patterns of professional practice by non-physician health professionals. This body should be legislatively mandated, but staffed independently of existing government agencies. In order to meet its responsibilities the body should have a budget that is adequate to support an appropriate staff and to allow the staff to conduct necessary analytic work. The government should continue to provide funds to support research on workforce issues. (BOT Rep. 44, A-95; Reaffirmed by CME Rep. 4, A-96; Reaffirmed by CME Rep. 1, I-96; Reaffirmed and Modified by BOT Rep. 45, A-97; Reaffirmed: Res. 222, I-97; Reaffirmed: CME Rep. 10, A-99; Modified: CME Rep. 2, I-03; Modified: CME Rep. 7, A-05)

H-305.969 Financial Information Requirements for Independent Medical Students

Our AMA urges the HHS to abolish its requirement that independent students submit parental financial information when applying for financial assistance, consistent with the current policy of the Department of Education. (Sub. Res. 250, A-89; Reaffirmed: Sunset Report, A-00)

H-305.971 Discrimination Against Resident Candidates Based on Graduate Medical Education Medicare Funding

The AMA urges hospitals and residency programs to use qualifications as a basis for filling available positions, and not the status of the Medicare component to graduate medical education funding. (Res. 126, I-88; Modified: Sunset Report, I-98; Modified: CME Rep. 7, A-05)

H-305.980 Student Loan Repayment Grace Period

The AMA supports giving consideration to grace periods in renewals of federal loan programs and attempting to secure the most favorable repayment terms. (CME Rep. I, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, I-00)

H-305.982 Student Loan Repayment Defaults

The AMA encourages the HHS Inspector General to pursue all legal avenues within his jurisdiction to withhold Medicare and Medicaid reimbursements, research grant awards, and salaries or stipends from physicians who have defaulted on repayments of student loans, unless a physician can prove hardship. (Sub. Res. 69, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

H-305.986 Student Loan Consolidation

The AMA supports the availability of opportunities for student loan consolidation, for example, through the Student Loan Marketing Association or a similar organization. (Res. 163, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

H-305.988 Cost and Financing of Medical Education and Availability of First-Year Residency Positions

The AMA: (1) believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
(2) in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
(3) believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
(4) believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
(5) supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
(6) supports continued study of the relationship between medical student indebtedness and career choice;
(7) believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
(8) supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
(9) encourages for profit-hospitals to participate in medical education and training;
(10) supports AMA monitoring of trends that may lead to a reduction in stipends paid to resident physicians;
(11) encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness. (CME Rep. A, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Res. 313, I-95; Reaffirmed by CME Rep. 13, A-97; Modified: CME Rep. 7, A-05; Modified: CME Rep. 13, A-06)

H-305.990 AMA Foundation Scholars Fund

The AMA urges that all student recipients of monies from the AMA Foundation Scholars Fund be made aware of the source of these funds, and that medical school financial aid offices and medical students be informed of the existence and activities of the AMA and the Medical Student Section. (Res. 134, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed and Modified with change in title: CME Rep. 2, A-05)

H-305.991 Repayment of Educational Loans

The AMA (1) believes that it is improper for any physician not to repay his or her educational loans; (2) urges increased efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students; and (3) encourages medical school financial aid officers to counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation. (Sub. Res. 47, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-305.997 Income Tax Exemption for Medical Student Loans and Scholarships

The AMA supports continued efforts to obtain exemption from income tax on amounts received under medical scholarship or loan programs. (Res. 65, I-76; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01)

H-305.999 Financial Aid to Medical Students

Our AMA urges physicians to contribute to the AMA Foundation for support of medical education and provision of scholarships and loans to medical students at reasonable rates. (Res. 6, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-310.000 Medical Education: Graduate
(See Also: Medical Education; Medical Education: Continuing; Medical Education: Financing and Support)

H-310.921 Credentialing Materials: Timely Submission by Residency and Fellowship Programs

1. Our AMA encourages residency programs and fellowship programs to submit credentialing and verification data requested on behalf of their graduating residents and fellows to the requesting agency within thirty days of the request.

2. Our AMA encourages the Accreditation Council for Graduate Medical Education to establish an accreditation standard for residency and fellowship programs calling for submission of credentialing and recredentialing verification data requested on behalf of their graduating residents and fellows to the requesting agency within thirty days of the request. (Res. 312, A-07)

H-310.922 Determining Residents' Salaries

Our AMA encourages that residents' level of training, cost of living, and other factors relevant to appropriate compensation be considered by graduate training programs when establishing salaries for residents. (Res. 303, A-06)

H-310.923 Eliminating Religious Discrimination from Residency Programs

Our AMA encourages residency programs to: (1) make an effort to accommodate residents' religious holidays and observances, provided that patient care and the rights of other residents are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious holidays and observances. (CME Rep. 10, A-06)

H-310.924 Fellowship Application Reform

Our AMA supports the concept of a standardized application and selection process for fellowship training positions. (CME Rep. 6, A-05)

H-310.925 National Resident Matching Program Reform

Our AMA supports the National Resident Matching Program as an efficient and effective placement system for filling positions in graduate medical education in the US. (CME Rep. 4, A-05; Reaffirmed: CME Rep. 15, A-06)

H-310.926 Resident/Fellow Work and Learning Environment

Our AMA supports education during residency training programs on sleep deprivation and fatigue. (Res. 322, A-03)

H-310.927 Resident Physician Working Conditions

(1) Our AMA adopts the following definitions for resident physician education: (a) "Total duty hours" represents those scheduled hours of activity associated with a residency program and include: (i) scheduled time providing direct patient care or supervised patient care that contributes to the ability of the resident physician to meet educational goals and objectives; (ii) scheduled time to participate in formal educational activities, (iii) scheduled time providing administrative and patient care services of limited or no educational value, and (iv) time needed to transfer the care of patients; and (b) "Organized educational activities" are of two types: (i) "Formal educational activities" include scheduled educational programs such as conferences, seminars, and grand rounds and (ii) "Patient care educational activities" include individualized instruction with a more senior resident or attending physician and teaching rounds with an attending physician.

(2) Resident physician total duty hours must not exceed 80 hours per week, averaged over a two-week period and that our AMA work with GME accrediting bodies to determine if an increase of 5% may be appropriate for some training programs.

(3) Workdays that exceed 12 hours are defined as on-call.

(4) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for up to 30 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time.

(5) On-call shall be no more frequent than every third night and there be at least one consecutive 24-hour duty-free period every seven days both averaged over a two-week period.

(6) On-call from home shall be counted in the calculation of total duty hours and on-call frequency if the resident physician can routinely expect to get less than eight hours of sleep.

(7) There should be a duty-free interval of at least 10 hours prior to returning to duty.

(8) Limits on total duty hours must not adversely impact resident physician participation in the organized educational activities of the residency program. Formal educational activities must be scheduled and available within total duty hour limits for all resident physicians for at least eight hours per week averaged over a two-week period.

(9) Scheduled time providing patient care services of limited or no educational value be minimized

(10) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work. (CME Rep. 9, A-02)

H-310.928 Resident/Fellow Work and Learning Environment

Our AMA may draft original, modify existing, or oppose legislation and pursue any regulatory or administrative strategies when dealing with resident work hours and conditions. (Res. 310, I-01; Reaffirmed: Res. 322, A-03)

H-310.929 Principles for Graduate Medical Education

Our AMA urges the Accreditation Council for Graduate Medical Education to incorporate these principles in the revised "Institutional Requirements" of the Essentials of Accredited Residencies of Graduate Medical Education, if they are not already present.

(1) PURPOSE OF GRADUATE MEDICAL EDUCATION. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

(3) EDUATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the Essentials for Accredited Residencies in Graduate Medical Education, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician’s education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution. (CME Rep. 9, A-99)

H-310.930 Attending Physician Supervision of Night-Float Rotations

Our AMA supports hospitals and residency programs including those utilizing a night-float system, continuing to assure that there is rapid access to appropriately qualified attending physicians for trainee supervision and the provision of the best quality of patient care. (Res. 320, A-99)

H-310.932 Annual Contracts for Continuing Residents

Our AMA urges the ACGME to require resident training programs to provide their residents with notice of non-renewal of contracts no later than four months prior to the end of their contract. (Sub. Res. 310, A-99)

H-310.933 Implementing Independent Housestaff Organizations

The AMA will develop and implement a nationwide program offering supporting materials as well as telephone and on-site assistance to groups of residents seeking to form independent housestaff organizations disavowing actions that could adversely affect the well being of patients. (Res. 322, A-98; Reaffirmed: Res. 914, A-99)

H-310.935 The Educational and Work Environment of Resident Physicians

AMA policy is that there should be resident organizations in place at institutions that sponsor graduate medical education programs to facilitate the ability of residents to negotiate about issues related to their working environment. (CME Rep. 11, A-98; Reaffirmed: CME Rep. 2, A-08)

H-310.937 Impact of Health Care Merging on Residents' Welfare

The AMA supports resident representation in negotiation of housestaff contracts and benefits and will take a leadership role and make available staff resources to facilitate the relocation of residents who are displaced abruptly by unexpected residency program closure or downsizing. (CME Rep. 2, I-96; Modified and Reaffirmed: CME Rep. 2, A-06)

H-310.943 Closing of Residency Programs

The AMA: (1) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (2) encourages the ACGME to develop guidelines for the institution to follow in such closings or reductions that provide for adequate notification and out-placement service (such as resource contacts, transfer assistance, and financial assistance); (3) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (4) encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (5) urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undo stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; and (6) urges institutions that initiate significant reductions in graduate medical education programs (in excess of 20 percent of the trainee complement or in excess of 10 percent of trainees for a given year), or that voluntarily close programs, be requested prior to or at the time of the reduction to file a concise summary of its educational impact with the Accreditation Council for Graduate Medical Education or the relevant Residency Review Committees. (Sub. Res. 328, A-94; Appended by CME Rep. 11, A-98; Reaffirmed: CME Rep. 7, A-06)

H-310.944 Obstetrics and Gynecology Training in Termination of Pregnancy

The AMA supports the Residency Review Committee for Obstetrics and Gynecology in its current efforts to revise language of the Special Requirements for Obstetrics-Gynecology to provide for specific educational standards for the knowledge and skills associated with the termination of pregnancy that will allow an exclusion for individuals or residency programs with religious/moral objections or legal restrictions, provided that the residents receive a satisfactory knowledge of the principles associated with the termination of pregnancy rather than the actual procedures, and that these exempt residency programs must establish a protocol to allow residents who wish to learn termination of pregnancy procedures to obtain this training in another institution. (Res. 321, I-93; Reaffirmed: CME Rep. 2, A-03)

H-310.945 Graduate Medical Education Faculty Evaluations

The AMA recommends that evaluations of residency program faculty should be done in a confidential manner, at least annually, and the areas evaluated should include teaching ability, clinical knowledge, scholarly contributions, attitudes, interpersonal skills, communication ability and commitment. Residency program directors should provide faculty members with a written summary of the evaluations. (CME Rep. 7, I-93; Reaffirmed and Modified: CME Rep. 2, A-05)

H-310.946 Training Physicians in Non-Traditional Sites

It is the policy of the AMA to promote and support the training of physicians in non-traditional sites, including nursing homes. (Res. 301, I-93; Reaffirmed: CME Rep. 2, A-03)

H-310.947 Revision of the "General Requirements" of the Essentials of Accredited Residency Programs

The AMA supports the following principles of the ACGME Institutional Requirements: Candidates for residencies must be fully informed of benefits including financial support, vacations, professional leave, parental leave, sick leave, professional liability insurance, hospital and health insurance, disability insurance, and other insurance benefits for the residents and their family and the conditions under which living quarters, meals and laundry or their equivalent are to be provided. Institutions sponsoring graduate medical education must provide access to insurance, where available, to all residents for disabilities resulting from activities that are part of the educational program. Institutions should have a written policy and an educational program regarding physician impairment, including substance abuse. (CME Rep. Q, A-93; Modified: CME Rep. 2, A-03)

H-310.952 Housestaff Input During the ACGME Review Process

The AMA asks its representatives to the Accreditation Council for Graduate Medical Education to support a requirement that site visitors to both residency training programs and institutions conduct interviews with residents, including peer-selected residents, as well as with administrators and faculty. (Res. 314, I-92; Reaffirmed: CME Rep. 2, A-03)

H-310.953 Practice Options and Skills Curriculum for Residents

The AMA will assist medical societies and residency programs in the development of model curricula for resident physicians and those entering practice regarding practice options and management skills, including information on CPT and ICD coding. (Sub. Res. 311, I-92; Reaffirmed: CME Rep. 2, A-03)

H-310.957 Resident Working Conditions Reform Update

(1) Our AMA supports the following new language pertaining to resident work hours and environment for the "General Requirements" of the "Essentials of Accredited Residencies in Graduate Medical Education": Each residency program must establish formal policies governing resident duty hours and working environment that are optimal for both resident education and the care of patients. (a) Special requirements relating to duty hours and on-call schedules shall be based on an educational rationale and patient need, including continuity of care. (b) The educational goals of the program and learning objectives of residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations. Duty hours, however, must reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times. Programs must ensure that residents are provided backup support when patient care responsibilities are especially difficult or prolonged. (c) Resident duty hours and on-call schedules must not be excessive. The structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the resident. Duty hours must be consistent with the General and Special Requirements that apply to each program. Detailed structuring of resident service is an integral part of the approval process and therefore close adherence to the General and Special Requirements is essential to program accreditation. (2) Our AMA supports the following proposed revision of the "Special Requirements" for surgery: It is desirable that residents' work schedule be designed so that on the average, excluding exceptional patient care needs, residents have at least one day out of seven free of routine responsibilities and be on-call in the hospital no more often than every third night. The ratio of hours worked and on-call time will vary, particularly at the senior levels, and therefore necessitates flexibility. (BOT Rep. YY, I-91; Reaffirmed: Sunset Report, I-01)

H-310.959 In-Service Training Examinations - Final Report

It is the policy of the AMA (1) to encourage entities responsible for in-service examinations and the ACGME to recognize that in-service training examinations should not be used in decisions concerning acceptance, denial, advancement, or retention in residency or fellowship training positions; should not be used by outside regulatory agencies for the purpose of assessing resident knowledge or the quality of training programs; and should not be used as a pretest to sit for specialty boards; (2) to encourage residency program directors to use the results of in-training examinations to counsel residents and as the basis for developing appropriate programs of remediation and also for the purpose of educational program evaluation; and (3) to urge that evaluation of residents for promotion or retention be based on valid and reliable measures of knowledge, skills, and behaviors, applied sequentially over time. In-training examinations should be administered under appropriate testing conditions. Residents should be relieved of on-call duty the night prior to and during the administration of the examination. The results, if used at all, should not be the sole factor in evaluation of residents. (CME Rep. A, I-91; Reaffirmed: Sunset Report, I-01)

H-310.960 Resident Education in Laboratory Utilization

Our AMA endorses the concept of practicing physicians devoting time with medical students and resident physicians for chart reviews focusing on appropriate test ordering in patient care. (Res. 84, A-91; Reaffirmed: Sunset Report, I-01)

H-310.961 Residency/Fellowship Working Conditions and Supervision

Our AMA will continue to work closely with the parties involved in the accreditation of graduate medical education programs to reaffirm the AMA's position on resident working conditions and supervision, to further clarify the various concerns related to resident working conditions, and to explain why specific language is essential to the general issue of working conditions. (BOT Rep. KKK, A-91; Modified: Sunset Report, I-01)

H-310.962 Residency Programs Prejudiced Against Applicants with Ethnic Names

The AMA encourages medical school admissions officers and directors of residency programs to select applicants on the basis of merit, without considering an ethnic name as a negative factor. (Res. 188, A-91; Reaffirmed by Res. 311, A-96; Reaffirmed: CME Rep. 2, A-06)

H-310.963 Residency/Fellowship Working Hours and Supervision

It is the policy of the AMA (1) to continue to work with the Accreditation Council for Graduate Medical Education to implement AMA policy for residency work hours reform; and (2) to use existing policy as a guideline in working with state medical societies to obtain modification, if needed, of pending and future legislation on total residency work hours, conditions and supervision. (Sub. Res. 191, I-90; Reaffirmed: Sunset Report, I-00)

H-310.966 Residency Interview Costs

It is the policy of the AMA to take all steps possible to reverse the U.S. Department of Education interpretation of current law so that medical students are again allowed to use Title IV aid for residency interview costs. (Res. 265, A-90; Reaffirmed: Sunset Report, I-00)

H-310.967 Resident Training in Varied Settings

Our AMA reaffirms the inclusion of ambulatory care settings and the participation of community hospitals in graduate medical education. (CME Rep. A, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation I-08)

H-310.968 Opposition to Centralized Postgraduate Medical Education

Our AMA (1) continues to support a pluralistic system of postgraduate medical education for house officer training; and (2) opposes the mandatory centralization of postgraduate medical training under the auspices of the nation's medical schools. (Res. 69, I-89; Reaffirmed: Sunset Report, A-00)

H-310.969 First Postgraduate Year

Our AMA believes that policy statements urging that all residents complete one year of a program in internal medicine, pediatrics, general surgery, family practice, or a transitional year before entering residency programs for other specialties should be modified by the addition of obstetrics and gynecology to those residency programs which offer a broad clinical experience. (Sub. Res. 33, I-89; Reaffirmed: Sunset Report, A-00)

H-310.970 Mandatory Helicopter Flight for Emergency Medical Residents in Training

Our AMA urges residency training programs that require helicopter transport as a mandatory part of their residency to notify applicants of that policy prior to and during the interview process. (Res. 239, A-89; Reaffirmed: Sunset Report, A-00)

H-310.972 Residency Review Committee Representation and Requirements

Our AMA (1) supports obtaining community practitioners representation on the Residency Review Committees (RRC); and (2) urges RRC members to be mindful of the concerns of community hospital residency programs in addressing residency program requirements and to become more representative of community hospital residency programs. (Res. 219, A-89; Reaffirmed: Sunset Report, A-00)

H-310.973 Primary Care Residencies in Community Hospitals

Our AMA advocates that the Accreditation Council for Graduate Medical Education support primary care residency programs, including community hospital based programs. (Sub. Res. 27, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-08)

H-310.976 Gender-Based Questioning in Residency Interviews

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

H-310.979 Resident Physician Working Hours and Supervision

(1) Our AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress: (a) Exemplary patient care is a vital component for any program of graduate medical education. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited residency program. Graduate medical education must never compromise the quality of patient care.
(b) Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.
(c) Institutional commitment to graduate medical education must be evidenced by compliance with Section III.B.4 of the ACGME Institutional Requirements, effective July 1, 2007: The sponsoring institution’s GME Committee must [m]onitor programs’ supervision of residents and ensure that supervision is consistent with: (i) Provision of safe and effective patient care; (ii) Educational

needs of residents; (iii) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (iv) Other applicable Common and specialty/subspecialty specific Program Requirements.
(d) The program director must be responsible for the evaluation of the progress of each resident and for the level of responsibility for the care of patients that may be safely delegated to the resident.
(e) Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.
(f) The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with Residency Review Committee (RRC) recommendations, and in compliance with the ACGME duty hour standards.
(g) The program director, with institutional support, must assure for each resident effective counseling as stated in Section II.D.4.k of the Institutional requirements: "Counseling services: The Sponsoring Institution should facilitate residents' access to confidential counseling, medical, and psychological support services."
(h) As stated in the ACGME Institutional Requirements (II.F.2.a-c), "The Sponsoring Institution must provide services and develop health care delivery systems to minimize residents' work that is extraneous to their GME programs' educational goals and objectives." These include patient support services, laboratory/pathology/radiology services, and medical records.
(i) Is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. As stated in the ACGME Common Program Requirements (VI.B) "the program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities."
(j) Individual resident compensation and benefits must not be compromised or decreased as a result of these recommended changes in the graduate medical education system.

(2) These problems should be addressed within the present system of graduate medical education, without regulation by agencies of government. (CME Rep. C, I-87; Modified: Sunset Report, I-97; Modified and Reaffirmed: CME Rep. 2, A-08)

H-310.982 Reevaluation of Residency Selection Process

The AMA supports continued cooperation with the Association of American Medical Colleges in the evaluation of the residency selection process, with emphasis on the reduction of pressures that induce premature specialty decisions within the undergraduate medical curriculum. (Sub. Res. 112, I-86; Amended by Sunset Report, I-96; Modified and Reaffirmed: CME Rep. 2, A-06)

H-310.983 Residency Positions for Sale

The AMA reaffirms its position that selection of residents should be based on the academic and personal qualifications of applicants and that monetary considerations should never compromise the selection process. (CME Rep. A, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06)

H-310.986 Education for Residents on Issue of Medical Ethics

The AMA believes that the presentation of educational materials on medical ethics should be in all residency training programs. (Sub. Res. 23, I-85; Modified by CLRPD Rep. 2, I-95; Reaffirmed by Sub. Res. 301, A-96; Reaffirmed: CME Rep. 2, A-06)

H-310.988 Adequate Resident Compensation

The AMA believes that housestaff should receive adequate compensation by their training programs. (Sub. Res. 124, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

H-310.989 Information on Shared Residency Positions

The AMA supports the continued collection and publication of data on shared schedule positions. (Sub. Res. 38, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

H-310.990 Support of Shared Schedule Residency Positions

The AMA supports the concept of shared schedule residency positions and encourages residency program directors to offer such positions where feasible. (Res. 81, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-310.991 Assistance in Completion of Residency Programs

The AMA supports efforts to assist residents in finding new positions, in the event of reductions in the number of residency positions. (Sub. Res. 106, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-310.993 Resident Participation on Hospital Committees

The AMA encourages hospitals with graduate medical education programs to include residents on hospital executive, fiscal and other committees. (Sub. Res. 37, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed and Modified: CME Rep. 2, A-05)

H-310.994 Curriculum Orientation of Medical Staff Membership in Teaching Programs

The AMA believes that teaching programs in hospitals with residencies throughout the US should incorporate information on the privileges and responsibilities of medical staff membership into their education program's orientation materials. (Res. 142, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-310.995 Anonymity for Resident Inquiries to Residency Review Committees

The AMA supports a detailed procedure to guarantee anonymity of a resident physician who initiates an inquiry by a residency review committee into the conduct of a residency program, to protect residents from reprisals and program directors from unfounded complaints. The procedure includes a mechanism for the resident who elects to forward a complaint to the residency review committee (RRC), outlines options for RRC action; and identifies possible final actions open to the RRC. (CME Rep. C, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-310.996 Residency Review Committee Representation

Our AMA: (1) supports resident membership on Residency Review Committees; (2) requests that the resident representatives to the Residency Review Committees (RRCs) of the Accreditation Council for Graduate Medical Education (ACGME) serve for at least a one-year term as a full and voting participant at all RRC meetings; and (3) requests that the resident members of the RRCs be peer-selected. (Res. 67, I-82; Reaffirmed: Sub. Res. 186, A-87; Reaffirmed: CLRPD Rep. A, I-92; Appended: Res. 306, I-98; Reaffirmed: CME Rep. 2, A-08)

H-310.997 Accreditation of Graduate Medical Education Programs

(1) The AMA believes that (a) accreditation and certification programs in graduate medical education should be designed and operated to objectively evaluate the educational quality and content of such programs and to assure a high level of professional training, achievement, and competence; (b) accreditation and certification programs in graduate medical education should not be administered as a means of regulating or restricting the number of physicians entering any specialty or field of medical practice; and (c) qualified physicians who possess the essential prerequisites are entitled to compete for training and subsequently to practice in the specialty or type of practice of their choice upon successful completion of their training. (2) The AMA opposes use of the accreditation and certification process as a means of controlling the number of physicians in any specialty or field of medical practice. (Res. 14, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

H-310.998 Residency Interview Schedules

The AMA encourages accredited residency programs to incorporate in their residency interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. The AMA asks the ACGME to require residency programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. The AMA strongly encourages residency programs to inform applicants in a timely manner about their interview status and provide a time frame of notification dates in the application materials. (Res. 93, I-79; Reaffirmed: CLRPD Rep. B, I-89; Appended: Res. 302 and Res. 313, I-97; Reaffirmed: CME Rep. 2, A-07)

H-310.999 Guidelines for Housestaff Contracts or Agreements

The "Essentials of Approved Residencies, " approved by the House of Delegates in 1970, includes a section on relationships of housestaff and institutions. The following outline is intended to promote additional guidance to all parties in establishing the conditions under which house officers learn and provide services to patients.

Training programs have been central to the process of graduate medical education which has produced a high level of medical competence in the United States. The American Medical Association recognizes that the integrity of these programs is a primary objective in achieving the best possible care of the patient. It is, therefore, incumbent upon members of the housestaff and the institutions in which they are being trained to be aware of the parameters and responsibilities applicable to their training programs. In the absence of such awareness, unreasonable expectations may arise to threaten the harmony between hospital and housestaff in the performance of their joint mission.

It should be emphasized that these guidelines are not intended as a fixed formula. Guidelines that seek to cover public, voluntary and proprietary hospitals necessarily entail so many variables from training institution to training institution that no single form of contract or agreement would be universally applicable. This set of guidelines has, therefore, been developed to cover the more significant

substantive provisions of a housestaff contract or agreement.

The subjects included in the Guidelines are not intended to be the only subjects important or appropriate for a contract or agreement. Moreover, the definition of the respective responsibilities, rights and obligations of the parties involved can assume various forms: individual contracts or agreements, group contracts or agreements, or as a part of the rules of government of the institution.

II. Proposed Terms and Conditions A. *Parties to the Contract or Agreement* (1) Contracts or agreements may be formed between individuals or groups, and institutions. Such a group might be a housestaff organization. (2) The two parties to an agreement or contract may be a single institution or a group of institutions, and an individual member of the housestaff, an informal group of the housestaff, or a formally constituted group or association of the housestaff, as determined by the housestaff organization.

B. *General Principles* (1) Contracts or agreements are legal documents and must conform to the laws, rules, and regulation to which the institutions are subject. Position, salary and all other benefits should remain in effect insofar as possible without regard to rotational assignments even when the member of the housestaff is away from the parent institution. Exceptions required by law or regulations should be clearly delineated to the house officer at the time of the appointment. Changes in the number of positions in each year of a training program should be made so as not to affect adversely persons already in, or accepted in, that program. The agreement should provide fair and equitable conditions of employment for all those performing the duties of interns, residents and fellows. When a general contract or agreement is in effect between an association and an institution, individual contracts or agreements should be consistent. (2) Adequate prior notification of either party's intent not to review the contract or agreement should be required, and the date of such notification should be included in the contract or agreement. (3) The institution and the individual members of the housestaff must accept and recognize the right of the housestaff to determine the means by which the housestaff may organize its affairs, and both parties should abide by that determination; provided that the inherent right of a member of the housestaff to contract and negotiate freely with the institution, individually or collectively, for terms and conditions of employment and training should not be denied or infringed. No contract should require or prescribe that members of the housestaff shall or shall not be members of an association or union.

C. *Obligation of the Housestaff* (1) Members of the housestaff agree to fulfill the educational requirements of the graduate training programs, and accept the obligation to use their efforts to provide safe, effective and compassionate patient care as assigned or required under the circumstances as delineated in the ACGME "Essentials of Approved Residencies" and previously approved standards of the AMA Council on Medical Education. (2) Members of the housestaff should comply with the laws, regulations, and policies to which the institution is subject.

D. *Obligation of the Institution* (1) The institution agrees to provide an educational program that meets the standards of the ACGME "Essentials of Approved Residencies." (2) The institution agrees to maintain continuously its staff and its facilities in compliance with all of the standards in the ACGME "Essentials of Approved Residencies."

E. *Salary for Housestaff* (1) The salary to be paid and the frequency of payment should be specified. The salary schedule should be published. The basis for increments and the time of the increments should be specified. (2) In determining the salary level of a member of the housestaff, prior educational experience should be considered, and a determination made as to whether credit should be given. (3) The responsibilities of senior residents should be recognized in salary differentials.

F. *Hours of Work*There should be recognition of the fact that long duty hours extending over an unreasonably long period of time or onerous on-call schedules are not consistent with the primary objective of education or the efficient delivery of optimal patient care. The institution should commit itself to fair scheduling of duty time for all members of the housestaff, including the provision of adequate off-duty hours.

G. *Off-Duty Activities* The contract or agreement should provide that a member of the housestaff is free to use his off-duty hours as he sees fit, including engaging in outside employment if permitted by the terms of the original contract or agreement, so long as such activity does not interfere with his obligations to the institution or to the effectiveness of the educational program to which he has been appointed.

H. *Vacation and Leave* The AMA encourages residency programs across the country to permit and schedule off-duty time separate from personal vacation time to enable residents to attend educational and/or organized medicine conferences. The amount of vacation, sick leave, and educational leave to which each member of the housestaff is entitled should be specified. Vacations should be expressed in terms of customary working days as defined by the institution. If vacations may be taken only at certain times of the year, this restriction should be stated. Any requirements for scheduling vacation time should also be stated. Provisions may also cover leaves for maternity, paternity, bereavement, military duty, examinations and preparations therefor, and educational conferences. Reimbursement for tuition and expenses incurred at educational conferences should be considered. The agreement should set forth any progressive increases in the amount of time allowed for vacation, sick leave, and educational leave. Educational leave should not be deducted from vacation time.

I. *Insurance Benefits* Insurance benefits should be set forth with particularity and should be tailored to the specific needs of the

housestaff. Some of the more common insurance benefit provisions are (1) hospitalization and basic medical coverage for the member of the housestaff, spouse, and minor children; (2) major medical coverage for the member of the housestaff, spouse, and minor children; and (3) group life insurance, and dismemberment and disability insurance for the member of the housestaff only. It should also be specified whether the institution will pay the full amount of premiums or only a portion of the premiums, the balance to be paid by the member of the housestaff. Co-paid benefits should be established, separately from other hospital employee benefits, as a means of maximizing benefits. In some instances, free care for the housestaff and their families at the training institutions may be provided. In lieu of insurance benefits, the contract or agreement may provide for fixed annual payments to a housestaff association for each member of the housestaff so that the housestaff association may determine and provide for insurance or other benefits for the housestaff.

J. *Professional Liability Insurance* The contract or agreement should specify the amount of professional liability insurance that the institution will provide for each member of the housestaff together with the limits of liability applicable to such coverage. It might also be appropriate to provide in the contract or agreement that the housestaff and the institution will cooperate fully with the insurance company in the handling of any professional liability claim.

K. *Committee Participation* Insofar as possible, the institution should agree to provide for appropriate participation by the housestaff on the various committees within the institution. This participation should be on committees concerning institutional, professional and administrative matters including grievance and disciplinary proceedings. Members should have full voting rights. Representatives of the housestaff should be selected by the members of the housestaff.

L. *Grievance Procedures* The contract or agreement should require and publish a grievance procedure. A grievance procedure typically involves the following: (1) A definition of the term "grievance" (e.g., any dispute or controversy about the interpretation or application of the contract, any rule or regulation, or any policy or practice). (2) The timing, sequence, and end point of the grievance procedure. (3) The right to legal or other representation. (4) The right of an individual member of the housestaff or a housestaff association to initiate a grievance procedure and the obligation of the housestaff to maintain patient care during the grievance procedure. (5) A statement of the bases and procedures for the final decision on grievances (end point), and agreement of both parties to abide by the decision. (6) Should costs arise in the grievance procedure, a prior agreement as to how these costs will be apportioned between the parties.

M. *Disciplinary Hearings and Procedure* With respect to disciplinary procedures, the provisions of Article VIII - Hearing and Appellate Review Procedure of the JCAHO Guidelines for the Formulation of Medical Staff Bylaws, Rules, and Regulations shall be applicable to the housestaff in the same manner as they are to all other members of the medical staff with the proviso that the Hearing and Appeals Committees shall contain appropriate representation of the housestaff.

N. *Description of the Educational Program* The specific details of the operation of the educational experience should be made available to each prospective candidate. These data should include specific descriptions of training programs, including numbers of resident positions at each level of training, copies of existing housestaff contracts or agreements, approval status of programs to which candidate is applying, methods of evaluation, procedures for grievances and disciplinary action, and commitments for further training.

O. *Patient-Care Issues* The quality of patient-care services and facilities may be specified in the contract, and could include such matters as adequate equipment, bedspace, clinical staffing, and clinical staff structuring.

P. *Other Provisions* The agreement should provide for adequate, comfortable, safe, and sanitary facilities.

The foregoing provisions are not all-inclusive. Depending upon the institution's size, resources, location, and affiliations, if any, and also depending upon the relationship between the institution and the housestaff association, other provisions may be included, such as: (1) Maintenance of existing benefits and practices not otherwise expressly covered; (2) Housing, meals, laundry, uniforms, living-out and telephone allowances; (3) Adequate office space, facilities, and supporting services for housestaff affairs; (4) Housestaff association seminars and meetings. (BOT Rep. H, I-74; Reaffirmed: CLRPD Rep. C, A-89; Appended: Res.323, I-97; Reaffirmation A-00; Reaffirmation A-08)

H-315.000 Medical Records and Patient Privacy
(See Also: Medical Review; Medicare: Carrier Review)

H-315.971 Patient Information in the Electronic Medical Record

AMA Guidelines for Patient Access to Physicians' Electronic Medical Record Systems:

(1) Online interactions are best conducted over a secure network, with provisions for privacy and security, including encryption.

(2) Physicians should take reasonable steps to authenticate the identity of correspondent(s) in electronic communication and to ensure that recipients of information are authorized to receive it. Physicians are encouraged to follow the following guidelines for patient

authentication:
(a) Have a written patient authentication protocol for all practice personnel and require all members of the physician's staff to understand and adhere to the protocol.
(b) Establish minimum standards for patient authentication when a patient is new to a practice or not well known.
(c) Keep a written record, electronic or paper, of each patient authenticated.

(3) Prior to granting a patient access to his or her EMR, informed consent should be obtained regarding the appropriate use of and limitations to access of personal health information contained in the EMR. Physicians should develop and adhere to specific guidelines and protocols for online communications and/or patient access to the EMR for all patients, and make these guidelines known to the patient as part of the informed consent process. Such guidelines should specify mechanisms for emergency access to the EMR and protection for and limitation of access to, highly sensitive medical information.

(4) If the patient is allowed to make annotations to his or her EMR (i.e., over-the-counter drug treatments, family medical history, other health information), the annotation should be indicated as authored by the patient with sourcing information (i.e., date and time stamp, login and IP address if applicable). A permanent record of all annotations and communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

(5) In order to maintain the legitimate recording of clinical events, patients should not be able to delete any health information in the record. Rather, in order to maintain the forensic nature of the record, patients should only be able to add notations when appropriate.

(6) Disclosures of Personal Health Information should comply with all applicable federal and state laws, privileges recognized in federal or state law, including common law, and the ethical requirements of physicians. (BOT Rep. 19, A-07)

H-315.972 HIPAA Business Associate Contracting, Domestic and Foreign, and Foreign Outsourcing

1. Our AMA encourages physicians who have entered or who are considering entering a business associate agreement (BAA) to undertake careful due diligence regarding the business associate and to consider with legal counsel the inclusion of contractual provisions such as:
a. strong confidentiality clauses;
b. required steps to mitigate any harmful effects of wrongful use or disclosure of protected health information (PHI);
c. assurance that, upon the contract's termination, all PHI is returned to the covered entity, and no copies are retained by the business associate, except as required for legal or audit purposes;
d. indemnification of the covered entity against any losses caused by a business associate;
e. the business associate's procurement of specified types of liability insurance which may either protect the covered entity or enable the business associate to meet its indemnity;
f. posting a surety bond (a.k.a. performance bond) to ensure faithful performance of the BAA by the business associate; or
g. physicians should take care that the original contract should contain provisions addressing the costs involved with the return and maintenance of the PHI at or after the end of the contract term.

2. Our AMA supports legislation and/or regulation requiring all third parties who receive and maintain clinical information from a clinician to make those data available to the clinician in usable form at the end of the business relationship. (BOT Rep. 17, I-06)

H-315.973 Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data

1. It is AMA policy that any payer, clearinghouse, vendor, or other entity that collects and uses electronic medical records and claims data adhere to the following principles:
a. Electronic medical records and claims data transmitted for any given purpose to a third party must be the minimum necessary needed to accomplish the intended purpose.
b. All covered entities involved in the collection and use of electronic medical records and claims data must comply with the HIPAA Privacy and Security Rules.
c. The physician must be informed and provide permission for any analysis undertaken with his/her electronic medical records and claims data, including the data being studied and how the results will be used.
d. Any additional work required by the physician practice to collect data beyond the average data collection for the submission of transactions (e.g., claims, eligibility) must be compensated by the entity requesting the data.
e. Criteria developed for the analysis of physician claims or medical record data must be open for review and input by relevant outside entities.
f. Methods and criteria for analyzing the electronic medical records and claims data must be provided to the physician or an independent third party so re-analysis of the data can be performed.
g. An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived from an analysis of his/her electronic medical records and claims data.
h. Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care operations.

2. It is AMA policy that any physician, payer, clearinghouse, vendor, or other entity that warehouses electronic medical records and claims data adhere to the following principles:
a. The warehouse vendor must take the necessary steps to ensure the confidentiality, integrity, and availability of electronic medical records and claims data while protecting against threats to the security or integrity and unauthorized uses or disclosure of the information.
b. Electronic medical records data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.
c. Physician and patient permission must be obtained for any person or entity other than the physician or patient to access and use individually identifiable clinical data, when the physician is specifically identified.
d. Following the request from a physician to transfer his/her data to another data warehouse, the current vendor must transfer the electronic medical records and claims data and must delete/destroy the data from its data warehouse once the transfer has been completed and confirmed. (CMS Rep. 6, I-06)

H-315.974 Guiding Principles, Collection and Warehousing of Electronic Medical Record Information

Our AMA expressly advocates for physician ownership of all claims data, transactional data and de-identified aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician's medical records, electronic health records, or practice management system, while preserving the principle that physicians act as trusted stewards of Protected Health Information. (Res. 802, I-05; Reaffirmed: BOT Rep. 19, I-06)

H-315.975 Police, Payer, and Government Access to Patient Health Information

(1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define "health care operations" narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.

(2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.

(3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.

(4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.

(5) Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule. (Res. 246, A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07)

H-315.976 Medical Records Signature

Our AMA seeks to have electronic signatures and electronic-authentication be accepted in the medical record as equivalent to a handwritten signature. (Res. 822, I-99)

H-315.977 Abuse of the Medical Record for Regulation or Financing the Practice of Medicine

(1) Our AMA continues to oppose the use of the physician office medical record as a tool of CMS, as well as any other agency or third party, to regulate the financing and practice of medicine. (2) The medical record shall be the property of the physician and the information contained therein, the property of the patient. (3) The physician's office medical record should be used solely to document the delivery of health care. (Res. 820, A-99; Reaffirmation I-08)

H-315.978 Privacy and Confidentiality

Our AMA policy is that where possible, informed consent should be obtained before personally identifiable health information is used for any purpose. However, in those situations where specific informed consent is not practical or possible, either (1) the information should have identifying information stripped from it or (2) an objective, publicly accountable entity must determine that patient consent is not required after weighing the risks and benefits of the proposed use. Re-identification of personal health information should only occur with patient consent or with the approval of an objective, publicly accountable entity. (BOT Rep. 36, A-99; Reaffirmation A-00; Reaffirmed: BOT Rep. 19, I-01; Reaffirmed: BOT Rep. 19, A-07)

H-315.979 Electronic Data Interchange Status Report

Our AMA will: (1) work to establish consensus on industry security guidelines for electronic storage and transmission of medical records as an important means of protecting patient privacy in a manner that avoids undue and non-productive burdens on physician practices; and (2) develop relevant educational tools or models in accordance with industry electronic security guidelines to assist physicians in compliance with state and federal regulations. (CMS Report 7, I-98; Reaffirmation I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, I-06)

H-315.980 Preservation of Medical Records

It is the policy of the AMA that medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes, chemotherapy records, and records documenting permanent structural alteration to the patients should always be part of the patient’s chart. (CSA Rep. 8, I-98; Reaffirmation A-04)

H-315.981 Privacy of a Physician’s Personal Medical Records

Our AMA opposes any attempt by hospitals, HMOs, managed care companies, and other entities that contract with physicians to provide patient care, to require access to a physician’s personal medical records as a criterion for participation. (CMS Rep. 4, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-315.982 CMS Documentation Guidelines for Teaching Physicians

The AMA will work with the CMS to: (1) reduce the redundant and burdensome documentation for teaching physicians; (2) accept documentation by the physician team under the supervision of a teaching physician if it collectively meets all CMS documentation requirements: and (3) accept a statement of the teaching physician’s level of participation in patient care as sufficient or adequate documentation. (Res. 861, A-98; Reaffirmed: CME Rep. 2, A-08)

H-315.983 Patient Privacy and Confidentiality

(1) Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure.

(2) Our AMA affirms: (a) that physicians who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians should not be required to report any aspects of their patients’ medical history to governmental agencies or other entities, beyond that which would be required by law.

(3) Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients and physicians should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

(4) Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

(5) The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

(6) Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

(7) Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

(8) When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

(9) Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

(10) Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

(11) Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures

(12) Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

(13) Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

(14) Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

(15) In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

(16) The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

(17) Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

(18) Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to

use their personal data for marketing purposes.

(19) Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

(20) Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes. (BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07)

H-315.984 Data Needs of Medical Research and Privacy of Medical Records

The AMA will work to assure that any forthcoming state or federal standards or legislation concerning the protection of privacy of medical records, including electronic transmissions thereof, include sufficient safeguards to prevent breaches of patient confidentiality without imposing unduly restrictive barriers that would impede or prevent access to data needed for medical or public health research. (Res. 812, A-97; Reaffirmation I-99)

H-315.986 Confidentiality of Patient Records

Our AMA opposes the concept that filing a claim for medical insurance coverage constitutes a blanket waiver of a patient's right to confidentiality of his/her medical records for all purposes. The AMA will engage in a major initiative to educate patients about the implications and consequences of blanket medical records releases, and educate patients about the need for possible legislative modifications. (Res. 243, I-94; Appended: Res 231, I-97; Reaffirmation I-98; Reaffirmation I-99)

H-315.987 Limiting Access to Medical Records

Our AMA: (1) will pursue the adoption of federal legislation and regulations that will: limit third party payers' random access to patient records unrelated to required quality assurance activities; limit third party payers' access to medical records to only that portion of the record (or only an abstract of the patient's records) necessary to evaluate for reimbursement purposes; require that requests for information and completion of forms be delineated and case specific; allow a summary of pertinent information relative to any inquiry into a patient's medical record be provided in lieu of a full copy of the records (except in instances of litigation where the records would be discoverable); and provide proper compensation for the time and skill spent by physicians and others in preparing and completing forms or summaries pertaining to patient records; and (2) supports the policy that copies of medical records of service no longer be required to be sent to insurance companies, Medicaid or Medicare with medical bills. (Sub. Res. 222, I-94; Appended: Res. 218, A-02; Reaffirmed: BOT Rep. 19, I-06)

H-315.989 Confidentiality of Computerized Patient Records

The AMA will continue its leadership in protecting the confidentiality, integrity, and security of patient-specific data; and will continue working to ensure that computer-based patient record systems and networks, and the legislation and regulations governing their use, include adequate technical and legal safeguards for protecting the confidentiality, integrity, and security of patient data. (BOT Rep. F, A-93; Reaffirmation I-99; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmation I-08)

H-315.990 Confidentiality of Computerized Patient Records

The AMA (1) reaffirms the importance of confidentiality of patient records regardless of the form in which they are stored; (2) will study and incorporate into its model legislation, Confidentiality of Health Care Information, a provision regulating third parties' use of computerized patient records in physicians' offices; and (3) will develop guidelines for physicians using computerized medical record systems to protect the confidentiality, integrity and security of patient records. (Res. 813, I-92; Reaffirmation I-99; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 19, A-07)

H-315.991 Mandatory Computerization of Patient Records

The AMA strongly urges third party payers and others to preserve the option of non-computerized medical records, with no disincentives and no punitive measures for those physicians who continue to use non-computerized medical records. (Sub. Res. 809, I-92; Reaffirmed: CMS Rep. 10, A-03)

H-315.992 Copying Records for Audits

Our AMA supports taking appropriate action to ensure that the financial responsibility for producing or copying patient records at the request of any regulatory agency having the authority to do so shall be borne entirely by the requesting agency and the request for said records shall be made at least 30 days in advance of any deadline. (Res. 75, A-91; Reaffirmed: Sunset Report, I-01)

H-315.995 Hospital Face Sheet: Physician Responsibility

The AMA believes that it is the responsibility of the attending physician to specify all diagnoses and procedures in the hospital records, and that no alteration should be made without his or her consent. (Res. 117, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CMS Rep. 7, A-05)

H-315.996 Scientific Accuracy in Racial, Ethnic and Religious Designations in Medical Records

The AMA advocates precision in racial, ethnic and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy of the patient. (Res. 4, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-315.997 Patients' Access to Information Contained in Medical Records

Allowing patients access to information in their medical records will have, on the whole, a favorable impact on patient care and physician-patient relationships, provided that appropriate safeguards are incorporated in the enabling legislation enacted by states. (CMS Rep. I, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-315.998 Medical Record Privacy

Our AMA supports continued efforts to ensure the confidentiality of information on medical records by encouraging reconsideration of the AMA model state legislation on this subject and by other appropriate means. (Sub. Res. 111, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmation I-98; Reaffirmation I-99)

H-320.000 Medical Review
(See also: Managed Care; Medical Records; Medicare: Carrier Review; Peer Review)

H-320.947 Third Party Intervention Requests

1. AMA policy is that physicians only should be asked to effect clinical interventions on behalf of their patients as requested by third parties when such interventions are evidence-based and appropriately compensated.

2. Our AMA encourages physicians to submit to it instances of inappropriate interventions by health insurance plans, disease management companies, radiology benefit managers, or pharmacy benefit managers; and, if warranted, consider developing AMA resources to stem future requests that are not evidence-based and appropriately compensated. (Res. 704, A-07)

H-320.948 Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans

It is the policy of our AMA, when a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient who received the service, shall receive written notification in a timely manner that includes: (1) the principal reason(s) for the determination; (2) the clinical rationale used in making the determination; and (3) a statement describing the process for appeal. (CMS Rep. 5, I-00; Reaffirmation I-01; Reaffirmation I-04; Reaffirmation A-08)

H-320.949 Clinical Practice Guidelines and Clinical Quality Improvement Activities

Our AMA adopts the following principles for the development and application of utilization management guidelines:
(1) The criteria or guidelines used for utilization management shall be based upon sound clinical evidence and consider, among other factors, the safety and effectiveness of diagnosis or treatment, and must be age appropriate
.
(2) These utilization management guidelines and the criteria for their application shall be developed with the participation of practicing physicians.

(3) Appropriate data, clinical evidence, and review criteria shall be available on request.

(4) When used by health plans or health care organizations, such criteria must allow variation and take into account individual patient differences and the resources available in the particular health care system or setting to provide recommended care. The guidelines should also include a statement of their limitations and restrictions.

(5) Patients and physicians shall be able to appeal decisions based on the application of utilization management guidelines.

(6) The competence of non-physician reviewers and the availability of same-specialty peer review must be delineated and assured.

(7) Maintaining the best interests of the patient uppermost, the final decision to discharge a patient, or any other patient management decision, remains the prerogative of the physician. (BOT Rep. 6, A-99; Reaffirmed: Res. 820, A-00)

H-320.950 Eliminating Precertification

Our AMA will: (1) advocate that all utilization review efforts focus on statistical outliers, rather than routine blanket review of whole populations of physicians or all instances of particular services; (2) advocate that managed care plans restrict their preauthorization requests to physicians whose claims have shown to be statistical outliers; and (3) encourage CMS to adopt regulations prohibiting Medicare secondary insurance carriers from utilizing independent precertification criteria. (Res. 705, A-99; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation I-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 839, I-08)

H-320.951 AMA Opposition to "Procedure-Specific" Informed Consent

Our AMA opposes legislative measures that would impose procedure-specific requirements for informed consent or a waiting period for any legal medical procedure. (Res. 226, A-99; Reaffirmed: Res. 703, A-00)

H-320.952 External Grievance Review Procedures

Our AMA establishes an External Grievance Review procedure for all health plans with the following basic components:

(1) It should apply to all health carriers;

(2) Grievances involving adverse determinations may be submitted by the policyholder, their representative, or their attending physician;

(3) Issues eligible for external grievance review should include, at a minimum, denials for (a) medical necessity determinations; and (b) determinations by carrier that such care was not covered because it was experimental or investigational;

(4) Internal grievance procedures should generally be exhausted before requesting external review;

(5) An expedited review mechanism should be created for urgent medical conditions;

(6) Independent reviewers practicing in the same state should be used whenever possible;

(7) Patient cost sharing requirements should not preclude the ability of a policyholder to access such external review;

(8) The overall results of external review should be available for public scrutiny with procedures established to safeguard the confidentiality of individual medical information;

(9) External grievance reviewers shall obtain input from physicians involved in the area of practice being reviewed. If the review involves specialty or sub-specialty issues the input shall, whenever possible, be obtained from specialists or sub-specialists in that area of medicine. (Res. 701, I-98; Reaffirmation I-99; Reaffirmation A-00)

H-320.953 Definitions of "Screening" and "Medical Necessity"

(1) Our AMA defines screening as: Health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.

(2) Our AMA recognizes that federal law (EMTALA) includes the distinct use of the word screening in the term "medical screening examination"; "The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist."

(3) Our AMA defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) Clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician,

or other health care provider.

(4) Our AMA incorporates its definition of "medical necessity" in relevant AMA advocacy documents, including its "Model Managed Care Services Agreement." Usage of the term "medical necessity" must be consistent between the medical profession and the insurance industry. Carrier denials for non-covered services should state so explicitly and not confound this with a determination of lack of "medical necessity".

(5) Our AMA encourages physicians to carefully review their health plan medical services agreements to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.

(6) Our AMA urges private sector health care accreditation organizations to develop and incorporate standards that prohibit the use of definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.

(7) Our AMA advocates that determinations of medical necessity shall be based only on information that is available at the time that health care products or services are provided.

(8) Our AMA continues to advocate its policies on medical necessity determinations to government agencies, managed care organizations, third party payers, and private sector health care accreditation organizations. (CMS Rep. 13, I-98; Reaffirmed: BOT Action in response to referred for decision Res. 724, A-99; Modified: Res. 703, A-03; Reaffirmation I-06)

H-320.954 Post-Partum Hospital Stay and Nurse Home Visits

The AMA: (1) opposes the imposition by third party payers of mandatory constraints on hospital stays for vaginal deliveries and cesarean sections as arbitrary and as detrimental to the health of the mother and of the newborn; and (2) urges that payers provide payment for appropriate follow-up care for the mother and newborn. (Sub. Res. 105, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06)

H-320.955 Conflict of Interest in Care Review

AMA policy is that utilization review organizations make every effort to avoid potential conflicts of interest for physician reviewers by not assigning cases to a physician reviewer who (1) is an associate or competitor of the physician under review, (2) actively practices in the same hospital as the physician under review when feasible, (3) participated in the development or execution of the patient's treatment plan, or (4) is a member of the patient's family. (Res. 701, A-95; Reaffirmed: CMS Rep. 7, A-05)

H-320.956 Advance Directives and Utilization Review

The policy of the AMA is that: (1) the prior existence of advance directives (expressions of intent to forgo resuscitative, extraordinary, unwanted or other care highly unlikely to improve or stabilize health status) should not jeopardize the provision of medically appropriate care, if the care is consistent with agreed upon limits; (2) individual physicians should not be reprimanded by reviewing bodies for abiding by the wishes of patients when providing appropriate care to individuals who have exercised advance directives. (Res. 716, I-94; Reaffirmed: CMS Rep. 5, A-04)

H-320.958 Emerging Trends in Utilization Management

The AMA will:

(1) maintain a leadership role in coordinating private sector efforts to develop and refine utilization management and quality assessment programs;

(2) establish an active role in the development of any national utilization management and quality assessment programs that are proposed in the ongoing health system reform debate; and

(3) advocate strongly for utilization management and quality assessment programs that are non-intrusive, have reduced administrative burdens, and allow for adequate input by the medical profession. (CMS Rep. 9, I-93; Reaffirmed and Modified: CMS Rep. 7, A-05)

H-320.960 Secondary Utilization Review

The AMA: (1) urges the Blue Cross and Blue Shield Association, the Health Insurance Association of America, and the American Managed Care and Review Association to develop mechanisms to coordinate utilization review procedures that are implemented by primary and secondary health insurance companies for a single case; (2) work with CMS to clarify on a national level that for patients who have Medicare indemnity as primary coverage, that the coverage and utilization management requirements of secondary payers are not applicable. (Sub. Res. 708, I-92; Appended by Res. 121, A-9; Reaffirmed: CMS Rep. 4, A-08)

H-320.961 Preauthorization for Payment of Services

Our AMA supports legislation and/or regulations that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization, unless fraud was committed or incorrect information provided at the time such prior approval was obtained. (Res. 701, I-92; Reaffirmed by Res. 723, A-95; Modified by Sub. Res. 704, I-96; Reaffirmed: CMS Rep. 5, I-00; Reaffirmation I-04)

H-320.962 Utilization Review as the Practice of Medicine

The AMA (1) reaffirms existing AMA model state legislation providing for physician involvement in utilization review programs; (2) will redistribute the model state legislation to state medical societies and the national medical specialty organizations; and (3) requests that, if a denial letter is given, then a written explanation signed by the reviewing physician(s) should be attached to the denial letter. (BOT Rep. A, A-92; Reaffirmation I-98)

H-320.963 Disclosure of Medical Review Criteria and Eligibility Guidelines

The AMA will continue to press for the release of all Medicare carrier screens nationwide, including local screens, frequency parameters, and computer edits to identify claims for medical review. (CMS Rep. I, A-92; Modified and Reaffirmed: CMS Rep. 10, A-03)

H-320.964 Study of Proposed Health Quality Improvement Administration in HHS

The AMA opposes the creation of a single, governmentally funded and administered program to undertake all medical review and quality assurance in both the private and public health care sector. (Sub. Res. 719, A-92; Modified: CMS Rep. 10, A-03)

H-320.965 Responsibility for Hospital Admissions

It is the policy of the AMA that the determination of the medical necessity for hospital admission should be made only by a doctor of medicine or a doctor of osteopathy licensed in the same jurisdiction as the treating physician. (Sub. Res. 811, I-91; Reaffirmed: CMS Rep. 13, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-320.967 Insurance Company Requests for Patient Information

It is the policy of the AMA (1) to study the issue of insurance company demands for unlimited access to patient records and to recommend guidelines for disclosure of information contained in a patient's medical records to insurance companies;

(2) to work with the insurance industry to ensure insurance company acceptance of and compliance with AMA guidelines for release of patient records;

(3) to seek to ensure that physicians are compensated for their costs of retrieving and providing these records; and

(4) that while awaiting the development of more detailed guidelines at some future date, requests made to physicians or hospitals for information must be time- and illness-specific so as to avoid compromising patient confidentiality. (Sub. Res. 106, I-91; Reaffirmation I-99)

H-320.968 Approaches to Increase Payer Accountability

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)

(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms

utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within two business days to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.
(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above. (BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMS Rep. 4, A-95; Reaffirmation I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 13 , I-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-00; Reaffirmed in lieu of Res. 839, I-08)

H-320.969 Concurrent Review Procedures of Inpatient Care by HMO Representatives

The AMA encourages state regulation of third party reviewers who are on site in hospitals evaluating inpatient management so that these representatives: (1) must accrue clinical data in the hospital only under the control of hospital-based utilization review/quality assurance (UR/QA) personnel; (2) must not be enabled to have any direct inpatient contact; (3) must both communicate such suggestions directly to the attending physician and document all actions in the hospital's utilization office if they wish to provide input regarding patient management; (4) it is the role of the utilization review program or managed care plan to credential/certify that its reviewers are appropriately licensed and have the required experience to perform review; (5) prior to the on-site review, the utilization review program or managed care plan should provide upon request the name(s), credentials and background of their reviewers to the medical staff credentials committee and/or quality assurance/utilization review committee; and (6) the medical staff should have: (a) established protocol for reviewers entry into the hospital and (b) a process for monitoring the reviewer's activities and the confidentiality of the records they review. (Res. 62, I-90; Res. 726, A-95; Reaffirmed: CMS Rep. 7, A-05)

H-320.970 Private Insurer's Medical Review Policy

It is the policy of the AMA to initiate discussions with private insurers to assure that state medical societies and appropriate specialty societies are consulted regarding the approval of coverage for new, safe and cost effective medical procedures and on any proposed medical policy change. (Res. 162, I-90; Reaffirmed: Sunset Report, I-00)

H-320.971 Third Party Payers and Patient Care Standards

Our AMA supports working with contracted medical review agencies of third party payers to eliminate the imposition of patient care standards and their implementation by these outside organizations without medical staff approval. (Res. 13, I-90; Reaffirmed: Sunset Report, I-00)

H-320.972 Problems with Review Entities

Our AMA recommends that individual physicians report persistent problems concerning review entities to their state insurance commissioner or other appropriate regulatory authorities. (CMS Rep. E, I-90; Modified: Sunset Report, I-00)

H-320.973 Utilization Review by Physicians

It is the policy of the AMA to urge its constituent medical associations to (1) seek the enactment of legislation requiring that utilization review for insurers shall be conducted by physicians licensed by the state in which they are doing the review; and (2) seek enactment of legislation that would require all agencies or groups doing utilization review to be registered with the appropriate health regulatory agency of the state in which they are doing review and to have an appropriately staffed office located in the state in which they are doing the review. (Sub. Res. 175, A-90; Reaffirmation A-97; Reaffirmation A-06)

H-320.974 Regulation of Private Third Party Utilization Review

It is the policy of our AMA (1) to work with state medical societies to develop appropriate and consistent standards for private third party utilization review; and (2) that appropriate and consistent standards are used at both the state and national level to seek legislative and regulatory approaches to ensure cost effective, consistent, fair and high quality third party utilization review as well as accessibility to third party reviewers. (Res. 258, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation I-04)

H-320.976 Medical Necessity of Diagnostic Tests

Our AMA approves the principle that the indication for a diagnostic test is based on the suspected diagnosis of a clinical disorder and that a test with normal results is not de facto unnecessary. (Res. 97, A-90; Reaffirmed: Sunset Report, I-00)

H-320.979 Potential Breaches of Confidentiality Resulting from Third Party Payers' Requests for Patient Information

Our AMA (1) supports compiling and disseminating information about the extent of the problems (especially those related to breaches of confidentiality) created by insurance company practices relating to requests for patient information; (2) supports expressing to major health insurance companies its objections to insurance company practices which potentially jeopardize a physician's ethical responsibility to protect patient confidentiality; and (3) encourages state and county medical associations to work with local carriers to solve problems created by insurance company requirements which potentially jeopardize a physician's ethical responsibility to protect patient confidentiality. (Res. 75, I-89; Reaffirmation I-99; Reaffirmation A-00)

H-320.982 Payer Accountability

Our AMA: (1) Urges that state medical associations and national medical specialty societies to utilize the joint Guidelines for Conduct of Prior Authorization Programs and Guidelines for Claims Submission, Review and Appeals Procedures in their discussions with payers at both the national and local levels to resolve physician/payer problems on a voluntary basis.

(2) Reaffirms the following principles for evaluation of preadmission review programs, as adopted by the House of Delegates at the 1986 Annual Meeting: (a) Blanket preadmission review of all or the majority of hospital admissions does not improve the quality of care and should not be mandated by government, other payers, or hospitals. (b) Policies for review should be established by state or local physician review committees, and the actual review should be performed by physicians or under the close supervision of physicians. (c) Adverse decisions concerning hospital admissions should be finalized only by physician reviewers and only after the reviewing physician has discussed the case with the attending physician. (d) All preadmission review programs should provide for immediate hospitalization, without prior authorization, of any patient whose treating physician determines the admission to be of an emergency nature. (e) No preadmission review program should make a payment denial based solely on the failure to obtain preadmission review or solely on the fact that hospitalization occurred in the face of a denial for such admission.

(3) Affirms as policy and advocates to all public and private payers the right of claimants to review by a physician of the same general specialty as the attending physician of any claim or request for prior authorization denied on the basis of medical necessity. (CMS Rep. O, A-89; Reaffirmation A-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation A-01; Reaffirmation A-02)

H-320.983 Mandatory Second Opinion

The AMA supports working for the elimination of federally mandated second opinions. (Res. 112, I-88; Reaffirmed: Sunset Report, I-98)

H-320.984 Mandated Second Opinions

The AMA (1) endorses the principle that it is appropriate to provide payment for a second opinion when medically necessary or required by Medicare. (Res. 65, A-87; Modified: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-320.985 Economic Discharge Order for Utilization Review Committee Denial

The AMA (1) reaffirms its policy that economic considerations should not conflict with a physician's primary responsibility to serve the best interests of his or her patient and that, if a third party payer or Medicare regulation results in urging of a physician to discharge a patient against the physician's medical judgment, the patient should be so informed and the physician should protest the limitation; and (2) advocates the position that any entity that imposes barriers between a physician and the best interests of a patient should be liable for any injury that the patient incurs. (Sub. Res. 82, A-87; Reaffirmed by Sub. Res. 105, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06)

H-320.986 Confidentiality and Utilization Review

(1) The AMA believes that: (a) in order to protect patient care and confidentiality, physicians should use judicious restraint when discussing any patient's care over the telephone; and (b) physicians who receive patient permission for a case discussion by telephone

from their patients on behalf of third party payers may, ethically and in their own best judgment, make a determination as to whether a reasonable charge for their time and expertise in providing such telephone case review discussions should be made, and that third party payers that demand such case reviews by telephone be encouraged to consider payment to physicians for their reasonable charges, if any, for these medical services. (2) The AMA objects to any utilization review performed solely upon the basis of an admitting diagnosis, without actual hospital record review, as being inadequate, incomplete and incapable of accuracy. (Res. 64, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmation I-99; Reaffirmation A-07)

H-320.987 Second Opinions When Required by Carrier

The AMA believes that second opinions for medical or surgical services and procedures are best provided by physicians who have the training, experience or skills which provide the necessary information base to assess the need for or advisability of a specific medical or surgical intervention. (Res. 28, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-320.988 Utilization Review Standards: Local Considerations

Our AMA urges utilization review entities, when rendering determinations of appropriateness and necessity, to (1) maintain focus and emphasis on quality, and not cost, and (2) take into consideration the entire system of alternative facilities and services, with close attention as to their availability and accessibility. (Res. 73, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmation I-04)

H-320.989 Third Party Utilization Review Programs

The AMA recommends that hospital medical staffs, prior to approving the written plan for utilization review, ensure the inclusion of provisions that require the hospital to seek formal review and recommendations from the medical staff concerning "any qualified outside organization" that is going to contract with the hospital to perform review activities specified in the plan, prior to entering into the contract. (BOT Rep. A, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-320.990 Standardization of Mandatory Second Surgical Opinion Programs

The AMA urges third party payers who require second opinions to inform their subscribers so that they understand the requirements of such programs. (Sub. Res. 53, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-320.991 Hospital Preadmission Review/Certification

The AMA believes that the following principle should be applied in evaluating any preadmission review program, so as to minimize any detrimental impacts on quality or accessibility of care: There should be direct and continuing communications to physicians and insureds regarding prior authorization requirements. (CMS Rep. B, A-86; Amended by Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-320.993 Utilization Management

The AMA encourages physicians to take a leadership role in implementing and maintaining utilization management programs within their hospitals. (Res. 114, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CMS Rep. 7, A-05)

H-320.994 Confidentiality

Our AMA believes that: (1) there has been an erosion of the confidential relationships between the patient and health professional, which has resulted from growing outside demands for the information shared in this relationship for the purpose of patient care;

(2) there is a need to sensitize the public to the intrusions into confidential medical information which can result from increased demands for accountability - in substantiating health insurance claims, in litigation, and in medical care evaluation;

(3) much of the erosion has emanated from the public, and properly so; however, an over-emphasis on society's right to know, at the expense of the individual's right to privacy and confidentiality, has resulted and a better balance is needed;

(4) one important contribution to restoring such balance would be greater education of patients and the public as to the full range of purposes for which confidential information is used, the policies governing the release of such information, and the individual's rights with respect thereto. (Joint BOT/CMS Rep., I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation I-98; Reaffirmation I-99; Reaffirmation A-00)

H-320.995 Medical Necessity Determinations

(1) Our AMA urges: (a) health insurance carriers and government health care financing agencies to rely on appropriate medical peer

review programs for adjudication and resolution of all matters concerning quality or utilization of medical services requiring professional judgment, and (b) that peer review programs have as their goal both improved quality of care and more efficient delivery of medical service.

(2) Our AMA urges health insurance carriers, government financing agencies, physicians and medical societies to explore ways of improving communications, such as the following: (a) In furtherance of past Association recommendations that policyholders be thoroughly and clearly informed as to the extent of their coverage, more detailed information explaining the "medical necessity" exclusion should be provided, especially when the exclusion refers more to the site of the service than to the service itself. (b) Insurers should develop formal protocols as to their methodology for determining "medical necessity," including distinctions between those instances where in-house medical expertise is considered sufficient and those where outside consultation is considered necessary; (c) Third party methodologies for determining "medical necessity" should be made available to medical societies and to individual physicians, as well as listings of those specific situations (such as the ordering of either experimental or outdated procedures or questionable hospital admissions) where additional data may be required; (d) In "medical necessity" decisions where the determination may be modified by additional medical evidence, there should be an opportunity for the treating physician to provide such evidence before a final decision not to pay is made. (CMS Rep. L, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation and Reaffirmed: Sub. Res. 713, A-01)

H-320.996 Confidentiality

The AMA continues to encourage state legislatures to amend their current privileged communication statutes pertaining to physician-patient relationships so as to assure appropriate protection for communications between patients and all health care providers. (CMS Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation I-98)

H-330.000 Medicare
(See Also: Health Care Reform; Hospitals: Reimbursement; Medicare: Carrier Review; Medicare: PRO; Physician Payment: Medicare)

H-330.893 Medicare Election Period

AMA policy is that physicians should be given the option of a Medicare semi-annual participation election period occurring at the end and the middle of the calendar year.

Our AMA will petition the Centers for Medicare and Medicaid Services to permit a semi-annual participation election period occurring at the end and the middle of the calendar year. (Res. 216, I-08)

H-330.894 Demonstration Project Regarding Medicare Part D

Our AMA will continue its policy of promoting beneficiary choice and market based options in the context of the Medicare prescription drug benefit program (Part D). (BOT Action in response to referred for decision Res. 142, A-07)

H-330.895 Medicare Beneficiary Access to Pulmonary Rehabilitation Services

Our AMA will support legislation to create a pulmonary rehabilitation benefit in the Medicare statute. (Res. 915, I-07)

H-330.896 Strategies to Strengthen the Medicare Program

Our AMA supports the following reforms to strengthen the Medicare program, to be implemented together or separately, and phased-in as appropriate:

1. Restructuring beneficiary cost-sharing so that patients have a single premium and deductible for all Medicare services, with means-tested subsidies and out-of-pocket spending limits that protect against catastrophic expenses. The cost-sharing structure should be developed to provide incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care. The use of preventive services such as those recommended by the US Preventive Health Task Force should also be encouraged. Simultaneously, policymakers will need to consider modifications to Medicare supplemental insurance (i.e., Medigap) benefit design standards to ensure that policies complement, rather than duplicate or undermine, Medicare's new cost-sharing structure.

2. Offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. All plans would be subject to the same fixed contribution amounts and regulatory requirements. Policies would need to be developed, and sufficient resources allocated, to ensure appropriate government standard-setting and regulatory oversight of plans.

3. Restructuring age-eligibility requirements and incentives to match the Social Security schedule of benefits. (CMS Rep. 10, A-07)

H-330.897 Quality Cancer Care Preservation Act

Our AMA continues to support existing policy principles in evaluating legislative language on matters relating to Medicare reimbursement for physician acquisition and administration of prescription drugs. (BOT Action in response to referred for decision Res. 129, A-03)

H-330.898 Long-Term Funding of Medicare

Our AMA reaffirms its policy that the current Medicare program should be replaced with a self-funded, private-sector approach to financing health care for the elderly, with equitable means testing provisions. Our AMA:

(1) Supports proposals to shift the funding of Medicare from the current tax financed pay-as-you-go system to a system of mandatory individually-owned private savings, with a required minimum contribution, accumulated tax-free and dedicated to funding post-retirement medical care. The government would provide a contribution to economically disadvantaged individuals making smaller than average contributions to their retirement accounts.

(2) Supports establishing incentives to encourage the use of accumulated balances in Health Savings Accounts for the funding of post-retirement medical care.

(3) Recognizes that while private sector solutions can address a large portion of the long-term funding of Medicare, there will still be a need and responsibility for support from government or charitable organizations for the economically disadvantaged.

(4) Continues to support modernization of the traditional Medicare program by combining the cost-sharing requirements of Parts A and B into a single deductible.

(5) Continues to support replacing Medicare's systems of price controls with a system of price competition.

(6) Supports the premise that the Federal Employees Health Benefit Program (FEHBP) should be used as a model for restructuring Medicare. This type of program would allow seniors to choose among competing private plans, including a modernized fee-for-service Medicare program, for the plan that best meets their needs. Private retiree health insurance also should be integrated into any FEHBP-modeled system.

(7) Supports the premise that during the transition from the current Medicare program to a system of pre-funding, workers would not only establish private savings accounts for their retirement expenses, but would also continue to support current and soon-to-be retirees through some level of taxation.

(8) Reaffirms that the fundamental goal of transforming Medicare should be to assure the health of the elderly and disabled populations. Patients must have access to high quality medical services. The best value in medical care can be achieved by ensuring that the medical profession has a central role in the design and implementation of a new Medicare program. Patients must also receive timely and accurate information on the necessity and important aspects of Medicare transformation. (Sub. Res. 84, A-88; BOT Rep. 44, A-95; Reaffirmed: BOT Rep. 19 and Res. 131, A-99; CMS Rep. 5, A-97; Appended by CMS Rep. 10, A-98; Reaffirmed: Sunset Report, I-98; Reaffirmed: BOT Rep. 19, A-99; Reaffirmation I-99; Reaffirmed: CMS Rep. 9, A-03; Appended and Modified: CMS Rep. 5, I-03; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation I-07)

H-330.899 Medicare Pharmaceutical Benefit

Our AMA utilizes the following principles in evaluating legislative proposals for the addition of a Medicare pharmaceutical benefit:

(1) Any pharmaceutical benefit should be fully funded by additional budgetary allocations, separate from existing budget provisions. The benefit should provide for adequate accounting so that drug program expenditures can be tracked separately from all other expenditures.

(2) The pharmaceutical benefit should be targeted to reduce hardship for those with low-incomes and those with catastrophic costs.

(3) Any legislation should provide a pharmaceutical benefit that is equal across geographic regions.

(4) A pharmaceutical benefit should be designed in a way that allows for benefits options under both the traditional Medicare fee-for-service program and any version of the Medicare program that relies on the private marketplace. Different levels of drug benefits for different products would be permissible.

(5) A pharmaceutical benefit should include a tiered deductible and co-payment structure that encourages economically responsible

behavior.

(6) Any pharmaceutical benefit should be designed to prevent adverse selection.

(7) Any pharmaceutical benefit should be designed in a manner that prevents interference with clinical decision-making and physician prescribing decisions.

(8) Any pharmaceutical benefit should be designed in a manner that minimizes the administrative burden placed on physicians.

(9) Any pharmaceutical benefit should be designed in a manner that ensures beneficiary access to local pharmacies, and not be limited to mail order pharmacies.

(10) In the implementation of any Medicare drug benefit, employers are highly encouraged to preserve existing coverage, and for Medicare beneficiaries with existing drug coverage, any Medicare benefit should be supplemental to and coordinated with that existing coverage. (BOT Rep. 27, A-00; Reaffirmed: Res. 103, A-01; Modified: CMS Rep. 11, A-02; Modified: CMS Rep. 9, A-03; Appended: Res. 723, I-03; Reaffirmation I-04; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-06)

H-330.900 Moving Drug Costs Out of Medicare Part B

Our AMA will urge Congress and/or the Centers for Medicare and Medicaid Services to establish a new budget pool under Medicare, separate from Medicare Part B, that would include drugs and agents now in Part B and also all covered drugs in the Medicare Program including the new Prescription Drug Benefit. (Res. 220, A-04)

H-330.901 Medicare Manual Information about Excluded Services

Our AMA urges Medicare to: (1) include a section in its beneficiary manual specifically listing the services that are not covered by Medicare, including but not limited to: screening physician exams, screening blood tests including cholesterol panels, prescription medications, cosmetic procedures and services provided for the convenience of the patient or family; and (2) include information in its beneficiary manual explaining the limits on physician charges imposed by Medicare and the fact that supplemental insurance covers only the portion of the Medicare-approved charge not covered by Medicare. (Res. 120, A-03)

H-330.902 Subsidizing Prescription Drugs for Elderly Patients

Our AMA strongly supports subsidization of prescription drugs for Medicare patients based on means testing. (Res. 122, A-03)

H-330.903 Benefits Improvement and Protection Act 2000 Medicare Coverage

Our AMA supports payment for administration of injectable medication in the outpatient setting when the treating physician determines that it is medically inappropriate for the medication to be administered by the patient or patient’s caregiver (Res. 102, A-02)

H-330.904 Lack of Medicare Coverage for Lipid and Diabetes Screening

Our AMA supports dialogue with the Centers for Medicare & Medicaid Services and Congress to cover screening lipid profiles and blood sugars to prevent complications of lipid disorders and diabetes, where such screening is consistent with evidence-based medicine. (Res. 120, I-01)

H-330.905 Adequate Reimbursement for Screening Mammography

Our AMA supports pending legislation and/or seeks regulation that would enhance women's timely access to mammography services by adequate payment for Medicare screening and diagnostic mammography at a rate commensurate with the cost of services by apportioning additional funds from the general fund and by not requiring reduction in payment for any other services. (Sub. Res. 231, A-01; Modified: Res. 103, A-04)

H-330.906 Use of "Medicare" Title

Our AMA urges that the governmental name "Medicare" shall not be used by a non-governmental health insurer without prior written authorization by the Secretary of the Department of Health and Human Services. (Res. 101, A-01)

H-330.907 Education of Physicians about CMS Documentation Pilot Studies

Our AMA: (1) recommends to physicians that they not participate in any pilot study of the Centers for Medicare & Medicaid

Services's 2000 E&M Guidelines that does not grant them immunity from prosecution or that places them at risk for Medicare post-payment review audits, (except in cases where knowing and willful fraud is proven), until and unless they understand and are prepared to assume the potentially serious risk of significant fiscal penalties and, sanctions or exclusion from programs and criminal action against them; (2) reaffirm, that in cooperation with the Federation, it will continue to work through the CPT Editorial Panel and with CMS to develop a simplified E & M documentation guideline within the most recent CPT framework that is clinically relevant, realistic, and practical; and (3) continues to advocate with CMS, for implementation of a plan whereby (a) the carriers may identify "outliers" using methods at their discretion; (b) carriers would review these statistical outliers against their own internal criteria; (c) carriers would refer suspect E&M services to peer reviewers identified by state medical associations with input from state specialty societies; the physicians selected should be board certified, actively practicing and should represent a cross section of practitioners by locale (d) the Carriers would pay for this review (e) any post payment review of E&M services would rely on similar peer review before any adverse actions are taken, (f) the initial purpose of the peer review should be educational; and (g) there should be an appeal process at all levels of review. (Sub. Res. 815, I-00)

H-330.908 CMS Required Diabetic Supply Forms

Our AMA requests that CMS change its requirement so that physicians need only re-write prescriptions for glucose monitors and related supplies every twelve months, instead of a six month requirement, for Medicare covered diabetic patients and make the appropriate diagnosis code sufficient for the determination of medical necessity. (Sub. Res. 102, A-00; Reaffirmation and Amended: Res. 520, A-02)

H-330.909 Medicare Coverage for Low Molecular Weight Heparin

Our AMA policy supports Medicare reimbursement for the outpatient cost of low molecular weight heparin for patients diagnosed with deep vein thrombosis (DVT) who meet criteria for safe management of their DVT at home, and that funding of such coverage come from Medicare Part A. (Res. 116, A-00)

H-330.910 Congressional Oversight Hearings and Legislative Reform of CMS

Our AMA will: (1) seek immediate and periodic Congressional oversight hearings of the CMS on issues related to the administration of the Medicare and Medicaid programs and additionally will seek legislation to reform CMS; and (2) undertake and support activities that would hold state and federal agencies, their contractors, and employees dealing with health care issues to the same level of accountability as are physicians. (Sub. Res. 207, A-00)

H-330.911 Medicare Physician Enrollment Process

Our AMA: (1) insists that CMS not exceed its statutory authority in the development of proposals relating to Form 855 and physicians' enrollment in the Medicare program, and consider pursuing litigation should CMS do so;
(2) insists that CMS refrain from subjecting physicians to additional administrative burdens in the Medicare enrollment process;
(3) strongly urges CMS to create an option during the Medicare enrollment process that will allow physicians to apply for and set up electronic billing and payment; and
(4) strongly urges CMS to institute temporary provider numbers for physicians during the Medicare enrollment application period. (CMS Rep. 15, I-99; Reaffirmation A-01)

H-330.912 Appropriate Medical Coverage for Medicare Beneficiaries

Our AMA will continue to stress that regulations should move in the direction of free market choice of plans. (BOT Rep. 16, A-99)

H-330.913 Medicare Managed Care Opt Out Rules

Our AMA: (1) opposes managed care "bait and switch" practices, whereby a plan entices patients to enroll by advertising large physician panels and/or generous patient benefits, then reduces physician reimbursement and/or patient benefits, so that physicians leave the plan, but patients who can't must choose new doctors; (2) supports current proposals to extend the 30 day waiting period that limits when Medicare recipients may opt out of managed care plans, if such proposals can be amended to create an exemption to protect patients whenever a plan alters benefits or whenever a patient's physician leaves the plan; and (3) supports changes in CMS regulations which would require Medicare managed care plans to immediately notify patients, whenever such a plan alters benefits or whenever a patient's physician leaves the plan, and to give affected patients a reasonable opportunity to switch plans. (Res. 707, A-99)

H-330.916 Legislation for Assuring Equitable Participation of Physicians in Medicare-Sponsored Managed Care Organizations

Our AMA seeks to have the CMS, while contracting with Medicare+Choice organizations for Medicare services, require the following

guarantees to assure quality patient care to medical beneficiaries: (1) A Medicare+Choice patient shall have the right to see a duly licensed physician of the appropriate training and specialty; (2) If CMS decertifies a Medicare+Choice plan, enrollees in that plan who are undergoing a course of treatment by a physician at the time of such termination shall continue to receive care from their treating physician until an appropriate transfer is accomplished; and (3) Any Medicare+Choice plan deselection of participating physicians may occur only after the physician has been given the opportunity to appeal the deselection decision to an Independent Review Body. (Res. 707, I-98)

H-330.917 Medicare Reimbursements for Medications

Our AMA continues to advocate for Medicare reimbursement for the physician expenses associated with maintenance and administration of physician purchased office medications and devices. (Sub. Res.126, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-330.918 Violation of Medicare Act

Our AMA will take all measures to oppose any provision in the Medicare law and regulations that permits inappropriate federal involvement in medical treatment decisions or control over the practice of medicine as prohibited by Section 1801 of the Social Security Act. (BOT Rep. 37, I-98; Reaffirmation A-99; Reaffirmed: Res. 217, A-01)

H-330.919 Outpatient Pharmaceutical Coverage for Medicare Beneficiaries

Our AMA urges: (1) CMS to place a high priority on educating Medicare beneficiaries of their plan and benefit choices under Medicare+Choice; and (2) CMS and Medicare Payment Advisory Commission to study mechanisms for funding parenteral pharmaceutical therapy provided to Medicare beneficiaries in non-hospital settings. (CMS Rep. 11, I-98; Reaffirmation A-00)

H-330.920 Documentation Guidelines for E&M Services

Our AMA continues to vigorously pursue, in all appropriate manners, the following activities and principles with respect to the development and implementation of documentation guidelines for evaluation and management services: (1) AMA in cooperation with the Federation, continue to work through the CPT Editorial Panel and with CMS to develop simplified E &M Guidelines that are clinically relevant, realistic and practical and do not require either excessive physician time or documentation in excess of that necessary for good patient care;

(2) Physicians' medical record documentation should be sufficient for a peer physician to determine whether services have been accurately reported and that payments were made for medically necessary and appropriate services;

(3) Consistency with simplified E & M documentation guidelines should provide a "safe harbor" for physicians whose E & M services are selected for review, but such review should involve peer physicians who are able to consider all pertinent information that would help determine that the level of service reported was correct;

(4) Continues to advocate for continuing the current "grace period" for implementation of new documentation guidelines until needed changes are made in the content of the 1997 guidelines. Any audits carried out during the grace period should conform with the principles contained in number 2;

(5) Support for adequate testing of revised guidelines through pilot tests that are scientifically valid and include a representative sample of all types of practice setting and geographic regions. The pilot studies should include issues such as cost of compliance, patient and physician satisfaction, effect of a peer review model, whether patient care is improved and whether medical care costs increased or decreased. Organized medicine should be involved in the design, implementation and evaluation of the pilot programs and that physicians participating in the pilot be granted immunity from Medicare sanctions and penalties;

(6) Urges CMS to adequately fund educational efforts for physicians and their office staff about documentation guidelines, once agreement on their content is reached;

(7) Continues efforts to make information on the revised guidelines available to members, relying on the AMA Website as well as printed publications such as JAMA and AMNews;

(8) Works with national medical specialty societies and state medical associations to develop documentation tools to assist in implementation of the guidelines, making use of the "members only" portion of the AMA Website for distribution of such tools as a member service; and

(9) the AMA opposes any documentation system that requires quantitative formulas or assigns numeric values to elements in the medical record to qualify as clinically appropriate medical record-keeping. (Sub. Res. 801, A-98; Reaffirmed: Res. 804, I-98; Reaffirmed: BOT Rep. 6, A-00; Reaffirmed: Sub. Res. 815, I-00)

H-330.921 Medicare Prepayment and Postpayment Audits

AMA policy is that with respect to prepayment and postpayment audits by the Medicare program, the following principles guide AMA advocacy efforts: (1) The confidential medical record should be preserved as an instrument of clinical care, with strong confidentiality protections and, we oppose its use as an accounting document;
(2) CMS should discontinue random prepayment audits of E&M services;
(3) In lieu of prepayment audits, CMS should use focused medical review of outliers based on reviews of patterns of services, using an independent medical peer review process, where physicians practicing in the same specialty, review their peers;
(4) No financial or legal penalties should be assessed based on one level of disagreement in E&M code assignment; and
(5) CMS must stop the practice of requiring physicians to repay alleged Medicare overpayments before an actual appeal is rejected or a final administrative decision or a court order is rendered. Legislative relief will be sought if advocacy with CMS is not successful in this regard. (Sub. Res. 801, A-98; Reaffirmed: Res. 804, I-98; Reaffirmed: Sub. Res. 815, I-00)

H-330.922 Waiver of Copayments of Certain Medicare Patients

Our AMA seek legislative and/or regulatory action that permits physicians in the exercise of their judgment to provide free medical services and/or waive deductibles and co-payments for patients with Medicare, Medicaid, and other health insurance. (Res. 254, A-98; Reaffirmation I-98; Modified: BOT Rep. 12, A-03)

H-330.923 Medicare Toll-Free Number

The AMA petitionss CMS to require Part B carriers to initiate and maintain toll-free telephone lines for physician callers. (Res. 112, A-98; Reaffirmed: CMS Rep. 4, A-08)

H-330.924 Changes In COBRA Federal Regulations

(1) The AMA, in cooperation with other organizations interested in the welfare of seniors, urge Congress to change existing law to allow COBRA coverage for employed seniors changing employment, irrespective of Medicare eligibility. (2) That for this population (i.e., persons still employed at the time of attaining age 65, who have no need, to enroll in Medicare Part B), an elimination of the 90-day waiting period for eligibility for Medicare Part B, together with an elimination of the penalties applied for a delayed application, be sought. (Res. 144, A-98)

H-330.925 Appropriate Payment Level Differences by Place and Type of Service

Our AMA: (1) encourages CMS to adopt policy and establish mechanisms to fairly reimburse physicians for office-based procedures;

(2) encourages CMS to adopt a single facility payment schedule for hospital outpatient departments and ambulatory surgical centers;

(3) advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services;

(4) continues to oppose the implementation of any prospectively determined classification and payment system for Medicare ambulatory services that is based upon a methodology that bundles or groups services;

(5) advocates for payments for hospital outpatient department services and ambulatory surgical services that are based on individual services;

(6) encourages the use of CPT codes across all sites-of-service as the only acceptable approach to payment methodology; and

(7) will join other interested organizations and lobby for any needed changes in existing and proposed regulations affecting payment for ambulatory surgical centers to assure a fair rate of reimbursement for ambulatory surgery. (Sub. Res. 104, A-98; Reaffirmation I-98; Appended: CMS Rep. 7, A-99; Reaffirmation A-00; Reaffirmation I-03)

H-330.926 Reform of CMS Technology Assessment Process

The AMA advocacy efforts on a new Medicare coverage policy process emphasize the following key principles: (1) Accountability: the procedures must be open and inclusive. (2) Predictability: the advisory committee process must utilize clear criteria based on scientific standards. (3) Timeliness: quality of life enhancing technologies must be addressed in a reasonable timeframe. (4) Flexibility: CMS should develop creative approaches to coverage policy, such as limited or conditional coverage. (5) Accessibility: a reasonable balance must be established between the goals of access to care for Medicare beneficiaries and the need to protect patients from inappropriate technologies (Res. 146, A-98; Reaffirmed: CMS Rep. 4, A-08)

H-330.927 Medicare Patient Copayments for Outpatient Procedures

The AMA (1) endorses the concept that Medicare beneficiaries should be protected from coinsurance liability that varies widely for the same surgical procedure depending on whether such procedure is performed in a hospital-based or affiliated outpatient facility or a non-hospital affiliated ambulatory surgical center; and (2) encourages the CMS, consumer groups and other appropriate organizations to inform Medicare beneficiaries of the present differences in coinsurance obligations between different types of outpatient facilities so as to facilitate informed choice of care. (CMS Rep. 5, A-98; Reaffirmation I-98; Reaffirmed: CMS Rep. 7, A-99)

H-330.928 Managed Medicare Reimbursement

The AMA advocates that Medicare managed care plans (eg, Medicare HMOs, Medicare Choice plans, etc.) that use the RBRVS do so in a manner that maintains the relativity of the RBRVS utilized in the traditional Medicare program. (Sub. Res. 819, I-97; Reaffirmation I-05)

H-330.929 Lessening the Impact of New Legislation on Physicians: An Anti-Hassle Proposal

AMA policy is to promote and further strengthen the Practicing Physician Advisory Council (PPAC) whose purpose is to identify proposed changes and to recommend needed clarification of regulations and legislation that impact physicians and medical practices. (Res. 206, I-97; Reaffirmed: BOT Rep. 33, A-07)

H-330.932 Cuts in Medicare and Medicaid Reimbursement

Our AMA: (1) continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients;

(2) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology;

(3) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services;

(4) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and

(5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases. (Sub. Res. 101, A-97; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reffirmation A-00; Reaffirmation I-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00; Reaffirmation A-01; Reaffirmation and Appended: Res. 113, A-02; Reaffirmation A-05)

H-330.934 Sharing Demographic Medicare Data with Other Public Entities by CMS

The AMA supports continued provision of aggregate anonymous demographic information to state and local health agencies where its use will promote community health and improve utilization of health care dollars, as long as adequate safeguards to protect individual privacy are preserved. (Sub. Res. 810, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-330.936 Physician Ordering of Durable Medical Equipment and Home Health Services

The AMA urges CMS and other payers to require that durable medical equipment and home health and other outpatient medical services be ordered by the physician responsible for the patient’s care, with appropriate documentation of medical necessity, before such services are offered to the patient or family; and that suppliers provide to the physician the charge for all durable medical equipment and home health and other outpatient services prior to the time the physician signs the order. (Res. 112, I-96; Reaffirmed by Res. 122, A-97; Amended: CMS Rep. 4, I-97; Reaffirmation A-99; Reaffirmation A-04; Reaffirmation A-08)

H-330.937 Local Medical Policy of Medical Payers

AMA policy states that when payers apply local medical policies to physicians in remote areas from where the local medical policy was originally developed, this local medical policy must be widely disseminated to the physicians in those areas along with printed explanations to the practitioners involved. (Res. 104, A-96; Reaffirmed: CMS Rep. 8, A-06)

H-330.938 Extension of Medicare Price Controls to the Federal Employees Health Benefit Program

The AMA will seek repeal of the Omnibus Budget Reconciliation Act (OBRA) 1993 provision that requires physicians to accept Medicare's limiting charges for services provided to federal retirees enrolled in the Federal Employees Health Benefit Program. (Res. 127, A-95; Reaffirmation I-99)

H-330.939 Reimbursement by Medicare for Psychotherapy Provided by Residents

The AMA will work with CMS to accomplish regulations for Medicare Part B payment for attending physicians' services that would not require the "physical presence" of the attending physician in the room at the same time that a resident provided psychotherapy. (CMS Rep. 2, A-95; Reaffirmed: CMS Rep. 7, A-05)

H-330.941 Medicare Limiting Charge for Injectable Drugs

The AMA will petition the federal government to suspend the limiting charge program for injectable drugs until such time as the Centers for Medicare & Medicaid Services can develop, in consultation with the AMA and appropriate specialty societies, a rational, understandable system for establishing payment levels for these drugs. (Res. 124, I-94; Reaffirmation I-99)

H-330.943 Physicians' Rights

Our AMA: (1) in conjunction with CMS, will seek to develop a simple, straightforward statement of a health care professional's or a provider's rights when initially under investigation for alleged fraud or abuse; and (2) urges that, where records or other information are requested from hospitals or other sources by a Medicare carrier fraud and abuse unit and where the investigation does not yield a potential case referable to the Office of the Inspector General, those sources from which information was sought and the involved physicians and others should be notified of their absolution after such an investigation. (Substitute Res. 212, I-94; Reaffirmation A-99; Reaffirmation I-01)

H-330.944 New Durable Medical Equipment Requirements

The AMA will work with CMS to develop and implement an exemption policy for low-cost DME supplies that are dispensed by physicians through their offices, based on such factors as current Medicare payment amounts, whether the item is usually disposable, linkage to a particular physician treatment, and specialty society recommendations. Claim for such supplies under these circumstances would not be subject to CMS's DME regulatory requirements and would be submitted to the local Medicare carrier. (CMS Rep. 5 -I-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmation A-04)

H-330.945 Durable Medical Equipment Requirements

The AMA will: (1) continue to seek legislation to prohibit unsolicited contacts by durable medical equipment suppliers that recommend medically unnecessary durable medical equipment to Medicare beneficiaries; and (2) reaffirm the concept that physicians are solely responsible for the medical needs of their patients and should be the initiators of orders for durable medical equipment. (Sub. Res. 205, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmation A-04)

H-330.946 Low Osmolar Contrast Agents for Radiography

The AMA: (1) urges CMS to reimburse the cost of nonionic contrast agents where, in the physician's judgment, there is a specific indication for their use; and (2) requests that CMS rescind its policy of prohibiting a Medicare patient the freedom to choose to purchase the low osmolar contrast agents when the patient has made a decision to request their use. (Sub. Res. 115, A-94; Reaffirmed: CMS Rep. 5, A-04)

H-330.948 Three Day Prior Hospital Stay Requirement

Our AMA will recommend that the Secretary of the U.S. Department of Health and Human Services, in consultation with health care professionals and skilled care providers, define a subset of patients (or DRGs) for whom the elimination of the three day prior hospital stay requirement for eligibility of the Medicare Skilled Nursing Facility benefit would avert hospitalization and generate overall cost savings. (Res. 805, I-93; Reaffirmation A-97; Reaffirmation I-00; Reaffirmation A-04)

H-330.949 Electronic and Paper Claims

Our AMA will petition Congress to require CMS to supply the CMS 1500 claim form and any other federal government required forms to physicians at no cost and opposes efforts by CMS to charge physicians for submission of any type of claims. (Res. 809, I-93; Reaffirmation A-01)

H-330.950 Post-Licensure Assessment as a Condition for Physician Participation in Medicare

The AMA opposes proposals for periodic post-licensure assessment as a condition for physician participation in the Medicare program or other health-related entitlement program. (Res. 231, I-93; Reaffirmed: BOT Rep. 28, A-03)

H-330.951 Non-Routine Waiver of Copayments and Deductibles Under Medicare Part B for Indigent Patients

The AMA will seek promulgation of a safe harbor provision by the Office of Inspector General, U.S. Department of Health and Human Services, for the non-routine waiver of Medicare Part B copayments and deductibles for indigent patients. (Res. 210, I-93; Reaffirmed: BOT Rep. 28, A-03)

H-330.952 Medicare Carrier Advisory Committee

The AMA will advocate to all relevant parties (e.g., CMS and Medicare carriers) that the role of the state medical associations and state specialty societies in representing the interests and views of physicians in their respective states should not in any way be diminished by the operations of the Medicare Carrier Advisory Committee. (BOT Rep. L, A-93; Modified: CMS Rep. 10, A-03)

H-330.954 Mandatory Transmission of Electronic Claims

Our AMA opposes: (1) mandation of the electronic submission of Medicare claims and supports the continued right of practitioners to have free choice, without penalty, to transmit claims data either by paper claim or electronically; and (2) the policy of local Medicare carriers of mandating that physicians choose between electronic remittance advice or standard paper remittance report until all secondary insurers accept the electronic remittance advice explanation of benefits in its present format. (Res. 815, A-93; Appended: Res. 107, I-00; Reaffirmation A-01)

H-330.955 Prescription of Durable Medical Equipment

(1) The AMA continues to voice its objection to CMS regarding its onerous requirement that physicians initiate and complete the entire certification of medical necessity form for durable medical equipment. (2) The AMA calls for CMS to revise its interpretation of the law to permit that the physician's prescription be the only certification of medical necessity needed to initiate an order for and to secure Medicare payment for durable medical equipment. (3) The AMA calls on physicians to be aware of the abuses caused by product-specific advertising by manufacturers and suppliers of durable medical equipment, the impact on the consumers of inappropriate promotion, and the contribution such promotion makes to unnecessary health care expenditures. (Res. 203, I-92; Reaffirmation A-97; Reaffirmation A-04)

H-330.957 Medicare Beneficiary Survey

Our AMA: (1) will continue to press strongly for the deletion of inflammatory and misleading questions and the correction of methodological problems in the Medicare Beneficiary Survey; (2) will continue to press strongly for the deletion of physician identifiers from the survey data after these identifiers have served their purpose of confirming respondents' answers through comparison with billing data; and (3) urges CMS to consult with physicians through their national and state organizations when future patient surveys of this nature are planned. (CMS Rep. E, A-92; Reaffirmation A-01)

H-330.958 Regionalization of Medicare Carriers

The AMA will continue to: (1) encourage state medical associations and national medical specialty societies to participate proactively in the Medicare Carrier "Notice and Comment" program with their respective carriers; and (2) monitor the impact of present and future Medicare carrier regionalization on the consistency of carrier interpretations and efficiency of operations. (CMS Rep. G, A-92; Reaffirmed: CMS Rep. 10, A-03)

H-330.960 Cost of Medically Related Services and Supplies

The AMA legislative or other appropriate department will seek a requirement that CMS and/or their contracted home health agencies, durable medical equipment suppliers, and non-emergency transportation services, provide cost estimates to physicians, to be provided along with the physician authorization form. (Res. 812, A-92; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-99; Reaffirmation A-04; Reaffirmation A-08)

H-330.963 Certificates of Medical Necessity for Medicare Oxygen

Our AMA supports informing CMS and the U.S. Congress of its objection to the CMS rule mandating that a Certificate of Medical Necessity for Medicare oxygen be filled out only by physicians or physicians' staff. (Res. 35, A-91; Reaffirmed: Sunset Report, I-01)

H-330.964 Federal Budgetary Process Reform as It Affects Medicare

Our AMA seeks legislative reform of the federal budgetary process to remove last-minute changes in Medicare funding in the reconciliation budget process and to insure appropriate and timely public input. (Res. 177, A-91; Reaffirmed: Sunset Report, I-01)

H-330.968 Private Insurance Alternatives for Medicare Part B

The AMA advocates and supports the development of a private alternative to Part B of Medicare so that both doctors and patients can avoid the abuses of CMS and patients may be spared the confusion, and conflict and rationing inherent in the present socialized system. (Res. 18, A-91; Reaffirmed: Res. 131, A-99)

H-330.969 Medicare Program

Our AMA: (1) urges the taking of all actions possible to repeal Public Law 101-239 and the restoration of the rights of physicians to privately contract with Medicare beneficiaries for the provision of health care services outside of the Medicare program, and (2) supports making its position known to the U.S. Congress. (Res. 30, A-91; Reaffirmation A-97; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02)

H-330.971 Medicare Policy on Inpatient Rehabilitation

Our AMA: (1) adopts the following statement of policy: The designation of who functions as attending physician - and consulting physician - in an inpatient rehabilitation setting should be the prerogative of the facility's medical staff and the decision should be made on an individual basis, depending on the qualifications and interests of the physicians concerned and the needs of the patients involved. The identification of the attending physician in an inpatient rehabilitative setting should not be specialty specific by designation, but be based on education, training, experience, and local peer recognition; and (2) urges the Centers for Medicare & Medicaid Services to instruct local carriers to pay claims submitted by attending physicians in inpatient rehabilitation settings irrespective of their specialty designations. (CMS Rep. K, I-90; Reaffirmed: Sunset Report, I-00)

H-330.974 Modification or Repeal of the Federal False Claims Act and Other Similar Statutes

It is the policy of the AMA to expend those resources necessary to monitor situations where physicians are under investigation, to provide financial and legal assistance where it is determined these are necessary, and to lobby for modification or repeal of the Federal False Claims Act and similar federal statutes. (Res. 152, A-90; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-01)

H-330.976 CMS Designated Specialty Authority

It is the policy of the AMA (1) to intervene with HHS and Congress in the implementation of designated specialty authority for particular procedures, particularly those for carotid doppler and transcranial doppler, as the previous decisions will severely limit high quality evaluation of stroke-prone individuals; and (2) that limiting one non-invasive procedure on a single day is contrary to high quality and cost effective medical care, especially for the elderly and poor. (Res. 130, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation I-00)

H-330.979 Providing Medicare Payment Status to all Physicians

It is the policy of the AMA to seek necessary changes in CMS's Medicare regulations to allow physicians access to patients' payment status information, and to provide notification to attending physicians when patients are paid by the Medicare carrier. (Res. 59, A-90; Reaffirmed: Sunset Report, I-00)

H-330.980 State Departments of Health Services Audit Results to CMS

It is the policy of the AMA to (1) oppose CMS's policy of accepting audit results and acting on them without considering the audited institution's responses or providing a hearing on these accusations in a timely manner which does not jeopardize patient safety; and (2) take all appropriate steps to secure regulatory or legislative action to change this policy and eliminate these due process abuses. (Res. 108, A-90; Reaffirmed: Sunset Report, I-00)

H-330.981 Hospital Responsibility for Diagnostic Reports

It is the policy of the AMA to encourage hospitals in conjunction with their hospital medical staffs to adopt mechanisms to promptly notify attending physicians of diagnostic test results that are reported after patients are discharged from the hospital. (Res. 276, A-90; Modified: Sunset Report, I-00)

H-330.986 Physician ("Doctors") Services Costs as Reported by HHS and Medicare

Our AMA urges HHS and CMS to, at all times, distinguish between MDs/DOs and non-MDs/DOs, and to discontinue the use of the

broad term "provider" when reporting or referring to the cost of physician services. (Res. 71, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-99; Reaffirmation A-02)

H-330.987 Medicare

The AMA supports continued efforts to obtain exact information regarding payment amounts made to providers of Medicare Part B services, especially regarding increasing use of non-physician providers, durable medical equipment and the Medicare prospective pricing system induced shift of services from inpatient to outpatient settings. (Sub. Res. 56, I-87; Modified: Sunset Report, I-97; Reaffirmation A-04)

H-330.988 Free Choice by Patient and Physician Guaranteed

Our AMA reaffirms the original intent of Title XVIII, Section 1802 of the Social Security Act, which guarantees free choice by patient and physician. (Res. 115, I-87; Reaffirmed: Res. 731, A-95; Reaffirmed: Res. 217, A-01)

H-330.992 Medicare Definition of Physician

The AMA supports limiting the application of the definition of the term "physician" under the Medicare program to doctors of medicine or osteopathy. (Sub. Res. 101, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-330.995 Amendments to the Medicare Civil Penalties Section of the Social Security Act

The AMA supports amendment of the Social Security Act to permit trial de novo for a physician who so requests when the sum of the penalties levied is greater than $10,000 and/or when a suspension from the Medicare program is applied. (Res. 93, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: BOT Rep. 34, A-06)

H-330.996 Conservation of Medicare Funds by Appropriate Certification for Durable Medical Equipment

The AMA calls to physicians' attention the enormous cost of the portion of the Medicare program for durable medical equipment and urges physicians to review and document carefully requests for certification of medical necessity for durable medical equipment. (Sub. Res. 59, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmation A-04)

H-330.998 Publicity on PL8997

The AMA expresses its deep concern over the fact that the American people may be expecting from Title XVIII, Part B, more than they have a reason to expect from a fiscal and benefit standpoint. The AMA will continue its educational program informing state and component societies and the public as to the provisions in the law and the high cost of the program. (Sub. Res. 18, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98)

H-335.000 Medicare: Carrier Review
(See also: Managed Care; Medical Review; Medicare; Medicare: PRO)

H-335.963 Member Education on Medicare Recovery Audit Contractors

Our AMA: (1) will educate our membership about the effect of the program’s safeguard contractor activity and Recovery Audit Contractor (RAC) audits on individual physician practices, expansion of the RAC program, and assistance that may be available through our AMA; and (2) will actively support the legislation currently before Congress to require an immediate moratorium on the expansion of the RAC program, and will seek the introduction of subsequent legislation that would limit or exclude physician billings from the authority of RAC audits altogether. (Sub. Res. 226, A-08)

H-335.964 Funding for the Agency for Healthcare Research and Quality

Our AMA: (1) strongly supports the AHRQ in its activities, programs and initiatives designed to provide evidence-based information to evaluate and improve health care in practice settings; and (2) supports legislation that would greatly expand the scope and budget of the AHRQ as the central federal agency coordinating the issues involved in implementing the changes discussed in the IOM report, Crossing the Quality Chasm. (Res. 811, A-02; Appended: BOT Rep. 14, I-02)

H-335.965 Patient Safety

Our AMA: (1) continues its advocacy efforts in the area of patient safety and work to promote a meaningful long-term approach to ensure greater patient safety in the delivery of health care in our nation;

(2) will work in collaboration with the National Patient Safety Foundation, national medical specialty societies, state and local medical societies, other provider groups and a broad range of public and private organizations to continually advance efforts to improve patient safety through educational activities and all other available means to discover and promote "best practices" in the delivery of health care services;

(3) continues to advance non-punitive, evidenced-based health systems error data collection as well as strong legal protections for participants in safety programs. At a minimum, these protections must ensure that all information reported or otherwise gathered in the process of patient safety and error reporting programs (including any data, report, memorandum, analysis, statement, or other communication) intended either for internal use, or to be shared with others solely for the same purposes, remain confidential and not be subject to discovery in legal proceedings. Such protections must extend from the time of reporting to post-incident review activities and with regard to the repositories of identifiable data from such reporting programs;

(4) continues to call for a central role for the Agency for Healthcare Research and Quality (AHRQ) in coordinating the multifaceted, multi-industry national patient safety initiative envisioned by the AMA. The AHRQ must have sufficient funding to carry out research and development activities to support and advance public and private patient safety initiatives across the nation; and

(5) continues to help us inform our patients and the public in general concerning on-going efforts to improve quality and reduce errors in medical care. (Sub. Res. 202, A-00; Reaffirmed: BOT Rep. 13, I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-05)

H-335.966 Medicare Carrier's Responsibility to Reveal Reasons for Denial

Our AMA seeks and/or supports federal regulations or legislation that require Medicare carriers to reveal the detailed reasons for failure to pay and to publish their parameters of reimbursement so that patients and physicians are better informed as to the proper manner in which to deal with government contractors. (Res. 815, I-99; Modified: CLRPD Rep. 1, A-03; Reaffirmation A-07)

H-335.970 Medicare Integrity Program

Our AMA strongly urges CMS to adhere to the following principles during the implementation of the Medicare Integrity Program (MIP): (1) continue support for physician development of local medical review policy through strong Carrier Advisory Committees;

(2) provide access to a Medical Director in each state;

(3) provide a mechanism for close surveillance and monitoring of the performance of the MIP contractors to assure their accountability to questions and concerns raised by patients and physicians about coverage and other issues;

(4) continue due process and appeals mechanisms for physicians; and

(5) initiate a widespread and comprehensive effort to educate physicians about all aspects of the MIP. (CMS Rep. 4, A-97; Reaffirmed: CMS Rep. 1, A-99; Reaffirmation A-02)

H-335.972 Medicare Limiting Charge Exception Reports

Our AMA urges CMS to: (1) authorize Medicare carriers to modify the language which currently appears on the Limiting Charge Exception Report and the notification to Medicare beneficiaries to reflect the manner in which a Medicare claim was processed, i.e., application of specific Medicare policy, rather than creating the impression that a physician billed a non-assigned claim in excess of the limiting charge; and (2) notify the involved physician at least 10 days prior to issuing the Notification to Medicare Beneficiary of a limiting charge "violation" in order to give the physician an opportunity to appeal. (Sub. Res. 106, A-93; Reaffirmation I-99)

H-335.973 Reimbursement Violations

Our AMA will urge physicians who experience problems with their Medicare carrier's application of Medicare review criteria to report those problems, issues or concerns to their state medical association and state "Medicare Carrier Advisory Committee" for discussion and resolution. (Sub. Res. 705, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed in lieu of Res. 716, I-04)

H-335.974 Elimination of Extrapolation Method in Medicare/Medicaid Physician Audits

The AMA will : (1) vigorously pursue all avenues, including legislative relief, to eliminate the extrapolation method in physician Medicare audits; and (2) strongly advocate that carriers notify a physician when billing errors are detected, adequately explain to the physician how to correct future errors, and monitor the physician's billing practices for a period of time before a carrier can extrapolate in post-payment audit activities. (Res. 247, A-92; Reaffirmed: I-92; Amended: CMS Rep. 11, A-99)

H-335.976 Medicare Repayment Policies

AMA policy is: (1) to continue to urge CMS to develop Medicare postpayment review procedures that would provide audited physicians with proper due process and the right to review audit samples with the Medicare carrier personnel responsible for the audit; (2) to work with the U.S. Congress and the CMS to insure that any audits now being required by Medicare be conducted by appropriately trained and qualified personnel, using reasonable policies and procedures; (3) to work with the U.S. Congress and the CMS to require that physician audit findings be primarily targeted to educating physicians concerning deficiencies in the claims and billing process and that audit findings be referred to the appropriate specialty society peer review committee and that remedial education be offered, if indicated, before any sanctions or legal actions are imposed; (4) to seek written publication of all Medicare postpayment review policies utilized by Medicare carriers; (5) to continue to support federal legislation that would prohibit Medicare carriers from seeking Medicare repayments until the administrative appeals process has been completed; (6) to work through regulatory and, if necessary, legislative or judicial channels to modify current Medicare postpayment policies to allow physicians and carriers to informally resolve payment disputes based upon sample audit findings while preserving the physician's administrative and judicial appellate rights in the event a resolution satisfactory to both parties is not reached; and (7) to seek limitations on the annual interest rate being charged to physicians for Medicare repayment purposes, and that Medicare carriers be required to pay interest at the same rate for any repayment amounts that are owed to physicians. (Sub. Res. 701, I-91; Reaffirmed: I-92; Appended: Res. 105, I-97; Appended by Res. 133, A-98; Reaffirmed: CMS Rep. 11, A-99)

H-335.978 Medicare Fair Hearing

The AMA urges CMS to encourage Medicare carriers to utilize as Hearing Officers licensed physicians of the same specialty and in the same geographical area as that of the physician who requests the Fair Hearing and to make known to the requesting physician, prior to the Fair Hearing, the educational and medical credentials of the Hearing Officer. (Res. 74, I-90; Reaffirmed: Res. 713, A-93; Reaffirmed: CMS Rep. 10, A-03)

H-335.979 Medicare Carrier Determinations Of Medical Necessity

Our AMA urges CMS to require Medicare carriers to provide physicians with the name and the telephone number of the physician responsible for making a determination as to medical necessity in the initial letter of inquiry sent by the carriers. (Res. 73, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: Sub. Res. 713, A-01)

H-335.980 Payment For Copying Medical Records

It is the policy of the AMA to seek legislation under which Medicare will be required to reimburse physicians and hospitals for the reasonable cost of copying medical records which are required for the purpose of postpayment audit. A reasonable charge will be paid by the patient or requesting entity for each copy (in any form) of the medical record provided. (Res. 161, I-90; Appended by Res. 819, A-98; Reaffirmation A-08)

H-335.981 Medical Office Screens

It is the policy of the AMA to take the following actions: (1) seek specific clarification from CMS on the process, procedures, and criteria of physician office postpayment review and recoupment;

(2) lobby for full due process protection for carrier postpayment review and recoupment situation;

(3) oppose the concept and application of extrapolation;

(4) oppose arbitrary, erratic, or inappropriate components of postpayment review and recoupment; and

(5) seek appropriate relief to achieve equitable treatment of physicians in office postpayment review and recoupment situations. (Sub. Res. 274, A-90; Reaffirmed: Sunset Report, I-00)

H-335.982 Medicare Medical Necessity Determinations

It is the policy of the AMA to advocate that Medicare Part B carriers: (1) provide guidelines in understandable language that clearly identify noncovered services and "medically unnecessary" services; and (2) establish a timely appeals process for physicians and patients before a determination is made that a service is noncovered or "medically unnecessary." (Res. 194, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: Sub. Res. 713 and Reaffirmation A-01)

H-335.983 Medicare Physician Profile Notices

It is the policy of the AMA to work to ensure (1) that the physician profiling criteria and Medicare carrier instructions that are to be

used in the Medicare Comparative Performance Report program are developed in a reasonable manner; and (2) that the Medicare Comparative Performance Report program is focused primarily on educational efforts. (Sub. Res. 134, A-90; Reaffirmed: Sunset Report, I-00)

H-335.984 Medicare Regulatory Relief Legislation

It is the policy of the AMA to initiate modifications to the Regulatory Relief Amendments or introduce additional legislation to address further areas where unwieldy or inequitable federal regulations or legislation place unrealistic or unfair demands on physicians and their office staff to: (1) abolish the A/B Data Link in which physician services provided during inpatient treatment, where payment to the hospital has been denied, are reviewed and can be denied as medically unnecessary years after the treatment has been provided;

(2) abolish the practice of downcoding claims where Medicare carriers arbitrarily alter physician claims so that physicians are paid for a lower level of service than the one actually provided;

(3) further clarify Section 6109 of OBRA 1989 that nullified the recoupment of funds from Texas physicians and patients so that the original intent of the legislation would be realized through repayment of funds to those physicians and beneficiaries who had already repaid funds to the government;

(4) include provisions that relieve patients and physicians of responsibility for implementation of the Medicare as a Secondary Payer provisions and that the Medicare carrier be charged with responsibility for obtaining payment from the proper insurer rather than from physicians or beneficiaries for any errors that may be made in the determination of a beneficiary's insurance status; and

(5) include provisions that would nullify Section 6102(g)(4) of OBRA 1989 that all Medicare claims be filed by physicians so that physicians who have large numbers of claims for small amounts would not be burdened with the transaction costs of meeting the mandatory claims filing provision, particularly since the OBRA 1989 provisions explicitly forbid physicians from requesting or receiving any additional payment for this costly and time-consuming service. (Res. 213, A-90; Reaffirmed: Sunset Report, I-00)

H-335.991 Medical Necessity Denial Screens

Our AMA supports pursuing all available means to effect release of the data necessary for physicians to comply with the onerous provisions of the Medical Necessity Denial/Refund law. (Res. 272, A-89; Reaffirmed: Res. 239, A-99)

H-335.992 Modifying the Medicare Unnecessary Services Program

(1) The AMA continues to support the repeal of the "medically unnecessary" provisions of Section 9332(c) of OBRA 1986. (2) Until such time as repeal is achieved, the AMA urges CMS to require that there be stated on the medically unnecessary notices mailed by carriers (a) the basis for the denial; (b) the name, position, and title of the person to be contacted regarding questions about the review; and (c) the screening criteria or parameter used in denying payment for the service. (Res. 86, I-88; Reaffirmed: Sunset Report, I-98)

H-335.993 Medicare Part B Appeals - Telephone Hearings

The AMA opposes any requirement which would mandate telephonic or verbal reviews and hearings at any level of the settlement process for Medicare Part B claims. (Res. 50, A-88; Reaffirmed: Sunset Report, I-98)

H-335.994 CMS - Standards of Care, Hospital Admissions

The AMA supports federal government funding for an independent study to examine and assess the present impact on the quality of medical care from mandated utilization review, medical necessity standards, methods of reimbursement, denial of hospital admissions for illness, and surgical or invasive procedures. (Sub. Res. 25, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-335.996 Spurious Medical Necessity Denials

(1) The AMA supports appropriate legislative relief from the "medically unnecessary" provisions of section 9332 (c) of OBRA 1986, including repeal of this provision. (2) Until such time as repeal of this provision is achieved, the AMA urges CMS and Medicare Part B carriers to make further changes in the implementation of this authority to correct problems being experienced, including: (a) making the denial criteria, parameters of treatment, and medical review policies available to the physician community; (b) obtaining assurances that carrier medical review policies are developed with practicing physician advice; (c) assuring that physicians are notified by the carrier prior to a "medically unnecessary" notification being sent to a patient; (d) urging carriers to facilitate the expeditious handling of physician requests for reconsiderations and appeals of "medically unnecessary" denials; (e) assure that patient notifications are worded in such a way so as not to put into question the attending physicians' professional judgment or the quality of

care received and that the services denied be clearly identified (by more than just procedure code) in such notices, and that they be referred to as "not covered by Medicare" as opposed to "medically unnecessary"; and (f) opposing required wording in the patient waiver form (advance exculpatory notice) that suggests that the physician is about to provide medically unnecessary services to his or her patients. (3) The AMA supports continued gathering of data and information regarding the nature and extent of problems experienced by physicians arising from the implementation of this authority, with particular attention to any evidence suggesting that non-assigned patient Medicare claims are subjected to greater scrutiny (and more likely denial) than assigned claims. (4) Should neither legislative nor administrative relief be forthcoming, the AMA then supports exploration of potential judicial relief. (Sub. Res. 101, A-88; Reaffirmed: Sunset Report, I-98)

H-335.997 CMS and Physician Payment

Our AMA: (1) urges CMS (a) to halt the retrospective denial of payment until all interested parties have an opportunity to speak to the issue, and (b) to develop new guidelines that will be equitable to all interested parties; (2) supports legislation that would provide hearing rights for physicians and beneficiaries in cases of retrospective denial. (Res. 114, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmation A-01)

H-335.999 Postpayment Utilization Review

Our AMA supports efforts to promote a change in Medicare regulation and policy to limit postpayment utilization review and requests to recoup payments to claims that are no more than two years old from date of submission, except in cases of suspected fraud. (Res. 40, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmation A-02)

H-340.000 Medicare: PRO
(See also: Medical Review; Medicare; Medicare: Carrier Review)

H-340.896 Medicare Review Activities

It is the policy of our AMA that a substantial portion of federal dollars allocated for identifying, policing, and deterring fraud and abuse under the Medicare Part B program would be best spent on educating physicians and other health care providers about Medicare rules to prevent billing errors. (CMS Rep. 7, I-01; Reaffirmation A-02)

H-340.897 Status Report on Medicare Review Activities

Our AMA continues to diligently advocate to the Centers for Medicare & Medicaid Services for the active participation of physician organizations in: (a) the implementation process of the Medicare Peer Review Organization Sixth Scope of Work, especially the Payment Error Prevention Program; and (b) the development and issuance of the PRO proposed guidelines regarding referrals to the Office of the Inspector General. (CMS Rep. 14, I-99)

H-340.898 Medicare Review Activities: Peer Review Organization Sixth Scope of Work, Medicare Integrity Program, and Carrier Post-Payment Audit Processes

Our AMA: (1) strongly urges CMS to provide physician organizations with the opportunity for significant comment and input in the development of Medicare Integrity Program task orders before they are implemented;
(2) continues to oppose any type of "bounty" system for compensation to any Medicare contractor, including those in the Medicare Integrity Program, and instead urge CMS to base compensation on the proper repayment of claims, rather than on the numbers of resulting referrals to law enforcement agencies;
(3) continues to advocate for the ongoing involvement of physician organizations and hospital and organized medical staffs in refining and implementing the Medicare Peer Review Organization (PRO) Sixth Scope of Work, especially the Payment Error Prevention Program, and the need to emphasize physician education and clinical improvements;
(4) urges CMS to delete all "incentives" or other "award fees: from the Payment Error Prevention Program in the Medicare PRO Sixth Scope of Work; and
(5) urges CMS to clarify in the PRO Sixth Scope of Work that: (a) extrapolation should not occur unless it is to develop educational or compliance program interventions; and (b) referrals to the Office of the Inspector General should not occur unless a hospital does not respond to intervention or when significant evidence of fraud exists. (CMS Rep. 11, A-99; Reaffirmed: CMS Rep. 14, I-99)

H-340.899 PRO Sixth Scope of Work

Our AMA will: (1) continue to work with the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare Peer Review Organization (PRO) Sixth Scope of Work in a manner that directs the PROs to focus on quality improvement activities that will improve care to Medicare beneficiaries, rather than on alleged fraud and abuse; (2) strongly urge CMS to eliminate the Payment Error Prevention Program, including the Performance-Based Service Contract incentive payment, from the PRO Sixth Scope of Work; and (3) strongly urge CMS to provide for more involvement from the AMA, other physician organizations, and hospital and organized

medical staffs in refining and implementing the PRO Sixth Scope of Work. (CMS Rep. 16, I-98; Reaffirmed: CMS Rep. 14, I-99)

H-340.900 Peer Review Organization Program Status

Our AMA urges implementation of a Medicare beneficiary complaint process under the Medicare Peer Review Organization program that meets the information needs of patients offers appropriate due process for physicians, and maintains confidentiality of review findings. (CMS Rep. 1, A-97; Reaffirmation A-01)

H-340.901 Peer Review Organization Program Status

Our AMA strongly urges CMS to require that Medicare Peer Review Organizations (PROs) adhere to the following principles: (1) physicians should be provided with the fundamental principles of fairness and due process throughout PRO proceedings;

(2) all appeal mechanisms available to physicians should be exhausted before PROs disclose their decisions to beneficiaries;

(3) the language used in PRO correspondence with beneficiaries should be properly worded to ensure that the patient/physician relationship is not jeopardized; and

(4) PROs should be required to receive affirmative physician consent before patients are notified of PRO review determinations. (CMS Rep. 7, I-96; Reaffirmed: CMS Rep. 16, I-98; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, I-01)

H-340.902 The New Role of PROs in Quality Improvement

Our AMA declares support for the concept of improving mainstream medical care through provider pattern analysis and quality improvement projects, rather than punitive-oriented peer review. (Res. 719, A-96; Amended: CMS Rep. 16, I-98; Reaffirmed: CMS Rep. 9, I-00)

H-340.903 Quality Improvement Organization Status

The AMA urges CMS to carefully review the potential for conflict of interest when the same organization that contracts as a Medicare Quality Improvement Organization fulfills similar quality improvement contracts in the private sector. (CMS Rep. 9, I-95; Reaffirmed and Modified with change in title: CMS Rep. 7, A-05)

H-340.904 Quality Improvement Organization Program Status

Our AMA will (1) maintain its active role in the ongoing refinement of the QIO Sixth Scope of Work; (2) urge CMS to ensure that QIOs involve state medical associations, state medical specialty societies, and representatives of the local medical community in the selection, development, and implementation of local quality improvement projects; and (3) advocate to CMS that QIOs work closely with state medical associations and representatives of the local medical community in the selection and development of any educational materials directed toward Medicare beneficiaries. (CMS Rep. 11, A-95; CMS Rep. 16, I-98; Modified and Reaffirmed: CMS Rep. 4, A-08)

H-340.907 Notification When Physician Specific Information is Exchanged

The AMA will petition CMS to require notification of a physician under focused review that his or her name is being exchanged between any carrier and the PROs and to identify the reason for this exchange of information. (Res. 704, A-93; Reaffirmed: CMS Rep. 10, A-03)

H-340.910 Quality Improvement Organization Program Status

Our AMA will: (1) monitor the implementation of the QIO Sixth Scope of Work and continue to work with CMS to direct the QIO program in an educational, nonpunitive manner consistent with AMA policy, including: (a) requiring QIOs to utilize specialty-specific physician reviewers to make all final determinations of appropriateness and quality of care; and (b) requiring QIOs to make available to physicians under review the identities and credentials of physician reviewers. (2) The AMA will monitor the implementation of the QIO quality review and documentation review processes and continue to work with CMS to refine these processes so that they are implemented in an educational, nonpunitive manner. (CMS Rep. H, I-92; Amended and Reaffirmed: CMS Rep. 16, I-98; Modified and Reaffirmed: CMS Rep. 4, A-08)

H-340.913 Peer Review by Actively Practicing Physicians

The AMA continues to urge CMS to assure that under the Medicare review process only actively practicing physicians in the same specialty and similar practice settings be allowed to perform Medicare reviews. (Sub. Res. 703, I-91; Reaffirmed: Sub. Res. 712, A-

94; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmation A-06)

H-340.914 Credentials and Qualifications of PRO Reviewers

Our AMA, through the U.S. Congress, will require that the credentials and background of peer review organization (PRO) reviewers be made known to the appropriate state medical association and to the physician being examined before the peer review process is performed. (Res. 714, I-91; Modified: Sunset Report, I-01)

H-340.917 Publication in Federal Register of Proposed Changes in PRO Review Process or Procedures

Our AMA strongly urges CMS to publish in the *Federal Register* for review and comment any significant proposed changes in the peer review organization (PRO) process or procedures which would affect physician practice patterns and/or the delivery of medical care. (Sub. Res. 710, I-91; Reaffirmed: Sunset Report, I-01)

H-340.918 Peer Review Organizations

It is the policy of the AMA to continue to support necessary changes to the current peer review organization system utilized by CMS and to work toward a true peer review system based on concern for quality of care with an emphasis on education rather than financial considerations. (Sub. Res. 702, I-91; Reaffirmed: CMS Rep. 14, I-99)

H-340.928 PRO Physician Advisor Confidentiality

The AMA petitions third party payers and CMS (1) to require PROs and carriers to publish and forward annually to the quality assurance chairman and the chief of staff of all hospitals under their jurisdictions as well as all state medical associations, the names of physician reviewers, their credentials, and their specialties, and (2) to require that the physician reviewers reveal their identity by signing the letter submitted to a physician placed under review. (Sub. Res. 200, A-91; Reaffirmation A-99)

H-340.929 True Peer Review

Our AMA requests CMS to require PROs to use specialty specific reviewers to make all final determinations of appropriateness and quality of care. If the PRO has no reviewer qualified to make a determination in a specific case, it must obtain the services of an appropriate non-PRO physician specialist to provide true peer review. (Res. 184, A-91; Reaffirmed: Sunset Report, I-01)

H-340.930 Peer Review Organization Sanctions

Our AMA supports vigorously pursuing with appropriate peer review organizations (1) the careful definition of an adverse event, (2) the identification of whether the event is avoidable or unavoidable and whether it is a recognized complication of diagnosis or treatment, and (3) whether the event establishes a pattern or trend pointing to inappropriate physician or institutional behavior. (Res. 185, A-91; Reaffirmed: Sunset Report, I-01)

H-340.931 Unannounced PRO Enforcement of Regulation

Our AMA petitions CMS to preclude application of a law, rule or regulation prior to its effective date and urges CMS to announce the date on which the enforcement of a law, rule or regulation applicable to the Medicare program will begin. (Res. 199, A-91; Reaffirmed: Sunset Report, I-01)

H-340.932 Time Restrictions Placed on PROs to Implement Changes in Review Procedures

Our AMA supports working with CMS to assure that peer review organizations are given adequate time for proper implementation of mandated changes to review processes and procedures. (Res. 95, A-91; Reaffirmed: Sunset Report, I-01)

H-340.933 PRO Data Dissemination

Our AMA discourages the use of any PRO data by any hospital, medical staff or other body for credentialing purposes. (Res. 249, A-91; Modified: Sunset Report, I-01)

H-340.934 Notification of Quality Problems

It is the policy of the AMA (1) to urge CMS to modify regulations so that (a) in regard to confirmed quality problems which have been finally adjudicated by the PRO Quality Assurance Committee, the PRO is required to notify both the physician and president of the hospital medical staff in all such cases, and (b) the PRO be required to implement a mechanism to verify receipt of the PRO's notice of both potential and confirmed quality problems by the physician; (2) to seek an amendment to the PRO law to require that

when the PRO review goes beyond the generic screen for review, the physician must be notified within 48 hours of the exact reason for said review; and (3) to seek an amendment to the PRO law to repeal the existing prohibition on the release to a PRO proposed sanctioned physician of documents or other information produced by a PRO in connection with its deliberation in making quality determinations. (CMS Rep. N, I-90; Reaffirmed: Sunset Report, I-00)

H-340.936 Peer Review Program Status

(1) Our AMA supports a continuation of its efforts to amend the PRO law to prohibit extension of PRO review to physicians' offices.

(2) If AMA's legislative efforts to prohibit such review are not successful, the AMA urges that PRO office review should not be expanded beyond the pilot projects described until they have shown significant remediable deficiencies in the quality of office-patient care, and until methods have been developed to minimize the administrative burdens and costs placed on physicians by utilization review organizations.

(3) If physician office review is implemented, the AMA supports attempting, by all means feasible, to assure that such office review is targeted and cost effective rather than all-inclusive in nature. Approaches to such targeted review could include: (a) claims monitoring of ambulatory services by Medicare carriers to target for PRO office review physicians for whom the frequency or type of claims deviate significantly from those of their peers; (b) review of the office care of patients who have required hospitalization because of suspected improper ambulatory care; (c) review of office records of physicians whose care of their hospitalized patients has been formally judged to be deficient; and (d) review of the office records of physicians who have been identified as providing care of substandard quality, e.g. those who have been the subject of formal disciplinary action by a state medical licensure or disciplinary board, or by a hospital review committee. (CMS Rep. M, I-90; Reaffirmed: Sunset Report, I-00)

H-340.939 Limitation of CMS Regulation Promulgation

It is the policy of the AMA to continue to work with CMS to address the inconsistencies and disparities in interpretation that results from manual letters and transmittals to the PROs and fiscal intermediaries. (Res. 259, A-90; Modified: Sunset Report, I-00)

H-340.940 Peer Review Organization Program Status

It is the policy of the AMA to (1) take the actions necessary to achieve participation in CMS and PRO considerations of acceptable levels of generic screen failures;

(2) continue to monitor the increasing level of federal concern with the PRO program, analyze recommendations for change in the program, and respond appropriately;

(3) continue to oppose changes to the current sanction provisions of the PRO statute that are inconsistent with existing AMA policy; and

(4) encourage state medical societies to develop PRO oversight committees to facilitate the resolution of disputes, including the legal disputes of its members, that arise between PROs and physicians. (CMS Rep. G, A-90; Modified: Sunset Report, I-00)

H-340.942 Due Process in PRO Quality Review

Our AMA requests CMS to modify its interpretation of confidentiality to allow physician counsel representation in Peer Review Organization hearings if requested by the affected physician. (Res. 209, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-05)

H-340.943 Notification of Denials by the PRO

It is the policy of the AMA to encourage physicians to share Quality Inquiry letters with the medical staff quality assurance committee. (Sub. Res. 38, A-90; Modified: Sunset Report, I-00)

H-340.944 PRO Communications with Patients

It is the policy of the AMA to work with CMS to revise the letters sent by PROs when questioning care rendered by a physician to remove the suggestion of wrongdoing and better indicate what additional information the PRO needs to complete its investigation. (Res. 58, A-90; Reaffirmed: Sunset Report, I-00)

H-340.945 Extension of PRO Activities to Physicians' Offices

Our AMA vigorously opposes any further expansion of PRO activities in reviewing charts of Medicare patients in physicians' offices until such a time when it can be clearly demonstrated and documented that such review is cost effective, genuinely educational to the

practicing physicians involved, not disruptive to physician-patient relationships and productive of improved quality of care for patients. (Res. 81, A-90; Reaffirmed: Sunset Report, I-00)

H-340.946 Due Process and PROs

It is the policy of the AMA (1) to attempt to reverse the PRO practice of withholding the identities and credentials of its physician reviewers; and (2) to demand that any physician subject to PRO review be guaranteed the right to representation by legal counsel at all stages and be granted due process protections that at least include: (a) A hearing before a trier of fact which will be a panel of unbiased practicing physicians who have not acted as an accuser, investigator, fact-finder or initial decision-maker in the same matter and, where feasible, shall include individuals practicing the same specialty as the physician. (b) The right to a reasonable opportunity to challenge the impartiality of any panel member. (c) The right to inspect and copy any documentary information relevant to the charges which the PRO has in its possession. (d) Exchange lists of witnesses and copies of documents expected to be introduced. (e) During the hearing, rights to all of the information made available to the trier of fact; a record of proceedings; to call, examine and cross-examine witnesses, including any specialist who the PRO asked to review the case; to present and rebut evidence; to submit a written statement at the close of the hearing. (f) Upon completion of the hearing, receive a written report of the panel's recommendations, findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the recommendation made; and an explanation of the procedure for decision-making and procedure for appealing the recommendations. (g) An appeal of the findings and recommendations of the panel to the PRO's Board of Directors. The appeals will include a right to appear and respond, to be represented by an attorney or other designated representative, and to receive the written decision of the Board. (Res. 105, A-90; Reaffirmed: Sunset Report, I-00)

H-340.947 Publication of Physician Sanctions

Our AMA strongly opposes the publication of PRO actions against physicians until final disposition of those allegations. (Res. 106, A-90; Reaffirmed: Sunset Report, I-00)

H-340.949 Repeal/Modification of OBRA 1989

It is the policy of the AMA to continue to seek repeal and/or modification of OBRA 1989 to (1) allow for transfer of women in labor when medically indicated, and (2) provide for regular PRO work-up prior to any referral to HHS Office of Inspector General. (Res. 214, A-90; Reaffirmed: Sunset Report, I-00)

H-340.950 Reimbursement of Costs of Photocopying For PROs

It is the policy of the AMA to petition CMS for per-page reimbursement of the costs of photocopying medical records for the PRO for ambulatory surgery centers and other outpatient facilities. (Res. 216, A-90; Reaffirmed: Sunset Report, I-00)

H-340.951 PRO Notices of Final Determination

Our AMA requests CMS to allow physician appeals to PRO Notice of Final Determination. (Res. 218, A-90; Reaffirmed: Sunset Report, I-00)

H-340.960 PRO Access to Data

Our AMA supports pursuing all necessary initiatives to prevent access by the PRO to proceedings or documents protected by state statute or regulation as confidential peer review information and quality assurance data. (Res. 269, A-89; Reaffirmed: Sunset Report, A-00)

H-340.966 PRO Sanctioning Procedures

Our AMA opposes: (1) any change in PRO sanctioning procedures that would allow the PRO or the Office of the Inspector General to arbitrarily impose sanctions without adherence to the specific written procedural criteria now required to be followed by the PRO in any potential sanction case; and (2) any legislative or regulatory change that would allow the PRO to impose punitive monetary fines in excess of the actual or estimated costs of the medically unnecessary or improper services provided. (CMS Rep. M, A-89; Reaffirmed: Sunset Report, A-00)

H-340.968 Medicare Review

The AMA supports (1) working to ensure that QIO standards and criteria are developed and applied equitably; (2) the initiation of any measures deemed appropriate, including the involvement of CMS, the AMA, and Congress, to ensure that QIO standards, criteria and procedures are implemented in a proper manner; and (3) the concept that qualified and practicing physicians should be designated as reviewers of physicians in the same specialty being reviewed. (Res. 40, A-88; Reaffirmed: Sunset Report, I-98; Modified and

Reaffirmed: CMS Rep. 4, A-08)

H-340.969 The Office of Inspector General Bounty Hunting System

The AMA supports taking all appropriate steps, including legislation if necessary, to abolish the policy of the HHS Office of Inspector General under which high level employees receive favorable performance rewards based on the number of PRO-recommended sanctions they impose and/or the amount of dollar penalties they recover. (Res. 192, A-88; Reaffirmed: Sunset Report, I-98)

H-340.971 Medicare Program Due Process

The AMA supports legislative and regulatory changes, as necessary, to assure the provision of PRO review with due process protections before any physician is sanctioned under the Medicare Program. Such due process should include at a minimum the following specific protections that would entitle the physician to: (1) a written statement of the charges against him or her; (2) adequate notice of the right to a hearing, his or her rights in the hearing, and a reasonable opportunity to prepare for the hearing; (3) discover the evidence and witnesses against him or her sufficiently in advance of the hearing to enable preparation of the defense; (4) a fair, objective, and independent hearing, with the right to ask questions of the panel members and of any hearing officer designed to reveal bias or prejudice, and the right to challenge the impartiality of any member or hearing officer; (5) be represented by an attorney or other person of the physician's choice; (6) the opportunity to be present at the hearing and hear all of the evidence against him or her; (7) the opportunity to present a defense to the charges, including, but not limited to, the right to call, examine and cross-examine witnesses; (8) a presumption of innocence and assurance that the hearing body shall not render a decision against the physician unless the evidence produced at the hearing clearly supports that adverse determination; (9) a hearing within a reasonable proximity of the location of the physician's practice; and (10) a hearing which protects the interests of the physician, the physician's patients, and the public in quality patient care. (Sub. Res. 107, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-340.972 Office of the Inspector General Involvement in Peer Review

The AMA supports (1) careful review of the involvement of the Office of Inspector General in peer review organization and other sanction activity against physicians based on the quality of care provided; and (2) taking all appropriate steps, including legislative action if necessary, to establish a fair review mechanism designed to ensure that quality of care determinations are medically correct. (Res. 67, I-87; Modified: Sunset Report, I-97

H-340.989 PRO Readmission Review

The AMA urges CMS to allow payment for second or subsequent admissions which reflect accepted standards of medical practice and which will benefit the quality of patient care. (Res. 141, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-340.990 QIO Involvement in Quality Review and Physician Sanctions

The AMA urges modification of CMS's QIO contracts and regulations to provide that: (1) any perceived quality review assessment involving a member of a hospital's organized medical staff be concurrently presented for comment and review by the appropriate committee(s) of the organized medical staff; (2) the organized medical staff have the opportunity to make appropriate recommendations for corrections, when it deems that it is applicable, before the QIO shall act on a quality review matter; (3) the organized medical staff should act and inform the QIO organization in a reasonable period of time concerning what action, if any, was taken in relation to a perceived quality review problem; and (4) the QIO should be prohibited from taking any further action, such as sanctions of a member of the medical staff, before such medical staff involvement, review and reporting has been completed. (Res. 118, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed and Modified: CMS Rep. 7, A-05)

H-340.997 Medicare Preauthorization Review

Our AMA opposes the mandating of blanket hospital preadmission review for all patients or for specific categories of patients by government or hospital edict, and supports the prerogative of physician-directed peer review organizations to implement focused preadmission review on a voluntary basis. (CMS Rep. G, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmation A-01)

H-340.999 Peer Review Improvement Act of 1982

The AMA believes it is important to (1) support and work to strengthen those elements of the PRO program which are consistent with present AMA policy on medical peer review; (2) seek modification through regulation and amendment of those mandatory elements which are not consistent with existing policy; and (3) expand assistance to physicians and medical societies in assuming a leadership role in medical peer review, and in negotiating contracts under the PRO program which would retain professional direction and control with appropriate emphasis on quality rather than cost. (CMS Rep. G, I-82; Reaffirmed: CLRPD Rep. A, I-92; Modified: CMS Rep. 10, A-03)

H-345.000 Mental Health
(See also: Health Insurance; Health Insurance: Benefits and Coverage; Medicare)

H-345.978 Access to Psychiatric Beds and Impact on Emergency Medicine

Our AMA supports efforts to facilitate access to both inpatient and outpatient psychiatric services and the continuum of care for mental illness and substance use disorders, ameliorate the psychiatric workforce shortage, and provide adequate reimbursement for the care of patients with mental illness. (CMS Rep. 2, A-08)

H-345.979 Evaluation of Delirium

Our AMA supports efforts to educate physicians regarding the importance of evaluation of delirium for high risk patients and patients who are symptomatic. (Res. 504, A-07)

H-345.980 Advocating for Reform in Payment of Mental Health and Addiction Services

Our AMA will advocate that funding levels for public sector mental health and addiction services not be decreased in the face of governmental budgetary pressures, especially because private sector payment systems are not in place to provide accessibility and affordability for mental health and addiction services to our citizens. (Res. 205, A-06)

H-345.981 Access to Mental Health Services

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness: (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
(2) improving public awareness of effective treatment for mental illness;
(3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
(4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;
(5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and
(6) reducing financial barriers to treatment. (CMS Rep. 9, A-01)

H-345.982 Discriminatory Treatment of Psychiatric Illness and Psychiatrists by the Insurance Industry

Our AMA petitions insurance companies to treat patients with psychiatric illness no differently than they treat any other patients with respect to utilization review and precertification policies, and to afford the same degree of authority to psychiatrists as they afford to all other physicians. (Sub. Res. 715, I-99; Reaffirmation A-00; Reaffirmation A-02)

H-345.983 Medical, Surgical, and Psychiatric Service Integration and Reimbursement

Our AMA advocates for: (1) health care policies that insure access to and reimbursement for integrated and concurrent medical, surgical, and psychiatric care regardless of the clinical setting; and (2) standards that encourage medically appropriate treatment of medical and surgical disorders in psychiatric patients and of psychiatric disorders in medical and surgical patients. (Res. 135, A-99; Reaffirmation A-00)

H-345.984 Awareness, Diagnosis and Treatment of Depression

(1) The AMA will disseminate information to physicians and the public that depression is a significant illness that should be treated and when it occurs with another medical illness is a separate condition requiring treatment. The AMA supports full reimbursement and payment, without prejudice, for physician services related to the diagnosis and treatment of clinical depression.

(2) Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression, both when it occurs by itself and when it occurs with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.

(3) Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression, to reduce the stigma associated with depression, and to increase patient access

to quality care for depression. (Res. 502, I-96; Reaffirm & Appended: CSA Rep. 7, I-97; Reaffirmation A-00)

H-345.985 Outpatient Psychiatric Services

Our AMA will sponsor legislation to repeal Section 1833(c) of the Social Security Amendments of 1965, which limits Medicare payment for outpatient psychiatric services to 62.5 percent of approved charges. (Res. 214, A-92; Reaffirmation A-00; Reaffirmation A-02)

H-345.986 Fifty Percent Copayment Requirement for Codes 290-310 Mental Disorders

Our AMA: (1) will pursue, through appropriate means, an end to discrimination by Medicare and the other third party carriers which reduce payment for mental disorders to 50 percent; (2) supports returning the unfair 50 percent co-pay for diagnosis and treatment of all disorders listed in ICD-9 Mental Disorders Section 290-319 to the 20 percent copayment of other conditions; and (3) strongly opposes the discriminatory 50% co-payment for psychiatric treatment received by Medicare patients and supports changing the 50% co-payment for the diagnosis and treatment of all disorders listed in the ICD-9 Mental Disorders Section 290.319 to the 20% co-payment of other conditions. (Res. 240, A-92; Reaffirmed: Res. 103, A-93; Reaffirmed: CSA Rep. 7, I-97; Appended: Res. 101 and Reaffirmation A-00; Reaffirmation A-02; Reaffirmation A-08)

H-345.987 CPT Codes for Medical Management of Mental Illness for Outpatients

Our AMA (1) continues to support the concept that medical management of mental illness is comparable to the medical management of any other illness; and (2) will communicate the appropriate ways to report medical management and case supervision of mental illness, both on an inpatient and outpatient basis, to physicians and third party payers. (BOT Rep. C, I-91; Reaffirmation A-99; Reaffirmation A-00)

H-345.989 Psychologist Prescribing

The AMA: (1) opposes the prescribing of medication by psychologists; (2) strongly urges through mail and electronic communications technology that all state medical societies work closely with local psychiatric societies to oppose legislative or ballot initiatives authorizing the prescribing of medications by psychologists; and (3) supports and will work in concert with the American Academy of Child and Adolescent Psychiatry, the American Psychiatric Association, and with state and other appropriate medical societies in order to defeat initiatives that authorize psychologist prescribing prescription medication.. (Sub. Res. 214, A-89; Res. 204, A-97; Reaffirmation A-99)

H-345.990 Electroconvulsive Therapy

The AMA supports the use of electroconvulsive therapy as an effective treatment modality in selected patients, as outlined by the American Psychiatric Association. (Res. 38, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-345.991 Psychologists' Admitting Privileges

The AMA encourages state medical associations to oppose legislation or regulations granting hospital admitting privileges to psychologists. (Sub. Res. 205, A-88; Reaffirmed: Sunset Report, I-98)

H-345.992 Health Insurance Coverage of Psychiatric Illness

Our AMA: (1) reaffirms its support for the provision of benefits for emotional and mental illness under all governmental and private insurance programs which are equivalent in scope and duration to those benefits provided for other illnesses;

(2) reaffirms its support for the continued expansion and improvement of peer review of the quality, necessity, and appropriateness of psychiatric services, and encourages all third party payers to work with and to utilize the resources of appropriate medical specialty groups in implementing such review;

(3) supports development of model legislation for use by states to require all insurance companies that offer either group or individual coverage of hospital, medical, and surgical services to make available for purchase and affirmatively offer coverage of psychiatric services comparable with the coverage provided for other illnesses in their standard group and individual policies; and

(4) supports legislation designed to expand psychiatric benefits provided under publicly financed programs of health care to a level comparable with those provided for other illnesses. (CMS Rep. G, I-87; Reaffirmation A-97; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSA Rep. 7, I-97; Reaffirmation A-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 9, A-01; Reaffirmation A-02; Reaffirmation I-03)

H-345.995 Prevention of Unnecessary Hospitalization and Jail Confinement of the Mentally Ill

Our AMA urges physicians to become more involved in pre-crisis intervention, treatment and integration of chronic mentally ill patients into the community in order to prevent unnecessary hospitalization or jail confinement. (Res. 16, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-345.996 Physicians, Psychotherapy and Mental Health Care

Our AMA supports efforts to inform physicians, the public and third party payers that physicians in the private sector are at the forefront of mental health care in their office practices and provide significant amounts of direct and preventive mental health services to the public. (Res. 17, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-345.997 Electroconvulsive Therapy

Our AMA opposes state laws controlling electroconvulsive therapy and encourages efforts to repeal such legislation if enacted or oppose if proposed. (Res. 30, A-75; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-345.998 Reaffirmation of Position Regarding Diagnosis and Treatment of Mental Disorder

Our AMA affirms that any legislation authorizing nonphysicians to engage in independent medical management of mental, emotional or nervous disorders is in conflict with recognized medical practice. (Sub. Res. 63, A-75; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-345.999 Statement of Principles on Mental Health

(1) Tremendous strides have already been made in improving the care and treatment of the emotionally disturbed, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat mental illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.
(2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs.
(3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.
(4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field. (A-62; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-99)

H-350.000 Minorities
The policies in this section are specific to minority populations and minority physicians. Other AMA policies that also are relevant to minority populations and minority physicians include: B-1.50, Discrimination; E-2.132, Genetic Testing by Employers; E-9.035, Gender Discrimination in the Medical Profession; E-9.12, Physician-Patient Relationship: Respect for Law and Human Rights; E-9.131, HIV-Infected Patients and Physicians; H-20.936, HIV Update and HIV-Infected Physicians; H-20.943, Discrimination Based on HIV Seropositivity; H-20.966, AMA HIV Policy Update; H-20.974, AIDS Prevention through Educational Materials Directed at Minority Populations; H-30.943, Alcoholism and Alcohol Abuse Among Women; H-65.984, Gender Discrimination in the Medical Profession; H-65.987, Gender Exploitation in the Workplace; H-65.988, Organizations Which Discriminate; H-65.989, Unfounded Bias Against Some Medical Patients; H-65.990, Civil Rights Restoration; H-65.992, Continued Support of Human Rights and Freedom; H-80.995, Evaluation of the Use of DNA Identification Testing in Criminal Proceedings; H-95.978, Drug Abuse in the United States - Strategies for Prevention; H-95.981, Drug Abuse in the United States - A Policy Report; H-160.959, Health Care Access for the Inner-City Poor; H-165.882, Improving Access for the Uninsured and the Underinsured; H-185.976, Insurance Discrimination Against Victims of Domestic Violence; H-200.971, Guidelines for Physician Workforce Planning; H-200.972, Primary Care Physicians in the Inner City; H-200.985, Increasing Support for Service in America's Inner Cities Through the National Health Service Corps; H-200.987, Supply and Distribution of Health Professionals; H-230.964, Physician Credentialing and Privileging; H-245.979, Opposition to Proposed Budget Cuts in WIC and Head Start; H-245.986, Infant Mortality in the United States; H-245.989, Adequate Funding of the WIC Program; H-245.993, Encouragement of Breast-Feeding by WIC Participants; H-245.994, Inclusion of Overseas Beneficiaries in WIC; H-250.993, Overseas Medical Education Developed by U.S. Medical Associations; H-255.987, Foreign Medical Graduates; H-255.988, Report of the Ad Hoc Committee on Foreign Medical Graduates; H-255.992, Discrimination Against Physicians; H-275.944, Board Certification and Discrimination; H-275.955, Physician Licensure Legislation; H-285.985, Discrimination Against Physicians by Health Care Plans; H-295.930, Council on Graduate Medical Education; H-295.955, Teacher-Learner Relationship in Medical Education; H-295.969, Nondiscrimination Toward Medical School and Residency Applicants on the Basis of Sexual Orientation; H-305.968, Medicare Direct and Indirect Medical Education Costs; H-305.973, Financing Undergraduate

Education; H-310.962, Residency Programs Prejudiced Against Applicants with Ethnic Names; H-310.976, Gender-Based Questioning in Residency Interviews; H-315.996, Scientific Accuracy in Racial, Ethnic and Religious Designations in Medical Records; H-370.974, Working Toward an Increased Number of Minorities Registered as Potential Bone Marrow Donors; H-410.995, Participation in the Development of Practice Guidelines by Individuals Experienced in the Care of Minority and Indigent Patients; H-440.938, Multiple-Drug Resistant Tuberculosis - A Multifaceted Problem; H-440.956, Measles Vaccine; H-460.927, Subject Selection for Clinical Trials; H-460.942, Enrollment in Clinical Trials; H-480.963, Folk Remedies Among Ethnic Subgroups; H-480.992, Moral and Ethical Issues in the Use of Health Care Technologies; H-500.992, Tobacco Advertising Directed to Children, Minorities and Women; H-525.981, Discrimination of Women Physicians in Hospital Locker Facilities; H-525.988, Women in Organized Medicine; H-630.080, Terminology; H-630.130, Discrimination; H-635.021, Outreach Strategy: Minority Physicians; and H-635.090, Role of AMA Councils in Membership Promotion.

H-350.960 Underrepresented Student Access to US Medical Schools

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students. (Res. 908, I-08)

H-350.961 Improving the Health of Minority Populations

Our AMA urges Congress to re-evaluate and expand the federal race and ethnicity categories to include additional ethnic subgroups in order to analyze and uncover racial and ethnic health and healthcare disparities. (Res. 906, I-08)

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-350.963 Minority Physician Recruitment

Our AMA (1) supports national efforts to improve the health services to underserved minority communities; and (2) encourages recruitment of qualified underrepresented minorities to the profession of medicine. (Res. 320, A-05)

H-350.964 Racial Ethnic Disparities in Health Care

Our AMA opposes the elimination of programs or mechanisms designed to increase the number of minority physicians. (BOT Rep. 4, A-03)

H-350.965 Culturally Effective Health Care

Our AMA renews its commitment to supporting the importance of culturally effective health care in eliminating disparities and to exploring ways to provide physicians with tools for improving the cultural effectiveness of their practices. (Res. 718, I-02)

H-350.966 Health Initiatives on Asian-Americans and Pacific Islanders

Our AMA urges existing federal agencies, commissions and Asian American and Pacific Islander health organizations to study how to improve the collection, analysis and dissemination of public health data on Asian Americans and Pacific Islanders. (Res. 404, A-00)

H-350.967 Eliminating Health Disparities

Our AMA will engage in activities, including but not limited to: educating members on Healthy People 2010 through sponsored Continuing Medical Education events and publications; encouraging state medical societies to engage in promoting activities that address the elimination of health disparities; and investigating the development of a partnership with the Department of Health and Human Services to work to accomplish the goal of eliminating disparities on the basis of race and ethnicity. (Res. 414, A-00)

H-350.968 Progress in Medical Education: the Medical School Admission Process

Our AMA encourages increased recruitment and retention of faculty members from underrepresented minority groups as part of efforts to increase the number of individuals from underrepresented minority groups entering and graduating from US medical schools. (CME Rep. 8, I-99)

H-350.969 Medical Education for Members in Underserved Minority Populations

Our AMA: (1) actively opposes the reduction of resources and opportunities used to increase the number of minority medical and premedical students in training; (2) uses its influence in states and local communities to increase the representation of minority group members in medical education, as long as domestic health care disparities exist between minority populations and the greater population at-large; and (3) supports the need for an increase in the participation of under-represented minorities as investigators, trainees, reviewers, and subjects in peer review biomedical research at all levels. (Sub. Res. 316, A-99; Reaffirmed CME Rep. 8, I-99)

H-350.970 Diversity in Medical Education

Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion. (BOT Rep. 15, A-99)

H-350.971 AMA Initiatives Regarding Minorities

The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components: (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine;
(2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities;
(3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;
(4) Response to inquiries and concerns of minority physicians and medical students; and
(5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine. (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-350.972 Improving the Health of Black and Minority Populations

Our AMA supports: (1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
(2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
(3) Continuing efforts for improving the health status of minority Americans through the Pepper Commission.
(4) Continued encouragement at the federal and state levels to expand Medicaid coverage to include all those below the federal poverty level.
(5) The speedy implementation of the JCAHO's policy that hospitals provide for effective communication with predominant population groups served by each hospital.
(6) Encouraging employers to offer health insurance for employees working in companies of 25 persons or more.
(7) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
(8) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis. (CLRPD Rep. 3, I-98; Reaffirmation A-01)

H-350.973 Sickle Cell Anemia

Our AMA supports: (1) Research and educational efforts directed to the profession and the public for the prevention of sickle cell anemia and the development of treatment forms. (2) Efforts to evaluate the effectiveness of screening and counseling programs and involvement with issues in genetic counseling. (3) Ongoing research programs.The AMA recommends that all sickle cell programs have input in the planning stage from the local African American community and all other sectors that would be involved and affected by sickle cell disease. (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-350.974 Racial and Ethnic Disparities in Health Care

Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

The AMA emphasizes three approaches that it believes should be given high priority:

(1) Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

(2) Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

(3) Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decisionmaking process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. (CLRPD Rep. 3, I-98; Appended and Reaffirmed:: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03)

H-350.975 Improving Healthcare of Hispanic Populations in the United States

It is the policy of our AMA to: (1) Encourage health promotion and disease prevention through educational efforts and health publications specifically tailored to the Hispanic community.
(2) Promote the development of substance abuse treatment centers and HIV/AIDS education and prevention programs that reach out to the Hispanic community.
(3) Encourage the standardized collection of consistent vital statistics on Hispanics by appropriate state and federal agencies.
(4) Urge federal and local governments, as well as private institutions, to consider including Hispanic representation on their health policy development organization.
(5) Support organizations concerned with Hispanic health through research and public acknowledgment of the importance of national efforts to decrease the disproportionately high rates of mortality and morbidity among Hispanics.
(6) Promote research into effectiveness of Hispanic health education methods.
(7) Continue to study the health issues unique to Hispanics, including the health problems associated with the United States/Mexican border. (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-350.976 Improving Health Care of American Indians

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians

reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07)

H-350.977 Indian Health Service

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.
(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population. (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-350.978 Minorities in the Health Professions

The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.
(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.
(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.
(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.
(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.
(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.
(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.
(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program. (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-350.979 Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
(4) Increasing the supply of minority health professionals.
(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school. (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-350.981 AMA Support of American Indian Health Career Opportunities

AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals.
(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population.
(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07)

H-350.983 Federal Guidelines for Standardization of Race/Ethnicity Codings

The 1997 revised office of Management and Budget guidelines should be used for the collection of data on race and ethnicity until more scientifically rigorous standards are available. Common Data Elements, as specified by the Standards and Liaison Committee of the Health Information and Surveillance Systems Board, should be used if greater specificity in coding is required. (BOT Rep. 23, A-98; Reaffirmed: CLRPD Rep. 3, I-98; Modified: CSA Rep. 5. I-00; Reaffirmed: Res. 509, A-01)

H-355.000 National Practitioner Data Bank
(See also: Licensure and Discipline; Quality of Care)

H-355.978 National Data Bank for Adverse Information on Physicians and other Health Care Practitioners

Our AMA through the most effective means possible requests the Secretary of Health and Human Services to contract with appropriate state agencies, state medical societies, specialty societies and or the Federation of State Medical Boards, which have data that is not flawed, which is accurate and not misleading to be the sources of adverse information on physicians and other healthcare practitioners. (Sub. Res. 223, A-01)

H-355.979 National Practitioner Data Bank

It is policy of the AMA to improve patient access to reliable information and as an alternative to a federally operated national data repository, our AMA strongly supports and actively encourages the provision of accurate and relevant physician-specific information through a system developed and operated by state licensing boards or other appropriate state agencies

Our AMA: (1) supports requiring felony convictions of physicians to be reported to state licensing boards; (2) supports federal block grants that provide states with sufficient financial resources to develop and implement officially recognized, Internet accessible,

physician-specific information systems that will assist patients in choosing physicians; and (3) believes that serious problems exist in correlating lawsuits with physician competence or negligence and some studies indicate lawsuits seldom correlate with findings of incompetence. Only a state licensing board should determine when lawsuit settlements and judgments should result in a disciplinary action, and public disclosure of lawsuit settlements and judgments should only occur in connection with a negative state medical board licensing action. (BOT Rep. 31, I-00; Reaffirmation & Reaffirmed: Res. 216, A-01)

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)

H-355.981 Guidelines for a Reporting Registry For Medical Incidents

Our AMA: (1) assures our patients and the American public that the physicians of America will not rest and the AMA will not cease its efforts to work to eliminate health care errors resulting in injury or adverse outcome; (2) continues to encourage the development of guidelines for a national reporting system for health care incidents or events which, at a minimum, should include: (a) There shall be a non-punitive mechanism for reporting incidents; (b) There shall be post-incident evaluation for prevention of subsequent occurrences; and (c) Federally guaranteed legislative protection from discovery for all aspects of this information; and (3) recognizes its leading role as an advocate for patient care through its proactive support of the National Patient Safety Foundation, whose efforts were recognized by the Institute of Medicine. (Sub. Res. 225, I-99; Reaffirmed: BOT Rep. 13, I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-05)

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)

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-355.985 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)

H-355.986 Peer Review Implications of Adding Allied Health Practitioners to National Practitioner Data Bank

The AMA will continue to pursue vigorously remedial action to correct all operational problems with the National Practitioner Data Bank. (Res. 817, A-93; Reaffirmed: BOT Rep. 28, A-03)

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)

H-355.988 Access to National Practitioner Data Bank

The AMA will inform its members that entities who are authorized to query the National Practitioner Data Bank should not request physicians to self-query on the entities' behalf. (Res. 804, A-93; Reaffirmed: BOT Rep. 28, A-03)

H-355.989 Access to National Practitioner Data Bank "Self-Query" Reports

(1) The AMA again requests a written opinion from the Health Resources and Services Administration's Bureau of Health Professions and/or the HHS Office of the Inspector General, as to the confidentiality of National Practitioner Data Bank (NPDB) information that is received directly or indirectly from the NPDB. (2) The AMA recommends that physicians who are compelled to release information received from the NPDB to entities not authorized to access the NPDB require that such entity provide them with written documentation that: information disclosed to the entity will be protected from further disclosure under the relevant state peer review immunity statute(s); that the requirements that the physician self-query the NPDB and disclose the information to the entity is in compliance with the intent and protections of the Health Care Quality Improvement Act of 1986; that the information will be used only for and maintained only for those purposes, such as quality assurance activities, that are protected under the relevant state peer review immunity statute(s); and that the entity will protect the confidentiality of the information to the fullest extent permitted by both state law and the Health Care Quality Improvement Act of 1986. (3) The AMA will provide model language until such legislation is enacted that physicians can use to protect confidentiality when they release information received from the NPDB to entities not authorized to access the NPDB. The AMA urges state and county medical societies to develop a mechanism physicians can use to report problems they encounter with these entities. (BOT Rep. L, I-92; Reaffirmed: BOT Rep. 28, A-03)

H-355.990 National Practitioner Data Bank

(1) The AMA shall continue to pursue vigorously remedial action to correct all operational problems with the National Practitioner Data Bank (NPDB). (2) The AMA requests that the Health Resources and Services Administration (a) prepare and disseminate to physician and hospital organizations a white paper addressing its plans to enhance the confidentiality/security provisions of the reporting and querying process no later than December 1992; (b) conduct a statistically valid sample of health care entities, other than hospitals, on the entity file to determine if entities that are not eligible to query under the statute and regulation have gained access to the NPDB information, and disseminate the results to the NPDB Executive Committee no later than December 1992; (c) implement appropriate steps to ensure and maintain the confidentiality of the practitioner's self-query reports no later than December 1992; (d) recommend to the Congress that small claims payments, less than $30,000, no longer be reported to the NPDB and provide the Executive Committee members the opportunity to attach their comments on the report that goes to the Congress; (e) allow by January 1, 1993, the practitioner to append an explanatory statement to the disputed report; and (f) release the evaluation report, prepared by Dr. Mohammad Akhter, on the NPDB's first year of operation to the AMA by July 1992. (3) The AMA will reevaluate at the 1992 Interim Meeting the progress on these issues. If the preceding requests are not met by the established due date and the House of Delegates is not satisfied with the progress on these issues, the AMA will again reevaluate the implementation of Policy H-355.991. (BOT Rep. QQ, A-92; Reaffirmed: BOT Rep. 28, A-03)

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)

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)

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)

H-355.994 Restriction of Use of National Practitioner Data Bank Information

The AMA seeks legislation making it illegal for any practitioner to be required to submit a copy of his file report from the National Practitioner Data Bank to any agency. (Res. 244, A-91; Amended: BOT Rep. L, I-92; Reaffirmed: Sub. Res. 820, I-99)

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)

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)

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)

H-360.000 Nurses and Nursing
(See also: Allied Health Professions; Health Manpower)

H-360.981 State Legislative Response to NBME Practice of Using USMLE Step 3 Physician Licensing Exam Questions for Doctors of Nursing Practice Certification

AMA policy is that the integrity of the physician (MD/DO) licensure process, through appropriate examination, be maintained so that no person is misled that the training of allied health professionals through their programs or certification is equivalent to the education, skills and training of physicians (MDs/DOs). (Res. 212, I-08)

H-360.982 Leadership for Patient Safety: Reducing the Hospital Registered Nurse Shortage at the Bedside

Our AMA supports:
1. increased physician awareness of their role in solving the RN shortage at the bedside and the importance of physicians' participation in efforts to relieve the shortage;
2. increased awareness of opportunities for physician leadership and participation in efforts to solve the RN shortage at the bedside;
3. physician efforts to identify those models and strategies that are most applicable to their communities and hospitals and, additionally, will produce the best results; and
4. national efforts to increase funding for bedside nursing education. (BOT Rep. 27, A-08)

H-360.983 Registered Nurse Participation in Epidural Analgesia

Our AMA, consistent with the American Society of Anesthesiologists position statement adopts the following statement on the administration of epidural analgesia: In order to provide optimum patient care, it is essential that registered nurses participate in the management of analgesic modalities. A registered nurse--qualified by education, experience and credentials--who follows a patient-specific protocol written by a qualified physician should be allowed to adjust and discontinue catheter infusions. (Res. 530, A-03)

H-360.984 Nursing Shortage

Our AMA supports proposals to increase basic nursing education opportunities, workforce incentives and similar efforts to increase the supply of registered nurses. (Res. 313, A-02)

H-360.985 Performance of Diagnostic X-Rays by Nurses Without Physician Supervision

Our AMA continues to vigorously oppose rules by CMS which lower the standard of training required for performance of diagnostic x-ray or other complex and potentially hazardous tests. (Res. 201, I-99)

H-360.986 Professional Nurse Staffing in Hospitals

The AMA: (1) encourages medical and nursing staffs in each facility to closely monitor the quality of medical care to help guide hospital administrations toward the best use of resources for patients;
(2) encourages medical and nursing staffs to work together to develop and implement in-service education programs and promote compliance with established or pending guidelines for unlicensed assistive personnel and technicians that will help assure the highest and safest standards of patient care;
(3) encourages medical and nursing staffs to use identification mechanisms, e.g. badges, that provide the name, credentials, and/or title of the physicians, nurses, allied health personnel, and unlicensed assistive personnel in facilities to enable patients to easily note the level of personnel providing their care;
(4) encourages medical and nursing staffs to develop, promote, and implement educational guidelines for the training of all unlicensed personnel working in critical care units, according to the needs at each facility; and
(5) encourages medical and nursing staffs to work with hospital administrations to assure that patient care and safety are not compromised when a hospital's environment and staffing are restructured. (BOT Rep. 11, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-360.987 Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice

Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care.

(2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team.

(3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians.

(4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team.

(5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities.

(6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices. (BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00)

H-360.988 Nurse Practitioner Reimbursement Under Medicare

Our AMA supports provision of payment to the employing physician for all services provided by physician assistants and nurse practitioners under the physician's supervision and direction regardless of whether such services are performed where the physician is physically present, so long as the ultimate responsibility for these services rests with the physician and so long as the services are provided in conformance with applicable state laws. With regard to physician assistants, such supervision in most settings includes the personal presence or participation of the physician. In certain practice settings where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, appropriate site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. (BOT Rep. UU, A-90; Reaffirmed: CMS Rep. 1, I-934; Reaffirmed: Res. 240 and Reaffirmation A-00; Reaffirmation A-02)

H-360.989 Independent Nursing Practice Models

It is the policy of the AMA to: (1) continue to monitor federal and state legislation for direct reimbursement of nonphysicians, so that statutory guidelines for physician supervision as a qualification for reimbursement may be maintained;

(2) continue to monitor federal and state legislation for independent nursing practice models and encourage statutory changes so that physicians may retain their intermediary responsibilities and advocacy for direct, quality patient care;

(3) work with medical educators to include as a part of the educational process physician education programs emphasizing collaborative case management with nurses, especially for chronically ill patients in the home, in acute and long-term care facilities, and in academic settings;

(4) confer with the hospital associations, CMS, and the Congress regarding further development of Medical Access Facilities, Essential Access Community Hospitals, and Rural Primary Care Hospitals and oppose any attempt at empowering nonphysicians to become unsupervised primary medical care providers and be directly reimbursed for case management activities;

(5) work with CMS and any other relevant government agencies to require the physician supervision of nurses who perform diagnostic imaging tests; and.

(6) take all appropriate action to achieve a reversal of CMS policy which allows payment for physician services rendered by nurse practitioners and certified nurse specialists that are performed without physician supervision. (BOT Rep. LL, A-90; Appended: Res. 240, A-00)

H-360.990 Shortage of Caregivers

If the shortage persists or worsens, the Association will review its potential to impact on the problem. (BOT Rep. LLL, A-90; Modified: Sunset Report, I-00)

H-360.991 Alleviating the Nursing Crisis by Restructuring Nursing Education

Our AMA (1) suggests that the nursing crisis could be alleviated, in part, if nursing education programs were structured to allow the entry-level individual an opportunity for work-study advancement from the level of the nursing aide to the level of the doctorally prepared nurse, and that occupational opportunities could best be achieved by easier transfer of educational credits from one school to another and from one level of nursing to another; and (2) supports asking the American Nurses' Association and other national group to consider supporting this policy. (Res. 65, I-89; Reaffirmed: Sunset Report, A-00)

H-360.992 Television Portrayal of the Nursing Profession

Our AMA objects to the portrayal of the nursing profession in the television program "Nightingales" and opposes re-runs of this program. (Sub. Res. 50, A-89; Reaffirmed: Sunset Report, A-00)

H-360.993 Local Physician-Nurse Committee to Find Solution for Bedside Nursing Shortage

The AMA encourages each hospital medical staff and local medical society to develop committees and local programs, in cooperation with local nursing organizations and hospital nursing staffs, to ensure an adequate supply of well-trained nurse professionals interacting with organized medical staffs so as to ensure optimal patient treatment for the future. (Res. 99, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 7, A-01)

H-360.995 Nursing Education and the Supply of Nursing Personnel in the United States

The AMA supports: (1) all levels of nursing education, at least until the crisis in the supply of bedside care personnel is resolved; (2) government and private initiatives that would facilitate the recruitment and education of nurses to provide care at the bedside; (3) economic and professional incentives to attract and retain high quality individuals to provide bedside nursing care; (4) hospital-based continuing education programs to promote the education of caregivers who assist in the implementation of medical procedures in critical care units, operating and emergency rooms, and medical-surgical care; and (5) cooperation with other organizations concerned with acute and chronic hospital care to develop quality educational programs and methods of accreditation of programs to increase the availability of caregivers at the bedside and to meet the medical needs of the public. (BOT Rep. CC, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CLRPD Rep. 2, A-07)

H-360.997 Nursing Education

The AMA (1) supports all levels of nursing education, including baccalaureate, diploma, associate degree and practical nursing in order that individuals may be able to choose from a number of alternatives, each of which legitimately fulfills the purpose of meeting the health care needs of the nation; (2) affirms that there is no substitute for bedside teaching and practical learning in any education program for nurses; and (3) recommends strong support of multiple levels of nursing education in order to make available career ladders in the various levels of nursing education without dead-ends or repetitions of education. (Res. 4, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

H-360.998 Cardiac Resuscitation by Nurses

With the intent of promoting good patient care, the AMA recognizes the propriety of registered nurses using monitoring, defibrillation, and resuscitative equipment, and instituting immediate life-saving corrective measures, if a licensed physician is not immediately available to do so, providing that: (1) The techniques to be used by a registered nurse in a hospital setting shall have been specified for the hospital by the medical staff on the basis of counsel by a committee representing authoritative medical and nursing opinion; (2) The registered nurse has been competently instructed in the techniques to be used; and (3) The registered nurse performs the authorized procedures: (a) upon the direct order of a doctor of medicine, or (b) pursuant to standing procedures established by the medical staff, these procedures to include provision for immediate summoning of a physician and such other personnel as may be needed. (Res. 42, I-67; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-360.999 Nursing Education

The AMA urges that a constructive attitude be assumed by the medical profession at all levels in an attempt to aid those closely concerned with nursing education, to increase the facilities for those training programs, and to aid in recruiting personnel into the training programs. (BOT Rep. D, A-59; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: CLRPD Rep. 1, I-98; Reaffirmed: CME Rep. 2, A-08)

H-365.000 Occupational Health
(See also: Preventive Medicine; Public Health)

H-365.980 OSHA Regulations Pertaining to Physicians' Offices and Hospitals

The AMA continues to review the data and rationale used to substantiate OSHA regulations pertaining to medical practice in physician offices and health care facilities. Where OSHA rules and regulations are found to be unnecessary or inappropriate, the AMA will work for their modification or repeal. (Sub. Res. 218, A-94; Reaffirmed: BOT Rep. 29, A-04)

H-365.981 Workers' Compensation

The AMA: (1) will promote the development of practice parameters, when appropriate, for use in the treatment of injured workers and encourages those experienced in the care of injured workers to participate in such development.
(2) will investigate support for appropriate utilization review guidelines for referrals, appropriate procedures and tests, and ancillary services as a method of containing costs and curbing overutilization and fraud in the workers' compensation system. Any such utilization review should be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession. Physicians with background appropriate to the care under review should have the ultimate responsibility for determining quality and necessity of care.
(3) will develop model state legislation mandating the appropriate use of the Guides to the Evaluation of Permanent Impairment. The correct use of the Guides can facilitate prompt dispute resolution by providing a single, scientifically developed, uniform, and objective means of evaluating medical impairment.
(4) encourages physicians to participate in the development of workplace health and safety programs. Physician input into healthy lifestyle programs (the risks associated with alcohol and drug use, nutrition information, the benefits of exercise, for example) could be particularly helpful and appropriate.

(5) will work with state medical societies to educate physicians about workers' compensation and state workers' compensation laws. Physicians treating injured workers should be aware of the state workers' compensation act in order to understand the patient's rights and the physician's responsibilities. Knowledge of the law and an increased understanding of the system may also result in an increased willingness, on the part of physicians, to participate in the workers' compensation system. One means of educating physicians which is being investigated is the development of an AMA publication which would provide an overview of workers' compensation in general (background on the system's history, the physician's role, problems with the system, and potential solutions). State medical societies could then be encouraged to develop more specific workers' compensation publications detailing individual state law.
(6) will work with state medical societies and other responsible entities to develop workers' compensation medical care data collection systems to improve the quality and efficiency of state workers' compensation systems.
(7) encourages the use of uniform claim forms (CMS 1500, UB82), electronic billing (with appropriate mechanisms to protect the confidentiality of patient information), and familiar diagnostic coding guidelines (ICD-9-CM, CPT), when appropriate, to facilitate prompt reporting and payment of workers' compensation claims.
(8) will evaluate the concept of Independent Medical Examinations (IME) and make recommendations concerning IME's (i) effectiveness; (ii) process for identifying and credentialing independent medical examiners; and (iii) requirements for continuing medical education for examiners.
(9) encourages state medical societies to support strong legislative efforts to prevent fraud in workers' compensation.
(10) will continue to monitor and evaluate state and federal health system reform proposals which propose some form of 24-hour coverage.
(11) will continue to evaluate these and other medical care aspects of workers' compensation and make timely recommendations as appropriate.
(12) will continue activities to develop a unified body of policy addressing the medical care issues associated with workers' compensation, disseminate information developed to date to the Federation and provide updates to the Federation as additional relevant information on workers' compensation becomes available. (BOT Rep. X, A-93; Reaffirmed CMS Rep. 10, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-365.983 Occupational Safety and Health Administration Regulations

The AMA (1) will work to modify the Occupational Safety and Health Administration regulations on Occupational Exposure to Bloodborne Pathogens to address its practicality and to make physician compliance possible; and (2) in conjunction with other national health provider groups, will work with Congress and other government regulatory agencies to ensure that all decisions regarding the regulation of medical practices be based upon scientific principles and/or fact. (Res. 242, I-92; Reaffirmed: BOT Rep. 28, A-03)

H-365.986 US Efforts to Address Health Problems Related to Agricultural Activities

Our AMA supports the endeavors of the U.S. Surgeon General and the National Institute of Occupational Safety and Health of CDC to address health problems related to agricultural activities. (Res. 212, A-91; Reaffirmed: Sunset Report, I-01)

H-365.987 Revising "Guides to the Evaluation of Permanent Impairment"

It is the policy of the AMA: (1) to speedily pursue the revision and updating of the Guides to the Evaluation of Permanent Impairment with input from physicians in all appropriate specialty groups; and (2) to consider developing appropriate methods to facilitate the use of the Guides, including expansion of introductory instructions. (Sub. Res. 133, A-90; Reaffirmed: Sunset Report, I-00)

H-365.988 Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies

Our AMA supports: (1) the development of model state legislation which would encourage the integration of occupational health and environmental health and injury prevention programs within existing health departments at the state and local level; (2) taking a leadership role in assisting state medical societies in implementation of such model legislation in each state; and (3) working with federal agencies to ensure that "health" is the primary determinant in establishing environmental and occupational health policy. (Res. 1, A-89; Reaffirmed: Sunset Report, A-00)

H-365.990 Adverse Health Effects of Video Display Terminals

Although no association has been found between radiation emissions from video display terminals and reported illnesses or injuries, the AMA: (1) encourages the National Institute on Occupational Safety and Health and others to continue to investigate the nature of VDT-worker complaints, with emphasis on ergonomics and stress-reduction measures, in order to reduce worker discomfort and to improve the job environment; and (2) encourages corporate management to be more cognizant of the importance of the man-machine interface, to provide a work environment that reflects this cognizance, and to encourage effective communication between system planners and users. (CSA Rep. F, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-365.991 NIOSH Cohort Mortality Studies

The AMA believes that physicians should (1) strive conscientiously to become familiar with the medical fitness requirements, the environment and the hazards of the work done by those they serve, and with the health and safety aspects of the products and operations involved; (2) communicate information about health hazards in a timely and effective fashion to individuals or groups potentially affected, and make appropriate reports to the scientific community; and (3) communicate understandably to those they serve any significant observations about their health, recommending further study, counsel, or treatment when indicated. (CEJA Rep. A, I-85; Reaffirmed: CLRPD Rep. 2, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-365.994 Funding of Educational Resource Centers Program

The AMA supports adequate federal funding for the NIOSH's Education and Research Centers program, as an appropriate means to help ensure that a sufficient number of physicians trained in occupational medicine will be available to meet future needs. (BOT Rep. O, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

H-365.995 Competence in Occupational Medicine of Hospital-Based Physicians Assigned to Occupational Medicine Practice

The AMA recognizes the broad fields encompassed in the practice of occupational medicine and commends those who seek formal training in this specialized field. (Sub. Res. 106, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-365.996 Regulation of Occupational Carcinogens

The AMA endorses the principle of using the best available scientific data, including data derived from animal models, as a basis for regulation of occupational carcinogens. (Sub. Res. 81, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-365.997 Corporation or Employer-Sponsored Examinations

The AMA encourages employers who provide or arrange for special or comprehensive medical examinations of employees to be responsible for assuring that these examinations are done by physicians competent to perform the type of examination required. Whenever practical, the employee should be referred to his or her personal physician for such professional services. In the many instances in which an employee does not have a personal physician, efforts should be made to assist him or her in obtaining one, with emphasis on continuity of care. This effort should be aided by the local medical society wherever possible. (CMS Rep. I, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CMS Rep. 10, A-03)

H-365.998 Confidentiality of Occupational Medical Records

Our AMA opposes the Department of Labor's rule requiring that, without the informed written consent of the patient-employee, his entire medical record shall be accessible to OSHA. (Res. 95, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-365.999 Physician's Role in Returning Patients to Their Jobs

Our AMA encourages physicians everywhere to advise their patients to return to work at the earliest date compatible with health and safety and recognizes that physicians can, through their care, facilitate patients' return to work. (Res. 149, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: CSA Rep. 12, A-04)

H-370.000 Organ Donation and Transplantation
(See also: Ethics)

H-370.967 Ethical Procurement of Organs for Transplantation

Our AMA will continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary. (BOT Rep. 13, A-08)

H-370.968 Endorsement of the Uniform Anatomical Gift Act (2006)

Our AMA endorses the Uniform Anatomical Gift Act of 2006, and urges all constituent state medical societies to work with donation stakeholders, including organ procurement organizations, eye banks, tissue banks, and other donation-related organizations, toward persuading their state legislatures to adopt UAGA (2006) in place of earlier versions of the UAGA. (BOT Action in response to referred for decision Res. 901, I-06)

H-370.970 Umbilical Cord Blood Transplantation: The Current Scientific Understanding

Our AMA: (1) urges physicians to recognize that umbilical cord blood transplantation is a viable alternative to bone marrow transplantation in appropriately selected patients;
(2) encourages the development of national standardized guidance to address the ethical, economic, and social issues surrounding umbilical cord blood transplantation; and
(3) will continue to study cord blood banking in this country, and work with appropriate specialty societies and organizations, such as the National Marrow Donor Program, to develop and disseminate materials to educate physicians and the public about the issues of marketing cord blood banking services directly to patients, the informed consent process, and the existence of federally mandated regulatory oversight of these processes to ensure safety and compliance with specific uniform standards. (CSA Rep. 2, A-03; Appended: Res. 503, A-06)

H-370.971 Increasing Organ Donation

Our AMA recognizes the importance of physician participation in the organ donation process and acknowledges organ donation as a specialized form of end-of-life care. (CSA Rep. 4, I-02)

H-370.972 Xenotransplantation: Scientific Implications

Our AMA: (1) supports the general xenotransplantation guideline documents produced in 2000 by the Public Health Service, the 1999 Food and Drug Administration (FDA) guidelines relating to nonhuman primates and xenotransplantation, the 1999 FDA guidelines on measures to reduce the possible risk of transmission of zoonoses from xenotransplantation, and the Institute of Medicine xenotransplantation guideline document; and (2) encourages continuation of research on xenotransplantation to gather data to determine more accurate risk analysis. (CSA Rep. 8, I-00)

H-370.973 Methadone Maintenance and Transplantation

Our AMA: (1) urges transplant centers across the nation to abrogate any policies that automatically exclude patients maintained on methadone from liver transplant recipient waiting lists; and (2) encourages transplant centers to assess patients maintained on methadone on a case-by-case basis using medically appropriate criteria supportable by peer-reviewed and published research. (Res. 405, I-00)

H-370.974 Working Toward an Increased Number of Minorities Registered as Potential Bone Marrow Donors

The AMA supports efforts to increase the number of all potential bone marrow donors registered in national bone marrow registries, especially minority donors, to improve the odds of successful HLA matching and bone marrow transplantation. (Res. 501, I-94; Reaffirmed: CSA Rep. 6, A-04)

H-370.975 Ethical Issues in the Procurement of Organs Following Cardiac Death

The Pittsburgh Protocol: The following guidelines have been adopted:
The Pittsburgh protocol, in which organs are removed for transplantation from patients who have had life-sustaining treatment withdrawn, may be ethically acceptable and should be pursued as a pilot project. The pilot project should (1) determine the protocol's acceptability to the public, and (2) identify the number and usability of organs that may be procured through this approach. The protocol currently has provisions for limiting conflicts of interest and ensuring voluntary consent. It is critical that the health care team's conflict of interest in caring for potential donors at the end of life be minimized, as the protocol currently provides, through maintaining the separation of providers caring for the patient at the end of life and providers responsible for organ transplantation. In addition to the provisions currently contained in the protocol, the following additional safeguards are recommended:
(a) To protect against undue conflicts of interest, the protocol should explicitly warn members of the health care team to be sensitive to the possibility that organ donation decisions may influence life-sustaining treatment decisions when the decisions are made by surrogates. Further, if there is some reason to suspect undue influence, then the health care team members should be required, not merely encouraged, to obtain a full ethics consultation.
(b) The recipients of organs procured under the Pittsburgh protocol should be informed of the source of the organs as well as any potential defects in the quality of the organs, so that they may decide with their physicians whether to accept the organs or wait for more suitable ones.
(c) Clear clinical criteria should be developed to ensure that only appropriate candidates, whose organs are reasonably likely to be suitable for transplantation, are considered eligible to donate organs under the Pittsburgh protocol. (CEJA Rep. 4 - I-94; Reaffirmed: CSA Rep. 4, I-02)

H-370.976 Regulating Human Tissue Industry

The AMA will: (1) monitor expanded federal authority to regulate bone, skin, cornea and other human tissues; and (2) reaffirm the

critical importance of basing medical policy decisions on scientific evidence. (Res. 513, I-93; Reaffirmed: BOT Rep. 28, A-03)

H-370.977 The Inclusion of Advance Directives Concerning Organ Donation in Living Wills

Our AMA will develop model legislation which would create provisions for organ donation within living will forms and other health care advance directives, including but not limited to durable power of attorney forms; and encourages physicians to discuss advance directives and organ donation as a part of the ongoing doctor-patient relationship. (Res. 218, I-93; Reaffirmed: Res. 3, A-99; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02)

H-370.981 Organ Procurement Legislation

Our AMA will develop model legislation requiring persons when issued a driver's license or state identification to declare their organ donor status (either wish to be considered, do not wish to be considered or do not wish to respond) and that this information be printed on the driver's license. (Res. 210, A-93; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02)

H-370.982 Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients

Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.

(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.

(3) Decisionmaking mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.

(4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.

(5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.

(6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them.

(7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means. (CEJA Rep. K, A-93; Reaffirmed: CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 6, A-00; Appended: Res. 512, A-02)

H-370.983 Tissue and Organ Donation

Our AMA will assist the United Network for Organ Sharing in the implementation of their recommendations through broad-based physician and patient education. (Res. 533, A-92; Reaffirmed: CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02)

H-370.984 Organ Donation Education

Our AMA encourages local organ procurement organizations to provide educational materials to driver education and safety classes. (Res. 504, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSA Rep. 4, I-02)

H-370.985 Insurance Coverage for Immunosuppression in Transplant Patients

Our AMA (1) affirms that immunosuppressive therapy is an effective, essential component of the therapeutic interventions of organ transplantation; (2) supports seeking federal legislation mandating the HFCA to cover under Medicare drugs used in the maintenance of organ transplants for the life of the transplanted organ; and (3) supports communicating these recommendations directly to the 1,000 subscribers to the DATTA Information Service that make appropriateness, coverage and benefits determinations in order that such a policy be implemented fully in the private sector. (BOT Rep. X, A-91; Modified: Sub. Res. 120, A-00)

H-370.986 Donor Tissues and Organs for Transplantation

The AMA strongly urges physicians or their designees to routinely contact their hospital's designated tissue or organ procurement agency (as appropriate), at or near the time of each patient's death, to determine the feasibility of tissue and/or organ donation. (Res. 103, I-90; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02)

H-370.987 Transplant Centers

It is the policy of the AMA to continue to work with the United Network for Organ Sharing, the national organ procurement and transplantation network, to evaluate the correlation of delivery system factors which impact graft survival and patient survival in transplantation. (Sub. Res. 69, I-90; Reaffirmed: Sunset Report, I-00)

H-370.988 Regulation of Tissue Banking

Our AMA: (1) supports the Food and Drug Administration's (FDA) proposed regulatory agenda for tissue banking organizations, and urges the FDA to continue working with nationally-recognized tissue banking organizations and other appropriate groups to implement the proposed oversight system; (2) promotes the adoption of the standards for tissue retrieval and processing established by nationally recognized tissue banking organizations that would mandate adherence to specific standards as a condition of licensure and certification for tissues banks; (3) supports FDA registration of all tissue banks; and (4) supports the continued involvement of the medical community in the further effort to ensure the safety and efficacy of the nation's supply of tissues. (BOT Rep. E, I-89; Reaffirmed: Sunset Report, A-00; Modified and Appended, CSA Rep. 5, I-01; Reaffirmation I-07)

H-370.989 State Regulation and Licensing of Human Tissue Banks

Our AMA encourages states to require licensing of human tissue banks in a manner consistent with the Food and Drug Administration's federal regulatory requirements. (Res. 68, I-87; Reaffirmed: Sunset Report, I-97; Modified: CSA Rep. 5, I-01)

H-370.990 Transplantable Organs as a National Resource

Our AMA: (1) supports the United Network of Organ Sharing (UNOS) policy calling for regional allocation of livers to status 1 (most urgent medical need) patients as an effort to more equitably distribute a scarce resource; (2) opposes any legislation, regulations, protocols, or policies directing or allowing governmental agencies to favor residents of a particular geo-political jurisdiction as recipients of transplantable organs or tissues; (3) reaffirms its position that organs and tissues retrieved for transplantation should be treated as a national, rather than a regional, resource; and (4) supports the findings and recommendations of the Institute of Medicine Committee on Organ Procurement and Transplantation Policy. (Res. 94, I-87; Reaffirmed: Sunset Report, I-97; Appended and Reaffirmed CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 4, I-02)

H-370.995 Organ Donor Recruitment

Our AMA supports development of "state of the art" educational materials for the medical community and the public at large, demonstrating at least the following:

(1) the need for organ donors;
(2) the success rate for organ transplantation;
(3) the medico-legal aspects of organ transplantation;
(4) the integration of organ recruitment, preservation and transplantation;
(5) cost/reimbursement mechanisms for organ transplantation; and
(6) the ethical considerations of organ donor recruitment. (Res. 32, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02)

H-370.996 Organ Donor Recruitment

Our AMA (1) continues to urge Americans to sign donor cards;

(2) supports continued efforts to teach physicians through continuing medical education courses, and the lay public through health education programs, about transplantation issues in general and the importance of organ donation in particular;

(3) encourages state governments to attempt pilot studies on promotional efforts that stimulate each adult to respond "yes" or "no" to the option of signing a donor card.; and

(4) in collaboration with all other interested parties, support the exploration of methods to greatly increase organ donation, such as the "presumed consent" modality of organ donation. (CSA Rep. D, A-81; Reaffirmed: CLRPD Rep. F, I-91; Appended: Res. 509, I-98; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02)

H-370.998 Organ Donation and Honoring Organ Donor Wishes

Our AMA: (1) continues to urge the citizenry to sign donor cards and supports continued efforts to educate the public on the desirability of, and the need for, organ donations, as well as the importance of discussing personal wishes regarding organ donation with appropriate family members; and (2) when a good faith effort has been made to contact the family, actively encourage Organ Procurement Organizations and physicians to adhere to provisions of the Uniform Anatomical Gift Act which allows for the procurement of organs when the family is absent and there is a signed organ donor card or advanced directive stating the decedent’s desire to donate the organs. (CSA Rep. D, I-80; CLRPD Rep. B, I-90; Amended: Res. 504, I-99; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02)

H-370.999 Computerized Donor Registry

Our AMA approves of the concept of computerized donor registration systems to identify available organs for transplantation. (Res. 11, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-373.000 Patients

H-373.998 Patient Information and Choice

Our AMA supports the following principles:

(1) Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system.

(2) Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.

(3) In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit.

(4) Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements, and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs.

(5) Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice.

(6) Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront. (BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: Sub. Res. 701, A-93; Sub. Res. 125, A-93; Reaffirmation A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: Sub. Res. 107, I-93; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94; BOT Rep. 36 - I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed by Sub. Res. 107, I-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmed by

Rules & Credentials Cmt., A-96; Reaffirmation A-96; Reaffirmation I-96; Reaffirmation A-97; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 9, A-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-08)

H-373.999 Patient Advocacy/Protection Activities

The AMA will continue to aggressively pursue legislative, regulatory, communications and advocacy opportunities to identify and correct patient care and access problems created by new health care delivery mechanisms. (BOT Rep. 55, A-96; Reaffirmed: Rules and Cred. Cmt., I-97; Renumbered: CMS Rep. 7, I-05)

H-375.000 Peer Review
(See Also: Managed Care; Medical Records; Medical Review; Medicare: Carrier Review)

H-375.963 Reduced Physician Role in Governance of Federally Contracted Quality Improvement Organizations

Our AMA supports the concept of improving diversity of representation on the governing bodies of Quality Improvement Organizations via the inclusion of non-physician professionals and consumers, but expresses deep concern and will forcefully advocate against any guidelines that would seek to link federal contracting with Quality Improvement Organizations with having the governing bodies of these organizations comprised of a majority of non-physicians, as being antithetical to the fundamental principles of physician peer review and evidence based quality improvement. (Res. 137, A-07)

H-375.964 IOM Report on QIO Program

Our AMA opposes the removal of medical review responsibilities from the QIO scope of work and further opposes conversion of contracts to national or regional contractors. (Res. 726, A-06)

H-375.965 Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations

AMA policy is that:

(1) Summary suspension of clinical privileges is an extraordinary remedy which should be used only when the physician's continued practice presents an "imminent danger to the health of any individual." The decision to summarily suspend a member's medical staff membership or clinical privileges should be made by the chief of staff, chair or vice-chair of the member's clinical department, or medical executive committee. The medical executive committee (MEC) must meet as soon as possible, but in no event more than 14 days after the summary suspension is imposed, or before the time in which a report would be required to the state licensing agency if applicable, whichever is shorter, to review and consider the summary suspension. The MEC shall then promptly modify, continue or terminate the summary suspension. The suspended physician must be invited to attend and make a statement concerning the issues under investigation, but the meeting with the MEC shall not constitute the physician's fair hearing. If the MEC sustains the suspension, said action will trigger the fair hearing procedures contained in these policies.

(2) At the request of a medical staff department or of a member under review, or at its own initiative if needed for adequate and unbiased review, the medical executive committee may arrange, through the state or local medical society, the relevant specialty society or other appropriate source, for an external hearing panel to hear the case in order to assure professional and impartial clinical assessment.

(3) Prior to any disciplinary hearing, the physician should be provided with a clear, and if applicable, clinically supported basis for the proposed professional review action. A hearing panel of a health care organization should be guided by generally accepted clinical guidelines and established standards in its review actions.

(4) Physician health and impairment issues should be identified and managed by a medical staff committee, which should operate separately from the disciplinary process. (BOT Action in response to referred for decision BOT Rep. 23, A-05)

H-375.966 Peer Review Protection Under Federal Law

Our AMA supports: (1) federal legislation that will enhance protection of peer review information even if such information is shared with governmental agencies in an effort to better and more comprehensively analyze the patient safety measures and quality of healthcare measures being utilized in clinical settings; and (2) federal legislation to afford peer-review protection to information sharing and reporting in the context of patient safety and quality improvement. (Res. 239, A-01; Appended: BOT Rep. 14, I-02; Reaffirmation A-05)

H-375.967 Supervision and Proctoring by Facility Medical Staff

Our AMA advocates that the conduct of medical staff supervision be included in medical staff bylaws and be guided by the following principles:
(1) Physicians serving as medical staff supervisors should be indemnified at the facility's expense from malpractice claims and other litigation arising out of the supervision function.
(2) Physicians being supervised should be indemnified at the facility's expense for any damages that might occur as a result of implementing interventions recommended by medical staff supervisors.
(3) AMA principles of peer review as found in Policies H-320.968 [2,d], H-285.998 [5], and H-320.982 [2c,d] should be adhered to in the conduct of medical staff supervision.
(4) The medical staff member serving as supervisor should be determined through a formal process by the department chair or medical staff executive committee.
(5) The scope of the medical staff supervision should be limited to the provision of services that have been restricted, are clearly questionable, or are under question, as determined by the department chair or medical staff executive committee.
(6) The duration of the medical staff supervision should be limited to the amount of time necessary to adequately assess the degree of clinical competence in the area of skill being assessed.
(7) Medical staff supervision should include a sufficient volume of procedures or admissions for meaningful assessment.
(8) Medical staff supervisors should provide periodic performance reports on each patient to the appropriate designated medical staff committee. The reports should be transcribed or transcripted by the medical staff office to assure confidentiality. The confidentiality of medical staff supervision reports must be strictly maintained.
(9) Physicians whose performance is supervised should have access to the performance reports submitted by medical staff supervisors and should be given the opportunity to comment on the contents of the reports. (CMS Rep. 3, A-99)

H-375.968 Supervision and Proctoring by Facility Medical Staff

Our AMA policy states that medical staff supervision refers to the imposition, usually involuntary and usually subsequent to an adverse event, of significant consultation, oversight, or close monitoring of a physician who has privileges and whose clinical competence, cognitive skills, procedural skills, or outcomes have been questioned. Supervision usually is limited to particular competencies under question and may apply to any site of service (CMS Rep. 3, A-99)

H-375.969 Physician Access to Performance Profile Data

AMA policy is that every physician should be given a copy of his/her practice performance profile information at least annually by each organization retaining such physician information. (Res. 827, A-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-375.970 Professional Review Organization Peer Review

The AMA strongly recommends that public and private sector review entities conduct their reviews using evidence-based guidelines or practice parameters developed by national medical specialty societies. (Sub. Res. 719, I-97; Reaffirmation I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-375.971 Peer Review Protection for Physician Organizations and Group Practices

The AMA will develop model state legislation that would give physician organizations that conduct peer review the same protections afforded to hospital medical staffs, as well as state and county medical societies. (Sub. Res. 728, A-97)

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)

H-375.973 Protecting Physicians at the Peer Review Process in the Current Managed Care Environment

Our AMA: (1) will work with the Federation of State Medical Boards to adopt a policy to support state legislative efforts to protect the integrity and effectiveness of the peer review process by prohibiting managed care companies from automatically terminating providers who have been sanctioned by state medical boards or by information being provided by the National Practitioners Data Bank without providing due process to the provider; and (2) espouses as policy the guarantee of due process and civil rights safeguards to physicians in peer review and in credentialing. (Res. 809, I-95; Appended: Res. 723, A-00; Reaffirmation A-05)

H-375.974 Clinical Proctoring

AMA policy states that clinical proctoring is an important tool for education and the evaluation of clinical competence of new physicians seeking privileges or existing medical staff members requesting new privileges. Therefore, the AMA:
(1) encourages hospital medical staffs to develop proctoring programs, with appropriate medical staff bylaws provisions, to evaluate the clinical competency of new physicians seeking privileges and existing medical staff members requesting new privileges; and
(2) encourages hospital medical staffs to consider including the following provisions in their medical staff bylaws for use in their proctoring program:
(a) Except as otherwise determined by the medical executive committee, all initial appointees to the medical staff and all members granted new clinical privileges shall be subject to a period of proctoring.
(b) Each appointee or recipient of new clinical privileges shall be assigned to a department where performance of an appropriate number of cases as established by the medical executive committee, or the department as designee of the medical executive committee, shall be observed by the chair of the department, or the chair's designee, during the period of proctoring specified in the department's rules and regulations, to determine the suitability to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chair or the chair's designee.
(c) The members shall remain subject to such proctoring until the medical executive committee has been furnished with: a report signed by the chair of the department(s) to which the member is assigned as well as other department(s) in which the appointee may exercise clinical privileges, describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogative of the category to which the appointment was made, and that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments. (BOT Rep. 30-A-94; Amended: CMS Rep. 3, A-99)

H-375.975 Dissolution of Medicare Peer Review Organization

The AMA will: (1) continue to support the educational, nonpunitive redirection of the Medicare Peer Review Organization (PRO) program and continue to work with CMS to make any additional, necessary changes to the program that are consistent with current AMA policy; and (2) will study the development of appropriate, alternative quality management programs that: (a) incorporate substantial input by actively practicing physicians and physician organizations; and (b) retain the educational, nonpunitive approach of the PRO program. (Sub. Res. 709, I-93; Modified: CMS Rep. 10, A-03)

H-375.977 Peer Review - Caused Litigation

The AMA urges medical staffs to review their hospital's policies for directors and officers liability and general liability coverage to determine if the policy provides defense, indemnity, or loss of income coverage for those members of the medical staff who are involved in a lawsuit as a result of the activities they have performed in good faith, conducting official peer review responsibilities or other official administrative duties of the medical staff. (Res. 707, I-92; Reaffirmed: CMS Rep. 10, A-03)

H-375.978 Medical Peer Review Outside Hospital Settings

The AMA requests state medical associations to study the need for, and if appropriate, to pursue the enactment of, legislation designed to protect the records of peer review activities in ambulatory health care facilities against discoverability in judicial or administrative proceedings. (Sub. Res. 722, A-92; Reaffirmed: CMS Rep. 10, A-03)

H-375.979 Litigation Over Hospital Peer Review Decisions

Our AMA believes that it is important to minimize expensive and time-consuming litigation over hospital peer review decisions if hospital peer review is to be a successful and effective mechanism for assuring the quality and appropriateness of hospital services. The AMA, therefore, recommends that state medical societies pursue one of the following alternatives to help minimize litigation over peer review decisions: (1) seek state legislation to create a forum that would qualify hospital peer review in the state for the state action exemption; (2) create a privately organized forum that would not qualify for the state exemption but would minimize the possibility of litigation by allowing for an objective evaluation of the decision outside of the hospital; and (3) pursue legislation that would create procedural protections designed to ensure fairness in the hospital peer review process that are the equivalent of or more substantial than those set forth in the Health Care Quality Improvement Act of 1986, or encourage hospital medical staffs to adopt bylaws with the requisite protections. (BOT Rep. DD, A-91; Reaffirmation A-00)

H-375.982 Peer Review Defined as the Practice of Medicine

Our AMA defines the act of peer review as the practice of medicine and encourages state medical associations to consider similar action. (Res. 104, A-89; Reaffirmed: Sunset Report, A-00)

H-375.983 Appropriate Peer Review Procedures

(1) Our AMA urges state medical associations to investigate applicable state law to determine if additional state agency supervision of peer review is needed to meet the active state supervision requirement set forth by the Supreme Court.

(2) Peer review procedures and actions should, at a minimum, meet the Health Care Quality Improvement Act of 1986 standards for federal immunity:
(a) In any situation where it appears that a disciplinary proceeding may be instigated against a physician that could result in the substantial loss or termination of the physician's medical staff membership and/or clinical privileges, the advice and guidance of legal counsel should be sought. The accused physician should have legal counsel separate from the health care organization or medical staff. The health care organization and the medical staff should each have separate legal counsel. The attorney of the body bringing the peer review action, be it the health care organization or the medical staff, should undertake the procedures needed to prepare for the hearing including the written notice of charges, the marshaling of evidence and the facts, and the selection of witnesses. This health care organization or medical staff attorney should be instructed that his or her role includes assuring that the proceedings are conducted fairly, bearing in mind the objectives of protecting consumers of health care and the physician involved against false or exaggerated charges. The attorney for the body which is not bringing the peer review action should work to ensure that proper peer review processes as outlined in the medical staff bylaws are followed. The role of the attorney for the accused physician is solely to defend his or her client.
(b) The medical executive committee, through its attorney, may consult with the health care organization, through its attorney, regarding appointment of a hearing officer. If an attorney is sought to be the hearing officer, those solo attorneys or attorneys from a firm regularly used by the hospital, medical staff, or the involved medical staff member or applicant for membership for legal advice regarding their affairs and activities, should not be eligible to serve as hearing officers. The hearing officer shall gain no direct financial benefit from the outcome.
(c) The attorney advising the medical staff or, in the limited situation where the hospital is prosecuting the correction action, the attorney advising the health care organization, and the attorney representing the physician involved should be accorded reasonable latitude in cross-examination, but acrimony should not be allowed by the hearing officer.
(d) Substantial latitude should be permitted in the presentation of evidence, medical reference works and testimony, within reasonable time constraints and at the discretion of the hearing officer.
(e) A court reporter should be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the court report shall be borne by the hospital, but the cost of the transcript, if any, shall be borne by the party requesting it.
(f) Within the discretion of the hearing officer, witnesses may be requested to testify under oath.
(g) The role of the hearing panel should be defined in the medical staff bylaws. The role of the hearing panel may include, without being limited to, such duties as: acting as an objective arbiter of evidence, examining witnesses, determining adherence to the standard of care, providing well-reasoned documented opinions and decisions, and other duties noted herein. The hearing panel should only consist of physicians, none of whom are direct economic competitors with the physician involved or who stand to gain through a recommendation or decision adverse to the physician. It is desirable that members of the hearing panel be physicians who have the respect of the medical community, and should include a fair representation of the same specialists/subspecialist physicians as the physician involved, whenever feasible.
(h) Physicians serving on the hearing panel should receive information and training in the elements and essentials of peer review. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible. Wherever feasible, data collection and analysis, or similar assessment instruments, and multiple reviewers should be used to increase reliability in evaluating whether peer review disciplinary proceedings are warranted. Where feasible, statistical analysis to compare with peers' performance must be used with appropriate case mix adjustments.
(i) Physicians who are direct economic competitors of the physician involved may testify as witnesses, whether they are called by the physician or the hearing panel or the health care organization, but a physician should not be deprived of his or her privileges solely on the basis of medical testimony by economic competitors. In any proceedings that result in the termination of privileges, there should be testimony from one or more physicians who are not economic competitors or who do not stand to gain economically by an adverse action, but who are knowledgeable in the treatment, patient care management and areas of medical practice or judgment upon which the adverse action is based.
(j) The hearing panel should credit the evidence brought before it in a manner reflective of the specificity of the evidence and the personal or economic biases of witnesses.
(k) When investigation is underway and indicates that a disciplinary proceeding is warranted for the purpose of reducing, restricting, or terminating a physician's hospital privileges, he or she should be notified that resignation will result in a report to the National Practitioner Data Bank. (BOT Rep. MMM, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: BOT Rep. 8, I-01; Reaffirmation A-05; Amended with change in title: BOT Action in response to referred for decision BOT Rep. 23, A-05; Reaffirmation A-08)

H-375.984 Peer Review

Our AMA affirms that it is the ethical duty of a physician to share truthfully quality care information regarding a colleague when requested by an authorized credentialing body, so long as the information that is shared with the credentialing body is protected by statute or regulation as confidential peer review information. Quality of care and patient safety are the goals of peer review. Peer

review should address the prevention of medical errors and appropriate system changes. (Sub. Res. 93, A-88; Reaffirmed: Sunset Report, I-98; Amended: BOT Action in response to referred for decision BOT Rep. 23, A-05)

H-375.989 Protection of Peer Review Records in Litigation

Our AMA believes that for peer review to be effective, peer review data must be kept confidential. (Sub. Res. 68, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: BOT Rep. 8, I-01; Reaffirmation A-05)

H-375.990 Peer Review of the Performance of Hospital Medical Staff Physicians

Our AMA encourages peer review of the performance of hospital medical staff physicians, which is objective and supervised by physicians. Membership on peer review committees and hearing panels should be open to all physicians on the medical staff and should not be restricted to those physicians who have an exclusive contract with the hospital, salaried physicians, or those on the faculty. (Res. 57, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: BOT Rep. 8, I-01; Amended: BOT Action in response to referred for decision BOT Rep. 23, A-05)

H-375.992 Confidentiality of Staff Activity

Our AMA (1) supports efforts to ensure the preservation of quality care activities as a primary function of the medical staff, through affirmation of the need for confidentiality codes relevant to medical staff peer review activities; and (2) encourages state medical societies to seek the strengthening of existing laws and the promulgation of laws in those states where confidentiality codes do not exist. (Sub. Res. 116, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: BOT Rep. 8, I-01)

H-375.993 Confidentiality in Medical Staff Peer Review

Our AMA encourages medical staff peer review committees to consider excluding non-physicians when evaluating the professional practices of fully licensed physicians. (Sub. Res. 147, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: BOT Rep. 8, I-01)

H-375.994 Peer Review in All Health Care Facilities

The AMA supports the provision of comparable peer review systems of medical services offered in public, private and governmental hospitals. (Sub. Res. 13, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CMS Rep. 7, A-05)

H-375.995 Implementation of Voluntary Medical Peer Review

The AMA: (1) reaffirms its policy that "peer review should be assigned the highest priority by state and county medical societies; that where these mechanisms exist, they should be strengthened, and where they do not exist they should be promptly established"; (2) recognizes the propriety of peer review organizations contracting with public as well as private organizations for financing of their review services, so long as professional direction and control are maintained; and (3) supports the development of public information programs to inform consumers about existing and newly developed quality assurance activities. (CMS Rep. A, A-82; Reaffirmed: CLRPD Rep. A, I-92; Modified: CMS Rep. 10, A-03)

H-375.996 Support for Voluntary Medical Peer Review

Our AMA (1) strongly reaffirms its continuing commitment to the development and maintenance of voluntary, professionally directed peer review of medical care; and (2) encourages physicians to expand their efforts to ensure that such care is of high quality, appropriate duration and reasonable cost. (CMS Rep. S, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-375.997 Voluntary Medical Peer Review

Our AMA advocates the following principles for voluntary medical peer review: (1) Medical peer review is an organized effort to evaluate and analyze medical care services delivered to patients and to assure the quality and appropriateness of these services. Peer review should exist to maintain and improve the quality of medical care.

(2) Medical peer review should be a local process.

(3) Physicians should be ultimately responsible for all peer review of medical care.

(4) Physicians involved in peer review should be representatives of the medical community; participation should be structured to maximize the involvement of the medical community. Any peer review process should provide for consideration of the views of individual physicians or groups of physicians or institutions under review..

(5) Peer review evaluations should be based on appropriateness, medical necessity and efficiency of services to assure quality medical care.

(6) Any system of medical peer review should have established procedures.

(7) Peer review of medical practice and the patterns of medical practice of individual physicians, groups of physicians, and physicians within institutions should be an ongoing process of assessment and evaluation.

(8) Peer review should be an educational process for physicians to assure quality medical services.

(9) Any peer review process should protect the confidentiality of medical information obtained and used in conducting peer review. (CMS Rep. A, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation I-98; Reaffirmed: BOT Rep. 8, I-01; Reaffirmation A-05)

H-375.998 Review Committees for Medical Practices

Our AMA recommends that, while duly constituted medical society review committees should review all aspects of medical care, final review decisions should be based upon acceptable medical practices, rather than considerations of cost or contractual limitations. (Sub. Res. 24, I-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation I-98; Reaffirmed: CMS Rep. 4, A-08)

H-375.999 Federal Hospital Utilization Review

Our AMA supports effective utilization review in federal and other governmental hospitals. (Res. 75, A-71; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-380.000 Physician Fees
(See also: Health Care Costs; Health Care Delivery; Health Care Reform; Physician Payment; Physician Payment: Medicare; Physician Payment: Medicare - Expenditures; Physician Payment: Medicare - RBRVS)

H-380.984 The Role of Cash Payments in All Physician Practices

GUIDING PRINCIPLES FOR OPERATING A CASH-BASED PRACTICE

1. Prior to transitioning to or opening a cash-based practice, physicians should develop a business plan that includes the following:

(a) An analysis of the target patient mix, and, if transitioning from a traditional practice, an analysis of how the target compares to the current patient population with respect to demographics such as age, income and health status.

(b) A description of the type(s) of care that will be offered by the practice.

(c) An evaluation of practice expenses to determine revenue requirements.

(d) A description of how the marketing, billing and collection needs of the practice will be met.

(e) Consideration of the legal, regulatory and contractual implications of opening or transitioning to a cash-based practice.

2. Cash-based practices should develop and maintain an appropriate and transparent fee schedule that is understandable and easily accessible to patients.

3. Cash-based practices should have clearly defined payment policies that help patients understand their payment responsibilities. These policies should include guidance about how patients can coordinate health insurance benefits with cash-based physician services.

4. Cash-based practices should encourage patients to maintain health insurance coverage for more complex or catastrophic health care events. (CMS Rep. 3, A-08)

H-380.986 Price Freeze

The AMA will oppose in every legitimate manner possible any attempt by the federal government to force a new price freeze on physicians' fees. (Res. 116, A-93; Reaffirmed: CMS Rep. 10, A-03)

H-380.987 Antitrust Relief as a Priority of the AMA

Our AMA will continue its aggressive efforts to achieve appropriate negotiations rights and opportunities and necessary antitrust relief for physicians, by whatever means. Achieving this important goal will remain a top priority for the Association. (Sub. Res. 223, A-93; Reaffirmed by BOT Rep. 33, A-96; Reaffirmation A-97; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-04; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08)

H-380.988 Right of Individuals to Purchase Medical Care

Our AMA: (1) acknowledges and articulates as policy the right of all individuals, including Medicare beneficiaries, to dispose of their financial resources in a discretionary manner, including the purchase of health care, and proclaims this position to the American public; and (2) supports proceeding in the most expeditious manner possible to reestablish and protect these rights of individuals, by whatever means are available, including political, judicial, regulatory and legislative. (Res. 127, A-91; Modified: Sunset Report, I-01)

H-380.989 Patient and Physician Right to Privately Contract for Health Care

It is the policy of the AMA: (1) that any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services;
(2) to pursue appropriate legislative and legal means to permanently preserve the patient's basic right to privately contract with physicians for wanted or needed health care services;
(3) to continue to expeditiously pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the physician/patient relationship; and
(4) to seek immediately suitable cases to reverse the limitations on patient and physician rights to contract privately that have been imposed by CMS or the private health insurance industry. (Sub. Res. 20, A-90; Reaffirmed: Sub. Res. 132, A-94; Reaffirmation A-97; Reaffirmed: CMS Rep. 7, A-99; Reaffirmation I-99; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation A-05)

H-380.990 Physician's Role and Billing Policy

Our AMA reaffirms its policy position that encourages physicians to discuss the charges for their services with patients and encourages patients to inquire about the costs of services and supplies prior to purchase. (Sub. Res. 199, A-89; Reaffirmed: Sunset Report, A-00)

H-380.991 Accurate Reporting of Physician Charges

The AMA believes that, since actual payment from Medicare and private insurers is substantially lower than submitted charges, it is misleading and inappropriate to draw inferences about physician fee inflation from submitted charge data. (BOT Rep. I, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-380.994 Physicians' Freedom to Establish Their Fees

Our AMA (1) affirms that it is a basic right and privilege of each physician to set fees for service that are reasonable and appropriate, while always remaining sensitive to the varying resources of patients and retaining the freedom to choose instances where courtesy or charity could be extended in a dignified and ethical manner; (2) supports the concept that health insurance should be treated like any other insurance (i.e., a contract between a patient and a third party for indemnification for expense or loss incurred by virtue of obtaining medical or other health care services); and (3) believes that the contract for care and payment is between the physician and patient. (BOT Rep. JJ, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 704 and Reaffirmation A-01)

H-380.995 Insurance Carrier Terminology

Our AMA urges individual physicians to consider including in their patient information materials an explanation as to why the amount billed may in some cases be more than the insurance benefit paid. (CMS Rep. F, I-81; CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-380.996 Voluntary Restraints of Physicians' Fee Increases

Our AMA favors continued commitment to programs for voluntary restraint of physician fees. (BOT Rep. LL, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-380.997 Limitation of Physicians' Fees

Our AMA opposes legislation or regulations which provide unfair or discriminatory limitations on physicians' fees. (Sub. Res. 129, A-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-380.999 Corporate Practice Identification

Our AMA urges physicians, including those in corporate practice, to be specifically named and identified in billing for services rendered. (Sub. Res. 80, A-71; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: CLRPD Rep. 2, I-99)

H-383.000 Physician Negotiation

H-383.992 Antitrust Relief

Our AMA will: (1) redouble efforts to make physician antitrust relief a top legislative priority, providing the necessary foundation for fair contract negotiations designed to preserve clinical autonomy and patient interest and to redirect medical decision making to patients and physicians; and (2) affirm its commitment to undertake all appropriate efforts to seek legislative and regulatory reform of state and federal law, including federal antitrust law, to enable physicians to negotiate effectively with health insurers. (Sub. Res. 905, I-07; Reaffirmation A-08)

H-383.993 Negotiations Issue

Our AMA:

(1) will continue its efforts to promote the involvement of physician organizations in health policy decisions by public and private institutions pursuant to health system reform;

(2) will continue its efforts to enhance the involvement of physician organizations in the current health system, including the Medicare program and private sector payers and institutions;

(3) will continue with its efforts to support and enhance the self regulatory structure of the profession, and will continue to review the development of new self regulatory efforts that may be needed to meet the challenges of the new environment;

(4) working through a consortium of appropriate interested organizations (i.e., specialties, groups), may act as the negotiator on behalf of, and with active input from, physicians and physician groups, for reimbursement of physician services, practice-related issues (including quality improvement), utilization review, physician supply and professional liability reform;

(5) believes that at the state and local level, physician-directed organizations (i.e. state or county associations) may act as a negotiator on behalf of member physicians after antitrust relief has been obtained; and

(6) will continue to pursue enhanced roles for physicians in private sector health plans, including lobbying for appropriate modification of the antitrust laws to facilitate physician negotiation with managed care plans and for legislation requiring managed care plans to allow participating physicians to organize for the purpose of commenting on medical review criteria, and including the development of an AMA team to develop the information and networks of consultants necessary to assist physicians in their interactions with managed care plans. (BOT Rep. QQ, I-92; BOT Rep. HHH, A-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: BOT Reps. 25 and 40, I-93; Reaffirmed: Sub. Res. 110, A-94; Reaffirmation I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-04; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, I-05; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-08)

H-383.994 Managed Care Plans and the Right to Set Fees

Our AMA opposes any government or hospital requirement that a hospital-based physician must accept the terms of any managed care plan accepted by the hospital. (Sub. Res. 704, A-01)

H-383.995 Physicians for Responsible Negotiation

Our AMA will: (1) urge all physician members to become sustaining members of Physicians for Responsible Negotiation (PRN); (2) request that all components of the AMA Federation inform PRN of situations in their home territory where PRN would be of benefit; and (3) consider whatever is legally possible and fiscally responsible to support the continued viability of PRN. (Res. 616, A-01; Reaffirmed: Sub. Res. 609, A-02)

H-383.996 Restriction of Physicians from Performing Procedures by Managed Care Organizations

Our AMA urges physicians to review their contracts carefully to ensure that they will receive payment for services that are appropriately provided in the office in accordance with their level of experience and training. (Sub. Res. 716, A-00)

H-383.997 Hospital-Based Physician Contracting

(1) It is the policy of the AMA that agreements between hospitals and hospital-based physicians should adhere to the following principles: (a) Physicians should have the right to negotiate and review their own portion of agreements with managed care organizations.
(b) Physicians should have the right to set the parameters and acceptable terms for their contracts with managed care plans in advance of contract negotiations.
(c) Physicians representing all relevant specialties should be involved in negotiating and reviewing agreements with managed care organizations when the agreements have an impact on such issues as global pricing arrangements, risks to the physician specialists, or expectations of special service from the specialty.
(d) Physicians should have the opportunity to renegotiate contracts with the hospital whenever the hospital enters into an agreement with a managed care plan that materially impacts the physician unfavorably.
(e) The failure of physicians to reach an agreement with managed care organizations should not constitute a breach of its agreement with the hospital, nor serve as grounds for termination.
(f) Physicians should seek a provision that allows them to opt out from managed care plans that pose unacceptable professional liability risks.
(g) Physicians should seek a provision to refuse to contract with, to modify contracts with, and/or to terminate contracts with managed care plans that are showing financial instability, or should seek a guarantee from the hospital that the plan will make timely payments.
(h) Physicians should receive advance notice of the hospital's intent to enter into any package or global pricing arrangements involving their specialties, and have the opportunity to advise the hospital of their revenue needs for each package price.
(i) Physicians should have the opportunity to request alternative dispute resolution mechanisms to resolve disputes with the hospital concerning managed care contracting.
(j) If the hospital negotiates a package pricing arrangement and does not abide by the pricing recommendations of the physicians, then the physicians should be entitled to a review of the hospital's actions and to opportunities to seek additional compensation.
(k) Physicians should be entitled to information regarding the level of discount being provided by the hospital and by other participating physicians.

(2) Our AMA urges physicians who believe hospitals are negotiating managed care contracts on their behalf without appropriate input, and who feel coerced into signing such contracts, to contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel.

(3) Our AMA encourages physicians to avail themselves of the contracting resources available though their relevant specialty societies, as well as the AMA Model Medical Services Agreement, and the Young Physician Section pamphlet entitled "Contracts: What You Need to Know," to evaluate and respond to contract proposals. (CMS Rep. 3, A-00; Reaffirmed: BOT Rep. 13, I-06)

H-383.998 Impact of the NLRB Ruling in the Boston Medical Center Case

Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients. (CME Rep. 7, A-00)

H-383.999 Formation of a National Negotiating Organization

(1) All activities of our American Medical Association regarding negotiation by physicians maintain the highest level of professionalism, consistent with the Principles of Medical Ethics and the Current Opinions of Council on Ethical and Judicial Affairs;

(2) Our AMA immediately implement a national labor organization under the National Labor Relations Act to support the development and operation of local negotiating units as an option for employed physicians;

(3) Our AMA immediately implement a national labor organization to support the development and operation of local negotiating units as an option for resident and fellow physicians who are authorized under state laws to collectively bargain;

(4) Our AMA continue to support the development of independent housestaff organizations for resident and fellow physicians and be prepared to implement a national labor organization to support the development and operation of local negotiating units as an option for all resident and fellow physicians at such time as the National Labor Relations Board determines that resident and fellow physicians are authorized to organize labor organizations under the National Labor Relations Act;

(5) Our AMA continue to vigorously support antitrust relief for physicians and medical groups by actively supporting federal legislation consistent with the current principles of the Quality Health Care Coalition Act of 1999 (H. R. 1304 introduced by Representative Tom Campbell, R-CA and John Conyers, D-MI), aggressively working with the Department of Justice and the Federal Trade Commission, and continue providing model legislation and information on the state-action doctrine to state medical associations

and members;

(6) Our AMA be prepared to immediately implement a national organization to support development and operation of local negotiating units as an option for self-employed physicians and medical groups when the current principles of the Quality Health Care Coalition Act of 1999 (H. R. 1304) become law;

(7) Our AMA continues to advance its private sector advocacy programs and explore, develop, advocate, and implement other innovative strategies, including but not limited to initiating litigation, to stop egregious health plan practices and to help physicians level the playing field with health care payers;

(8) That should the BOT determine that the Quality Health Care Coalition Act of 1999 (H. R. 1304) or similar legislation will not become law, our AMA immediately pursue the creation or adoption of new antitrust legislation to achieve the same goal; and

(9) Our AMA, concurrent to proceeding with the establishment of any collective bargaining unit, undertake an extensive education program, directed at its member and non-member physicians, as to the possible limits on benefits and the risks to the formation of such a unit. (Sub. Res. 901, A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmation A-06; Reaffirmation A-08)

H-385.000 Physician Payment
(See Also: Health Care Costs; Health Care Delivery; Health Care Reform; Physician Fees; Physician Payment: Medicare; Physician Payment: Medicare - Expenditures; Physician Payment: Medicare - RBRVS)

H-385.921 Health Care Access for Medicaid Patients

It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be at minimum 100% of the RBRVS Medicare allowable. (Res. 103, A-07; Reaffirmed: CMS Rep. 2, I-08)

H-385.922 Payment Terminology

It is AMA policy to change the terminology used in compensating physicians from "reimbursement" to "payment." (Res. 138, A-07)

H-385.923 Definition of "Usual, Customary and Reasonable" (UCR)

Our AMA adopts as policy the following definitions:
(1) "usual; fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee);
(2) a fee is 'customary' when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and
(3) a fee is 'reasonable' when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans. (Res. 109. A-07)

H-385.924 Support for State Medical Association Economic Research, Development and Planning

The AMA urges state medical associations to establish bureaus or departments of economic research, development and planning to study, develop and disseminate data concerning the economic aspects of medical practice. The AMA continues to assist state associations in collecting such data and to act as a clearinghouse for data so gathered. The AMA encourages state medical associations to designate representatives to deal energetically with third party agencies and programs, utilizing the concept of usual, customary or reasonable charges. (CLRPD Rep., A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CLRPD Rep. 2, A-06)

H-385.925 Selective Revenue Taxation of Physicians and Other Health Care Providers

Our AMA: (1) strongly opposes the imposition of a selective revenue tax on physicians and other health care providers; (2) will continue to work with state medical societies on issues relating to physician and other provider taxes, providing assistance and information as appropriate; (3) strongly opposes the use of provider taxes or fees to fund health care programs or to accomplish health system reform; and (4) believes that the cost of taxes which apply to medical services should not be borne by physicians, but through adequate broad-based taxes for the appropriate funding of Medicaid and other government health care programs. (Sub. Res. 258, A-92; Reaffirmed: Res. 134, A-93; Res. 207, I-93; Reaffirmation A-99; Reaffirmation A-00; Appended Res. 132, A-01; Reaffirmation A-05; Consolidated and Renumbered: CMS Rep. 7, I-05)

H-385.926 Physician Choice of Practice

Our AMA: (1) encourages the growth and development of the physician/patient contract; (2) supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.); (3) supports the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers. (This right may be limited by contractual agreement.) An accompanying responsibility of the physician is to provide to the patient adequate fee information prior to the provision of the service. In circumstances where it is not feasible to provide fee information ahead of time, fairness in application of market-based principles demands such fees be subject, upon complaint, to expedited professional review as to appropriateness; and (4) encourages physicians when setting their fees to take into consideration the out-of-pocket expenses paid by patients under a system of individually selected and owned health insurance. (BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: Sub. Res. 701, A-93; Reaffirmation A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: Sub. Res. 107, I-93; Res. 124, I-93; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmation A-96; Reaffirmation I-96; Reaffirmation A-97; Reaffirmation I-98; Reaffirmation A-99; Appended by Res. 127, A-98; Reaffirmed: CMS Rep. 6, A-99; Reaffirmation A-00; Reaffirmation A-00; Sub. Res. 116, I-00; Reaffirmation & Reaffirmed: Res. 217, A-01; Reaffirmation A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation A-07)

H-385.927 Additional Prompt Payment Advocacy

Our AMA continues to support state medical association and national medical specialty society efforts and work independently with federal and state legislators and agencies to provide for a percentage of the financial penalty and/or accrued interest to be paid directly to the physician in the cases where payers do not make payment within the specified time frame. (Res. 815, I-02; Reaffirmation I-04)

H-385.928 Patient Interpreters

Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government. (Res. 219, I-01; Reaffirmed: BOT Rep 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07)

H-385.929 Availability and Payment for Medical Interpreters Services in Medical Practices

It is the policy of our AMA to: (1) the fullest extent appropriate, to actively oppose the inappropriate extension of the OCR LEP guidelines to physicians in private practice; and (2) continue our proactive, ongoing efforts to correct the problems imposed on physicians in private practice by the OCR language interpretation requirements. (BOT Rep. 25, I-01; Reaffirmation I-03; Reaffirmed: Res. 907, I-03)

H-385.930 Compensation for Coumadin Management

Our AMA advocates that insurers, including Medicare carriers, reimburse physicians for telephone contacts involved in the evaluation and management of patients taking therapeutic anticoagulants. (Res. 118, I-01)

H-385.931 Costs to the Private Medical Practitioner of Complying with New Unfunded Mandate Called the "Needlestick Safety and Prevention Act"

Our AMA seeks expeditious regulatory change by the Centers for Medicare & Medicaid Services and all third party payers to compensate physicians in an adequate and timely manner for the increased cost of implementing federal health care mandates such as those included in the Needlestick Safety and Prevention Act. (Res. 233, A-01)

H-385.932 Contact Capitation of Specialists

Our AMA strongly encourages all physicians contemplating entering into contact capitation agreements to exercise extreme caution, with attention to business skills and competencies needed to successfully practice under contact capitation arrangements and potentially uncontrollable market forces that may impact upon ones ability to provide quality patient care. (CMS Rep. 1, A-01)

H-385.933 Actuarially Sound Capitation

AMA policy is that it is an unfair business practice for any entity to contract with physicians to provide services when the entity knows or should know that the capitated payment offered is inadequate to pay for the services to be provided. (Res. 701, I-00)

H-385.934 Reimbursement for Office-Based or Outpatient Ultrasound Imaging

Our AMA supports reimbursement for ultrasound imaging performed by appropriately trained physicians (Sub. Res. 108, A-00)

H-385.935 Medicare National Physician Payment Schedule

Our AMA opposes any efforts by Congress or CMS to grant Medicare "most favored nations" status by interpreting "actual charge" as meaning, in whole or in part, a negotiated rate that a physician obtains from a private third party payer or other source. (Res. 118, I-99)

H-385.936 Payment for Complicated Care and Necessary Follow-Up Care

Our AMA advocates for appropriate reimbursement for follow-up care of complications and staged procedures from payers, including state and federal agencies. (Res. 115, A-99)

H-385.937 Retroactive Denials Under Federal Health Plans

Our AMA supports legislation in Congress to establish time limits on retroactive denials of claims under ERISA and FEHB laws. (Res. 212, I-98; Reaffirmation A-01; Reaffirmation I-01)

H-385.938 Most Favored Nation Clause within Insurance Contracts

Our AMA opposes the inclusion of "Most Favored Nation Clauses" into insurance contracts that require a physician or other health care provider to give a third party payer his most discounted rate for medical services. (Res. 712, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-385.939 Hospital Billing on Behalf of Physicians

Our AMA: (1) advocates that personnel performing diagnostic and procedural coding of physicians' services provide that information, including itemized billing information, collection rates, procedures, and remittance information, to those physicians providing the coded services; (2) urges physicians to participate in the processes used by entities submitting claims for and receiving payment on behalf of physicians; (3) urges that any entity billing for physicians' services ensure that, when a physician's choice of CPTcode has been changed, the physician be so notified and the recoder identified before submission of a bill; (4) encourages physicians to carefully evaluate their billing procedures upon selling their practice or contracting for billing services; (5) encourages physicians to establish billing practice policies and billing compliance programs that include monitoring and reviewing billing accuracy; and (6) encourages physicians who sell their practice or contract out billing services to establish a mechanism for continually reviewing the collection methods and procedures of the billing entity. (CMS Rep. 6, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-385.940 CPT Codes for Evening and Night Services

Our AMA will continue its efforts to advocate for the fair and equitable payment of services described by CPT codes, including those CPT codes which already exist for off-hour services and unusual travel. (Sub. Res. 821, A-98; Reaffirmed: BOT Rep. 6, I-01)

H-385.941 Opposition to CMS User Fees

Our AMA strongly: (1) opposes any attempt on the part of the federal or state governments or other entities to impose user fees, provider taxes, access fees, or bed taxes on physicians and other health care providers to subsidize or fund any health care program; (2) opposes any directive from the CMS to slow down the rate of payment of Medicare claims or reduce administrative services to patients, physicians, and other health care providers; and (3) urges Congress to appropriate sufficient funds to enable the CMS and its carriers to carry out their statutorily required functions. (Sub. Res. 201, A-98; Reaffirmation A-05)

H-385.942 CMS Use of Regulatory Authority to Implement Reimbursement Policy

The AMA urge (1) CMS in the strongest terms possible to solicit the participation and counsel of relevant professional societies before implementing reimbursement policies that will affect the practice of medicine; (2) CMS to make every effort to determine the clinical consequences of such reimbursement policy changes before the revised policies are put in place; and (3) CMS in the strongest terms possible not to misapply either quality measurement data or clinical practice guidelines developed in good faith by the professional medical community as either standards or the basis for changes in reimbursement policies. (Res. 124, A-98; Modified and Reaffirmed: CMS Rep. 4, A-08)

H-385.944 Insurance Company Denial of Payment for Office Visit and Invasive Procedure Done on the Same Day

Our AMA supports insurance company payment for evaluation and management services and procedures performed on the same day, where consistent with CPT guidelines. (Sub. Res. 829, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmation I-07)

H-385.945 Equal Payment for Services

The AMA urges that insurers not discriminate in payments based on physicians' years of practice. (Sub. Res. 104, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-385.946 Collective Bargaining for Physicians

The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation. (Res. 239, A-97; Reaffirmation I-98; Reaffirmation A-01; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08)

H-385.948 Reasonable Charge for Preauthorization

The AMA strongly supports and advocates fair compensation for a physician's administrative costs when providing service to managed care patients. (Res. 815, A-97; Reaffirmation A-04)

H-385.950 Managed Care Secondary Payers

Our AMA: (1) will seek regulatory changes that require all payers of secondary Medicare insurance to reimburse the co-insurance and applicable deductible obligations of Medicare beneficiaries;

(2) will require that these co-insurance and deductible obligations cannot be waived contractually;

(3) will develop model state legislation that would mandate that all secondary insurers to Medicare either pay their contracted physicians full Medicare deductible and coinsurance amounts regardless of whether their fee schedules are lower than Medicare, or allow physicians to bill Medicare beneficiaries directly for the full Medicare deductible and coinsurance amounts;

(4) will consider the development of draft federal legislation to require Medicare to recognize the total coinsurance and deductible amounts facing Medicare beneficiaries in instances where Medicare provides secondary insurance coverage;

(5) advocates that all patients covered by Medicare as their primary carrier and another health insurance plan (not a Medigap policy) as their secondary carrier should be entitled to receive payment in full from their secondary carriers for all Medicare patient deductible and copayments without regard to the amount of the Medicare payment for the service; and

(6) advocates that all patients covered by Medicare as their primary carrier and another health insurance plan as secondary should be entitled to receive payment in full from their secondary plans for all Medicare patient deductibles and copayments without regard to any requirement that there be prior authorization by the secondary plan for medical care and treatment that is medically necessary under Medicare, by imposing limits on the amount, type or frequency of services covered, and by thereby seeking to "manage" the Medicare benefit, as if the secondary carrier were the primary carrier. (BOT Rep. 33, A-96; Appended: Res. 122, A-98; Reaffirmed: Res. 105, A-00; Sub. Res. 104, A-01; Reaffirmation I-01; Appended: Res. 105 and 106, A-03)

H-385.951 Remuneration for Physician Services

Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols. (Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08)

H-385.952 Appropriate Physician Reimbursement by Centers for Medicare & Medicaid Services

Our AMA: (1) opposes both CMS's and local carriers' efforts to reduce or deny physician payments for appropriate services; and (2) will work to assure that all evaluation and management services are appropriately reimbursed. (Res. 118, I-95; Reaffirmation A-00; Reaffirmation A-02; Reaffirmation A-06)

H-385.953 Medicare Coronary Artery Bypass and Cataract Surgery Demonstrations: Status Report

(1) The AMA continues to oppose federally funded physician/hospital packaged payment demonstration projects. (2) The AMA advocates that packaged payment arrangements (i.e., lump-sum payments for major medical procedures covering the combined services of physicians, hospitals and other providers) should include: (a) physician payment independent of the system for paying hospitals and other providers, (b) when used, selective contracting criteria of the type specified by AMA policies 285.991 and 285.997

(including opportunity for participation, publicized criteria for participation, and a system of due process when contract termination is initiated by a payer), (c) no cash rebates to patients for participating in a packaged payment demonstration, (d) guarantees that quality and cost-effectiveness of patient care have been tested and proven to be maintained or improved, and (e) program development and implementation that include the full and informed participation of all physicians involved. (3) The AMA opposes federal government use of the term "Medicare Participating Centers of Excellence" or "Centers of Excellence" when describing Medicare or other government demonstration projects and sites, or other contracting arrangements with physicians and providers. (BOT Rep. 11, I-95; Sub. Res. 132, A-96; Reaffirmed: CMS Rep. 8, A-06)

H-385.954 Producer Price Index for Physician Services

The AMA will: continue to promote the use of the services component of the consumer price index (CPI) if some CPI index is to be used in any formula for determining annual physician payment increases; advocate that both the consumer price index for physician services and the producer price index (PPI) for physician services be used in the development of reports that discuss changes in prices of physician services; and continue to monitor and analyze the PPI and make comparisons and recommendations as appropriate. (CMS Rep. 13, A-95; Reaffirmed: CMS Rep. 7, A-05)

H-385.955 Denial of Payment for Treatment of Immediate Family Members

The AMA calls upon CMS to amend its regulations denying payment for physician services and services incident to a physician's professional services for treatment of immediate family members by permitting an exception applicable to the services of any physician who is the single source of medical care in the community. (Res. 119, A-95; Reaffirmed: CMS Rep. 7, A-05)

H-385.956 Payment for Ethics Consultations

The policy of the AMA is that physician provision of clinical ethics consultations for the guidance of individual patients or physicians, apart from and beyond their duties as members of hospital ethics committees, is an appropriately compensable medical service. Payment for these services should be made when they are reported with the appropriate existing CPT consultation codes (and prolonged physician service codes, if appropriate). The AMA recognizes that this does not address any aspect of payment for ethics consultations by non-physicians. (CMS Rep. 16 -I-94; Reaffirmed: CMS Rep. 5, A-04)

H-385.957 Regulation of Fee Review Companies

The AMA encourages appropriate regulatory agencies to review the financial arrangements between managed care organizations or organizations financing health care services and entities with which they contract to review coding decisions and fees billed by physicians and other health care providers; and opposes financial arrangements between those parties that are structured to provide inducements or incentives to the entity conducting the review to adjust codes inappropriately for the primary purpose of decreasing reimbursement to physicians and other health care providers. (BOT Rep. 28, A-94; Reaffirmed: CMS Rep. 7, A-05)

H-385.958 Payment for Services Not Authorized by Health Plans

Our AMA advocates that all health plan contracts contain a provision to permit the direct billing of patients for medical services for which authorization was denied by a health plan, which the rendering physician, based upon reasonable evidence, determines to be essential for the welfare of the patient and for which prior patient consent was obtained. (Sub. Res. 705, I-93; Reaffirmation A-02)

H-385.959 Primary and Consultative Care

The AMA will promulgate policies to recognize the services of internists, pediatricians, family physicians and obstetrician/gynecologists as capable of providing both primary care and consultative care. (Res. 311, I-93; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 9, A-07)

H-385.961 Medicare Private Contracting

Our AMA will: (1) continue to pursue legal and administrative efforts to permit patients to contract privately with their physicians in appropriate circumstances; and (2) support repeal of the restrictions placed on private contracts between physicians and Medicare beneficiaries to ensure that there is no interference with Medicare beneficiaries' freedom to choose a physician to provide covered services and give priority to this goal as a legislative objective. (BOT Rep. OO, A-93; Reaffirmed: Sub. Res. 132, A-94; Appended: Res. 203, I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation I-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation A-04; Reaffirmation A-08)

H-385.962 Physician Bargaining

The AMA acknowledges that some state medical associations are in favor of a budgeting process that incorporates the ability for

physician groups to bargain collectively on state-level budgets and will continue to support such state medical associations in their negotiations and development of budgeting process. (Res. 126, A-93; Reaffirmed: CMS Rep. 10, A-03)

H-385.963 Physician Review of Accounts Sent for Collection

(1) The AMA encourages all physicians and employers of physicians who treat patients to review their accounting/collection policies to ensure that no patient's account is sent to collection without the physician's knowledge. (2) The AMA urges physicians to use compassion and discretion in sending accounts of their patients to collection, especially accounts of patients who are terminally ill, homeless, disabled, impoverished, or have marginal access to medical care. (Res. 127, I-92; Reaffirmed: CMS Rep. 10, A-03)

H-385.967 Incentives and Penalties to Encourage Third Party Payers to Make Prompt Payment of Health Insurance Claims

It is the policy of our AMA to investigate and document reports of problems with delays in payments by third party payers, including the federal government, and to seek legislation or regulations that assure prompt payment by all third party payers. (Res. 113, I-91; Reaffirmed: Res. 138, A-98; Reaffirmation I-01; Reaffirmation I-04)

H-385.968 Physician Fee Determination by Contractual Arrangements Between Third Party Payers and Hospital

Our AMA condemns the practice of negotiating or creating contractual arrangements between third party payers and hospitals limiting reimbursement to physicians unless those physicians have been involved in the negotiation process and have been given a good faith opportunity to participate. (Sub. Res. 248, A-91; Reaffirmed: Sunset Report, I-01)

H-385.969 Assistants at Surgery

The AMA (1) opposes any effort by Medicare or any other third party payer to limit payment for medically necessary care, especially in the area of assistants at surgery; (2) supports and participates in, as appropriate, the efforts of state and specialty societies to develop guidelines for appropriate use of physicians as assistants at surgery; and (3) continues to oppose and seek regulatory and/or legislative relief from the discriminatory downgrading or elimination of Medicare payments for assistants at surgery. (Sub. Res. 229, A-91; Reaffirmed: BOT Rep. 32, A-99)

H-385.970 Payment of Physicians' Services for Patients in Observational or Short Stay Units

Our AMA supports seeking reimbursement from all third party payers for physicians' services to patients who are appropriately managed in short stay units. (Res. 182, A-91; Reaffirmed: Sunset Report, I-01)

H-385.971 Physician Negotiations with Third Party Payers

The AMA (1) will aid, encourage and guide medical societies in efforts to directly negotiate with any larger payer of medical services; (2) will negotiate with national third party payers with regard to national policies which arbitrarily interfere with patient care; and (3) will use its legal and legislative resources to the maximum extent to change the laws to permit physicians to fairly and collectively deal with third party payers. (BOT Rep. MMM, A-91; Reaffirmation A-97; Reaffirmation I-06)

H-385.973 Collective Negotiations

It is the policy of the AMA to seek amendments to the National Labor Relations Act and other appropriate federal antitrust laws to allow physicians to negotiate collectively with payers who have market power. (Res. 95, A-90; Reaffirmed by BOT Rep. 33, A-96; Reaffirmation A-97; Reaffirmation I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08)

H-385.974 Reaffirmation of Support for Indemnity Payment Plans

The AMA reaffirms its support for the indemnity approach to fee-for-service physician payment. (Res. 211, A-90; Reaffirmed: Res. 105, A-99)

H-385.976 Physician Collective Bargaining

Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians.

(2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their

understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature.

(3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively.

(4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.

(5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care. (BOT Rep. P, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-04; Reaffirmed in lieu of Res. 105, A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08)

H-385.977 Counseling - Serious Medical Problems

The AMA (1) affirms that physician counseling of patients and their families with respect to serious medical problems is a vital medical service; (2) believes that insurance companies, third party carriers, and governmental agencies involved in medical care should regard and treat counseling by physicians as an important medical service; and (3) urges all physicians not only to counsel their patients with respect to serious medical problems, but also to use the CSN/CPT codes for counseling when billing patients or third parties for medical services. (Res. 56, A-88; Reaffirmed: Sunset Report, I-98)

H-385.979 Reimbursement for Physicians in a Rehabilitation Setting

The AMA supports regulatory and/or legislative changes on a national level that would assure appropriate reimbursement for physician visits in a rehabilitation setting. (Res. 77, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-385.982 Payment for Physician Standby Services

The AMA urges all third party payers to provide coverage at an appropriate payment level for physicians' standby services when (1) the attending physician certifies that such standby services are medically necessary to the health or safety of the patient in surgery, and (2) the standby physician is providing such services to only one patient at a time and is either physically present in the operating suite or immediately available to monitor the patient's condition, make medical judgments as to the patient's needs, and furnish services as necessary. (CMS Rep. L, I-87; Reaffirmed: Sunset Report, I-97; Modified and Reaffirmed: CMS Rep. 9, A-07)

H-385.984 Fee for Services When Fulfilling Third Party Payer Requirements

The AMA believes that the attending physician should perform without charge simple administrative services required to enable the patient to receive his benefits. When more complex administrative services are required by third parties, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage, it is the right of the physician to be recompensed for his incurred administrative costs. (CMS Rep. J, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation I-08)

H-385.985 Denial of Payment for Medical Services Based Solely on Fiscal Considerations

Our AMA: (1) affirms that medical judgment as to the need for an assistant in any surgical procedure, or the need to provide any form of medical care, should be made by the physician based on what is best for the health and welfare of the patient and not on fiscal restraints or considerations; and (2) opposes any law, rule or regulation, or any decision by a third party carrier which denies payment for medical services due solely to fiscal considerations and which does not have as its primary purpose the health and safety of the patient. (Res. 12, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: BOT Rep. 32, A-99; Reaffirmation A-02)

H-385.986 National Mandatory Fee Schedule

The AMA opposes any type of national mandatory fee schedule. (Res. 27, A-85; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: CMS Rep. 7, A-05)

H-385.987 Support for Indemnity Payment System

The AMA reaffirms its support for the validity of the indemnity payment system as one of a pluralistic approach to payment methods, and supports implementation of the indemnity payment system as a preferred policy at the national level as is appropriate and feasible. (Res. 65, A-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: Res. 105, A-99)

H-385.989 Payment for Physicians Services

Our AMA: (1) supports a pluralistic approach to third party payment methodology under fee-for-service, and does not support a preference for "usual and customary or reasonable" (UCR) or any other specific payment methodology; (2) affirms the following four principles: (a) Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment. (b) Physicians should continue to volunteer fee information to patients, to discuss fees in advance of service where feasible, to expand the practice of accepting any third party allowances as payment in full in cases of financial hardship, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. (c) Physicians should have the right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service. (d) All methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service; and (3) supports modification of current legal restrictions, so as to allow meaningful involvement by physician groups in: (a) negotiations on behalf of those physicians who do not choose to accept third party allowances as full payment, so that the amount of such allowances can be more equitably determined; (b) establishing additional limits on the amount or the rate of increase in charge-related payment levels when appropriate; and (c) professional fee review for the protection of the public. (CMS Rep. A, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: Sub. Res. 716, A-00; Reaffirmation A-02; Reaffirmation A-07)

H-385.990 Payment for Physicians' Services

Our AMA:

(1) Recognizes the validity of a pluralistic approach to third party reimbursement methodology and recognizes that indemnity reimbursement, as a schedule of benefits, as well as "usual and customary or reasonable" (UCR), have positive aspects which merit further study.

(2) Reaffirms its support for: (a) freedom for physicians to choose the method of payment for their services and to establish fair and equitable fees; (b) freedom of patients to select their course of care; and (c) neutral public policy and fair market competition among alternative health care delivery and financing systems.

(3) Reaffirms its policy encouraging physicians to volunteer fee information to patients and to discuss fees in advance of services, where feasible.

(4) Urges physicians to continue and to expand the practice of accepting third party reimbursement as payment in full in cases of financial hardship, and to voluntarily communicate to their patients through appropriate means their willingness to consider such arrangements in cases of financial need or other circumstances. (CMS Rep. B, I-83; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 137, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: BOT Rep. 10, I-05)

H-385.991 Balance Billing

Our AMA supports the right of the physician to balance bill a patient for any care given, regardless of method of payment, where permissible by law or contractual agreement. (Sub. Res. 128, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 704, A-01; Reaffirmation A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06)

H-385.992 Reimbursement for CT Scans and Other Procedures

The AMA (1) opposes denial of a physician's right to perform specific services or to be compensated for such services solely on the basis of his specialty designation; (2) supports balanced third party coverage of alternative services and settings, and opposes reimbursement policies that discourage provision of care in the most cost-effective setting; (3) opposes attempts by private third party payers to deny payment for services, otherwise meeting that third party's requirements for reimbursement, solely on the basis that the services billed were provided using equipment not approved by placement review. (CMS Rep. C, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CMS Rep. 7, A-05)

H-385.994 Insurance Assignments

Our AMA supports efforts to minimize or eliminate the problem of erroneous payments to insurance beneficiaries, instead of to physicians to whom they have assigned such payments. (Sub. Res. 51, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-01; Reaffirmation I-01)

H-385.995 Manipulative Casting of Congenital Deformities of the Extremities

Our AMA encourages all third party payers to classify manipulative casting of congenital deformities of the extremities as a surgical procedure, whether performed in the office or hospital. (CMS Rep. L, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-385.996 Support of the Concept of Cost Containment and Cost Effectiveness by Encouraging Patient Care in the Least Expensive Setting

In the interest of achieving greater use of the physician's office, the AMA encourages private sector insurance companies to provide reimbursement not only for professional services, but also for other costs which are incurred in that setting, such as surgical trays, sterile draping and necessary supplies. (Res. 67, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-385.998 Reimbursement for Diagnostic or Therapeutic Procedures

Our AMA: (1) reaffirms its policy calling for the clinical acceptability of and compensation for specific medical procedures to be determined by professional peers and encouraging third parties to seek consultation from the profession prior to reimbursement decisions; and (2) will continue through its currently established mechanisms to provide for consultation and involvement by medical specialty organizations as appropriate. (CMS Rep. G, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation A-99)

H-390.000 Physician Payment: Medicare
(See also: Health Care Costs; Health Care Delivery; Health Care Reform; Physician Fees; Physician Payment; Physician Payment: Medicare - Expenditures; Physician Payment: Medicare - RBRVS)

H-390.850 Limiting Charge Rule Adjustment

Until such time as Medicare’s limiting charge is eliminated, our AMA will advocate for increasing Medicare’s limiting charge each year until reimbursement reflects the cost of providing physician services plus a reasonable allowance for the physician’s efforts. (Sub. Res. 718, I-07)

H-390.851 Changes to the Medical Profession Resulting from Medicare Administrative Contracting Reforms

1. Our AMA will review and monitor the impacts of the Medicare Administrative Contracting reforms as they evolve over the next several years with periodic reports to the House of Delegates, to include at a minimum: (a) growth, nature and outcomes of actions against physicians by Payment Safeguard Contractors and Recovery Audit Contractors; (b) changes in structure and/or function of Contractor Advisory Committees; and (c) changes in access to Medicare Administrative Contractor Medical Directors and other Medicare Administrative Contractor personnel.

2. All information gathered by our AMA regarding the impact of Medicare administrative contracting reforms will be shared in a timely manner with all state and national medical specialty societies. (Res. 710, I-07)

H-390.852 Legislative Action to End Medicare SGR Problems

1. Our AMA, working with our state and specialty society colleagues, will pursue enactment of legislation that provides for at least two years of positive updates that accurately reflect the increases in costs of caring for Medicare beneficiaries and lays the groundwork for complete repeal in the near future.
2. The AMA’s ultimate goal continues to be complete repeal of the SGR and its replacement with a fair and equitable payment system that adequately reflects increases in the cost of caring for Medicare beneficiaries. (BOT Rep. 31, A-07; Reaffirmation I-08)

H-390.853 Protecting Patient Access to High Quality Imaging Services

Our AMA actively supports repeal or delay of the provision under Section 5102 of the Deficit Reduction Omnibus Reconciliation Act of 2005 that reduces the technical component payment (including the technical component of the global payment) for an imaging service under the physician payment schedule if it exceeds (without regard to geographic wage adjustment factor) the outpatient department payment schedule amount for the service established under the Medicare prospective payment system for hospital outpatient departments. (Res. 208, A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmation I-06)

H-390.854 Freedom of Choice

(1) The AMA will seek appropriate cases to challenge the legality and constitutionality of Medicare restrictions on non-participating physicians' medical practice and on patient freedom of choice by such mechanisms as limitations on balance billing and prohibitions

on private "opt out" arrangements between physicians and patients. (2) The AMA will strongly resist such restrictions being extended to other payers in national health care reform legislation. (Res. 117, I-92; Reaffirmed: CMS Rep. 10, A-03; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-06)

H-390.855 Replacement of Sustainable Growth Rate System

Our AMA continues to assign a top priority to the prevention of further Medicare payment cuts due to the Sustainable Growth Rate system and to seek replacement of the Sustainable Growth Rate system with payment updates that reflect increases in the cost of medical practice. (Res. 910, I-04; Reaffirmed: CMS Rep. 4, A-05; Reaffirmed: BOT Rep. 35, A-05; Reaffirmation A-06; Reaffirmation I-06; Reaffirmation I-08)

H-390.856 Eliminate Medicare's "Limiting Charge"

Our AMA supports eliminating Medicare's "limiting charge" for non- participating Medicare physicians (Res. 112, A-02; Reaffirmed: Sub. Res. 718, I-07)

H-390.857 Secondary Insurance Claims with Medicare Electronic Remittance Advice

Our AMA urges that a single Medicare explanation of benefits be universally accepted by secondary insurers regardless of format. (Res. 107, I-00)

H-390.858 Medicare Coverage for Cardiovascular Stress Testing

Our AMA calls upon CMS to include the diagnoses of hyperlipidemia (272.0-272.7), fatigue (780.79), chest pain (786.50-786.59), neck or jaw pain, interscaplar pain syncope or near syncope dyspnea (786.00-786.06) and palpitations (785.1) as appropriate evidence of medical necessity for treadmill stress testing and therefore eligible for reimbursement by Medicare. (Res. 809, A-00)

H-390.859 Reimbursement for Telephonic and Electronic Communications

(1) The policy of our AMA is that physicians should uniformly be compensated for their professional services, at a fair fee of their choosing, for established patients with whom the physician has had previous face-to-face professional contact, whether the current consultation service is rendered by telephone, fax, electronic mail or other form of communication. (2) Our AMA presses CMS and other payers for separate recognition of such supplemental communication work, not as bundled into existing service codes, or have such services recognized as not covered by Medicare and therefore chargeable as a patient convenience service outside the benefit package of Medicare. (Res. 810, A-00; Reaffirmation I-04; Reaffirmation A-05; Reaffirmation A-07; Reaffirmation A-08)

H-390.860 Medicare Payments to Teaching Physicians, the Primary Care Exception

Our AMA will: (1) support the continuation of the "primary care exception" for teaching physicians providing Part A Medicare covered services;

(2) work with CMS, and Congress if necessary, to modify the primary care exception rule to extend to physicians' offices and patients' homes the same provisions that now apply to hospital outpatient departments and ambulatory care departments when and if such sites become eligible for payments under part A of the Medicare Trust Fund;

(3) seek legislative initiatives with specific language to enhance the availability of teaching physicians in all specialties through fair and consistent compensation for this vital service; and

(4) support extension of the "primary care exception" to all specialties. (CME Rep. 6, A-99)

H-390.863 Resolution of DHHS Inspector General Audits of Teaching Physicians

Our AMA will join with other interested organizations, such as the Association of American Medical Colleges and the American Hospital Association and with academic medical centers, universities and faculty practice plans, to encourage the Office of the Inspector General (OIG) of the Department of Health and Human Services and the Department of Justice to accept the following principles in dealing with institutions that cooperate with the OIG audits of teaching physicians who have billed through Medicare: (1) That punitive damages be limited to instances in which systematic, fraudulent behavior has been clearly demonstrated. (2) That full reimbursement with interest be accepted for inappropriate Medicare payments that were based on academic institutions' improper interpretation of Intermediary Letter (IL) 372, inadequate documentation, or other inadvertent errors in billing. (Res. 317, I-96; Reaffirmed: CME Rep. 2, A-06)

H-390.865 Universal Explanation of Benefits Forms

Our AMA: (1) favors the use of a standardized, easy-to-understand explanation of Benefits form, whether in print or electronic form, for all third party payers, both public and private; and (2) encourages third party payers, including CMS, to use the standard EOMB forms. Our AMA will seek national implementation of a universally inclusive Explanation of Medical Benefits (EOMB) form that would conform, at a minimum, to the following requirements:
(a) The EOMB must be issued to the physician and to the patient when a reimbursement check is issued or payment is denied, and contain appropriate identifying information so the physician can relate a specific reimbursement or denial to the applicable claimant, the service (s) billed and the date of service.
(b) The carrier shall use the physician's claim form's listed CPT codes and descriptors to demonstrate how each charge has been reduced or disallowed.
(c) The EOMB shall specify what underlying managed care organization's contractual fee schedule is used for determining reimbursement and/or applicable discounts.
(d) The EOMB shall clearly identify the insured's remaining financial responsibility under the contract.
(e)The standardized form should clearly state information such as the patient's name, the insured's name, the patient's date of birth, the date of service, the CPT code submitted, the amount charged, the amount allowed, the amount discounted, the amount of co-pay, the deductible amount, the withhold amount and the payment to the physician. (Res. 101, I-96; Appended by Sub. Res. 126, A-98; Reaffirmed and Appended: Sub. Res. 106, I-98; Reaffirmation A-05; Reaffirmed in lieu of Res. 710, A-06; Reaffirmation A-08)

H-390.866 DRGs for Physician Pay

The AMA will take appropriate action to prevent a diagnosis related group (DRG) or similar physician reimbursement scheme that combines hospital and physician payment from being implemented by the Centers for Medicare & Medicaid Services. (Res. 103, I-96; Reaffirmation A-06; Reaffirmed: CMS Rep. 8, A-06)

H-390.867 Medical Rehabilitation Services

The AMA believes: (1) Rehabilitation criteria for reimbursement should be defined by medical needs of patients for rehabilitative care that includes functional, cognitive, social considerations, and cognitive status, specifically the so called "three hour rule" is not a valid exclusion criterion for entry into a rehabilitation unit nor can it be the basis for denial of ongoing coverage in such a unit. (2) The severity of medical conditions, regardless of settings, must be accounted for, including a case-mix approach adjusted for regional variances to meet individual patient needs for high quality, cost effective medical, rehabilitation services. (BOT Rep. 6, A-96; Reaffirmation A-04)

H-390.868 Ambulatory Patient Groups

AMA policy opposes Medicare lump-sum prospective payments to hospitals for outpatient services that: (1) are based on a bundling approach, such as ambulatory patient groups, which includes the individual physician's payment; and (2) make a physician's payments dependent on the system for paying the hospital. (BOT Rep. 3, I-95; Reaffirmed: CMS Rep. 7, A-05)

H-390.870 Payment Denial Explanation on Medicare Benefit Statements

The AMA will request CMS to instruct Medicare carriers not to use wording on the Medicare Explanation of Medicare Benefits (EOMB) that is inflammatory and misleading (e.g., "this service may not have been medically necessary") but rather, to use language that accurately reflects the reason for the denial (e.g., "This service may be necessary but it is not paid for by Medicare...or is beyond the scope of Medicare coverage."). (Sub. Res. 101, I-94; Reaffirmed by Sub. Res. 126, A-95; Reaffirmation I-98; Reaffirmed: CMS Rep. 4, A-08)

H-390.872 Compensation for Physicians Who Accompany Seriously Ill or Injured Patients to Hospitals

The AMA: (1) urges CMS to allow payment for the services of physicians who accompany seriously ill or injured patients in the ambulance to hospitals and who report the appropriate level of evaluation and management service along with *Prolonged Physician Service with Direct (Face-to-Face) Patient Contact* (codes 99354 and 99355) or the *Critical Care Services* codes (99291 and 99292); and (2) urges CMS to expand its guidelines to carriers to allow payment for a physician's return trip from accompanying an ambulance-borne patient, consistent with above, using code 99082, *Unusual travel (e.g., transportation and escort of patient)*. (CMS Rep. 13, A-94; Reaffirmed: CMS Rep. 7, A-05)

H-390.874 Repayment of Medicare Overpayments Made in Error

The AMA will request CMS to require Medicare carriers to be financially responsible for repayment to CMS of any overpayments made by the carrier to physicians where physicians could not reasonably be aware that the payments were overpayments or in error and where the physicians relied on calculations by the carrier. (Res. 224, I-93; Reaffirmed: CMS Rep. 10, A-03)

H-390.875 Customary and Reasonable Fees

Our AMA will: (1) continue its work with CMS and other third party payers in developing Explanations of Benefits (EOBs) that clearly explain reasons for payment levels compared with physicians' charges;
(2) encourage local medical societies to work on the EOB issue with third party payers in their states;
(3) continue to update explanations of physician payment through its existing consumer information programs; and
(4) modify and promulgate its model Explanation of Benefits Act - to allow access by physicians, upon request, to the customary and reasonable fee schedules developed independently by various payers. (BOT Rep. 3, I-933; Reaffirmation I-01)

H-390.877 Home Health Care Services

Our AMA urges the federal government to provide an 'explanation of medical benefits' statement for post-acute and long-term care (i.e., post-hospital care for sub-acute and chronic illnesses in a variety of health care settings, such as home health agencies and skilled nursing facilities), to the responsible physician, upon his or her request, and to the recipient of such care when covered by Medicare; and urges the federal government to apply a beneficiary co-payment to all home health care services covered by Medicare. (Res. 121, I-93; Reaffirmed by Res. 122, A-97; Modified: CMS Rep. 1, A-00)

H-390.878 Promoting Recognition for Physician Case Management Services

The AMA will place a high priority on working with CMS and other third party payers to assure appropriate reimbursement for physician case management services including care plan oversight, telephone consultations and other case management services by physicians with other health care professionals; and supports the inclusion of physician case management services in health insurance benefits packages. (Sub. Res. 802, A-93; Reaffirmed by Res. 731, A-95; Reaffirmation A-99)

H-390.879 Medicare Reimbursement for Multiple Physician's Visits on the Same Day Regardless of the Place of Service

The AMA urges CMS to permit separate reimbursement for medically necessary multiple visit services rendered to Medicare patients on the same day by the same physician regardless of the setting in which those services were provided. (Res. 811, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed in lieu of Res. 831, I-08)

H-390.880 Interest Rates Charged and Paid by CMS

(1) Our AMA will (a) determine if the recent interest rate changes implemented by CMS comply with current Medicare laws; (b) seek to ensure that CMS's interest charges do not exceed legal limits; and (c) work with CMS to ensure parity in interest rates assessed against physicians by CMS and interest rates paid to physicians by CMS. (2) If an agreement cannot be reached with CMS, the AMA will seek legislation to correct this situation. (Res. 221, I-92; Reaffirmed: BOT Rep. 28, A-03)

H-390.881 Medicare Certification and Recertification Form

Our AMA (1) will work to eliminate the requirement for the hospital and physician to complete the "Medicare Certification and Recertification" form; and (2) will continue to oppose Medicare regulations which increase the administrative burdens on physicians. (Res. 101, I-92; Reaffirmation A-01)

H-390.883 Elimination of 10 Percent Reduction in Physician Payment for Delayed Submission of Medicare Claims

The AMA seeks the elimination of the 10 percent reduction in payment for services to Medicare beneficiaries for claims submitted within 24 months from the day of such service. (Res. 108, I-92; Reaffirmation A-99)

H-390.884 Medicare Policy Change

Primary Care Consultation Policy: The AMA opposes Medicare's policy regarding denial of payment for consultation provided by primary care physicians for patients who are being cleared for surgery, as this policy is contrary to the best interests of Medicare patients and the fundamental goals of RBRVS, and will take any measures possible to have this policy changed. (Res. 132, I-92; Reaffirmed: CMS Rep. 10, A-03)

H-390.885 Advance Payments During Medicare Slow-Downs

The AMA will continue to seek legislation requiring CMS to make interim payments available to physicians when disruptions in Medicare claims processing result in undue delays in the normal flow of Medicare payments. (Sub. Res. 242, A-92; Reaffirmed: BOT Rep. 28, A-03)

H-390.887 Medicare Physician Time Survey

Our AMA will work with CMS to modify the time survey process for physicians involved in Medicare Part A funded activities so that it will be less labor-intensive, in order to maximize the time spent in patient care. (Res. 105, A-92; Reaffirmation A-01)

H-390.888 Payment for Concurrent Care

The AMA (1) seeks enactment of federal legislation and/or a change in CMS policy to establish more equitable standards for fair and prompt payment for concurrent care for both primary care and specialist physicians; (2) seeks uniformity among Medicare carriers and other third party payers in application of concurrent care policies; (3) seeks to allow physicians to be identified by their specialty and subspecialty as reported to the carrier, rather than by an arbitrary carrier definition for such policies, and that medical subspecialties not be included in the broad category "internal medicine"; (4) requests that CMS reimburse primary care physicians (MD/DO) appropriately for medically necessary documented services such as counseling and coordination of care in the surgical patient; (5) will communicate to CMS the importance of carrier understanding that more than one physician can be involved in a case and that the carrier or insurance company not expect a physician to manage a medical problem outside his/her area of expertise or specialty, and that both the primary care physician or other specialist be reimbursed for this care in accordance with their responsibilities; and (6) will use all appropriate means to have CMS and/or its carriers not routinely deny all but the first claim received for services rendered to the same patient on the same day for the same diagnosis and urges that carrier systems not automatically reject such claims. (Sub. Res. 113, A-92; Reaffirmed: Res. 110, A-93: Reaffirmed: CMS Rep. 10, A-03; Reaffirmation I-08)

H-390.889 Medicare Reimbursement of Telephone Consultations

It is the policy of the AMA to: (1) support and advocate with all payers the right of physicians to obtain payment for telephone calls not covered by payments for other services;

(2) continue to work with CMS and the appropriate medical specialty societies to assure that the relative value units assigned to certain services adequately reflect the actual telephone work now performed incident to those services;

(3) continue to work with CMS, other third party payers and appropriate medical specialty societies to establish the criteria by which certain telephone calls would be considered separate services for payment purposes;

(4) request the CPT Editorial Panel to identify or consider developing the additional service code modifiers that may be required to certify specific types of telephone calls as separate from other services; and

(5) seek enactment of legislation as needed to allow separate Medicare payment for those telephone calls that can be considered discrete and medically necessary services performed for the patient without his/her presence. (CMS Rep. N, A-92; Reaffirmed: Res. 122, I-97; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-01; Reaffirmation A-07)

H-390.891 Hospital Services Provided Within Three Days of Hospital Admission

The AMA will resist strongly efforts to incorporate payment for Medicare Part B physician services into hospital payments. (BOT Rep. Y, A-92; Reaffirmed: CMS Rep. 10, A-03)

H-390.895 Medicare Patient Surveys

It is the policy of the AMA to negotiate with CMS to rescind rules and regulations that inordinately withhold payment to physicians for services rendered to Medicare beneficiaries until the beneficiary completes a survey or questionnaire. (Res. 102, I-91; Reaffirmation A-01; Reaffirmed: Sunset Report, I-01)

H-390.896 Payment for Case Management Services

Our AMA requests CMS to specifically assign a payment schedule to the established evaluation and case management service codes as they exist in the CPT and reimburse for same. (Res. 143, A-91; Reaffirmed: Sunset Report, I-01)

H-390.898 Equity in Medicare Payment Levels

Our AMA: (1) adopts as a major legislative priority for 1991 the adequate funding of the Medicare program; and (2) supports the initiation of legislation to prevent any further reduction of the current Medicare limiting charges (140 percent for evaluation and management services, 125 percent for all other services). (Sub. Res. 165, A-91; Reaffirmation I-99; Reaffirmation A-06)

H-390.899 Payment Reform and Access to Care

The AMA supports evaluating the impact of balance-billing limitations, the implementation of limiting charges, and the reduction of payment for so-called over-valued procedures on the public's access to and availability of medical services. (Res. 224, A-91; Reaffirmation I-99)

H-390.901 Medicare Outpatient Service Charge Limit

Our AMA vigorously opposes the Medicare Part B Policy of Outpatient Physician Charge Limit. (Res. 70, A-91; Modified: Sunset Report, I-01)

H-390.904 Timely Part B Medicare Payments to Physicians

The AMA urges CMS to require that Medicare carriers develop and implement a mechanism to make interim payments to physicians on a temporary basis when they are unable to process a substantial fraction of Medicare Part B claims for physicians' services within the statutory timeframes, with it clearly understood that such a program is to be conducted only until delays can be remedied and that such remedies shall be of the highest priority for CMS and the relevant carriers. (Res. 228, A-91; Reaffirmed by Res. 138, A-98; Reaffirmed: CMS Rep. 4, A-08)

H-390.905 Timely Early Disclosure of All Limiting Charges Information

It is the policy of the AMA to work with CMS to allow a 30-day decision period between the time that the full and complete schedule of limiting charges is made available by the carrier and the deadline date for the decision on whether to become a participating physician. (Res. 194, A-91; Reaffirmation I-99)

H-390.906 Medicare Notification of Payment

Our AMA requests CMS to direct Medicare Part B carriers to furnish all physicians with an Explanation of Medicare Benefits on all claims whether assigned or nonassigned. (Res. 62, A-91; Reaffirmed: Sunset Report, I-01)

H-390.910 Repeal of Portions of Catastrophic Coverage Act of 1988

It is the policy of the AMA to continue to work to effect legislation to repeal those portions of any law or regulation that would require that CMS include information in every Explanation of Benefits form for unassigned claims on how Medicare assignment would have affected nonassigned claims. (Sub. Res. 63, I-90; Reaffirmed: Sunset Report, I-00)

H-390.912 Equal Medicare Reimbursement for All Physicians

It is the policy of the AMA (1) to continue to develop new legal and legislative strategies to secure 100 percent Medicare payments for new physicians and to ensure continued patient access to all young physicians; and (2) to encourage state medical societies and national medical specialty organizations to petition Congress to secure 100 percent Medicare payment for new physicians. (Res. 165, I-90; Reaffirmed: Sunset Report, I-00)

H-390.916 Payment for Patient Conferences Regarding Advance Directives

Our AMA encourages payment for medical conferences with patients and/or relatives and guardians regarding medical management and future medical management, particularly as it relates to the discussion of advance directives (i.e., living wills and durable powers of attorney for health care). (Res. 1, I-90; Reaffirmed: Sunset Report, I-00; Modified in lieu of Res. 101, A-07)

H-390.917 Consultation Follow-Up and Concurrent Care of Referral for Principal Care

(1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation (in the inpatient setting these encounters may be reported using the follow-up consultation codes in CPT and in the outpatient setting these encounters may be reported using the appropriate office or other outpatient setting codes); and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; he/she may also have the patient referred for care and thus become the principal care physician. (2) The AMA communicate the appropriate use of consultation and office medical services codes to third party payers and advocate the appropriate reimbursement for these services in order to encourage high quality, comprehensive and appropriate consultations for patients. (Sub. Res. 42, A-90; Amended: BOT Rep. P, I-92; CMS Rep. 3, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation I-08)

H-390.918 Concurrent Care

It is the policy of the AMA to work with CMS and other payers to allow identification of the specialty and subspecialty of the

physician who provides each service for the purposes of recognizing jointly provided medically necessary services, such as concurrent care. (Sub. Res. 43, A-90; Reaffirmed: Sunset Report, I-00)

H-390.919 Seeking Standardized Interpretation Of CMS Directives

It is the policy of the AMA (within proper legal channels) to work with CMS, Medicare intermediaries, carriers and PROs to make CMS directives more explicit, to eliminate uneven interpretations of those directives, and therefore make the reimbursement process even and equitable. (Res. 85, A-90)

H-390.921 Uniformity of Operations of Part B Medicare Carriers

It is the policy of the AMA (1) to use its influence and resources to bring about uniformity of business policies and procedures among the Part B Medicare carriers, and (2) to investigate and monitor the differing policies and procedures among the Part B Medicare carriers with respect to physician reimbursement. (Res. 154, A-90; Reaffirmed: Sunset Report, I-00)

H-390.923 Purchased Diagnostic Tests

It is the policy of the AMA (1) that physicians may continue to bill and be paid for their professional component of purchased diagnostic tests (as defined by Medicare); and (2) to strongly encourage physicians to report and document these services accurately, using appropriate CPT codes for interpretation or other professional services. (CMS Rep. N, A-90; Reaffirmed: Sunset Report, I-00)

H-390.925 Medicare Billing

It is the policy of the AMA to work with government officials, legislators, and other appropriate parties to create reasonable exceptions to the Medicare policy that forbids one physician to bill for a colleague's services. (Res. 96, A-90; Reaffirmed: Sunset Report, I-00)

H-390.926 Opposition to Denial of Payment for Assistants at Surgery

Our AMA supports the prerogatives of Medicare patients to be allowed to pay for an assistant surgeon if Medicare disallows use of an assistant and the patient and his or her physician believes it is necessary. (Res. 47, I-89; Reaffirmed: BOT Rep. 32, A-99)

H-390.927 Rehabilitation Physician Visits

Our AMA: (1) believes that a visit per day by the attending rehabilitation physician is appropriate for patients in certified acute inpatient rehabilitation units or facilities; and (2) supports communicating this position to CMS. (Sub. Res. 141, I-89; Reaffirmed: Sunset Report, A-00)

H-390.944 Reimbursement from Medicare

Our AMA supports actions to require Medicare to make direct payment in all cases to physicians who have accepted assignment, regardless of whether or not Medicare is a primary or secondary insurer. (Res. 66, I-88; Reaffirmed: Rules & Credentials Cmt., A-96; Reaffirmed: Res. 127, A-00)

H-390.945 Legal Action to Resolve Medicare Reimbursement Disparities

Our AMA believes that: (1) current geographic inequities in Medicare payments for physician services pose a serious threat to access to care for many Medicare beneficiaries; and; (2) such payment inequities must be addressed and remedied in a timely manner, without awaiting implementation of a new Medicare indemnity physician payment system. (Sub. Res. 69, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-06; Reaffirmed in lieu of Res. 921, I-06; Reaffirmation I-07)

H-390.947 Medicare Payment Policies/Requirement That Carriers Delay Processing Claims

Our AMA supports repeal of the federal Medicare payment policies that require carriers to delay processing claims as set forth in Social Security Act XVIII, Section 1816(c)(3). (Res. 65, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-390.951 Medicare Deductibles and Co-Payments

The AMA urges the federal government to inform the public that physicians accepting Medicare assignment are required to make a reasonable attempt to bill for and collect deductible and co-payment amounts. (Res. 46, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-390.953 Medicare Payments for Physicians' Services in Puerto Rico

The AMA supports the elimination of inequities in Medicare reimbursement so that physicians' fees for Medicare patients in Puerto Rico are adjusted according to the Medicare regulations applicable in the continental United States. (Res. 94, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-390.957 Direct Physician Reimbursement for Assigned Medicare Claims from Secondary Insurance Carriers

Our AMA endorses legislation requiring secondary insurance carriers to reimburse co-insurance and deductible payments for Medicare patients directly to physicians accepting assignment. (Res. 69, A-88; Reaffirmed: Rules & Credentials Cmt., A-96; Reaffirmed: Res. 105, A-00; Reaffirmation A-01; Reaffirmation I-01)

H-390.961 Opposition to Mandatory Acceptance of Medicare

The AMA (1) continues to actively oppose, through appropriate political and legal means, any and all actions by any government body or legislative body, which would require mandatory acceptance of Medicare assignment; and (2) encourages all concerned physicians to join with the AMA in the active opposition to such oppressive action. (Res. 114, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-390.962 Notification to Patients of Charge Amounts Prior to Service as Per Omnibus Reconciliation Act of 1986

(1) The AMA opposes efforts by commercial carriers or the federal government which would require physicians to predict reimbursement for services rendered. (2) The AMA supports the repeal of the provision of OBRA 1986 regarding notification of patients receiving elective surgery of the physician charge, the expected amount of Medicare reimbursement, and the balance that the patient would be responsible for paying when the charge for the service is $500 or more and the claim is not accepted on an assigned basis. (3) The AMA supports repeal of those provisions of OBRA that require physicians to refund payments associated with Medicare services that are deemed medically unnecessary by CMS after the fact. (4) The AMA believes that increases in Medicare reimbursement need to be universal, that current reimbursement should be adjusted and that there should be no discrimination in schedules between participating and nonparticipating physicians (Sub. Res. 13, I-87; Reaffirmed: Res. 237, A-93; Reaffirmed: BOT Rep. 28, A-03)

H-390.965 Medicare Denial Relief Act

The AMA supports using every means to ensure that changes in CMS regulations are adequately publicized to allow time for review and comment by the public and the profession, so that arbitrary denial of payment for medical services will not occur. (Res. 51, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-390.971 Hospitals Limited to Participating Physicians

Our AMA (1) advises its members that the decision of whether or not to be a "participating" physician in Medicare is a personal choice;

(2) supports use of all appropriate means to rescind those recently enacted regulations and statutes which unfairly discriminate against health care providers and which jeopardize the quality, availability and affordability of health care for the aged and the infirm;

(3) urges a return to the original intent of the Medicare Law (Title XVIII) as expressed in Sections 1801 and 1802 enacted in 1965 which read as follows: "Section 1801 [42 U.S.C. 1895] Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person." "Section 1802 [42 U.S.C. 1895a] Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services";

(4) supports rescinding the "incentive" in OBRA 1986 regarding hospital referral of Medicare patients to participating physicians;

(5) supports amendment of the Medicare law to eliminate any financial incentives to Medicare carriers for signing up large numbers of physician providers; and

(6) supports rescinding OBRA 1986 provision that requires a nonparticipating physician who performed an elective surgical procedure on an unassigned basis for a Medicare beneficiary to provide the beneficiary in writing the estimated approved charge under Medicare, the excess of the physician's actual charge over the approved amount, and the coinsurance applicable to the procedure. (Res. 31, A-

87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 217, A-01)

H-390.972 Special Payment Arrangements for Low-Income Medicare Beneficiaries

(1) The AMA supports state and local medical society programs that promote voluntary Medicare assignment. (2) The AMA believes that, in addition to voluntarily accepting assignment for low-income beneficiaries, it is also desirable for physicians to waive Medicare's copayment and deductible on a case-by-case basis for beneficiaries experiencing exceptional financial hardship. In the view of the AMA, current CMS policy does allow physicians the latitude and flexibility to make such waiver decisions on an individual basis. However, the AMA believes it is extremely important for any physician who is contemplating such case-by-case waivers to discuss any proposed waiver practice with the carrier. Assurance should be obtained that this practice will not affect fee profiles or create a risk of sanctions. This is particularly true for physicians with a significant number of patients meriting such arrangements. (CMS Rep. E, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-390.976 Delayed Payment of Medical Insurance Claims

Our AMA (1) expresses its concern and displeasure about CMS's practice of slowing payment of Medicare claims, which places an unwarranted financial burden upon the elderly and the practitioners and facilities which serve senior citizens; (2) supports model state legislation to establish incentives and/or penalties among private and public third party payers to rectify the problem of delayed insurance reimbursements; and (3) believes that reasonable interest should begin on uncontroverted claims not later than 30 days following receipt of a claim by the payer. (Sub. Res. 20, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Res. 138, A-98; Reaffirmation I-04)

H-390.977 Reimbursement for Diagnostic Studies Identified as Surgical Procedures

(1) The AMA supports the concept of separate payment by private and public payers for the services of physicians who perform diagnostic procedures separately and apart from surgical therapy. (2) The AMA supports the concept of one inclusive fee or payment to a physician by private and public payers for diagnostic surgical procedures performed in conjunction with and as a part of surgical therapy, and encourages payers to utilize for payment purposes a coding system which can recognize the greater complexity or extent of the service which may be rendered. (3) The AMA urges physicians billing third parties to ensure that all services provided are completely described or coded on the appropriate claim form(s). (CMS Rep. E, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-390.985 CMS Consultation With Physicians

The AMA encourages CMS to consult with clinically experienced practicing physicians on all determinations affecting medical practice and patient care. (Sub. Res. 71, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CMS Rep. 5, A-04)

H-390.987 Medicare Assignments and Laboratory Reimbursements

The AMA supports educational efforts to assist physicians in differentiating between procedural billing and professional billing, particularly as they relate to billing for the drawing of a specimen and billing for interpreting the laboratory test results. (Res. 20, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CMS Rep. 5, A-04)

H-390.991 CMS Reimbursement Policy for Physicians in Solo Practice "Covering" Medicare Patients for Each Other

The AMA supports permitting physicians in solo practice, and those in different groups, to "cover" Medicare patients for each other, and making it possible for the personal physicians of Medicare patients to bill and to receive reimbursement for professional services rendered by their colleagues who "cover" for them. (Res. 68, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CMS Rep. 7, A-05)

H-390.992 Prospective Payment System and DRGs for Physicians

The AMA (1) endorses the concept that any system of reimbursement for physicians' services should be independent of reimbursement systems for other providers of health care; and (2) opposes expansion of prospective pricing systems until their impact on the quality, cost and access to medical care have been adequately evaluated. (Sub. Res. 70, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CMS Rep. 7, A-05; Reaffirmation A-06)

H-390.994 Government Regulations

Our AMA vigorously opposes regulations and legislation which would: (1) interfere with and/or redefine the practice of medicine; (2) substitute hourly wages or annual salaries for present reimbursement mechanisms for physicians' services to patients; (3) base physician reimbursement on any system which does not give recognition to knowledge, skill, time and effort; or (4) otherwise impinge significantly upon the practice of medicine. (Sub. Res. 28, I-82; Amended: CLRPD Rep. A, I-92; Reaffirmed

by Sub. Res. 203, A-98; Reaffirmation A-00; Reaffirmation I-01)

H-390.996 Medicare Reimbursement Policy

Our AMA requests CMS to relieve radiologists and pathologists of the burden of providing diagnoses, frequently unavailable to them, in order to be reimbursed by insurance carriers of government sponsored programs such as Medicare and other third parties. (Res. 8, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-390.998 Medicare Reimbursement Policy

Our AMA supports the elimination of undesirable aspects of the arbitrary assignment of a profile by Medicare to physicians establishing a new practice. (Res. 80, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-390.999 Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediaries

When a physician assumes responsibility for the services rendered to a patient by a resident or an intern, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction, and supervision. (CMS Rep. H, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-395.000 Physician Payment: Medicare - Expenditures
(See also: Health Care Costs; Health Care Delivery; Health Care Reform; Physician Fees; Physician Payment; Physician Payment: Medicare; Physician Payment: Medicare - RBRVS)

H-395.995 Expenditure Targets for Medicare

Our AMA (1) reaffirms its willingness to participate in efforts to control the cost of Medicare in a manner that preserves the quality and availability of health care to Medicare recipients;

(2) reaffirms its position that the Medicare program establish actuarially sound financing of benefits as stated in Policy 165.993;

(3) urges Congress to incorporate the following considerations when applying budgetary controls to Medicare in place of expenditure targets: (a) assure a high priority to health care for Medicare patients in relation to other programs when allocating federal funds; (b) given Medicare's finite resources, develop a mechanism to channel those resources to those patients with greater financial need and to require a proportionately larger financial contribution by the more affluent toward their own health care; and (c) reduce the cost of defensive medicine (approximately $20 billion a year) caused by the present tort system. (Sub. Res. 200, A-89; Reaffirmed: Sunset Report, A-00)

H-395.997 Expenditure Targets for Medicare

Our AMA vigorously opposes the concept of expenditure targets in the Medicare program or any other action which would lead to the rationing of or reduced access to medical care. (Res. 87, A-89; Reaffirmed: Sunset Report, A-00)

H-400.000 Physician Payment: Medicare - RBRVS
(See also: Health Care Costs; Health Care Delivery; Health Care Reform; Physician Fees; Physician Payment; Physician Payment: Medicare; Physician Payment: Medicare Expenditures)

H-400.945 Insurance Compensation When Medicare Rates Are Decreased

Our AMA advocates that the conversion factor for the physician payment schedules of commercial health plans be based on an actuarial and financial analysis of the specific circumstances and not simply linked to the conversion factor for the Medicare physician payment schedule. (Res. 715, A-03; Reaffirmed in lieu of Res. 830, I-08; Reaffirmation I-08)

H-400.946 Uncoupling Commercial Fee Schedules from Medicare Conversion Factors

Our AMA urges that uncoupling of commercial fee schedules from Medicare conversion factors should persist until such time as our AMA determines that a new and acceptable formula for computation of the Medicare conversion factors has been implemented. (Res. 137, A-02; Reaffirmed in lieu of Res. 830, I-08; Reaffirmation I-08)

H-400.947 Conscious Sedation

Our AMA urges the Centers for Medicare & Medicaid Services to recognize the increased complexity, liability and responsibility in determining the physician work component of its fee schedule for procedures that are done using moderate sedation/analgesia

("conscious sedation"). (Res. 107, A-01)

H-400.948 Relative Value Unit Change for Critical Care Codes 99291/99292

Our AMA: (1) calls for CMS to immediately restore the physician work relative values for the critical care services to the 1999 levels, with any correction occurring after January 1, 2000 be made retroactive to January 1, 2000; and (2) strongly urges CMS to develop work relative values that are based on the physician work required to perform a service. (Sub. Res. 821, I-99)

H-400.950 Medicare Average Adjusted Per Capita Cost

Our AMA supports: (1) development of a Medicare risk payment methodology that would set payment levels that are fair and equitable across geographic regions; in particular, such methodology should allow for equitable payment rates in those localities with relatively low utilization rates due to cost containment efforts; reaffirms its support for geographic variations in public programs' capitation rates that reflect only demonstrable variations in practice costs and validated variation in utilization as the result of demonstrable differences in health care need; supports reduction in the current wide variation and volatility in Average Adjusted Per Capita Cost (AAPCC) payment rates; and (2) changing the current geographic unit from the county to a broader geographic area, such as a metropolitan statistical area or statewide locality; supports the development of improved risk adjusters with implementation at the Medicare beneficiary level that include demographic factors, health status and other effective predictors of health care use; and calls for adjusting AAPCC-based payment rates after the removal of graduate medical education and disproportionate share hospital payments and the appropriate redistribution of these special payments. (Sub. Res. 120, A-97; Reaffirmed: Res. 222, I-97; Reaffirmed CMS Rep. 2, I-00)

H-400.952 Consolidation of Medicare Fee Schedule Areas

The AMA will continue to petition CMS to improve the accuracy of the Geographic Practice Cost Indices (GPCIs) through the use of accurate practice costs and timely data; and will petition CMS and, if necessary, the Congress to retain as distinct Medicare localities, cities where recent inclusion in state-wide localities by CMS is based on criteria that do not allow for appropriate recognition of the higher costs associated with practice in these areas. (Res. 118, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed in lieu of Res. 921, I-06; Reaffirmation I-07)

H-400.953 Update on the RBRVS

The AMA advocates that future CMS periodic reviews address all three components of the RBRVS: the physician work component, the practice expense component, and the professional liability insurance component. (BOT Rep. 11, A-96; Reaffirmed: CMS Rep. 8, A-06)

H-400.955 Establishing Capitation Rates

(1) Our AMA believes Geographic variations in capitation rates from public programs (e.g., Medicare or Medicaid) should reflect only demonstrable variations in practice costs and correctly validated variations in utilization that reflect legitimate and demonstrable differences in health care need. In particular, areas that have relatively low utilization rates due to cost containment efforts should not be penalized with unrealistically low reimbursement rates. In addition, these payments should be adjusted at the individual level with improved risk adjustors that include demographic factors, health status, and other useful and cost-effective predictors of health care use.

(2) Our AMA will work to assure that any current or proposed Medicare or Medicaid (including waivers) capitated payments should be set at levels that would establish and maintain access to quality care.

(3) Our AMA seeks modifications as appropriate to the regulations and/or statues affecting Medicare HMOs and other Medicare managed care arrangements to incorporate the revised Patient Protection Act and to ensure equal access to Medicare managed care contracts for physician-sponsored managed care organizations.

(4) Our AMA supports development of a Medicare risk payment methodology that would set payment levels that are fair and equitable across geographic regions; in particular, such methodology should allow for equitable payment rates in those localities with relatively low utilization rates due to cost containment efforts. (CMS Rep. 3, A-95; CMS Rep. 7, I-95; Modified and Reaffirmed: Sub. Res. 120, A-97; Reaffirmation A-99; Reaffirmed: CMS Rep. 4, I-99; Reaffirmation A-00; Reaffirmation A-05)

H-400.956 RBRVS Development

(1) That the AMA strongly advocate CMS adoption and implementation of all the RUC's recommendations for the five-year review; (2) That the AMA closely monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful

opportunities to participate, and that any implementation plans are consistent with AMA policies;
(3) That the AMA work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work;
(4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and
(5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians. (BOT Rep. 16, A-95; BOT Rep. 11, A-96; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08)

H-400.957 Medicare Reimbursement of Office-Based Procedures

Our AMA will: (1) encourage CMS to expand the extent and amount of reimbursement for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective; (2) seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures; and (3) work with CMS to develop consistent regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery. (Sub. Res. 103, I-93; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-04; Reaffirmation I-04)

H-400.959 Refining and Updating the Physician Work Component of the RBRVS

The AMA: (1) supports the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee's (RUC's) work with the American Academy of Pediatrics and other specialty societies to develop pediatric-specific CPT codes and physician work relative value units to incorporate children's services into the RBRVS; (2) supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies and for assisting CMS in a more comprehensive review and refinement of the work component of the RBRVS; and (3) continues to object to use of the relative values as a mechanism to preserve budget neutrality. (BOT Rep. I-93-26; Reaffirmed by BOT Rep. 8 - I-94; Res. 806, I-94; Reaffirmed: Sub. Res. 816, I-99; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08)

H-400.960 Harnessing Market Forces in Medical Pricing

Our AMA: (1) continues its non-endorsement of the Medicare RBRVS-based physician payment system until such time as it is adequately corrected and refined and will continue to pursue all efforts to correct the problems with this system identified in Policies 400.965 and 400.972, especially as they affect primary care services;

(2) calls for CMS to conduct a study and collect cost data necessary for development of a methodologically sound resource-based approach to practice expenses for the Medicare RBRVS, with all deliberate speed. In addition, the AMA advocates that CMS be given the authority to immediately correct identified anomalies in the current RBRVS practice expense relative value units. All applications of these methods should refrain from reductions in payments for services without complementary increases in services that this method identifies as "undervalued";

(3) advocates the following additional principles for physician payment under Health Access America and any other relevant health system reform proposal:
(a) An RBRVS that is annually updated and rigorously validated could be a basis for non-Medicare physician fee and payment schedules. This policy pertains to the RBRVS relative values only. It does not apply to Medicare's conversion factor, balance billing limits, GPCIs, and inappropriate payment policies. In addition, the AMA will continue to seek the reversal of the 2.8% across-the-board "budget neutrality" reduction in the 1993 Medicare RBRVS relative value units (RVUs), with all RVUs restored to the levels that would have been in effect without this reduction. The AMA will vigorously oppose any such future reductions in the Medicare RBRVS relative values.
(b) There should be two or more affordable fee-for-service plans offered on an annual basis by each employer or "health alliance." Each health alliance should be required to make a good faith effort, to ensure that there are at least two such plans. In all but the most extreme circumstances, which do not include the level of the plan premium, each alliance must have at least one fee-for-service plan.
(c) There should be advance disclosure of physician and all other provider fees and charges and plan payments. With RBRVS payment, physicians and payers would set or contract for conversion factors.
(d) Physician fees should not be regulated by governments or health alliances. (Reaffirmed: Sub. Res. 132, A-94)
(e) There should be no annual regulated budgets for fee-for-service plans. If such budgets are required, fees outside of plan allowances should not be subject to the budgets; patients should be free to make such unsubsidized payments;

(4) will provide assistance and guidance to state medical associations, national medical specialty societies, physician practices, and public and private third party payers to help ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods; and

(5) supports the position that the RBRVS should not be implemented by private payers as a cost containment device; savings from

payment reductions should be used for the purpose of increasing payments for undervalued services. (BOT Rep. UU, A-93; Reaffirmed: BOT Rep. 3, I-937; Reaffirmed: Res. 101, I-93: BOT Rep. 25, A-94; Reaffirmed: CMS Rep. 11, A-94; Reaffirmed by Sub. Res. 802, A-96; Reaffirmed: CMS Rep. 12, A-99; Reaffirmed: CMS Rep. 2, I-00)

H-400.962 The AMA/Specialty Society RVS Update Process

Our AMA will strengthen its efforts to secure CMS adoption of the AMA/Specialty Society RVS Update Committee's (RUC) recommendations. (BOT Rep. N, A-93; Reaffirmed: Sub. Res. 821, I-99; Reaffirmed: BOT Rep. 14, A-08)

H-400.965 Accuracy of RBRVS Conversion Factor Update Process

(1) The AMA will review the calculations, assumptions and methods used by CMS to determine the conversion factor update and Medicare Volume Performance Standards (MVPS) to assure they appropriately account for increases in the Medicare eligible population as well as the increasing number of very elderly beneficiaries. (2) The AMA will take all appropriate steps to assure the overall integrity and accuracy of the calculations used in the conversion factor update process, including the MVPS. (3) The AMA will pursue legislation to implement a Medicare conversion factor update system similar to the Physician Payment Review Commission's Sustainable Growth Rate system as a positive alternative to the current system based on Volume Performance Standards (MVPS) that preserves the purchasing power of Medicare payments to physicians which acknowledges the presence of inflation in our economic system. (Res. 115, I-92; Modified by BOT Rep. 5, A-97; Reaffirmed: Res. 127, A-99)

H-400.966 Medicare Payment Schedule Conversion Factor

(1) The AMA will aggressively promote the compilation of accurate data on all components of physician practice costs and the changes in such costs over time, as the basis for informed and effective advocacy with Congress and the Administration concerning physician payment under Medicare. (2) The AMA will work aggressively with CMS, the Bureau of Labor Statistics, and other appropriate federal agencies to improve the accuracy of such indices of market activity as the Medicare Economic Index and the medical component of the Consumer Price Index. (CMS Rep. B, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 6, I-08)

H-400.967 Medicare Physician Payment Reform

The AMA affirms that the concept of the RBRVS physician work component continues to be an appropriate part of a resource-based relative value system. (BOT Rep. DD, I-92; Modified: CMS Rep. 10, A-03)

H-400.969 RVS Updating

Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; and (3) encourages CMS to rely upon this process as it considers new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues. (BOT Rep. O, I-92; Reaffirmed by BOT Rep. 8 - I-94; Reaffirmed by BOT Rep. 7, A-98; Reaffirmed: CMS Rep.12, A-99; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08)

H-400.972 Physician Payment Reform

It is the policy of the AMA to (1) take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to, (a) reduction of allowances for new physicians; (b) the non-payment of EKG interpretations; (c) defects in the Geographic Practice Cost Indices and area designations; (d) inappropriate Resource-Based Relative Value Units; (e) the deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system; (f) the need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality; (g) the inadequacy of payment for services of assistant surgeons; and (h) the loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);

(2) seek an evaluation of (a) stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments; and (b) descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients;

(3) evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that

the concept for the work component continues to be an appropriate part of a resource-based relative value system;

(4) seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors;

(5) seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures;

(6) seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992;

(7) seek the elimination of regulations directing patients to points of service;

(8) support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change;

(9) take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs;

(10) support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes;

(11) request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations;

(12) pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index;

(13) continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform; and

(14) take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements. (Sub. Res. 109, A-92; Reaffirmed: I-92; Reaffirmed by CMS Rep. 8, A-95 and Sub. Res. 124, A-95; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reaffirmation A-02; Reaffirmation A-06; Reaffirmation I-07; Reaffirmed: BOT Rep. 14, A-08)

H-400.973 Limited Licensed Practitioners and RBRVS

It is the policy of the AMA to: (1) take immediate action to demonstrate that services provided by fully licensed practitioners are indeed substantially different from identically coded services provided by limited licensed practitioners because the training required for a full license brings a broad range of experience and insight to a service that a limited licensed practitioner lacks by definition; (2) advocate development and use of a code modifier to identify Medicare services provided by limited licensed practitioners; and (3) advocate that Medicare expenditure data clearly differentiate between the services of fully licensed physicians and those of limited licensed practitioners and of other Part B services/ (Sub. Res. 124, I-91; Reaffirmed: BOT Rep. DD, I-92; Modified: CMS Rep. 10, A-03)

H-400.980 Behavioral Adjustments on Physician Payments

It is the policy of the AMA to do whatever it deems necessary to make certain that the RBRVS fee schedule does not include behavioral adjustments. (Res. 169, I-90; Reaffirmed: BOT Rep. 7, A-98; Reaffirmed: Sub. Res. 821, I-99)

H-400.981 Malpractice Costs in the Medicare Fee Schedule

It is the policy of the AMA: (1) to review the recommendations for incorporating malpractice costs in Relative Value Units in order to correct inequities in such a system so that physicians will be reimbursed for current costs in a fair and equitable manner under the Medicare Physician Payment System; and (2) to pursue legislative, regulatory and all other relevant means to effect such change. (Sub. Res. 170, I-90; Reaffirmed: Sunset Report, I-00)

H-400.984 Geographic Practice Costs

Our AMA will work to ensure that the most current, valid and reliable data are collected and applied in calculating accurate geographic practice cost indices (GPCIs) and in determining geographic payment areas for use in the new Medicare physician payment system, with data collected from rural practice sites for this purpose. (Sub. Res. 25, A-90; Modified: Sunset Report, I-00)

H-400.987 Medicare Geographic Payment Variations

Our AMA reaffirms its policies that: (1) geographic payment variations under a Medicare physician payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially professional liability insurance premiums, with further adjustments as appropriate to remedy demonstrable patient access problems in specific geographic areas; and (2) differences in Medicare DRG-based payments to different categories of hospitals should be based only on true differences in the costs of providing services by these hospitals, rather than on arbitrary geographic criteria. (BOT Rep. R, I-89; Reaffirmed: Sunset Report, A-00)

H-400.988 Medicare Reimbursement, Geographical Differences

The AMA reaffirms its policy that geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with further adjustments as needed to remedy demonstrable access problems in specific geographic areas. (Sub. Res. 82, A-89; Reaffirmed: BOT Rep. DD, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-06; Reaffirmation I-07; Reaffirmation A-08)

H-400.989 Physician Negotiations

The AMA supports federal legislation that would allow the AMA and state medical associations, on behalf of physicians, to negotiate payment schedules on federal and state policies, respectively, impacting on physician reimbursement. (Res. 223, A-89; Reaffirmed: BOT Rep. DD, I-92; Reaffirmed: Sub. Res. 110, A-94; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmation A-06)

H-400.990 Refinement of Medicare Physician Payment System

The AMA: (1) reaffirms its support for development and implementation of a Medicare indemnity payment schedule according to the policies established in Policy 400.991; (2) supports reasonable attempts to remedy geographic Medicare physician payment inequities that do not substantially interfere with the AMA's support for an RBRVS-based indemnity payment system; (3) supports continued efforts to ensure that implementation of an RBRVS-based Medicare payment schedule occurs upon the expansion, correction, and refinement of the Harvard RBRVS study and data as called for in Board Report AA (I-88), and upon AMA review and approval of the relevant proposed enabling legislation; and (4) continues to oppose any effort to link the acceptance of an RBRVS with any proposal that is counter to AMA policy, such as expenditure targets or mandatory assignment. (BOT Rep. BBB, A-89; Reaffirmed: I-92; Reaffirmed and Modified: CMS Rep. 10, A-03)

H-400.991 Guidelines for the Resource-Based Relative Value Scale

(1) The AMA reaffirms its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using: (a) an appropriate RVS based on the resource costs of providing physician services; (b) an appropriate monetary conversion factor; and (c) an appropriate set of conversion factor multipliers.

(2) The AMA supports the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected and refined, would provide an acceptable basis for a Medicare indemnity payment system.

(3) The AMA reaffirms its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing. (Reaffirmed: Sub. Res. 132, A-94)

(4) The AMA reaffirms its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits.

(5) The AMA promotes enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system.

(6) The AMA supports expanding its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries.

(7) The AMA reaffirms its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other

practice costs.

(8) The AMA believes that payment localities should be determined based on principles of reasonableness, flexibility and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan and nonmetropolitan areas within states) based on the availability of high quality data.

(9) The AMA believes that, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented.

(10) Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to: (a) partial completion of a residency plus time in practice; (b) local peer recognition; and (c) carrier analysis of practice patterns. A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years.

(11) The AMA strongly opposes any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings.

(12) The AMA believes that whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies. (BOT Rep. AA, I-88; Reaffirmed: I-92; Reaffirmed and Modified: CMS Rep. 10, A-03; Reaffirmation A-06)

H-400.994 Payment for Physician Services Under Medicare

The AMA supports the position that payment for physician services under the Medicare program should include an indemnity system based on a defined schedule of allowances that would (1) be based on a realistic resource cost relative value scale; (2) allow appropriate regional differences in allowances to reflect differences in the costs of practice; and (3) indemnify patients for covered services, maintaining the rights of physicians and patients to enter into individual contracts wherein physicians establish their own fees and agree or do not agree to accept amounts identified by the schedule of allowances as payment in full. (Res. 71, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: CMS Rep. 7, A-05)

H-400.996 Physician Reimbursement Under Medicare

(1) A new RVS, developed with the active and substantive involvement of organized medicine, could provide a basis for a physician reimbursement mechanism that would enable the federal government to improve the predictability and efficiency of Medicare Part B expenditures on physicians' services, while at the same time imposing minimal disruptions in the care that Medicare beneficiaries receive. (2) The AMA emphasizes that any payment system based on a new RVS must take into account the often substantial variations in practice costs from one geographic area to another. Of even greater importance is the principle of physician freedom to collect the difference between a third party payment and the actual charge to the patient, when and if warranted. The AMA would strongly oppose any attempt to use a newly developed physician reimbursement system that mandated acceptance of the third party payment as payment in full. (BOT Rep. ZZ, A-85; Reaffirmed: I-92; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: CMS Rep. 7, A-05)

H-400.999 Cognitive Services Reimbursement

Our AMA supports the concept that third party payers should provide more equitable reimbursement for physicians' services which are solely cognitive in comparison with their procedural services. (Sub. Res. 76, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmation I-04)

H-405.000 Physicians
(See also: Disabled; Licensing and Discipline; Medical Education; Medical Societies; Peer Review; Professional Liability; Women)

H-405.962 The Practice of Public Health by Physicians

Our AMA: (1) recognizes the practice of public health by physicians as the practice of medicine; (2) opposes specialty-specific license restrictions for American Board of Medical Specialties (ABMS)-recognized specialties; and (3) encourages the ABMS and the Federation of State Medical Boards to adopt similar policies recognizing the practice of public health by physicians as a legitimate practice of medicine and opposing specialty-specific license restrictions for ABMS-recognized specialties. (Res. 815, I-06)

H-405.963 Political Diploma Mills

Our AMA policy is that it is inappropriate for physicians to participate in physician award processes which involve political contributions as a quid pro quo. (Res. 5, A-05)

H-405.964 Truth in Advertising

AMA policy is that any published lists of "Best Physicians" should include a full disclosure of the selection criteria, including direct or indirect financial arrangements. (Sub. Res. 9, A-02)

H-405.965 Essentials for Approval of Examining Boards in Medical Specialties

The AMA endorses the eleventh revision of the Essentials for the Approval of Examining Boards in Medical Specialties (as presented in CME Report 5, A-00). (CME Rep. 5, A-00)

H-405.966 Resident Physician Licenses

The AMA supports the option of limited educational licenses in all states for resident physicians to provide care within their residency programs; and supports reduced licensure fees for resident physicians for participation solely in graduate medical education training programs when full medical licensure is required by a state. (Sub. Res. 312, A-96; Reaffirmed: CME Rep. 2, A-06)

H-405.967 Truth in Corporate Advertising: Using Professional Degrees in Advertising Listings

The AMA opposes US West Yellow Pages or any other corporation which misrepresents physicians by failing to list their professional degrees in the corporation's advertising directory. (Sub. Res. 4, I-95; Reaffirmed with change in title: CLRPD Rep. 1, A-05)

H-405.968 Clarification of the Term "Provider" in Advertising, Contracts and Other Communications

Our AMA supports requiring that health care entities, when using the term "provider" in contracts, advertising and other communications, specify the type of provider being referred to by using the provider's recognized title which details education, training, license status and other recognized qualifications; and supports this concept in state and federal health system reform. (Sub. Res. 712, I-94; Reaffirmed: Res. 226, I-98; Reaffirmation I-99)

H-405.969 Definition of a Physician

The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.

AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor", and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree. (CME Rep. 4-A-94; Reaffirmed by Sub. Res. 712, I-94; Reaffirmed and Modified: CME Rep. 2, A-04; Res. 846, I-08)

H-405.970 Specialty Board Certification Fee Requirements

The AMA strongly encourages member boards of the American Board of Medical Specialties to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms. (Res. 303, A-93; Reaffirmed: CME Rep. 2, A-03)

H-405.971 Use of Physician Time on Computerized Information Systems

(1) The AMA supports the need for cooperation among all sectors of the health care industry to design, carry out, and analyze the results of scientifically rigorous studies to measure the benefits (in effectiveness and quality of care, and in efficiency and costs of its provision) and the costs (in time use, behavioral, and organizational change, as well as in monetary costs) of physician use of computers in all health care settings. (2) The AMA urges health care facilities designing, selecting, and/or implementing clinical information systems for physician use to: (a) establish an oversight committee of clinically respected physicians who can act as internal advocates, provide input into all phases of system design and selection, and can make and enforce necessary decisions; (b) select technologies for data entry and retrieval that are easily and rapidly mastered and are acceptable to the physician users; and (c) design and/or select systems that are flexible and provide users with multiple options for display formats and navigation paths that can be stored and rapidly retrieved by individual users. (3) The AMA will instruct representatives to interprofessional groups working on

computerized medical records to work vigorously for design features that reduce the physician time requirements for information entry, data retrieval and display, and to make appropriate reports to the House on progress in that direction. (BOT Rep. R, A-93; Reaffirmed: CSA Rep. 8, A-03)

H-405.972 Recertification Alternatives

Our AMA continues to support the development and validation of alternatives to recertification by standardized testing. (Res. 317, I-92; Reaffirmed: Res. 306, I-97; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07)

H-405.973 Board Certification

It is the policy of the AMA (1) to continue to work with other medical organizations to educate the profession and the public about the board certification process; and (2) that, when the occasion arises that equivalency of board certification must be determined, the Essentials for Approval of Examining Boards in Medical Specialties be utilized for that determination. (CME Rep. D, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 7, A-07)

H-405.974 Specialty Recertification Examinations

Our AMA (1) encourages the American Board of Medical Specialties and its member boards to continue efforts to improve the validity and reliability of procedures for the evaluation of candidates for certification; and (2) believes that the holder of a certificate without time limits should not be required to seek recertification. (CME Rep. E, A-92; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07)

H-405.975 Recertification Exam for the American Board of Medical Specialties

Our AMA actively encourages those specialty boards that issue time limited certificates to include young physicians with such certificates in the decision-making process for any design of plans for recertification. (Res. 303, A-92; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 7, A-07)

H-405.976 Definition of a Physician

The AMA urges all physicians to insist on being identified as a physician and to sign only those professional or medical documents identifying them as physicians. The AMA will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as health care providers. The AMA supports seeking immediate modification of the social security laws to change the definition of a physician to conform with AMA policy. The AMA will seek legislation prohibiting the use of the term "physician" as a descriptor other than in the context of a medical doctor (MD) or doctor of osteopathy (DO). (Res. 243, A-91; Reaffirmed BOT Rep. I-93-25; Reaffirmed Sub. Res. 712, I-94; Res. 241, A-97; Reaffirmed in lieu of Res. 615, A-05)

H-405.978 Physicians with Communicable Diseases

Our AMA supports the development of general and specific recommendations relating to provision of patient care by physicians infected with communicable diseases of all types. (Res. 222, A-91; Reaffirmed: Sunset Report, I-01)

H-405.980 Caller Identification

Our AMA, based on the concerns of protecting physicians' privacy, supports efforts to allow individuals to block caller identification at no cost to the caller. (Sub. Res. 225, A-91; Reaffirmed: Sunset Report, I-01)

H-405.981 Professional Autonomy

It is the policy of the AMA to study avenues for strengthening self-regulatory and disciplinary activities of the AMA and state and county medical societies regarding the practice of medicine. (Res. 21, I-90; Reaffirmed: Sunset Report, I-00)

H-405.982 Medical Informatics - Policy Initiatives for the AMA

It is the policy of the AMA to (1) develop appropriate strategies to foster the identification and continuing development of activities designed to make the computer a useful tool for creating a more efficient work environment for the physician, while at the same time improving patient care; and (2) participate as appropriate in major, national initiatives associated with medical applications of computers, particularly in the areas of quality assurance, physician education, computer stored medical records, biomedical terminology, component and systems standardization, patient care, and office management. (Joint CSA/CLRPD Rep., A-90; Reaffirmed: BOT Rep. R, A-93; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: Sub. Res. 101, A-08)

H-405.983 American Board of Medical Specialties - Yellow Pages Listings

Our AMA urges the ABMS to abandon the entrepreneurial endeavor of placing display advertisements in the major Yellow Pages telephone directories where board certified specialists are located, and insists that truth in advertising demands that the ABMS state to all callers that their display listings may not represent a complete listing of all board certified specialists. (Res. 187, I-89; Reaffirmed: Sunset Report, A-00)

H-405.984 Physician and Public Attitudes on Medicine as a Career

Our AMA (1) supports continuation of its many efforts to address issues, such as professional liability and excessive regulation and interference by third parties, which contribute to the professional dissatisfaction expressed by some physicians;

(2) supports continuation of its efforts to communicate to students, from elementary through college level, the rewards of a career in medicine, emphasizing the positive aspects of a career in medicine;

(3) supports utilizing the Association's communications resources to make the 40 percent of the physician population who are dissatisfied with medicine as a career aware of the impact they are having on the career decisions of potential medical students and the implications that this has for the future of medicine; and

(4) encourages the majority of physicians who feel positive about their career, and who understand that the profession is both challenging and rewarding, to aggressively convey, on a personal basis, their thoughts on the attributes of medicine as a career to students, the media, and other interested parties. (CLRPD Rep. D, I-89; Reaffirmed: Sunset Report, A-00)

H-405.985 Truthful Specialty Information

Our AMA: (1) reaffirms its policy that: (a) individual character, training, competence, experience and judgment be the criteria for granting privileges in hospitals; (b) physicians representing several specialties can and should be permitted to perform the same procedures if they meet these criteria; (c) a physician who acquires new skills as a result of additional education or training should be given individual evaluation and the same consideration as a new physician applying for privileges; and (2) believes that advertising by physicians should comply with ethical opinion 5.02 of the Council of Ethical and Judicial Affairs. (Sub. Res. 11, I-89; Reaffirmed: Sunset Report, A-00)

H-405.987 Identification of Board Certified Physicians

Our AMA urges physicians to identify themselves by stating the full name of their certifying board. (Res. 99, A-89; Reaffirmed: Sunset Report, A-00)

H-405.989 Physicians and Surgeons

(1) It is AMA policy to refer only to Doctors of Medicine (MDs) and Doctors of Osteopathy (DOs) as "physicians and surgeons." (2) The AMA supports working to ensure that federal and state regulations and hospital medical staff bylaws comply with this designation. (Res. 78, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed in lieu of Res. 615, A-05; Reaffirmed: Res. 809, I-05)

H-405.990 Physician Managers

The AMA advocates (1) compiling and making available to interested medical students, residents, and practicing physicians information on management career opportunities and educational programs; (2) liaison activities with recognized national organizations that represent the interests of physician managers, and (3) continued efforts to collect and disseminate relevant and useful data pertaining to physician managers. (CLRPD Rep. A, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)

H-405.991 Volunteerism and Community Service

The AMA supports continued promotion of community service and volunteerism by its membership. (Sub. Res. 129, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-405.992 "Doctor" as a Title

The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title "Doctor," which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ. (Res. 138, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)

H-405.993 Median Physician Income

The AMA encourages all who prepare reports on physician income to include not simply "mean" (average) data, but also "median" data and quartile distributions, which are far more representative of actual physician income profiles and are better reflections of medical care costs. (Res. 80, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-405.994 Exemption of Physicians from Jury Service

Our AMA favors modification of federal and state laws so as to facilitate jury service for physicians, without jeopardizing patient care. (Sub. Res. 13, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: Res. 201, I-00)

H-405.995 Administration and Supervision of Rehabilitation Units

The AMA believes that (1) third party coverage for the administration and supervision of patient rehabilitation in the office, hospital, and free-standing units should continue to be determined by physician competence based on training and experience, and should not be denied on the basis of specialty certification; and (2) the determination of criteria for qualification in the administration and supervision of rehabilitation units should be based on competence gained by training and experience, and should not be arbitrarily restricted by specialty designation. (Res. 44, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

H-405.996 Voluntary Service by Physicians

Our AMA does not believe it would be appropriate to establish a separate committee to serve as a clearinghouse for service opportunities and to promote voluntary service, but encourages state association awards for exceptional voluntary community service and wider recognition of physicians who perform voluntary services. (BOT Rep. W, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-405.997 Physician-Patient Relationship

Our AMA: (1) believes the terms "physician" and "patient" should be used rather than vendor, provider, recipient or consumer in order to maintain optimum physician-patient relationships and will do so in its medical publications; and (2) encourages third parties, including the U.S. Department of Health and Human Services and federal and state legislative bodies, to use the terms "physician" and "patient" where appropriate in actions, statements and reports. (Res. 9, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sub. Res. 102, I-94; Reaffirmation I-99; Reaffirmation A-02; Reaffirmation A-07)

H-405.998 Opposition to the Concept of Withholding Medical Services

Our AMA reaffirms the tradition of the medical profession of not withholding medical services or performing any act that will interfere with the public welfare as a bargaining mechanism. (Res. 86, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-405.999 Physicians in Public Affairs

(1) The AMA encourages its members to take a greater interest in public affairs. (2) The AMA urges its individual members, as private citizens, to take a more active part in the local, state and national government endeavoring to select qualified candidates for office, regardless of party affiliation of such candidates, and urges individual members of the Association to work toward the creation of policies which preserve representative government, free enterprise, fiscal solvency and the integrity of the dollar. (3) The AMA encourages its component medical societies to further this program on the local level. (Res. 3, A-60; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-406.000 Physician-Specific Health Care Data

H-406.992 The AMA's Medical Practice Survey Research Program

Our AMA: (1) continues to be the world's leader in obtaining, synthesizing and disseminating information on medical practice to physicians by continually evaluating and considering enhancements to its Socioeconomic Monitoring System data collection program;
(2) continues to monitor and study the impact of changes in the socioeconomic environment on physicians and medical practices;
(3) continues to pursue proactive news management to mitigate negative press treatment of physician income data;
(4) considers studying the impact of changes in the socioeconomic environment on women, minorities, and physicians in settings not currently covered by the Socioeconomic Monitoring System survey; and
(5) will survey separate family practice from general practice physician data. (BOT Rep. 4, I-99)

H-406.993 Development and Use of Physician Profiles

The AMA: (1) urges state medical associations, national medical specialty societies, hospital medical staff, and individual physicians to seek active involvement in the development, implementation, and evaluation of physician profiling initiatives; (2) encourages research to develop improved data sources, methods, and feedback approaches to physician profiling initiatives; (3) opposes the use of profiling procedures that do not meet AMA principles for the credentialing or termination of physicians by managed care plans; (4) opposes physician profiling data being used for economic credentialing purposes; (5) believes that any disclosure or release of physician profiles shall follow strict conformance to AMA policy on the use and release of physician-specific health care data (Policy 406.996); and (6) will monitor the use of profiling procedures related to physician profiling. (CMS Rep. J, A-93; Res. 808, A-95; CMS Rep. 10, A-96; Reaffirmation A-05)

H-406.994 Principles of Physician Profiling

Our AMA advocates that managed care organizations, third party payers, government entities, and others that develop physician profiles adhere to the following principles: (1) The active involvement of physician organizations and practicing physicians in all aspects of physician profiling shall be essential.

(2) The methods for collecting and analyzing data and developing physician profiles shall be disclosed to relevant physician organizations and physicians under review.

(3) Valid data collection and profiling methodologies, including establishment of a statistically significant sample size, shall be developed.

(4) The limitations of the data sources used to develop physician profiles shall be clearly identified and acknowledged.

(5) Physician profiles shall be based on valid, accurate, and objective data and used primarily for educational purposes.

(6) To the greatest extent possible, physician profiling initiatives shall use standards-based norms derived from widely accepted, physician-developed practice parameters.

(7) Physician profiles and any other information that have been compiled related to physician performance shall be shared with physicians under review.

(8) Comparisons among physician profiles shall adjust for patient case-mix, control for physician specialty, and distinguish between the ordering or referring physician and the physician providing the service or procedure.

(9) Effective safeguards to protect against the unauthorized use or disclosure of physician profiles shall be developed.

(10) The quality and accuracy of physician profiles, data sources, and methodologies shall be evaluated regularly. (CMS Rep. J, A-93; CMS Rep. 10, A-96; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation A-05; Reaffirmed in lieu of Res. 724, A-05)

H-406.995 Research Related to the Collection, Use and Release of Physician-Specific Health Care Data

The AMA (1) encourages the collection of accurate information on the impact of the release of physician-specific health care data on the access to, quality of, and cost of health care services; (2) encourages research to develop improved approaches to collect, evaluate and disseminate health care data. (BOT Rep. Q, I-92; BOT Rep. P, A-91; CMS Rep. 10, A-96; Reaffirmed: CMS Rep. 8, A-06)

H-406.996 Use and Release of Physician-Specific Health Care Data

(1) Our AMA advocates that third party payers, government entities and others that use and release physician-specific health care data adhere to the following principles: (a) Physicians under review and relevant physician organizations shall be provided with an adequate opportunity to review and respond to proposed physician-specific health care data interpretations and disclosures prior to their publication or release. (b) Effective safeguards to protect against the dissemination of inconsistent, incomplete, invalid, inaccurate or subjective physician-specific health care data shall be established. (c) Reliable administrative, technical, and physical safeguards to prevent the unauthorized use or disclosure of physician-specific health care data shall be developed. (d) Such safeguards shall treat all underlying physician-specific health care data and all analyses, proceedings, records, and minutes from quality review activities on physician-specific health care data as confidential, and provide that none of these documents shall be subject to discovery, or admitted into evidence in any judicial or administrative proceeding.

(2) Our AMA supports release of severity-adjusted physician-specific health care data from carefully selected pilot projects where the data may be deemed accurate, reliable, and meaningful to physicians, consumers, and purchaser;

(3) Our AMA urges that any published physician-specific health care data be limited to appropriate data concerning the quality of health care, access to health care, and the cost of health care;

(4) Our AMA opposes the publication of physician-specific health care data collected outside of carefully selected pilot studies or where the data are not deemed accurate, reliable, or meaningful;

(5) Our AMA urges that a copy of the information in any such profile be forwarded to the subject physician, and that the physician be given the right to review and certify adequacy of the information prior to any profile being distributed, including being placed on the Internet; and

(6) Our AMA urges that the costs associated with creation of any such profiling system should not be paid for by physicians licensure fees. (BOT Rep. Q, I-92; BOT Rep. W, A-92; Reaffirmed: Res. 719, A-93; CMS Rep. 10, A-96; Appended: Res. 316, I-97; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation A-05; Reaffirmed in lieu of Res. 724, A-05)

H-406.997 Collection and Analysis of Physician-Specific Health Care Data

(1) Our AMA advocates that third party payers, government entities, and others that collect and analyze physician-specific health care data adhere to the following principles: (a) The methods for collecting and analyzing physician-specific health care data shall be disclosed to physicians under review and the public. (b) Physician-specific health care data shall be valid, accurate, objective and used primarily for the education of both consumers and physicians. (c) Data elements used in the collection of physician-specific health care data, including severity adjustment factors, shall be determined by advisory committees which include actively practicing, and where relevant, specialty-specific, physicians from the region where the data are being collected. (d) Statistically valid data collection, analysis, and reporting methodologies, including establishment of a statistically significant minimum number of cases, shall be developed and appropriately implemented prior to the release of physician-specific health care data. (e) The quality and accuracy of the physician-specific health care data shall be evaluated by conducting periodic medical record audits.

(2) Our AMA believes that health care coalitions which include physicians as full voting members are an appropriate forum for undertaking health care data collection and analysis activities; in consideration of the potential for misinterpretation, violation of privacy rights, and antitrust concerns, it is recommended that charge or utilization data provided to such entities by government, third party payers, and self-insureds companies be in the form of ranges or averages and not be physician-specific. (BOT Rep. Q, I-92; BOT Rep. Y, I-85; Amended: CLRPD Rep. 2, I-95; CMS Rep. 10, A-96; Reaffirmation A-01; Reaffirmation A-05; Reaffirmed in lieu of Res. 724, A-05)

H-406.998 Role of Physicians and Physician Organizations in Efforts to Collect Physician-Specific Health Care Data

Our AMA: (1) believes that physicians, as patient advocates and possessing unique qualifications in the review and analysis of health care data, must take the initiative in developing data collection systems at the local level which maintain high standards of confidentiality, accuracy and fairness;

(2) urges state medical societies, national medical specialty societies, hospital medical staffs and individual physicians to: (a) participate in health care data collection programs designed to improve the quality of care; (b) be aware of the limitations of health care data; (c) encourage active involvement of physician organizations and practicing physicians in all aspects of health care data collection and interpretation; and (d) develop strategies to assist state agencies and others in improving the collection and interpretation of health data;

(3) urges health data commissions and other entities that collect, evaluate, and disseminate health care data to: (a) facilitate active involvement of physician organizations and practicing physicians in all aspects of the efforts to collect health care data; (b) provide adequate opportunity for physician organizations and practicing physicians to review and respond to proposed data interpretations and disclosures; (c) ensure accuracy of information in the data base; and (d) assure valid interpretation and use of health care data;

(4) encourages relevant physician organizations to develop effective mechanisms to assist physicians in evaluating, using, and responding to physician-specific health care data;

(5) encourages medical societies to use this information for educational purposes and for addressing such areas as utilization variation, quality assessment and appropriate cost containment activities;

(6) encourages medical societies to play an active role in appropriate data collection and dissemination activities at the local level; and

(7) urges state medical societies, hospital medical staffs and physicians to propose, monitor, and seek to influence quality of care and cost containment legislation to comply with AMA principles. (BOT Rep. Y, I-85; Reaffirmed: CLRPD Rep. 2, I-95; BOT Rep. P, A-91; BOT Rep. Q, I-92; CMS Rep. 10, A-96; Reaffirmation A-01; Reaffirmation A-05)

H-406.999 Goal of Health Care Data Collection

The AMA (1) continues to advocate that health care data collected by government and third party payers be used for education of both consumers and providers; and (2) believes that government, third party payers and self-insured companies should make physician-specific utilization information available to medical societies. (BOT Rep. W, A-92; Reaffirmed: Res. 719, A-93; BOT Rep. Y, I-85; Reaffirmed CLRPD Rep. 2, I-95; CMS Rep. 10, A-96; Reaffirmed: CMS Rep. 8, A-06)

H-410.000 Practice Parameters
(See also: Health Care Reform; Quality of Care)

H-410.956 Fairness and Quality in Medical Imaging Interpretation

Our AMA: (1) actively opposes efforts by federal and state legislators, regulatory bodies, private payers, public payers and radiology business management companies to preauthorize, precertify or otherwise restrict the application of advanced imaging services when such services are provided by qualified physicians in accordance with appropriateness guidelines, practice guidelines and technical standards for the imaging modalities utilized, as developed by specialty societies involved with the diagnosis and treatment of such patients; and (2) will actively work to ensure that all physician specialties involved in the care of patients with specific illnesses who need imaging services have equal participation and authority in the development of quality and efficiency measures for imaging services; and (3) will report back to the House of Delegates on an annual basis with details of actions AMA has taken to oppose efforts by private and public payers, radiology benefits managers and others to deny patients' access to appropriate, high quality imaging services provided by qualified physicians regardless of their medical specialty. (Sub. Res. 208, A-08)

H-410.957 Intraoperative Neurophysiologic Monitoring

Our AMA policy is that supervision and interpretation of intraoperative neurophysiologic monitoring constitutes the practice of medicine, which can be delegated to non-physician personnel who are under the direct or online real time supervision of the operating surgeon or another physician trained in, or who has demonstrated competence in, neurophysiologic techniques and is available to interpret the studies and advise the surgeon during the surgical procedures. (Res. 201, A-08)

H-410.958 Interventional Pain Management: Advancing Advocacy to Protect Patients from Treatment by Unqualified Providers

Our AMA: (1) encourages and supports state medical boards and state medical societies in adopting advisory opinions and advancing legislation, respectively, that interventional pain management of patients suffering from chronic pain constitutes the practice of medicine; and (2) will work to ensure that interventional pain management is the practice of medicine and the treatment rendered to patients by qualified MDs and DOs is directed by best evidence. Further, our AMA will collect, synthesize and disseminate information regarding the educational programs in pain management and palliative care offered by nursing programs and medical schools in order to demonstrate adherence to current standards in pain management. (Res. 903, I-07)

H-410.959 Criminalization of Physician Departure from Guidelines and Standards

Our AMA condemns the criminalization of medical decisions and actions by physicians and other health care providers who in loyalty to their patients and who in proper exercise of their clinical judgment depart from established medical care and resource allocation guidelines or standards for appropriate reasons, and seeks and/or supports legislation or rules/regulations at federal and state levels preventing such criminalization. (Res. 718, I-04; Modified: BOT Rep. 28, A-05)

H-410.960 Quality Patient Care Measures

Our AMA encourages all physicians to be open to the development and broader utilization of evidence-based quality improvement guidelines (pathways, parameters) and indicators for measurement of quality practice. (Res. 811, I-02)

H-410.961 Adding a Disclaimer to Clinical Practice Guidelines

Our AMA recommends that all specialty and subspecialty societies the placement of a disclaimer on each clinical practice guideline reaffirming that guidelines are not a substitute for the experience and judgment of a physician and are developed to enhance the physicians' ability to practice evidence-based medicine. (Res. 806, A-02; Reaffirmation A-06)

H-410.962 National Forum for Health Care Quality

Our AMA: (1) advocates that the National Quality Forum (NQF) maintain meaningful roles for its private sector participants and remain focused on its mission related to performance measurement and reporting; (2) will take appropriate action to make certain that the National Technology Transfer and Advancement Act is not used by CMS to empower the NQF to set national health care

standards. (Res. 724, A-00)

H-410.963 Clinical Pathways, Practice Parameters and Guidelines

Our AMA formally rejects the Milliman & Robertson Guidelines as a clinical standard of care. (Res. 822, A-00)

H-410.964 Education Programs for Performance Improvement Activities in Physician Offices

Our AMA, national medical specialty societies, and state medical associations will continue to be involved in the development and establishment of professional standards and performance measurement systems for physicians to use in their practices. (BOT Rep. 14, A-00)

H-410.965 Clinical Practice Guidelines, Performance Measures, and Outcomes Research Activities

(1) Our AMA, through the Practice Parameters Partnership, is to establish an "appeals mechanism" for the Clinical Practice Guidelines Recognition Program that will enable guideline sponsors to obtain a second-level review for guidelines not achieving "AMA.Recognition" upon initial review.

(2) Our AMA continues to work with the Agency for Health Care Policy and Research and the American Association of Health Plans to advance the establishment of the National Guideline Clearinghouse and ensure the integrity of the Clearinghouse clinical practice guideline database.

(3) Our AMA will work with medical specialty societies and others in the development of standards that can be applied to existing or future physician-level, clinical performance measurement systems developed by national medical specialty societies, state or county medical societies, healthcare organizations, or other public or private entities-for demonstrating equivalence with AMAP clinical performance measurement systems.

(4) Our AMA encourages medical specialty societies and others with existing or future physician-level, clinical performance measurement systems to demonstrate equivalence with AMAP standards for clinical performance measurement systems and apply for inclusion as an AMAP-approved clinical performance measurement system.

(5) Our AMA provides the relevant national medical specialty societies the opportunity to review and have input into proposed performance indicators before implementing any pilot-testing of such indicators.

(6) Our AMA continues to work with national medical specialty societies and others in the development of standards for the appropriate collection, analysis, and reporting of valid and reliable physician-specific clinical performance and outcomes data.

(7) Our AMA urges guideline sponsors to support the Clinical Practice Guideline Recognition Program, pending reinstatement, by submitting their guidelines to the AMA for review. (Clinical Practice Guideline Recognition Program Discontinued by BOT Rep. 12, A-00)

(8) Our AMA continues to work with the Agency for Health Care Policy and Research and the American Association of Health Plans to advance the establishment of the National Guideline Clearinghouse.

(9) The newly established Specialty Advisory Committee serves as the primary source of clinical expertise in the development of the Clinical Performance and Patient Care Results components of the American Medical Accreditation Program.

(10) The AMA will work with the newly established Specialty Advisory Committee and Performance Measures Advisory Committee in the development and review of criteria for recognizing physician-level, clinical performance measurement systems for the American Medical Accreditation Program. (BOT Rep. 8, I-97; Appended: BOT Rep. 13, A-98; Reaffirmed: Res. 702, I-98; Modified: BOT Rep. 12, A-00)

H-410.967 Guide to Clinical Preventive Services

The AMA: (1) recommends the USPSTF Guide to Clinical Preventive Services to clinicians and medical educators as one resource for guiding the delivery of clinical preventive services. The Guide should not be construed as AMA policy on screening procedures and should not take the place of clinical judgment and the need for individualizing care with patients; physicians should weigh the utility of individual recommendations within the context of their scope of practice and the situation presented by each clinical encounter; (2) will continue to encourage the adoption of practice guidelines as they are developed based on the best scientific evidence and methodology available; and (3) will continue to promote discussion, collaboration, and consensus among expert groups and medical specialty societies involved in preparation of practice guidelines. (CSA Rep. 1, A-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07)

H-410.969 Payer Use of Practice Parameters

The AMA: (1) advocates that any decision by third party payers requiring physician use of specific practice parameters involve the direct input of actively practicing local physicians and relevant physician organizations prior to any endorsement or use of any required practice parameters; (2) advocates that any decision by third party payers requiring physician use of specific practice parameters include the rationales used to select such practice parameters; (3) advocates that any decision by third party payers to require physician use of specific practice parameters be followed by an evaluation of the impact of implementing such practice parameters; and (4) advocates that third party payers be assigned liability arising from requiring participating physicians to adhere to a specific set of practice parameters. (Consolidated by CMS Rep. 8, I-96; Reaffirmation I-98; Reaffirmed: CMS Rep. 4, A-08)

H-410.970 Use of Practice Parameters

Our AMA: (1) urges organizations that have developed practice parameters to recognize that practice parameters are educational tools, not mechanisms to determine reimbursement or credentialing, to assist physicians in clinical decision making and are not replacements for clinical decision making. Physicians must retain autonomy to vary from practice parameters without retribution in order to provide the quality of care that meets the individual needs of their patients; (2) encourages physicians to be cost conscious and to exercise discretion, consistent with good medical care, when implementing practice parameters; and (3) encourages physician organizations developing practice parameters to include appropriate explanatory disclaimers to ensure that practice parameters are used in a manner that is consistent with AMA policy. (Consolidated by CMS Rep. 8, I-96; Reaffirmation I-98; Reaffirmed: Res. 820, A-00; Reaffirmation A-06)

H-410.971 Clinical Algorithm Impact on Patient Care

The AMA has established the following policy that incorporates provisions regarding the use and development of clinical algorithms, which may include the following: (1) Clinical algorithms are guidelines established to aid a physician in the diagnosis and treatment of patients. As such, they should be used by the physicians as guidelines, but recognizing that each patient is an individual and has unique needs and problems, the physician should use his or her best judgment in the use of the guidelines and should never be forced to specifically follow these guidelines rigidly. (2) Clinical algorithms should include suggested tests and procedures to arrive at a correct diagnosis in the most direct and expeditious manner. These guidelines should suggest criteria as to when referrals to the correct specialist/subspecialist are appropriate and in the best interest of the patient. (3) The treating physicians should always have the option of ordering the suggested tests, procedures and referrals at their discretion, and may opt to make these choices earlier or later than is suggested, and is not mandated to make any of these choices, depending on their clinical assessment of the patient and their needs. (4) When the algorithms are created, physicians from the specialty(ies)/subspecialty(ies) who diagnose and treat the condition should participate in their creation. These physicians should be representatives from their official specialty society(ies). (5) The validity of any clinical algorithms should be under constant review and evaluation by the appropriate specialty/subspecialty society(ies). (6) Whenever possible consensus clinical data from peer review journals will be used. (Res. 719, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-410.974 Development of Practice Parameters by Non-Physician Organizations

Practice parameters developed by the federal government, managed care plans, third party payers, utilization review organizations, or other non-physician organizations should be developed and implemented in conjunction with relevant physician organizations. Such non-physician organizations should consult with relevant physician organizations prior to the development and implementation of practice parameters. (Consolidated by CMS Rep. 8, I-96; Reaffirmed: Res. 820, A-00)

H-410.980 Principles for the Implementation of clinical practice guidelines at the Local/State/Regional Level

Our AMA has adopted the following principles regarding the implementation of clinical practice guidelines at the local/state/regional level: (1) Relevant physician organizations and interested physicians shall have an opportunity for input/comment on all issues related to the local/state/regional implementation of clinical practice guidelines, including: issue identification; issue refinement, identification of relevant clinical practice guidelines, evaluation of clinical practice guidelines, selection and modification of clinical practice guidelines, implementation of clinical practice guidelines, evaluation of impact of implementation of clinical practice guidelines, periodic review of clinical practice guideline recommendations, and justifications for departure from clinical practice guidelines..

(2) Effective mechanisms shall be established to ensure opportunity for appropriate input by relevant physician organizations and interested physicians on all issues related to the local/state/regional implementation of clinical practice guidelines, including: effective physician notice prior to implementation, with adequate opportunity for comment; and an adequate phase-in period prior to implementation for educational purposes.

(3) clinical practice guidelines that are selected for implementation at the local/state/regional level shall be limited to practice

parameters that conform to established principles, including relevant AMA policy on practice parameters.

(4) Prioritization of issues for local/state/regional implementation of clinical practice guidelines shall be based on various factors, including: availability of relevant and high quality practice parameter(s), significant variation in practice and/or outcomes, prevalence of disease/illness, quality considerations, resource consumption/cost issues, and professional liability considerations.

(5) clinical practice guidelines shall be used in a manner that is consistent with AMA policy and with their sponsors' explanations of the appropriate uses of their clinical practice guidelines, including their disclaimers to prevent inappropriate use.

(6) clinical practice guidelines shall be adapted at the local/state/regional level, as appropriate, to account for local/state/regional factors, including demographic variations, patient case mix, availability of resources, and relevant scientific and clinical information.

(7) clinical practice guidelines implemented at the local/state/regional level shall acknowledge the ability of physicians to depart from the recommendations in clinical practice guidelines, when appropriate, in the care of individual patients.

(8) The AMA and other relevant physician organizations should develop principles to assist physicians in appropriate documentation of their adherence to, or appropriate departure from, clinical practice guidelines implemented at the local/state/regional level.

(9) clinical practice guidelines, with adequate explanation of their intended purpose(s) and uses other than patient care, shall be widely disseminated to physicians who will be impacted by the clinical practice guidelines.

(10) Information on the impact of clinical practice guidelines at the local/state/regional level shall be collected and reported by appropriate medical organizations. (CMS Rep. D, A-93; Reaffirmed: CMS Rep. 10, A-03)

H-410.986 Resident Involvement in Practice Parameters

Our AMA urges national medical specialty societies to work with resident physicians within their specialty in developing practice parameters. (Res. 52, A-91; Reaffirmed: Sunset Report, I-01)

H-410.987 Practice Parameters - Their Relevance to Physician Credentialing

(1) The terms practice parameters or guidelines should be used to refer to strategies for patient management that are designed to assist physicians in clinical decision-making. The terms should not be used to refer to the criteria for professional training, skills and experience utilized in the granting of general or procedure-specific clinical privileges. (2) The documentation of adherence to, or intent to practice within, relevant practice parameters or guidelines should not be used as an additional criterion for the granting of general or procedure-specific clinical privileges unless and until a relationship between adherence to such practice parameters or guidelines and desired patient outcomes is adequately documented. (3) Practice parameters or guidelines developed by a particular medical specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter or guideline by physicians not formally credentialed in that specialty or specialties. Individual character, training, competence, experience, and judgment should continue to be the criteria for granting general or procedure-specific clinical privileges. (CMS Rep. F, A-91; Reaffirmed: CME Rep. 8, I-93; Reaffirmed and Modified: CSA Rep. 8, A-05)

H-410.995 Participation in the Development of Practice Guidelines by Individuals Experienced in the Care of Minority and Indigent Patients

Our AMA encourages those experienced in the care of poor and minority patients (e.g., minority and public hospital providers and organizations) to participate actively in the development of clinical guidelines, practice parameters, patient management guidelines, medical practice guidelines, etc. (Res. 87, A-90; Reaffirmed: Sunset Report, I-00)

H-410.997 Practice Parameters and Review Criteria

Our AMA believes that variations from medical practice guidelines and parameters are not, except in very limited circumstances, per se indicators of quality or medical necessity problems. Only where a variation involves provision of a service or procedure deemed by the preponderance of medical opinion to be inappropriate in any clinical situation should it be used as a per se indicator for judgments regarding quality or payment denials. Otherwise, variations from the guidelines and parameters should constitute only a signal for further peer-to-peer considerations relative to quality or payment issues. (Consolidated by CMS Rep. 8, I-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06)

H-410.998 Development of Practice Parameters

Our AMA: (1) supports the development by physician organizations of clinically relevant practice parameters designed to assure that patients receive high quality medical care;

(2) believes that practice parameters should be: (a) developed by physician organizations primarily for use by physicians in their day-to-day practice; (b) based on sound research findings and the clinical experience of practicing physicians; (c) based upon substantive input from physicians practicing in the relevant clinical areas representing all appropriate specialties and practice settings; (d) based upon consideration of the various clinical conditions of individual patients; (e) based on quality rather than cost considerations; (f) based on use of reliable sources, methodologies, and processes that are explicitly stated; (g) accompanied by adequate explanatory information on appropriate uses on the practice parameters and sufficient disclaimers to prevent inappropriate use; and (h) made widely available to physicians in a practical and useful format;

(3) supports establishing a process to evaluate practice parameters on an ongoing basis, endorsing those that are developed in conformance with and meet the foregoing AMA principles, and developing practice parameters as needed in clinical areas not otherwise addressed;

(4) supports working with the Federation to assure the dissemination of AMA endorsed practice parameters; and

(5) continues to advocate strongly that all practice parameters/guidelines, including those sponsored by proprietary, government or other non-physician organizations, be developed in conformance with AMA principles. (Consolidated by CMS Rep. 8, I-96; Reaffirmation A-97; Reaffirmation I-99; Reaffirmed: Res. 820, A-00)

H-415.000 Preferred Provider Arrangements
(See also: Health Care Delivery; Health Insurance; Health Maintenance Organizations)

H-415.987 Improper Discounts by Third Party Payers

Our AMA: (1) advocates that medical services agreements between physicians and preferred provider organizations (PPOs) should adhere to the following principles:(a) Discounts shall be extended only to enrollees of PPOs who have cards identifying them as such.(b) All PPO members eligible for discounts shall be subject to mechanisms that will direct patients to the physician's practice.(c) The types of entities that can be added to the network shall be identified in advance, and providers shall receive timely notice when payers or employers are added.(d) All members added to the PPO shall be subject to the same mechanisms to direct patients to the physician's practice.(e) Any discounts applicable to a PPO enrollee shall be disclosed at the time coverage is verified.(f) The sale or other unauthorized use of contract rate information shall be specifically prohibited; (2) encourages physicians to verify carefully that payments received from third party payers only include discounts for the provision of health care services for those patients who are entitled to such discounts; and (3) encourages physicians and physician organizations experiencing the application of improper discounts by third party payers to contact the AMA/State Medical Society Litigation Center. (CMS Rep. 5, I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-00)

H-415.988 Informed Choice for Patients

Our AMA in order to protect patient choice of health care providers, supports state and federal legislation mandating that patients be notified of who will provide their medical care, and be given the choice of who will provide their medical care. (Res. 215, A-98)

H-415.993 AMA Initiatives in Health Delivery Systems

The AMA believes that it is inappropriate for the Association to develop a nationwide health delivery system and that it is also inconsistent with AMA policy for the Association to develop an "IPA Network." (BOT Rep. R, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-415.998 Preferred Provider Organizations

The AMA: (1) opposes federal legislation that would preempt state regulation of PPOs; and (2) encourages state medical associations to support legislation that: (a) insures proper state regulation of PPOs, with particular attention to such practices as arbitrary determinations of medical necessity by carriers, "hold harmless" clauses, and predatory pricing concepts; and (b) requires independent, physician-directed peer review of the services provided by PPOs. (Sub. Res. 16, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: BOT Rep. 29, A-04)

H-415.999 Preferred Provider Organizations

The AMA believes that state and local medical societies should (1) monitor PPOs which develop in their areas and should apprise their members of the status, structure and extent of physician and provider enrollment in any such plans; and (2) consider investigating the pros and cons of the society itself serving as an organizational focus for local physicians' effective and informed responses to PPOs, without compromising support for the existing policy of pluralism in health care delivery systems. (CMS Rep. F, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CMS Rep. 10, A-03)

H-420.000 Pregnancy and Childbirth
(See also: Infants; Children and Youth)

H-420.958 Surgical Sterilization and Family PACT Eligibility

Our AMA supports a change in the Family Planning, Access, Care and Treatment (Family PACT) legislation, and the appropriate funding necessary, such that surgical sterilization shall not be a reason for exclusion from the Family PACT program. (Res. 210, A-08)

H-420.959 Access to Comprehensive Reproductive Health Care

(1) In the case of mergers and/or acquisitions of health care systems, our AMA support action to ensure continued patient access to pregnancy prevention services within the community, including tubal sterilization and vasectomy.

(2) When reproductive services are a covered benefit, our AMA shall seek enforcement of existing law which requires health plans to be responsible to provide access to those services for their enrollees.

(3) Our AMA vigorously opposes the interference by third parties with privileged patient-physician communications, including those concerning reproductive health care.

(4) Our AMA reaffirms its policy that neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. (Sub. Res. 218, A-00)

H-420.960 Effects of Work on Pregnancy

Our AMA: (1) supports the right of employees to work in safe workplaces that do not endanger their reproductive health or that of their unborn children;
(2) supports workplace policies that minimize the risk of excessive exposure to toxins with known reproductive hazards irrespective of gender or age;
(3) encourages physicians to consider the potential benefits and risks of occupational activities and exposures on an individual basis and work with patients and employers to define a healthy working environment for pregnant women;
(4) encourages employers to accommodate women's increased physical requirements during pregnancy; recommended accommodations include varied work positions, adequate rest and meal breaks, access to regular hydration, and minimizing heavy lifting; and
(5) acknowledges that future research done by interdisciplinary study groups composed of obstetricians/gynecologists, occupational medicine specialists, pediatricians, and representatives from industry can best identify adverse reproductive exposures and appropriate accommodations. (CSA Rep. 9, A-99)

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

AMA adopts as policy the following guidelines for, and encourage the implementation of, Maternity and Family Leave for Residency Programs and Employed Medical Staffs:
(1) The AMA urges medical schools, residency training programs, medical specialty boards, and the Accreditation Council for Graduate Medical Education to incorporate and/or encourage development of written leave policies, including parental leave, family leave, and medical leave;
(2) Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave;
(3) Physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons;
(4) Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling;
(5) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in

the workloads of other physicians, particularly those in residency programs;
(6) Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status; and
(7) Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up); because of leave for eligibility for board certification. Residency program directors must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility. (CME Rep. 6, A-98; Reaffirmation I-03)

H-420.962 Perinatal Addiction - Issues in Care and Prevention

The AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education within the context of its "War on Drugs." In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs; (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol abuse during pregnancy and to routinely inquire about alcohol and drug use in the course of providing prenatal care; and (6) will address the special needs of pregnant drug abusers within the context of its ongoing Health Access America programs. (CSA Rep. G, A-92; Reaffirmation A-99)

H-420.964 Fetal Alcohol Syndrome Educational Program

Our AMA supports joining with others to plan and implement an educational campaign to inform physicians about Fetal Alcohol Syndrome and the referral and treatment of alcohol abuse by pregnant women or women at risk of becoming pregnant. (Res. 122, A-91; Reaffirmed: Sunset Report, I-01)

H-420.965 Carrier Screening for Cystic Fibrosis

Our AMA: (1) supports the concept that participation in pilot studies or in any subsequent population screening program be on a voluntary basis, with informed consent for all who wish to be tested; (2) encourages insurance companies and employers not to discriminate against CF carriers; (3) encourages physicians to become more knowledgeable regarding genetic tests such as the one for CF, the interpretation of these tests, and genetic counseling; and (4) encourages physicians to become involved in educating the public about the nature of carrier screening for CF. Community education was an important factor in the successful Tay-Sachs screening program. (CSA Rep. C, A-91; Modified: Sunset Report, I-01)

H-420.966 Parental Leave

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

H-420.967 Maternity Leave Policies

Over the past decade, the medical community has made significant progress in responding to the unique needs of women medical students and physicians, including the issue of maternity leave. The continuation and enhancement of these efforts should be encouraged. Therefore,

(1) The AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of written maternity leave policies as part of the physician's standard benefit agreement.

(2) AMA policy regarding recommended components of maternity leave policies for physicians, as specified in Policy 420.987 is expanded to include physicians in practice, reading as follows: (a) Residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' work loads, particularly in residency programs; and (c) Physicians should be able to return to their practices or training programs after taking maternity leave without the loss of status.

(3) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their maternity leave

policies a six-week minimum leave allowance, with the understanding that no woman should be required to take a minimum leave. (BOT Rep. HH, I-90; Modified: Sunset Report, I-00)

H-420.968 Universal Hepatitis B Virus (HBV) Antigen Screening for Pregnant Women

It is the policy of the AMA to communicate the available guidelines for testing all pregnant women for HBV infection. (Res. 19, I-90; Reaffirmed: Sunset Report, I-00)

H-420.969 Legal Interventions During Pregnancy

Court Ordered Medical Treatments And Legal Penalties For Potentially Harmful Behavior By Pregnant Women: (1) Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances.

(2) The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.

(3) A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus.

(4) Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.

(5) Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.

(6) To minimize the risk of legal action by a pregnant patient or an injured fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendation. (BOT Rep. OO, A-90; Reaffirmed: Sunset Report, I-00)

H-420.970 Treatment Versus Criminalization - Physician Role in Drug Addiction During Pregnancy

It is the policy of the AMA (1) to reconfirm its position that drug addiction is a disease amenable to treatment rather than a criminal activity;

(2) to forewarn the U.S. government and the public at large that there are extremely serious implications of drug addiction during pregnancy and there is a pressing need for adequate maternal drug treatment and family supportive child protective services;

(3) to oppose legislation which criminalizes maternal drug addiction or requires physicians to function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment; and

(4) to provide concentrated lobbying efforts to encourage legislature funding for maternal drug addiction treatment rather than prosecution, and to encourage state and specialty medical societies to do the same. (Res. 131, A-90; Reaffirmed: Sunset Report, I-00)

H-420.971 Infant Victims of Substance Abuse

It is the policy of the AMA: (1) to develop educational programs for physicians to enable them to recognize, evaluate and counsel women of childbearing age about the impact of substance abuse on their children; and (2) to call for more funding for treatment and research of the long-term effects of maternal substance abuse on children. (Res. 101, A-90; Reaffirmation A-99)

H-420.972 Prenatal Services to Prevent Low Birthweight Infants

Our AMA encourages all state medical associations and specialty societies to become involved in the promotion of public and private programs that provide education, outreach services, and funding directed at prenatal services for pregnant women, particularly women at risk for delivering low birthweight infants. (Res. 231, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-07; Reaffirmation I-07)

H-420.973 Adoption

It is the policy of the AMA to (1) support the provision of adoption information as an option to unintended pregnancies; and (2)

support and encourage the counseling of women with unintended pregnancies as to the option of adoption. (Res. 146, A-90; Reaffirmed: Sunset Report, I-00)

H-420.974 Warnings Against Alcohol Use During Pregnancy

Our AMA urges pharmaceutical companies that manufacture over-the-counter pregnancy and ovulation tests and related products to include written or pictorial warnings against alcohol, tobacco and illicit drug use during pregnancy in their package inserts. (Res. 15, I-89; Reaffirmation A-99)

H-420.975 Reduction in Prenatal Care Visits

Our AMA: (1) opposes any recommendation by the National Institutes of Health that women at no apparent risk receive less care than other prenatal patients; and (2) believes current ACOG standards for prenatal care should be observed and any deviations from these standards should be reviewed with ACOG before implementation. (Res. 91, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-07)

H-420.976 Alcohol and Other Substance Abuse During Pregnancy

Our AMA: (1) supports ongoing efforts to educate the public, especially adolescents, about the effects of alcohol abuse on prenatal and postnatal development; (2) favors expanding these efforts to target abuse of other substances; and (3) encourages intensified research into the physical and psychosocial aspects of maternal substance abuse as well as the development of efficacious prevention and treatment modalities. (Res. 244, A-89; Reaffirmation A-99; Reaffirmation A-07)

H-420.977 Posting of Warnings Against Use of Alcohol During Pregnancy

The AMA supports seeking appropriate federal or state legislation to require that warning signs stating that drinking alcoholic beverages during pregnancy can cause birth defects be posted in a prominently visible location in all places where alcoholic beverages are sold. (Sub. Res. 123, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-420.978 Access to Prenatal Care

(1) The AMA supports development of legislation or other appropriate means to provide for access to prenatal care for all women, with alternative methods of funding, including private payment, third party coverage, and/or governmental funding, depending on the individual's economic circumstances. (2) In developing such legislation, the AMA urges that the effect of medical liability in restricting access to prenatal and natal care be taken into account. (Res. 33, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmation A-07)

H-420.979 AMA Statement on Family and Medical Leave

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy;
(2) maternity leave for the employee-mother;
(3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and
(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. (BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-420.981 Fetal Alcohol Syndrome Warning Legislation

The AMA supports appropriate mechanisms, including legislation, intended to increase public awareness of Fetal Alcohol Syndrome. (Sub. Res. 76, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-420.982 Standard Terminology for Reporting of Reproductive Health Statistics in the United States

The AMA supports attempts to standardize terminology for reproductive health statistics and, thus, to provide a uniform basis from which the collection and analysis of statistical data may proceed. (BOT Rep. J, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed:

CSAPH Rep. 3, A-06)

H-420.984 Paternity Leave

The AMA supports the requirement by the Accreditation Council for Graduate Medical Education (ACGME) for maternity and paternity leave guidelines. (Sub. Res. 88, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

H-420.986 Maternal and Child Health Care

The AMA opposes any further decreases in funding levels for maternal and child health programs; encourages more efficient use of existing resources for maternal and child health programs; encourages the federal government to allocate additional resources for increased health planning and program evaluation within Maternal and Child Health Block Grants; and urges increased participation of physicians through advice and involvement in the implementation of block grants. (BOT. Rep. V, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07)

H-420.987 Maternity Leave for Residents

The AMA believes that: (1) Residency program directors should review federal law concerning maternity leave and note that for policies to be in compliance, pregnant residents must be allowed the same sick leave or disability benefits as other residents who are ill or disabled.
(2) The duration of disability leave should be determined by the pregnant resident's physicians, based on the individual's condition and needs.
(3) All residency programs should develop a written policy on maternity and paternity leave for residents that addresses: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; (i) leave policy for adoption; and (j) leave policy for paternity.
(4) Resident numbers and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other residents' work loads.
(5) Residents should be able to return to their training program after disability leave without loss of training status. (BOT Rep. Z, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

H-420.988 Uniform Perinatal Terminology

The AMA encourages acceptance by health statisticians and state health departments nationwide of the following definition of a stillborn infant for statistical purposes: stillbirth - death prior to expulsion, extraction, or delivery in which the fetal weight is greater than 500 grams or, if weight is unknown, the duration of pregnancy exceeds 22 completed weeks' gestation. When neither birth weight nor gestational age is available, a body length of 25 cm (crown-heel) is considered equivalent to a 500 gram weight. (Sub. Res. 31, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-420.990 Effects of Pregnancy on Work Performance

The AMA (1) encourages research to document the physical and emotional impact of pregnancy on women and their ability to work; (2) encourages physicians to remain aware of potential discrepancies between cultural beliefs, myths and taboos about pregnancy and scientific data; and (3) reminds physicians of the need to adapt recommendations on pregnancy to each pregnant woman individually. (CSA Rep. H, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-420.991 Fetal Effects of Maternal Alcohol Use

The AMA believes that (1) The evidence is clear that a woman who drinks heavily during pregnancy places her unborn child at substantial risk for fetal damage and physical and mental deficiencies in infancy. Physicians should be alert to signs of possible alcohol abuse and alcoholism in their female patients of child-bearing age, not only those who are pregnant, and institute appropriate diagnostic and therapeutic measures as early as possible. Prompt intervention may prevent adverse fetal consequences from occurring in this high-risk group.
(2) The fetal risks involved in moderate or minimal alcohol consumption have not been established through research to date, nor has a safe level of maternal alcohol use been established. One of the objectives of future research should be to determine whether there is a level of maternal alcohol consumption below which embryotoxic and teratogenic effects attributable to alcohol are virtually non-existent.
(3) Until such a determination is made, physicians should inform their patients as to what the research to date does and does not show and should encourage them to decide about drinking in light of the evidence and their own situations. Physicians should be explicit in reinforcing the concept that, with several aspects of the issue still in doubt, the safest course is abstinence.

(4) Long-term longitudinal studies should be undertaken to give a clearer perception of the nature and duration of alcohol-related birth defects. Cooperative projects should be designed with uniform means of assessing the quantity and extent of alcohol intake.
(5) To enhance public education efforts, schools, hospitals, and community organizations should become involved in programs conducted by governmental agencies and professional associations.
(6) Physicians should take an active part in education campaigns. In so doing, they should emphasize the often overlooked consequences of maternal drinking that are less dramatic and pronounced than are features of the fetal alcohol syndrome, consequences that are at least indicated, if not sharply delineated, by some of the research that has been conducted in several parts of the world with diverse populations. (CSA Rep. E, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-420.992 Genetic Counseling and Prevention of Birth Defects

Our AMA believes that: (1) Adequate genetic counseling must be incorporated into any prenatal screening program established for the detection of birth defects and should be available both before and after the test is made.
(2) States should enhance their laboratory capability through broader utilization of those laboratories performing genetic screening, perhaps through regionalization of facilities so that karotyping of amniotic fluid cell cultures and their biochemical analysis can be more widely available.
(3) Specialty societies should enhance their efforts to train physicians in the newer techniques of ante-natal diagnosis.
(4) Although the case for widespread carrier screening for common heterozygous abnormalities is far from established, pilot studies should be encouraged which will explore the cost-effective level of pre-natal testing in each locality. (CSA Rep. B, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-420.995 Medical Care for Indigent and Culturally Displaced Obstetrical Patients and Their Newborns

Our AMA (1) reaffirms its long-standing position regarding the major importance of high-quality obstetrical and newborn care by qualified obstetricians, family physicians, and pediatricians and the need to make such care available to all women and newborns in the United States; (2) favors educating the public to the long-term benefit of antepartum care and hospital birth, as well as the hazards of inadequate care; and (3) favors continuing discussion of means for improving maternal and child health services for the medically indigent and the culturally displaced. (CSA Rep. C, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-420.996 Maternity Leave for Housestaff

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

H-420.998 Obstetrical Delivery in the Home or Outpatient Facility

Our AMA (1) believes that obstetrical deliveries should be performed in properly licensed, accredited, equipped and staffed obstetrical units; (2) believes that obstetrical care should be provided by qualified and licensed personnel who function in an environment conducive to peer review; (3) believes that obstetrical facilities and their staff should recognize the wishes of women and their families within the bounds of sound obstetrical practice; and (4) encourages public education concerning the risks and benefits of various birth alternatives. (Res. 23, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-420.999 Statement on Parent and Newborn Interaction

Our AMA encourages medical staffs to review, develop and formulate hospital policies relating to all aspects of professional support for the birth and nurturing processes. (CSA Rep. A, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-425.000 Preventive Medicine
(See also: Acquired Immunodeficiency Syndrome; Accident Prevention; Accident Prevention: Motor Vehicles; Firearms: Safety and Regulation; Environmental Health; Public Health; Sports and Physical Fitness; Tobacco; Tobacco: Labeling and Warnings; Tobacco: Marketing and Promotion; Tobacco: Prohibitions on Sale and Use)

H-425.974 Appropriate Aspirin Use for Prevention of Heart Disease and Stroke

Our AMA supports: 1) increasing physician awareness and education on the importance of appropriate aspirin counseling for the prevention of heart disease and stroke; 2) improving the hospital and physician office environment, including use of staff, for the promotion of appropriate aspirin use; and 3) coverage benefits in public and private insurance plans for counseling about appropriate aspirin use. (Res. 526, A-08)

H-425.975 Promoting Prevention Strategies in Waiting Rooms

Our AMA encourages health care settings to place diverse educational tools, including interactive media, in their waiting rooms to

promote preventive health measures that can empower patients to become more proactive about their health. (Res. 402, A-07)

H-425.976 Preconception Care

1. Our AMA supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care that state:

(1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan;
(2) Consumer awareness--increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts;
(3) Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes;
(4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact);
(5) Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth);
(6) Pre-pregnancy checkup--offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy;
(7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception care;
(8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes;
(9) Research--increase the evidence base and promote the use of the evidence to improve preconception health; and
(10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor preconception health.

2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman’s reproductive health. (Res. 414, A-06; Reaffirmation I-07)

H-425.977 Encouraging Vision Screenings for Schoolchildren

Our AMA:

(1) encourages and supports outreach efforts to provide vision screenings for school-age children prior to primary school enrollment;

(2) encourages the development of programs to improve school readiness by detecting undiagnosed vision problems; and

(3) supports periodic pediatric eye screenings based on American Academy of Pediatrics, American Academy of Family Physicians and American Academy of Ophthalmology evidence-based guidelines with referral to an ophthalmologist for a comprehensive professional evaluation as appropriate. (Res. 430, A-05)

H-425.978 Stroke Prevention and Care Legislation

Our AMA supports comprehensive stroke legislation such as S.1274, the Stroke Treatment and Ongoing Prevention Act (STOP Stroke Act) as introduced, and work with Congress to enact legislation that will help improve our nation’s system of stroke prevention and care. (Res. 215, I-01)

H-425.979 Coverage of Therapeutic Shoes as a Preventive Measure

Our AMA: (1) recommends that public and private health insurance programs provide appropriate therapeutic shoes to patients with peripheral neuropathy who meet the eligibility criteria defined under Part 3, Section 2134 of the Medicare Carriers manual; and (2) strongly urges public and private health insurance programs to provide appropriate therapeutic shoes to patients with peripheral neuropathy who meeting the folloiwng criterion: they are currently being treated under a comprehensive treatment plan and have one of the following: (a) peripheral neuropathy with evidence of callus formation; (b) history of pre-ulcerative calluses; (c) history of previous ulceration; (d) foot deformity; (e) previous amputation of the foot or part of the foot; or (f) poor circulation. (Sub. Res. 122, A-00)

H-425.980 Screening and Early Detection of Prostate Cancer

Our AMA believes that:(1) the launching of mass screening programs for the early detection of prostate cancer is premature at this time.

(2) All men who would be candidates for and interested in active treatment for prostate cancer should be provided with information regarding their risk of prostate cancer and the potential benefits and harms of prostate cancer screening, sufficient to support well-informed decision making.

(3) Prostate cancer screening, if elected by the informed patient, should include both prostate-specific antigen testing and digital rectal examination.

(4) Men most likely to benefit from tests for early detection of prostate cancer should have a life expectancy of at least 10 years and include: (a) Men 40 years of age or older of African American descent; (b) Men 40 years of age or older with an affected first-degree relative; and (c) Men 50 years of age or older. (CSA rep. 9, A-00)

H-425.981 Reimbursement of Screening Bone Densitometry

Our AMA: (1) advocates for the use of bone densitometry as an important tool in assessing fracture risk and in the diagnosis of osteoporosis;
(2) advocates that a clinical evaluation accompany any bone mass measurement for the evaluation of fracture risk and osteoporosis;
(3) advocates for the continued participation of the patient's physician in the diagnosis, treatment, and prevention of osteoporosis;
(4) encourages private third party payers to provide coverage for bone mass measurement technology and services for those individuals at high risk of osteoporosis; and
(5) will lobby Congress to add men undergoing testosterone-suppressing treatment for prostate cancer and men who are at high risk for any other reason to the list of beneficiaries receiving Medicare coverage of bone density testing to screen for osteoporosis. (CMS Rep. 9, A-99; Appended: Res. 113, I-99)

H-425.982 Training in the Principles of Population-Based Medicine

The AMA will continue to monitor and support the progress made by medical and public health organizations in championing disease prevention and health promotion; and will continue to develop initiatives to bring schools of medicine and public health back into a closer relationship. (CME Rep. 5, I-95; Reaffirmed: CME Rep. 2, A-05)

H-425.983 The Preservation of Guidelines for Adolescent Preventive Services (GAPS) in Current Practice Settings

The AMA: (1) strongly advocates the universal incorporation of GAPS into routine patient care schedule used in all settings in which care is provided to adolescent patients, including HMOs and hospital clinics; (2) advocates for the inclusion of GAPS in any future versions of health system reform; (3) urges appropriate physician payment for health education related to patient care when reported with the appropriate CPT codes; and will work with all interested medical societies and other professional groups to urge third party payers to provide coverage and payment for proper pediatric/adolescent care at appropriate intervals. (Substitute Res. 114, I-94; Reaffirmation I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-425.984 Clinical Preventive Services

Implications for Adolescent, Adult, and Geriatric Medicine: (1) Prevention should be a philosophy that is espoused and practiced as early as possible in undergraduate medical schools, residency training, and continuing medical education, with heightened emphasis on the theory, value, and implementation of both clinical preventive services and population-based preventive medicine. (2) Practicing physicians should become familiar with authoritative clinical preventive services guidelines and routinely implement them as appropriate to the age, gender, and individual risk/environmental factors applicable to the patients in the practice at every opportunity, including episodic/acute care visits. (3) Where appropriate, clinical preventive services recommendations should be based on outcomes-based research and effectiveness data. Federal and private funding should be increased for further investigations into outcomes, application, and public policy aspects of clinical preventive services. (CSA Rep. D, I-92; Reaffirmed by CME Rep. 5, I-95; Reaffirmed and Modified: CSA Rep. 8, A-05; Reaffirmed: BOT Rep. 8, I-06)

H-425.986 Challenges in Preventive Medicine

It is the policy of the AMA that (1) physicians should become familiar with and increase their utilization of clinical preventive services protocols; (2) individual physicians as well as organized medicine at all levels should increase communication and cooperation with and support of public health agencies. Physician leadership in advocating for a strong public health infrastructure is particularly important; (3) physicians should promote and offer to serve on local and state advisory boards; and (4) in concert with other groups, physicians should study local community needs, define appropriate public health objectives, and work toward achieving public health goals for the community. (BOT Rep. R, I-91; Reaffirmed by CME Rep. 5, I-95; Reaffirmed and Modified with change in title: CSA Rep. 8, A-05)

H-425.987 Preventive Medicine Services

Our AMA supports (1) continuing to work with the appropriate national medical specialty societies in evaluating and coordinating the development of practice parameters, including those for preventive services; (2) continuing to actively encourage the insurance industry to offer products that include coverage for general preventive services; and (3) appropriate reimbursement and coding for established preventive services. (CMS Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-07)

H-425.988 The US Preventive Services Task Force Guide to Clinical Preventive Services

It is the policy of the AMA: (1) to continue to work with the federal government, specialty societies, and others, to develop guidelines for, and effective means of delivery of, clinical preventive services; and (2) to continue our efforts to develop and encourage continuing medical education programs in preventive medicine. (CME Rep. I, A-90; Reaffirmed by CME Rep. 5, I-95; Reaffirmed and Modified with change in title: CME Rep. 2, A-05; Reaffirmation A-07)

H-425.989 Encouraging Health Activism by Physicians

Our AMA encourages physicians to participate in educational workshops designed to help physicians incorporate the techniques of primary prevention and health promotion in their daily practices. (Res. 14, I-89; Reaffirmed: Sunset Report, A-00)

H-425.990 Prevention of Coronary Artery Disease

The AMA believes that (1) total serum cholesterol should be measured under supervision of a physician, with proper safeguards for quality assurance and (2) when serum cholesterol levels are excessive, appropriate measures should be taken to educate the patient concerning methods to improve serum lipids and thereby reduce the risk of coronary heart disease. (Res. 165, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-425.991 Support for Preventive Medicine

The AMA reaffirms its commitment to preventive medicine . (Res. 135, I-87; Modified: Sunset Report, I-97; Modified and Reaffirmed: CME Rep. 2, A-07)

H-425.992 Coverage of Preventive Medical Services by Medicare

The AMA advocates revision of current Medicare guidelines to include coverage of appropriate preventive medical services. (Res. 85, A-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmation A-99; Reaffirmed in lieu of Res. 104, A-06; Reaffirmation A-07; Reaffirmation I-07)

H-425.993 Health Promotion and Disease Prevention

The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; and (5) strongly emphasizes the important opportunity for savings in health care expenditures through prevention. (Presidential Address, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: BOT Rep. 8, I-06)

H-425.994 Medical Evaluations of Healthy Persons

The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease. (2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes. (4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified. (5) Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs. (6) Continued investigation is required to determine the usefulness of test procedures that may be of value in

detecting disease among asymptomatic populations. (CSA Rep. D, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-425.996 Health Screening Programs

It is the position of the AMA that organizations, agencies or other entities that operate or sponsor multiphasic health screening programs should be urged to include in their promotional and explanatory materials on the availability of the program a definitive statement that reports on the screening test results will be furnished to the individual participants only and that each participant is responsible for obtaining any needed medical evaluation or follow-up should the results of the tests deviate from the normal range. Those operating or sponsoring multiphasic health screening programs also should be urged to utilize report forms that state in bold-face type that the report does not constitute a medical diagnosis or evaluation and that the participant should consult a physician of his or her choice if the screening test results are not within the normal limits indicated on the report. (BOT Rep. L, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Res. 806, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-425.997 Preventive Services

1. Our AMA encourages the development of policies and mechanisms to assure the continuity, coordination and continuous availability of patient care, including professional preventive care and early-detection screening services, provided the services are cost effective.

2. It is the policy of the AMA that any preventive service that is being considered for inclusion in public or private sector insurance products have evidence-based data to demonstrate improved outcomes or quality of life and the cost effectiveness of the service.

3. Our AMA believes that preventive care should ideally be coordinated by a patient's physician. (BOT Rep. A, NCCMC Rec. 31, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report and Reaffirmed and Appended: CMS Rep. 7, A-00; Reaffirmed in lieu of Res. 104, A-06; Reaffirmation A-07; Modified and Reaffirmed: Sub. Res. 101, A-08)

H-425.998 Pharmacist in Hypertension Screening

(1) Physicians should encourage the establishment of adequate training programs in blood pressure measurement, under the supervision of qualified physicians or other qualified personnel, for pharmacists and other non-physicians in order to assure adequate personnel for hypertension screening programs.

(2) The medical profession should participate in the development of programs which assure an adequate system for monitoring blood pressure measurement and referring patients when indicated to physicians.

(3) Community programs should be established to educate the public on the importance of participation in screening programs and adherence to subsequently prescribed courses of therapy, with periodic blood pressure measurement and evaluation of the effectiveness of the therapeutic regimen by licensed physicians.

(4) The particular program to be implemented in any community should receive the full support of the medical profession and be built upon the existing community facilities and health personnel resources, taking into consideration applicable state legal restriction or requirements. (BOT Rep. Q, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-425.999 Statement of Essential Hypertension

Our AMA urges physicians to cooperate fully in a national program to combat hypertension. (BOT Rep. N, part 1, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-430.000 Prisons
(See also: AIDS; Crime; Legal Medicine)

H-430.987 Opiate Replacement Therapy Programs in Correctional Facilities

Our AMA endorses: (1) the medical treatment model of employing opiate replacement therapy (ORT) as an effective therapy in treating opiate-addicted persons who are incarcerated; and (2) ORT for opiate-addicted persons who are incarcerated, in collaboration with the National Commission on Correctional Health Care and the American Society of Addiction Medicine. (Res. 443, A-05)

H-430.988 Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities

(1) Medical Testing and Care of Prisoners

a) Federal and state correctional systems should provide comprehensive medical management for all entrants, which includes mandatory testing for HIV infection and tuberculosis followed by appropriate treatment for those infected;

b) During incarceration, prisoners should be tested for HIV infection as medically indicated or on their request;

c) All inmates and staff should be screened for tuberculosis infection and retested at least annually. If an increase in cases of tuberculosis or HIV infection is noted, more frequent retesting may be indicated;

d) Testing for HIV infection and tuberculosis should be mandatory for all prisoners within 60 days of their release from prison;

e) Physicians who practice in correctional institutions should evaluate all tuberculin-positive inmates for HIV infection and all HIV-positive patients for tuberculosis, since HIV status may affect subsequent management of tuberculosis infection or disease and tuberculosis may accompany HIV infection;

f) Correctional institutions should assure that informed consent, counseling, and confidentiality procedures are in place to protect the patient, when HIV testing is appropriate;

g) During their post-test counseling procedures, prison medical directors should encourage HIV-infected inmates to confidentially notify their sexual or needle-sharing partners; and

h) Correctional medical care must, as a minimum, meet the prevailing standards of care for HIV-infected persons in the outside community at large. Prisoners should have access to all approved therapeutic drugs and generally employed treatment strategies.

(2) HIV/AIDS Education and Prevention

Our AMA:

a) Encourages the inclusion of HIV-prevention information as a regular part of correctional staff and inmate education. AIDS education in state and federal prisons should stress abstinence from drug use and high-risk sexual practices, as well as the proper use of condoms as one way of decreasing the spread of HIV;

b) Will pursue legislation that encourages state, local, and federal correctional institutions to make condoms available to inmates; and

c) Urges medical personnel in correctional institutions to work closely with state and local health department personnel to control the spread of HIV/AIDS, tuberculosis, and other serious infectious diseases within and outside these facilities.

(3) Prison-based HIV Partner Notification Program

Our AMA:

a) Urges state health departments to take steps to initiate with state departments of correctional services the development of prison-based HIV Partner Notification Programs for inmates convicted of drug-related crimes and their regular sexual partners; and

b) Believes that all parties should recognize that maximum effectiveness in an HIV Partner Notification Program will depend on the truly voluntary participation of inmates and the strict observance of confidentiality at all levels. (CSA Rep. 4, A-03)

H-430.989 Disease Prevention and Health Promotion in Correctional Institutions

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing. (CSA Rep. 4, A-03)

H-430.990 Bonding Programs for Women Prisoners and their Newborn Children

Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of

female inmates who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children. (CSA Rep. 3, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-430.994 Prison-Based Treatment Programs for Drug Abuse

Our AMA: (1) encourages the increased application to the prison setting of the principles, precepts and processes derived from drug-free residential therapeutic community experience; (2) urges state health departments or other appropriate agencies to take the lead in working with correction and substance abuse agencies for the expansion of such prison-based drug-free treatment programs; and (3) urges the Alcohol, Drug Abuse and Mental Health Administration, the Department of Justice and the Office of Treatment Improvement to assist in the expansion of such programs. (Sub. Res. 124, I-89; Reaffirmed: Sunset Report, A-00)

H-430.996 Correctional Health Accreditation Program

The AMA supports the concept of a national program of accreditation of health care services in correctional institutions. (Sub. Res. 71, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04)

H-430.997 Standards of Care for Inmates of Correctional Facilities

Our AMA believes that correctional and detention facilities should provide medical care that meets prevailing community standards. (Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99)

H-430.998 Use of the Choke and Sleeper Hold in Prisons

The AMA (1) does not regard the choke and sleeper holds as casually applied and easily reversible tranquilizers, but as the use of deadly force with the potential to kill; and (2) advocates that with all incidents involving the application of choke and sleeper holds there should be timely medical surveillance of the inmate. (Res. 3, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-430.999 Searches of Body Orifices

Our AMA supports the following guidelines for searches of body orifices of individuals held by law enforcement authorities: (1) Since searches of body orifices are conducted for security and not medical reasons, there is usually no need for them to be performed by medical personnel and, as a general rule, it is preferable that they be performed by correctional personnel who have been given special training. (2) Where state laws or agency regulations require that body cavity searches be conducted only by physicians or other medical personnel such as physician assistants, nurses or nurse practitioners, such searches should be performed by health care personnel other than those employed to provide care to inmates. (3) Where searches of body orifices to discover contraband are conducted by non-medical personnel, the following principles should be observed: (a) the persons conducting these searches should receive training from a physician or other qualified health care provider regarding how to probe body cavities so that neither injuries to the tissue nor infections from unsanitary conditions result; (b) searches of body orifices should not be performed with the use of instruments; and (c) the search should be conducted in privacy by a person of the same sex as the inmate. (BOT Rep. EE, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-435.000 Professional Liability
(See also: Health Care Reform; Licensure and Discipline; Quality of Care; Peer Review)

H-435.948 Equality of Civil Liability Preemption for Physicians

Our AMA supports (1) efforts to grant physicians at least the same level of protection as manufacturers, whether by court decision or statute; and (2) state and federal legislation that addresses the civil liability of physicians who use FDA-approved devices and pharmaceuticals in a reasonable and prudent manner, so that physicians have at least the same level of protection offered the manufacturer for adverse events resulting from the use of said products. (Res. 201, I-08)

H-435.949 Liability Relief for Physicians Who Volunteer at Free Clinics

Our AMA urges states to adopt legislation that provides for liability relief for volunteer physicians who serve at free clinics, deliver pro bono care, or volunteer in times of disaster. (Res. 929, I-07)

H-435.950 Apologizing to Patients

AMA policy is that any statements by physicians of apology, confessions of regret, or admission of errors to patients and/or their

families regarding less than anticipated clinical outcomes be subsequently inadmissible in court, and will seek to incorporate such policy into medical liability reform legislation. (Res. 217, A-07; Reaffirmation A-08)

H-435.951 Health Court Principles

AMA PRINCIPLES FOR HEALTH COURTS

- These principles are intended to serve as legislative guidelines for state medical associations and can be amended on an as needed basis.
- Health courts should be structured to create a fair and expeditious system for the resolution of medical liability claims - with a goal of resolving all claims within one year from the filing date.
- Health court judges should have specialized training in the delivery of medical care that qualifies them for serving on a health court.
- Negligence should be the minimum threshold for compensation to award damages.
- Health court judgments should not limit the recovery of economic damages, but non-economic damages should be based on a schedule.
- Qualified experts should be utilized to assist a health court in reaching a judgment.
- Health court pilot projects should have a sunset mechanism in place to ensure that participating physicians, hospitals, and insurers do not experience a drastic financial impact based on the new judicial format.

I. Health Court Structure

Jurisdiction
- Health courts should only be established at the state or local level.
- If a health court is established on a statewide or local basis, then it should be established within the state's trial court of general jurisdiction. Using the already established system would lessen the financial and administrative burden.
- To capture all medical liability cases, a health court that is established as a statewide or local program should have exclusive jurisdiction over any lawsuit (contract or tort) which involves an injury arising from the alleged negligence of a health care provider.
- Appeals should be handled within the health court system as well.
- The jurisdiction's discovery rules should be modified to be consistent with the timeline for resolving a case before a health court.
- Eventually, health courts should have expanded jurisdiction over the validity of advance directives, managed care independent review decisions, and other health law issues.

Trial Format
- One option for a health court is to have a bench trial before a specially trained judge.
- Another option is for a health court to have a jury trial under the authority of a specially trained judge.
- Health courts utilizing a jury should provide juries with a specialized educational session on the basics of medical care delivery and the distinction between negligence and adverse outcomes as well as appropriate guidelines on the purpose of awarding non-economic damages.

Administrative Option
- An administrative system (e.g. established by a hospital or insurer) should include many of the same requirements that the AMA supports for a health court established within a jurisdiction's standard judicial system.
- Health court pilot programs established through an insurer or hospital should have jurisdiction over patients who choose to opt in to the system.

II. Health Court Judges

Selection of Health Court Judges
- Health court judges should be appointed by a health court task force.
- The health court task force should be comprised of four physicians, four lawyers, and four laypersons.
- The majority and minority leaders in each of the state's legislative chambers should pick one member from each category (i.e., house majority leader would pick one physician, one lawyer, and one layperson for the task force. The house minority leader, the senate majority leader, and the senate minority leader would do the same.)
- The health court task force chairmanship should rotate on an annual basis.
- The majority and minority leaders in each legislative chamber should ask the state medical association for a list of health court task force candidates before making an appointment.
- Governmental entities should adjust the term of a health court judge based on the length of terms in their state for other special courts.

Training for Health Court Judges
- Health court judges should complete a judicial training program which provides an overview of medical and legal issues that often arise in medical liability cases.

- The curriculum should be established by the health court task force.
- The medical portion of the training program should include both in-classroom clinical training and an internship whereby the judge "shadows" a physician in different health care settings.
- States and other government bodies with an existing judicial training program should have this office administer the special training program for judges assigned to the health court.

III. Health Court Procedure

Threshold for Patient Compensation
- Negligence must be proven for a patient to recover in a health court proceeding.

Damages
- Economic damages should not be limited. Injured parties should be fully compensated for their economic losses.
- Non-economic damage awards should be established by a schedule. Consistent injuries should result in consistent non-economic damage awards based on the schedule. The health court task force should establish the schedule.
- One option for the schedule is to base it on type/severity of the injury. Another option is to have the schedule link non-economic damages awards to the amount of economic damages included in the judgment.
- Punitive damages, if allowed, should not be awarded unless the party alleging such damages meets the burden of producing clear and convincing evidence of oppression, fraud, malice, or the opposing party's intent to do harm.
- Health court judges should give jury instructions that provide clear delineations between the purposes of economic damages (for economic loss), non-economic damages (for pain and suffering), and punitive damages (for punishment to prevent future bad behavior). The instructions should also distinguish the different burden of proof needed for punitive damages.
- Future damages should be paid on a periodic basis as authorized by a health court.

Other Procedural Issues
- Health courts should be designed to resolve claims within one year from the filing date.
- Health courts should limit attorney’s fees to maximize the award to the patient.
- Collateral payment sources should be admissible as evidence in a health court proceeding.
- Health court damage awards should include mandatory offsets for collateral payments for the same injury.
- An affidavit/certificate of merit should be a prerequisite to filing a medical liability case before a health court.
- A pre-trial screening panel should be utilized prior to the start of a trial before a health court.
- The statute of limitations in a health court should be two years from the act or omission.
- The period for suspending the application of state statutes of limitations for minors should be no more than six years after birth. The statute should include a three-year statute of repose from manifestation as well for minors.
- In a health court proceeding, statements of sympathy, apology or regret made by a health care provider or their staff to an alleged victim or family of the victim relating to the discomfort, pain, suffering, injury, or death resulting from an unanticipated outcome of medical care should be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.

IV. Medical Error Reporting

Medical Error Reporting
- The AMA continually strives to advance efforts to improve patient safety through educational activities and all other available means to discover and promote "best practices" in the delivery of health care services. Toward this end, a health court system should encourage the reporting of medical errors.
- The reporting system should be non-punitive, and it should be confidential and not subject to discovery in legal proceedings.
- The medical error reporting system should collaborate with the Patient Safety Organization (PSO) (which will be established pursuant to the federal Patient Safety and Quality Improvement Act of 2005) in its state or region to encourage the efficient reporting and analysis of the data.

V. Experts

Court Appointed Medical Experts
- The health court task force should maintain a list of qualified medical experts from which a judge may select to help clarify or interpret medical testimony given in legal proceedings.
- A health court judge should use and rely on the testimony of a court appointed medical expert.
- A court appointed medical expert must, at a minimum, meet the same qualifications as the medical experts who testify on behalf of a party in the presiding lawsuit.

Party Expert Witnesses
- Health courts should only allow medical expert witnesses to testify if the expert witness is licensed as a doctor of medicine or osteopathy.
- An expert witness should be trained and experienced in the same field as the defendant or has specialty expertise in the disease

process or procedure performed in the case.
- An expert witness should be certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association, or by a board with equivalent standards.
- An expert witness should, within five years of the date of the alleged occurrence or omission giving rise to the claim, be in active medical practice in the same field as the defendant, or have devoted a substantial portion of his time teaching at an accredited medical school, or in university-based research in relation to the medical care and type of treatment at issue.
- A person who testifies as an expert witness in a health court should be deemed to have a temporary license to practice medicine in the state for the purpose of providing such testimony and should be subject to the jurisdiction of the state medical board.

VI. Review and Sunset

Review
- The health court task force should be charged with reviewing the health court program on an ongoing basis. They should issue quarterly reports, open to the public, on claims filed, decisions rendered, claims paid, and claims resulting in no payment.

Sunset
- The health court task force may recommend to the governor and the legislative leaders that the health court system should be sunset if it is not financially viable or does not result in a more balanced and fair process.
- Given that the costs are unknown and could potentially be charged to physicians, a health court system should include appropriate funding from government or foundation sources to protect participants from significant financial losses based on their participation under a health court format rather than the traditional medical liability system. (BOT Rep. 15, A-07)

H-435.952 Savings Accounts for Extended Reporting Endorsement Policies and Other Liability Insurance Costs

Our AMA supports changes to the Internal Revenue Code to allow a pre-tax Extended Reporting Endorsement Savings Account whereby the amount of money contributed before taxes and interest on earnings from those monies be allowed to grow tax free until such time as an extended reporting endorsement must be purchased and that the balance of any remaining funds would return to the physician without IRS penalty and be subject to taxation at that time. (BOT Rep. 30, A-06)

H-435.953 Minor Statute of Repose/Limitations

Our AMA supports federal legislation that would establish a Minor Statute of Repose/Limitations that includes the following language: An action by a minor upon a medical claim shall be commenced within 3 years from the date of the alleged manifestation of injury, except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides the longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor. (BOT Action in response to referred for decision Res. 230, A-05)

H-435.954 Impact of US Medical Liability Premiums on Clinical Medical Education

Our AMA opposes increases in medical liability insurance premiums based solely on preceptor or volunteer faculty status. (CME Rep. 2, I-05)

H-435.955 Administrative and Liability Surcharges

Our AMA supports the ability of physicians to institute an "administrative surcharge" and/or a "liability surcharge." (BOT Rep. 27, A-05)

H-435.956 Professional Liability Alternative Financing

Our AMA supports legislation that would amend the Internal Revenue Code to allow medical professionals and entities to establish tax-exempt professional liability trusts to pay medical liability claims. (BOT Rep. 16, A-05)

H-435.957 Uniform and Consistent Tort Reform

Our AMA will not pursue federal medical liability reform legislation that would divide or diminish the voice of the House of Medicine. (Sub. Res. 910, I-03; Reaffirmed in lieu of Res. 216, A-04)

H-435.958 Immunity from Professional Liability Tort for Volunteer Services During State or National Emergencies

The policy of the AMA is to formulate and support federal legislation granting legal immunity, including medical liability immunity, for volunteer medical services arising from declared state or national emergencies. (Res. 911, I-02; Reaffirmation A-06; Reaffirmed

in lieu of Res. 223, A-06)

H-435.959 Liability Reform

(1) Our AMA states that liability reform is our highest legislative priority; and (2) any federal liability reform legislation advocated by the AMA shall not preempt or supersede any law that imposes greater protections for health care providers and health care organizations from liability, loss, or damages than those provided by this legislation. (Sub. Res. 215, A-02; Reaffirmed: Sub. Res. 910, I-03; Reaffirmed: CME Rep. 2, I-05)

H-435.960 Physician Relief from Product Class Actions

Our AMA: (1) asks Congress to pass legislation which prevents naming the treating physician as a party to product liability lawsuits when the treating physician has used a Food and Drug Administration-approved drug or device; and (2) promotes the introduction of legislation which would exempt physicians who have properly prescribed usage of Food and Drug Administration-approved medications from liability in class action suits against pharmaceutical companies. (Res. 208 & 225, A-01; Reaffirmed in lieu of Res. 905, I-06)

H-435.961 Prohibition of Forum Shopping

Our AMA will continue to support laws which limit a plaintiff's right to sue to the state of the defendant's residence or the state where at least a substantial element of the alleged professional negligence arose. (BOT Rep. 8, I-98)

H-435.962 Tort Reform and Managed Care

AMA policy states that medical liability reform be construed in the context of managed care and be consistent with these objectives: that (1) all managed care organizations (MCOs) are held responsible for assuring quality healthcare, and are held liable for any negligence on the part of the health plan resulting in patient injury; (2) physicians know and are able to carry out their professional obligations to patients despite cost constraints and contractual obligations to MCOs; and (3) coordinated patient safety systems tailored to managed care arrangements are in place. (BOT Rep. 18, I-96; Reaffirmation I-98; Reaffirmation A-99)

H-435.963 Professional Liability Claims Reporting

The AMA opposes the need for reporting on medical staff and other non-licensing board applications, including insurance company credentialing applications, (excepting professional liability insurance applications) any threatened, pending, or closed professional liability claims where the claim did not result in payment on behalf of that physician. (Sub. Res. 818, A-95; Modified: BOT Rep. 18, A-03; Reaffirmed: Res. 806, I-03; Reaffirmation A-04)

H-435.964 Federal Preemption of State Professional Liability Laws

The AMA supports professional liability reform on the federal level that will preempt state constitutional, statutory, regulatory and common laws that prohibit a cap on liability awards; and such federal legislation shall not preempt state constitutional, statutory, regulatory and common laws that set caps or other restrictions on liability awards which are lower or more comprehensive than the caps on liability awards established by such federal legislation. (Res. 237, A-95; Reaffirmed: Sub. Res. 910, I-03)

H-435.965 "Clear and Convincing" Standard of Proof in Medical Liability Cases

The AMA continues to support the use of the clear and convincing evidence standard of proof in medical negligence cases in which the plaintiff seeks punitive damages and will continue to advocate civil justice reform designed to prevent nonmeritorious claims from being filed or to quickly resolve them before extensive litigation proceeds. (BOT Rep. 51, A-94; Reaffirmed: BOT Rep. 12, A-05)

H-435.966 Prohibit Third Party Payers from Requiring Professional Liability Coverage Beyond Mandated Limits

The AMA finds unreasonable the demand by any hospital or third party payer that their providers carry professional liability coverage in excess of the minimum mandated of physicians by state law; and will design and distribute model legislation that prevents any health care institution or third party payer from requiring their physicians to carry professional liability coverage in excess of the minimum mandated by law. (Res. 203, I-93; Reaffirmed: BOT Rep. 28, A-03)

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-435.968 Enterprise Liability

The AMA: (1) affirms its position that effective medical liability reform based on California's MICRA model is integral to health system reform, and must be included in any comprehensive health system reform proposal that hopes to be effective in containing costs, providing access to health care services and promoting the quality and safety of health care services; (2) opposes any proposal that would mandate or impose enterprise liability concepts. Federal funding to evaluate the comparative advantages and disadvantages of enterprise liability may be best spent studying the operation, effect on liability costs and patient safety/injury prevention results of liability channeling systems that already exist and function as close analogs to the enterprise liability model (BOT Rep. I-93-53); and (3) supports strong patient safety initiatives and the investigation of alternative dispute resolution models, appropriate uses of practice parameters in medical liability litigation and other reform ideas that have the potential to decrease defensive medicine costs and more fairly and cost-effectively compensate persons injured in the course of receiving health care services. (BOT Rep. III, A-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmation A-04)

H-435.969 Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability

Our AMA: (1) reaffirms its support for investigating promising Alternative Dispute Resolution (ADR) mechanisms, in the context of demonstration projects designed to evaluate whether they resolve medical liability claims fairly and in a more timely and cost-effective manner. (2)The AMA strongly recommends that if cost containment goals are to be achieved, ADR proposals designed to provide greater access to legal process must incorporate effective mechanisms to: (a) identify non-meritorious claims and dispose of them; (b) decrease the proportion of cases being litigated; (c) increase the portion of any settlement payment received by the patient; and (d) identify appropriate guidelines for the payment of damages; and (3) continues to monitor and disseminate information to state and component medical societies about state and federal initiatives that address the issue of protections from liability risks for physicians who provide volunteer activities and care of the indigent, as well as the effectiveness of those initiatives. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform. (BOT Rep. M, I-92; BOT Rep. I-93-53; Modified: Sub. Res. 205 and Reaffirmation A-00; Reaffirmation A-04; Reaffirmation A-06)

H-435.972 Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability

The AMA will continue to address the need for effective nationwide tort reform through the AMA's coalition-building activities and efforts on behalf of state and federal tort reform. (BOT Rep. M, A-92; Reaffirmed: BOT Rep. 28, A-03)

H-435.973 Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability

(1) Medical Expert Witness Testimony: Courts should admit into evidence only expert medical testimony that is shown through a proper legal foundation to be based on (a) widely accepted theories of medical science or (b) theories that are supported by a respectable minority of experts in the field at issue. (2) Implementation of the "Loser Pays" Rule in Medical Liability Litigation: Responsibility for a prevailing party's legal expenses, including attorney fees, should not be shifted to a losing party in medical liability litigation unless (a) some provision is made for retrieving fees owed to a prevailing party from the losing party's attorney in the event the losing party has no available assets;
(b) some provision is made to calculate fees owed to a plaintiff's attorney on the basis of the reasonable value of time expended, regardless of the existence of a contingency fee arrangement;
(c) the rule is adopted that no losing party will be required to pay expenses including legal fees that exceed his or her own bill for such goods or services; and
(d) other efforts are made as necessary to insure that the "loser pays" disincentive to pursue litigation applies equally to all parties. (3) Punitive Damages Awards: Punitive damages in medical liability cases should not be awarded unless the party alleging such damages

meets the burden of producing clear and convincing evidence of the opposing party's intent to do harm. (BOT Rep. CC, I-91; Reaffirmed: BOT Rep. 9, I-99; Reaffirmed: BOT Rep. 13, A-07)

H-435.974 Support of Campaigns Against Lawsuit Abuse

Our AMA supports expanding its tort reform activities by assisting state and county medical societies and interested civic groups in developing and implementing anti-lawsuit abuse campaigns and by encouraging members to involve themselves in these campaigns. (Res. 223, I-91; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01)

H-435.975 Bush Administration Professional Liability Proposal

Our AMA commends the Bush Administration for its legislative efforts designated to achieve medical liability reform and supports the elements of legislative proposals introduced in the 102nd Congress which are consistent with Association policy, including (1) limitations of $250,000 or lower on recovery of non-economic damages;

(2) the mandatory offset of collateral sources of plaintiff compensation;

(3) a decreasing, sliding scale regulation of attorney contingency fees;

(4) periodic payment of future awards of damages; and

(5) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than six years after birth. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform. (Sub. Res. 158, A-91; BOT Rep. I-93-53; Reaffirmation A-00; Reaffirmation I-03)

H-435.976 Liability Protection for Medical Volunteers

It is the policy of the AMA to endorse the concept of liability protection for medical volunteer services and to promote legislative efforts to achieve that goal. (Res. 86, A-90; Reaffirmed: BOT Rep. M, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmation A-06; Reaffirmed in lieu of Res. 223, A-06)

H-435.978 Federal Medical Liability Reform

Our AMA: (1) supports federal legislative initiatives implementing the following medical liability reforms: (a) limitation of $250,000 or lower on recovery of non-economic damages; (b) the mandatory offset of collateral sources of plaintiff compensation; (c) decreasing sliding scale regulation of attorney contingency fees; and (d) periodic payment for future awards of damages; (2) reaffirms its support for the additional reforms identified in Report L (A-89) as appropriate for a federal reform vehicle. These are: (a) a certificate of merit requirement as a prelude to filing medical liability cases; and (b) basic medical expert witness criteria; (3) supports for any federal initiative incorporating provisions of this type would be expressly conditional. Under no circumstances would support for federal preemptive legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states or the ability of the states in the future to enact tort reform tailored to local needs. Federal preemptive legislation that endangers state-based reform will be actively opposed. Federal initiatives incorporating extended or ill-advised regulation of the practice of medicine also will not be supported. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform. (BOT Rep. S, I-89; BOT Rep. I-93-53; Reaffirmed: BOT Rep. 8, I-98; Reaffirmation A-00; Reaffirmation I-03; Reaffirmed: Sub. Res. 910, I-03)

H-435.982 AMA Strategies for Tort Reform

Our AMA supports the use of appropriate resources to develop strategies and actions, including possible initiatives in the federal legislative and judiciary systems, to combat the recent Wyoming Supreme Court decision to declare the Wyoming State Medical Review Panel unconstitutional. (Res. 210, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-00)

H-435.983 Impact of Product Liability on the Development of New Medical Technologies

The AMA (1) urges the continuation of efforts at the state and federal level to reform product liability laws, (2) supports creative solutions to prevent product liability suits from slowing the development and utilization of medical technologies in this country. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform; and (3) continues to support efforts to alleviate the growing health crisis caused by decreasing availability or provision of biomaterials to manufacturers of medical devices and implants and to support legislative efforts to provide legal protection to biomaterial suppliers to ensure that all Americans have access to medical devices. (BOT Rep. BB, A-88; Reaffirmed: BOT Rep. O, I-91; BOT Rep. I-93-53; Appended by Res. 518, A-98)

H-435.988 Risk Management

The AMA believes that: (1) a risk management activity should not undermine the physician's responsibility to provide quality patient care and physicians should have ample opportunity to participate in risk management activities; (2) the physician's responsibility and ability to provide quality patient care should remain paramount. (CMS Rep. J, A-87; Modified: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-435.991 Professional Liability Countersuits

Our AMA supports the principle that the "special injury" element required to win a malicious prosecution countersuit in some jurisdictions should be eliminated. (Res. 44, I-84; Reaffirmed: Sunset Report, I-98; Reaffirmed: Sub. Res. 914, I-04)

H-435.993 Tort Liability Reform

Our AMA: (1) supports the efforts of state medical societies to form coalitions supporting tort reform in each state and representing the numerous interests adversely affected by present escalating tort liability costs; and (2) believes these coalitions should address such issues as reform of laws governing product and professional liability, and development of appropriate public education programs regarding the impact and cost to consumers of present liability laws. (Sub. Res. 6, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmation A-00; Reaffirmation I-08)

H-435.997 Medical School Malpractice Risk Prevention Curriculum

Our AMA (1) acknowledges the continuing and growing severity of the problem of physician professional liability insurance nationwide and (2) urges medical schools and directors of residency programs to assist students and residents to understand and apply the determinants of sound risk management to clinical practice. (Sub. Res. 48, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-435.998 Equitable Risk Classification in Medical Liability Premiums

Our AMA supports the concept that premiums for medical liability insurance should reflect the costs and risks of providing that insurance to each category insofar as feasible based on accepted underwriting principles. Further, the policy of the AMA is that physicians who practice part-time should be entitled to reduced professional liability insurance premiums (Res. 15, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed and Appended: CMS Rep. 12, A-02; Reaffirmation I-03)

H-440.000 Public Health
(See also: Acquired Immunodeficiency Syndrome; Accident Prevention; Accident Prevention: Motor Vehicles; Environmental Health; Firearms: Safety and Regulation; Sports and Physical Fitness; Tobacco; Tobacco: Labeling and Warnings; Tobacco: Marketing and Promotion; Tobacco: Prohibitions on Sale and Use)

H-440.860 Financing of Adult Vaccines: Recommendations for Action

1. Our AMA supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.

2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States:

Provider-related
a. Develop a data-driven rationale for improved vaccine administration fees.
b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
c, Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.

Federal-related
a. Increase federal resources for adult immunization to: (i) Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations; (ii) Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered; (iii) Fund an adequate universal reimbursement rate for all federal and state immunization programs.
b. Optimize use of existing federal resources by, for example: (i) Vaccinating eligible adolescents before they turn 19 years of age to

capitalize on VFC funding; (ii) Capitalizing on public health preparedness funding.
c. Ease federally imposed immunization burdens by, for example: (i) Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B; (ii) Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient; (iii) Simplifying the reimbursement process to eliminate payment-related barriers to immunization.
d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.

State-related
a. State Medicaid programs should increase state resources for funding vaccines by, for example: (i) Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees; (ii) Establishing and requiring payment of a minimum reimbursement rate for administration fees; (iii) Increasing state contributions to vaccination costs; and (iv) Exploring the possibility of mandating immunization coverage by third party payers.
b. Strengthen support for adult vaccination and appropriate budgets accordingly.

Insurance-related
1. Provide assistance to providers in creating efficiencies in vaccine management by: (i) Providing model vaccine coverage contracts for purchasers of health insurance; (ii) Creating simplified rules for eligibility verification, billing, and reimbursement; (iii) Providing vouchers to patients to clarify eligibility and coverage for patients and providers; and (iv) Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines.
b. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
c. Improve accountability by adopting performance measurements.
d. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as part of the health plan.
e. Provide incentives to encourage providers to begin immunizing by, for example: (i) Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations; (ii) Simplifying payment to and encouraging immunization by nontraditional providers; (iii) Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).

Manufacturer-related
Market stability for adult vaccines is essential. Thus: (i) Solutions to the adult vaccine financing problem should not deter research and development of new vaccines; (ii) Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets; (iii) Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines; (iv) Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.

3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management. (CSAPH Rep. 4, I-08)

H-440.861 National Diabetes Education Program

Our AMA formally endorses the work of the National Diabetes Education Program (NDEP), a joint venture of the National Institutes of Health, the Centers for Disease Control and Prevention, and over 200 organizations, and will seek inclusion in the NDEP Steering Committee to help guide the development of diabetes educational materials in line with existing AMA policy. (BOT Action in response to referred for decision Res. 604, I-07)

H-440.862 Immunization Access to Parents of High-Risk Infants Younger Than Six Months of Age

Our AMA: (1) endorses the use of the neonatal intensive care unit (NICU) and hospital newborn nursery as practical and legitimate venues for parents and first-person contacts of vulnerable infants (those less than six months of age and/or premature) to obtain vaccines against communicable respiratory pathogens such as influenza and pertussis; and (2) recommends that hospitals with NICUs and newborn nurseries consider making vaccines against communicable respiratory pathogens available, and support local and state governments in efforts to make these vaccinations available, to parents and first-person contacts of those infants under the hospital's care. (Res. 518, A-08)

H-440.863 Restoring the Independence of the Office of the US Surgeon General

Our AMA: (1) recognizes the Office of the United States Surgeon General as the esteemed position of the "nation's doctor"; and (2) calls for the Office of the United States Surgeon General to be free from the undue influence of politics, and be guided by science and

the integrity of his/her role as a physician in fulfilling the highest calling to promote the health and welfare of all people. (Sub. Res. 434; A-08)

H-440.864 Noise Pollution

Our AMA recognizes noise pollution as a public health hazard, with respect to hearing loss, and supports initiatives to increase awareness of the health risks of loud noise exposure. (Sub. Res. 417, A-08)

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-440.866 The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity

Our AMA supports:

(1) greater emphasis in physician educational programs on the risk differences among ethnic and age groups at varying levels of BMI and the importance of monitoring waist circumference in individuals with BMIs below 35 kg/m2;

(2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and

(3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks. (CSAPH Rep. 1, A-08)

H-440.867 School Bus Safety

Our AMA supports federal regulations requiring age appropriate restraint systems for school buses. (Res. 902, I-07)

H-440.868 Expedited Partner Therapy

Our AMA supports state legislation that permits physicians to provide expedited partner therapy to patients diagnosed with gonorrhea and/or chlamydia infection. (Sub. Res. 928, I-07)

H-440.869 Establishment of Model Legislation to Develop State Commission/Taskforce to Eliminate Racial and Ethnic Health Care Disparities

Our AMA will develop model legislation and encourage and assist state and local medical societies to advocate for creation of statewide commissions to eliminate health disparities in each state. (Res. 914, I-07)

H-440.870 Amending Child Restraint Laws

Our AMA supports: (1) federal legislation that increases law enforcement standards for child safety seat use in the United States; and (2) state and federal legislation that updates child car seat violation codes from a secondary to primary law. (Res. 913, I-07)

H-440.871 Collaboration Between Human and Veterinary Medicine

Our AMA:

(1) supports an initiative designed to promote collaboration between human and veterinary medicine;

(2) supports joint educational efforts between human medical and veterinary medical schools;

(3) encourages joint efforts in clinical care through the assessment, treatment, and prevention of cross-species disease transmission;

(4) supports cross-species disease surveillance and control efforts in public health;

(5) supports joint efforts in the development and evaluation of new diagnostic methods, medicines, and vaccines for the prevention

and control of diseases across species; and

(6) will engage in a dialogue with the American Veterinary Medical Association to discuss strategies for enhancing collaboration between human and veterinary medical professions in medical education, clinical care, public health, and biomedical research. (Res. 530, A-07)

H-440.872 HPV Vaccine and Cervical Cancer Prevention Worldwide

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.

2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.

3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, and (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations. (Res. 503, A-07)

H-440.873 Update on Influenza Immunization

Our AMA will continue efforts to communicate strongly to its partners involved in influenza vaccine production and distribution that physicians who serve high-risk populations must receive influenza vaccines in a timely and equitable manner in order to serve these populations as recommended by the CDC's Advisory Committee on Immunization Practices and will broadly disseminate Board of Trustees Report 26-A-07, Update on Influenza Immunization, to specialty and state medical societies. (BOT Rep. 26, A-07)

H-440.874 Support of Legislation Regarding Global and Domestic Tuberculosis Control

Our AMA supports federal legislation to increase resources for global and domestic TB control. (Res. 227, A-07)

H-440.875 Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines

1. It is AMA policy that all persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as soon as possible following publication of these recommendations in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR).

2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.

3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.

4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ACIP-recommended vaccines, and the timely distribution of ACIP-recommended vaccines to providers).

5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ACIP-recommended vaccines.

6. Our AMA will work with the Centers for Medicare and Medicaid Services to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.

7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines. (BOT Action in response to referred for decision Res. 524, A-06; Reaffirmation A-07; Appended: Res. 531, A-07)

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)

H-440.877 Distribution and Administration of Vaccines

AMA policy is that:
(1) all qualified health care providers should have fair and equitable access to all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines. However, when there is a vaccine shortage, those health care providers immunizing patients who are prioritized to receive the vaccine based upon medical risks/needs according to the recommendations of the ACIP must be ensured timely access to adequate vaccine supply; and
(2) all vaccines be administered by a licensed physician, or by a qualified health care provider under the supervision of a physician; and
(3) patients should be provided with documentation of all vaccinations for inclusion in their medical record, particularly when the vaccination was provided by someone other then the patient's primary care provider. (Sub. Res. 512, A-06; Reaffirmed: BOT Rep. 26, A-07)

H-440.878 Pertussis and Influenza Immunization

Our AMA encourages all hospitals, health care systems, and health care providers to immunize providers and appropriate patients as defined by the Advisory Committee on Immunization Practices guidelines against both influenza and pertussis, as a priority, both for their own protection and to reduce the risk of transmission to others. (Res. 510, A-06; Reaffirmed in lieu of Res. 813, I-06)

H-440.879 Expedited Partner Therapy (Patient-delivered Partner Therapy): An Update

Our AMA supports the Centers for Disease Control and Prevention's guidance on expedited partner therapy (EPT) that was published in its 2006 white paper, *Expedited Partner Therapy in the Management of Sexually Transmitted Diseases*. (CSAPH Rep. 7, A-06)

H-440.880 Definition of Health

The AMA officially adopts the following definition of health: "Health is a state of physical and mental well-being." (CLRPD Rep., A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CLRPD Rep. 2, A-06)

H-440.881 Liability Protection for Adult Vaccines

Our AMA supports the expansion of the Vaccine Injury Compensation Fund to include any vaccine encouraged or recommended by the Advisory Committee on Immunization Practices for routine use in the adult population. (BOT Rep. 10, A-05)

H-440.882 Secure National Vaccine Policy

Our AMA advocates for and supports programs that ensure the production, quality assurance and timely distribution of sufficient quantities of those vaccines recommended by the Centers for Disease Control and Prevention to the US population at risk. (Res. 709, I-04; Reaffirmation A-05)

H-440.883 United States Influenza Vaccine Supply: Update and Future Directions for Adult Immunization

Our American Medical Association supports the development of a strong adult and adolescent immunization program in the United States. (BOT Rep. 28, I-04; Reaffirmation A-05)

H-440.884 Food Allergic Reactions in Schools and Airplanes

Our AMA recommends that all:
(1) schools provide increased student and teacher education on the danger of food allergies;
(2) schools have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the school administration be trained and certified in the indications for and techniques of their use; and

(3) commercial airlines have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the flight staff, such as the head flight attendant, be trained and certified in the indications for and techniques of their use. (Res. 415, A-04)

H-440.885 National Health Survey

Our AMA supports a national health survey that incorporates a representative sample of the U.S. population of all ages (including adolescents) and includes questions on sexual orientation, gender identity, and sexual behavior. (CSA Rep. 4, A-03; Modified: BOT Rep. 11, A-07)

H-440.886 State Tracking of HIV/AIDS and Other Serious Infectious Diseases

(1) Our AMA encourages state medical associations to support state legislation to establish requirements for reporting and case follow-up for HIV/AIDS and other serious infectious diseases, nationwide. Specific statutes must be drafted that, while protecting to the greatest extent possible the confidentiality of patient information: (a) provide a method for warning unsuspecting sexual partners, needle-sharing partners, or other close contacts; (b) protect physicians from liability for failure to warn the unsuspecting third party; but (c) establish clear standards for when a physician should inform the public health authorities;

(2) Our AMA will assist states in their efforts to take whatever actions are necessary to allow blood banks and health departments to share information for the purpose of locating and informing persons who have any transmissible bloodborne disease. (CSA Rep. 4, A-03; Reaffirmation A-07)

H-440.888 Public Health Leadership

Our AMA: (1) urges that appropriately trained and experienced licensed physicians (MDs or DOs) be employed by state and local health departments to be the responsible leader when patient care decisions are made, whether for individuals in the STD or TB Clinics or for the community at large when an epidemic is to be managed; and

(2) defines public health leadership and decision-making that promotes health and prevents disease in the community as the practice of medicine, requiring a licensed practitioner with all the skills, training, experience and knowledge of a public health trained physician. (Res. 438, A-03)

H-440.889 Smallpox: A Scientific Update

Our AMA strongly supports the June 20, 2002, Advisory Committee on Immunization Practices (ACIP) recommendations on the use of vaccinia (smallpox) vaccine in light of the available science and data. (CSA Rep. 2, I-02)

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)

H-440.891 Support of a National Laboratory Network

Our AMA supports the efforts of the Centers for Disease Control and Prevention in establishing a national laboratory network for communicating, coordinating, and collaborating with physicians and laboratory professionals on public health concerns. (Res. 516, I-01)

H-440.892 Bolstering Public Health Preparedness

Our AMA supports: (1) the concept that enhancement of surveillance, response, and leadership capabilities of state and local public health agencies be specifically targeted as among our nation’s highest priorities; and (2) in principle, the funding of research into the determinants of quality performance by public health agencies, including but not limited to the roles of Boards of Health and how they can most effectively help meet community needs for public health leadership, public health programming, and response to public health emergencies. (Sub. Res. 407, I-01)

H-440.893 Peacetime Military Exercises in Populated Areas

Our AMA believes that the Department of Defense, working with other relevant federal and state agencies and qualified scientists, should undertake studies to determine the effects of military exercises on the health of civilian and military personnel. (BOT Rep. 5, I-01)

H-440.894 Support of Four Principles of Hand Awareness

Our AMA: (1) endorses the Four Principles of Hand Awareness: (a) Wash your hands when they are dirty and before eating, (b) Do not cough into your hands, (c) Do not sneeze into your hands, and (d) Above all, do not put your fingers into your eyes, nose or mouth; and (2) encourages physicians to "adopt a school" in their communities and promote the Four Principles of Hand Awareness. (Res. 404, I-01)

H-440.895 Antimicrobial Use and Resistance

Our AMA is opposed to the use of antimicrobials at non-therapeutic levels in agriculture, or as pesticides or growth promoters, and urges that non-therapeutic use in animals of antimicrobials (that are also used in humans) should be terminated or phased out based on scientifically sound risk assessments. (Res. 508, A-01)

H-440.896 Influenza Vaccine Availability and Distribution

Our AMA:
(1) will work with all appropriate agencies and organizations, including vaccine manufacturers, to prioritize the distribution channels for influenza vaccine to assure the vaccine is available to patients in accordance with Centers for Disease Control and Prevention guidelines for high risk patients;
(2) urges Congress and the Secretary of the US Department of Health and Human Services to develop a mechanism to assure appropriate distribution of influenza vaccine initially to those providers, public and private, who will immunize the highest risk individuals first, and then use the remainder to protect other members of the public;
(3) will work with the Centers for Disease Control and Prevention, appropriate medical specialty societies, and influenza immunization partners to ensure, in future influenza seasons, adequate influenza vaccine distribution and administration to the high-priority populations as recommended by the Advisory Committee on Immunization Practices (ACIP);
(4) will work with the CDC, through the National Influenza Vaccine Summit, to ensure compliance with the ACIP's annual recommendations with respect to the immunization of patients prioritized to receive influenza vaccine; and
(5) advocates vigorously that for every influenza season, an adequate number of doses of every manufacturer's vaccine supply be sold directly to health care providers immunizing patients identified by the ACIP as being high priority for receiving influenza vaccine; and
(6) will prepare a comprehensive report educating physicians on the complexities of influenza vaccine supply and distribution. (Sub. Res. 416, I-00; Reaffirmation A-05; Appended: Sub. Res. 514, A-06)

H-440.897 Noise Induced Hearing Loss In Children And Adolescents

Our AMA: (1) encourages public education about the dangers of noise-induced hearing loss especially from toys and electronic devices; and (2) encourages the Consumer Product Safety Commission and other appropriate agencies to study the impact of toys and electronic devices on noise-induced hearing loss among children and adolescents. (Res. 407, I-00; Reaffirmed: CSAPH Rep. 6, A-08)

H-440.898 Recommendations on Folic Acid Supplementation

Our AMA will:
(1) encourage the Centers for Disease Control and Prevention (CDC) to continue to conduct surveys to monitor nutritional intake and the incidence of neural tube defects (NTD);
(2) continue to encourage broad-based public educational programs about the need for women of child-bearing potential to consume adequate folic acid through nutrition, food fortification, and vitamin supplementation to reduce the risk of NTD;
(3) encourage the CDC and the National Institutes of Health to fund basic and epidemiological studies and clinical trials to determine causal and metabolic relationships among homocysteine, vitamins B12 and B6, and folic acid, so as to reduce the risks for and incidence of associated diseases and deficiency states;
(4) encourage research efforts to identify and monitor those populations potentially at risk for masking vitamin B12 deficiency through routine folic acid supplementation of enriched food products;
(5) urge the Food and Drug Administration to increase folic acid fortification to 350 µg per 100 g of enriched cereal grain; and
(6) encourage the FDA to require food, food supplement, and vitamin labeling to specify milligram content, as well as RDA levels, for critical nutrients, which vary by age, gender, and hormonal status (including anticipated pregnancy); and
(7) encourage the FDA to recommend the folic acid fortification of all refined grains marketed for human consumption, including grains not carrying the "enriched" label. (CSA Rep. 8, A-99; Modified: CSAPH Rep. 6, A-06)

H-440.899 Immunization Registries

Our AMA encourages physicians to participate in the development of immunization registries in their communities and use them in their practices. (Res. 415, A-99; Reaffirmed: 415, A-01)

H-440.900 Treatment of Chlamydia Trachomatis

Our AMA: (1) supports the application of strategies used to control sexually transmitted diseases (i.e., screening, counseling, treatment, contact tracing) for the prevention and control of chlamydia trachomatis and (2) encourages physicians to participate in strategies for prevention and control of chlamydia trachomatis. (Sub. Res. 415, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-440.901 Achieving National Adolescent Immunization Goals

Our AMA: (1) endorses the National Adolescent Vaccine Coverage Goals; and (2) endorses the collaboration of physicians, public health officials and legislators in each state to carry out strategies that ensure the National Adolescent Vaccine Coverage Goals are met. (Res. 411, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

H-440.902 Obesity as a Major Health Concern

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of obese patients; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat overweight and obese patients. (Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04)

H-440.903 Public Health Care Benefits

Our AMA actively lobby the federal and state governments to restore and maintain funding for public health care benefits for all legal immigrants. (Res. 219, A-98; Reaffirmation A-02)

H-440.904 Food-Borne Illness

Our AMA will work with appropriate federal agencies, medical specialty societies, and public health organizations to (1) educate physicians and the public on measures to prevent food-borne illness; and (2) ensure enforcement of existing regulations for the safe production, handling, and transportation of food items. (Sub. Res. 518, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-440.905 Confidentiality, Counseling and Treatment in the Tuberculosis Screening of Health Care Workers

The AMA encourages all health care organizations that require Tuberculosis screening tests to adopt standards which guarantee health care workers and medical students the right to confidentiality, appropriate counseling, and treatment following the positive results of a tuberculosis skin test; and encourages all health care organizations that require Tuberculosis screening tests to adopt standards which guarantee prospective health care workers and volunteers confidentiality and education about treatment options following the positive results of a tuberculosis skin test. (Sub. Res. 210, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-440.906 Immunization of Health Care Workers with Varicella Vaccine

The AMA: (1) advocates that, unless contraindicated, all susceptible health care workers, including students working in health care facilities, should receive the varicella vaccine. Whereas individuals with a definite history of VZV infection can be considered immune, those with a negative or uncertain history should undergo serologic testing and, if seronegative, should be immunized; (2) urges health care facilities to incorporate guidelines for use of the varicella vaccine into infection control programs to prevent nosocomial transmission of VZV. Such guidelines should address the management of vaccinated individuals who are exposed to VZV as well as those who develop a varicella-like rash or breakthrough varicella subsequent to vaccination; and (3) encourages appropriate federal agencies to support research to determine the long-term safety and efficacy of the varicella vaccine and closely monitor the impact of widespread use of the vaccine on the epidemiology of varicella and herpes zoster. (CSA Rep. 2, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-440.907 Hand Washing

The AMA urges, not only professionals, but the public to adopt hand washing as an important personal priority. (Res. 409, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-440.908 Nosocomial Transmission of Disease via Stethoscope

The AMA advocates that health care providers frequently clean their stethoscopes and take all reasonable precautions with their other

hand-held instruments in order to minimize the potential risk of nosocomial infection. (Res. 501, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-440.909 Regulation of Tattoo Artists and Facilities

The AMA encourages the state regulation of tattoo artists and tattoo facilities to ensure adequate procedures to protect the public health; and encourages physicians to report all adverse reactions associated with tattooing to the Food and Drug Administration MedWatch program. (Res. 506, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-440.910 Medicine-Public Health Congress: Follow-Up Action

The Speakers of the AMA House of Delegates will establish a specific forum during the Interim Meeting at which leaders in medicine, public health and other appropriate disciplines are able to debate or discuss the health of Americans. These policy discussions and debates will be designed to recommend (1) changes in medical and public health education;

(2) joint research efforts;

(3) methods to devise common views of health and illness;

(4) means by which public health and clinical specialists might cooperate in the health delivery process; and

(5) a process to develop common health assessment parameters. Our AMA and its Federation members, in conjunction with the American Association of Public Health Physicians, will continue to move together to translate ideas into appropriate action. (Res. 408, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-440.911 Medicine/Public Health Initiative

The AMA endorses the following recommendations of the Medicine/Public Health Initiative:

Recommendation 1. Engage the community. Seek to change existing thinking within academic health centers, health-oriented community organizations, health care delivery systems and providers, and among health care purchasers to focus on improving the health of the community. Specific local implementation strategies might include: (a) Organizing health-oriented networks of community institutions to improve health of vulnerable populations and the community at large. (b) Stimulating the institutional and curriculum changes necessary for academic health centers to develop interdisciplinary teams to work with communities to improve their health. (c) Establishing community-based research programs that focus on locally relevant health problems and develop knowledge likely to benefit the community.

Recommendation 2. Change the education process. Enhance the practice of medicine and public health by expanding public health's understanding of medicine and medicine's understanding of public health. Specific strategies might include: Public health help for medicine through providing clinicians with better means to analyze procedures and resource use, and to think epidemiologically and statistically. Medicine's help for public health to understand the full meaning of the care of a patient, and also how to mobilize the practice community to better implement disease prevention and health promotion goals. A common core of knowledge taught to all students of public health and medicine. An organizational strategy to accomplish cross-over education, eg, jointly sponsored program tracks and department to department program affiliations between public health and medical schools, and program agreements for special instruction and training with health departments, health care delivery systems, and practitioners. Giving medical and public health students and medical residents the training and clinical opportunities to learn to function as a team to improve health and serve individuals in the context of their communities. Targeting younger audiences, including high school and college students, to encourage participation in and learning about the relation between medicine and public health.

Recommendation 3. Create joint research efforts. Develop a common research agenda for public health and medicine using a three-fold approach. First, educate clinical and public health researchers about the advantages of joining and applying their knowledge in the formulation, design, and execution of research projects. Second, focus these projects on significant health issues. Third, promote public and private funding of research that encourages conceptual and institutional linkages between public health and medicine.

Recommendation 4. Devise a shared view of health and illness. Develop a conceptual framework that gives public health and medicine a common approach to health and illness. Specific implementation strategies might include: Creating a unified framework of health and illness for public health and medicine which would utilize a health-illness continuum and focus on adaptive responses to and interactions with the environment. Developing means of transmitting this knowledge to students and practitioners, and to health care organizations. Devising research projects to implement the approach to health and illness contained in the unified framework. Identifying policy implications of the unified framework of health and illness, and educating policy makers about them.

Recommendation 5. Work together in health care provision. Develop a framework, including standards and strategies, for integrating

health promotion and prevention services and activities into both the clinical and community settings. Specific implementation strategies might include: Reviewing the strengths and weaknesses of different approaches to integrating health promotion and prevention services into health care delivery systems, including the impact of public and private purchasing strategies, as they have evolved in various health care markets across the country. Surveying and evaluating the effectiveness of state and federal regulatory incentives designed to encourage maximum integration of community-wide public health practice into the delivery of health care services and medical practice. Reviewing, summarizing, and encouraging research on the costs and effectiveness of health promotion and disease prevention programs. Fostering public/private community-wide health promotion and public information efforts to create an environment which is supportive of public health and prevention services and strengthens their impact on improving overall health status. Developing a model package of prevention and health promotion services and activities (including information on "best" practice guidelines), which could be adopted by health plan companies, integrated delivery systems and practitioners. Promoting the development of a national standardized health information system that would integrate public health and health services data. Initiating collaborations between public and private organizations to assess and respond to the changing health needs of communities. Developing health promotion and disease prevention standards and performance measures to include in quality assurance programs for health plan companies, integrated delivery systems and other providers.

Recommendation 6. Jointly Develop Health Care Assessment Measures. Synthesize the knowledge of medicine and public health to improve the quality, effectiveness, and outcome measures of health care. Specific implementation strategies might include: Developing better measurement, monitoring, and accountability indices for the use of practitioners, health care provider institutions, and policy-makers. Developing better methods and criteria to establish databases, sufficiently standardized so that they can be readily shared by investigators. Emphasizing the importance of a combined role for medicine and public health in evaluating and placing in perspective major technological advances such as molecular biological screening and gene therapy. Establishing networks and collaborative groups, identifying teaching, intern and extern sites, and synthesizing core training material to accomplish the above objectives.

Recommendation 7. Translate Initiative Ideas Into Actions. Outline processes for translating substantive proposals from the Medicine/Public Health Initiative into successful actions. Specific implementation strategies might include: Establishing a national steering committee of organizations represented in the Initiative to develop and coordinate implementation strategies. Linking such a national committee to parallel local committees developed in states and regions, having practitioners, health care provision organizations, public health officials, academic health centers, etc., as members. Defining and developing structured places in practice and policy venues for those students who wish to focus on the integration of medicine/public health concepts. Creating demonstration projects based on relations between public health and medicine within the health provider, academic, community, and policy environments. (BOT Rep. 4, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-440.912 Federal Block Grants and Public Health

(1) Our AMA should collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated; such efforts may include the development of a common core of knowledge for public health and medical professionals, as well as educational vehicles to disseminate this information.

(2) Our AMA urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; and (c) involve national medical and public health organizations in deliberations on proposed changes in funding of public health programs.

(3) Our AMA will work with and through state and county medical societies to: (a) improve understanding of public health, including the distinction between publicly funded medical care and public health; (b) determine the roles and responsibilities of private physicians in public health, particularly in the delivery of personal medical care to underserved populations; (c) advocate for essential public health programs and services; (d) monitor legislative proposals that affect the nation's public health system; (e) monitor the growing influence of managed care organizations and other third party payers and assess the roles and responsibilities of these organizations for providing preventive services in communities; and (f) effectively communicate with practicing physicians and the general public about important public health issues.

(4) Our AMA urges state and county medical societies to: (a) establish more collegial relationships with public health agencies and increase interactions between private practice and public health physicians to develop mutual support of public health and clinical medicine; and (b) monitor and, to the extent possible, participate in state deliberations to ensure that block grant funds are used appropriately for health-related programs.

(5) Our AMA urges physicians and medical societies to establish community partnerships comprised of concerned citizens, community groups, managed care organizations, hospitals, and public health agencies to: (a) assess the health status of their communities and determine the scope and quality of population- and personal-based health services in their respective regions; and (b) develop performance objectives that reflect the public health needs of their states and communities. (CSA Rep. 3, A-96; Reaffirmation A-01)

H-440.913 Cellular Phone Location of 911 Emergency Calls

The AMA encourages the development of 911 emergency cellular phone service locating systems; encourages that such locating systems be made available to the purchaser of a cellular phone for the benefit of the consumer; and urges appropriate state and federal agencies (e.g., the FCC) to facilitate universal access to 911 services via cellular telephones. (Res. 421, A-96; Res. 223, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-440.914 Intake of Dietary Calcium to Reduce the Incidence of Osteoporosis

The AMA supports the recommendations made by the 1994 National Institutes of Health Consensus Conference Statement on the minimum daily intakes of dietary calcium required to optimize skeletal status and minimize bone loss later in life. (CSA Rep. 3, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-440.916 Heat Related Illness

The AMA urges its state medical associations, in coordination with relevant agencies, to regularly alert their members and the public, through public service announcements or other means, of the imminent return of heat-related illness as summer begins and when periods of extreme heat are predicted; and urges practicing physicians in organized medical settings to recognize the unique opportunity they have to screen and to worn the frail elderly and their relatives, as well as other high risk groups, about the threat of heat-related illness. (Res. 413, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-440.917 Increased Physical Activity for Most US Adults

The AMA endorses, in principle, the movement calling for every adult to accumulate in the course of each day 30 or more minutes of physical activity of moderate intensity; and urges physicians to review the consensus statement of the Centers for Disease Control and Prevention and the American College of Sports Medicine which extends the traditional concept of physical fitness to include intermittent cumulative physical activity and the scientific evidence on which this advice rests. (Res. 408, A-95; Reaffirmed: CSA Rep. 8, A-05)

H-440.918 Improving Public Awareness of Immunization Guidelines

The AMA encourages and supports the frequent and regular dissemination of the Recommended Childhood Immunization Schedule recommendations through appropriate media throughout the US. (Res. 417, A-95; Reaffirmed and Modified: CSA Rep. 8, A-05)

H-440.919 Toward the Control of E. Coli Infection

The AMA: (1) urges physicians to: (a) familiarize themselves with infection due to E. coli 0157:H7; (b) regularly request culture for this organism in any study of infection associated with bloody diarrheal stools; and (c) expand efforts to educate consumers, food processors, and food handlers about the general importance of proper food handling and preparation; and (2) encourages and supports the continuing efforts of the FDA, and of the U.S. Department of Agriculture and its Food Safety and Inspection Service, to develop new and improved methods and technologies for reducing or eliminating bacterial contamination of meat and meat products for human consumption. (Sub. Res. 509, I-94; Reaffirmed and Modified: CSA Rep. 6, A-04)

H-440.920 Endorsement as Guidelines of the "Standards for Pediatric Immunization Practices"

The AMA: (1) encourages members who may be vaccine providers to become thoroughly familiar with the published Standards for Pediatric Immunization Practices in order that they are aware of the guidelines that have been established to assist the nation in achieving the Year 2010 national goal of 90% immunization coverage levels of children by the age of two;
(2) formally endorses as guidelines the Standards for Pediatric Immunization Practice recommended by the National Vaccine Advisory Committee, approved by the U.S. Public Health Service, and endorsed by the American Academy of Pediatrics and the American Academy of Family Physicians;
(3) encourages its members and state and local medical societies to work with their departments of public health, chapters of the American Academy of Pediatrics and the American Academy of Family Physicians, and the AMA Alliance to implement the guidelines and goals included in the Standards; and
(4) advises its members as well as state and local medical societies to work with appropriate organizations to develop coordinated immunization and tracking systems in partnership with relevant local, state, and federal government agencies. (CSA Rep. 1 -I-94; Reaffirmed and Modified: CSA Rep. 6, A-04)

H-440.921 Drug Resistant Streptococcus Pneumoniae Pneumonia

Our AMA encourages state medical societies to urge their members to expand their use of 23 valent pneumococcal vaccine for those

at increased risk for serious pneumococcal infection age two and over, and for all persons age 65 and over in light of the accelerating rise in frequency of multiple resistant strains to penicillin and related drugs. (Res. 512, A-94; Reaffirmed: Res. 515. I-01; Reaffirmed: Res. 520, A-02)

H-440.922 Gambling Can Become Compulsive Behavior

The AMA: (1) encourages physicians to advise their patients of the addictive potential of gambling; (2) encourages states which operate gambling programs to provide a fixed percentage of their revenue for education, prevention and treatment of gambling compulsive behavior; and (3) requests that states which operate gambling programs affix to all lottery tickets and display at all lottery counters a sign which states that gambling may become a compulsive behavior and help is available through your local gambling hotline. (Res. 430, A-94; Reaffirmed: CSA Rep. 6, A-04)

H-440.924 Screening for Sexually Transmitted Chlamydial Infection in Routine Care

(1) The AMA supports the recommendation that physicians and other health care providers recognize the public health need to include screening for Chlamydial infection as an important part of routine care of sexually active, at risk individuals, and recognize the public health key to reaching large numbers of individuals with symptomatic infection. (2) The AMA urges state and appropriate specialty medical societies to alert their members to the new diagnostic screening tests and the therapies available for the management of Chlamydial infection. (3) The AMA: supports national, state, and local programs of the Centers for Disease Control and Prevention (CDC) and other public health agencies for the control of chlamydial infection and encourages enhanced funding for these programs; and recognizes the value to chlamydial screening and control efforts of the availability of highly sensitive and specific diagnostic test such as those using DNA amplification technology and specimens such as first voided urine, and encourages their availability and use by all physicians, diagnostic laboratories, and health departments. (Res. 414, A-94; Reaffirmed and Modified by CSA Rep. 1, I-95; Reaffirmed and Modified: CSA Rep. 8, A-05)

H-440.925 Possible Repeal of the National Vaccine Injury Compensation Program

The AMA continues to support in principle the National Vaccine Injury Compensation Program and will work with the American Academy of Pediatrics and the United States Public Health Service in seeing that the program maintains a rational scientific basis for just compensation. (BOT Rep. 3, A-94; Reaffirmed: CSA Rep. 8, A-05)

H-440.926 United States Surgeon General

The AMA, in order to best protect the health care needs of the American people, will seek changes in federal law to require that the Surgeon General of the United States be an MD/DO, whether the Surgeon General is confirmed by the U.S. Senate or appointed to serve on an acting or interim basis. (Sub. Res. 211, I-93; Reaffirmed: BOT Rep. 28, A-03)

H-440.927 Tuberculosis

Public Health Policy, Compliance and Coercion: The AMA: (1) supports the initiative of public health authorities to modernize the health codes of their states on tuberculosis control including specific authorization for implementation of a Commissioner-ordered program of directly observed therapy for tuberculosis when patient compliance poses a risk to the public;
(2) supports the view that directly observed therapy for tuberculosis for newly discharged patients from hospitals is seen as desirable routine policy for community control against the evolution of multi-drug resistant strains;
(3) supports the view that, in cases when coercive examination, evaluation, treatment or detention are seen as necessary by public health authorities, each decision should be individualized and subject to due process; and
(4) recognizes that the control of tuberculosis (TB) in the foreign-born population is critical to the elimination of TB in the United States, and supports current Centers for Disease Control and Prvention (CDC) recommendations on the prevention and control of TB among foreign-born persons. (Res. 407, A-93; Appended: CSA Rep. 1, I-99)

H-440.928 Update on Immunizations and Vaccine Purchases

Our AMA: (1) encourages state and local health departments to identify local barriers to immunization and collaborate with state and local medical societies to devise plans to eliminate the barriers.

(2) encourages the Administration and Congress to consider immunization initiatives within the broader context of health system reform and payment for preventive care services, and not only as a separate issue.

(3) supports increased federal funding for purchasing vaccines and implementing the national vaccine strategy, including monies for education of the American public about the importance of immunization and for support to state and local governments to remove barriers to effective immunization.

(4) encourages states and other public health entities to make greater use of the option they have through their grantee to use their own appropriated funds to purchase vaccines at the Centers for Disease Control and Prevention contract price and encourages vaccine manufacturers to make the contract vaccine price widely available to such purchasing agents. This would further increase availability of vaccines at the best available price.

(5) encourages private physicians and groups such as HMOs to work together with vaccine manufacturers to secure a negotiated bulk purchase price for vaccines by guaranteeing a larger volume of purchase and lower administrative costs.

(6) encourages health insurance companies to cover the cost of vaccine purchase and administration for all childhood immunizations since immunization of young children is highly cost effective.

(7) encourages all states to alter their Medicaid program so that childhood vaccines can be purchased at the federal contract price and private physicians can be reimbursed for immunization services and cost of vaccine purchase. (BOT Rep. RR, A-93; Amended: CSA Rep. 8, A-03; Reaffirmation A-05; Reaffirmation A-07)

H-440.929 Vaccine Liability

Update on the National Childhood Vaccine Injury Act of 1986: Our AMA: (1) urges the Administration to support and Congress to appropriate sufficient additional funds to pay for all of the retrospective claim awards anticipated for this and future fiscal years by the Division of Vaccine Injury Compensation (the potential shortfall for this year is estimated to be as high as $174 million) to assure that plaintiffs with retrospective claims do not return to the tort system with all the attendant problems of the past.

(2) encourages the Administration to support and Congress to reauthorize the excise tax and the spending authority of the Trust Fund immediately so that payments from the fund may be made for vaccines administered after September 30, 1992, since this is needed both to compensate those injured by vaccines after that date and to afford vaccine providers with a measure of liability protection.

(3) supports the development and implementation of an administrative mechanism to adjust federal vaccine excise tax rates to avoid an unnecessarily high surplus of funds in the trust fund for post-1988 claims. (BOT Rep. QQ, A-93; Modified: BOT Rep. 28, A-03; Reaffirmation A-05)

H-440.931 Update on Tuberculosis

It is the policy of the AMA that: (1) In local areas with a high prevalence of TB, all hospital admissions should be tuberculin skin-tested and those who are found to be positive be managed as medically appropriate and contact tracing performed.
(2) All prison inmates should be tuberculin skin-tested upon arrival, annually thereafter, and within 60 days of their release. Those who are positive should be managed as medically appropriate, contact tracing performed, and provisions made for the continued treatment and follow-up of those who are released prior to the completion of their therapy.
(3) Staff of both prisons and jails should be tuberculin-tested upon employment and annually thereafter. Those who are positive should be managed as medically appropriate and contact tracing performed.
(4) Both public and health care worker education about TB, its transmission, and the necessity for preventive as well as therapeutic treatment should be increased.
(5) Current CDC guidelines for the prevention of tuberculosis in congregate settings should be fully implemented. The protection of persons who are immunocompromised needs to be addressed especially by treatment centers housing such persons.
(6) While powered air-purification respirators may be useful for the protection of HIV-infected and other immunocompromised health care workers who care for patients with infectious TB, their routine use for the prevention of the nosocomial transmission of TB is uncalled for in health care facilities where CDC guidelines are fully implemented.
(7) States should review their TB control laws using current CDC recommendations and recent legal and ethical publications as guidelines. Where necessary to further protect the public health from the disease, existing laws should be modified and/or new ones added. (BOT Rep. JJ, A-93; Reaffirmed: CSA Rep. 8, A-03)

H-440.932 Hepatitis B Vaccine

Our AMA supports: (1) the implementation of a nationally mandated Hepatitis B vaccination program for all infants; (2) the education of the public, physicians and other health care providers, and legislators of the importance of Hepatitis B vaccine inoculation of all infants and groups at high risk; and (3) the recommendations to state and local health departments that all healthy full-term infants born in the U.S. receive the first dose of Hepatitis B vaccine before discharge from the newborn nursery regardless of the mother's HBsAg (Hepatitis B surface antigen) status. (Res. 403, A-93; Amended: CSA Rep. 8, A-03)

H-440.934 Adequacy of Sterilization in Commercial Enterprises

The AMA requests that state medical societies explore with their state health departments the adequacy of sterilization of instruments used in commercial enterprises (tattoo parlors, beauty salons, barbers, manicurists, etc.) because of the danger of exchange of infected

blood-contaminated fluids. (Sub. Res. 409, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-440.935 Transferable Pension Benefits for Public Health Professionals

Our AMA (1) endorses the concept of separable and portable pension plans for all public health professionals, which would permit professionals employed at a public health agency in one state to move to a public health agency in another state and retain pension benefits; and (2) encourages and supports continued communications between the American Association of Public Health Physicians and the Office of the Assistant Secretary of Health regarding that office's study of the portability of pensions for public health officials. (BOT Rep. Y, I-92; Reaffirmed: CLRPD Rep. 5, A-03)

H-440.936 Elimination of Polarization Between the Private and Public Sector Medical Communities

The AMA urges county and state medical societies to create an ex officio position without vote on their governing bodies for the respective public health officer of their jurisdiction so that proper interchange between the private and public health communities can take place. (Res. 14, I-92; Reaffirmed: CLRPD Rep. 5, A-03)

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)

H-440.938 Multiple-Drug Resistant Tuberculosis - A Multifaceted Problem

(1) Testing for tuberculous infection should be performed routinely on all HIV-infected patients, according to current recommendations from the U.S. Public Health Service.

(2) Testing for HIV infection should be routinely performed on all persons with active tuberculosis.

(3) Reporting of HIV infection and tuberculosis should be linked to enhance appropriate medical management and epidemiologic surveillance.

(4) Aggressive contact tracing should be pursued for cases of active tuberculosis, especially if HIV-infected contacts or multiple-drug resistant tuberculosis strains have been involved.

(5) HIV-infected health care workers and their physicians must be aware of the high risk of clinical TB for persons whose immune systems are compromised, due to HIV or other causes. They should be carefully apprised of their risk, and the risks and benefits of their caring for persons with active TB or suspected TB should be carefully considered.

(6) HIV-infected and other immunocompromised patients should be sufficiently separated from tuberculosis patients and the air they breathe so that transmission of infection is unlikely.

(7) All health care workers should have a tuberculin skin test upon employment, with the frequency of retesting determined by the prevalence of the disease in the community. Individuals with a positive skin test should be evaluated and managed according to current public health service recommendations.

(8) Health care facilities that treat patients with tuberculosis should rigorously adhere to published public health service guidelines for preventing the nosocomial transmission of tuberculosis.

(9) Adequate and safe facilities must be available for the care of patients with tuberculosis; in some areas this may necessitate the establishment of sanitariums or other regional centers of excellence in tuberculosis treatment.

(10) Clinical tuberculosis laboratories should develop the capability of reliably performing or having reliably performed for them rapid identification and drug susceptibility tests for tuberculosis.

(11) Routinely, drug susceptibility tests should be performed on isolates from patients with active tuberculosis as soon as possible.

(12) A program of directly observed therapy for tuberculosis should be implemented when patient compliance is a problem.

(13) The AMA should enlist the aid of the Pharmaceutical Research and Manufacturers of America (PhRMA) in encouraging manufacturers to develop new drugs and vaccines for tuberculosis.

(14) The federal government should increase funding significantly for tuberculosis control and research to curtail the further spread of tuberculosis and encourage development of new and effective diagnostics, drug therapies, and vaccines.

(15) The special attention of physicians, public health authorities, and funding sources should be directed toward high risk and high incidence populations such as the homeless, immigrants, minorities, health care workers in high risk environments, prisoners, children, adolescents, and pregnant women.

(16) The AMA will develop educational materials for physicians that will include but not be limited to the subtleties of testing for TB in HIV-infected individuals; potential risk to HIV-infected individuals exposed to infectious diseases, including TB; and other issues identified in this report.

(17) The AMA encourages physicians to remain informed about advances in the treatment of tuberculosis, including the availability of combination forms of drugs, that may reduce the emergence of drug-resistant strains. (BOT Rep. OO, A-92; Sub. Res. 505, I-94; Reaffirmed and Modified: CSA Rep. 6, A-04)

H-440.939 Qualifications for State Health Directors

The AMA recommends to state medical societies that they advocate with their respective legislatures the adoption of statutory requirements that the qualifications for State Health Director include a doctoral degree in medicine or osteopathy, public health training or experience, and preparation, both academic and experiential, adequate for the management of a large and complex health agency. (Sub. Res. 204, A-92; Reaffirmed by Sub. Res. 425, I-95; Reaffirmed Sub. Res. 421, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-440.941 High Cost and Shortage of Vaccines

The AMA seeks to ensure in an administratively efficient manner the ready availability of vaccines to immunize individuals at reasonable cost. (Res. 506, A-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-05)

H-440.942 State Health Officer Report at Annual Meeting of State Medical Society Meetings

The AMA urges each state medical society to extend to their respective state health officer a standing invitation to participate in and report to the annual meeting of their house of delegates upon issues, accomplishments, problems, and needs of public health significance within the state. (Res. 429, I-91; Reaffirmed by Res. 417, I-94; Reaffirmed: CSA Rep. 6, A-04)

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)

H-440.944 Relationship with American Public Health Association

Our AMA strongly supports the active involvement of the medical profession in all aspects of the American Public Health Association, particularly in view of its recent health policy-making activities on health care delivery. (Res. 411, I-91; Reaffirmed: Sunset Report, I-01)

H-440.945 Fluoride Content of Municipal Water Supplies

Local and state medical societies and individual physicians have the opportunity to become involved in correcting the problem of fluoride underfeeding by (1) ascertaining whether municipal water supplies are optimally fluoridated and (2) working with public health agencies to take corrective action if suboptimal fluoridation is found. (BOT Rep. RR, I-91; Reaffirmed: Sunset Report, I-01)

H-440.946 Health Care Workers and HBV - Nonresponders to HBV Vaccine

It is the policy of the AMA that (1) health care workers who practice invasive procedures and who have been immunized with HBV vaccine be tested for evidence of immunity as determined by a protective anti-HBs level (as currently defined by the United States Public Health Service) one to six months after the completion of an immunization series;
(2) such health care workers who fail to respond with an adequate anti-HBs level be counseled about their immune status, its possible impact on their careers, and offered a complete revaccination series;
(3) health care workers given a revaccination series be tested again for an adequate anti-HBs level one to six months following the completion of the immunization series. Those who again fail to respond with a protective level should be counseled about the need to continue to follow universal precautions and the risk to their health if they continue to perform invasive procedures; and
(4) health care workers be encouraged to maintain HBV immunity by obtaining appropriate booster immunization when indicated.

(BOT Rep. X, I-91; Reaffirmed: Sunset Report, I-01)

H-440.947 Sexually Transmissible Diseases

Our AMA supports the use of the word transmissible to describe those diseases which may be transferred by sexual acts and supports the dissemination of this information to agencies (public and private), communications media and health departments. (Res. 138, A-91; Reaffirmed: Sunset Report, I-01)

H-440.948 Health Care Workers Infected with Hepatitis B Virus

(1) Any health care worker who is infected with HBV and in whom HBeAg can be demonstrated should abstain from performing invasive procedures that pose an identifiable or measurable risk of transmission. (2) All health care workers who are at risk of infection with HBV should be fully immunized with HBV vaccine. (3) For the purposes of these recommendations, a health care worker should be considered as any person involved in patient care in a paid capacity or as a volunteer and as a student, resident, trainee, or trained worker. (BOT Rep. H, A-91; Reaffirmation I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-440.949 Immunity to Hepatitis B Virus

It is the policy of the AMA that a health care worker who is at risk for HBV infection, has no immunity resulting from a natural infection, and who has not initiated immunization with HBV vaccine, either be immunized or should abstain from performing invasive procedures. (BOT Rep. CCC, A-91; Modified: Sunset Report, I-01)

H-440.950 Premarital Testing

Our AMA encourages individual states to review and reassess the need for mandatory premarital testing for infectious diseases for their respective populations and to determine whether there is a favorable cost/benefit ratio for the specific disease in question. In the absence of a favorable ratio, states should consider abandoning mandatory premarital testing for an infectious disease. (BOT Rep. Z, A-91; Reaffirmed: Sunset Report, I-01)

H-440.952 More Rapid Phasing-In of Routine Immunization Against Measles in Children and Youth

Our AMA, in acting on this principle, endorses recommendations of both the American Academy of Pediatrics and the Centers for Disease Control with the implication of support for a policy of a second dose of measles vaccine (in the form of MMR) for children entering junior high school as well as kindergarten, school and college. (Res. 85, I-90; Modified: Sunset Report, I-00)

H-440.954 Revitalization of Local Public Health Units for the Nation

The AMA (1) reaffirms its support of state and local health departments; (2) recommends that health departments be directed by well qualified public health trained physicians; and (3) urges federal, state and local governments to study public health and preventive services, and urges the allocation of necessary resources to maintain these services at a high level of quality. (Res. 132, A-90; Reaffirmed by Sub. Res. 425, I-95; Reaffirmed Sub. Res. 421, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-440.955 Federal Funding to Eliminate Tuberculosis as a Public Health Problem

Our AMA (1) urges the Administration and the Congress to commit the nation to completion of the Centers for Disease Control 20-year plan to eliminate tuberculosis as a public health problem and to provide adequate funding each step of the way; and (2) in its submission of support for reauthorization of grants to the states for tuberculosis, urges the Congress to rename the state's grant program under Section 317 of the Public Health Service Act Grants for the Elimination of Tuberculosis as the best expression of a national commitment. (Res. 191, A-90; Reaffirmed: Sunset Report, I-00)

H-440.956 Measles Vaccine

It is the policy of the AMA (1) to encourage state medical societies through their state journals and other publications to campaign for measures that improve the delivery and storage of measles vaccine to inner city and other vulnerable populations; (2) to promote the development of guidelines for the proper vaccine storage and shipment to lower the incidence of measles vaccine failure; and (3) to use its publications to inform residents and house staff training programs and medical schools about appropriate measures to ensure that house staff and medical students have adequate immunity to measles. (Sub. Res. 192, A-90; Reaffirmed: Sunset Report, I-00)

H-440.957 Reporting Potential for Hearing Loss Due to Personal Listening Devices

It is the policy of the AMA that (1) physicians counsel patients about the potential loss of hearing associated with the misuse of personal listening devices; (2) research be directed at more specific definition of the relationship between acute and chronic use of

personal listening devices and the occurrence of short-term and long-term noise-induced hearing loss; and (3) the AMA work with the National Institute on Deafness and Other Communication Disorders to enhance awareness, knowledge and remediation of causes of noise induced hearing loss. (BOT Rep. A, A-90; Reaffirmed: Sub. Res. 506, I-93; Amended: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 6, A-08)

H-440.958 Universal Immunization for Hepatitis B Virus

For enhanced effectiveness in decreasing the incidence of hepatitis B in the United States, it appears to be necessary to broaden current immunization strategies. Safe and effective vaccines are available for prevention of the disease but this use is limited by cost. Eradication of the disease on a national and international basis is a definite hope, but may not be possible without the development of antiviral treatments to control or eliminate the virus in the carrier state and in infected vaccine nonresponders. Education about the disease and its transmission is an essential element for any effective program to reduce the incidence of hepatitis B. Therefore,
(1) The AMA endorses the principle of the universal immunization with hepatitis B vaccine of all infants, adolescents, military recruits, and students entering colleges and technical schools. While the ultimate goal is the complete immunization of all these groups, the process will need to be a gradual one beginning with the immunization of high-risk groups and then the phasing-in of infants, adolescents, and the other groups.
(2) The AMA encourages the immunization of all students entering medical school. The costs for the immunizations should be included in the school tuition.
(3) The Association supports the immunization of all other risk groups with special emphasis on patients attending sexually transmitted disease clinics and drug rehabilitation centers.
(4) The Association supports the proposed regulation of OSHA requiring the vaccination of all healthcare workers at risk of hepatitis B virus infection.
(5) The Association encourages further professional and public education on hepatitis B disease, its transmission, and prevention. Such education should include state and federal legislators and emphasize the need for funding for immunization programs. In addition, education concerning hepatitis B should be a part of every sex and AIDS education course in the nation.
(6) The Association encourages the scientific community to intensify its efforts to find effective therapies for patients infected with hepatitis B virus.
(7) The Association encourages the U.S. Public Health Service and the World Health Organization to develop strategies for the elimination of hepatitis B both nationally and globally. (BOT Rep. AA, A-90; Reaffirmation I-96; Reaffirmed: CSA Rep. 18, A-99)

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)

H-440.960 The IOM Report (The Future of Public Health) and Public Health

Our AMA (1) encourages medical societies to establish liaison committees through which physicians in private practice and officials in public health can explore issues and mutual concerns involving public health activities and private practice;

(2) seeks increased dialogue, interchange, and cooperation among national organizations representing public health professionals and those representing physicians in private practice or academic medicine;

(3) actively supports promoting and contributing to increased attention to public health issues in its programs in medical science and education;

(4) continues to support the providing of medical care to poor and indigent persons through the private sector and the financing of this care through an improved Medicaid program and mandated employer health insurance;

(5) encourages public health agencies, as the IOM report suggests, to focus on assessment of problems, assurance of healthy living conditions, policy development, and activities such as those mentioned in the "Model Standards";

(6) encourages physicians and others interested in public health programs to apply the messages and injunctions of the IOM report as these fit their own situations and communities; and

(7) encourages physicians in private practice and those in public health to work cooperatively, striving to ensure better health for each person and an improved community as enjoined in the Principles of Medical Ethics. (CSA Rep. E, I-89; Reaffirmed: Sunset Report, A-00)

H-440.964 Elimination of Tuberculosis

Our AMA supports the advisory committee for elimination of tuberculosis, established by HHS, in collaboration with the Division of Tuberculosis Elimination, CDC, and supports working with other governmental agencies to assist in carrying out the task of the committee. (Res. 174, A-89; Reaffirmed: Sunset Report, A-00)

H-440.965 The Future of Public Health

The AMA (1) encourages all its members to reevaluate and renew their commitment to working cooperatively with public health officials; and (2) urges its members to utilize this commitment to strengthen the quality of the delivery of public health services and to insure quality health care for all citizens within their communities. (Res. 82, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-440.966 Elimination of Tuberculosis as a Public Health Problem

The AMA (1) endorses the Strategic Plan for the Elimination of Tuberculosis, as developed by the CDC Advisory Committee for the Elimination of Tuberculosis; (2) supports cooperative efforts with other national medical and public health organizations to help implement the policies of the Strategic Plan for the Elimination of Tuberculosis; (3) supports the promulgation of information on the appropriate methods for evaluating, diagnosing, treating, and preventing tuberculosis; and (4) encourages and assists state and county medical associations to work with state, county and city health officials to achieve the long-range objective of reducing the incidence of active tuberculosis in the United States to one case per million before the year 2010. (Res. 75, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

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)

H-440.969 Meeting Public Health Care Needs Through Health Professions Education

(1) Faculties of programs of health professions education should be responsive to the expectations of the public in regard to the practice of health professions. Faculties should consider the variety of practice circumstances in which new professionals will practice. Faculties should add curriculum segments to ensure that graduates are cognizant of the services that various health care professionals and alternative delivery systems provide. Because of the dominant role of public bodies in setting the standards for practice, courses on health policy are appropriate for health professions education. Additionally, governing boards of programs of education for the health professions, as well as the boards of the institutions in which these programs are frequently located, should ensure that programs respond to changing societal needs. Health professions educators should be involved in the education of the public regarding health matters. Programs of health professions education should continue to provide care to patients regardless of the patient's ability to pay and they should continue to cooperate in programs designed to provide health practitioners in medically underserved areas.

(2) Faculty and administrators of health professions education programs should participate in efforts to establish public policy in regard to health professions education. Educators from the health professions should collaborate with health providers and practitioners in efforts to guide the development of public policy on health care and health professions education. (BOT Rep. NN, A-87; Reaffirmed: CSA Rep. 8, A-05)

H-440.970 Religious Exemptions from Immunizations

Since religious/philosophic exemptions from immunizations endanger not only the health of the unvaccinated individual, but also the health of those in his or her group and the community at large, the AMA (1) encourages state medical associations to seek removal of such exemptions in statutes requiring mandatory immunizations; (2) encourages physicians and state and local medical associations to work with public health officials to inform religious groups and others who object to immunizations of the benefits of vaccinations and the risk to their own health and that of the general public if they refuse to accept them; and (3) encourages state and local medical

associations to work with public health officials to develop contingency plans for controlling outbreaks in exempt populations and to intensify efforts to achieve high immunization rates in communities where groups having religious exemptions from immunizations reside. (CSA Rep. B, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-440.972 Statewide Fluoridation

The AMA urges state health departments to consider the value of requiring statewide fluoridation (preferably a comprehensive program of fluoridation of all public water supplies, where these are fluoride deficient), and to initiate such action as deemed appropriate. (Sub. Res. 9, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-440.973 Immunization of Adults

Our AMA (1) encourages physicians and other health and medical workers (in practice and in training) to set positive examples by assuring that they are completely immunized; (2) urges physicians to advocate immunization with all adult patients to whom they provide care, to provide indicated vaccines to ambulatory as well as hospitalized patients, and to maintain complete immunization records, providing copies to patients as necessary; (3) promotes use of available public and professional educational materials to increase use of vaccines and toxoids by physicians and to increase requests for and acceptance of these antigens by adults for whom they are indicated; (4) encourages third party payers to provide coverage for adult immunizations; and (5) will urge manufacturers and distributors of influenza vaccine to provide a dedicated ordering system for small- and medium-size medical practices to pre-order vaccine up to an appropriate volume threshold. (Res. 3, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Appended: Sub. Res. 514, A-06; Reaffirmation A-08)

H-440.975 Community Control of Public Sources of Spread of Sexually Transmitted Diseases

The AMA endorses the efforts of federal, state and local health authorities to close down or control public reservoirs of infection represented by commercial sex establishments, as these may be defined in state and local statutes. (Res. 9, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-440.977 Hepatitis B Vaccine

The AMA urges the appropriate use of hepatitis B vaccine and the dissemination of professional educational materials to increase the use of the hepatitis B vaccine by physicians whose patients are in high risk groups, including physicians in training and other medical personnel who come into contact with blood and blood products, tissues, secretions and excretions demonstrated to be potential reservoirs of hepatitis B virus. (Sub. Res. 3, A-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed and Modified: CSA Rep. 8, A-05)

H-440.979 Control of Sexually Transmitted Diseases

The AMA urges increased efforts at all levels of organized medicine to bring sexually transmitted diseases under control, through professional and public education, and support of the efforts of state Departments of Health, the Centers for Disease Control, the National Institutes of Health, and other appropriate organizations. (Res. 84, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmation A-99)

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)

H-440.982 Centers for Disease Control Funding

The AMA supports funding for the Centers for Disease Control that is adequate to support its important and expanding public health activities. (BOT Rep. Q, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-440.983 Update on Venereal Disease

The AMA (1) urges medical students, primary care residents, and physicians in all specialties to familiarize themselves with sexually transmitted diseases (STD), so that they will be better able to diagnose and treat them; (2) encourages physicians to always include a sexual history as part of their routine history and physical exam; (3) encourages STD instruction, both didactic and clinical, in all medical school and primary residency programs; (4) encourages the establishment of STD fellowships by primary care specialties in order to develop a pool of clinical and research expertise in the area; (5) encourages state and local medical societies to promote STD public service TV and radio announcements in their communities; and (6) supports continued communication of updated STD

information regularly through AMA publications. (CSA Rep. E, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmation A-99)

H-440.984 Mandatory Immunization Requirements for Foreign Students Applying for Visas

The AMA favors requiring that all foreign students, as well as their spouses and offspring, submit as a condition for obtaining a visa, acceptable medical evidence that they have either acquired immunity through previous infection with certain infectious disease agents or through appropriate immunizations against same, in keeping with statutory mandates commonly prevalent in this country. (Res. 11, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-440.988 Pneumococcal, Influenza and Hepatitis-B Vaccines

Our AMA advocates: (1) that patients at risk of pneumococcal or influenzal infections receive the appropriate vaccination;

(2) that individuals, including health care professionals at high risk of hepatitis-B infection, be given the informed option of receiving HBV vaccine. Until further experience has alleviated concerns about possible late hazards from this vaccine, a more widespread usage is not currently justified;

(3) study of possible solutions to the problems of payment for HBV and influenza vaccination for segments of the population at increased risk;

(4) research to improve the efficacy of pneumonia and influenza vaccines in selected populations and to develop artificial HBV antigens, with a view to reducing the cost to patients of this important new vaccine;

(5) physicians to follow the recommendations of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention on the Prevention of Pneumococcal Disease; and

(6) third party payers to appropriately reimburse physicians for the administration of recommended vaccinations. (CSA Rep. K, I-82; Reaffirmed: CLRPD Rep. A, I-92; Appended: Res. 410, A-99; Reaffirmed: Res. 515, I-01; Reaffirmed: Res. 520, A-02)

H-440.989 Continuation of the Commissioned Corps

Our AMA strongly supports the continuation of the Commissioned Corps of the US Public Health Service. (Res. 5, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-440.991 Immunization Programs for Children

Our AMA (1) continues to support efforts toward the prevention of childhood disease through immunizations; (2) favors using its position in international health organizations to promote appropriate immunization programs for children throughout the world, especially in such critical and cost-effective areas as the prevention of poliomyelitis and measles; and (3) expresses the need for private and public research institutions to help develop more technically advanced products, such as new heat stable vaccines, necessary for the effective immunization of children throughout the world. (Sub. Res. 37, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 416, A-05)

H-440.992 National Immunization Program

Our AMA believes the following principles are required components of a national immunization program and should be given high priority by the medical profession and all other segments of society interested and/or involved in the prevention and control of communicable disease: (1) All US children should receive recommended vaccines against diseases in a continuing and ongoing program.

(2) An immunization program should be designed to encourage administration of vaccines as part of a total preventive health care program, so as to provide effective entry into a continuous and comprehensive primary care system.

(3) There should be no financial barrier to immunization of children.

(4) Existing systems of reimbursement for the costs of administering vaccines and follow-up care should be utilized.

(5) Any immunization program should be either (a) part of a continuing physician/patient relationship or (b) the introductory link to a continuing physician/patient relationship wherever possible.

(6) Professionals and allied health personnel who administer vaccines and manufacturers should be held harmless for adverse reactions occurring through no fault of the procedure.

(7) Provision should be made for a sustained, multi-media promotional campaign designed to educate and motivate the medical profession and the public to expect and demand immunizations for children and share responsibility for their completion.

(8) An efficient immunization record-keeping system should be instituted. (Res. 44, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-440.993 Smallpox Vaccination Policy

Our AMA supports the recommendations of the Public Health Service Advisory Committee on Immunization Practices that systematic programs of routine vaccination for smallpox for hospital and health personnel no longer be required. (BOT Rep. P, A-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-440.994 Sexually Transmitted Disease Prevention

Our AMA endorses the use of the condom as an effective method of prevention of sexually transmitted disease and urges state and county medical societies to endorse the display and sale of condoms of assured quality by the usual retail outlets for the prevention of sexually transmitted disease, and suggests that each package contain information about the hazards of sexually transmitted disease. (BOT Rep. T, A-74; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed by CSA Rep. 3, A-95; Reaffirmed and Modified with change in title: CSA Rep. 8, A-05)

H-440.995 More Complete and More Prompt Reporting of Measles (Rubeola)

Our AMA: (1) encourages and requests all physicians and others charged with the responsibility for reporting cases of measles to report them promptly, preferably by telephone, to the local and state public health officials; and (2) encourages both public health officials and those in the private practice of medicine to intensify and expand their efforts at immunization of persons susceptible to measles whenever second or successive generation cases of measles are detected in a locality. (Res. 108, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-440.996 Gonorrhea Control

Our AMA (1) supports continued action to assert appropriate leadership in a concerted program to control venereal disease;

(2) urges physicians to take all appropriate measures to reverse the rise in venereal disease and bring it under control;

(3) encourages constituent and component societies to support and initiate efforts to gain public support for increased appropriations for public health departments to fund research in development of practical methods for prevention and detection of venereal disease, with particular emphasis on control of gonorrhea; and

(4) in those states where state consent laws have not been modified, encourages the constituent associations to support enactment of statutes that permit physicians and their co-workers to treat and search for venereal disease in minors legally without the necessity of obtaining parental consent. (Sub. Res. 6, I-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-440.997 Research and Control of Gonorrhea

Our AMA reaffirms its concern and urges additional support of research and control of gonorrhea, and urges constituent and component medical associations to increase their educational activities and to participate in cooperative programs at the local level to encourage prevention, reporting and prompt adequate treatment of gonorrhea. (Res. 113, A-67; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-440.998 US Public Health Service

In matters pertaining to the traditional responsibilities of the United States Public Health Service, the medical and related scientific decisions should remain within the purview and jurisdiction of those who are trained medical officers. (Res. 58, I-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-440.999 Increase in Venereal Disease

The AMA takes official cognizance of the resurgence of syphilis and gonorrhea to the proportions of a national health problem; supports initiating through appropriate channels of the AMA a comprehensive inquiry of the causative factors for this sharp increase in diseases for which a simple cure is now available; supports taking the leadership in educational and research measures designed to control and eliminate syphilis; and supports providing guidance to private physicians in the epidemiology of the venereal diseases and

of their social implications. (Res. 22, A-64; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-445.000 Public Relations

H-445.986 Strategy to Promote AMA to the Public

In order to enhance the visibility of how physicians attend to their patients and to strengthen the confidence the public has in us, our AMA should seek opportunities, including telecasts and interviews with the news media, for its leadership, as well as the elected officers of state, local, and specialty societies, to enhance our image with the public. (Res. 618, A-01)

H-445.987 Sexually Exploitative Advertising to Physicians

The AMA opposes the use of exploitative sexual themes in the marketing of medical products and technologies to physicians. (Res. 502, I-94; Reaffirmed: CLRPD Rep. 1, A-04)

H-445.989 Government Statements Regarding the Delivery and Cost of Medical Care

It is the policy of the AMA to increase its efforts to monitor statements by government officials relevant to medical care and to challenge in a highly visible public manner all statements and conclusions not supported by fact or scientifically and statistically based data. (Res. 231, I-91; Reaffirmed: CMS Rep. 4, I-00; Reaffirmation A-07)

H-445.990 Hospital and Medical Facility Communications with Scientific Content

Our AMA encourages hospitals and other medical care facilities to develop appropriate policy for scientific review of communications to the public that have scientific content. (Res. 97, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-07)

H-445.994 Corporate Visitation Program

Our AMA encourages all county and state medical associations to embark upon efforts to establish an improved and ongoing communication with the nation's business community and seek AMA's support in their implementation, which may be enhanced by enlisting the cooperation of the senior medical officer or medical consultant, if any, of the corporations contacted. (Res. 44, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-445.995 Responses to News Reports and Articles

Our AMA encourages the public relations committees of all county, state and national medical societies to initiate positive programs with the media and to make timely responses to misleading and inaccurate media releases giving the general public a more accurate and balanced perspective of the medical profession and medical issues. (Res. 10, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-07)

H-445.996 Public Awareness and Education

Our AMA supports efforts to improve the image of medicine as presented in television shows and, when possible, to encourage portrayal of the positive aspects of good medical practice. (Sub. Res. 27, I-75; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-07)

H-445.997 Interviews with News Media

Our AMA: (1) recommends that, when spokesmen for medicine cooperate with the media in the production of news stories and documentaries, every effort should be made to provide media personnel with additional information and medical authentication of materials being prepared for presentation to the public; and (2) urges media personnel to seek such assistance from medical spokesmen being interviewed for their program material. (Sub. Res. 3, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-07)

H-445.998 Propriety of Professional Public Communications

Our AMA encourages: (1) the initiative of those physicians who desire to speak out as individuals, on public issues; and (2) all authorized spokesmen for component societies to participate in local, state and national issues as responsible physicians in order that the voice of organized medicine be heard. (Res. 42, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-07)

H-445.999 Chambers of Commerce

The AMA reaffirms its previously adopted recommendation to all state medical societies that they become active in the U.S. and state chambers of commerce and requests that a similar recommendation be made to all county medical societies so that they too might be encouraged to become active in local, state and U.S. chambers of commerce programs. (Res. 21, I-63; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-450.000 Quality of Care
(See also: Health Care Delivery; Health Care Reform; Medical Review; Medicare: PRO; Medicare: Carrier Review; Peer Review; Practice Parameters

H-450.936 Physician Quality Reporting Initiative Payment

Our AMA will continue to advocate for improvements in the Physician Quality Reporting Initiative (PQRI) including early education and outreach to physicians by the Centers for Medicare and Medicaid Services (CMS), the provision of confidential interim and final feedback reports from CMS to physicians on potential problems in their PQRI reporting, easier access to feedback reports, development of meaningful dispute resolution processes, and the provision to our AMA of the 2007 PQRI data set file. (Sub. Res. 219, I-08)

H-450.937 Medical Care Outside the United States

Our AMA advocates that employers, insurance companies, and other entities that facilitate or incentivize medical care outside the US adhere to the following principles:

(1) Medical care outside of the US must be voluntary.

(2) Financial incentives to travel outside the US for medical care should not inappropriately limit the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options.

(3) Patients should only be referred for medical care to institutions that have been accredited by recognized international accrediting bodies (e.g., the Joint Commission International or the International Society for Quality in Health Care).

(4) 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 US.

(5) Coverage for travel outside the US for medical care must include the costs of necessary follow-up care upon return to the US.

(6) Patients should be informed of their rights and legal recourse prior to agreeing to travel outside the US for medical care.

(7) 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 US.

(8) The transfer of patient medical records to and from facilities outside the US should be consistent with HIPAA guidelines.

(9) Patients choosing to travel outside the US for medical care should be provided with information about the potential risks of combining surgical procedures with long flights and vacation activities (CMS Rep. 1, A-08)

H-450.938 Value-Based Decision-Making in the Health Care System

PRINCIPLES TO GUIDE PHYSICIAN VALUE-BASED DECISION-MAKING

1. Physicians should encourage their patients to participate in making value-based health care decisions.

2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.

3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.

4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.

5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.

6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life. (CMS Rep. 7, A-08)

H-450.939 Activities of the National Quality Forum

Our AMA will: (1) continue to advocate for the Physician Consortium for Performance Improvement as the measure developer for physician-level performance measurement; (2) continue to monitor the National Quality Forum's (NQF) activities to ensure physician representation and involvement in all activities and leadership; and (3) oppose any efforts to expand the NQF's mission to include measure development or other actions that would effectively limit or eliminate the Physician Consortium for Performance Improvement's principal role in the measure development process. (BOT Rep. 1, I-07)

H-450.940 National Quality Forum

Our AMA opposes any efforts to expand the National Quality Forum's (NQF) mission to include measure development or other actions that would effectively limit or eliminate the Physician Consortium for Performance Improvement's principal role in the measurement development process and will report on the ongoing activities of the NQF at the 2007 Interim Meeting. (Res. 230, A-07)

H-450.941 Pay-For-Performance, Physician Economic Profiling, and Tiered and Narrow Networks

1. Our AMA will collaborate with interested parties to develop quality initiatives that exclusively benefit patients, protect patient access, do not contain requirements that permit third party interference in the patient-physician relationship, and are consistent with AMA policy and Code of Medical Ethics, including Policy H-450.947, which establishes the AMA's Principles and Guidelines for Pay-for-Performance and Policy H-406.994, which establishes principles for organizations to follow when developing physician profiles, and that our AMA actively oppose any pay-for-performance program that does not meet all the principles set forth in Policy H-450.947.

2. Our AMA strongly opposes the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors.

3. Our AMA pledges an unshakable and uncompromising commitment to the welfare of our patients, the health of our nation and the primacy of the patient-physician relationship free from intrusion from third parties.

4. Because there are reports that pay-for-performance programs may pose more risks to patients than benefits, our AMA will prepare an annual report on the risks and benefits of pay-for-performance programs, in general and specifically the largest programs in the country including Medicare, for the House of Delegates over the next three years, beginning at the 2007 Interim Meeting. This report should shall clearly delineate between private pay-for-performance programs and voluntary public pay-for-reporting and other related quality initiatives.

5. Our AMA will continue to work with other medical and specialty associations to develop effective means of maintaining high quality medical care which may include physician accountability to robust, effective, fair peer review programs, and use of specialty-based clinical data registries.

6. As a step toward providing the Centers for Medicare and Medicaid Services (CMS) with data on special populations with higher health risk levels and developing variable incentives in achieving quality, our AMA will continue to work with CMS to encourage and support pilot projects, such as the Physician Quality Reporting Initiative (PQRI), by state and specialty medical societies that are developed collaboratively to demonstrate effective incentives for improving quality, cost-effectiveness, and appropriateness of care.

7. Our AMA will advocate that physicians be allowed to review and correct inaccuracies in their patient specific data well in advance of any public release, decreased payments, or forfeiture of opportunity for additional compensation. (BOT Rep. 18, A-07; Reaffirmed in lieu of Res. 729, A-08)

H-450.942 Patient Adherence to Treatment Plans

It is AMA policy that patient adherence to any medical treatment program is necessary in order to achieve high quality and cost-effective health care. (Res. 505, A-06)

H-450.943 Effects of Pay-for-Performance on Minority Health Disparities

Our AMA urges that physicians with expertise in eliminating racial and ethnic health disparities be involved in the design, implementation and evaluation of pay-for-performance programs. (Res. 210, A-06)

H-450.944 Protecting Patients Rights

Our AMA opposes Medicare pay-for-performance initiatives (such as value-based purchasing programs) that do not meet our AMA's "Principles and Guidelines for Pay-for-Performance," which include the following five Principles: (1) ensure quality of care; (2) foster the patient/physician relationship; (3) offer voluntary physician participation; (4) use accurate data and fair reporting; and (5) provide fair and equitable program incentives. (Sub. Res. 902, I-05; Reaffirmation A-06; Reaffirmation I-06; Reaffirmation A-07)

H-450.945 Science in Medicine and Quality of Care in Health System Reform

It is a critical role of the AMA to preserve, protect and enhance the quality of medical care now and in the future by: (1) advancing the art and science of medicine and the health of the public, (2) advocating for patients, physicians and the public, (3) enhancing the profile and priority within the AMA of science as the basis of medicine; and (4) bringing science advocacy to the forefront of health system reform. (Res. 511, I-93, Reaffirmed: CSA Rep. 8, A-03; Renumbered: CMS Rep. 7, I-05)

H-450.946 Ensuring Quality in Health System Reform

Our AMA: (1) will discuss quality of care in each of its presentations on health system reform; (2) will advocate for effective quality management programs in health system reform that: (a) incorporate substantial input by actively practicing physicians and physician organizations at the national, regional and local levels; (b) recognize and include key quality management initiatives that have been developed in the private sector, especially those established by the medical profession; and (c) are streamlined, less intrusive, and result in real reduced administrative burdens to physicians and patients; and (3) will take a leadership role in coordinating private and public sector efforts to evaluate and enhance quality of care by maintaining a working group of representatives of private and public sector entities that will: (a) provide for an exchange of information among public and private sector quality entities; (b) oversee the establishment of a clearinghouse of performance measurement systems and outcomes studies; (c) develop principles for the development, testing, and use of performance/outcomes measures; and (d) analyze and evaluate performance/outcomes measures for their conformance to agreed upon principles. (Sub. Res. 703, I-93; Reaffirmation A-01; Renumbered: CMS Rep. 7, I-05)

H-450.947 Pay-for-Performance Principles and Guidelines

(1) The following *Principles for Pay-for-Performance and Guidelines for Pay-for-Performance* are the official policy of our AMA.

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.
4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.
5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.

- Evidence-based quality of care measures must be the primary measures used in any program.
1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
4. Performance measures should be scored against both absolute values and relative improvement in those values.
5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.
6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
7. Performance measures must be selected for clinical areas that have significant promise for improvement.

- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.

- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.

- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.

- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.

- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.

- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.

- Programs must not create conditions that limit access to improved care.
1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

- Programs must neither directly nor indirectly encourage patient de-selection.

- Programs must recognize outcome limitations caused by patient non-compliance, and sponsors of PFP programs should attempt to minimize non-compliance through plan design.

Physician Participation

- Physician participation in any PFP program must be completely voluntary.

- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or

out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.

- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.

- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.

- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
1. Programs should provide physicians with tools to facilitate participation.
2. Programs should be designed to minimize financial and technological barriers to physician participation.

- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.

- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.

- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.

- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).

- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
1. Programs should use accurate administrative data and data abstracted from medical records.
2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.

- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.

- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.

- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.

- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

- Programs must be based on rewards and not on penalties.

- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.

- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.

- Programs must finance bonus payments based on specified performance measures with supplemental funds.

- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.

- Programs must not reward physicians based on ranking compared with other physicians in the program.

- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.

- Programs must not financially penalize physicians based on factors outside of the physician's control.

- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.

(2) Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance." (BOT Rep. 5, A-05; Reaffirmation A-06; Reaffirmed: Res. 210, A-06; Reaffirmed in lieu of Res. 215, A-06; Reaffirmed in lieu of Res. 226, A-06; Reaffirmation I-06; Reaffirmation A-07)

H-450.948 Support of Patient Safety Aspects of JCAHO

AMA policy is that evidence-based medicine be used to determine useful safety standards whenever possible. (Res. 530, A-04)

H-450.949 Update on Patient Safety

Our AMA: (1) asserts that quality improvement programs must always consider patient safety when selecting their objectives; and (2) encourages all physicians to become familiar with and capitalize on opportunities to use technology to ensure patient safety in prescribing medications and medical devices. (BOT Rep. 13, I-00)

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)

H-450.951 American Medical Accreditation Program (AMAP)

Our Board of Trustees will develop principles regarding the ways in which the House of Delegates may have ongoing input on issues related to AMAP structure and operations, for consideration by the House of Delegates. (BOT Rep. 26, I-99)

H-450.952 Regional Input Into the Accreditation Process

(1) It is the policy of the AMA that voluntary accreditation organizations provide opportunities for interested parties to have input and to submit comments during the survey process. (2) Our AMA, through its representatives to NCQA, request that changes in the accreditation process be made to provide interested parties with the opportunity to provide input and submit comments during the survey process. (BOT Rep. 10, I-99)

H-450.955 Education of the General Public on the Role of Physician and Non-Physician Health Care Providers

The AMA will educate the general public and legislators to the differences between physician and non-physician providers of clinical services regarding their unique training, experience, broad based knowledge, ability and expertise, which impacts on their ability to provide high quality clinical care. (Res. 308, A-98; Reaffirmation A-99)

H-450.958 Support for Development of Measures of Quality

The AMA will take appropriate action encouraging the federal government to increase support for research, through the Agency for Health Care Policy and Research and other appropriate organizations, into the measurement of quality of care and system analysis. (Res. 718, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-450.961 Health Plan "Report Cards"

The AMA: (1) supports the development and appropriate use of health plan performance standards;
(2) The AMA urges all organizations that are developing, or planning to develop, health plan performance measures to include actively practicing physicians, physician organizations, and consumers in the development, evaluation and refinement of such measures;
(3) The AMA urges all organizations that are developing health plan performance measures to work toward greater uniformity both in the content of such measures and in the formulas used for calculating performance results;
(4) The AMA encourages national medical specialty societies and state medical associations to participate in the development, evaluation, and refinement of health plan performance measures;
(5) The AMA advocates that individual health plans, government entities, private sector accreditation organizations and others that develop performance measures for use in programs to evaluate the performance of health plans adhere to the following principles:
(a) Health plan performance measures shall be developed for a variety of users, including health care purchasers, physicians and other health care providers, and the public.
(b) The involvement of actively practicing physicians and physician organizations in the development, evaluation, refinement, and use of health plan performance measures shall be essential.
(c) Health plan performance measures shall include an appropriate mix of process-oriented and outcomes-oriented measures.
(d) Health plan performance measures shall be representative of the full range of services typically provided by health plans, including preventive services.
(e) The limitations of data sources used in health plan performance measures shall be clearly identified and acknowledged.
(f) Valid health plan performance data collection and analysis methodologies, including establishment of statistically significant sample sizes for areas being measured, shall be developed.
(g) Performance data used to compare performance among health plans shall be adjusted for severity of illness, differences in case-mix, and other variables such as age, sex, and occupation and socioeconomic status.
(h) Health plan performance data that are self-reported by health plans shall be verified through external audits.
(i) The methods and measures used to evaluate health plan performance shall be disclosed to health plans, physicians and other health care providers, and the public.
(j) Health plans being evaluated shall be provided with an adequate opportunity to review and respond to proposed health plan performance data interpretations and disclosures prior to their publication or release.
(k) Effective safeguards to protect against the unauthorized use or disclosure of health plan performance data shall be developed.
(l) The validity and reliability of health plan performance measures shall be evaluated regularly. (CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05)

H-450.962 National Committee for Quality Assurance

The AMA: (1) promotes physician-developed guidelines for evaluating patient and physician satisfaction with plans, accreditation standards, utilization, quality and cost policies; and (2) will develop policy and medically appropriate guidelines for review of physician offices as promulgated by NCQA. (BOT Rep. 12, A-95; Reaffirmation I-96; Reaffirmed: CSAPH Rep. 3, A-07)

H-450.963 National Committee for Quality Assurance In-Office Review Standards

The AMA opposes to the National Committee for Quality Assurance in-office review standards for managed care accreditation. (Res. 717, I-93; Reaffirmed: CMS Rep. 10, A-03)

H-450.964 National Committee for Quality Assurance

The AMA believes that the National Committee for Quality Assurance (NCQA) is not an appropriate organization to determine criteria for physician credientialing. The AMA: (1) advocates for appropriate changes in the NCQA policies, standards, and accreditation procedures that are consistent with AMA policy (Reaffirmed in lieu of Res. 701, I-94);
(2) urges NCQA to study ways of modifying its standards and accreditation procedures to reduce the potential burdens placed on physicians and their employees in responding to the on-site office review requests made by managed care organizations;
(3) urges NCQA to ensure that managed care organizations are prohibited from requesting and reviewing medical records of patients who are not enrollees of the health plan of the managed care organization being surveyed by NCQA;
(4) urges NCQA to develop means of involving practicing physicians in NCQA's accreditation processes; and
(5) urges NCQA to include physician satisfaction surveys of practicing physicians participating in managed care organizations as an additional measure of assessing the quality of managed care organizations under NCQA's accreditation processes. (BOT Rep. 6, A-94; Reaffirmed by Sub. Res. 722, I-96; Amended by Res. 710, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-450.965 Medical Staff Leadership in Continuous Quality Improvement

The AMA will work with the AHA to assure that hospitals, in their continuous quality improvement/total quality management (CQI/TQM) programs, include practicing physicians in the development and implementation of such programs, especially the development of criteria sets and clinical indicators; provide feedback on CQI/TQM findings to physicians on a confidential basis; and inform all members of the medical staff on the CQI/TQM programs developed. (Sub. Res. 701, A-94; Reaffirmed: CLRPD Rep. 1, A-04)

H-450.966 Quality Management

The AMA: (1) continues to advocate for quality management provisions that are consistent with AMA policy;
(2) seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures;
(3) continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures;
(4) emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts;
(5) urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures; and
(6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts:
(a) Standards and measure shall have demonstrated validity and reliability.
(b) Standards and measures shall reflect current professional knowledge and available medical technologies.
(c) Standards and measures shall be linked to health outcomes and/or access to care.
(d) Standards and measures shall be representative of the range of health care services commonly provided by those being measured.
(e) Standards and measures shall recognize the informational needs of patients and physicians.
(f) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations.
(g) Standards and measures shall recognize the importance and implications of patient choice and preference.
(h) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured.
(i) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measures.
(BOT Rep. 35, A-94; Reaffirmed: CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05)

H-450.968 Release of Practice Specific Information

The AMA encourages third party payers to divulge aggregate performance data without physician specific identifiers to organized medical groups for educational purposes, such as studying practice variations and developing practice parameters. (Res. 710, I-93; Reaffirmed and Modified: CMS Rep. 10, A-03)

H-450.970 Quality Management Principles

Our AMA (1) continues to support the concept that physicians and healthcare organizations should strive continuously to improve the quality of health care;

(2) encourages the ongoing evaluation of continuous quality improvement models;

(3) promotes implementation of effective quality improvement models; and

(4) identifies the useful approaches for assisting physicians in implementing quality improvement procedures in their medical practices and office management. (BOT Rep. AA, A-92; Reaffirmed: CMS Rep. 9, I-00)

H-450.971 Quality Improvement of Health Care Services

Our AMA will continue to encourage the development and provision of educational and training opportunities for physicians and others to improve the quality of medical care. (BOT Rep. I, I-91; Modified: Sunset Report, I-01)

H-450.973 Outcomes Research

(1) It is the policy of the AMA to (a) continue to promote outcomes research as an effective mechanism to improve the quality of medical care, (b) urge that the results of outcomes research be used for educational purposes and not as part of punitive processes, (c) promote the use of outcomes research in the development of practice parameters, (d) advocate that findings of outcomes research which identify individual physicians should only be disclosed within formal peer review processes, and (e) monitor outcomes research

activities of the federal government, research organizations, and others. (2) The AMA urges state medical societies, national medical specialty societies, hospital medical staffs, and individual physicians to (a) assist organizations in the planning, development, implementation, and evaluation of appropriate outcomes research, (b) identify the significance and limitations of the findings of outcomes research, and (c) ensure that outcomes research is conducted in a manner that protects the confidentiality of patients and physicians. (3) The AMA urges organizations conducting or planning to conduct outcomes research to (a) ensure the accuracy of the data used in outcomes research, (b) include relevant physician organizations and practicing physicians in all phases of outcomes research, including the planning, development, implementation, and evaluation of outcomes research, (c) provide physician organizations and practicing physicians with adequate opportunity to review and comment on interpretations of the results of outcomes research, and (d) ensure that outcomes research is conducted in a manner that maintains patient and physician confidentiality. (BOT Rep. K, A-91; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CMS Rep. 7, A-05)

H-450.975 Definition of Quality

Our AMA adopts the following statement defining patient care quality: Quality of care is defined as the degree to which care services influence the probability of optimal patient outcomes. (CMS Rep. E, A-91; Reaffirmed: Sunset Report, I-01)

H-450.976 Corrective Action and Exclusive Contracts

It is the policy of the AMA that exclusive contracts should never be used as a mechanism to solve quality assurance problems in lieu of appropriate peer review processes. (Res. 3, A-91; Modified: Sunset Report, I-01)

H-450.979 Impact of Quality of Care Analysis

Our AMA supports continued examination and evaluation of the impact of quality analysis of medical care on physicians' treatment methods. (Sub. Res. 62, I-89; Reaffirmed: Sunset Report, A-00)

H-450.982 Patient Satisfaction and Quality of Care

Our AMA believes that: (1) much may be gained by encouraging physicians to be sensitive to the goals and values of patients; and (2) efforts should be continued to improve the measurement of patient satisfaction and to document its relationship, if any, to favorable outcomes and other accepted criteria of high quality. (CMS Rep. E, A-89; Reaffirmed: Sunset Report, A-00)

H-450.984 Quality of Care Study

The AMA supports continuing studies to evaluate the impact on quality of care when the method of payment (i.e., capitation, gatekeeper, Medicare, managed care systems, DRG, RVS, etc.) affects the quality of medical care and access to care. (Res. 128, A-88; Reaffirmed: Sunset Report, I-98)

H-450.987 Education of Physicians in Utilization and Quality Review Matters

The AMA (1) commends medical schools that provide instruction in quality assurance and utilization review; (2) advocates making available model curriculum information to medical schools wishing to undertake such instruction; (3) reaffirms its support for the provision in the ACGME Program Requirements which requires that residents participate in patient care review activities; and (4) supports and encourages accredited sponsors which currently provide continuing medical education on the subject of quality assurance and utilization review or those which may be interested in developing educational activities for this purpose. (CME Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CME Rep. 2, A-08)

H-450.988 Guidelines for Quality Assurance

The AMA believes that the following guidelines should be utilized in any medical peer review system: (1) The general policies and processes to be utilized in any quality assurance system should be developed and concurred with by the professionals whose performance will be scrutinized, and should be objectively and impartially administered.
(2) Any remedial quality assurance activity related to an individual practitioner should be triggered by concern for that individual's overall practice patterns, rather than by deviation from specified criteria in single cases.
(3) The institution of any remedial activity should be preceded by discussion with the practitioner involved.
(4) Emphasis should be placed on education and modification of unacceptable practice patterns rather than on sanctions.
(5) The quality assurance system should make available the appropriate educational resources needed to effect desired practice modifications.
(6) Feedback mechanisms should be established to monitor and document needed changes in practice patterns.
(7) Restrictions or disciplinary actions should be imposed on those practitioners not responsive to remedial activities, whenever the appropriate professional peers deem such action necessary to protect the public.
(8) The imposition of restrictions or discipline should be timely, consistent with due process.

(9) Quality assurance systems should be structured and operated so as to assure immunity for practitioners conducting or applying such systems who are acting in good faith.
(10) To the degree possible, quality assurance systems should be structured to recognize care of high quality as well as correcting instances of deficient practice. (CMS Rep. C, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-450.990 Physician Information for Credentialing

Our AMA: (1) affirms that it is the ethical duty of a physician to share truthfully quality care information regarding a colleague when requested by an authorized credentialing body; and (2) believes that legal immunity for submitting or sharing truthful and accurate information on quality care should be provided to physicians by appropriate legislation. (Res. 91, I-87; Reaffirmed: CME Rep. 8, I-93; Reaffirmed: CME Rep. 2, A-05)

H-450.994 Quality Assurance in Health Care

(1) Accountability through voluntary, professionally directed quality assurance mechanisms should be part of every system of health care delivery. The cost of quality assurance programs and activities should be considered a legitimate element in the cost of care. (Reaffirmed: Res. 711, A-94)
(2) To fulfill their fundamental responsibility to maximize the quality of services, health care institutions should establish, through their governing bodies, a formal structure and process to evaluate and enhance the quality of their health care services. This should be accomplished by participation of the professional staff, management, patients and the general public. When appropriate, health care institutions should be urged by licensing and accrediting bodies to establish a formal committee to coordinate all quality assurance activities that occur among the various health care professions within the facility.
(3) Voluntary accreditation programs with standards that exceed those of state licensure and that focus on quality of care issues should be offered to all health care facilities. Various agencies that accredit health care facilities should develop a formal interagency structure to coordinate their activities and to resolve any inter-organizational problems that may arise.
(4) Public and private payment programs should limit their coverage for services provided in health care facilities to those that meet professionally acceptable standards of acceptable quality, should structure their reimbursement to support the improvement of quality, and should provide information on quality for the benefit of their subscribers.
(5) Educational programs on quality assurance issues for health care professionals should be expanded through the inclusion of such material in health professions education programs, in preceptorships, in clinical graduate training and in continuing education programs.
(6) Educational programs should be developed to inform the public about the various aspects of quality assurance. Health care facilities and national and local health care organizations should make information available to the public about the factors that determine the quality of care provided by health care facilities, and about the extent to which individual health care facilities meet professionally acceptable standards of quality.
(7) Research should be undertaken to assess the effects of peer review programs and payment mechanisms on the overall quality of health care. (BOT Rep. NN, A-87; Modified: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-450.995 Quality of Care - Essentials and Guidelines for Quality Assessment

(1) Including favorable outcome as one characteristic, the AMA believes that medical care of high quality should: (a) produce the optimal possible improvement in the patient's physiologic status, physical function, emotional and intellectual performance and comfort at the earliest time possible consistent with the best interests of the patient;
(b) emphasize the promotion of health, the prevention of disease or disability, and the early detection and treatment of such conditions;
(c) be provided in a timely manner, without either undue delay in initiation of care, inappropriate curtailment or discontinuity, or unnecessary prolongation of such care;
(d) seek to achieve the informed cooperation and participation of the patient in the care process and in decisions concerning that process;
(e) be based on accepted principles of medical science and the proficient use of appropriate technological and professional resources;
(f) be provided with sensitivity to the stress and anxiety that illness can generate, and with concern for the patient's overall welfare;
(g) make efficient use of the technology and other health system resources needed to achieve the desired treatment goal; and
(h) be sufficiently documented in the patient's medical record to enable continuity of care and peer evaluation.

(2) The AMA believes that the following guidelines for quality assessment should be incorporated into any peer review system. (a) The criteria utilized to assess the degree to which medical care exhibits the essential elements of quality should be developed and concurred in by the professionals whose performance will be reviewed.
(b) Such criteria can be derived from any one of the three basic variables of care: structure, process, or outcome. However, emphasis in the review process should be on statistically verifying linkages between specific elements of structure and process, and favorable outcomes, rather than on isolated examination of each variable.
(c) To better isolate the effects of structure and process on outcome, outcome studies should be conducted on a prospective as well as a retrospective basis to the degree possible.
(d) The evaluation of "intermediate" rather than "final" outcomes is an acceptable technique in quality assessment.

(e) Blanket review of all medical care provided is neither practical nor needed to assure high quality of care. Review can be conducted on a targeted basis, a sampling basis, or a combination of both, depending on the goals of the review process. However, judgment as to performance of specific practitioners should be based on assessment of overall practice patterns, rather than solely on examination of single or isolated cases. By contrast, when general assessment of the quality of care provided by a given health care system or across systems is desired, random sampling of all care episodes may be the more appropriate approach.
(f) Both explicit and implicit criteria are useful in assessing the quality of care.
(g) Prior consultation as appropriate, concurrent and retrospective peer review are all valid aspects of quality assessment.
(h) Any quality assessment program should be linked with a quality assurance system whereby assessment results are used to improve performance.
(i) The quality assessment process itself should be subject to continued evaluation and modification as needed. (CMS Rep. A, A-86; Reaffirmed: CMS Rep. E, A-91; Reaffirmed: Sunset Report, I-01)

H-450.997 Quality Assurance and Peer Review for Hospital Sponsored Programs

The AMA urges hospital medical staffs to make certain that all hospital sponsored, initiated, or affiliated medical services have appropriate peer review and quality assurance programs. (Sub. Res. 92, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CMS Rep. 5, A-04)

H-450.999 Practice Evaluation

(1) Our AMA urges state and local medical societies to consider developing public information programs to inform consumers about existing quality assurance activities. (2) Our AMA encourages increased use of office or hospital outpatient facilities, and use of these facilities for diagnostic testing prior to hospitalization whenever medically feasible, and where quality of service can be assured. (3) Currently, the courts decide professional liability cases on the basis of all the facts and circumstances involved in an individual case. The "standard of care" is established for that case by qualified experts. The courts have recognized that it would be difficult, if not impossible, to mandate that certain medical procedures be followed in all cases. The expert must be presented with the unique set of facts and circumstances before being able to determine whether an acceptable level of care was given in a specific case. Although the AMA continues to support the development of sample review criteria for use as guidelines by local peer review mechanisms, it believes that mandating the use of these criteria by the courts or providers in professional liability cases is neither desirable nor feasible. (BOT Rep. II, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

H-455.000 Radiation and Radiology
(See also: Environmental Health; Public Health)

H-455.978 Nuclear Regulatory Commission Medical Use Program

The AMA encourages the efforts of the Nuclear Regulatory Commission to assure that any regulations that affect the practice of nuclear medicine and radiology be science-based. (Sub. Res. 516, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-455.980 National Biomedical Tracer Facility

The AMA supports the establishment of a National Biomedical Tracer Facility with federal funding to serve as a national resource for clinical medicine, research and education. (Res. 513, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-455.983 Radiographic Contrast Media

(1) Manufacturers should adopt just and appropriate pricing policies for low osmolar contrast media (LOCM).

(2) Third party payers should provide full reimbursement for the use of the contrast media which is deemed medically necessary by the physician.

(3) Avoidance of waste in the use of contrast media should be encouraged.

(4) The development and implementation by hospitals of procedures and policies to help ensure that nonionic contrast media are used when medically appropriate should be supported. (Joint CMS/CSA Rep. , I-90; Reaffirmed: Sunset Report, I-00)

H-455.984 Health Effects of Radon Exposure

It is the policy of the AMA: (1) to continue its surveillance of the growing understanding of the health risks of exposure to radon and contribute to this understanding wherever possible;

(2) that physicians continue to increase their knowledge about radon and its health effects and advise patients and the public in their

communities on how to make intelligent decisions and take responsible actions on this issue;

(3) that physicians, when discussing the prevention of lung cancer, place greatest emphasis on the need to stop smoking; measures to decrease radon exposures should be encouraged if appropriate, but be placed in proper perspective, because smoking is a substantially more significant cause of lung cancer;

(4) to emphasize the need for more definitive data concerning the magnitude of the lung cancer risk from radon exposure and encourage the generation of these data as a needed public health measure; and

(5) to continue its efforts to help physicians understand the health risks associated with radon exposure and communicate this understanding to patients and the public. (CSA Rep. A, A-90; Reaffirmed: Sunset Report, I-00)

H-455.986 Radon in Homes

The AMA supports assuming a leadership role in educating physicians, others of the health care community, and the public concerning the significance of radon levels in homes and other buildings and the possible health effects of those levels. (CSA Rep. H, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06)

H-455.987 Radioepidemiologic Tables

The AMA believes that the present radioepidemiologic tables (1) should be applied only under the conditions for which they were originally intended, namely, to those military personnel and the public who are seeking redress for alleged damages from radioactive fallout and uranium mining exposures (i.e., to estimate PC values for those individuals whose exposure conditions are similar to the conditions under which the Tables were derived); (2) should not be applied to situations involving diagnostic or therapeutic medical exposures; and (3) should not be applied to other situations for which they were not intended, such as occupational exposures to radiation. (CSA Rep. A, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-455.988 Public Education on the Danger of Radiation Exposure

The AMA encourages the appropriate federal agency to develop a nationwide public education program on the effects of radiation exposure. (Res. 121, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-455.989 Involvement of Physician Expertise in Non-Military Radiation Emergencies

The AMA encourages physicians to provide expertise on the health aspects of radiation incidents, emergencies and accidents to the public, the media and responsible government agencies. (Res. 74, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-455.990 Safe Use of Radioactive Materials in Medical Practice

The AMA reaffirms that proper training of physicians in the use of radioactive materials is important for the safety and health of patients and the public, but that hours of training alone should not be the measure of competence in health and safety matters. (CSA Rep. C, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06)

H-455.991 Physician Training for Management of Injuries Encountered in Nuclear Explosions

The AMA supports educating and training physicians in the management of injuries that may be encountered in isolated nuclear incidents. (Res. 17, I-83; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)

H-455.992 Management of Nuclear and Isotope-Related Injuries and Contamination

The AMA advocates utilizing appropriate opportunities to publicize the many benefits of the medical use of radioisotopes and the fact that such uses differ from the medical consequences of thermonuclear incidents. (Sub. Res. 2, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-455.993 Treatment of Radiation Accident Victims

Our AMA (1) encourages all acute care facilities, through their medical staffs, to review and become familiar with radiation accident contingency plans required by the JCAHO, particularly those facilities in areas where major radiation-emitting equipment is located; and (2) supports the development of guidelines for training and preparedness of medical staffs, proper treatment regimens and the maintenance and use of decontamination equipment for use at the time of radiation accidents. (Res. 36, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-455.994 Risks of Nuclear Energy and Low-Level Ionizing Radiation

Our AMA supports the following policy on nuclear energy and low-level ionizing radiation: (1) Usefulness of Nuclear Energy: Energy produced by nuclear reactors makes an important contribution to the generation of electricity in the US at present, and it will continue to do so in the foreseeable future. Investigation and research should continue in order to develop improved safety and efficiency of nuclear reactors, and to explore the potential of competing methods for generating electricity. The research should include attention to occupational and public health hazards as well as to the environmental problems of waste disposal and atmospheric pollution.

(2) Research on Health Effects of Low Level Radiation: There should be a continuing emphasis on research that is capable of determining more precisely the health effects of low level ionizing radiation.

(3) Uranium Mill Tailings: Uranium mill tailings should be buried or otherwise covered.

(4) Radioactive Waste Disposal: There should be acceleration of pilot projects to evaluate techniques for the disposal of high-level radioactive wastes. The decommissioning of nuclear reactors is a source of nuclear waste which requires accelerated technological investigation and planning. Local laws should be modified to allow the disposal of low level radioactive waste materials in accordance with AMA model state legislation.

(5) Occupational Safety: The philosophy of maintaining exposures of workers at levels "as low as reasonably achievable (ALARA)" is commended. The present federal standards for occupational exposure to ionizing radiation are adequate. The responsibilities of the various federal agencies regarding workers in the nuclear energy industry should be clarified; these agencies include the Departments of Energy, Defense, HHS, Labor and Transportation; and the NRC, VA and EPA.

(6) Minimizing Exposures to Radiation: Each physician should attempt to minimize exposures of patients to ionizing radiation in accord with good medical practice.

(7) Radiation Exposure Standards: The present standards for exposure of populations to ionizing radiation are adequate for the protection of the public.

(8) Emergencies and Governmental Readiness: Government agencies at all levels should be prepared to respond to nuclear energy-related emergencies. There is need for improved public planning by the several federal agencies involved, including the Federal Emergency Management Agency (FEMA) and the agencies of state and local governments. Responsible officials should develop skills and undergo periodic retraining in order to be able to act appropriately during major radiation emergencies. Because emergency planning is a complex task involving aspects of health as well as problems related to utilities, state and local governments and the federal government (FEMA) would benefit from the cooperation of physicians and others in the health sciences.

(9) Federal Radiation Emergency Planning Responsibilities: Federal groups such as the NRC and FEMA must work together closely to fulfill responsibilities in radiological emergency preparedness and in crisis management. There is a need for NRC and FEMA to define better the roles of community hospitals and of physicians.

(10) Reactor Operators and Radiation Inspectors: There is a need for better training of operating personnel with regard to prevention and management of untoward reactor operating conditions. Selection, training, and ongoing performance evaluation of operating personnel, and of radiation inspectors, are key elements in the safety of reactor workers and of the public. Physicians should help develop methods of selecting and evaluating personnel in the nuclear power industry.

(11) Radiation Training for Physicians: Physicians should be prepared to answer the questions of their patients about ionizing radiation, especially if there is a radiation emergency. Each hospital should have adequately trained physicians and a plan and protocol for receiving and caring for radiation victims.

(12) Radiation Education for the Public: Further education of the public about ionizing radiation is recommended.

(13) Location of Nuclear Reactors: All nuclear reactors built in the future should be placed in areas of low population density; present reactors located in low density areas should be managed so that the populations surrounding them remain small.

(14) Multiple Sources of Power Generation: AMA recommends the use of a diverse set of electricity generating methods and a continuing emphasis on the conservation of energy. (CSA Rep. A, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-455.996 Nuclear Regulatory Commission Licensure Requirements for Physicians

Our AMA urges the U.S. Nuclear Regulatory Commission to continue to require that the training requisite for licensure be

documented, and that it contain elements of instruction in radiological physics, radiation biology, radiation safety, nuclear instrumentation, and the safe and effective clinical use of radionuclides in patients. (Res. 148, A-80; Reaffirmed: CLRPD Rep. B, I-90; Modified: Sunset Report, I-00)

H-455.997 Human Use of Byproduct Material

Our AMA supports rescission of the Nuclear Regulatory Commission regulation requiring a physician to use an approved radiopharmaceutical drug in accordance with the manufacturer's package insert as regards chemical and physical form, route of administration and dosage range. (Res. 131, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-455.999 Radioactive Pharmaceuticals

Our AMA: (1) reaffirms its policy that shipments of radioactive materials for medical diagnosis, therapy and medical research continue to be accepted on scheduled passenger airline flights; (2) encourages federal and transportation industry organizations to work toward the solution of practical problems relating to such transportation on a cooperative basis; and (3) expresses its willingness to cooperate with medical specialty groups which have primary interests in the uses of radiopharmacueticals, such as the American College of Radiology, the College of American Pathologists, the American College of Nuclear Medicine, and the American College of Nuclear Physicians. (Sub. Res. 135, A-75; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-460.000 Research
(See also: Medical Education)

H-460.909 Comparative Effectiveness Research

The following Principles for Creating a Centralized Comparative Effectiveness Research Entity are the official policy of our AMA:

PRINCIPLES FOR CREATING A CENTRALIZED COMPARATIVE EFFECTIVENESS RESEARCH ENTITY:

A. Value. Value can be thought of as the best balance between benefits and costs, and better value as improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. Improving value in the US health care system will require both clinical and cost information. Quality comparative clinical effectiveness research (CER) will improve health care value by enhancing physician clinical judgment and fostering the delivery of patient-centered care.

B. Independence. A federally sponsored CER entity should be an objective, independent authority that produces valid, scientifically rigorous research.

C. Stable Funding. The entity should have secure and sufficient funding in order to maintain the necessary infrastructure and resources to produce quality CER. Funding source(s) must safeguard the independence of a federally sponsored CER entity.

D. Rigorous Scientifically Sound Methodology. CER should be conducted using rigorous scientific methods to ensure that conclusions from such research are evidence-based and valid for the population studied. The primary responsibility for the conduct of CER and selection of CER methodologies must rest with physicians and researchers.

E. Transparent Process. The processes for setting research priorities, establishing accepted methodologies, selecting researchers or research organizations, and disseminating findings must be transparent and provide physicians and researchers a central and significant role.

F. Significant Patient and Physician Oversight Role. The oversight body of the CER entity must provide patients, physicians (MD, DO), including clinical practice physicians, and independent scientific researchers with substantial representation and a central decision-making role(s). Both physicians and patients are uniquely motivated to provide/receive quality care while maximizing value.

G. Conflicts of Interest Disclosed and Minimized. All conflicts of interest must be disclosed and safeguards developed to minimize actual, potential and perceived conflicts of interest to ensure that stakeholders with such conflicts of interest do not undermine the integrity and legitimacy of the research findings and conclusions.

H. Scope of Research. CER should include long term and short term assessments of diagnostic and treatment modalities for a given disease or condition in a defined population of patients. Diagnostic and treatment modalities should include drugs, biologics, imaging and laboratory tests, medical devices, health services, or combinations. It should not be limited to new treatments. In addition, the findings should be re-evaluated periodically, as needed, based on the development of new alternatives and the emergence of new safety or efficacy data. The priority areas of CER should be on high volume, high cost diagnosis, treatment, and health services for which there is significant variation in practice. Research priorities and methodology should factor in any systematic variations in disease prevalence or response across groups by race, ethnicity, gender, age, geography, and economic status.

I. Dissemination of Research. The CER entity must work with health care professionals and health care professional organizations to effectively disseminate the results in a timely manner by significantly expanding dissemination capacity and intensifying efforts to communicate to physicians utilizing a variety of strategies and methods. All research findings must be readily and easily accessible to physicians as well as the public without limits imposed by the federally supported CER entity. The highest priority should be placed on targeting health care professionals and their organizations to ensure rapid dissemination to those who develop diagnostic and treatment plans.

J. Coverage and Payment. The CER entity must not have a role in making or recommending coverage or payment decisions for payers.

K. Patient Variation and Physician Discretion. Physician discretion in the treatment of individual patients remains central to the practice of medicine. CER evidence cannot adequately address the wide array of patients with their unique clinical characteristics, co-morbidities and certain genetic characteristics. In addition, patient autonomy and choice may play a significant role in both CER findings and diagnostic/treatment planning in the clinical setting. As a result, sufficient information should be made available on the limitations and exceptions of CER studies so that physicians who are making individualized treatment plans will be able to differentiate patients to whom the study findings apply from those for whom the study is not representative. (CMS Rep. 5, I-08)

H-460.910 Systemic Lupus Erythematosus and Its Impact on Minority Health

Our AMA: (1) supports increased funding for biomedical research and educational programs that work toward finding the cause and a cure for lupus; and (2) will collaborate with medical specialty societies and federal organizations, including the Office of Research on Women's Health at the National Institutes of Health, involved with research and educational initiatives pertaining to lupus. (Res. 510, A-08)

H-460.911 Increasing Minority Participation in Clinical Research

1. Our AMA advocates that:
a. The Food and Drug Administration (FDA) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.
b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and
c. Resources be provided to community level agencies that work with those minorities who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities in clinical trials:
a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs;
b. Increased outreach to female physicians to encourage recruitment of female patients in clinical trials;
c. Continued minority physician education on clinical trials, subject recruitment, subject safety, and possible expense reimbursements;
d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and
e. Fiscal support for minority recruitment efforts and increasing trial accessibility through transportation, child care, reimbursements, and location.

3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist. (BOT Rep. 4, A-08)

H-460.912 Principles for Conduct and Reporting of Clinical Trials

Our AMA: (1) endorses the Association of American Medical Colleges' "Principles for Protecting Integrity in the Conduct and Reporting of Clinical Trials"; and (2) commends the AAMC, the Centers for Education and Research in Therapeutics and the BlueCross BlueShield Association for the development and dissemination of these principles. (Res. 544, A-06)

H-460.913 Use of the Anal Pap Smear as a Screening Tool for Anal Dysplasia

Our AMA supports continued research on the diagnosis and treatment of anal cancer and its precursor lesions, including the evaluation

of the anal pap smear as a screening tool for anal cancer. (Res. 512, A-04)

H-460.914 Influence of Funding Source on Outcome, Validity, and Reliability of Pharmaceutical Research

Our AMA:
(1) policy is that all medical journal editors and authors should adhere to the revised CONSORT (Consolidated Standards for Reporting of Trials Group) Statement and Uniform Requirements for Manuscripts Submitted to Biomedical Journals;
(2) recommends that (a) the Department of Health and Human Services establish a comprehensive registry for all clinical trials conducted in the United States; (b) every clinical trial should have a unique identifier; and (c) all results from registered clinical trials be made publicly available through either publication or an electronic data-repository; and
(3) urges that Institutional Review Boards consider registration of clinical trials to an existing registry as condition of approval. (CSA Rep. 10, A-04)

H-460.915 Cloning and Stem Cell Research

Our AMA: (1) supports biomedical research on multipotent stem cells (including adult and cord blood stem cells); (2) supports the use of somatic cell nuclear transfer technology in biomedical research (therapeutic cloning); (3) opposes the use of somatic cell nuclear transfer technology for the specific purpose of producing a human child (reproductive cloning); (4) encourages strong public support of federal funding for research involving human pluripotent stem cells; and (5) will continue to monitor developments in stem cell research and the use of somatic cell nuclear transfer technology. (CSA Rep. 5, A-03)

H-460.916 Protection of Human Subjects in Research

Our AMA: (1) encourages institutions conducting research with human subjects to implement an ongoing credentialing process to assure that all investigators and relevant staff have been appropriately educated in the ethical principles and relevant government regulations related to human subjects research; (2) will work with other relevant professional organizations to establish procedures for accreditation of institutions to ensure that appropriate clinical research standards are maintained; and (3) urges the Clinical Research Roundtable to study the issue of conflicts of interest related to physicians who conduct or enroll patients in clinical trials. Res. 528, A-00)

H-460.918 Update on Clinical Research

Our AMA: (1) supports the findings of the National Clinical Research Summit as developed at the Graylyn Consensus Development Conference, November 20-22, 1998; (2) actively supports the establishment of the Clinical Research Roundtable as a component of the National Academy of Sciences/Institute of Medicine and Commission on Life Science; and (3) encourages the Clinical Research Roundtable (of which our AMA is a member) to study the problem of clinical trial funding and to offer recommendations. (CSA Rep. 13, I-99; Modified Res. 509 and Reaffirmation A-00)

H-460.919 Privacy and Confidentiality

Our AMA policy is that research projects that fall outside the purview of an Institutional Review Board (IRB) process, as well as operational uses of personally identifiable health information, should be subject to review by local Confidentiality Assurance Boards (CABs) and should be held to the same standards that apply to Institutional Review Boards. (BOT Rep. 36, A-99; Reaffirmed: BOT Rep. 19, I-01; Reaffirmed: BOT Rep. 19, A-07)

H-460.920 Public Access to Unpublished Research Data

Our AMA will oppose extension of the Freedom of Information Act to require premature release of research data from federally-funded research and work with other scientific and medical organizations to seek repeal of this requirement. (Res. 238, A-99)

H-460.921 Support for Institutional Review Boards

Our AMA: (1) commends the thousands of Institutional Review Board (IRB) members who each have volunteered hundreds of hours annually; (2) urges medical schools and teaching hospitals to provide IRBs with adequate personnel and other resources to accomplish their mission to safeguard the rights and welfare of human research subjects; and (3) encourages the National Institutes of Health to develop a program that provides flexible funding to institutions, including support directed at IRBs, as in the Research Innovation Opportunity program proposed by the Association of American Medical Colleges and others. (Res. 317, I-98; Reaffirmed: Res. 528, A-00)

H-460.923 Melanoma Registry

Our AMA encourages the National Cancer Institute to establish, in collaboration with pertinent national and state medical groups, an

effective melanoma registry which will capture data from both inpatient and outpatient settings. (Res. 512, A-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-460.924 Race and Ethnicity as Variables in Medical Research

Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately;
(2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations;
(3) physicians recognize that race and ethnicity are conceptually distinct;
(4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants;
(5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected;
(6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and
(7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients. CSA Rep. 11, A-98; Appended: Res. 509, A-01)

H-460.926 Funding of Biomedical, Translational, and Clinical Research

Our AMA: (1) reaffirms its long-standing support for ample federal funding of medical research, including basic biomedical research, translational research, clinical research and clinical trials, health services research, outcomes research, and prevention research; (2) encourages the National Institutes of Health, the Agency for Healthcare Research and Quality and other appropriate bodies to develop a mechanism for the continued funding of translational research; and (3) continues to support efforts by Research!America and others to double the current federal medical research budget by the year 2002. (Sub. Res. 507, I-97; Reaffirmed: CSA Rep. 13, I-99; Modified: Res. 503, and Reaffirmation A-00)

H-460.929 Expanded Public Education Program in Support of Animal Research

The AMA opposes legislative limits placed on the appropriate and humane use of animals in research. (Sub. Res. 516, I-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06)

H-460.930 Council on Scientific Affairs Conference: "Clinical Research: Assessing the Future in a Changing Environment"

(1) Given the profound importance of clinical research as the transition between basic science discoveries and standard medical practice of the future, the AMA will a) be the principal advocate for clinical research; b) promote the importance of this science and of well-trained researchers to conduct it; and c) facilitate communication among different organizations and groups, including managed care organizations, that are essential for broad-based support of clinical research.

(2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Health Care Policy and Research, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense.

(3) Traditional sources of financial support for clinical research and for academic health centers are diminishing significantly in the evolving health care environment of the 1990s. All endeavors that depend upon development of new knowledge and technologies for their continued success recognize the need to devote a proportion of revenue for research and development. The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research.

(4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research.

(5) Our AMA believes that one obligation of organized medicine and physicians is to support clinical research, as the basis of advances in medicine. To facilitate this, the AMA should explore ways physicians and physician organizations can encourage and assist in educating the public about the importance of clinical research such as through educational materials and programs for children and schools.

(6) Our AMA encourages and supports development of community and practice-based clinical research networks. (CSA Rep. 2, I-96;

Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: CME Rep. 4, I-08)

H-460.931 Genetics Testing Legislation

The AMA opposes legislative initiatives on genetic testing that would unduly restrict the ability to use stored tissue for medical research; and will continue to support existing federal and private accreditation and quality assurance programs designed to ensure the accuracy and reliability of tests, but oppose legislation that could establish redundant or duplicative federal programs of quality assurance in genetic testing. (Sub. Res. 219, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-460.932 Increased Public Education Regarding Animal Research

Our AMA: (1) supports providing educational materials on the appropriate and compassionate use of animals in biomedical research to students of all grades from kindergarten through grade 12; (2) encourages physicians to work actively in their communities to introduce educational materials on the appropriate and compassionate use of animals in biomedical research into the curricula of all grades from kindergarten through grade 12; and (3) continues to oppose the use of violence, intimidation, and distortion by the opponents of the appropriate and compassionate use of animals in biomedical research. (Sub. Res. 511, A-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06)

H-460.933 Clinical Research and the AMA

Our AMA: (1) strongly supports the principle that fundamental and applied clinical research is essential to provide the knowledge base for the practice of modern medicine and is the essential link connecting advances in basic scientific knowledge to advances in the diagnosis and treatment of human disease; (2) supports efforts now underway by various professional societies, the National Institutes of Health, and the U.S. Congress to fully delineate those factors which impede the conduct of clinical research in all settings; and (3) in concert with other professional organizations, actively seeks to ensure full participation in clinical research by managed care organizations, including appropriate reimbursement for health care provided to patients participating in clinical research. (Res. 512, A-96; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00)

H-460.936 Maintenance of an Appropriate Level of Funding for Biomedical Research

Our AMA supports the continued growth of public funding for biomedical research. (Res. 322, A-95; Reaffirmation A-00)

H-460.938 Effects of Electric and Magnetic Fields

The AMA: (1) will continue to monitor developments and issues related to the effects of electric and magnetic fields, even though no scientifically documented health risk has been associated with the usually occurring levels of electromagnetic fields; (2) encourages research efforts sponsored by agencies such as the National Institutes of Health, U.S. Department of Energy, and the National Science Foundation to continue on exposures to electromagnetic fields and their effects, average public exposures, occupational exposures, and the effects of field surges and harmonics; and (3) supports broad dissemination of findings and recommendations of authoritative, multidisciplinary committees, such as those convened under the auspices of the National Academy of Sciences, National Council on Radiation Protection, International Agency for Research on Cancer, and the National Institute for Environmental Health Sciences. (CSA Rep. 7 - I-94; Reaffirmed and Modified: CSA Rep. 6, A-04)

H-460.940 Support for Federal Funding of Early-Stage Embryo Research

The AMA supports federal funding of biomedical research which promises significant human and scientific benefits. (Res. 242, I-94; Reaffirmed: CSA Rep. 6, A-04)

H-460.941 Science and Biomedical Research

Opportunities, Challenges and Health System Reform: The AMA will: (1) take every appropriate opportunity during the health system reform debate and implementation stages to educate the public, the Administration, and Congress about the importance of support for science and biomedical research and about the potential problems if these areas are not given sufficient consideration in health system reform;
(2) take steps to become the coordinating point for efforts, both within and outside of the Federation, to promote, enhance, and defend biomedical science;
(3) continue and expand its efforts to advocate for the primacy of science and biomedical research as the basis of quality medical care by working with and influencing both the private sector and the federal government, including the legislative, executive, and judicial branches;
(4) take necessary steps to monitor the scientific enterprise, establish programs and policies as appropriate, and initiate advocacy efforts as needed;
(5) consider and take the necessary steps to anticipate and establish guidelines to assist physicians and others in responding to the

ethical issues emerging from the scientific revolution; and
(6) increase its educational efforts to the public and to the profession to explain how science is critical to the future of the profession and to the future development of high quality medical care. (CSA Rep. 8, A-94; Reaffirmed: CSA Rep. 8, A-05)

H-460.942 Enrollment in Clinical Trials

The AMA supports and encourages researchers and funding agencies to establish mechanisms to ensure that research on human subjects reflects the diversity of the American population, including women and minorities and their subpopulations. (Sub. Res. 507, A-94; Reaffirmed: CSA Rep. 6, A-04)

H-460.943 Potential Impact of Health System Reform Legislative Reform Proposals on Biomedical Research and Clinical Investigation

The AMA, to encourage and support the continuing development of new advances in science and medicine and the development and implementation of meaningful quality assurance programs essential to improving the delivery of medical and health care in the United States, advocates:
(1) Strong support and funding for medical education programs at all levels to attract and stimulate gifted students and physicians to receive training and experience in, and to participate in, basic science or clinically-oriented research programs.
(2) Strong financial and policy support for all aspects of biomedical science and research, including: basic science research (investigator initiated grant-funded research) in a wide variety of fields; laboratory-based clinical studies (including surgical studies); clinical studies and therapy trials; clinical outcomes research; behavioral science research, including studies to assess implementation of health promotion and/or disease prevention activities; and technology transfer research, with an emphasis on diffusing information about, training personnel in, and encouraging appropriate use of new technologies.
(3) Adequate federal funding for biomedical science programs, including an appropriate balance of funding for basic, clinical, health service, and public health/prevention research.
(4) Support and funding for evaluation and implementation research, including drug and technology assessment, medical device review, and developing and setting standards for computerized medical records. (CSA Rep. 10, A-94; Reaffirmed: CSA Rep. 8, A-05)

H-460.944 Support for Investigator-Initiated Medical Research

The AMA reaffirms its support for non-targeted investigator-initiated research as the cornerstone of the biomedical research enterprise in the United States. (Res. 319, I-93; Reaffirmed: CSA Rep. 8, A-03)

H-460.945 Physicians and Other Health Care Personnel as Targets of Threats, Harassment, and Violence

Our AMA will: (1) develop educational materials to assist physicians in identifying the legal options available to protect them from targeted harassment, threats, and stalking; (2) support increased national, state, and local protection for physicians and other personnel providing health care services or engaged in biomedical research; and (3) develop model state legislation that defines "stalking" as a crime, and that includes adequate provisions relating to physicians and other health care personnel. (Sub. Res. 215, I-93; Reaffirmation I-99; Reaffirmed: CME Rep. 3, A-03)

H-460.946 Support for the National Center for Research Resources of the National Institutes of Health

The AMA, as part of its support of the National Institutes of Health, strongly supports the activities of the National Center for Research Resources as infrastructure essential for the successful transfer of basic bench research to patient care. (Res. 516, A-93; Reaffirmed: CSA Rep. 8, A-03)

H-460.948 Consumer Product Testing

The AMA urges the FDA and other appropriate governmental agencies to require safety evaluations, which may necessitate animal testing, of appropriate cosmetic and household products. (Sub. Res. 511, I-92; Reaffirmed: BOT Rep. 28, A-03)

H-460.953 Biomedical Research and Animal Activism

Our AMA: (1) Our AMA opposes the addition of new United States Department of Agriculture regulatory requirements concerning the care, treatment and reporting of laboratory rats, mice and birds;

(2) supports working with Congress to establish a uniform method to assure a prompt, unbiased review by scientific peers of federally funded research projects before grant or contract monies can be withheld from any investigator or institution;

(3) supports working through Congress to oppose legislation which inappropriately restricts the choice of scientific animal models used in research;

(4) will work with Congress and the USDA to ensure that needs and views of patients and the scientific community are heard during further consideration of USDA's role in laboratory animal oversight;

(5) supports the Facilities Protection Act (S 544 and HR 2407) which makes it a federal crime, and similar legislation at state levels to make it a felony, to trespass and/or destroy laboratory areas where biomedical research is conducted; and

(6) emphasizes to Congress and the American public the need for research on trauma that affects Americans of all ages. (Res. 238, A-91; Appended: Res. 513, I-00; Reaffirmation A-01)

H-460.954 Researchers Lending Their Names as Co-authors of Laboratory Findings in Which They Did Not Participate

Our AMA condemns the practice of those persons who permit their names to be used as co-authors of papers publishing laboratory findings in which they did not participate, noting that persons who engage in such practice bear equal responsibility with those who are guilty of falsifying laboratory findings. Our AMA urges editors of scientific journals to reject for publication any paper reporting laboratory findings and research in which any person named as a co-author was not an active participant. (Res. 101, A-91; Reaffirmed: Sunset Report, I-01)

H-460.956 The Need for Increased Research and Development in Nuclear Fusion to Reduce Environmental Pollution

Our AMA urges Congress, the Administration, energy companies, and organized public interest groups to press for the establishment of a national strategy for energy research and production that includes appropriate consideration, support and development of fusion technology. The strategy should include a prolonged commitment and the appropriate funding to accomplish this mission in the most reasonable period of time. (CSA Rep. C, I-90; Reaffirmed: Sunset Report, I-00)

H-460.957 Medical Research Involving Animals

The AMA urges state and county medical societies to support the appropriate and humane use of animals in research and to help ensure the continued availability of animals for essential medical education and medical research; and reaffirms its support for the appropriate and compassionate use of animals in biomedical research programs. (Sub. Res. 94, I-90; Sub. Res. 511, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-460.959 Health Services Research Training

Our AMA urges the nation's academic health science centers to expand their efforts in health services research, and to train additional numbers of physicians in health services research. (Res. 176, I-90; Reaffirmed: Sunset Report, I-00)

H-460.960 Department of Defense Biological Defense Research Program

It is the policy of the AMA (1) to continue to support the efforts of the Utah Medical Association to have the Department of Defense recognize and address the health and safety concerns which have been raised by the Utah Medical Association and the Utah Department of Health concerning the Department of Defense Biological Defense Research Program; and (2) as part of that support, to utilize its congressional lobbyists to help inform the appropriate congressional appropriations committees and subcommittees that funding for the Biological Defense Research Program should be predicated upon the Department of Defense adequately addressing these health and safety concerns. (Res. 196, A-90; Modified: Sunset Report, I-00)

H-460.962 Human Genome Project

Our AMA endorses the scientific and medical objectives of the Human Genome Project and asks appropriate medical and scientific organizations to (1) encourage worldwide support, including monetary support, of advances in human genome research; (2) promote the free and open exchange of sequence information among nations; and (3) express their hope that the information obtained from this international scientific research effort will be used solely for the benefit of mankind. (Res. 279, A-90; Reaffirmed: Sunset Report, I-00)

H-460.964 Use of Animals in Research

Our AMA: (1) strongly reemphasizes its support for the humane use of animals in biomedical research in all educational institutions and research facilities; and (2) supports and promotes legislation that is favorable to biomedical research at local, state and national levels and continues to oppose restrictive legislation. (Res. 150, I-89; Reaffirmed: Sunset Report, A-00)

H-460.965 Viability of Clinical Research Coverages and Reimbursement

Our AMA believes that: (1) third party payers should cover patient care costs of nationally approved (e.g., NIH, VA, ADAMHA, FDA), scientifically based research protocols or those scientifically based protocols approved by nationally recognized peer review mechanisms;

(2) third party payers should formally integrate the concept of risk/benefit analysis and the criterion of availability of effective alternative therapies into their decision-making processes;

(3) third party payers should be particularly sensitive to the difficulty and complexity of treatment decisions regarding the seriously ill and provide flexible, informed and expeditious case management when indicated;

(4) its efforts to identify and evaluate promising new technologies and potentially obsolete technologies should be enhanced;

(5) its current efforts to identify unproven or fraudulent technologies should be enhanced;

(6) sponsors (e.g., NIH, pharmaceutical firms) of clinical research should finance fully the incremental costs added by research activities (e.g., data collection, investigators' salaries, data analysis) associated with the clinical trial. Investigators should help to identify such incremental costs of research;

(7) supports monitoring present studies and demonstration projects, particularly as they relate to the magnitude (if any) of the differential costs of patient care associated with clinical trials and with general practice;

(8) results of all trials should be communicated as soon as possible to the practicing medical community maintaining the peer reviewed process of publication in recognized medical journals as the preferred means of evaluation and communication of research results;

(9) funding of biomedical research by the federal government should reflect the present opportunities and the proven benefits of such research to the health and economic well-being of the American people; and

(10) the practicing medical community, the clinical research community, patient advocacy groups and third party payers should continue their ongoing dialogue regarding issues in payment for technologies that benefit seriously ill patients and evaluative efforts that will enhance the effectiveness and efficiency of our nation's health care system. (CSA Rep. F, I-89; Reaffirmed: Joint CMS/CSA Rep., I-92; Reaffirmed: BOT Rep.40, I-93; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 4, A-02)

H-460.966 Scientific Fraud and Misrepresentation

Our AMA: (1) urges medical schools and biomedical research institutions to implement the guidelines set forth in Framework for Institutional Policies and Procedures to Deal With Fraud in Research; (2) urges the Liaison Committee on Medical Education to require the programs that it accredits to have in place a formal process for dealing with alleged instances of scientific fraud; and (3) urges medical schools and biomedical research institutions to install a mechanism for promoting structured discussions of ethics in research and clinical practice with required participation by medical students, graduate students, and research fellows. (Joint Report CSA & CEJA, I-89; Reaffirmed: Sunset Report, A-00)

H-460.969 Biomedical Research Protection

Our AMA: (1) encourages state medical associations to support legislation which would amend current criminal codes to specifically state that the unauthorized removal of research animals and/or damage to research projects/facilities is a crime, and the minimum penalty for this offense shall be a felony; and (2) supports passage of the intent of the Federal Animal Research Facilities Protection Act of 1989 (S 727) as originally proposed by Senator Heflin (D-Alabama). (Res. 251, A-89; Reaffirmed: Sunset Report, A-00)

H-460.970 Maintaining Progress in Biomedical Research

Our AMA supports continued leadership by the Association in maintaining progress in biomedical research. (Res. 211, A-89; Reaffirmed: Sunset Report, A-00)

H-460.971 Support for Training of Biomedical Scientists and Health Care Researchers

Our AMA: (1) continues its strong support for the Medical Scientists Training Program’s stated mission goals;

(2) supports taking immediate steps to enhance the continuation and adequate funding for stipends in federal research training programs in the biomedical sciences and health care research, including training of combined MD and PhD, biomedical PhD, and post-doctoral (post MD and post PhD) research trainees;

(3) supports monitoring federal funding levels in this area and being prepared to provide testimony in support of these and other programs to enhance the training of biomedical scientists and health care research;

(4) supports a comprehensive strategy to increase the number of physician-scientists by: (a) emphasizing the importance of biomedical research for the health of our population; (b) supporting the need for career opportunities in biomedical research early during medical school and in residency training; (c) advocating National Institutes of Health support for the career development of physician-scientists; and (d) encouraging academic medical institutions to develop faculty paths supportive of successful careers in medical research; and

(5) supports strategies for federal government-sponsored programs, including reduction of education-acquired debt, to encourage training of physician-scientists for biomedical research. (Res. 93, I-88; Reaffirmed: Sunset Report, I-98; Amended: Sub. Res. 302, I-99; Appended: Res. 515 and Reaffirmation A-00)

H-460.972 Fraud and Misrepresentation in Science

The AMA supports (1) the promotion of structured discussions of ethics that include research, clinical practice, and basic human values within all medical school curricula and fellowship training programs; (2) the promotion, through AMA publications and other vehicles, of (a) a clear understanding of the scientific process, possible sources of error, and the difference between intentional and unintentional scientific misrepresentation, and (b) multidisciplinary discussions to formulate a standardized definition of scientific fraud and misrepresentation that elaborates on unacceptable behavior; (3) the promotion of discussions on the peer review process and the role of the physician investigator; (4) the development of specific standardized guidelines dealing with the disposition of primary research data, authorship responsibilities, supervision of research trainees, role of institutional standards, and potential sanctions for individuals proved guilty of scientific misconduct; and (5) the sharing of information about scientific misconduct among institutions, funding agencies, professional societies, and biomedical research journals. (CSA Rep. F, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-03)

H-460.973 Protection of Scientific Freedom from Special Interest Groups

The AMA reaffirms that the principles of scientific freedom for individual investigators should be upheld by all research funding agencies, administrators, and professional societies. (Sub. Res. 91, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-460.974 Animal Research/Rights

The AMA (1) reaffirms its commitment to public education by encouraging physicians to place copies of material describing the medical benefits of animal research in their office waiting rooms; (2) supports heightened public awareness and education with regard to the types of animal models employed in research and efforts employed to avoid animal suffering; and (3) stresses to the public its concern with regard to the impact of the animal rights movement on the conduct of biomedical research, as well as support for the proper and humane treatment of animals in research. (Sub. Res. 64, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-460.975 Support for NIH Research Facilities

Our AMA urges: (1) the enactment of federal legislation which would grant to the National Institutes of Health (NIH) funding authority to expand, remodel, and renovate existing biomedical research facilities and to construct new research facilities; (2) that the authority be granted to the NIH Director and not fragmented at the categorical institute level; and (3) that institutions be required to match federal funding for this program in a systematic way. (BOT Rep. S, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-00)

H-460.976 Congressional Earmarking of Federal Research Funds

The AMA (1) strongly reaffirms the time-honored and proven peer review process of determining which scientific research projects are the most meritorious and deserving of federal support; and (2) urges Congress to refrain from granting federal dollars to individual projects that have bypassed the competitive review process by a jury of the applicant's peers. (Sub. Res. 118, A-88; Reaffirmed: Sunset Report, I-98)

H-460.977 Proposed Moratorium on New Animal Patents

The AMA supports (1) monitoring the issue of animal patents and continuing a legislative course of action, as appropriate; and (2) continuing to caution Congress against a moratorium or other detrimental action on animal patents and encouraging Congress to hold appropriate hearings on this matter. (Sub. Res. 173, A-88; Reaffirmed: Sunset Report, I-98)

H-460.978 Communication Among the Research Community, the Media and the Public

(1) The scientific understanding of the American public should be improved to foster realistic expectations and knowledgeable support of scientific undertakings and to assist in the formulation of informed health care decisions. (2) Those parties engaged in biomedical research should determine how to handle inquiries from, and how to effectively communicate with, the media. Increased cooperation is needed between the scientific community and the media to improve the reporting of biomedical research findings and to enhance the quality of health care information that is disseminated to the public. Both scientists and journalists should communicate biomedical research findings accurately and in an appropriate context. Journalists should include information on the limitations of research and should be cognizant of the emotional content of the health news they report. (3) Academic institutions, private industry, individual scientists, and funding agencies should not publicly announce results of biomedical research unless they have received critical review by others in the scientific community. (4) Medical and science writers should be encouraged to participate in continuing education seminars sponsored by public and private organizations to assess and broaden their skills and to increase their scientific knowledge. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-460.979 Use of Animals in Research

(1) Researchers should include in their protocols a commitment to ethical principles that promote high standards of care and humane treatment of all animals used in research. Further, they should provide animal review committees with sufficient information so that effective review can occur. For their part, institutions should strengthen their animal review committees to provide effective review of all research protocols involving animals. (2) The appropriate and humane use of animals in biomedical research should not be unduly restricted. Local and national efforts to inform the public about the importance of the use of animals in research should be supported. (3) The development of suitable alternatives to the use of animals in research should be encouraged among investigators and supported by government and private organizations. The selection of alternatives ultimately must reside with the research investigator. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CEJA Rep. 7, A-07)

H-460.980 Ethical and Societal Considerations in Research

(1) Private organizations and academic institutions should jointly develop a means to continue and enhance broadly based study and discussion of ethical and societal issues in biomedical research. (2) The federal government should provide the resources to support new initiatives within the National Institutes of Health for the funding of research studies in bioethics. Existing federal programs that fund bioethical research studies should be preserved. Private foundations should be encouraged to provide resources to support research studies in bioethics. (3) A uniform set of federal regulations governing research with human subjects, based on the core regulations of the Department of Health and Human Services should be adopted by all federal agencies. Uniformity should not preclude additions to Department regulations that do not conflict with the core regulations or that enhance the protection of research subjects. (4) Associations of regional institutional review boards (IRBs) should be formed to enhance IRB performance through the development of educational site visits and local workshops. (5) Each institution should have a system both for monitoring the conduct of biomedical research and for investigating and reporting allegations of research misconduct. (6) All investigators involved in research projects should be responsible for the clear articulation and enforcement of standards that ensure the integrity of scientific data and conclusions. Regardless of whether the research project is a result of individual or collaborative efforts, investigators should thoroughly understand the data and conclusions in research publications and studies. (7) As part of their formal training in research investigation, graduate, medical and postdoctoral students should be instructed on the importance of adhering to the ethical and scientific requirements in research conduct and in the reporting of research results. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07)

H-460.981 University-Industry Cooperative Research Ventures

(1) Academic institutions and industrial firms should establish explicit guidelines, policies and goals for cooperative research ventures that will best accommodate the interests and integrity of both organizations. The mission of academic institutions should not be compromised in any manner through participation in cooperative ventures.
(2) Faculty members should disclose the nature of and time spent in university-industry research ventures. When their major orientation becomes commercial development rather than teaching and research, faculty members should take a leave of absence or leave the university to pursue their dominant interest.
(3) Regardless of the nature of the partnership arrangement, patent and licensing rights emanating from university-industry cooperative ventures should accrue to university, investigator and industry by a mechanism agreed upon in advance. The degree to which a research project depends on proprietary information should be a prime consideration during the planning stages of a university-industry cooperative venture. Proprietary information can rightfully be viewed as being excluded from full disclosure of research results and, thus, its confidentiality should be maintained by both parties.
(4) Universities should not engage in research at the expense of the educational mission of the institutions. Monetary profits emanating from cooperative ventures should accrue to the university, investigators and industry by an agreeable mechanism.
(5) The free and expeditious communication of research findings to the scientific community should be a major objective of academia and industry. Reasonable delays for review of patentable subject matter and for filing of a patent application should be permitted.
(6) The federal government should encourage the participation of small businesses in cooperative research ventures, and should

continue to support starter programs for such projects. The federal government should be charged with conducting an ongoing analysis of the productivity and capacity of the nation's biomedical research enterprise, with the university-industry partnership as the focal point of the analyses.
(7) State and local governments should be encouraged to provide a legislative, economic and research environment conducive to the establishment of university and industry cooperatives ventures.
(8) Private industry should increase its financial support of university-industry cooperative ventures in biomedical research. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-460.982 Availability of Professionals for Research

(1) In its determination of personnel and training needs, major public and private research foundations, including the Institute of Medicine of the National Academy of Sciences, should consider the future research opportunities in the biomedical sciences as well as the marketplace demand for new researchers.
(2) The number of physicians in research training programs should be increased by expanding research opportunities during medical school, through the use of short-term training grants and through the establishment of a cooperative network of research clerkships for students attending less research-intensive schools. The number of physicians in research training programs should be increased by providing financial incentives for research centers.
(3) The current annual production of PhDs trained in the biomedical sciences should be maintained into the 1990s.
(4) The numbers of nurses, dentists, and other health professionals in research training programs should be increased.
(5) Members of the industrial community should increase their philanthropic financial support to the nation's biomedical research enterprise. Concentration of support on the training of young investigators should be a major thrust of increased funding. The pharmaceutical and medical device industries should increase substantially their intramural and extramural commitments to meeting postdoctoral training needs. A system of matching grants should be encouraged in which private industry would supplement the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration sponsored Career Development Awards, the National Research Service Awards and other sources of support.
(6) Philanthropic foundations and voluntary health agencies should continue their work in the area of training and funding new investigators. Private foundations and other private organizations should increase their funding for clinical research faculty positions.
(7) The National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration should modify the renewal grant application system by lengthening the funding period for grants that have received high priority scores through peer review.
(8) The support of clinical research faculty from the National Institutes of Health Biomedical Research Support Grants (institutional grants) should be increased from its current one percent.
(9) The academic medical center, which provides the multidisciplinary research environment for the basic and clinical research faculty, should be regarded as a vital medical resource and be assured adequate funding in recognition of the research costs incurred. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSA Rep. 13, I-99; Reaffirmed: CME Rep. 4, I-08)

H-460.983 Availability of Funding for Research

(1) Federal funding of basic and applied medical research should be increased at an annual rate of 10 percent (after inflation) for the remainder of the 1980s, and funding in the 1990s should be at a level sufficient to ensure appropriate growth in the nation's biomedical research enterprise. The major recipients of these increases should be the National Institutes of Health, the Veterans Administration, the Alcohol, Drug Abuse and Mental Health Administration, the Food and Drug Administration, and the Centers for Disease Control.(2) The National Institutes of Health, the Alcohol, Drug Abuse and Mental Health Administration, and other granting agencies should fund 40 percent of the approved grant applications each year for the remainder of the 1980s. (3) Appropriate measures to reform patent, tax and licensing laws, as well as measures to enhance the efficiency of regulatory processes, should be adopted by the federal government to encourage private industry involvement in basic and applied biomedical research. (BOT Rep. NN, A-87; Reaffirmed: BOT Rep. 40, I-93; Reaffirmation A-00; Reaffirmation I-08)

H-460.985 Support for Use of Animals in Teaching, Product Safety Testing and Research

The AMA: (1) reaffirms its unequivocal endorsement for the humane care, treatment and proper stewardship of animals in research as reflected in current laws and regulations; (2) supports continued work with other organizations to develop programs to educate physicians and the public regarding the benefits of the use of animals in research; (3) supports continued efforts to defend and promote the use of animals in meaningful research, product safety testing, and teaching programs; (4) condemns illegal acts by the so-called "animal liberationists"; (5) supports the policy of obtaining animals for medical research and education from animal control units, and the studying of ways to ensure that the animals used are indeed unwanted and abandoned; (6) affirms its commitment to the pursuit of alternative models for research where appropriate; and (7) encourages physician involvement in public policy issues concerned with the use of animals in research in order to insure the optimum environment for the creation of new knowledge to better diagnose, treat, and prevent disease. (Sub. Res. 109, I-86; Amended by Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: Res. 506, A-06; Reaffirmed in lieu of Res. 526, A-07)

H-460.986 Financial Protection for Clinical Research

Our AMA believes that clinical research should be adequately funded by both public and private sources. (CMS Rep. A, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00)

H-460.988 Need for Continued Use of Animals in Research and Education

The AMA supports (1) the humane use of animals essential to research, education and the development of drugs and medical devices; and (2) efforts to assure the availability of animals for these purposes. (Res. 140, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CSA Rep. 6, A-04)

H-460.989 Animals as Experimental Subjects

The AMA encourages medical school faculty who use animals in the education of students to continue instruction of students on the appropriate use and treatment of animals. (Res. 93, I-83; Reaffirmed: CME Rep. 2, A-05)

H-460.993 Biopsychomedical Research Funding

Our AMA, while recognizing the compelling need for a prudent and conservative federal budget, supports the continued adequate federal funding of biomedical, behavioral and clinical research activities at a level which will enable the excellence of research to continue. (Sub. Res. 29, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation A-00; Reaffirmation I-08)

H-460.994 Support for Careers in Research

Our AMA: (1) supports joining with other public and private bodies in encouraging multiple approaches at local, state and national levels in support of the development of physician-investigators, and specifically encourages research and training grants without a pay-back provision; (2) encourages the several specialty boards through the Interspecialty Advisory Board to allow one or more years of clinical investigative training, as long as it has some relevance to that specialty, in lieu of a year of post-doctoral clinical experience, where appropriate; and (3) encourages the NIH to increase the stipends for NIH research traineeships and fellowships without reducing the actual number of available positions. (CSA Rep. G, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-460.995 Support for Careers in Research

Our AMA: (1) recognizes the serious decline in the number of physicians seeking to prepare for a career in research, which is fundamental to the advancement of the practice of medicine, and urges that: (a) medical students be made aware of the challenging and important career option of biomedical research, and (b) schools of medicine be made aware of the impending shortage and provide increased opportunities for students to participate in research; and (2) supports policies and legislation designed to increase the number of physician-investigators. Such support should include encouragement for training of physicians in careers in biomedical research and for supportive legislation to make physician-investigators eligible for forgiveness in certain government scholarship and loan programs for qualified candidates in numbers consistent with national needs. (Sub. Res. 79, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

H-460.996 Basic Research

Our AMA supports an increase in funding for research toward basic scientific understanding of disease mechanisms. (BOT Rep. A, NCCMC Rec. 44, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-460.998 Support of Biomedical Research

Our AMA endorses and supports the following ten principles considered essential if continuing support and recognition of biomedical research vital to the delivery of quality medical care is to be a national goal: (1) The support of biomedical research is the responsibility of both government and private resources.

(2) The National Institutes of Health must be budgeted so that they can exert effective administrative and scientific leadership in the biomedical research enterprise.

(3) An appropriate balance must be struck between support of project grants and of contracts.

(4) Federal appropriations to promote research in specifically designated disease categories should be limited and made cautiously.

(5) Funds should be specifically appropriated to train personnel in biomedical research.

(6) Grants should be awarded under the peer review system.

(7) The roles of the private sector and of government in supporting biomedical research are complementary.

(8) Although the AMA supports the principle of committed federal support of biomedical research, the Association will not necessarily endorse all specific legislative and regulatory action that affects biomedical research.

(9) To implement the objectives of section 8, the Board will establish mechanisms for continuing study, review and evaluation of all aspects of federal support of biomedical research.

(10) Our AMA will accept responsibility for informing the public on the relevance of basic and clinical research to the delivery of quality medical care. (BOT Rep. S, A-74; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: CSA Rep. 13 , Sunset Report and Reaffirmation A-00; Reaffirmation I-08)

H-460.999 Support of Continued Government Funding for Basic and Applied Clinical Research

Our AMA (1) reaffirms its interest in promoting research; and (2) supports restoration and continuation of government funds for basic and applied clinical research. (Res. 8, A-71; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: CSA Rep. 13, Sunset Report, and Reaffirmation A-00)

H-465.000 Rural Health
(See also: Health Care Delivery; Health Care Reform; Health Manpower; Hospitals: Reimbursement; Physician Payment; Physician Payment: Medicare - RBRVS)

H-465.980 Rural Community Health Networks

AMA policy is that development of rural community health networks be organized using the following principles: (1) Local delivery systems should be organized around the physical, mental and social needs of the community;

(2) Clinical decision-making and financial management should reside within the community health network whenever feasible with physicians retaining responsibility for a network's medical, quality and utilization management;

(3) Savings generated by community health networks should be reinvested in the local health care delivery system, rather than redirected elsewhere, since rural health systems and economies are fundamentally intertwined;

(4) Patients should retain access to the spectrum of local health services, thereby preserving patient-physician relationships and continuity of care; and

(5) Participation in rural community health networks should be voluntary, but open to all qualified rural physicians and other health care providers wishing to participate. (Sub. Res. 721, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-465.981 Enhancing Rural Physician Practices

The AMA: (1) supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas's Health Professional Shortage Area (HPSA) status; (2) encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements; (3) will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result; and (4) supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders. (CMS Rep. 9, A-96; Reaffirmed: CMS Rep. 8, A-06)

H-465.982 Rural Health

The AMA: (1) encourages state medical associations to study the relevance of managed competition proposals to meeting health care needs of their rural populations; (2) encourages state associations to work with their respective state governments to implement rural health demonstration projects; and (3) will provide all adequate resources to assist state associations in dealing with managed competition in rural areas. (CMS Rep. H, A-93; Reaffirmed: CMS Rep. 10, A-03)

H-465.984 Access to Physician Services in Rural Health Clinics

Our AMA strongly encourages CMS and appropriate state departments of health to review the Rural Health Clinic Program eligibility

and certification requirements to ensure that independent (e.g., physician) and provider-based (e.g., hospital) facilities are certified as Rural Health Clinics only in those areas that truly do not have appropriate access to physician services. (Sub. Res. 717, I-91; Reaffirmed: Sunset Report, I-01)

H-465.986 Rural Health

(1) The AMA urges CMS to disseminate widely information on the Rural Health Clinics Program, not only to states and health facilities but to state medical associations as well. (2) The AMA encourages state medical associations to evaluate the potential benefits and drawbacks to rural practices of seeking certification as rural health clinics, and transmit the result of such evaluation to their members. (3) The AMA encourages state medical associations to carefully evaluate the relevant practice acts in their jurisdictions to identify any modifications needed to allow the most effective use of mid-level practitioners in improving access to care, while assuring appropriate physician direction and supervision of such practitioners. (CMS Rep. A, A-91; Reaffirmed by CMS Rep. 8, A-95; Reaffirmed: CMS Rep. 7, A-05)

H-465.988 Educational Strategies for Meeting Rural Health Physician Shortage

In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that: (1) Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.

(2) Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.

(3) Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.

(4) Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.

(5) Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.

(6) Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.

(7) Our AMA support full funding of the new federal National Health Service Corps loan repayment program.

(8) Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.

(9) Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.

(10) Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.

(11) Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.

(12) Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners. (CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08)

H-465.989 Rural Health

It is the policy of the AMA that: (1) the AMA closely monitor the impact of balance billing restrictions mandated by the Budget Reconciliation legislation on reimbursement levels and access to care in rural areas, and take action as needed to moderate that impact; (2) the AMA closely monitor implementation of the legislation establishing essential access community hospitals and rural primary care hospitals, to ensure that this program is implemented in a manner conducive to high quality of patient care and consistent with Association policy concerning the functions and supervision of physician assistants and nurse practitioners; (3) state medical associations be encouraged to monitor similarly and to influence any legislation or regulations governing the development and operation of such limited service rural hospital facilities in their own jurisdictions; and (4) the AMA establish liaison with the

American Hospital Association, Congress and the Centers for Medicare & Medicaid Services regarding any further development of essential access community hospitals and rural primary care hospitals grants. (CMS Rep. K, A-90; Modified: Sunset Report, I-00)

H-465.990 Closing of Small Rural Hospitals

Our AMA encourages legislation to reduce the financial constraints on small rural hospitals in order to improve access to health care. (Res. 145, A-90; Reaffirmed: Sunset Report, I-00)

H-465.992 Rural Medical Care

Our AMA supports proposals of the Rural Health Care Coalition that are consistent with AMA policy and that develop and enhance the medical care resources of America's rural areas. (Sub. Res. 129, A-90; Reaffirmed: Sunset Report, I-00)

H-465.994 Committee on Rural Health

The AMA (1) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (2) urges physicians practicing in rural areas to be actively involved in these efforts, and (3) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public. (Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-465.996 Change in Criteria for Rural Referral Center Designation

The AMA opposes any changes to rural referral center designations that may adversely affect the access to or quality of medical services provided by rural referral centers. (BOT Rep. F, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-465.997 Access to and Quality of Rural Health Care

(1) Our AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources. (2) In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued. (CMS Rep. G, A-87; Modified: Sunset Report, I-97; Reaffirmation A-01)

H-465.999 Certification of Rural Hospitals for Medicare

The AMA (1) urges the Secretary of HHS to reassess the regulations prescribing conditions of participation and to adopt a more realistic and humanitarian approach toward certification of small, rural area hospitals, and (2) recommends that state medical associations and state licensing and certifying agencies establish and maintain close surveillance of the certification and accreditation problems of small hospitals. (Res. 42, A-68; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-470.000 Sports and Physical Fitness
(See also: Preventive Medicine; Public Health)

H-470.961 Requirement for Daily Free Play in Schools

Our AMA recommends that elementary schools maintain at least thirty minutes of daily free play or physical education that is consistent with CDC guidelines. (Res. 409, A-04; Reaffirmation A-07)

H-470.962 Cardiovascular Preparticipation Screening of Student Athletes

The role of the AMA includes working with appropriate medical specialty societies to increase awareness among physicians, state and local medical societies, parent-teacher organizations, state legislatures, athletic associations, school administrators, and school boards of the availability of consensus medical guidelines and recommendations for sports preparticipation evaluations (CSA Rep. 5, I-99)

H-470.963 Boxing Injuries

It is the policy of the AMA that: (1) until such time as boxing is banned in this country, the following preventive strategies should be pursued to reduce brain and eye injuries in boxers: (a) Ideally, head blows should be prohibited. Otherwise, our AMA should

encourage universal use of protective garb such as headgear, and thumbless, impact-absorbing gloves.
(b) the World Boxing Council, World Boxing Association, and other regulatory bodies should develop and enforce objective brain injury risk assessment tools to exclude individual boxers from sparring or fighting including APOE ?4 screening, neuroimaging, clinical neurological assessment, neurophysiological assessment, and indices of cumulative brain injury.
(c) the World Boxing Council, World Boxing Association, and other regulatory bodies should develop and enforce standard criteria for referees, ringside officials, and ringside physicians to halt sparring or boxing bouts when a boxer has experienced concussive or subconcussive blows that place him or her at imminent risk of more serious injury.
(d) the World Boxing Council, World Boxing Association, and other regulatory bodies should encourage implementation of measures advocated by the World Medical Boxing Congress designed to reduce the incidence of brain and eye injuries.
(e) the World Boxing Council, World Boxing Association, and other regulatory bodies should require initial and repeat eye examinations for amateur and professional boxers and mandate suspensions from sparring or boxing for specific ocular pathology according to recommendations of the American Academy of Ophthalmology.

(2) Our AMA promotes the concept that the professional responsibility of the physician who serves in a medical capacity at a boxing contest is to protect the health and safety of the contestants. The desire of spectators, promoters of the event, or even injured athletes that they not be removed from the contest should not be controlling. The physician's judgment should be governed only by medical considerations. (CSA Rep. 3, A-99; Reaffirmed: Res. 412, A-02)

H-470.964 Youth Training for Participating in Olympic Level Competition

The AMA will work with the United States and International Olympic Committees to encourage the development of guidelines and establish measures to assure the physical and psychological health of children and adolescents participating in Olympic-level training programs and similar highly intensive and competitive training activities. (Sub. Res. 407, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-470.965 Ultimate and Extreme Fighting

Our AMA: (1) opposes ultimate fighting and extreme fighting events; and (2) encourages states which have not banned these events to pass a law doing so. (Res. 405, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-470.966 Harmful Practices in Child Athletics

The AMA will work with all interested organizations to identify harmful practices in the sports training of children and adolescents; and be it further Resolved, That the AMA support the establishment of appropriate health standards for sports training of children and adolescents. (Res. 417, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-470.967 Safety in Youth Baseball and Softball

The AMA: (1) urges youth baseball and softball organizations to adopt policies for the use of protective equipment; (2) will create greater public awareness regarding the potential dangers of using baseballs and softballs with children; and (3) encourages sponsors of organized youth sports activities to adopt written emergency and a first responder plans. (Res. 408, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-470.968 Infectious Disease and Athletic Competition

The AMA: (1) urges sports organizations to consult a qualified physician to provide necessary guidance on appropriate infection control measures; and (2) recognizing the absence of data in this area, encourages sports organizations to systematically collect data on transmission of bloodborne infections. (BOT Rep. 36, I-93; Reaffirmed and Modified: CSA Rep. 8, A-05)

H-470.969 Gender Verification in Olympic Competition

Our AMA declares its opposition to the use of laboratory testing for genetic sex as a basis for verification of gender in athletic competition and urges the International Olympic Committee to make permanent the 1999 conditional ban on this practice for all future competitions. (Res. 525, I-92; Modified: CSA Rep. 3, I-01

H-470.970 Disclosure of Medical Information by Student Athletes

The AMA supports informing the public through appropriate means that parents and caretakers of students and student athletes should fully inform examining physicians of any possible symptom of medical problems that the student may be experiencing. (Res. 81, A-91; Reaffirmed: CSA Rep. 3, A-99)

H-470.971 Athletic Preparticipation Examinations for Adolescents

To promote the health and safety of adolescents, our AMA recommends that state medical societies work with appropriate state and local agencies to promote the following: (1) The development of standards for preparticipation athletic examinations that are consistent with consensus recommendations of the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine.

(2) Only licensed MDs, DOs, and licensed physician extenders practicing under the supervision of licensed MDs and DOs perform preparticipation examinations.

(3) The decision of whether or not an adolescent is healthy and physically mature enough to participate in a particular sport is made by a qualified physician.

(4) The decision of when an injured athlete resumes participation is made by a qualified physician.

(5) The most current guidelines established by the American Academy of Pediatrics, American College of Cardiology, American College of Sports Medicine, and other appropriate medical specialty societies are used to determine eligibility for sports participation. (BOT Rep. R, A-90; Amended: CSA Rep. 5, I-99)

H-470.972 Medical and Nonmedical Uses of Anabolic-Androgenic Steroids

Our AMA (1) reaffirms its concern over the nonmedical use of drugs among athletes, its belief that drug use to enhance or sustain athletic performance is inappropriate, its commitment to cooperate with various other concerned organizations, and its support of appropriate education and rehabilitation programs;

(2) reaffirms its support of increased criminal penalties enacted as a part of the Anti-Drug Abuse Act of 1988 and its support of state legislation that addresses the problem of misprescribing;

(3) reaffirms its willingness to work closely with sports groups, coaches, team owners, amateur and professional athletes, and parents;

(4) continues to endorse the public and professional education campaign of the FDA;

(5) supports making available to practicing physicians, legislators, sports organizations, educators, adolescents, and the public existing and proposed educational materials and model state legislation on the nonmedical use of anabolic steroids;

(6) supports identifying and widely disseminating information on successful initiatives and activities to curtail the problem of nonmedical use;

(7) encourages survey efforts that provide a better understanding of the nature and prevalence of nonmedical use;

(8) actively encourages further research on short- and long-term health effects, and encourages reporting of suspected adverse effects to the FDA; and

(9) supports continued efforts to work with sports organizations to increase understanding of health effects and to discourage use of steroids on this basis. (CSA Rep. A, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 501, A-01; Modified: CSA Rep. 9, A-03)

H-470.973 Boxing as an Olympic Sport

The AMA requests the United States Olympic Committee to transmit AMA's policy of opposition to boxing to the International Olympic Committee and ask that boxing be eliminated as an Olympic sport. (Sub. Res. 40, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSA Rep. 3, A-99)

H-470.974 Athletic Helmets

The AMA urges the Consumer Product Safety Commission to establish standards that athletic and recreational helmets, including but not limited to football, baseball, hockey, horse back riding, bicycle and motorcycle riding, lacrosse, and skiing, produced or sold in the United States provide protection against head injury; and that the AMA advocate the use of appropriate and safe clear face guards as a permanent installation on the current bilateral ear protective batter's helmet to be worn by all baseball and softball players as required safety equipment in all organized baseball and softball for those children from 5 to 14 years of age. (Sub. Res. 16, I-88; Res. 419, A-93; Reaffirmed: CSA Rep. 8, A-03)

H-470.975 Mandatory Physical Education

The AMA continues its commitment to support state and local efforts to implement quality physical education programs for all students, including the handicapped, in grades kindergarten through twelve, including ungraded classes. (Sub. Res. 1, I-88; Reaffirmation and Sunset Report, I-98; Reaffirmation A-07)

H-470.976 Abuse of Anabolic Steroids

The AMA (1) believes that the prescription of anabolic steroids for the enhancement of athletic ability is entirely inappropriate; (2) supports the development of state legislation or administrative rules to prohibit the use of anabolic steroids for the purpose of enhancing athletic ability; and (3) supports continued efforts to educate physicians, sports group administrators, coaches, parents, and athletes on the dangers of abuse of anabolic steroids. (Res. 131, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-470.977 Use of Protective Headgear During Equestrian Activities

The AMA reaffirms its support for (1) educational programs for parents, riding instructors, show organizers and managers outlining the risks in horseback riding and methods to minimize them; (2) selection of satisfactory protective headgear for each type of riding activity and the wearing of such headgear when riding or preparing to ride; and (3) efforts to encourage individuals riding horses to wear protective headgear. (Sub. Res. 92, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-470.978 Blood Doping

The AMA believes that a physician who participates in blood doping is deviating from his professional responsibility and that blood doping must be considered in the category of unnecessary medical services. (CEJA Rep B, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-470.979 Drugs and Athletes

The AMA favors cooperative efforts with the National Collegiate Athletic Association, the National Intercollegiate Athletic Association, the National Federation of High Schools and all other appropriate organizations to establish drug education, testing and treatment programs in all their respective athletic programs. (Sub. Res. 116, A-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-470.980 Hazards of Boxing

The AMA (1) encourages the elimination of both amateur and professional boxing, a sport in which the primary objective is to inflict injury;
(2) supports communicating its opposition to appropriate regulating bodies;
(3) supports state medical societies' efforts to work with their state legislatures to enact laws to eliminate boxing in their jurisdictions; and
(4) supports efforts to educate the American public, especially children and young adults, about the dangerous effects of boxing on the health of participants. (Sub. Res. 26, I-84; Reaffirmed: Sub. Res. 408, I-93; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmed: CSA Rep. 3, A-99)

H-470.981 Protective Headgear for Horseback Riders

The AMA supports the following guidelines regarding participation in horseback riding activities: (1) Educational programs should be given to parents, riding instructors, show organizers and managers, outlining the risks in horseback riding and methods to minimize them. (2) Satisfactory protective headgear should be selected for each type of riding activity and worn when riding or preparing to ride. (3) Individuals riding horses should be encouraged to wear protective headgear. (Sub. Res. 107, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04)

H-470.983 Boxing as a Health Hazard

The AMA (1) supports publicizing the deleterious effects of boxing on the health of participants; and (2) encourages the elimination of boxing from amateur scholastic, intercollegiate and governmental athletic programs as detrimental to the health of participants. (Res. 80, A-83; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

H-470.984 Brain Injury in Boxing

The AMA supports the following series of steps designed to protect amateur and professional boxers from injuries: (1) Encourage the

establishment of a "National Registry of Boxers" for all amateur and professional boxers, including "sparring mates," in the country. The proposed functions of a computer-based central registry would be to record the results of all licensed bouts, including technical knockouts, knockouts, and other boxing injuries, and to compile injury and win/loss records for individual boxers.

(2) Plan and conduct a conference with representatives of the American Association of Ringside Physicians, medical representatives of the various state and local boxing commissions, and representatives of organized professional and amateur boxing organizations to review criteria for the physical examination of boxers, to determine other comprehensive medical measures necessary for the prevention of brain injury in the sport, and to develop specific criteria for the discontinuance of a bout for medical reasons.

(3) Recommend to all boxing jurisdictions that the ring physician should be authorized to stop any bout in progress, at any time, to examine a contestant and, when indicated, to terminate a bout that might, in his opinion, result in serious injury for either contestant.

(4) Urge state and local commissions to conduct frequent medical training seminars for all ring personnel.

(5) Recommend to all boxing jurisdictions that no amateur or professional boxing bout should be permitted unless: (a) the contest is held in an area where adequate neurosurgical facilities are immediately available for skilled emergency treatment of an injured boxer; (b) a portable resuscitator with oxygen equipment and appropriate endotracheal tubes are available at ringside; and (c) a comprehensive evacuation plan for the removal of any seriously injured boxer to hospital facilities is ready.

(6) Inform state legislatures that unsupervised boxing competition between unlicensed boxers in "tough man" contests is a most dangerous practice that may result in serious injury or death to contestants, and should be condemned.

(7) Urge state and local boxing commissions to mandate the use of safety equipment, such as plastic safety mats and padded cornerposts, and to encourage continued development of safety equipment.

(8) Urge state and local boxing commissions to extend all safety measures to sparring partners.

(9) Urge state and local boxing commissions to upgrade, standardize and strictly enforce medical evaluations for boxers. (CSA Rep. F, A-82; Reaffirmed: A-83; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: Sub. Res. 408, I-93; Reaffirmed: CSA Rep. 3, A-99)

H-470.985 Goalie Face Masks in Hockey

Our AMA endorses the mandatory use of an adequate cage-type face mask for goalies in all amateur, high school and college hockey programs in the nation. (Res. 4, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-470.986 Helmets for Hockey Referees

Our AMA endorses the use of hockey helmets for all referees in amateur, high school and college hockey programs in the US. (Res. 123, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-470.988 Face Masks in Hockey

Our AMA urges all amateur high school and college hockey programs throughout the nation to require the use of hockey face masks. (Sub. Res. 65, A-80; Reaffirmed: CLRPD Rep. C, I-90; Reaffirmed: Sunset Report, I-00)

H-470.989 Physical Fitness and Physical Education

Our AMA: (1) urges school boards, administrators and parents to provide physical education programs during elementary, junior high and senior high years; and (2) stresses that these programs be conducted by qualified personnel, be designed to teach health habits and physical skills, and be designed to instill a desire in the student for physical fitness that will carry over into adult life. (CSA Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmation I-98; Reaffirmation A-04; Reaffirmation A-07)

H-470.990 Promotion of Exercise Within Medicine and Society

Our AMA supports (1) education of the profession on exercise, including instruction on the role of exercise prescription in medical practice in its continuing education courses and conferences, whenever feasible and appropriate;

(2) medical student instruction on the prescription of exercise;

(3) physical education instruction in the school system; and

(4) education of the public on the benefits of exercise, through its public relations program. (Res. 56, I-78; Reaffirmed: CLRPD Rep.

C, A-89; Reaffirmation I-98; Reaffirmation A-07)

H-470.991 Promotion of Exercise

Our AMA: (1) supports the promotion of exercise, particularly exercise of significant cardiovascular benefit; and (2) encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest. (Res. 83, parts 1 and 2, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-470.992 Mandatory Use of Helmets in Hockey

Our AMA strongly recommends that all professional hockey leagues adopt mandatory use of helmets for practices and games. (Res. 44, I-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-470.993 Weight Loss in Amateur Wrestling

Our AMA: (1) supports the position of the American College of Sports Medicine that rapid and significant weight loss or unrealistic weight maintenance over protracted periods in amateur wrestlers are practices detrimental to good health and can induce potentially serious illness in younger athletes; (2) opposes dangerous weight loss techniques used by amateur athletes to achieve competitive weight; and (3) strongly urges amateur athletic associations to institute a mandatory ban on weight loss techniques including, but not limited to, fluid deprivation and the use of diuretics, hot rooms and impermeable suits. (BOT Rep. M, I-76; Reaffirmed: CLRPD Rep. C A-89; Appended by Res. 429, A-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

H-470.994 Non-Therapeutic Use of Pharmacological Agents by Athletes

Our AMA: (1) opposes the use of drugs for the purpose of enhancing athletic performance or sustaining athletic achievement. This action in no way should be construed as limiting a physician's proper use of drugs in indicated treatment of athletic injuries or clinical symptoms of individual athletes; and (2) endorses efforts by state level high school athletic associations to establish programs which include enforceable guidelines concerning weight and body fat changes on a precompetition basis for those sports in which weight management is a concern. (Res. 89 part 2, A-72; Reaffirmed: CLRPD Rep. C, A-89; Modified by Res. 401, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-470.995 Athletic (Sports) Medicine

Our AMA believes that: (1) the Board of Education and the Department of Health of the individual states should encourage that an adequate Athletic Medicine Unit be established in every school that mounts a sports program;

(2) the Athletic Medicine Unit should be composed of an allopathic or osteopathic physician director with unlimited license to practice medicine, an athletic health coordinator (preferably a NATABOC certified athletic trainer), and other necessary personnel;

(3) the duties of the Athletic Medicine Unit should be prevention of injury, the provision of medical care with the cooperation of the family’s physician and others of the health care team of the community, and the rehabilitation of the injured;

(4) except in extreme emergencies, the selection of the treating physician is the choice of the parent or guardian and any directed referral therefore requires their consent;

(5) the Athletic Medicine Units should be required to submit complete reports of all injuries to a designated authority;

(6) medical schools, colleges, and universities should be urged to cooperate in establishing education programs for athletic health coordinators (NATABOC certified athletic trainers) as well as continuing medical education and graduate programs in Sports Medicine;

(7) high school administrators, athletic directors, and coaches to work with local physicians, medical societies, and medical specialty societies, as well as government officials and community groups to undertake appropriate measures to ensure funding to provide the services of a certified athletic trainer to all high school athletes; and

(8) not all high schools have the resources to procure the services of a certified athletic trainer and further recognizing that athletic trainers cannot be present at all practices and competitions, that the AMA encourage high school administrators and athletic directors to ensure that all coaches are appropriately trained in emergency first aid and basic life support. (Res. 112, A-69; Reaffirmed: CLRPD Rep. C, A-89; Modified and Reaffirmed by Ref. Cmt. D, I-96; Amended and Appended by CSA Rep. 5, A-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-470.996 School and College Physical Education

Our AMA encourages effective instruction in physical education for all students in our schools and colleges. (BOT Rep. I, A-69; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation I-98; Reaffirmation A-07)

H-470.997 Exercise and Physical Fitness

The AMA encourages all physicians to utilize the health potentialities of exercise for their patients as a most important part of health promotion and rehabilitation, and urges state and local medical societies to emphasize through all available channels the need for physical activity for all age groups and both sexes. The AMA encourages other organizations and agencies to join with the Association in promoting physical fitness through all appropriate means. (BOT Rep. K, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

H-470.998 Youth Physical Fitness

The AMA and its state and local components should reemphasize their support of local school and college youth fitness programs. (Res. 82, A-62; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

H-470.999 Youth Fitness

The AMA (1) approves in principle the aims and objectives of the President's Council on Youth Fitness and the President's Citizens Advisory Committee on the Fitness of American Youth and urges its member physicians to cooperate in the promotion of properly developed and soundly conceived plans and programs for youth fitness, and (2) requests the constituent associations and their member local medical societies to work cooperatively with reputable professional and other ethical groups interested in the improvement of youth fitness. (BOT Rep. A-59; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-07)

H-475.000 Surgery
(See also: Blood; Organ Donation and Transplantation; Physician Payment; Physician Payment: Medicare; Technology)

H-475.983 Definition of Surgery

Our AMA adopts the following definition of “surgery” from American College of Surgeons Statement ST-11:

Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel.

Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards. (Res. 212; A-07)

H-475.984 Office-Based Surgery Regulation

Our AMA supports the following Core Principles on Office-Based Surgery:

Core Principle #1: Guidelines or regulations for office-based surgery should be developed by states according to levels of anesthesia defined by the American Society of Anesthesiologists (ASA) excluding local anesthesia or minimal sedation. (American Society of Anesthesiologists. Continuum of depth of sedation. Available at: http//www. asahq.org/publications and services/standards/20.htm. Accessed February 27, 2003).

Core Principle #2: Physicians should select patients for office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia by criteria including the ASA Physical Status Classification System and so document. (American Society of Anesthesiologists. ASA physical status classification system. Available at: http://www.asahq.org/clinical/physical status.htm. Accessed February 27, 2003).

Core Principle #3: Physicians who perform office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have their facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), American Osteopathic Association (AOA), or by a state recognized entity, such as the Institute for Medical Quality (IMQ), or be state licensed and/or Medicare certified.

Core Principle #4: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospital, or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital.

Core Principle #5: States should follow the guidelines outlined by the Federation of State Medical Boards (FSMB) regarding informed consent. (Report of the Special Committee on Outpatient [Office-Based] Surgery. (Med. Licensure Discipline. 2002; 88:-160-174).

Core Principle #6: For office surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, states should consider legally privileged adverse incident reporting requirements as recommended by the FSMB and accompanied by periodic peer review and a program of Continuous Quality Improvement. (Report of the Special Committee on Outpatient (Office-Based) Surgery. Journal Medical Licensure and Discipline. 2002; 88:160-174).

Core Principle #7: Physicians performing office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia must obtain and maintain board certification by one of the boards recognized by the American Board of Medical Specialties, American Osteopathic Association, or a board with equivalent standards approved by the state medical board within five years of completing an approved residency training program. The procedure must be one that is generally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care.

Core Principle #8: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia may show competency by maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center, for the procedures they perform in the office setting. Alternatively, the governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards.

Core Principle #9: For office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, at least one physician who is credentialed or currently recognized as having successfully completed a course in advanced resuscitative techniques (e.g., ATLS, ACLS, or PALS), must be present or immediately available with age- and size-appropriate resuscitative equipment until the patient has met the criteria for discharge from the facility. In addition, other medical personnel with direct patient contact should at a minimum be trained in Basic Life Support (BLS).

Core Principle #10: Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have appropriate education and training. (BOT Action in response to referred for decision BOT Rep. 23, A-03)

H-475.985 Protecting the Integrity of General Surgery as a Specialty

AMA policy is that general surgery is a single specialty, distinct from other surgical specialties and that general surgery should be recognized as such by state regulatory agencies. (Res. 317, A-05)

H-475.986 Surgical Assistants other than Licensed Physicians

Our AMA: (1) affirms that only licensed physicians with appropriate education, training, experience and demonstrated current competence should perform surgical procedures;

(2) recognizes that the responsible surgeon may delegate the performance of part of a given operation to surgical assistants, provided the surgeon is an active participant throughout the essential part of the operation. Given the nature of the surgical assistant's role and the potential of risk to the public, it is appropriate to ensure that qualified personnel accomplish this function;

(3) policy related to surgical assistants, consistent with the American College of Surgeons' Statements on Principles states:(a) The surgical assistant is limited to performing specific functions as defined in the medical staff bylaws, rules and regulations. These generally include the following tasks: aid in maintaining adequate exposure in the operating field, cutting suture materials, clamping and ligating bleeding vessels, and, in selected instances, actually performing designated parts of a procedure.
(b) It is the surgeon's responsibility to designate the individual most appropriate for this purpose within the bylaws of the medical staff. The first assistant to the surgeon during a surgical operation should be a credentialed health care professional, preferably a physician, who is capable of participating in the operation, actively assisting the surgeon.
(c) Practice privileges of individuals acting as surgical assistants should be based upon verified credentials and the supervising physician's capability and competence to supervise such an assistant. Such privileges should be reviewed and approved by the

institution's medical staff credentialing committee and should be within the defined limits of state law. Specifically, surgical assistants must make formal application to the institution's medical staff to function as a surgical assistant under a surgeon's supervision. During the credentialing and privileging of surgical assistants, the medical staff will review and make decisions on the individual's qualifications, experience, credentials, licensure, liability coverage and current competence.
(d) If a complex surgical procedure requires that the assistant have the skills of a surgeon, the surgical assistant must be a licensed surgeon fully qualified in the specialty area. If a complication requires the skills of a specialty surgeon, or the surgical first assistant is expected to take over the surgery, the surgical first assistant must be a licensed surgeon fully qualified in the specialty area.
(e) Ideally, the first assistant to the surgeon at the operating table should be a qualified surgeon or resident in an education program that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) and/or the American Osteopathic Association (AOA). Other appropriately credentialed physicians who are experienced in assisting the responsible surgeon may participate when a trained surgeon or a resident in an accredited program is not available. The AMA recognizes that attainment of this ideal in all surgical care settings may not be practicable. In some circumstances it is necessary to utilize appropriately trained and credentialed unlicensed physicians and non-physicians to serve as first assistants to qualified surgeons. (BOT Rep. 32, A-99; Reaffirmed: Res. 240, 708, and Reaffirmation A-00)

H-475.987 Freedom of Speech in Medical Information

The AMA opposes the Multi-District Litigation (MDL) pertaining to pedicle screws because it impedes the progress of medical science and the availability of the highest quality care for patients; and opposes any and all actions that interfere with the free and unfettered exchange of medical information. (Res. 510, A-97; Reaffirmed: CSAPH Rep. 2, A-08)

H-475.988 Laser Surgery

The AMA supports the position that revision, destruction, incision or other structural alteration of human tissue using laser is surgery. (Res. 316, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-475.989 Laser Surgery

Our AMA (1) adopts the policy that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services; and (2) encourages state medical associations to support state legislation and rulemaking in support of this policy. (Sub. Res. 39, I-90; Reaffirmed: Sunset Report, I-00)

H-475.990 Physicians Credentialing

Our AMA reaffirms that the place for physician credentialling be through the monitoring and updating by the appropriate hospital credentialling committees and not through the actions of third party payers. (Res. 48, A-90; Reaffirmed: Sunset Report, I-00)

H-475.991 Postoperative Care - Responsibility and Reimbursement

Our AMA: (1) continues to support repeal of the federal law which allows reimbursement to optometrists for the unsupervised/independent provision of postoperative care; and (2) reaffirms its position that physicians performing surgery have an ethical and professional responsibility to continue the care of their individual patients through the post-surgical recovery and healing period, or to arrange coordination of such care, especially in those situations where there is a reasonable expectation that another physician will provide postoperative surgical care. (Sub. Res. 8, A-89; Reaffirmed: Sunset Report, A-00; BOT Action in response to referred for decision CMS Rep. 3, I-06)

H-475.992 Definitions of "Cosmetic" and "Reconstructive" Surgery

(1) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer. (CMS Rep. F, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed, A-03)

H-475.993 Postoperative Care

Our AMA believes that physicians and medical societies at the state and local levels should work with their state legislatures to modify relevant practice acts where such changes are deemed necessary to help assure the provision of high quality care. (CMS Rep. K, A-89; Reaffirmed: Sunset Report, A-00)

H-475.994 Mandated Outpatient Surgery

The AMA (1) believes that the choice of operating environment must remain a matter of professional judgment of the patient's physician; and (2) requests that third party payers reevaluate their positions on this issue. (Sub. Res. 81, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-475.996 Revision of AMA Surgical Screening Criteria

The AMA (1) urges national medical specialty societies to review all criteria sets in use within the QIO program to determine whether sections applicable to the practice of their members are in need of revision and, if they are, to develop recommendations for change; (2) encourages state medical societies to organize specialty specific liaison activities between specialty groups and their respective QIOs in order to address particular issues that may arise concerning the development or application of criteria; and (3) supports continued efforts to collect information on screening criteria sets and to evaluate the process by which they are being applied. (CMS Rep. F, I-86; Reaffirmed: Sunset Report, I-96; Modified and reaffirmed: CMS Rep. 8, A-06)

H-475.997 Same-Day Admission for Elective Surgery

The AMA accepts the practice of same-day admission for elective surgery, unless this practice is determined to be detrimental to the patient's health by his or her physician. The determination of the advisability of same-day admission and/or outpatient surgery should be based on the judgment of the patient's physician and not solely on prescribed lists of procedures. (BOT Rep. E, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06)

H-475.998 Cochlear Implants

The AMA endorses cochlear implants, auditory prostheses designed to stimulate electrically the remaining population of eighth nerve neurons in the cochlea of profoundly deaf people. (CSA Rep. B, I-82; Reaffirmed: CLRPD Rep. A, I-92; Amended: CSA Rep. 8, A-03)

H-478.000 Technology - Computer

H-478.993 Implementing Electronic Medical Records

It is the policy of our AMA that public and private insurers should not require the use of electronic medical records. (Sub. Res. 707, A-06; Reaffirmation A-07)

H-478.994 Health Information Technology

Our AMA will support the principles that when financial assistance for Health IT originates from an inpatient facility: (1) it not unreasonably constrain the physician’s choice of which ambulatory HIT system to purchase; and (2) it promote voluntary rather than mandatory sharing of Protected Health Information (HIPAA-PHI) with the facility consistent with the patient’s wishes as well as applicable legal and ethical considerations. (Res. 723, A-05)

H-478.995 National Health Information Technology

Our AMA supports the development, adoption, and implementation of national health information technology standards through collaboration with public and private interests, and consistent with current efforts to set health information technology standards for use by the federal government. (Res. 730, I-04; Reaffirmed in lieu of Res. 726, A-08)

H-478.996 Medical Care Online

It is the policy of the AMA to support efforts to address the economic, literacy, and cultural barriers to patients utilizing information technology. (CMS Rep. 4, A-01)

H-478.997 Guidelines for Patient-Physician Electronic Mail

New communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient’s care. These guidelines do not address communication between physicians and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.

(1) For those physicians who choose to utilize e-mail for selected patient and medical practice communications, the following guidelines be adopted.

Communication Guidelines:

(a) Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
(b) Inform patient about privacy issues.
(c) Patients should know who besides addressee processes messages during addressee's usual business hours and during addressee's vacation or illness.
(d) Whenever possible and appropriate, physicians should retain electronic and/or paper copies of e-mail communications with patients.
(e) Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.
(f) Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
(g) Request that patients put their name and patient identification number in the body of the message.
(h) Configure automatic reply to acknowledge receipt of messages.
(i) Send a new message to inform patient of completion of request.
(j) Request that patients use autoreply feature to acknowledge reading clinicians message.
(k) Develop archival and retrieval mechanisms.
(l) Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
(m) Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
(n) Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
(o) Explain to patients that their messages should be concise.
(p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
(q) Remind patients when they do not adhere to the guidelines.
(r) For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

Medicolegal and Administrative Guidelines:

(a) Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:
(b)Terms in communication guidelines (stated above).
(c) Provide instructions for when and how to convert to phone calls and office visits.
(d) Describe security mechanisms in place.
(e) Hold harmless the health care institution for information loss due to technical failures.
(f) Waive encryption requirement, if any, at patient's insistence.
(g) Describe security mechanisms in place including:
(h) Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.
(i) Never forwarding patient-identifiable information to a third party without the patient's express permission.
(j) Never using patient's e-mail address in a marketing scheme.
(k) Not sharing professional e-mail accounts with family members.
(l) Not using unencrypted wireless communications with patient-identifiable information.
(m) Double-checking all "To" fields prior to sending messages.
(n) Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
(o) Commit policy decisions to writing and electronic form.

(2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.

(3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate. (BOT Rep. 2, A-00; Modified: CMS Rep. 4, A-01; Modified: BOT Rep. 24, A-02)

H-478.998 Health Data and Modern Medical Professionalism

Our AMA: (1) carefully prioritize its involvement with standards development organizations and other groups focusing on electronic commerce to ensure the inclusion of physicians' perspectives and to facilitate development of a standardized aggregation and analysis of clinical data; and (2) promotes the AMA/Intel Corporation Digital Certificate System to all physicians engaged in electronic transactions of medical information to ensure that the identity of individual physicians can be trusted by anyone receiving an online message from a physician. (BOT Rep. 4, A-00)

H-478.999 An International Code of Ethics for Internet Health Sites

Our AMA supports of a universal code of ethics for Internet health sites. (Res. 615, A-00)

H-480.000 Technology - Medical

H-480.954 National Agency for Technology Evaluations

Our AMA advocates for active AMA input into any national agency whose role would be to evaluate technology for its value, to assist Medicare and other payors in making appropriate coverage decisions. (Res. 221, I-08)

H-480.955 "Keepsake" Fetal Ultrasonography

Our AMA: (1) adopts the current Food and Drug Administration (FDA) policy on use of non-diagnostic fetal ultrasound, which views "keepsake" fetal videos as an unapproved use of a medical device; and (2) will lobby the federal government to enforce the current FDA position, which views "keepsake" fetal videos as an unapproved use of a medical device, on non-medical use of ultrasonic fetal imaging. (Res. 501, A-05)

H-480.956 Commercialized Medical Screening

AMA policy is that relevant specialty societies continue to evaluate the validity and clinical use of screening imaging procedures that are advertised directly to the public and make available to the broader physician community unbiased evaluations to help primary care physicians advise their patients of the risks and benefits of these procedures. (CSA Rep. 10, A-03)

H-480.957 Health Plan Liability for Complementary and Alternative Therapy Requests

Our AMA recommends that physicians include indemnification clauses for CAT referrals in all health plan contracts when such plans require referral for CAT. (BOT Rep. 36, A-02)

H-480.958 Genetically Modified Crops and Foods

(1) Our AMA recognizes the continuing validity of the three major conclusions contained in the 1987 National Academy of Sciences white paper "Introduction of Recombinant DNA-Engineered Organisms into the Environment." [The three major conclusions are: (a)There is no evidence that unique hazards exist either in the use of rDNA techniques or in the movement of genes between unrelated organisms; (b) The risks associated with the introduction of rDNA-engineered organisms are the same in kind as those associated with the introduction of unmodified organisms and organisms modified by other methods; (c) Assessment of the risk of introducing rDNA-engineered organisms into the environment should be based on the nature of the organism and the environment into which it is introduced, not on the method by which it was produced.)

(2) That federal regulatory oversight of agricultural biotechnology should continue to be science-based and guided by the characteristics of the plant, its intended use, and the environment into which it is to be introduced, not by the method used to produce it, in order to facilitate comprehensive, efficient regulatory review of new genetically modified crops and foods.

(3) Our AMA believes that as of December 2000, there is no scientific justification for special labeling of genetically modified foods, as a class, and that voluntary labeling is without value unless it is accompanied by focused consumer education.

(4) Our AMA supports efforts for the systematic safety assessment of genetically modified foods and encourages: (a) development and validation of additional techniques for the detection and/or assessment of unintended effects;
(b) continued use of methods to detect substantive changes in nutrient or toxicant levels in genetically modified foods as part of a substantial equivalence evaluation;
(c) development and use of alternative transformation technologies to avoid utilization of antibiotic resistance markers that code for clinically relevant antibiotics, where feasible; and
(d) that priority should be given to basic research in food allergenicity to support the development of improved methods for identifying potential allergens.

(5) Our AMA supports continued research into the potential consequences to the environment of genetically modified crops including the: (a) assessment of the impacts of pest-protected crops on nontarget organisms compared to impacts of standard agricultural methods, through rigorous field evaluations;
(b) assessment of gene flow and its potential consequences including key factors that regulate weed populations; rates at which pest resistance genes from the crop would be likely to spread among weed and wild populations; and the impact of novel resistance traits on weed abundance;

(c) implementation of resistance management practices and continued monitoring of their effectiveness; and
(d) development of monitoring programs to assess ecological impacts of pest-protected crops that may not be apparent from the results of field tests.

(6) Our AMA recognizes the many potential benefits offered by genetically modified crops and foods, not support a moratorium on planting genetically modified crops, and encourage ongoing research developments in food biotechnology.

(7) Our AMA recognizes that the government, industry, and the scientific and medical communities have a responsibility to educate the public and improve the availability of unbiased information on genetically modified crops and of research activities. (CSA Rep. 10, I-00)

H-480.959 Reprocessing of Single-Use Medical Devices

Our AMA: (1) supports the Food and Drug Administration (FDA) guidance titled "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals" that was issued on August 2, 2000;

(2) supports the development of device-specific standards for the reuse and reprocessing of single-use medical devices involving all appropriate medical and professional organizations and the medical device industry;

(3) encourages increased research by the appropriate organizations and federal agencies into the safety and efficacy of reprocessed single-use medical devices; and

(4) supports the proper reporting of all medical device failures to the FDA so that surveillance of adverse events can be improved. (CSA Rep. 3, I-00)

H-480.960 Preventing Needlestick Injuries in Health Care Settings

(1) Our AMA strongly urges: (a) Health care employers to evaluate the implementation of needlestick prevention devices, with the participation of physicians and other health care workers who will use such devices and, where appropriate, introduce such devices accompanied by the necessary education and training, as part of a comprehensive sharps injury prevention and control program. (b) Health care employers to record and evaluate staff feedback on newly implemented needlestick prevention devices to continually enhance the introduction, evaluation, and replacement of such devices. (c) Health care employers to report difficulties associated with the use of newly implemented needlestick prevention devices to the Food and Drug Administration's MedWatch program. (2) Our AMA encourages the reporting of all needlestick injuries to the appropriate authorities in order that the proper therapeutic intervention may be provided and that more accurate epidemiological data on the efficacy of needlestick prevention devices may be obtained. (3) Our AMA encourages continued research and development of new technologies that will facilitate reduction and eventual elimination of needlestick injuries in health care facilities. (CSA Rep. 1, A-00)

H-480.961 Teleconsultations and Medicare Reimbursement

Our AMA demands that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various "fee splitting" or "fee sharing" reimbursement schemes. (Res. 144, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07)

H-480.962 Patient Access to Devices Pending Approval

Our AMA will work with the FDA and the appropriate manufacturers to develop streamlined mechanisms, which include adequate safeguards, that will permit patients on an individual case-by-case basis who have demonstrated need (but do not qualify for clinical trials) to have timely access to devices not yet approved, but showing reasonable promise for safety and effectiveness. (Res. 520, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-480.963 Folk Remedies Among Ethnic Subgroups

The AMA: (1) does not recommend the sole use of unvalidated folk remedies to treat disease without scientific evidence regarding their safety or efficacy; (2) encourages research to determine the safety and efficacy of folk remedies; (3) physicians should be aware that the use of folk remedies may delay patients from seeking medical attention or receiving conventional therapies with proven benefit for disease treatment and prevention; (4) practicing physicians should routinely ask patients whether they are using folk medicine or family remedies for their symptoms. Physicians can educate patients about the level of scientific information available about the therapy they are using, as well as conventional therapies that are known to be safe and efficacious; and (5) physicians should be aware of folk remedies in use and the level of scientific information available about such remedies, and should include this information when discussing conventional treatments and therapies with their patients. (CSA Rep. 13, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-480.964 Alternative Medicine

Policy of the AMA on alternative medicine is: (1) There is little evidence to confirm the safety or efficacy of most alternative therapies. Much of the information currently known about these therapies makes it clear that many have not been shown to be efficacious. Well-designed, stringently controlled research should be done to evaluate the efficacy of alternative therapies. (2) Physicians should routinely inquire about the use of alternative or unconventional therapy by their patients, and educate themselves and their patients about the state of scientific knowledge with regard to alternative therapy that may be used or contemplated. (3) Patients who choose alternative therapies should be educated as to the hazards that might result from postponing or stopping conventional medical treatment. (CSA Rep. 12, A-97; Reaffirmed: BOT Rep. 36, A-02)

H-480.966 Multiplex DNA Testing for Genetic Conditions

Policy of the AMA is that: (1) physicians should not routinely order DNA-based tests for multiple genetic conditions;
(2) tests for more than one genetic condition should be ordered only when clinically relevant and after the patient has had full counseling and has given informed consent;
(3) efforts should be made to educate clinicians and society about the uncertainty surrounding DNA-based genetic testing; and
(4) before genetic testing, physicians should counsel patients on the familial implications of genetic test results and emphasize the importance of sharing results in instances where there is a high likelihood that a relative is at risk of serious harm, and where the relative could benefit from early monitoring or from treatment. (CEJA Rep. 1, I-96; Appended: BOT Rep. 16, I-99; Modified: CSA Rep. 3, A-03)

H-480.967 Alternative Therapies for the Symptoms of Menopause

Although many patients use alternative therapies to treat the symptoms of menopause, there is very little scientific evidence about the safety or efficacy of most of these therapies. In some cases, use of alternative therapies by patients may delay use of conventional therapies proven to have benefit for disease prevention in addition to relief of symptoms. The Council on Scientific Affairs of the AMA cannot recommend the use of unproven alternative therapies for the treatment of the symptoms of menopause.
Physicians should routinely learn about and ask patients about their use of alternative therapies and educate them about the level of scientific information available about the therapy they are using, as well as conventional alternatives.
Physicians should inquire about the presence of unpleasant or uncomfortable symptoms among patients in the perimenopausal stage of development. In this way, the physician can assist the patient in gaining relief while providing an opportunity to discuss the importance of preventing menopause-related disease processes. (CSA Rep. 4, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-480.968 Telemedicine

The AMA: (1) encourages all national specialty societies to work with their state societies to develop comprehensive practice standards and guidelines to address both the clinical and technological aspects of telemedicine; (2) will assist the national specialty societies in their efforts to develop these guidelines and standards; and urges national private accreditation organizations (e.g., URAC and JCAHO) to require that medical care organizations which establish ongoing arrangements for medical care delivery from remote sites require practitioners at those sites to meet no less stringent credentialing standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery. (Res. 117, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-480.969 The Promotion of Quality Telemedicine

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:
(a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state;
(b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation;
(c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and
(d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.
(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and

other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions. (3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties). (CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99)

H-480.970 Latex Allergy Warning

The AMA supports the appropriate labeling of latex-containing medical devices with warnings about possible allergic reactions. The AMA strongly encourages health care facilities to provide non-latex alternatives of at least comparable efficacy alongside their latex counterparts in all areas of patient care. (Sub. Res. 503, A-96; Appended Res. 504, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-480.971 The Computer-Based Patient Record

The following steps will allow the AMA to act as a source of physician input to the revolutionary developments in computer-based medical information applications, as a coordinator, and as an educational resource for physicians. The AMA will: (1) Provide leadership on these absolutely critical and rapidly accelerating issues and activities. (2) Work, in cooperation with state and specialty associations, to bring computer education and information to physicians. (3) Work to define the characteristics of an optimal medical record system; the goal being to define the content, format and functionality of medical record systems, and aid physicians in evaluating systems for office practice computerization. (4) Focus on the CPR aspect of human-computer interaction (the physician data input step) and work with software venders on the design of facile interfaces. (5) Provide guidance on the use of computer diagnosis and therapeutic support systems. (6) Continue to be involved in national forums on issues of electronic medical data control, access, security, and confidentiality. (7) Continue to work to ensure that issues of patient confidentiality and security of data are continually addressed with implementation resolved prior to the implementation and use of a computer-based patient record. (BOT Rep. 29, A-96; Reaffirmation A-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08)

H-480.972 Medical Device Safety and Physician Responsibility

The AMA supports: (1) the premise that medical device manufacturers are ultimately responsible for conducting the necessary testing, research and clinical investigation and scientifically proving the safety and efficacy of medical devices approved by the Food and Drug Administration; and (2) conclusive study and development of Center for Devices and Radiological Health/Office of Science and Technology recommendations regarding safety of article surveillance and other potentially harmful electronic devices with respect to pacemaker use.. (Res. 507, I-95; Res. 509, A-96; Appended Res. 504, A-99)

H-480.973 Unconventional Medical Care in the United States

Our AMA: (1) encourages the Office of Alternative Medicine of the National Institutes of Health to determine by objective scientific evaluation the efficacy and safety of practices and procedures of unconventional medicine; and encourages its members to become better informed regarding the practices and techniques of alternative or unconventional medicine; and (2) utilizes the National Institutes of Health's National Center for Complementary and Alternative Medicine's classification system of alternative medicine, "Major Domains of Complementary and Alternative Medicine,: in order to promote future discussion and research about the efficacy, safety, and use of alternative medicine. (BOT Rep. 15, A-94; Reaffirmed and Modified by Sub. Res. 514, I-95; Appended: Res. 505, A-00)

H-480.974 Evolving Impact of Telemedicine

Our AMA: (1) will evaluate relevant federal legislation related to telemedicine;

(2) urges CMS and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;

(3) urges medical specialty societies involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine; (Reaffirmed by CME/CMS Rep. A-96)

(4) encourages the CPT Editorial Board to develop CPT codes or modifiers for telemedical services;

(5) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;

(6) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine; and

(7) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries. (CMS/CME Rep., A-94; Reaffirmation A-01)

H-480.975 Patents on Medical and Surgical Procedures

The AMA condemns the patenting of medical and surgical procedures and will work with Congress to outlaw this practice. (Sub. Res. 2, A-94; Reaffirmed: BOT Rep. 29, A-04)

H-480.978 Expected Rise in Cost of Medical Care as a Result of Innovations

It is the policy of the AMA to continue to publicly support adequate funding for the development and implementation of medical innovations, and that the reasoning behind this position be communicated to physicians, the public, and appropriate policymakers. (Sub. Res. 508, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-480.981 Cryotherapy, Therapeutic Ultrasound and Diathermy

Our AMA recognizes that the application of heat or cold is a therapeutic modality used by a variety of practitioners. When these modalities are used and are expected to cause tissue destruction, the AMA recommends that those using the modality be appropriately trained, licensed physicians or be individuals appropriately trained and under the supervision of a physician. (BOT Rep. P, I-91; Reaffirmed: Sunset Report, I-01)

H-480.982 Precertification Denials

It is the policy of the AMA (1) to continue and to expand its efforts to evaluate the safety, effectiveness, and indications for use of health care technologies, with increased emphasis on evaluation of emerging or investigational technologies which show promise for specific patients or conditions, but that are not yet an established part of medical practice, and on identification of obsolete technologies which should no longer be used; (2) that, consistent with recommendations in Policy 480.984 the AMA expand its DATTA program to meet more closely the need for assessment information by all segments of the health care community and to establish a mechanism for speedy dissemination of evolving information on the safety and effectiveness of new and emerging technology; and (3) through the Council on Medical Service (CMS), the Council on Scientific Affairs (CSA), and other appropriate units of the AMA to advocate strongly to payer groups the need for increased flexibility and responsiveness in coverage policies for therapies and diagnostic technology which are generally accepted in the medical community but have not undergone formal scientific testing, relying on professional opinion, peer review and the evaluation programs conducted by the profession, such as DATTA; (4) through the CMS and CSA expand its efforts to evaluate new technologies through DATTA and similar activities; and (5) to advocate strongly to payer groups the need for similar increased flexibility and responsiveness in coverage policy for investigational technologies, when adjudged the most effective therapy for the individual patient by the treating physician. (CMS Rep. D, I-91; Reaffirmed: Sunset Report, I-01)

H-480.983 Clinical Ecology

It is the policy of the AMA (1) to continue to monitor the published literature on clinical ecology and to report as appropriate; and (2) that those who support a new test, procedure, or treatment must prove by appropriately controlled peer reviewed trials that it is effective for the purposes for which it is used and that the burden should not be shifted to opponents to prove that a new test or therapy is invalid. (CSA Rep. K, I-91; Reaffirmed by CSA Rep. 4, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-480.984 Technology Assessment in Medicine

(1) The AMA believes that technology assessment programs and coverage determinations should be based upon the following principles in order to assure sound clinical practice and equitable public policy: (a) The primary objective of health care technology assessment should be the development of accurate and complete information for physicians on safety, effectiveness, and clinical indications in order to enhance the appropriate utilization of health care technology. (b) The development of information on safety, effectiveness, and indications for use should be based upon a rigorous scientific methodology. (c) The primary responsibility for the conduct of technology assessment should rest with the medical profession, with participation from both the research and practice communities. Participation in such assessment by all appropriate medical specialties is important, particularly when use of the technology crosses specialties. (d) The pluralistic approach to technology assessment in both the public and private sectors should be strongly encouraged and continued. (e) The results of technology assessment must be communicated in an accurate and timely manner

throughout the research and practice communities; specialty societies and other health care professional organizations should intensify efforts to disseminate such information. (f) Health care technologies should be re-evaluated on a continuing basis after their introduction, particularly if they are expensive or have the potential to cause serious harm if applied inappropriately. (g) Obsolete technologies should be identified and their further use should be discouraged. (h) Cost-effectiveness is an important consideration in technology assessment, but it should remain subordinate to considerations of safety and effectiveness. (i) Decisions as to the cost-effectiveness of technology can best be made by the physician on an individual patient basis, taking into consideration the needs of the individual and the results of cost-effectiveness analyses. Therefore, cost-effectiveness should not be used by payers to preclude or limit the availability of a safe and effective technology by either refusal to reimburse or by the provision of more limited reimbursement for such technology. (j) Payer determinations regarding coverage for health care technologies must be made with the involvement of the medical community and the public. Such determinations should be timely and responsive to the evolving information on safety and effectiveness. (k) Payer coverage policies for investigational technologies should be flexible and reviewed frequently so as to assure that the needs of individual patients are met. (l) Payers should integrate the concept of risk/benefit analysis into their decision-making and adapt their coverage policy accordingly. In serious and life-threatening illnesses, payers must recognize that patient and physician may agree upon a particular therapy, notwithstanding a lesser degree of certitude about that therapy's safety and effectiveness, if no other alternative therapies are available.

(2) The AMA should continue its efforts to educate the public about the contributions of innovations in health care technology to the health and well-being of all people and the prevention of disease.

(3) The AMA should emphasize access to effective technologies (and reimbursement for such technologies) which may be more appropriate for a subset of patients, even though other technologies may be more effective for the majority of patients for a given clinical condition, in order to protect physician judgment and patient preference in selection of therapy.

(4) When safety, effectiveness and availability have been established, cost should be a substantial determining factor in the choice of technology. (Joint CMS/CSA Rep., I-90; Reaffirmed in lieu of Res. 711, I-93; Amended: CSA Rep. 8, A-03)

H-480.985 Biotechnology and the American Agricultural Industry

It is the policy of the AMA to (1) endorse or implement programs that will convince the public and government officials that genetic manipulation is not inherently hazardous and that the health and economic benefits of recombinant DNA technology greatly exceed any risk posed to society;

(2) where necessary, urge Congress and federal regulatory agencies to develop appropriate guidelines which will not impede the progress of agricultural biotechnology, yet will ensure that adequate safety precautions are enforced;

(3) encourage and assist state medical societies to coordinate programs which will educate physicians in recombinant DNA technology as it applies to public health, such that the physician may respond to patient query and concern;

(4) encourage physicians, through their state medical societies, to be public spokespersons for those agricultural biotechnologies that will benefit public health; and

(5) actively participate in the development of national programs to educate the public about the benefits of agricultural biotechnology. (CSA Rep. D, A-90; Reaffirmed: Sunset Report, I-00)

H-480.986 Registry of Implantable Devices

It is the policy of the AMA: (1) to support the concept of a computerized national tracking system for long-term implanted devices that pose a significant risk of serious harm or death to patients if they malfunction or fail completely; (2) that such a system include the communication of the potential for malfunction or failures to the attending surgeon or physician and from the physician to the patient; and (3) to work with all involved parties to satisfactorily address this issue. (BOT Rep. JJ, A-90; Reaffirmed: Sunset Report, I-00)

H-480.988 Allocation of Privileges to Use Health Care Technologies

The AMA (1) affirms the need for the Association and specialty societies to enhance their leadership role in providing guidance on the training, experience and knowledge necessary for the application of specific health care technologies; (2) urges physicians to continue to ensure that, for every patient, technologies will be utilized in the safest and most effective manner by health care professionals; and (3) asserts that licensure of physicians by states must be based on scientific and clinical criteria. (BOT Rep. F, I-88; Reaffirmed: CME Rep. 8, I-93; Reaffirmed: CME Rep. 2, A-05)

H-480.990 The Transfer of Technology

(1) All providers, payers, manufacturers, health care facilities, governmental units, and consumers of health care have an obligation to contribute to an orderly process of technology diffusion. The nature of each group's involvement should be based on the characteristics of the technology, which include safety and effectiveness, potential for societal benefit and cost.
(2) The availability and application of technology should never be limited in the health care sector because of cost alone, but continuing analysis of cost-effectiveness and cost-benefit should always be a major factor in the continued availability and utilization of a given technology. Public and private payers should make coverage available for any costly technology that can be demonstrated to improve health or quality of life and that is cost-effective. Coverage decisions by payers should be based on clear criteria for clinical indications and contraindications.
(3) Both third party payers and professional associations have a part to play in determining the payment level by third party payers for a new technology, based on a technology's resource cost relative to other technologies.
(4) Health care facilities should use processes that incorporate data regarding safety, effectiveness, cost and conditions of use; and these factors should be balanced with the institution's mission, community need, delivery capacity and financial feasibility in decisions regarding the acquisition of costly resource-intensive technology.
(5) Third party payers should contribute to the acquisition of technologies that may be expensive but that improve the quality of care; they should also contribute to clinical research for the development, refinement and evaluation of new and established therapies.
(6) Health care professionals and their organizations should ensure that the results of biomedical research and of technology assessment are communicated in an accurate and timely manner to both the research and the practicing communities. Specialty societies, health care professional organizations, and local and state medical societies should intensify their efforts to disseminate information to their members on the effective use of technology.
(7) Health care professionals should employ a variety of methods, including formal continuing medical education and self-directed studies, to acquire the necessary knowledge to use technology appropriately.
(8) To enable them to use a health care technology, individual consumers have a right to receive sufficient information from suppliers of health care technology, providers of health care, and relevant governmental agencies. Consumers have an obligation to comply with the instructions for the use of health care technologies. Providers should make available sufficient information to allow self-administration of low-risk technologies, and consumers should exercise their preferences for these technologies either independently or in conjunction with the appropriate health care professional.
(9) In addition to assuring safety and efficacy, federal regulatory agencies should be given the additional charge of assessing the long-term effects of their activities on the development of new technologies. These agencies should be given the necessary resources to perform this activity.
(10) Manufacturers of health care technologies and the Department of Health and Human Services and its branches should continue to cooperate in the research of rare disorders and in the development of technologies for rare disorders. Additionally, manufacturers should maintain the availability of currently utilized investigational and marketed products. The federal government should improve the interagency coordination of research efforts and product regulation.
(11) The Food and Drug Administration (FDA) and other appropriate government agencies should be allocated greater resources with which to strengthen postmarketing surveillance programs. With regard to the FDA, pharmaceutical and device manufacturers should modify their postmarketing surveillance activities to augment FDA activity.
(12) Manufacturers and suppliers of health care technologies should ensure that promotional material and marketing strategies provide accurate and balanced information regarding the risks, benefits, and uses of products to be used in health care. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07)

H-480.991 Allocation of Privileges to Use Health Care Technologies

(1) Each health care facility should decide which professionals (both as a class and individually) are allowed to use each technology in the facility, subject to the facility's licensure requirements and the standards developed by health professional associations. Such decisions should be consistent with the professional practice acts in the state. (2) Health professional associations should establish mechanisms to ensure that health professionals providing technology in offices or other out-of-facility health care settings are qualified to use such technology safely and effectively. (3) Privileges to use technologies that are truly "investigative" may be restricted to those health professionals and facilities that can demonstrate sufficient experience in using related technologies; guarantee a critical mass of candidates for whom use of the technology is clinically appropriate; devise a research protocol that can meet recognized scientific standards; and demonstrate willingness to share data for collaborative studies, while insuring confidentiality of individual patient information. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-480.994 Reimbursement for New Technology

Our AMA policy regarding reimbursement for new technology is as follows: (1) That under present Medicare law and private insurance contracts, in the absence of explicit exclusionary language in such law or contracts, procedures should be reimbursed where they are deemed safe, effective, and non-investigational by professional standards.

(2) That costs to society as a whole of new medical technology should be recognized as a legitimate concern of legislators, administrators, beneficiaries of public and private insurance programs and the medical and other healing professions.

(3) That such concern for costs should not be used as the basis for limiting or eliminating benefits without specific statutory or

contract changes, and that any such changes should be preceded by development of clear criteria for coverage and denial, due notice, and full public discussion by all concerned sectors of society, including the medical profession.

(4) That to the degree possible, alternate means of financing high cost care which has been excluded from basic coverage (such as voluntary catastrophic insurance or "high tech" riders) should be developed and made widely available. (CMS Rep. B, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-480.996 Medical Device Amendments of the FDA

(1) The AMA reiterates its concerns regarding the implementation of the Medical Device Amendments to the Food and Drug Administration (FDA) and urges that regulations be promulgated or interpreted so as to: (a) not interfere with the physician-patient relationship; (b) not impose regulatory burdens that may discourage creativity and innovation in advancing device technology; (c) not change the character and mandate of existing Institutional Review Boards to unnecessarily burden members of the IRB's and clinical investigators; (d) not raise the cost of medical care and new medical technology without any concomitant benefit or additional safeguards being provided the patients; and (e) not interfere with patient records' confidentiality. (2) The AMA urges that existing mechanisms to assure ethical conduct be used to minimize burdensome reporting requirements and keep enforcement costs to a minimum for patients, health care providers, industry and the government. (Res. 146, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-480.999 Health Care Technology Assessment and Information Dissemination

There should be a substantial expansion of efforts to assess health care technology and to collect and disseminate the resulting information. (BOT Rep. S, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-485.000 Television

H-485.991 Identification of Physicians by the Media

It is the policy of our AMA to communicate to the media that when a physician is interviewed or provides commentary he or she be specifically identified with the appropriate initials "MD" or "DO" after his or her name; and that others be identified with the appropriate degrees after their names. (Res. 601, I-01)

H-485.992 Support for Increased Educational Children's Television Programming

The AMA encourages independent television stations and network affiliates throughout the United States to broadcast at least one hour per day, during regular viewing hours, of educational programming for children. (Res. 404, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-485.994 Television Broadcast of Sexual Encounters and Public Health Awareness

The AMA urges television broadcasters, producers, and sponsors to encourage education about safe sexual practices, including but not limited to condom use and abstinence, in television programming of sexual encounters, and to accurately represent the consequences of unsafe sex. (Res. 421, I-91; Reaffirmed: CSA Rep. 3, A-95; Reaffirmed: CSA Rep. 8, A-05)

H-485.995 TV Violence

The AMA reaffirms its vigorous opposition to television violence and its support for efforts designed to increase the awareness of physicians and patients that television violence is a risk factor threatening the health of young people. (Res. 19, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-485.997 Television Sensationalism of Dangerous Stunts

Our AMA publicly condemns television programs that sensationalize dangerous stunts and thus unavoidably encourage the imitation of such stunts. (Sub. Res. 80, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-485.998 Television Commercials Aimed at Children

Our AMA opposes TV advertising and programming aimed specifically at exploiting children, particularly those ads and programs that have an impact on the health and safety of children. (Res. 27, A-79; Reaffirmed: CLRPD Rep. B, I-89; Sub. Res. 220, I-91; Reaffirmed: Sunset Report, I-01)

H-485.999 Objection to Sex on TV

Our AMA opposes television programming which is sexually suggestive or pornographic. (Res. 108, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-490.000 Tobacco Use, Prevention and Cessation

H-490.911 Smoke-Free America

Our AMA makes the passage of legislation for a smoke-free America, that includes all public and workplaces and includes provisions for support of smoking cessation programs, a legislative priority for the AMA until such legislation is passed. (Res. 415, A-06; Reaffirmed: BOT Rep. 8, A-08)

H-490.912 Tobacco as an Incentive in Behavior Modification Programs

The AMA condemns the use of tobacco as an incentive in behavior modification programs. (CSA Rep. 3, A-04)

H-490.913 Smoke-Free Environments and Workplaces

On the issue of the health effects of environmental tobacco smoke (ETS) and passive smoke exposure in the workplace and other public facilities, our AMA:

(1) (a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free campuses for business, labor, education, and government;

(2) (a) honors companies and governmental workplaces that go smoke-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking in public places and businesses, which would include language that would prohibit preemption of stronger local laws.

(3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free schools and eliminating smoking in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children; (d) encourages state or local legislation or regulations that prohibit smoking in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe, and cigar smoking in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking; (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking efforts in the prohibition of smoking in open and closed stadia;

(4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts;

(5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools;

(6) will work with the Department of Defense to explore ways to encourage a smoke-free environment in the military through the use of mechanisms such as health education, smoking cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and

(7) encourages and supports local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking in all casinos and gaming venues. (CSA Rep. 3, A-04; Appended: Sub. Res. 426, A-04; Modified: CSAPH Rep. 1, I-07)

H-490.914 Tobacco Prevention and Youth

Our AMA:

(1) (a) urges the medical community, related groups, educational institutions, and government agencies to demonstrate more effectively the health hazards inherent in the use of tobacco products; (b) encourages state and local medical societies to actively advise municipalities and school districts against use of health education material sponsored or distributed by the tobacco industry; and (c) publicly rejects the tobacco industry as a credible source of health education material;

(2) opposes the use of tobacco products of any kind in day care centers or other establishments where pre-school children attend for educational or child care purposes;

(3) advises public and private schools about the very early smoking habits observed in children and encourages appropriate school authorities to prohibit the use of all tobacco products in elementary through senior high school by anyone during the school day and during other school-related activities;

(4) (a) supports the concept that a comprehensive health education program stressing health maintenance be part of the required curriculum through 12th grade to: (i) help pre-teens, adolescents, and young adults avoid the use of tobacco products, including smokeless tobacco; and (ii) emphasize the benefits of remaining free of the use of tobacco products; (b) will work with other public and private parties to actively identify and promote tobacco prevention programs for minors and encourages the development, evaluation, and incorporation of appropriate intervention programs, including smoking cessation programs, that are tailored to the needs of children; and (c) recommends that student councils and student leaders be encouraged to join in an anti-smoking campaign.

(5) urges state medical societies to promote the use of appropriate educational films and educational programs that reduce tobacco use by young people;

(6) (a) favors providing financial support to promising behavioral research into why people, especially youth, begin smoking, why they continue, and why and how they quit; (b) encourages research into further reducing the risks of cigarette smoking; and (c) continues to support research and education programs, funded through general revenues and private sources, that are concerned with health problems associated with tobacco and alcohol use;

(7) opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products, as youth are particularly susceptible;

(8) supports working with appropriate organizations to develop a list of physicians and others recommended as speakers for local radio and television to discuss the harmful effects of tobacco usage and to advocate a tobacco-free society; and

(9) commends the following entities for their exemplary efforts to inform the Congress, state legislatures, education officials and the public of the health hazards of tobacco use: American Cancer Society, American Lung Association, American Heart Association, Action on Smoking and Health, Inc., Groups Against Smoker's Pollution, National Congress of Parents and Teachers, National Cancer Institute, and National Clearinghouse on Smoking (HEW). (CSA Rep. 3, A-04)

H-490.915 Tobacco Use in Prison Populations

It is the policy of our AMA to (1) recognize and promote the policy that all anti-smoking policies that apply to the general population should apply equally to persons who are incarcerated in local jails, state prisons, and federal prisons; (2) work actively to stop the manufacture of cigarettes by any prison or jail system in the United States; (3) work actively to stop the subsidy of cigarette sales in all jail and prison systems; (4) ensure that the prohibition of smoking by minors be enforced in the correctional system; (5) be committed to smoking cessation programs in correctional facilities and encourage physicians working in correctional systems to include smoking cessation counseling and programs for their patients who smoke; (6) work through its representative to the National Commission on Correctional Health Care to ensure that smoking cessation counseling be made a national standard for correctional medicine; (7) develop model legislation providing for smoke-free prison areas for all inmates, and particularly that common areas including cell blocks and recreation areas not be smoking areas; and (8) support legislation banning smoking in prisons and jails. (CSA Rep. 3, A-04)

H-490.916 Health Insurance and Reimbursement for Tobacco Cessation and Counseling

Our AMA:

(1) (a) continues to support development of an infrastructure for tobacco dependence treatment; (b) will work with the U.S. Public Health Service, particularly the Agency for Health Research and Quality, health insurers, and others to develop recommendations for third party payment for the treatment of nicotine addiction; (c) urges third party payers and governmental agencies involved in medical care to regard and treat nicotine addiction counseling and/or treatment by physicians as an important and legitimate medical service; and (d) supports the ready availability of health insurance coverage and reimbursement for pharmacologic and behavioral treatment of nicotine dependence and smoking cessation efforts;

(2) (a) requests Congress to provide matching funds for Medicaid coverage for evidence-based programs and Food and Drug Administration (FDA)-approved products that lead to smoking cessation; and (b) seeks the requirement that state Medicaid programs, prepaid health plans, and insurance companies provide evidence-based approaches for smoking cessation and nicotine withdrawal, including FDA-approved pharmacotherapy, as part of their standard benefit packages. (CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08)

H-490.917 Physician Responsibilities for Tobacco Cessation

Cigarette smoking is a major health hazard and a preventable factor in physicians' actions to maintain the health of the public and reduce the high cost of health care. Our AMA takes a strong stand against smoking and favors aggressively pursuing all avenues of educating the general public on the hazards of using tobacco products and the continuing high costs of this serious but preventable problem. Additionally, our AMA supports and advocates for appropriate surveillance approaches to measure changes in tobacco consumption, changes in tobacco-related morbidity and mortality, youth uptake of tobacco use, and use of alternative nicotine delivery systems. In view of the continuing and urgent need to assist individuals in smoking cessation, physicians, through their professional associations, should assume a leadership role in establishing national policy on this topic and assume the primary task of educating the public and their patients about the danger of tobacco use (especially cigarette smoking). Accordingly, our AMA:

(1) encourages physicians to refrain from engaging directly in the commercial production or sale of tobacco products;

(2) supports (a) development of an anti-smoking package program for medical societies; (b) making patient educational and motivational materials and programs on smoking cessation available to physicians; and (c) development and promotion of a consumer health-awareness smoking cessation kit for all segments of society, but especially for youth;

(3) encourages physicians to use practice guidelines for the treatment of patients with nicotine dependence and will cooperate with the Agency for Health Research and Quality (AHRQ) in disseminating and implementing evidence-based clinical practice guidelines on smoking cessation, and on other matters related to tobacco and health;

(4) (a) encourages physicians to use smoking cessation activities in their practices including (i) quitting smoking and urging their colleagues to quit; (ii) inquiring of all patients at every visit about their smoking habits (and their use of smokeless tobacco as well); (iii) at every visit, counseling those who smoke to quit smoking and eliminate the use of tobacco in all forms; (iv) prohibiting all smoking in the office by patients, physicians, and office staff; and discouraging smoking in hospitals where they work (v) providing smoking cessation pamphlets in the waiting room; (vi) becoming aware of smoking cessation programs in the community and of their success rates and, where possible, referring patients to those programs; (b) supports the concept of smoking cessation programs for hospital inpatients conducted by appropriately trained personnel under the supervision of a physician;

(5) (a) supports efforts to identify gaps, if any, in existing materials and programs designed to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (b) supports the production of materials and programs which would fill gaps, if any, in materials and programs to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (c) supports national, state, and local efforts to help physicians and medical students develop skills necessary to counsel patients to quit smoking; (d) encourages state and county medical societies to sponsor, support, and promote efforts that will help physicians and medical students more effectively counsel patients to stop smoking; (e) encourages physicians to participate in education programs to enhance their ability to help patients quit smoking; (f) encourages physicians to speak to community groups about tobacco use and its consequences; and (g) supports providing assistance in the promulgation of information on the effectiveness of smoking cessation programs;

(6) (a) supports the concept that physician offices, clinics, hospitals, health departments, health plans, and voluntary health associations should become primary sites for education of the public about the harmful effects of tobacco and encourages physicians and other health care workers to introduce and support healthy lifestyle practices as the core of preventive programs in these sites; and (b) encourages the development of smoking cessation programs implemented jointly by the local medical society, health department, and pharmacists; and

(7) (a) believes that collaborative approaches to tobacco treatment across all points of contact within the medical system will maximize opportunities to address tobacco use among all of our patients, and the likelihood for successful intervention; and (b) supports efforts by any appropriately licensed health care professional to identify and treat tobacco dependence in any individual, in the various clinical contexts in which they are encountered, recognizing that care provided in one context needs to take into account other potential sources of treatment for tobacco use and dependence. (CSA Rep. 3, A-04; Appended: Res. 444, A-05; Reaffirmed: BOT Rep. 8, A-08)

H-495.000 Tobacco Products

H-495.976 Opposition to Exempting the Addition of Menthol to Cigarettes

Our AMA:

(1) will continue to support the Food and Drug Administration (FDA) legislation as amended by the House of Representatives and urge its passage and enactment as soon as possible as a major step forward in regulating tobacco products and the harm they create;

(2) shall immediately petition the FDA to conduct inquiries and take steps to ban the use and marketing of menthol in cigarettes as a harmful additive, if the current bill is passed without the menthol amendment, once enacted into law; and

(3) encourages and will assist its members to seek state bans on the sale of menthol cigarettes regardless of whether the current FDA legislation is enacted. (BOT Action in response to referred for decision Res. 436, A-08)

H-495.977 Banning the Sale of Tobacco Products and/or Tobacco By-Products in Retail Outlets Housing Store-Based Health Clinics By-Products in Retail Outlets Housing Store-Based Health Clinics

Our AMA supports efforts to ban the sale of tobacco products and/or tobacco by-products in retail outlets housing store-based health clinics. (Res. 422, A-08)

H-495.978 Proper FDA Authority to Regulate Tobacco

Our AMA will continue to support federal legislation that would give the Food and Drug Administration strong regulatory authority over tobacco products. (Res. 440, A-07; Reaffirmed: BOT Rep. 8, A-08)

H-495.979 Evaluation of the Health Hazards of Clove Cigarettes

AMA's existing policy vigorously opposing the use of any tobacco product is extended to include explicit opposition to the use of clove cigarettes. Further, AMA recognizes that clove cigarette smoking may present an additional hazard to susceptible individuals. (CSA Rep. 3, A-04)

H-495.980 Cigar Smoking

Our AMA will work to have federal and state governments take legal, regulatory, and educational action to protect the public from the ill effects of cigar smoking in a manner similar to those actions taken regarding cigarettes. (CSA Rep. 3, A-04)

H-495.981 Light and Low-Tar Cigarettes

Our AMA concurs with the key scientific findings of National Cancer Institute Monograph 13, Risks Associated with Smoking Cigarettes with Low Machine-Measured Yields of Tar and Nicotine:
(a) Epidemiological and other scientific evidence, including patterns of mortality from smoking-caused diseases, does not indicate a benefit to public health from changes in cigarette design and manufacturing over the last 50 years.
(b) For spontaneous brand switchers, there appears to be complete compensation for nicotine delivery, reflecting more intensive smoking of lower-yield cigarettes. (c) Cigarettes with low machine-measured yields by Federal Trade Commission (FTC) methods are designed to allow compensatory smoking behaviors that enable a smoker to derive a wide range of tar and nicotine yields from the same brand.
(d) Widespread adoption of lower yield cigarettes in the United States has not prevented the sustained increase in lung cancer among older smokers.
(e) Many smokers switch to lower yield cigarettes out of concern for their health, believing these cigarettes to be less risky or to be a step toward quitting; many smokers switch to these products as an alternative to quitting.
(f) Advertising and promotion of low tar cigarettes were intended to reassure smokers who were worried about the health risks of smoking, were meant to prevent smokers from quitting based on those same concerns; such advertising was successful in getting smokers to use low-yield brands.
(g) Existing disease risk data do not support making a recommendation that smokers switch cigarette brands. The recommendation

that individuals who cannot stop smoking should switch to low yield cigarettes can cause harm if it misleads smokers to postpone serious attempts at cessation.
(h) Measurements of tar and nicotine yields using the FTC method do not offer smokers meaningful information on the amount of tar and nicotine they will receive from a cigarette.

Our AMA seeks legislation or regulation to prohibit cigarette manufacturers from using deceptive terms such as "light," "ultra-light," "mild," and "low-tar" to describe their products. (CSA Rep. 3, A-04)

H-495.982 Tax-Free Tobacco Products

Our AMA encourages Native American nations to stop selling tax-free tobacco products because of the profound public health implications of the sale of tax-free tobacco products. (CSA Rep. 3, A-04)

H-495.983 Tobacco Litigation Settlements

Our AMA:

(1) strongly supports the position that all monies paid to the states in the Master Settlement Agreement and other agreements be utilized for research, education, prevention and treatment of nicotine addiction, especially in children and adolescents, and for treatment of diseases related to nicotine addiction and tobacco use;

(2) supports efforts to ensure that a substantial portion of any local, state or national tobacco litigation settlement proceeds be directed towards preventing children from using tobacco in any form, helping current tobacco users quit, and protecting nonsmokers from environmental tobacco smoke, and that any tobacco settlement funds not supplant but augment health program funding;

(3) strongly supports efforts to direct tobacco settlement monies that are not directed to other specific tobacco control activities to enhance patient access to medical services;

(4) strongly supports legislation codifying the position that all monies paid to the states through the various tobacco settlements remain with the states; and that none be reimbursed to the Federal government on the basis of each individual state’s Federal Medicaid match; and

(5) opposes any provision of tort reform legislation that would grant exclusion from liability or special protection to tobacco companies or tobacco products. (CSA Rep. 3, A-04)

H-495.984 Tobacco Advertising and Media

Our AMA:

(1) in keeping with its long-standing objective of protecting the health of the public, strongly supports a statutory ban on all advertising and promotion of tobacco products;

(2) as an interim step toward a complete ban on tobacco advertising, supports the restriction of tobacco advertising to a "generic" style, which allows only black-and-white advertisements in a standard typeface without cartoons, logos, illustrations, photographs, graphics or other colors;

(3) (a) recognizes and condemns the targeting of advertisements for cigarettes and other tobacco products toward children, minorities, and women as representing a serious health hazard; (b) calls for the curtailment of such marketing tactics; and (c) advocates comprehensive legislation to prevent tobacco companies or other companies promoting look-alike products designed to appeal to children from targeting the youth of America with their strategic marketing programs;

(4) supports the concept of free advertising space for anti-tobacco public service advertisements and the use of counter-advertising approved by the health community on government-owned property where tobacco ads are posted;

(5) (a) supports petitioning appropriate government agencies to exercise their regulatory authority to prohibit advertising that falsely promotes the alleged benefits and pleasures of smoking as well worth the risks to health and life; and (b) supports restrictions on the format and content of tobacco advertising substantially comparable to those that apply by law to prescription drug advertising;

(6) publicly commends those publications that have refused to accept cigarette advertisements and supports publishing annually, via JAMA and other appropriate publications, a list of those magazines that have voluntarily chosen to decline tobacco ads, and circulation of a list of those publications to every AMA member;

(7) urges physicians to mark the covers of magazines in the waiting area that contain tobacco advertising with a disclaimer saying that the physician does not support the use of any tobacco products and encourages physicians to substitute magazines without tobacco ads for those with tobacco ads in their office reception areas;

(8) urges state, county, and specialty societies to discontinue selling or providing mailing lists of their members to magazine subscription companies that offer magazines containing tobacco advertising;

(9) encourages state and county medical societies to recognize and express appreciation to any broadcasting company in their area that voluntarily declines to accept tobacco advertising of any kind;

(10) urges the 100 most widely circulating newspapers and the 100 most widely circulating magazines in the country that have not already done so to refuse to accept tobacco product advertisements, and continues to support efforts by physicians and the public, including the use of written correspondence, to persuade those media that accept tobacco product advertising to refuse such advertising;

(11) (a) supports efforts to ensure that sports promoters stop accepting tobacco companies as sponsors; (b) opposes the practice of using athletes to endorse tobacco products and encourages voluntary cessation of this practice; and (c) opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products;

(12) will communicate to the organizations that represent professional and amateur sports figures that the use of all tobacco products while performing or coaching in a public athletic event is unacceptable. Tobacco use by role models sabotages the work of physicians, educators, and public health experts who have striven to control the epidemic of tobacco-related disease;

(13) (a) encourages the entertainment industry, including movies, videos, and professional sporting events, to stop portraying the use of tobacco products as glamorous and sophisticated and to continue to de-emphasize the role of smoking on television and in the movies; (b) will aggressively lobby appropriate entertainment, sports, and fashion industry executives, the media and related trade associations to cease the use of tobacco products, trademarks and logos in their activities, productions, advertisements, and media accessible to minors; and (c) advocates comprehensive legislation to prevent tobacco companies from targeting the youth of America with their strategic marketing programs; and

(14) encourages the motion picture industry to apply an "R" rating to all new films depicting cigarette smoking and other tobacco use. (CSA Rep. 3, A-04; Appended: Res. 427, A-04; Reaffirmation A-05)

H-495.985 Smokeless Tobacco

Given that the use of smokeless tobacco (snuff and chewing tobacco) is associated with health risks, our AMA:

(1) supports publicizing the increasing evidence that the use of snuff or chewing tobacco is associated with adverse health effects and encourages ongoing research to further define the health risks associated with snuff and chewing tobacco, including the risk of developing cardiovascular disease, and the effectiveness of cessation and prevention programs;

(2) objects strongly to the introduction of "smokeless" cigarettes;

(3) opposes the use of smokeless tobacco products by persons of all ages;

(4) urges that the same requirements and taxes placed on cigarette sales and advertising be applied to smokeless tobacco products;

(5) supports legislation to prohibit the sale of smokeless tobacco products to minors and encourages states to enforce strictly the prohibition on purchasing and distributing all tobacco products to individuals under the age of 21 years;

(6) supports public and school educational programs on the health effects of smokeless tobacco products;

(7) urges the commissioners of professional athletic organizations to discourage the open use of smokeless tobacco by professional athletes and recommends that professional athletes participate in media programs that would discourage the youth of America from engaging in this harmful habit; and

(8) is committed to exerting its influence to limit exposure of young children and teenagers to advertising for smokeless tobacco and look-alike products, and urges that manufacturers take steps to diminish the appeal of snuff and chewing tobacco to young persons. (CSA Rep. 3, A-04)

H-495.986 Tobacco Product Sales and Distribution

Our AMA:

(1) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;

(2) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;

(3) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;

(4) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;

(5) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;

(6) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;

(7) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members;

(8) opposes the sale of tobacco at any facility where health services are provided; and

(9) supports that the sale of tobacco products be restricted to tobacco specialty stores. (CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 817, I-07; Reaffirmation A-08; Reaffirmation I-08)

H-495.987 Tobacco Taxes

(1) Our AMA will work for and encourages all levels of the Federation and other interested groups to support efforts, including education and legislation, to pass increased federal, state, and local excise taxes on tobacco in order to discourage tobacco use.

(2) An increase in federal, state, and local excise taxes for tobacco should include provisions to make substantial funds available that would be allocated to health care needs and health education, and for the treatment of those who have already been afflicted by tobacco-caused illness, including nicotine dependence, and to support counter-advertising efforts.

(3) Our AMA continues to support legislation to reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of tobacco products; and advocates that the added tax revenues obtained as a result of reducing or eliminating the tobacco advertising/promotion tax deduction be utilized by the federal government for expansion of health care services, health promotion and health education. (CSA Rep. 3, A-04; Modified: BOT Rep. 8, A-05; Reaffirmed: BOT Rep. 8, A-08)

H-495.988 FDA Regulation of Tobacco Products

Our AMA:

(1) reaffirms its position that all tobacco products are harmful to health, and that there is no such thing as a safe cigarette;

(2) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance;

(3) reaffirms its position that the Food and Drug Administration (FDA) does have, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing;

(4) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations;

(5) urges Congress to pass legislation to phase in the production of less hazardous and less toxic tobacco, and to authorize the FDA have broad-based powers to regulate tobacco products;

(6) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; and

(7) encourages the FDA to assert its authority over the manufacture of tobacco products to reduce their addictive potential at the earliest practical time, with a goal for implementation within 5-10 years. (CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08)

H-495.989 Tobacco Product Labeling

Our AMA:

(1) supports working toward more explicit and effective health warnings regarding the use of tobacco (and alcohol) products, including the extension of labeling requirements of ingredients to tobacco products sold in the United States;

(2) supports legislation or regulations that require (a) tobacco companies to accurately label their products indicating nicotine content in easily understandable and meaningful terms that have plausible biological significance; (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the United States; (c) an increase in the size of warning labels to include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack of cigarettes to carry a legible, boxed warning such as: "Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;" and

(3) urges the Congress to require that: (a) warning labels on cigarette packs should appear on the front and the back and occupy twenty-five percent of the total surface area on each side and be set out in black-and-white block; (b) in the case of cigarette advertisements, warning labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (c) warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets. (CSA Rep. 3, A-04)

H-500.000 Tobacco: AMA Corporate Policies and Activities

H-500.974 AMA Sponsorship of World Conferences on Tobacco and Health

The AMA will continue to support future World Conferences on Tobacco and Health. (CSA Rep. 3, A-04)

H-500.975 AMA Corporate Policies on Tobacco

(1) Our AMA: (a) continues to urge the federal government to reduce and control the use of tobacco and tobacco products; (b) supports developing an appropriate body for coordinating and centralizing the Association's efforts toward a tobacco-free society; and (c) will defend vigorously all attacks by the tobacco industry on the scientific integrity of AMA publications.

(2) It is the policy of our AMA to continue to use appropriate lobbying resources to support programs of anti-tobacco health promotion and advertising.

(3) Our AMA's House of Delegates endorses the April 24, 1996, statement by the AMA Secretary-Treasurer that all physicians, health professionals, medical schools, hospitals, public health advocates, and citizens interested in the health and welfare of our children should review their personal and institutional investments and divest of any tobacco holdings (including mutual funds that include tobacco holdings); and specifically calls on all life and health insurance companies and HMOs to divest of any tobacco holdings.

(4) Our AMA defines the Tobacco Industry as companies or corporate divisions that directly produce or purchase tobacco for production or market tobacco products, along with their research and lobbying groups, including the Council for Tobacco Research and the Smokeless Tobacco Research Council. A company or corporate division that does not produce or market tobacco products but that has a tobacco producing company as or among its owners will not be considered a prohibited part of the tobacco industry as long as it does not promote or contribute to the promotion, sale and/or use of tobacco products. If such promotional practices begin, the company will be placed on an "unacceptable for support" list.

(5) Accordingly, it is the policy of our AMA (a) not to invest in tobacco stocks or accept financial support from the tobacco industry;

(b) to urge medical schools and their parent universities to eliminate their investments in corporations that produce or promote the use of tobacco and discourage them from accepting research funding from the tobacco industry; (c) to likewise urge all scientific publications to decline such funded research for publication; and (d) to encourage state and county medical societies and members to divest of any and all tobacco stocks.

(6) Our AMA (a) encourages state and local medical societies to determine whether candidates for federal, state and local offices accept gifts or contributions of any kind from the tobacco industry, and publicize their findings to both their members and the public; and (b) urges state and county medical societies and local health professionals along with their allies to support efforts to strengthen state and local laws that require public disclosure of direct and indirect expenditures to influence legislation or ordinances, given recent allegations about tobacco industry strategies. (CSA Rep. 3, A-04)

H-505.000 Tobacco: Federal and International Policies

H-505.962 Smoking on International Flights

The AMA (1) will join other concerned organizations to seek an FAA ban on smoking on all flights originating from or destined to the U.S.; and (2) in conjunction with the World Health Organization and the World Medical Association, will work with the medical department of the International Civil Aviation Organization to ban smoking on all international flights. (CSA Rep. 3, A-04)

H-505.963 Support for Federal Interagency Committee on Smoking and Health Report

Our AMA endorses the following proposals approved by the Federal Interagency Committee on Smoking and Health on February 11, 2003:
(1) establish a federally-funded National Tobacco Quitline network;
(2)implement an ongoing, extensive paid media campaign to help Americans quit using tobacco;
(3) include evidence-based counseling and medications for tobacco cessation in benefits provided to all Federal beneficiaries and in all federally-funded healthcare programs by FY 2005;
(4) invest in a research agenda by FY 2005 to improve the access, effectiveness and utilization of tobacco dependence interventions for individuals and populations;
(5) invest in clinician education and training by FY 2005 to provide the necessary knowledge, skills, and support systems to help patients quit tobacco use; and
(6) establish the Smokers' Health Fund by FY 2005 through revenue generated through an increase in the Federal Excise Tax on cigarettes by $2.00 per pack and similar increases on other tobacco products, with at least 50 percent of revenue for the Fund being used to implement these proposals (CSA Rep. 3, A-04)

H-505.964 International Tobacco Control Efforts

Our AMA:

(1) supports the international tobacco control efforts of the World Health Organization and urges the appropriate bodies and persons within the U.S. government (including Congress, the State Department, the Department of Commerce, and the Department of Health and Human Services) to participate fully in international tobacco control efforts, including supporting efforts to bring to fruition a Framework Convention on Tobacco Control;

(2) will work for the enactment of federal legislation or regulations that would prohibit the exportation of tobacco products to other countries. Pending the enactment of such legislation or regulation, our AMA (a) urges the U.S. government to alter trade policies and practices that currently serve to promote the world smoking epidemic; (b) continues to support the following activities: (i) federal legislation requiring health warning labels in the appropriate native language or symbolic form to be on packages of cigarettes exported and require foreign advertising by U.S. tobacco producers to be at least as restrictive as types of advertising permitted in the U.S.; (ii) labeling on tobacco products manufactured abroad to be at least as restrictive as those produced in the U.S.; (iii) opposition to efforts by the U.S. government to persuade countries to relax regulations concerning tobacco promotion and consumption; and (iv) encouragement of the World Health Organization to increase its worldwide anti-smoking efforts; (c) supports working with the World Medical Association as well as directly with national medical societies to expand activities by the medical profession to reduce tobacco use worldwide; (d) supports establishing close working relations with the World Health Organization to promote more physician involvement in anti-tobacco activities, particularly in developing and recently developed countries; (e) supports working with the Centers for Disease Control and Prevention's Office on Smoking and Health to promote worldwide anti-tobacco activities; (f) supports periodically monitoring the success of worldwide anti-tobacco efforts to control the growing worldwide smoking epidemic; and (g) supports the right of local jurisdictions to enact tobacco regulations that are stricter than those that exist in state statutes and encourages state and local medical societies to evaluate and support local efforts to enact useful regulations; and

(3) opposes any efforts by the government or its agencies to actively encourage, persuade or compel any country to import tobacco products and favors legislation that would prevent the government from actively supporting, promoting or assisting such activities.

(CSA Rep. 3, A-04; Reaffirmation I-05)

H-505.965 Federal Tobacco Price Supports

Our AMA:

(1) supports federal legislation to cease all price supports from the federal government to farmers for growing tobacco and urges the federal government, for the three years after termination of price supports, to provide assistance to needy tobacco farmers to begin production of other agricultural products;

(2) believes that it is glaringly inconsistent to mandate the reduction of death and disease through peer review organization activity, while continuing to subsidize tobacco--a substance known to be a major cause of cardiovascular disease and cancer;

(3) encourages its members to gather signatures from their patients on petitions to be presented to their congressional delegations demanding that the U.S. government discontinue spending any tax dollars in support of the tobacco industry, and encourages state and county medical associations to urge all physicians throughout the U.S. to do the same in an effort to achieve the AMA's and the Surgeon General's goal of creating a smoke-free society; and

(4) will inform all appropriate national medical-oriented organizations of the importance of AMA policy that expresses opposition to federal support to the tobacco industry and, further, urges and challenges other organizations to take similar action. (CSA Rep. 3, A-04)

H-510.000 Veterans Medical Care
(See also: Armed Forces; War)

H-510.989 Health Care for Veterans and Their Families

Our AMA supports the recommendations of the President’s Commission on Care for America’s Wounded Warriors report "Serve, Support, Simplify." (BOT Rep. 6, A-08)

H-510.990 Health Care Policy for Veterans

Our AMA encourages the Department of Veterans Affairs to continue to explore alternative mechanisms for providing quality health care coverage for United States Veterans, including an option similar to the Federal Employees Health Benefit Program (FEHBP). (Sub. Res.115, A-00; Reaffirmation I-03)

H-510.991 Veterans Administration Health System

Our AMA supports approaches that increase the flexibility of the Veterans Health Administration to provide all veterans with improved access to health care services. (CMS Rep. 8, A-99)

H-510.994 Ethics Reform Act of 1989 (PL 101194)

It is the policy of the AMA to work with representatives of [the] Central Office, Department of Veterans Affairs, to develop provisions to exclude either by regulation or by legislation part-time Department of Veterans Affairs physicians (as well as attending and consulting physicians) from the provisions of the Ethics Reform Act of 1989. (Res. 254, A-90; Reaffirmed: Sunset Report, I-00)

H-510.995 Budgetary and Management Needs of the Department of Veterans Affairs' (DVA) Department of Medicine and Surgery

Our AMA urges Congress and the President to provide the DVA: (1) with funding sufficient to allow its hospitals and clinics to provide proper care to the patients the DVA is mandated to treat; and (2) with maximum flexibility in eliminating unneeded or duplicative services and in closing clinics or hospitals. (BOT Rep. EE, A-89; Reaffirmed: Sunset Report, A-00)

H-510.998 Ophthalmology Service in VA Hospital System

Our AMA supports the establishment of an Ophthalmology Service within the Central Office of the VA Hospital System and the appointment of an ophthalmologist as the director of such service. (Res. 34, I-78:171; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-515.000 Violence and Abuse
(See also: Children and Youth)

H-515.961 Elder Mistreatment

Our AMA recognizes: (1) elder mistreatment as a serious and pervasive public health problem that requires an organized effort from physicians and all medical professionals to improve the timely recognition and provision of clinical care in vulnerable elders who experience mistreatment; and (2) the importance of an interdisciplinary and collaborative approach to this issue, and encourage states to bring together teams with representatives from medicine, nursing, social work, adult protective services (APS), criminal and civil law, and law enforcement to develop appropriate interventions and evaluate their effectiveness. (CSAPH Rep. 7, A-08)

H-515.962 Renewed Focus on Domestic Violence

Our AMA will renew its commitment to combat family and intimate partner violence by including violence prevention and education as part of the ongoing strategic planning process. (Res. 610, A-07)

H-515.963 Diagnosis and Management of Family Violence

Our AMA recommends that questions to assess risk for family violence should be included within the context of taking a routine social history, past medical history, history of present illness, and review of systems as part of emergency, diagnostic, preventive, and chronic care management. (CSA Rep. 7, A-05)

H-515.964 Violence Activities

Our AMA: (1) endorses the Declaration of Washington, which urges national medical associations worldwide to promote an international ethos condemning the development, production, or use of toxins and biological agents that have no justification for peaceful purposes;

(2) specifically endorses the WHO's World Report on Violence and Health and recognizes the value of its global perspective on all forms of violence; and

(3) supports investment in primary prevention activities related to violence as well as in research and services that encourage physicians to get involved in violence prevention (e.g., detect violence among patients, advocate for legislation), and encourages the development of curricula for teaching of violence prevention in schools of medicine. (BOT Rep. 9, A-03)

H-515.965 Family and Intimate Partner Violence

(1) Our AMA believes that all forms of family and intimate partner violence are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of victims. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society. Our AMA's efforts will be guided, in part, by its Advisory Council on Family Violence.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula when developed. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist victims. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter victims on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to:
(a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care;
(b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course;
(c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible;

(d) Have written lists of resources available for victims of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid;
(e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence;
(f) Become aware of local resources and referral sources that have expertise in dealing with trauma from victimization;
(g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either victims or abusers themselves;
(h) Give due validation to the experience of victimization and of observed symptomatology as possible sequelae;
(i) Record a patient's victimization history, observed traumata potentially linked to the victimization, and referrals made;
(j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level;

(4) Within the larger community, our AMA: (a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all victims of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
(b) Believes it is critically important that programs be available for victims and perpetrators of intimate violence.
(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA opposes the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult victims of intimate partner violence if the required reports identify victims. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of victims' identities;
(b) allow competent adult victims to opt out of the reporting system if identifiers are required;
(c) provide that reports be made to public health agencies for surveillance purposes only;
(d) contain a sunset mechanism; and
(e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that: (a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence. (CSA Rep. 7, I-00)

H-515.966 Violence and Abuse Prevention in the Healthcare Workplace

Our AMA encourages all healthcare facilities to adopt policies to reduce and prevent workplace violence and abuse and to develop policies to manage reported occurrences of workplace violence and abuse. (Res. 424, I-98; Reaffirmation I-99)

H-515.967 Protection of the Privacy of Sexual Assault Victims

The AMA opposes the publication or broadcast of sexual assault victims' names, addresses, or likenesses without the explicit permission of the victim. (Res. 406, A-98)

H-515.968 Informing the Public & Physicians about Health Risks of Sedative Hypnotics, Especially Rohypnol

The AMA re-emphasizes to physicians and public health officials the fact that Rohypnol (a benzodiazepine), other benzodiazepines, and other sedatives and hypnotics carry the risk of misuse, morbidity and mortality. The AMA supports public education and public health initiatives regarding the dangers of the use of sedatives and hypnotics in sexual abuse and rape, especially when mixed with

ethanol ingestion. (Sub. Res. 408, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-515.971 Public Health Policy Approach for Preventing Violence in America

The AMA supports the ongoing efforts of the CDC to develop appropriate and useful surveillance methodologies for tracking violence-related injuries and encourages the CDC to develop tracking strategies that can be efficiently implemented by physicians, with careful evaluations of pilot programs and demonstration projects prior to their implementation, and will report back on these CDC efforts. (BOT Rep. 34, A-95; Reaffirmed by BOT Rep. 16, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-515.973 Memories of Childhood Abuse

The AMA: (1) recognizes that few cases in which adults make accusations of childhood sexual abuse based on recovered memories can be proved or disproved and it is not yet known how to distinguish true memories from imagined events in these cases; (2) encourages physicians to address the therapeutic needs of patients who report memories of childhood sexual abuse and that these needs exist quite apart from the truth or falsity of any claims; and (3) encourages physicians treating possible adult victims of childhood abuse to subscribe to the *Principles of Medical Ethics* when treating their patients and that psychiatrists pay particular attention to the *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*. (CSA Rep. 5, A-94; Reaffirmed: CSA Rep. 8, A-05)

H-515.974 Mass Media Violence and Film Ratings

Redressing Shortcomings in the Current System: The AMA: (1) will speak out against the excessive portrayal of violence in the news and entertainment media, including newscasts, movies, videos, computer games, music and print outlets, and encourage the depiction of the medical, social and legal consequences of violence by the media;

(2) advises physicians to counsel parents about the known effects of media violence on children's behavior and encouraging them to reduce the amount of violent programming viewed by their children;

(3) monitors changes in the current ratings system and working through state medical societies to inform physicians and their patients about these changes; and

(4) supports all other appropriate measures to address and reduce television, cable television, and motion picture violence. (BOT Rep. 18, A-94; Modified: Res. 417, I-95; Appended: Sub. Res. 419, A-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

H-515.975 Alcohol, Drugs, and Family Violence

(1) Given the association between alcohol and family violence, physicians should be alert to look for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse, should screen for alcohol use.
(2) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
(3) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
(4) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
(5) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence. (CSA Rep. A, A-93; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: CSA Rep. 8, A-03)

H-515.979 Violence as a Public Health Issue

The AMA reaffirms and expands current policy by (a) declaring violence in America to be a major public health crisis; and (b) supporting research into the causes of violent behavior and appropriate interventions which may result in its prevention or cure. (Sub. Res. 408, I-92; Amended: CSA Rep. 8, A-03)

H-515.981 Family Violence-Adolescents as Victims and Perpetrators

The AMA (1) will use its communications mechanisms to (a) encourage physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse,

irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urge physicians to consider issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence. (CSA Rep. I, A-92; Reaffirmed: CSA Rep. 8, A-03)

H-515.982 Violent Acts Against Physicians

Our AMA (1) condemns acts of violence against physicians involved in the legal practice of medicine; and (2) will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians as a result of the physician's acting in a professional capacity. (Res. 605, A-92; Reaffirmation I-99)

H-515.983 Physicians and Family Violence

Ethical Considerations:

(1) The medical profession must demonstrate a greater commitment to ending family violence and helping its victims. Physicians must play an active role in advocating increased services for victims and abusers. Protective services for abused children and elders need to be better funded and staffed, and follow-up services should be expanded. Shelters and safe homes for battered women and their children must be expanded and better funded. Mechanisms to coordinate the range of services, such as legal aid, employment services, welfare assistance, day care, and counseling, should be established in every community. Mandatory arrest of abusers and greater enforcement of protection orders are important law enforcement reforms that should be expanded to more communities. There should be more research into the effectiveness of rehabilitation and prevention programs for abusers.

(2) Informed consent for interventions should be obtained from competent victims of abuse. For minors who are not deemed mature enough to give informed consent, consent for emergency interventions need not be obtained from their parents. Physicians can obtain authorization for further interventions from a court order or a court-appointed guardian.

(3) Physicians should inform parents of a child-abuse diagnosis and they should inform an elderly patient's representative when the patient clearly does not possess the capacity to make health care decisions. The safety of the child or elderly person must be ensured prior to disclosing the diagnosis when the parents or caretakers are potentially responsible for the abuse. For competent adult victims physicians must not disclose an abuse diagnosis to caregivers, spouses, or any other third party without the consent of the patient. (CEJA Rep. B, I-91; Reaffirmed: CSA Rep. 7, I-00; Modified and Reaffirmed: CEJA Rep. 1, A-03)

H-515.988 Repeal of Religious Exemptions in Child Abuse and Medical Practice Statutes

Our AMA (1) reaffirms existing policy supporting repeal of the religious exemption from state child abuse statutes; (2) recognizes that constitutional barriers may exist with regard to elimination of the religious exemption from state medical practice acts; and (3) encourages state medical associations that are aware of problems with respect to spiritual healing practitioners in their areas to investigate such situations and pursue all solutions, including legislation where appropriate, to address such matters. (BOT Rep. H, A-90; Reaffirmed: Sunset Report, I-00)

H-515.989 Evidence of Standards for Child Sexual Abuse

The AMA continues to support the standardization of evidence in child sexual abuse cases and urges that examination and treatment of child abuse victims be done by a physician. (Res. 78, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-515.995 Corporal Punishment in Schools

The AMA (1) supports the abolition of corporal punishment in schools; (2) encourages universities that train teachers to emphasize alternative forms of discipline during their training; (3) encourages physicians to work toward the abolition of corporal punishment in their communities; (4) encourages state medical societies to support legislation prohibiting corporal punishment in their state; (5) encourages parents and school personnel in those districts that have abolished corporal punishment to ensure the implementation of existing policies; (6) supports providing information to physicians and medical societies for use in the abolition of corporal punishment; and (7) supports working with the American Academy of Pediatrics to implement these policies. (BOT Rep. AA, A-85;

Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-520.000 War
(See also: Armed Forces; Veterans: Medical Care)

H-520.987 Condemning the Use of Children as Instruments of War

Our AMA: (1) condemns the use of children as instruments of war; and (2) encourages evaluation, treatment, and follow-up for children who have been used as instruments of war (Res. 411, I-01)

H-520.988 Abolition of Nuclear Weapons and Other Weapons of Mass and Indiscriminate Destruction

The AMA supports the elimination by all nations of nuclear weapons and other weapons of mass and indiscriminate destruction. (Res. 617, I-96; Reaffirmed: CLRPD Rep. 2, A-06)

H-520.989 Elimination of Anti-Personnel Landmines

Our AMA: (1) urges the US government to (a) renounce its claimed exceptions to a ban on anti-persomel landmines, (b) effectuate through the United Nations an international ban on the product, stockpiling, sale, transfer, or export of these weapons, (c) establish a hemispheric landmine free zone in support of the Organization of American States position, and (d) sign the Ottawa Treaty banning all anti-personnel landmines by December 1997;

(2) encourages the US government and all members of the United Nations, as well as other interested charitable and medical organizations to contribute funds for the care, treatment and rehabilitation of landmine trauma victims;

(3) will work with the US Delegation to the United Nations to ban the manufacturing, trade and use of all landmines; and

(4) endorses a domestic and international ban on the manufacture, stockpiling, sale and use of anti-personnel landmines, and urges the President and the US Congress to work toward the achievement of this goal. (Res. 424, I-96; Res. 619, A-97; Res. 628, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-520.992 Chemical and Biologic Weapons

Our AMA condemns the use of chemical and biologic weapons. (Res. 175, I-89; Reaffirmed: Sunset Report, A-00)

H-520.994 Nuclear Test Ban

The AMA acknowledges the threat from nuclear weapons to the health of the people of the world and favors the establishment of a mutual, verifiable, and comprehensive nuclear test ban. (Res. 90, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-520.995 Nuclear Weapons Reduction

The AMA supports continued efforts to publicize its position that there is no adequate medical response to nuclear war. (BOT Rep. V, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CEJA Rep. 7, A-07)

H-520.996 Arms Reduction

The AMA encourages the President and Congress to continue the process of bilateral and verifiable nuclear arms reduction. (Res. 69, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CLRPD Rep. 5, A-03)

H-520.997 Physician and Public Education on the Consequences of Thermonuclear Warfare

Our AMA supports: (1) informing the President and Congress of the medical consequences of nuclear war, so that policy decisions can be made with adequate factual information;
(2) the preparation of appropriate informational materials to educate the physician population and the public on the medical consequences of nuclear war;
(3) cooperation with responsible authorities in dealing with matters having to do with health and medical care in the event of national emergencies, including those associated with military hostility; and
(4) not becoming involved in political issues outside its professional expertise, such as national defense and the politics of nuclear war preparedness, inasmuch as it is not appropriate for the AMA to do so. (BOT Rep. DD, I-81; Reaffirmed: A-83; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-520.998 Medical Neutrality

Our AMA supports medical neutrality, under the principles of the Geneva Convention, for all health care workers and the sick and wounded in all countries. (Sub. Res. 72, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-520.999 Opposition to Nuclear War

The AMA recognizes the catastrophic dangers to all life in the event of nuclear war and supports efforts for the prevention of such a nuclear holocaust. (Sub. Res. 82, A-81; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-525.000 Women
(See also: Cancer; Civil and Human Rights; Pregnancy)

H-525.980 Expansion of AMA Policy on Female Genital Mutilation

The AMA (1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the procedure; and (4) supports that physicians who are requested to perform female genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with changing societal mores. (CSA Rep. 5, I-94; Res. 513, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-525.981 Discrimination of Women Physicians in Hospital Locker Facilities

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

H-525.984 Breast Implants

Our AMA:

(1) supports the FDA's request that women be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose;

(2) urges physicians to recognize and address the considerable public anxiety concerning the safety of breast implants. This anxiety is not warranted based on current scientific evidence;

(3) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated; and

(4) urges the FDA and its Commissioner, David A. Kessler, MD, to adopt, endorse and promulgate the recommendation of its advisory panel, thus allowing silicone gel-filled breast implants to remain on the market pending further studies. (CSA Rep. M, I-91; Modified: Sunset Report, I-01; Reaffirmed: Res. 727, I-02)

H-525.985 Safety and Performance Standards for Mammography

Our AMA actively encourages the development of new activities, and supports the coordination of ongoing activities, to ensure the following: (1) that the techniques used in performing mammograms and in interpreting mammograms meet high quality standards of performance, including evidence of appropriate training and competence for professionals carrying out these tasks;
(2) that the equipment used in mammography is specifically designed and dedicated. The performance of mammography imaging systems is assessed on a regular basis by trained professionals;
(3) that the American College of Radiology Breast Imaging Reporting and Database System is widely used throughout the United States and that mammography outcome data in this database are used to regularly assess the effectiveness of mammography screening and diagnostic services as they are provided for women in the United States; and
(4) regular breast physical examination by a physician and regular breast self-examination should be performed in addition to screening mammography. (BOT Rep. JJ, A-91; Reaffirmed: Sunset Report, I-01)

H-525.986 Guidelines and Medicare Coverage for Screening Mammography

Our AMA: (1) supports continuing to work with interested groups to facilitate the participation of all women eligible under Medicare in regular screening mammography; (2) supports the coordination of ongoing programs and encourages the development of new activities in quality assurance for mammography; and (3) supports monitoring studies addressing the issue of the appropriate interval for screening mammography in women over 64 years of age. (BOT Rep. CC, A-91; Modified: Sunset Report, I-01)

H-525.987 Surgical Modification of Female Genitalia

Our AMA (1) encourages the appropriate obstetric/gynecologic and urologic societies in the United States to develop educational programs addressing medically unnecessary surgical modification of female genitalia, the many complications and possible corrective surgical procedures, and (2) opposes all forms of medically unnecessary surgical modification of female genitalia. (Res. 13, A-91; Reaffirmed: Sunset Report, I-01)

H-525.988 Sex and Gender Differences in Medical Research

Our AMA: (1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;

(2) affirms the need to include both genders in studies that involve the health of society at large and publicize its policies;

(3) supports increased funding into areas of women's health research;

(4) supports the recent trend of increased research on women’s health and participation of women in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women from diverse cultural and ethnic groups, geographic locations, and socioeconomic status; and

(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based analysis of data, even if such comparisons are negative. (Res. 80, A-91; Appended: CSA Rep. 4, I-00)

H-525.989 Women's Vietnam Memorial in Washington, DC

Our AMA honors the contributions made by United States nurses and other servicewomen, and supports the Vietnam Women's Memorial Project, Inc., by disseminating to all of the state medical societies information concerning this honorable project, thereby allowing all physicians the opportunity to show their appreciation to our women colleagues by supporting this great and lasting endeavor. (Res. 19, A-91; Reaffirmed: Sunset Report, I-01)

H-525.991 Inclusion of Women in Clinical Trials

Our AMA encourages the inclusion of women in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women alike. (Res. 183, I-90; Reaffirmed: Sunset Report, I-00)

H-525.992 Women in Medicine

Our AMA reaffirms its policy of commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine. (BOT Rep. G, A-89; Reaffirmed: Sunset Report, A-00)

H-525.993 Mammography Screening in Asymptomatic Women Forty Years and Older

1. Our AMA strongly endorses the positions of the American College of Obstetrics and Gynecology, the American Cancer Society, and the American College of Radiology that all women have screening mammography as per current guidelines.

2. Our AMA favors participation in and support of the efforts of the professional, voluntary, and government organizations to educate physicians and the public regarding the value of screening mammography in reducing breast cancer mortality.

3. Our AMA advocates remaining alert to new epidemiological findings regarding age-specific breast cancer mortality reduction following mammography screening.

4. Based on recent summary data our AMA recommends annual screening mammograms and continuation of clinical breast examinations in asymptomatic women 40 years and older.

5. Our AMA encourages the periodic reconsideration of these recommendations as more epidemiological data become available

6. Our AMA supports seeking common recommendations with other organizations.

7. Our AMA reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians. (CSA Rep. F, A-88; Reaffirmed: Res. 506, A-94; Amended: CSA Rep. 16, A-99; Appended: Res. 120, A-02)

H-525.994 Quality of Pap Smear Analysis

The AMA reaffirms its long-standing support of the Pap smear as an effective screening method for the detection of cervical cancer. (Res. 92, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-525.998 Women in Organized Medicine

Our AMA: (1) reaffirms its policy advocating equal opportunities and opposing sex discrimination in the medical profession;

(2) supports the concept of increased tax benefits for working parents;

(3) (a) supports the concept of proper child care for families of working parents; (b) reaffirms its position on child care facilities in or near medical centers and hospitals; (c) encourages business and industry to establish employee child care centers on or near their premises when possible; and (d) encourages local medical societies to survey physicians to determine the interest in clearinghouse activities and in child care services during medical society meetings;

(4) reaffirms its policy supporting flexibly scheduled residencies and encourages increased availability of such programs; and

(5) supports that the AMA Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures be updated by the AMA Women Physicians Congress, and forwarded to the House of Delegates for approval, and include not only resources for training programs but also private practice settings. To facilitate wide distribution and easy access, the Guidelines will be placed on the AMA Web site. (BOT Rep. T, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation A-00; Modified: CME Rep. 3, A-03)

PRINCIPLES OF MEDICAL ETHICS

PREAMBLE:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

Adopted June 1957; revised June 1980; revised June 2001

E-1.01 Terminology

The term "ethical" is used in opinions of the Council on Ethical and Judicial Affairs to refer to matters involving (1) moral principles or practices and (2) matters of social policy involving issues of morality in the practice of medicine. The term "unethical" is used to refer to professional conduct which fails to conform to these moral standards or policies.

Many of the Council’s opinions lay out specific duties and obligations for physicians. Violation of these principles and opinions represents unethical conduct and may justify disciplinary action such as censure, suspension, or expulsion from medical society membership. (II) Issued prior to April 1977; Updated June 1994 and June 1996.

E-1.02 The Relation of Law and Ethics

The following statements are intended to clarify the relationship between law and ethics.

Ethical values and legal principles are usually closely related, but ethical obligations typically exceed legal duties. In some cases, the law mandates unethical conduct. In general, when physicians believe a law is unjust, they should work to change the law. In exceptional circumstances of unjust laws, ethical responsibilities should supersede legal obligations.

The fact that a physician charged with allegedly illegal conduct is acquitted or exonerated in civil or criminal proceedings does not necessarily mean that the physician acted ethically. (III) Issued prior to April 1977; Updated June 1994.

E-2.00 Opinions on Social Policy Issues

E-2.01 Abortion

The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good

medical practice and under circumstances that do not violate the law. (III, IV) Issued prior to April 1977.

E-2.015 Mandatory Parental Consent to Abortion

Physicians should ascertain the law in their state on parental involvement to ensure that their procedures are consistent with their legal obligations.

Physicians should strongly encourage minors to discuss their pregnancy with their parents. Physicians should explain how parental involvement can be helpful and that parents are generally very understanding and supportive. If a minor expresses concerns about parental involvement, the physician should ensure that the minor's reluctance is not based on any misperceptions about the likely consequences of parental involvement.

Physicians should not feel or be compelled to require minors to involve their parents before deciding whether to undergo an abortion. The patient, even an adolescent, generally must decide whether, on balance, parental involvement is advisable. Accordingly, minors should ultimately be allowed to decide whether parental involvement is appropriate. Physicians should explain under what circumstances (eg, life-threatening emergency) the minor's confidentiality will need to be abrogated.

Physicians should try to ensure that minor patients have made an informed decision after giving careful consideration to the issues involved. They should encourage their minor patients to consult alternative sources if parents are not going to be involved in the abortion decision. Minors should be urged to seek the advice and counsel of those adults in whom they have confidence, including professional counselors, relatives, friends, teachers, or the clergy. (III, IV) Issued June 1994 based on the report "Mandatory Parental Consent to Abortion;" adopted June 1992. (JAMA. 1993; 269: 82-86)

E-2.02 Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse

Interpersonal violence and abuse were once thought to primarily affect specific high-risk patient populations, but it is now understood that all patients may be at risk. The complexity of the issues arising in this area requires three distinct sets of guidelines for physicians. The following guidelines address assessment, prevention, and reporting of interpersonal violence and abuse.

(1) When seeking to identify and diagnose past or current experiences with violence and abuse, physicians should adhere to the following guidelines:

(a) Physicians should routinely inquire about physical, sexual, and psychological abuse as part of the medical history. Physicians should also consider abuse as a factor in the presentation of medical complaints because patients' experiences with interpersonal violence or abuse may adversely affect their health status or ability to adhere to medical recommendations.

(b) Physicians should familiarize themselves with the detection of violence or abuse, the community and health care resources available to abused or vulnerable persons, and the legal requirements for reporting violence or abuse.

(c) Physicians should not be influenced in the diagnosis and management of abuse by such misconceptions as the beliefs that abuse is a rare occurrence, does not occur in "normal" families, is a private problem best resolved without outside interference, or is caused by the victims own actions.

(2) The following guidelines are intended to guide physicians' efforts to address acts of violence and abuse:

(a) Physicians must treat the immediate symptoms and sequelae of violence and abuse, while also providing ongoing care for patients so as to address any long-term health consequences that may arise as the result of exposure.

(b) Physicians should be familiar with current information about cultural variations in response to abuse, public health measures that are effective in preventing violence and abuse, and how to work cooperatively with relevant community services. Physicians should help in developing educational resources for identifying and caring for victims. Comprehensive training in matters pertaining to violence and abuse should be required in medical school curricula and in post graduate training programs.

(c) Physicians should also provide leadership in raising awareness regarding the need to assess and identify signs of abuse. By establishing guidelines and institutional policies it may be possible to reduce the volume of abuse cases that go unidentified, and consequently, help to ensure that all patients receive the benefit of appropriate assessment regardless of their age, gender, ethnicity, or social circumstances. The establishment of appropriate mechanisms should also direct physicians to external community or private resources that might be available to aid patients.

(d) Physicians should support research in the prevention of violence and abuse and seek collaboration with relevant public health authorities and community organizations.

(3) Physicians should comply with the following guidelines when reporting evidence of violence or abuse:

(a) Physicians should familiarize themselves with any relevant reporting requirements within the jurisdiction in which they practice.

(b) When a jurisdiction mandates reporting suspicion of violence and abuse, physicians should comply. However, physicians should only disclose minimal information in order to safeguard patients' privacy. Moreover, if available evidence suggests that mandatory reporting requirements are not in the best interests of patients, physicians should advocate for changes in such laws.

(c) In jurisdictions where reporting suspected violence and abuse is not legally mandated, physicians should discuss the issue sensitively with the patient by first suggesting the possibility of abuse, followed by describing available safety mechanisms. Reporting when not required by law requires the informed consent of the patient. However, exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision. (I, III) Issued December 1982. Updated June 1994 based on the report "Physicians and Family Violence: Ethical Considerations," adopted December 1991 (JAMA. 1992; 267: 3190-93); updated June 1996; updated June 2000 based on the report "Domestic Violence Intervention," adopted June 1998 and updated June 2008 based on the report "Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse," adopted November 2007.

E-2.03 Allocation of Limited Medical Resources

A physician has a duty to do all that he or she can for the benefit of the individual patient. Policies for allocating limited resources have the potential to limit the ability of physicians to fulfill this obligation to patients. Physicians have a responsibility to participate and to contribute their professional expertise in order to safeguard the interests of patients in decisions made at the societal level regarding the allocation or rationing of health resources.

Decisions regarding the allocation of limited medical resources among patients should consider only ethically appropriate criteria relating to medical need. These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. Non-medical criteria, such as ability to pay, age, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.

Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. When very substantial differences do not exist among potential recipients of treatment on the basis of the appropriate criteria defined above, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula. Decision-making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally.

The treating physician must remain a patient advocate and therefore should not make allocation decisions. Patients denied access to resources have the right to be informed of the reasoning behind the decision. The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession. (I,VII) Issued March 1981; Updated June 1994 based on the report "Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients," adopted June 1993 (Archive of Internal Medicine 1995; 155: 29-40).

E-2.035 Futile Care

Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them. Denial of treatment should be justified by reliance on openly stated ethical principles and acceptable standards of care, as defined in Opinion 2.03, "Allocation of Limited Medical Resources," and Opinion 2.095, "The Provision of Adequate Health Care," not on the concept of "futility," which cannot be meaningfully defined. (I, IV) Issued June 1994.

E-2.037 Medical Futility in End-of-Life Care

When further intervention to prolong the life of a patient becomes futile, physicians have an obligation to shift the intent of care toward comfort and closure. However, there are necessary value judgments involved in coming to the assessment of futility. These judgments must give consideration to patient or proxy assessments of worthwhile outcome. They should also take into account the physician or other provider's perception of intent in treatment, which should not be to prolong the dying process without benefit to the patient or to others with legitimate interests. They may also take into account community and institutional standards, which in turn may have used physiological or functional outcome measures.

Nevertheless, conflicts between the parties may persist in determining what is futility in the particular instance. This may interrupt satisfactory decision-making and adversely affect patient care, family satisfaction, and physician-clinical team functioning. To assist in fair and satisfactory decision-making about what constitutes futile intervention:

(1) All health care institutions, whether large or small, should adopt a policy on medical futility; and

(2) Policies on medical futility should follow a due process approach. The following seven steps should be included in such a due process approach to declaring futility in specific cases.

(a) Earnest attempts should be made in advance to deliberate over and negotiate prior understandings between patient, proxy, and physician on what constitutes futile care for the patient, and what falls within acceptable limits for the physician, family, and possibly also the institution.

(b) Joint decision-making should occur between patient or proxy and physician to the maximum extent possible.

(c) Attempts should be made to negotiate disagreements if they arise, and to reach resolution within all parties' acceptable limits, with the assistance of consultants as appropriate.

(d) Involvement of an institutional committee such as the ethics committee should be requested if disagreements are irresolvable.

(e) If the institutional review supports the patient's position and the physician remains unpersuaded, transfer of care to another physician within the institution may be arranged.

(f) If the process supports the physician's position and the patient/proxy remains unpersuaded, transfer to another institution may be sought and, if done, should be supported by the transferring and receiving institution.

(g) If transfer is not possible, the intervention need not be offered. (I, V) Issued June 1997 based on the report "Medical Futility in End-of-Life Care," adopted December 1996 (JAMA. 1999; 281: 937-41).

E-2.04 Artificial Insemination by Known Donor

Any individual or couple contemplating artificial insemination by husband, partner, or other known donor should be counseled about the full range of infectious and genetic diseases for which the donor or recipient can be screened, including communicable disease agents and diseases. Full medical history disclosure and appropriate diagnostic screening should be recommended to the donor and recipient but are not required.

Informed consent for artificial insemination should include disclosure of risks, benefits, and likely success rate of the method proposed and potential alternative methods. Individuals should receive information about screening, costs, and procedures for confidentiality, when applicable. The prospective parents or parent should be informed of the laws regarding the rights of children conceived by artificial insemination, as well as the laws regarding parental rights and obligations.

Sex selection of sperm for the purposes of avoiding a sex-linked inheritable disease is appropriate. However, physicians should not participate in sex selection for reasons of gender preference. Physicians should encourage a prospective parent or parents to consider the value of both sexes.

If semen is frozen and the donor dies before it is used, the frozen semen should not be used or donated for purposes other than those originally intended by the donor. If the donor left no instructions, it is reasonable to allow the remaining partner to use the semen for artificial insemination but not to donate it to someone else. However, the donor should be advised of such a policy at the time of donation and be given an opportunity to override it. (I, V) Issued June 1993; updated December 2004.

E-2.05 Artificial Insemination by Anonymous Donor

Thorough medical histories must be taken of all candidates for anonymous semen donation. All potential donors must also be screened for infectious or inheritable diseases which could adversely affect the recipient or the resultant child. Frozen semen should be used for artificial insemination because it enables the donor to be tested for communicable disease agents and diseases at the time of donation, and again after an interval before the original semen is used, thus increasing the likelihood that the semen is free of blood-borne pathogens. Physicians should rely on the guidelines formulated by relevant professional organizations, such as the American Society of Reproductive Medicine, the Centers for Disease Control and Prevention, and the Food and Drug Administration, in determining which disorders to screen for and which procedures to use in screening. Physicians should maintain a permanent record which includes both identifying and non-identifying health and genetic screening information. Other than exceptional situations where identifying information may be required, physicians should release only non-identifying health-related information in order to

preserve the confidentiality of the semen donor.

Physicians should maintain permanent records of donors to fulfill the following obligations: (1) to exclude individuals from the donor pool who test positive for infectious or inheritable diseases, (2) to limit the number of pregnancies resulting from a single donor source so as to avoid future consanguineous marriages or reproduction, (3) to notify donors of screening results which indicate the presence of an infectious or inheritable disease, and (4) to notify donors if a child born through artificial insemination has a disorder which may have been transmitted by the donor.

Informed consent for artificial insemination should include disclosure of risks, benefits, likely success rate of the method proposed and potential alternative methods, and costs. Both recipients and donors should be informed of the reasons for screening and confidentiality. They should also know the extent of access to non-identifying and identifying information about the donor. Participants should be advised to consider the legal ramifications, if any, of artificial insemination by anonymous donor.

The consent of the husband is ethically appropriate if he is to become the legal father of the resultant child from artificial insemination by anonymous donor. Anonymous donors cannot assume the rights or responsibilities of parenthood for children born through therapeutic donor insemination, nor should they be required to assume them.

In the case of single women or women who are part of a homosexual couple, it is not unethical to provide artificial insemination as a reproductive option.

Sex selection of sperm for the purposes of avoiding a sex-linked inheritable disease is appropriate. However, physicians should not participate in sex selection of sperm for reasons of gender preference. Physicians should encourage a prospective parent or parents to consider the value of both sexes.

In general, it is inappropriate to offer compensation to donors to encourage donation over and above reimbursement for time and actual expenses. (I, V) Issued June 1993; updated December 2004.

E-2.055 Ethical Conduct in Assisted Reproductive Technology

The following guidelines are intended to emphasize the value of existing standards to ensure ethical practices in assisted reproductive technology (ART):

(1) The medical profession’s development of technical and ethical guidelines for ART should continue. Education of the profession and patients should be pursued through widely disseminated information. Such material should include information on clinic-specific success rates.

(2) Fertility laboratories not currently participating in a credible professional accreditation program are encouraged to do so. Professional self-regulation is also encouraged through signed pledges to meet established ethical standards and to comply with laboratory accreditation efforts. Physicians who become aware of unethical practices must report such conduct to the appropriate body. Physicians also should be willing to provide expert testimony when needed. Specialty societies should discuss the development of mechanisms for disciplinary action, such as revocation of membership, for members who fail to comply with ethical standards.

(3) Patients should be fully informed about all aspects of ART applicable to their particular clinical profile. A well-researched, validated informed consent instrument would be useful for the benefit of patients and professionals. Payment based on clinical outcome is unacceptable.

(4) Physicians and clinicians practicing ART should use accurate descriptors of available services, success rates, and fee structure and payment obligations in promotional materials.

If legislation on regulation of ART laboratories, advertising practices, or related issues is adopted, it should include adequate financial resources to ensure the intended action can be implemented. Improved legislative protection may be needed to protect physicians and their professional organizations when they provide testimony on unethical conduct of colleagues. (I, V) Issued December 1998 based on the report "Issues of Ethical Conduct in Assisted Reproductive Technology," adopted June 1996.

E-2.06 Capital Punishment

An individual’s opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. Physician participation in execution is defined generally as actions which would fall into one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

Physician participation in an execution includes, but is not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution.

In the case where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel.

The following actions do not constitute physician participation in execution: (1) testifying as to medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying as to medical diagnoses as they relate to the legal assessment of competence for execution; (2) certifying death, provided that the condemned has been declared dead by another person; (3) witnessing an execution in a totally nonprofessional capacity; (4) witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a nonprofessional capacity; and (5) relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.

Physicians should not determine legal competence to be executed. A physician’s medical opinion should be merely one aspect of the information taken into account by a legal decision maker such as a judge or hearing officer. When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner for the purpose of restoring competence unless a commutation order is issued before treatment begins. The task of re-evaluating the prisoner should be performed by an independent physician examiner. If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. No physician should be compelled to participate in the process of establishing a prisoner’s competence or be involved with treatment of an incompetent, condemned prisoner if such activity is contrary to the physician’s personal beliefs. Under those circumstances, physicians should be permitted to transfer care of the prisoner to another physician.

Organ donation by condemned prisoners is permissible only if (1) the decision to donate was made before the prisoner’s conviction, (2) the donated tissue is harvested after the prisoner has been pronounced dead and the body removed from the death chamber, and (3) physicians do not provide advice on modifying the method of execution for any individual to facilitate donation. (I) Issued July 1980. Updated June 1994 based on the report "Physician Participation in Capital Punishment," adopted December 1992, (JAMA. 1993; 270: 365-368); updated June 1996 based on the report "Physician Participation in Capital Punishment: Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed," adopted in June 1995; Updated December 1999; and Updated June 2000 based on the report "Defining Physician Participation in State Executions," adopted June 1998.

E-2.065 Court-Initiated Medical Treatments in Criminal Cases

Physicians can ethically participate in court-initiated medical treatments only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. In accordance with ethical practice, physicians should treat patients based on sound medical diagnoses, not court-defined behaviors. This is particularly important where the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment. In these cases, diagnosis can be made initially by the physician who will do the treatment, but must then be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.

A recognized, authoritative medical body, such as a national specialty society, should pre-establish scientifically valid treatments for medically determined diagnoses. Such pre-established acceptable treatments should then be applied on a case-by-case basis.

The physician who will perform the treatment must be able to conclude, in good conscience and to the best of his or her professional judgment, that the informed consent was given voluntarily to the extent possible, recognizing the element of coercion that is inevitably present. In cases involving in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that the informed consent was given in accordance with these guidelines. (I, III) Issued December 1998 based on the report "Court-Initiated Medical Treatment in Criminal Cases," adopted June 1998.

E-2.067 Torture

Torture refers to the deliberate, systematic, or wanton administration of cruel, inhumane, and degrading treatments or punishments during imprisonment or detainment.

Physicians must oppose and must not participate in torture for any reason. Participation in torture includes, but is not limited to, providing or withholding any services, substances, or knowledge to facilitate the practice of torture. Physicians must not be present when torture is used or threatened.

Physicians may treat prisoners or detainees if doing so is in their best interest, but physicians should not treat individuals to verify their health so that torture can begin or continue. Physicians who treat torture victims should not be persecuted. Physicians should help provide support for victims of torture and, whenever possible, strive to change situations in which torture is practiced or the potential for torture is great. (I, III) Issued December 1999.

E-2.068 Physician Participation in Interrogation

E-2.068 Physician Participation in Interrogation

Interrogation is defined as questioning related to law enforcement or to military and national security intelligence gathering, designed to prevent harm or danger to individuals, the public, or national security. Interrogations are distinct from questioning used by physicians to assess the physical or mental condition of an individual. To be appropriate, interrogations must avoid the use of coercion-—that is, threatening or causing harm through physical injury or mental suffering. In this Opinion, "detainee" is defined as a criminal suspect, prisoner of war, or any other individual who is being held involuntarily.

Physicians who engage in any activity that relies on their medical knowledge and skills must continue to uphold principles of medical ethics. Questions about the propriety of physician participation in interrogations and in the development of interrogation strategies may be addressed by balancing obligations to individuals with obligations to protect third parties and the public. The further removed the physician is from direct involvement with a detainee, the more justifiable is a role serving the public interest. Applying this general approach, physician involvement with interrogations during law enforcement or intelligence gathering should be guided by the following:

(1) Physicians may perform physical and mental assessments of detainees to determine the need for and to provide medical care. When so doing, physicians must disclose to the detainee the extent to which others have access to information included in medical records. Treatment must never be conditional on a patient's participation in an interrogation.

(2) Physicians must neither conduct nor directly participate in an interrogation, because a role as physician-interrogator undermines the physician's role as healer and thereby erodes trust in the individual physician-interrogator and in the medical profession.

(3) Physicians must not monitor interrogations with the intention of intervening in the process, because this constitutes direct participation in interrogation.

(4) Physicians may participate in developing effective interrogation strategies for general training purposes. These strategies must not threaten or cause physical injury or mental suffering and must be humane and respect the rights of individuals.

(5) When physicians have reason to believe that interrogations are coercive, they must report their observations to the appropriate authorities. If authorities are aware of coercive interrogations but have not intervened, physicians are ethically obligated to report the offenses to independent authorities that have the power to investigate or adjudicate such allegations. (I, III, VII, VIII) Issued November 2006 based on the report "Physician Participation in Interrogation," adopted June 2006.

E-2.07 Clinical Investigation

The following guidelines are intended to aid physicians in fulfilling their ethical responsibilities when they engage in the clinical investigation of new drugs and procedures.
(1) A physician may participate in clinical investigation only to the extent that those activities are a part of a systematic program competently designed, under accepted standards of scientific research, to produce data which are scientifically valid and significant.
(2) In conducting clinical investigation, the investigator should demonstrate the same concern and caution for the welfare, safety, and comfort of the person involved as is required of a physician who is furnishing medical care to a patient independent of any clinical investigation.
(3) Minors or mentally incompetent persons may be used as subjects in clinical investigation only if:
(a) The nature of the investigation is such that mentally competent adults would not be suitable subjects.
(b) Consent, in writing, is given by a legally authorized representative of the subject under circumstances in which informed and prudent adults would reasonably be expected to volunteer themselves or their children as subjects.
(4) In clinical investigation primarily for treatment:
(a) The physician must recognize that the patient-physician relationship exists and that professional judgment and skill must be exercised in the best interest of the patient.
(b) Voluntary written consent must be obtained from the patient, or from the patient's legally authorized representative if the patient

lacks the capacity to consent, following: (i) disclosure that the physician intends to use an investigational drug or experimental procedure, (ii) a reasonable explanation of the nature of the drug or procedure to be used, risks to be expected, and possible therapeutic benefits, (iii) an offer to answer any inquiries concerning the drug or procedure, and (iv) a disclosure of alternative drugs or procedures that may be available. Physicians should be completely objective in discussing the details of the drug or procedure to be employed, the pain and discomfort that may be anticipated, known risks and possible hazards, the quality of life to be expected, and particularly the alternatives. Especially, physicians should not use persuasion to obtain consent which otherwise might not be forthcoming, nor should expectations be encouraged beyond those which the circumstances reasonably and realistically justify.
(i) In exceptional circumstances, where the experimental treatment is the only potential treatment for the patient and full disclosure of information concerning the nature of the drug or experimental procedure or risks would pose such a serious psychological threat of detriment to the patient as to be medically contraindicated, such information may be withheld from the patient. In these circumstances, such information should be disclosed to a responsible relative or friend of the patient where possible.
(ii) Ordinarily, consent should be in writing, except where the physician deems it necessary to rely upon consent in other than written form because of the physical or emotional state of the patient.
(5) In clinical investigation primarily for the accumulation of scientific knowledge:
(a) Adequate safeguards must be provided for the welfare, safety, and comfort of the subject. It is fundamental social policy that the advancement of scientific knowledge must always be secondary to primary concern for the individual.
(b) Consent, in writing, should be obtained from the subject, or from a legally authorized representative if the subject lacks the capacity to consent, following: (i) disclosure of the fact that an investigational drug or procedure is to be used, (ii) a reasonable explanation of the nature of the procedure to be used and risks to be expected, and (iii) an offer to answer any inquiries concerning the drug or procedure.
(6) No person may be used as a subject in clinical investigation against his or her will.
(7) The overuse of institutionalized persons in research is an unfair distribution of research risks. Participation is coercive and not voluntary if the participant is subjected to powerful incentives and persuasion.
(8) The ultimate responsibility for the ethical conduct of science resides within the institution (academic, industrial, public, or private) which conducts scientific research and with the individual scientist. Research institutions should assure that rigorous scientific standards are upheld by each of their faculty, staff, and students and should extend these standards to all reports, publications, and databases produced by the institution. All medical schools and biomedical research institutions should implement guidelines for a review process for dealing with allegations of fraud. These guidelines should ensure that (a) the process used to resolve allegations of fraud does not damage science, (b) all parties are treated fairly and justly with a sensitivity to reputations and vulnerabilities, (c) the highest degree of confidentiality is maintained, (d) the integrity of the process is maintained by an avoidance of real or apparent conflicts of interest, (e) resolution of charges is expeditious, (f) accurate and detailed documentation is kept throughout the process, and (g) responsibilities to all involved individuals, the public, research sponsors, the scientific literature, and the scientific community is met after resolution of charges. Academic institutions must be capable of, and committed to, implementing effective procedures for examining allegations of scientific fraud. No system of external monitoring should replace the efforts of an institution to set its own standards which fulfill its responsibility for the proper conduct of science and the training of scientists.
(9) With the approval of the patient or the patient's lawful representative, physicians should cooperate with the press and media to ensure that medical news concerning the progress of clinical investigation or the patient's condition is available more promptly and more accurately than would be possible without their assistance. On the other hand, the Council does not approve of practices designed to create fanfare, sensationalism to attract media attention, and unwarranted expressions of optimism because of short-term progress, even though longer range prognosis is known from the beginning to be precarious. With the approval of the patient or the patient's family, the Council, however, encourages the objective disclosure to the press and media of pertinent information. If at all possible, the identity of the patient should remain confidential if the patient or the patient's family so desires. The situation should not be used for the commercial ends of participating physicians or the institutions involved. (I, III, V) Issued prior to April 1977; Updated June 1994 and June 1998.

E-2.071 Subject Selection for Clinical Trials

Ethical considerations in clinical research have traditionally focused on protecting research subjects. These protections may be especially important for those from socioeconomically diasdavantaged populations who may be more vulnerable to coercive pressures. The benefits from altruism that result from participation in research, particularly for severely chronically ill persons, may justify equitable consideration of historically disadvantaged populations such as the poor. With these considerations in mind, the following guidelines are offered:
(1) Although the burdens of research should not fall disproportionately on socioeconomically disadvantaged populations, neither should such populations be categorically excluded, or discouraged, from research protocols.
(2) Inclusion and exclusion criteria for a clinical study should be based on sound scientific principles. Conversely, participants in a clinical trial should be drawn from the qualifying population in the general geographic area of the trial without regard to race, ethnicity, economic status, or gender.

If a subject's primary care physician determines that the subject received a clear medical benefit from the experimental intervention which is now moving towards marketing approval and chooses to seek authorization from the Food and Drug Administration (FDA) for continued use of the investigational therapy during the time period between the end of the protocol and the availability of the drug on the market, the investigator should work with the primary care physician, the product sponsor, and the FDA to allow continued

availability of the product. (I, V, VII) Issued June 1998 based on the report "Subject Selection for Clinical Trials," adopted December 1997 (IRB. 1998; 20(2-3): 12-15).

E-2.075 The Use of Placebo Controls in Clinical Trials

Placebo controls are an important part of medicine's commitment to ensuring that the safety and efficacy of new drugs are sufficiently established. Used appropriately, placebo controls can safely provide valuable data and should continue to be considered in the design of clinical trials. The existence of an accepted therapy does not necessarily preclude the use of such controls; however, physician-investigators should adhere to the following guidelines to ensure that the interests of patients who participate in clinical trials are protected.

(1) Investigators must be extremely thorough in obtaining informed consent from patients. To the extent that research is dependent upon the willingness of patients to accept a level of risk, their understanding of the potential harms involved must be a top priority of any clinical investigation. The possibility presented in some studies that patients often do not fully understand the research protocol and therefore truly cannot give informed consent demonstrates a need to heighten the efforts of researchers to impress upon their subjects the nature of clinical research and the risks involved. Patients are capable of making decisions when presented with sufficient information, and it is the responsibility of the institutional review board (IRB) and the individual investigators involved to ensure that each subject has been adequately informed and has given voluntary consent. Each patient must also be made aware that they can terminate their participation in a study at any time.

(2) Informed consent cannot be invoked to justify an inappropriate trial design. IRBs as well as investigators have an obligation to evaluate each study protocol to determine whether a placebo control is necessary and whether an alternative study design with another type of control would be sufficient for the purposes of research. Protocols that involve conditions causing death or irreversible damage cannot ethically employ a placebo control if alternative treatment would prevent or slow the illness progression. When studying illnesses characterized by severe or painful symptoms, investigators should thoroughly explore alternatives to the use of placebo controls. In general, the more severe the consequences and symptoms of the illness under study, the more difficult it will be to justify the use of a placebo control when alternative therapy exists. Consequently, there will almost certainly be conditions for which placebo controls cannot be justified. Similarly, the use of a placebo control will more easily be justified as the severity and number of negative side effects of standard therapy increase.

(3) Researchers and IRBs should continue to minimize the amount of time patients are given placebo. The rationale provided by investigators for the length of study will give IRBs the opportunity to ensure that patients are given placebo therapy for as short a time as possible to provide verifiable results. Additionally, the interim data analysis and monitoring currently in practice will allow researchers to terminate the study because of either positive or negative results, thus protecting patients from remaining on placebo unnecessarily. (I, V) Issued June 1997 based on the report "Ethical Use of Placebo Controls in Clinical Trials," adopted June 1996.

E-2.076 Surgical "Placebo" Controls

The term surgical "placebo" controls refers to the control arm of a research study where subjects undergo surgical procedures that have the appearance of therapeutic interventions, but during which the essential therapeutic maneuver is omitted.

The appropriateness of a surgical "placebo" control should be evaluated on the basis of guidelines provided in Opinion 2.07, "Clinical Investigation," as well as the following requirements:

(1) Surgical "placebo" controls should be used only when no other trial design will yield the requisite data.

(2) Particular attention must be paid to the informed consent process when enrolling subjects in trials that use surgical "placebo" controls. Careful explanation of the risks of the operations must be disclosed, along with a description of the differences between the trial arms emphasizing the essential procedure that will or will not be performed. Additional safeguards around the informed consent process may be appropriate such as using a neutral third party to provide information and get consent, or using consent monitors to oversee the consent process.

(3) The use of surgical "placebo" controls may be justified when an existing, accepted surgical procedure is being tested for efficacy. It is not justified when testing the effectiveness of an innovative surgical technique that represents only a minor modification of an existing, accepted surgical procedure.

(4) When a new surgical procedure is developed with the prospect of treating a condition for which no known surgical therapy exists, using surgical "placebo" controls may be justified, but must be evaluated in light of whether the current standard of care includes a non-surgical treatment and the benefits, risks, and side effects of that treatment.

(a) If foregoing standard treatment would result in significant injury and the standard treatment is efficacious and acceptable to the patient (in terms of side effects, personal beliefs, etc), then it must be offered as part of the study design.

(b) When the standard treatment is not fully efficacious, or not acceptable to the patient, surgical "placebo" controls may be used and the standard treatment foregone, but additional safeguards must be put in place around the informed consent process. (I, V) Issued December 2000 based on the report "Surgical Placebo Controls," adopted June 2000; updated June 2003.

E-2.077 Ethical Considerations in International Research

Physicians, either in their role as investigators or as decision-makers involved in the deliberations related to the funding or the review of research, hold an ethical obligation to ensure the protection of research participants. When the research is to be conducted in countries with differing cultural traditions, health care systems, and ethical standards, and in particular in countries with developing

economies and with limited health care resources, US physicians should respect the following guidelines:
(1) First and foremost, physicians involved in clinical research that will be carried out internationally should be satisfied that a proposed research design has been developed according to a sound scientific design. Therefore, investigators must ascertain that there is genuine uncertainty within the clinical community about the comparative merits of the experimental treatment and the one to be offered as a control in the population among which the study is to be undertaken. In some instances, a three-pronged protocol, which offers the standard treatment in use in the US, a treatment that meets a level of care that is attainable and sustainable by the host country, and a placebo (see Opinion 2.075, "Surgical 'Placebo' Controls"), may be the best method to evaluate the safety and efficacy of a treatment in a given population. When US investigators participate in international research they must obtain approval for such protocols from U.S. Institutional Review Boards (IRBs).
(2) IRBs, which are responsible for ensuring the protection of research participants, must determine that risks have been minimized and that the protocol's ratio of risks to benefits is favorable to participants. In evaluating the risks and benefits that a protocol presents to a population, IRBs should obtain relevant input from representatives from the host country and from the research population. It is also appropriate for IRBs to consider the harm that is likely to result from forgoing the research.
(3) Also, IRBs are required to protect the welfare of individual participants. This can best be achieved by assuring that a suitable informed consent process is in place. Therefore, IRBs should ensure that individual potential participants will be informed of the nature of the research endeavor and that their voluntary consent will be sought. IRBs should recognize that, in some instances, information will be meaningful only if it is communicated in ways that are consistent with local customs.
(4) Overall, to ensure that the research does not exploit the population from which participants are recruited, IRBs should ensure that the research corresponds to a medical need in the region where it is undertaken. Furthermore, they should foster research with the potential for lasting benefits, especially when it is undertaken among populations that are severely deficient in health care resources. This can be achieved by facilitating the development of a health care infrastructure that will be of use during and beyond the conduct of the research. Additionally, physicians conducting studies must encourage research sponsors to continue to provide beneficial study interventions to all study participants at the conclusion of the study. (I, IV, VII, VIII, IX) Issued December 2001 based on the report "Ethical Considerations in International Research," adopted June 2001.

E-2.078 Guidelines to Prevent Malevolent Use of Biomedical Research

Physicians who engage in biomedical research are bound by the ethical obligations of the medical profession and also are required to meet responsibilities of the scientific community. Beyond their commitment to the advancement of scientific knowledge and the betterment of public health, physician-researchers must strive to maintain public trust in the profession through their commitment to public welfare and safety, as demonstrated through individual responsibility, commitment to peer review, and transparency in the design, execution, and reporting of research.

Biomedical research may generate knowledge with potential for both beneficial and harmful application. Before participating in research, physician-researchers should assess foreseeable ramifications of their research in an effort to balance the promise of benefit from biomedical innovation against potential harms from corrupt application of the findings.

In exceptional cases, assessment of the balance of future harms and benefits of research may preclude participation in the research; for instance, when the goals of research are antithetical to the foundations of the medical profession, as with the development of biological or chemical weapons. Properly designed biomedical research to develop defenses against such weapons is ethical.

The potential harms associated with some research may warrant regulatory oversight. Physician-researchers have a responsibility not only to adhere to standards for research, but also to lend their expertise to the development of safeguards and oversight mechanisms, both nationally and internationally. Oversight mechanisms should balance the need to advance science with the risk of malevolent application.

After research has been conducted, consideration should be given to the risk of unrestricted dissemination of the results. Only under rare circumstances should findings be withheld, and then only to the extent required to reasonably protect against dangerous misuse.

These ethical principles should be part of the education and training of all physicians involved in biomedical research. (II, III, V, VII) Issued December 2004 based on the report "Guidelines to Prevent Malevolent Use of Biomedical Research," adopted June 2004.

E-2.079 Safeguards in the Use of DNA Databanks in Genomic Research

The following safeguards should be applied to the use of databases for the purpose of population-based genomic research:
(1) Physicians who participate as investigators in genomic research should have adequate training in genomic research and related ethical issues so as to be able to discuss these issues with patients and/or potential research subjects.
(2) If research is to be conducted within a defined subset of the general population, that is, an identifiable community, then investigators should consult with the community to design a study that will minimize harm not only for individual subjects, but also for the community. When substantial opposition to the research is expressed within the community, investigators should not conduct the study. When the community supports a proposal, investigators nevertheless should obtain individual consent in the usual manner. The same procedure should be followed whether the investigators intend to collect new samples and data or whether they wish to use

previously archived data sets.
(3) When obtaining the informed consent of individuals to participate in genomic research, standard informed consent requirements apply (see Opinion 2.07, "Clinical Investigation"). In addition:
(a) Special emphasis should be placed on disclosing the specific standards of privacy contained in the study: whether the material will be coded (ie: encrypted so that only the investigator can trace materials back to specific individuals) or be completely de-identified (ie: stripped of identifiers).
(b) If data are to be coded, subjects should be told whether they can expect to be contacted in the future to share in findings or to consider participating in additional research, which may relate to the current protocol or extend to other research purposes.
(c) Individuals should always be free to refuse the use of their biological materials in research, without penalty.
(d) Disclosure should include information about whether investigators or subjects stand to gain financially from research findings (see Opinion 2.08, "Commercial Use of Human Tissue"). Such disclosure should refer to the possible conflicts of interest of the investigators (see Opinion 8.0315, "Managing Conflicts of Interest in the Conduct of Clinical Trials").
(e) Subjects should be informed of when, if ever, and how archived information and samples will be discarded.
(4) To strengthen the protection of confidentiality, genomic research should not be conducted using information and samples that identify the individuals from whom they were obtained (ie: by name or social security number). Furthermore, to protect subsets of the population from such harms as stigmatization and discrimination, demographic information not required for the study's purposes should be coded. (I, IV, V, VII) Issued June 2002 based on the report "The Use of DNA Databanks in Genomic Research: The Imperative of Informed Consent,"adopted December 2001.

E-2.08 Commercial Use of Human Tissue

The rapid growth of the biotechnology industry has resulted in the commercial availability of numerous therapeutic and other products developed from human tissue. Physicians contemplating the commercial use of human tissue should abide by the following guidelines:
(1) Informed consent must be obtained from patients for the use of organs or tissues in clinical research.
(2) Potential commercial applications must be disclosed to the patient before a profit is realized on products developed from biological materials.
(3) Human tissue and its products may not be used for commercial purposes without the informed consent of the patient who provided the original cellular material.
(4) Profits from the commercial use of human tissue and its products may be shared with patients, in accordance with lawful contractual agreements.
(5) The diagnostic and therapeutic alternatives offered to patients by their physicians should conform to standards of good medical practice and should not be influenced in any way by the commercial potential of the patient's tissue. (II, V) Issued June 1994 based on the report "Who Should Profit from the Economic Value of Human Tissue? An Ethical Analysis," adopted June 1990.

E-2.09 Costs

While physicians should be conscious of costs and not provide or prescribe unnecessary medical services, concern for the quality of care the patient receives should be the physician's first consideration. This does not preclude the physician, individually or through medical or other organizations, from participating in policy-making with respect to social and economic issues affecting health care. (I, VII) Issued March 1981; Updated June 1994 and June 1998; Updated December 2003.

E-2.095 The Provision of Adequate Health Care

Because society has an obligation to make access to an adequate level of health care available to all of its members regardless of ability to pay, physicians should contribute their expertise at a policy-making level to help achieve this goal. In determining whether particular procedures or treatments should be included in the adequate level of health care, the following ethical principles should be considered: (1) degree of benefit (the difference in outcome between treatment and no treatment), (2) likelihood of benefit, (3) duration of benefit, (4) cost, and (5) number of people who will benefit (referring to the fact that a treatment may benefit the patient and others who come into contact with the patient, as with a vaccination or antimicrobial drug).
Ethical principles require that a just process be used to determine the adequate level of health care. To ensure justice, the process for determining the adequate level of health care should include the following considerations: (1) democratic decision making with broad public input at both the developmental and final approval stages, (2) monitoring for variations in care that cannot be explained on medical grounds with special attention to evidence of discriminatory impact on historically disadvantaged groups, and (3) adjustment of the adequate level over time to ensure continued and broad public acceptance.
Because of the risk that inappropriate biases will influence the content of the basic benefits package, it may be desirable to avoid rigid or precise formulas to define the specific components of the basic benefits package. After applying the five ethical values listed above, it will be possible to designate some kinds of care as either clearly basic or clearly discretionary. However, for care that is not clearly basic or discretionary, seemingly objective formulas may result in choices that are inappropriately biased. For that care, therefore, it may be desirable to give equal consideration (eg, through a process of random selection) to the different kinds of care when deciding which will be included in the basic benefits package. The mechanism for providing an adequate level of health care should ensure that the health care benefits for the poor will not be eroded over time. (VII) Issued June 1994 based on the report "Ethical Issues in Health System Reform: The Provision of Adequate Health Care," adopted December 1993 (JAMA. 1994; 272: 1056-62).

E-2.10 Fetal Research Guidelines

The following guidelines are offered as aids to physicians when they are engaged in fetal research:

(1) Physicians may participate in fetal research when their activities are part of a competently designed program, under accepted standards of scientific research, to produce data which are scientifically valid and significant.

(2) If appropriate, properly performed clinical studies on animals and nongravid humans should precede any particular fetal research project.

(3) In fetal research projects, the investigator should demonstrate the same care and concern for the fetus as a physician providing fetal care or treatment in a non-research setting.

(4) All valid federal or state legal requirements should be followed.

(5) There should be no monetary payment to obtain any fetal material for fetal research projects.

(6) Competent peer review committees, review boards, or advisory boards should be available, when appropriate, to protect against the possible abuses that could arise in such research.

(7) Research on the so-called dead fetus, macerated fetal material, fetal cells, fetal tissue, or fetal organs should be in accord with state laws on autopsy and state laws on organ transplantation or anatomical gifts.

(8) In fetal research primarily for treatment of the fetus:
(a) Voluntary and informed consent, in writing, should be given by the gravid woman, acting in the best interest of the fetus.
(b) Alternative treatment or methods of care, if any, should be carefully evaluated and fully explained. If simpler and safer treatment is available, it should be pursued.

(9) In research primarily for treatment of the gravid female:
(a) Voluntary and informed consent, in writing, should be given by the patient.
(b) Alternative treatment or methods of care should be carefully evaluated and fully explained to the patient. If simpler and safer treatment is available, it should be pursued.
(c) If possible, the risk to the fetus should be the least possible, consistent with the gravid female's need for treatment.

(10) In fetal research involving a fetus in utero, primarily for the accumulation of scientific knowledge:
(a) Voluntary and informed consent, in writing, should be given by the gravid woman under circumstances in which a prudent and informed adult would reasonably be expected to give such consent.
(b) The risk to the fetus imposed by the research should be the least possible.
(c) The purpose of research is the production of data and knowledge which are scientifically significant and which cannot otherwise be obtained.
(d) In this area of research, it is especially important to emphasize that care and concern for the fetus should be demonstrated. (I, III, V) Issued March 1980; Updated June 1994.

E-2.105 Patenting Human Genes

A patent grants the holder the right, for a limited amount of time, to prevent others from commercializing his or her inventions. At the same time, the patent system is designed to foster information sharing. Full disclosure of the invention--enabling another trained in the art to replicate it--is necessary to obtain a patent. Patenting is also thought to encourage private investment into research. Arguments have been made that the patenting of human genomic material sets a troubling precedent for the ownership or commodification of human life. DNA sequences, however, are not tantamount to human life, and it is unclear where and whether qualities uniquely human are found in genetic material.
Genetic research holds great potential for achieving new medical therapies. It remains unclear what role patenting will play in ensuring such development. At this time the Council concludes that granting patent protection should not hinder the goal of developing new beneficial technology and offers the following guidelines:
(1) Patents on processes--for example, processes used to isolate and purify gene sequences, genes and proteins, or vehicles of gene therapy--do not raise the same ethical problems as patents on the substances themselves and are thus preferable.
(2) Substance patents on purified proteins present fewer ethical problems than patents on genes or DNA sequences and are thus preferable.
(3) Patent descriptions should be carefully constructed to ensure that the patent holder does not limit the use of a naturally occurring form of the substance in question. This includes patents on proteins, genes, and genetic sequences.

One of the goals of genetic research is to achieve better medical treatments and technologies. Granting patent protection should not hinder this goal. Individuals or entities holding patents on genetic material should not allow patents to languish and should negotiate and structure licensing agreements in such a way as to encourage the development of better medical technology. (V, VII) Issued June 1998 based on the report "Patenting the Human Genome," adopted December 1997.

E-2.11 Gene Therapy

Gene therapy involves the replacement or modification of a genetic variant to restore or enhance cellular function or to improve the reaction of non-genetic therapies.

Two types of gene therapy have been identified: (1) somatic cell therapy, in which human cells other than germ cells are genetically altered, and (2) germ line therapy, in which a replacement gene is integrated into the genome of human gametes or their precursors, resulting in expression of the new gene in the patient's offspring and subsequent generations. The fundamental difference between germ line therapy and somatic cell therapy is that germ line therapy affects the welfare of subsequent generations and may be associated with increased risk and the potential for unpredictable and irreversible results. Because of the far-reaching implications of germ line therapy, it is appropriate to limit genetic intervention to somatic cells at this time.

The goal of both somatic cell and germ line therapy is to alleviate human suffering and disease by remedying disorders for which available therapies are not satisfactory. This goal should be pursued only within the ethical tradition of medicine, which gives primacy to the welfare of the patient whose safety and well-being must be vigorously protected. To the extent possible, experience with animal studies must be sufficient to assure the effectiveness and safety of the techniques used, and the predictability of the results.

Moreover, genetic manipulation generally should be utilized only for therapeutic purposes. Efforts to enhance "desirable" characteristics through the insertion of a modified or additional gene, or efforts to "improve" complex human traits--the eugenic development of offspring--are contrary not only to the ethical tradition of medicine, but also to the egalitarian values of our society. Because of the potential for abuse, genetic manipulation to affect non-disease traits may never be acceptable and perhaps should never be pursued. If it is ever allowed, at least three conditions would have to be met before it could be deemed ethically acceptable: (1) there would have to be a clear and meaningful benefit to the person, (2) there would have to be no trade-off with other characteristics or traits, and (3) all citizens would have to have equal access to the genetic technology, irrespective of income or other socioeconomic characteristics. These criteria should be viewed as a minimal, not an exhaustive, test of the ethical propriety of non-disease-related genetic intervention. As genetic technology and knowledge of the human genome develop further, additional guidelines may be required.

As gene therapy becomes feasible for a variety of human disorders, there are several practical factors to consider to ensure safe application of this technology in society. First, any gene therapy research should meet the Council's guidelines on clinical investigation (Opinion 2.07, "Clinical Investigation") and investigators must adhere to the standards of medical practice and professional responsibility. The proposed procedure must be fully discussed with the patient and the written informed consent of the patient or the patient's legal representative must be voluntary. Investigators must be thorough in their attempts to eliminate any unwanted viral agents from the viral vector containing the corrective gene. The potential for adverse effects of the viral delivery system must be disclosed to the patient. The effectiveness of gene therapy must be evaluated fully, including the determination of the natural history of the disease and follow-up examination of subsequent generations. Gene therapy should be pursued only after the availability or effectiveness of other possible therapies is found to be insufficient. These considerations should be reviewed, as appropriate, as procedures and scientific information develop. (I, V) Issued December 1988; Updated June 1994 based on the report "Prenatal Genetic Screening," adopted December 1992 (Arch Fam Med. 1994; 2: 633-642), and updated June 1996.

E-2.12 Genetic Counseling

Three primary areas of prenatal genetic testing are (1) screening or evaluating prospective parents for genetic disease before conception to predict the likelihood of conceiving an affected child; (2) analysis of a pre-embryo at the preimplantation stage of artificial reproductive techniques; and (3) in utero testing after conception, such as ultrasonography, amniocentesis, fetoscopy, and chorionic villus sampling, to determine the condition of the fetus. Physicians engaged in genetic counseling are ethically obligated to provide prospective parents with the basis for an informed decision for childbearing. Counseling should include reasons for and against testing as well as discussion of inappropriate uses of genetic testing. Prenatal genetic testing is most appropriate for women or couples whose medical histories or family backgrounds indicate an elevated risk of fetal genetic disorders. Women or couples without an elevated risk of genetic disease may legitimately request prenatal diagnosis, provided they understand and accept the risks involved. When counseling prospective parents, physicians should avoid the imposition of their personal moral values and the substitution of their own moral judgment for that of the prospective parents.

The physician should be aware that where a genetic defect is found in the fetus, prospective parents may request or refuse an abortion. Physicians who consider the legal and ethical requirements applicable to genetic counseling to be in conflict with their moral values and conscience may choose to limit their services to preconception diagnosis and advice or not provide any genetic services. However, the physician who is so disposed is nevertheless obligated to alert prospective parents when a potential genetic problem does exist, so that the patient may decide whether to seek further genetic counseling from another qualified specialist.

Genetic selection refers to the abortion or discard of a fetus or pre-embryo with a genetic abnormality. In general, it is ethically permissible for physicians to participate in genetic selection to prevent, cure, or treat genetic disease. However, selection to avoid a genetic disease may not always be appropriate, depending on factors such as the severity of the disease, the probability of its occurrence, the age at onset, and the time of gestation at which selection would occur. It would not be ethical to engage in selection on

the basis of non-disease-related characteristics or traits. (II, IV, V, VI) Issued June 1983; Updated June 1994 based on the report "Prenatal Genetic Screening," adopted December 1992 (Arch Fam Med. 1994; 3: 633-642).

E-2.13 Genetic Engineering.

The Federal Recombinant DNA Advisors Committee and the Food and Drug Administration oversee and regulate gene splicing, recombinant DNA research, chemical synthesis of DNA molecules, and other genetic engineering research. However, for genetic engineering technologies that represent a significant departure from familiar practices there should be independent input from the scientific community, organized medicine, industry, the public, and others, in addition to the federal government, to prevent abuse from any sector of society, private or public. Such departures include the use of novel vectors, gene transfer in utero, potential germ line modification, and gene transfer to normal volunteers.
If and when gene replacement with normal DNA becomes a practical reality for the treatment of human disorders, the following factors should be considered:
(1) If procedures are performed in a research setting, reference should be made to the Council's guidelines on clinical investigation.
(2) If procedures are performed in a non-research setting, adherence to usual and customary standards of medical practice and professional responsibility would be required.
(3) Full discussion of the proposed procedure with the patient would be required. The consent of the patient or the patient's legal representative should be informed, voluntary and written.
(4) There must be no hazardous or other unwanted virus on the viral DNA containing the replacement or corrective gene.
(5) The inserted DNA must function under normal control within the recipient cell to prevent metabolic damage that could damage tissue and the patient.
(6) The effectiveness of the gene therapy should be evaluated as well as possible. This will include determination of the natural history of the disease and follow-up examination of subsequent generations.
(7) Such procedures should be undertaken in the future only after careful evaluation of the availability and effectiveness of other possible therapy. If simpler and safer treatment is available, it should be pursued.
(8) These considerations should be reviewed, as appropriate, as procedures and scientific information are developed in the future. (I, V, VII) Issued March 1980; Updated June 1996.

E-2.131 Disclosure of Familial Risk in Genetic Testing

(1) Physicians have a professional duty to protect the confidentiality of their patients' information, including genetic information.
(2) Pre- and post-test counseling must include implications of genetic information for patients' biological relatives. At the time patients are considering undergoing genetic testing, physicians should discuss with them whether to invite family members to participate in the testing process. Physicians also should identify circumstances under which they would expect patients to notify biological relatives of the availability of information related to risk of disease. In this regard, physicians should make themselves available to assist patients in communicating with relatives to discuss opportunities for counseling and testing, as appropriate.
(3) Physicians who order genetic tests should have adequate knowledge to interpret information for patients. In the absence of adequate expertise in pre-test and post-test counseling, a physician should refer the patient to an appropriate specialist.
(4) Physicians should encourage genetic education throughout a medical career. (I, IV, V, VIII) Issued December 2003 based on the report "Disclosure of Familial Risk in Genetic Testing," adopted June 2003.

E-2.132 Genetic Testing by Employers

As a result of the human genome project, physicians will be able to identify a greater number of genetic risks of disease. Among the potential uses of the tests that detect these risks will be screening of potential workers by employers. Employers may want to exclude workers with certain genetic risks from the workplace because these workers may become disabled prematurely, impose higher health care costs, or pose a risk to public safety. In addition, exposure to certain substances in the workplace may increase the likelihood that a disease will develop in the worker with a genetic risk for the disease.
(1) It would generally be inappropriate to exclude workers with genetic risks of disease from the workplace because of their risk. Genetic tests alone do not have sufficient predictive value to be relied upon as a basis for excluding workers. Consequently, use of the tests would result in unfair discrimination against individuals who have positive test results. In addition, there are other ways for employers to serve their legitimate interests. Tests of a worker's actual capacity to meet the demands of the job can be used to ensure future employability and protect the public's safety. Routine monitoring of a worker's exposure can be used to protect workers who have a genetic susceptibility to injury from a substance in the workplace. In addition, employees should be advised of the risks of injury to which they are being exposed.
(2) There may be a role for genetic testing in the exclusion from the workplace of workers who have a genetic susceptibility to injury. At a minimum, several conditions would have to be met:
(a) The disease develops so rapidly that serious and irreversible injury would occur before monitoring of either the worker's exposure to the toxic substance or the worker's health status could be effective in preventing the harm.
(b) The genetic testing is highly accurate, with sufficient sensitivity and specificity to minimize the risk of false negative and false positive test results.
(c) Empirical data demonstrate that the genetic abnormality results in an unusually elevated susceptibility to occupational injury.

(d) It would require undue cost to protect susceptible employees by lowering the level of the toxic substance in the workplace. The costs of lowering the level of the substance must be extraordinary relative to the employer's other costs of making the product for which the toxic substance is used. Since genetic testing with exclusion of susceptible employees is the alternative to cleaning up the workplace, the cost of lowering the level of the substance must also be extraordinary relative to the costs of using genetic testing.
(e) Testing must not be performed without the informed consent of the employee or applicant for employment. (IV) Issued June 1991 based on the report "Genetic Testing by Employers," adopted June 1991 (JAMA 1991; 266: 1827-1830).

E-2.135 Insurance Companies and Genetic Information

Physicians should not participate in genetic testing by health insurance companies to predict a person's predisposition for disease. As a corollary, it may be necessary for physicians to maintain separate files for genetic testing results to ensure that the results are not sent to health insurance companies when requests for copies of patient medical records are fulfilled. Physicians who withhold testing results should inform insurance companies that, when medical records are sent, genetic testing results are not included. This disclosure should occur with all patients, not just those who have undergone genetic testing. (IV) Issued June 1994 based on the report "Physician Participation in Genetic Testing by Health Insurance Companies," adopted June 1993; Updated June 1996.

E-2.136 Genetic Information and the Criminal Justice System

The release of genetic information from a physician's records without the consent of the patient constitutes a breach of confidentiality. Opinion 5.05, "Confidentiality," acknowledges that law and overriding social considerations may permit physicians to disclose confidential information in limited circumstances. However, such circumstances present ethical challenges. The following guidelines are intended to aid physicians in considering the ethical basis for the release of genetic information to the criminal justice system:
(1) Physicians should release a patient's genetic information only with the patient's consent or in compliance with a warrant or other order of a court of law. The circumstances in which law enforcement may seek a suspect's genetic information from the suspect's physician depend on whether any specific suspect has been identified, and if the suspect is in custody.
(a) If law enforcement personnel have identified a suspect and the suspect cannot be located to provide a genetic sample, physicians should release clinical genetic information only when a warrant or court order mandates such a release.
(b) When law enforcement personnel have identified a suspect, and the suspect has been located but refuses to provide a sample or is deceased (but his or her body is available), physicians should not be required to release genetic information as in these circumstances a court can authorize collection of a sample from the suspect or from postmortem tissue.
(c) Searching clinical and research databases of genetic information, or extracting and analyzing DNA from clinical or research tissue repositories, should not be conducted for the mere possibility that there is a match to a suspect's DNA unless there is a warrant or court order to do so.
(2) When genetic information is provided to the judicial system, physicians should provide the minimum amount of information necessary for the explicit identification procedure being performed. Other elements of the medical record or the results of any genetic testing or genetic diagnosis should not be released without the patient's consent or further warrant or order of the court.
(3) It is unethical for any genetic information obtained from a physician for identification purposes to be used subsequently for other purposes, such as research, unless appropriate ethical guidelines are followed and the informed consent of the individual is obtained (or the legally appropriate surrogate if the individual is incompetent or deceased, in compliance with Opinion 5.051, "Confidentiality of Medical Information Postmortem").
(4) Databases that contain only the genetic identifiers from the specific loci that are typically used for identification purposes do not present the same ethical concerns that are presented by databases which contain genotypic or phenotypic information. Physicians participating in the creation of genetic databases for the exclusive use of the criminal justice system should ensure that the database is not used inappropriately for purposes other than identification.
(5) In general, requiring that the genetic sample be destroyed or returned after the analysis necessary for identification is performed affords protection against inappropriate uses.
(6) When the criminal justice system seeks genetic information for the purposes of identifying a deceased victim, the above relevant guidelines also apply. (III, IV) Issued June 2001 based on the report "Genetic Information and the Criminal Justice System," adopted June 2000. (J. Law, Med. & Ethics. 2002: 30; 88-94).

E-2.137 Ethical Issues in Carrier Screening of Genetic Disorders

All carrier testing must be voluntary, and informed consent from screened individuals is required. Confidentiality of results is to be maintained. Results of testing should not be disclosed to third parties without the explicit informed consent of the screened individual. Patients should be informed as to potential uses for the genetic information by third parties, and whether other ways of obtaining the information are available when appropriate.
Carrier testing should be available uniformly among the at-risk population being screened. One legitimate exception to this principle is the limitation of carrier testing to individuals of childbearing age. In pursuit of uniform access, physicians should not limit testing only to patients specifically requesting testing. If testing is offered to some patients, it should be offered to all patients within the same risk category.
The direction of future genetic screening tests should be determined by well-thought-out and well-coordinated social policy. Third parties, including insurance companies or employers, should not be permitted to discriminate against carriers of genetic disorders

through policies which have the ultimate effect of influencing decisions about testing and reproduction. (IV, V) Issued June 1994 based on the report "Ethical Issues in Carrier Screening for Cystic Fibrosis and Other Genetic Disorders," adopted June 1991.

E-2.138 Genetic Testing of Children

Genetic testing of children implicates important concerns about individual autonomy and the interest of the patients. Before testing of children can be performed, there must be some potential benefit from the testing that can reasonably be viewed as outweighing the disadvantages of testing, particularly the harm from abrogating the children's future choice in knowing their genetic status. When there is such a potential benefit, parents should decide whether their children will undergo testing. If parents unreasonably request or refuse testing of their child, the physician should take steps to change or, if necessary, use legal means to override the parents' choice. Applying these principles to specific circumstances yields the following conclusions:
(1) When a child is at risk for a genetic condition for which preventive or other therapeutic measures are available, genetic testing should be offered or, in some cases, required.
(2) When a child is at risk for a genetic condition with pediatric onset for which preventive or other therapeutic measures are not available, parents generally should have discretion to decide about genetic testing.
(3) When a child is at risk for a genetic condition with adult onset for which preventive or other therapeutic measures are not available, genetic testing of children generally should not be undertaken. Families should still be informed of the existence of tests and given the opportunity to discuss the reasons why the tests are generally not offered for children.
(4) Genetic testing for carrier status should be deferred until either the child reaches maturity, the child needs to make reproductive decisions, or, in the case of children too immature to make their own reproductive decisions, reproductive decisions need to be made for the child.
(5) Genetic testing of children for the benefit of a family member should not be performed unless the testing is necessary to prevent substantial harm to the family member.

When a child's genetic status is determined incidentally, the information should be retained by the physician and entered into the patient record. Discussion of the existence of this finding should then be taken up when the child reaches maturity or needs to make reproductive decisions, so that the individual can decide whether to request disclosure of the information. It is important that physicians be consistent in disclosing both positive and negative results in the same way since if physicians raise the existence of the testing results only when the results are positive, individuals will know what the results must be. This information should not be disclosed to third parties. Genetic information should be maintained in a separate portion of the medical record to prevent mistaken disclosure.
When a child is being considered for adoption, the guidelines for genetic testing should be the same as for other children. (IV) Issued June 1996 based on the report "Testing Children for Genetic Status," adopted June 1995.

E-2.139 Multiplex Genetic Testing

Multiplex testing--where tests are offered for several different medical conditions in a single session--presents a series of challenges to adequate communication between the patient and the physician. It increases the total number of marginally indicated or non-indicated tests, thereby bolstering the rate of false results. These results may lead to psychological stress and misinformed life-altering decisions, and may also impact the ability of a physician to obtain informed consent. Multiplex testing and its resultant information may also have widespread societal implications that include discriminatory practices against not only individuals but specific ethnic groups that have been designated "at risk" populations.
Before such tests reach health care providers, clinics, and drugstores, the ethical and social implications of these tests must be well-understood, and careful restrictions and regulations must be established. The following guidelines are offered on the future possibilities of multiplex genetic testing:
(1) Physicians should not routinely order tests for multiple genetic conditions.
(2) Tests for more than one genetic condition should be ordered only when clinically relevant and after the patient has had full counseling and has given informed consent for each test.
(3) Efforts should be made to educate clinicians and society about the uncertainty surrounding genetic testing. (IV, V) Issued June 1998 based on the report "Multiplex Genetic Testing," adopted December 1996 (Hastings Center Report. 1998; 28(4): 15-21).

E-2.14 In Vitro Fertilization

The technique of in vitro fertilization and embryo transplantation enables certain couples previously incapable of conception to bear a child. It is also useful in the field of research directed toward an understanding of how genetic defects arise and are transmitted and how they might be prevented or treated. Because of serious ethical and moral concerns, however, any fertilized egg that has the potential for human life and that will be implanted in the uterus of a woman should not be subjected to laboratory research.
All fertilized ova not utilized for implantation and that are maintained for research purposes shall be handled with the strictest adherence to the Principles of Medical Ethics, to the guidelines for research and medical practice expressed in the Council's opinion on fetal research, and to the highest standards of medical practice. (I, V, VII) Issued June 1983.

E-2.141 Frozen Pre-Embryos

The practice of freezing extra pre-embryos harvested during the in vitro fertilization process (IVF) has enhanced the ability of infertile couples to preserve embryos for future implantation. This practice has also posed a number of ethical and legal dilemmas, including questions regarding decision-making authority over the pre-embryos and appropriate uses of pre-embryos.

This country's cultural and legal traditions indicate that the logical persons to exercise control over a frozen pre-embryo are the woman and man who provided the gametes (the ovum and sperm). The gamete providers have a fundamental interest at stake, their potential for procreation. In addition, the gamete providers are the parties most concerned with the interests of a frozen pre-embryo and most likely to protect those interests.

Gamete providers should be able to use the pre-embryos themselves or donate them for use by other parties, but not sell them. In addition, research on pre-embryos should be permitted as long as the pre-embryos are not destined for transfer to a woman for implantation and as long as the research is conducted in accordance with the Council's guidelines on fetal research. Frozen pre-embryos may also be allowed to thaw and deteriorate.

The gamete providers should have an equal say in the use of their pre-embryos and, therefore, the pre-embryos should not be available for use by either provider or changed from their frozen state without the consent of both providers. The man and woman each has contributed half of the pre-embryo's genetic code. In addition, whether a person chooses to become a parent and assume all of the accompanying obligations is a particularly personal and fundamental decision. Even if the individual could be absolved of any parental obligations, he or she may have a strong desire not to have offspring. The absence of a legal duty does not eliminate the moral duty many would feel toward any genetic offspring.

Advance agreements are recommended for deciding the disposition of frozen pre-embryos in the event of divorce or other changes in circumstances. Advance agreements can help ensure that the gamete providers undergo IVF and pre-embryo freezing after a full contemplation of the consequences but should not be mandatory. (I, III, IV, V) Issued March 1992 based on the report "Frozen Pre-Embryos," adopted December 1989 (JAMA. 1990; 263: 2484-2487); Updated June 1994.

E-2.145 Pre-Embryo Splitting

The technique of splitting in vitro fertilized pre-embryos may result in multiple genetically identical siblings.

The procedure of pre-embryo splitting should be available so long as both gamete providers agree. This procedure may greatly increase the chances of conception for an infertile couple or for a couple whose future reproductive capacity will likely be diminished. Pre-embryo splitting also can reduce the number of invasive procedures necessary for egg retrieval and the necessity for hormonal stimulants to generate multiple eggs. The use and disposition of any pre-embryos that are frozen for future use should be consistent with the Council's opinion on frozen pre-embryos (Opinion 2.141, "Frozen Pre-embryos").

The use of frozen pre-embryo identical siblings many years after one child has been born raises new ethical issues. Couples might wait until they can discover the mental and physical characteristics of a child before transferring a genetically identical sibling for implantation, they might sell their frozen pre-embryos based upon the outcome of a genetically identical child, or they might decide to transplant a genetically identical sibling based on the need to harvest the child's tissue.

The Council does not find that these considerations are sufficient to prohibit pre-embryo splitting for the following reasons:

(1) It would take many years to determine the outcome of a child and most families want to complete their childbearing within a shorter time.

(2) The sale of pre-embryos can and should be prohibited.

(3) The small number of couples who might bear identical siblings solely for purposes of harvesting their tissue does not outweigh the benefits which might be derived from pre-embryo splitting. Additionally, it is not evident that a sibling would have negative psychological or emotional consequences from having acted as an organ or tissue donor. Indeed, the child may derive psychological benefits from having saved the life of a sibling.

To the extent possible, discussion of these issues should be had with gamete providers prior to pre-embryo splitting and freezing so as to inform the prospective parents of possible future ethical dilemmas. (I, III, IV, V) Issued June 1994.

E-2.146 Cloning-for-Biomedical-Research

Stem cells derived from cloned human embryos resulting from somatic cell nuclear transfer technology are promising as a potential source of treatment in a wide range of diseases. However, much controversy arises from the necessity to destroy embryos in order to extract their stem cells for use in biomedical research. The conflict centers on the moral status of embryos, a question that divides ethical opinion and that cannot be resolved by medical science.

(1) While the pluralism of moral visions that underlie this debate must be respected, physicians collectively must continue to be guided by their paramount obligation to the welfare of their patients. In this light, cloning-for-biomedical-research is consistent with medical ethics. Every physician remains free to decide whether to participate in stem cell research or to use its products.

(2) Cloning-for-biomedical-research requires appropriate oversight and monitoring. At a minimum, not only is the oversight of an institutional review board required, but also that of a regulatory body, such as the Office for Human Research Protections, to monitor progress in the field, assist in developing relevant guidelines, and ensure that the technique of cloning-for-biomedical-research is used only if uniquely promising.

(3) Informed consent by subjects participating in cloning-for-biomedical-research is governed by standard principles: voluntary

participation and disclosure of all relevant risks and benefits to subjects. Disclosure to the donor of the oocyte and the donor of the somatic cell also must include:
(a) Description of the procurement procedures specific to the donor
(b) Statement of the intention to create a cloned human embryo through introduction of the somatic cell's nucleus into the enucleated egg for research purposes (and not for transfer to a woman's uterus)
(c) Acknowledgment that the extraction of stem cells will require the cloned embryo's destruction
(d) The intention to derive immortal cell lines from the stem cells to be used in research and possibly in therapeutic contexts; primary and secondary uses should be disclosed and individuals should be free to refuse the use of their biological materials for specified purposes
(e) Potential commercial uses and patent or ownership issues (as described in Opinion E-2.08, "Commercial Use of Human Tissue")
(4) The informed consent process for potential recipients of stem cells derived from cloned embryos should conform with ethical standards outlined in the Council on Ethical and Judicial Affairs' Opinion E-2.07, "Clinical Investigation," and address additional disclosures including provenance of stem cells.
(5) Due to the possibilities of contamination by infectious agents from other species and damage to DNA during growth of new tissues and organs, products of cloning-for-biomedical-research raise ethical concerns similar to those surrounding xenotransplantation. Therefore, the informed consent process for potential recipients of these products also should conform to Opinion E-2.169, "The Ethical Implications of Xenotransplantation." (V) Issued December 2003 based on the report "Cloning-for-Biomedical-Research," adopted June 2003.

E-2.147 Cloning to Produce Children

Somatic cell nuclear transfer (SCNT) is the process in which the nucleus of a somatic cell of an organism is transferred into an enucleated oocyte. "Cloning-to-produce-children" is the application of SCNT to the creation of a human being that shares all of its nuclear genes with the donor of the human somatic cell.

To clarify the many existing misconceptions about this use of cloning, physicians should help educate the public about the intrinsic limits of cloning-to-produce-children as well as about the current ethical and legal protections that would prevent certain uses of cloned human embryos. These include the following:
(1) Using cloning-to-produce-children as an approach to replicate a person (the donor of the somatic cell) is a concept based on the mistaken notion that one's genotype largely determines one's individuality. A cloned child created via this process would not be identical to the donor of the somatic cell.
(2) Current ethical and legal standards hold that under no circumstances should any use of cloning occur without informed consent from the somatic cell and the oocyte donor(s).
(3) Current ethical and legal standards hold that a child produced from a clone would be entitled to the same rights, freedoms, and protections as every other individual in society. The fact that a human clone's nuclear genes would derive from a single individual rather than two would not change its moral standing.

Physicians have an ethical obligation to consider the harms and benefits of new medical procedures and technologies. Physicians should not participate in cloning-to-produce-children at this time because further investigation and discussion regarding the harms and benefits of this use of cloning are required. Concerns include:
(1) Unknown physical harms introduced by SCNT technology. SCNT has not yet been refined and its long-term safety has not yet been proven. The risk of producing individuals with genetic anomalies gives rise to an obligation to seek better understanding of—and potential medical therapies for—the unforeseen medical consequences that could stem from cloning-to-produce-children.
(2) Psychosocial harms introduced by cloning, including violations of privacy and autonomy. Cloning-to-produce children risks limiting, at least psychologically, the seemingly unlimited potential of new human beings and thus creating enormous pressures on the cloned child to live up to expectations based on the life of the somatic cell donor.
(3) The impact of cloning-to-produce-children on familial and societal relations. The family unit may be altered with the introduction of this use of cloning, and more thought is required on a societal level regarding how to construct familial relations.
(4) Potential effects on the gene pool. Like other interventions that can change individuals' reproductive patterns and the resulting genetic characteristics of a population, cloning-to-produce-children has the potential to be used in a eugenic or discriminatory fashion—practices that are incompatible with the ethical norms of medical practice. Moreover, cloning-to-produce-children could alter irreversibly the gene pool and exacerbate genetic problems that arise from deleterious genetic mutations, resulting in harms to future generations.

Two potentially realistic and possibly appropriate medical uses of cloning-to-produce-children are for assisting individuals or couples to reproduce and for generating tissues when the donor is not harmed or sacrificed. Given the unresolved issues regarding cloning identified above, the medical profession should not undertake cloning-to-produce-children at this time and pursue alternative approaches that raise fewer ethical concerns.

Because SCNT technology is not limited to the United States, physicians should help establish international guidelines governing uses. (V) Issued December 1999 based of the report "The Ethics of Human Cloning," adopted June 1999; updated December 2003, based on the report "Cloning for Biomedical Research," adopted June 2003.

E-2.15 Transplantation of Organs from Living Donors

Living organ donors are exposed to surgical procedures that pose risks but offer no physical benefits. The medical profession has pursued living donation because the lives and quality of life of patients with end-stage organ failure depend on the availability of transplantable organs and some individuals are willing to donate the needed organs. This practice is consistent with the goals of the profession--treating illness and alleviating suffering--only insofar as the benefits to both donor and recipient outweigh the risks to both.

(1) Because donors are initially healthy and then are exposed to potential harms, they require special safeguards. Accordingly, every donor should be assigned an advocate team that includes a physician. This team is primarily concerned with the well-being of the donor. Though some individuals on the donor advocate team may participate in the care of the recipient, this team ideally should be as independent as possible from those caring for the recipient. This can help avoid actual or perceived conflicts of interest between donors and recipients.

(a) To determine whether a potential living donor is an appropriate candidate, the advocate team must provide a complete medical evaluation to identify any serious risk to the potential donor's life or health. This includes a psychosocial evaluation of the potential donor to identify disqualifying factors, address specific needs and explore potential motivations to donate.

(b) Before the potential donor agrees to donate, the advocate team should provide information regarding the donation procedure and its indications, as well as the risks and potential complications to both donor and recipient. Informed consent for donation is distinct from informed consent for the actual surgery to remove the organ.

(i) The potential donor must have decision-making capacity, and the decision to donate must be free from undue pressure. The potential donor must demonstrate adequate understanding of the disclosed information.

(ii) Unemancipated minors and legally incompetent adults ordinarily should not be accepted as living donors because of their inability to fully understand and decide voluntarily. However, in exceptional circumstances and with the informed consent of their legal guardians, they may be considered for donation to recipients with whom they are emotionally connected. Under no circumstance should individuals without full decision-making capacity be allowed to serve as living donors to strangers.

(iii) Potential donors must be informed that they may withdraw from donation at any time before undergoing the operation and that, should this occur, the health care team is committed to protect the potential donor from pressures to reveal the reasons for withdrawal. If the potential donor withdraws, the health care team should report simply that the individual was unsuitable for donation. From the outset, all involved parties must agree that the reasons why any potential donor does not donate will remain confidential for the potential donor's protection.

(c) Living donation should never be considered if the intended recipient's condition is clinically futile.

(2) Living donors should not receive payment for any of their solid organs. However, donors should be treated fairly; reimbursement for travel, lodging, meals, lost wages, and the medical care associated with donation is ethically appropriate.

(3) The distribution of organs from living donors may take several different forms:

(a) It is ethically appropriate for donors to designate a recipient, whether a close relative or a known, unrelated recipient.

Designation of a stranger as the intended recipient is ethical if it produces a net gain of organs in the organ pool, without unreasonably disadvantaging others on the waiting list. Variations that have received recent attention involve potential donors who respond to public solicitation for organs or who wish to participate in a paired donation (also known as an organ swap)--e.g., blood type incompatible donor-recipient pairs Y and Z are recombined to make compatible pairs: donor-Y with recipient-Z and donor-Z with recipient-Y.

Such variations require further study and ethical examination to evaluate the potential impact on the fairness of allocation.

(b) Organs donated by living donors who do not designate a recipient should be allocated according to the algorithm that governs the distribution of deceased donor organs.

(4) To enhance the safety of living organ donation through better understanding of the harms and benefits associated with living organ donation, physicians should support the development and maintenance of a national database of living donor outcomes, similar to that of deceased donation. (I, V, VII, VIII) Issued November 2005 based on the report "Transplantation of Organs from Living Donors," adopted June 2005.

E-2.151 Cadaveric Organ Donation: Encouraging the Study of Motivation

Physicians have an obligation to hold their patients' interests paramount and to support access to medical care (Principles VIII and IX). To discharge these obligations, physicians should participate in efforts to increase organ donation including promotion of voluntary donation. Beyond educational programs, however, physicians should support innovative approaches to encourage organ donation. Such efforts may include encouragement of and, if appropriate, participation in the conduct of ethically designed research studies of financial incentives.

Because the potential benefits and harms of financial incentives for cadaveric organ donation are unknown, physicians have an obligation to study financial incentives. Whether or not they are ethical depends upon the balance of benefits and harms that result from them. Physicians should encourage and support pilot studies, limited to relatively small populations, that investigate the effects of financial incentives for cadaveric organ donation for the purpose of examining and possibly revising current policies in the light of scientific evidence.

Pilot studies of the effects of financial incentives for cadaveric organ donation should be implemented only after certain considerations have been met, including:
(1) Consultation and advice is sought from the population within which the pilot study is to take place.
(2) Objectives and strategies as well as sound scientific design, measurable outcomes and set time frames are clearly defined in written protocols that are publicly available and approved by appropriate oversight bodies, such as Institutional Review Boards.
(3) Incentives are of moderate value and at the lowest level that can be reasonably expected to increase organ donation.
(4) Payment for an organ from a living donor is not a part of any study.
(5) Financial incentives apply to cadaveric donation only, and must not lead to the purchase of donated organs; the distribution of organs for transplantation should continue to be governed by United Network for Organ Sharing (UNOS), based on ethically appropriate criteria related to medical need. (I, III, V, VII, VIII, IX) Issued December 2002 based on the report "Cadaveric Organ Donation: Encouraging the Study of Motivation," adopted June 2002, (Transplantation 2003; 76(4): 748-751).

E-2.152 Solicitation of the Public for Directed Donation of Organs for Transplantation

The obligation of physicians to hold their patients' interests paramount and to support access to medical care requires that maximizing the number of medically suitable solid organs for transplantation by ethical means should remain a priority of the medical profession. Donation of organs to specified recipients has been permitted since the beginning of organ transplantation. Although directed donation is permitted under current national policy, solicitation of organs from potential donors who have no preexisting relationship with the recipient is controversial. The following guidelines regarding solicitation of organ donors are offered:

(1) Solicitation of the public for organ donation has unknown effects on the organ supply and on transplant waiting lists. Policies should be based, as far as possible, on facts rather than assumptions, so physicians should support study of the current system and development of policy based on the results of such studies.

(2) Directed donation policies that produce a net gain of organs in the organ pool and do not unreasonably disadvantage others on the waiting list are ethically acceptable, as long as donors receive no payment beyond reimbursement for travel, lodging, lost wages, and the medical care associated with donation.

(3) The health care team must fully evaluate the medical and psychosocial suitability of all potential donors, regardless of the nature of the relationship between the potential donor and transplant candidate.

A physician should resist pressure to participate in a transplant that he or she believes to be ethically improper and should not pressure others to participate if they refuse on ethical or moral grounds. (VII, VIII, IX) Issued November 2006 based on the report "Solicitation of the Public for Directed Donation of Organs for Transplantation," adopted June 2006.

E-2.155 Presumed Consent and Mandated Choice for Organs from Deceased Donors

The supply of organs for transplantation to treat end-stage organ failure is inadequate to meet the clinical need. Therefore, physicians should support the development of policies that will increase the number of organ donors. Two prominent proposals aimed at increasing organ donation would change the approach to consent for deceased donation: mandated choice and presumed consent.

Under a presumed consent model, deceased individuals are presumed to be organ donors unless they indicate their refusal to donate. Such donations would be ethically appropriate only if it could be determined that individuals were aware of the presumption and if effective and easily accessible mechanisms for documenting and honoring refusals to donate were established. Moreover, physicians could proceed with organ procurement only after verifying that there was no documented prior refusal by the decedent and that the family was unaware of any objection to donation by the decedent.

Under a mandated choice model, individuals are required to express their preferences regarding organ donation at the time of

performing a state-regulated task. This contrasts with the widespread model of voluntary organ donation under which individuals are afforded an opportunity to indicate their preferences. A mandated choice model would be ethically appropriate only if an individual's choice were made in accordance with the principles of informed consent, which would require a meaningful exchange of information. Physicians could proceed with organ procurement only after verifying that an individual's consent to donation was documented.

It is not known whether implementation of ethically appropriate models of presumed consent or mandated choice for deceased donation would positively or negatively affect the number of organs transplanted. Therefore, physicians should encourage and support properly designed pilot studies, in relatively small populations, that investigate the effects of these policies. Unless there are data that suggest a positive effect on donation, neither presumed consent nor mandated choice for deceased donation should be widely implemented.

In all models, education of individuals to facilitate informed consent is requisite. (I, III, V) Issued June 1994 based on the report "Strategies for Cadaveric Organ Procurement: Mandated Choice and Presumed Consent," adopted December 1993 (JAMA. 1994; 272: 809-12).

Updated November 2005 based on the report "Presumed Consent for Organ Donation," adopted June 2005.

E-2.157 Organ Donation After Cardiac Death

Given the increasing need for donor organs, protocols for donation after cardiac death (DCD) have been developed. Controlled DCD allows patients who have agreed to be taken off of life support or their surrogate decision makers the opportunity to donate the patients' organs once death has been declared. In these cases, life support is discontinued in or near the operating room so that organs can be removed promptly after death is pronounced. DCD also may be considered from patients who suffer unexpected cardiac death (uncontrolled DCD). It requires that they be cannulated and perfused with cold preservation fluid (*in situ* preservation) within minutes after death to maintain the viability of organs. Both of these methods may be ethically permissible, with attention to certain safeguards.

(1) Hospital policies should specify important details of the DCD process, such as the required time delay before death can be pronounced after cardiac arrest.

(2) In all instances, it is critical to avoid perceived or actual conflicts of interest in the health care team with respect to caring for the patient versus facilitating organ donation. The health care professionals providing care at the end of life should be distinct from those participating on the transplant team. No member of the transplant team may have any role in the decision to withdraw life support or in the process leading to pronouncement of death.

(3) Clear clinical criteria should be in place to ensure that only appropriate candidates, whose organs are reasonably likely to be suitable for transplantation, are considered eligible to donate organs under these protocols.

(4) Palliative care for DCD candidates should continue after removal of life support until death is declared.

(5) In controlled DCD, the decision to withdraw life support should be made by the patient or the patient's surrogate decision maker before any mention of organ donation (unless the patient or surrogate spontaneously broaches the subject). This is meant to ensure that withdrawal of life support is not influenced by the prospect of organ donation.

The informed consent for controlled DCD should include specific discussion of pre-mortem interventions aimed at organ preservation, to improve the opportunity for successful transplantation, rather than to benefit the patient. Interventions that are likely to hasten death must not be used.

(6) In cases of uncontrolled DCD, prior consent of the decedent or consent of the decedent's surrogate decision maker is ethically required. Perfusion without consent to organ donation violates requirements of informed consent for medical procedures and is not permissible. (I, III, V) Issued June 1996 based on the reports "Ethical Issues in the Procurement of Organs Following Cardiac Death: The Pittsburgh Protocol" and "Ethical Issues in Organ Procurement Following Cardiac Death: In Situ Preservation of Cadaveric Organs," adopted December 1994.

Updated November 2005 based on the report "Organ Procurement Following Cardiac Death, *Amendment*," adopted June 2005.

E-2.16 Organ Transplantation Guidelines

The following statement is offered for guidance of physicians as they seek to maintain the highest level of ethical conduct in the transplanting of human organs.
(1) In all professional relationships between a physician and a patient, the physician's primary concern must be the health of the patient. The physician owes the patient primary allegiance. This concern and allegiance must be preserved in all medical procedures,

including those which involve the transplantation of an organ from one person to another where both donor and recipient are patients. Care must, therefore, be taken to protect the rights of both the donor and the recipient, and no physician may assume a responsibility in organ transplantation unless the rights of both donor and recipient are equally protected. A prospective organ transplant offers no justification for a relaxation of the usual standard of medical care for the potential donor.
(2) When a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician. Death shall be determined by the clinical judgment of the physician, who should rely on currently accepted and available scientific tests.
(3) Full discussion of the proposed procedure with the donor and the recipient or their responsible relatives or representatives is mandatory. The physician should ensure that consent to the procedure is fully informed and voluntary, in accordance with the Council's guidelines on informed consent. The physician's interest in advancing scientific knowledge must always be secondary to his or her concern for the patient.
(4) Transplant procedures of body organs should be undertaken (a) only by physicians who possess special medical knowledge and technical competence developed through special training, study, and laboratory experience and practice, and (b) in medical institutions with facilities adequate to protect the health and well-being of the parties to the procedure.
(5) Recipients of organs for transplantation should be determined in accordance with the Council's guidelines on the allocation of limited medical resources.
(6) Organs should be considered a national, rather than a local or regional, resource. Geographical priorities in the allocation of organs should be prohibited except when transportation of organs would threaten their suitability for transplantation.
(7) Patients should not be placed on the waiting lists of multiple local transplant centers, but rather on a single waiting list for each type of organ. (I, III, V) Issued prior to April 1977; Updated June 1994 based on the report "Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients," adopted June 1993.

E-2.161 Medical Applications of Fetal Tissue Transplantation

The principal ethical concern in the use of human fetal tissue for transplantation is the degree to which the decision to have an abortion might be influenced by the decision to donate the fetal tissue. In the application of fetal tissue transplantation the following safeguards should apply: (l) The Council on Ethical and Judicial Affairs' guidelines on clinical investigation and organ transplantation are followed, as they pertain to the recipient of the fetal tissue transplant (see Opinion 2.07, "Clinical Investigation," and Opinion 2.16, "Organ Transplantation Guidelines"); (2) a final decision regarding abortion is made before initiating a discussion of the transplantation use of fetal tissue; (3) decisions regarding the technique used to induce abortion, as well as the timing of the abortion in relation to the gestational age of the fetus, are based on concern for the safety of the pregnant woman; (4) fetal tissue is not provided in exchange for financial remuneration above that which is necessary to cover reasonable expenses; (5) the recipient of the tissue is not designated by the donor; (6) health care personnel involved in the termination of a particular pregnancy do not participate in or receive any benefit from the transplantation of tissue from the abortus of the same pregnancy; and (7) informed consent on behalf of both the donor and the recipient is obtained in accordance with applicable law. (I, IV, V) Issued March 1992 based on the report "Medical Applications of Fetal Tissue Transplantation," adopted June 1989 (JAMA. 1990; 263: 565-570); Updated June 1996.

E-2.162 Anencephalic Neonates as Organ Donors

Anencephaly is a congenital absence of major portion of the brain, skull, and scalp. Anencephalic neonates are thought to be unique from other brain-damaged beings because of a lack of past consciousness with no potential for future consciousness.
Physicians may provide anencephalic neonates with ventilator assistance and other medical therapies that are necessary to sustain organ perfusion and viability until such time as a determination of death can be made in accordance with accepted medical standards, relevant law, and regional organ procurement organization policy. Retrieval and transplantation of the organs of anencephalic infants are ethically permissible only after such determination of death is made, and only in accordance with the Council's guidelines for transplantation. (I, III, V) Issued March 1992 based on the report "Anencephalic Infants as Organ Donors," adopted December 1988; Updated June 1994; Updated December 1994 based on the report "The Use of Anencephalic Neonates as Organ Donors," adopted December 1994; and updated June 1996 based on the report "Anencephalic Infants as Organ Donors - Reconsideration," adopted December 1995.

E-2.165 Umbilical Cord Blood Banking

Umbilical cord blood stem cells are useful for some therapeutic purposes. Physicians providing obstetrical care should be prepared to inform pregnant women of the various options regarding cord blood donation or storage and the potential uses of donated samples. Collection procedures must not interfere with standard delivery practices and the safety of a newborn or the mother.

Informed consent for the collection of umbilical cord blood stem cells should be obtained, when feasible, before the onset of labor. Physicians' ties to public and private cord blood banks must be disclosed during the informed consent process. Physicians shall not accept financial or other inducements for providing samples to cord blood banks.

The utility of umbilical cord blood stem cells is greater when the donation is to a public rather than private bank. Therefore, physicians should encourage women who wish to donate cord blood to donate to a public bank if one is available. Doing so will result

in greater availability of stem cells to patients from minority populations.

Private banking should be considered in the unusual circumstance when there exists a family predisposition to a condition in which umbilical cord stem cells are therapeutically indicated. However, because of its cost, limited likelihood of use, and inaccessibility to others, private banking should not be recommended to low-risk families.

Because safety and effectiveness of various methods of cord blood collection and use continue to evolve, physicians should monitor the results of ongoing research. (I, V) Issued June 1994. Updated June 1996 and June 2008 based on the report "Umbilical Cord Blood Banking," adopted November 2007.

E-2.169 The Ethical Implications of Xenotransplantation

Xenotransplantation includes any procedure that involves the transplantation, implantation, or infusion into a human recipient of either (a) live cells, tissues, or organs from a non-human animal source or (b) human body fluids, cells, tissues or organs that have had ex vivo contact with live non-human animal cells, tissues, or organs. Although xenotransplantation offers a potential source of tissue, and organs for medical procedures, research in this area may uncover physical and psychological conditions that require medical attention. As such, physicians need to be involved in developing and implementing guidelines for continued research. Therefore, the following guidelines are offered for the medical and scientific communities:
(1) Physicians should encourage education and public discussion of xenotransplantation because of the potential unique risks such procedures pose to individual patients and the public.
(2) The medical and scientific communities should support oversight for the development of clinical trial protocols and of ongoing xenotransplantation research.
(3) Given the uncertain risk xenotransplantation poses to society, participants in early clinical trials may have to agree to (a) postoperative measures such as life-long surveillance, disclosure of sexual contacts, autopsy; and (b) a waiver of the traditional right to withdraw from a clinical trial until the risk of late xenozoonoses is reasonably known not to exist. These requirements may continue even if the transplanted tissue is rejected or removed. The informed consent process should include a discussion of the above issues as well as potential risks to third parties and psychological concerns associated with receiving an organ or tissue graft from an animal. Careful attention must be paid to both the content of the consent disclosure and the manner in which consent is obtained.
(4) It would be ethical to include children and incompetent adults in xenotransplantation research protocols only when the patients are terminally ill and alternative treatments are not available.
(5) Allocation protocols must be fair and in accordance with Opinion 2.03, "Allocation of Limited Medical Resources," which recommends that decisions regarding the allocation of medical resources among patients be based only on ethically appropriate criteria relating to medical need. These criteria include, but are not limited to, the likelihood of benefit, the urgency of need, the change in quality of life, the duration of benefit, and, in some cases, the amount of resources required for treatment.
(6) Sponsors of xenotransplantation research should assure that adequate funding exists for life-long surveillance and treatment of complications arising from xenotransplantation procedures on research subjects.
(7) At a minimum, all on-going research should adhere to the Public Health Service Guideline on Infectious Disease Issues in Xenotransplantation, FDA guidelines relating to xenotransplantation, Opinion 2.07 "Clinical Research," and any additional precautionary measures believed to minimize potential risks to the public or to patients. It is inappropriate to participate in xenograft procedures outside federal guidelines.
(8) All xenotransplantation research should continue to promote high standards of care and humane treatment of all animals used in research (H-460.979, "Use of Animals in Research") and to apply these standards to the care and treatment of animals used as sources of transplantation material. (IV, VII) Issued June 2001 based on the report "The Ethical Implications of Xenotransplantation," adopted December 2000.

E-2.17 Quality of Life

In the making of decisions for the treatment of seriously disabled newborns or of other persons who are severely disabled by injury or illness, the primary consideration should be what is best for the individual patient and not the avoidance of a burden to the family or to society. Quality of life, as defined by the patient's interests and values, is a factor to be considered in determining what is best for the individual. It is permissible to consider quality of life when deciding about life-sustaining treatment in accordance with Opinions 2.20, "Withholding or Withdrawing Life-Sustaining Medical Treatment," 2.215, "Treatment Decisions forSeriously Ill Newborns," and 2.22, "Do-Not-Resuscitate Orders." (I, III, IV) Issued March 1981; Updated June 1994.

E-2.18 Surrogate Mothers

"Surrogate" motherhood involves the artificial insemination of a woman who agrees, usually in return for payment, to give the resulting child to the child's father by surrendering her parental rights. Often, the father's infertile wife becomes the child's adoptive mother. The woman bearing the child is in most cases genetically related to the child, though gestational surrogacy (in which the ovum is provided by the father's infertile wife or other donor) is possible as well.
Ethical, social, and legal problems may arise in surrogacy arrangements. Surrogate motherhood may commodify children and women's reproductive capacities, exploit poor women whose decision to participate may not be wholly voluntary, and improperly

discourage or interfere with the formation of a natural maternal-fetal or maternal-child bond. Psychological impairment may occur in a woman who deliberately conceives with the intention of bearing a child which she will give up. In addition, the woman who has contracted to bear the child may decide to have an abortion or to refuse to relinquish her parental rights. Alternatively, if there is a subsequent birth of a disabled child, prospective parents and the birth mother may not want to or will be unable to assume the responsibilities of parenthood.

On the other hand, surrogate motherhood arrangements are often the last hope of prospective parents to have a child that is genetically related to at least one of them. In addition, most surrogacy arrangements are believed by the parties involved to be mutually beneficial, and most are completed without mishap or dispute. In light of the concerns expressed above, however, some safeguards are necessary to protect the welfare of the child and the birth mother. The Council believes that surrogacy contracts, while permissible, should grant the birth mother the right to void the contract within a reasonable period of time after the birth of the child. If the contract is voided, custody of the child should be determined according to the child's best interests.

In gestational surrogacy, in which the surrogate mother has no genetic tie to the fetus, the justification for allowing the surrogate mother to void the contract becomes less clear. Gestational surrogacy contracts should be strictly enforceable (ie, not voidable by either party). (I, II, IV) Issued December 1983; Updated June 1994.

E-2.19 Unnecessary Services

Physicians should not provide, prescribe, or seek compensation for medical services that they know are unnecessary. (II, VII) Issued prior to April 1977; Updated June 1996; Updated December 2003.

E-2.20 Withholding or Withdrawing Life-Sustaining Medical Treatment

The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the patient should prevail. The principle of patient autonomy requires that physicians respect the decision to forego life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

A competent, adult patient may, in advance, formulate and provide a valid consent to the withholding or withdrawal of life-support systems in the event that injury or illness renders that individual incompetent to make such a decision. A patient may also appoint a surrogate decision maker in accordance with state law.

If the patient receiving life-sustaining treatment is incompetent, a surrogate decision maker should be identified. Without an advance directive that designates a proxy, the patient's family should become the surrogate decision maker. Family includes persons with whom the patient is closely associated. In the case when there is no person closely associated with the patient, but there are persons who both care about the patient and have sufficient relevant knowledge of the patient, such persons may be appropriate surrogates.

Physicians should provide all relevant medical information and explain to surrogate decision makers that decisions regarding withholding or withdrawing life-sustaining treatment should be based on substituted judgment (what the patient would have decided) when there is evidence of the patient's preferences and values. In making a substituted judgment, decision makers may consider the patient's advance directive (if any); the patient's values about life and the way it should be lived; and the patient's attitudes towards sickness, suffering, medical procedures, and death. If there is not adequate evidence of the incompetent patient's preferences and values, the decision should be based on the best interests of the patient (what outcome would most likely promote the patient's well-being).

Though the surrogate's decision for the incompetent patient should almost always be accepted by the physician, there are four situations that may require either institutional or judicial review and/or intervention in the decision-making process: (1) there is no available family member willing to be the patient's surrogate decision maker; (2) there is a dispute among family members and there is no decision maker designated in an advance directive; (3) a health care provider believes that the family's decision is clearly not what the patient would have decided if competent; and (4) a health care provider believes that the decision is not a decision that could reasonably be judged to be in the patient's best interests. When there are disputes among family members or between family and health care providers, the use of ethics committees specifically designed to facilitate sound decision making is recommended before resorting to the courts.

When a permanently unconscious patient was never competent or had not left any evidence of previous preferences or values, since there is no objective way to ascertain the best interests of the patient, the surrogate's decision should not be challenged as long as the decision is based on the decision maker's true concern for what would be best for the patient.

Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death.

Even if the patient is not terminally ill or permanently unconscious, it is not unethical to discontinue all means of life-sustaining medical treatment in accordance with a proper substituted judgment or best interests analysis. (I, III, IV, V) Issued December 1984 as Opinion 2.18, Withholding or Withdrawing Life-Prolonging Medical Treatment, and Opinion 2.19, Withholding or Withdrawing Life-Prolonging Medical Treatment -- Patients' Preferences. In 1989, these Opinions were renumbered 2.20 and 2.21, respectively. Updated June 1994 based on the reports "Decisions Near the End of Life" and "Decisions to Forego Life-Sustaining Treatment for Incompetent Patients," both adopted June 1991 (Decisions Near the End of Life. JAMA. 1992; 267: 2229-2233), and updated June 1996. [In March 1981, the Council on Ethical and Judicial Affairs issued Opinion 2.11, Terminal Illness. The Opinion was

renumbered 2.15 in 1984 and was deleted in 1986.]

E-2.201 Sedation to Unconsciousness in End-of-Life Care

The duty to relieve pain and suffering is central to the physician's role as healer and is an obligation physicians have to their patients. Palliative sedation to unconsciousness is the administration of sedative medication to the point of unconsciousness in a terminally ill patient. It is an intervention of last resort to reduce severe, refractory pain or other distressing clinical symptoms that do not respond to aggressive symptom-specific palliation. It is an accepted and appropriate component of end-of-life care under specific, relatively rare circumstances. When symptoms cannot be diminished through all other means of palliation, including symptom-specific treatments, it is the ethical obligation of a physician to offer palliative sedation to unconsciousness as an option for the relief of intractable symptoms. When considering the use of palliative sedation, the following ethical guidelines are recommended:

(1) Patients may be offered palliative sedation to unconsciousness when they are in the final stages of terminal illness. The rationale for all palliative care measures should be documented in the medical record.

(2) Palliative sedation to unconsciousness may be considered for those terminally ill patients whose clinical symptoms have been unresponsive to aggressive, symptom-specific treatments.

(3) Physicians should ensure that the patient and/or the patient's surrogate have given informed consent for palliative sedation to unconsciousness.

(4) Physicians should consult with a multidisciplinary team, if available, including an expert in the field of palliative care, to ensure that symptom-specific treatments have been sufficiently employed and that palliative sedation to unconsciousness is now the most appropriate course of treatment.

(5) Physicians should discuss with their patients considering palliative sedation the care plan relative to degree and length (intermittent or constant) of sedation, and the specific expectations for continuing, withdrawing, or withholding future life-sustaining treatments.

(6) Once palliative sedation is begun, a process must be implemented to monitor for appropriate care.

(7) Palliative sedation is not an appropriate response to suffering that is primarily existential, defined as the experience of agony and distress that may arise from such issues as death anxiety, isolation and loss of control. Existential suffering is better addressed by other interventions. For example, palliative sedation is not the way to address suffering created by social isolation and loneliness; such suffering should be addressed by providing the patient with needed social support.

(8) Palliative sedation must never be used to intentionally cause a patient's death. (I, VII) Issued November 2008 based on the report "Sedation to Unconsciousness in End-of-Life Care", adopted June 2008.

E-2.21 Euthanasia

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.
It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.
The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life. Euthanasia could also readily be extended to incompetent patients and other vulnerable populations.
Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV) Issued June 1994 based on the report "Decisions Near the End of Life," adopted June 1991 (JAMA. 1992; 267: 2229-2233); Updated June 1996.

E-2.211 Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).
It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be

difficult or impossible to control, and would pose serious societal risks.
Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV) Issued June 1994 based on the reports "Decisions Near the End of Life," adopted June 1991, and "Physician-Assisted Suicide," adopted December 1993 (JAMA. 1992; 267: 2229-33); Updated June 1996.

E-2.215 Treatment Decisions for Seriously Ill Newborns

The primary consideration for decisions regarding life-sustaining treatment for seriously ill newborns should be what is best for the newborn. Factors that should be weighed are (1) the chance that therapy will succeed, (2) the risks involved with treatment and nontreatment, (3) the degree to which the therapy, if successful, will extend life, (4) the pain and discomfort associated with the therapy, and (5) the anticipated quality of life for the newborn with and without treatment.
Care must be taken to evaluate the newborn's expected quality of life from the child's perspective. Life-sustaining treatment may be withheld or withdrawn from a newborn when the pain and suffering expected to be endured by the child will overwhelm any potential for joy during his or her life. When an infant suffers extreme neurological damage, and is consequently not capable of experiencing either suffering or joy, a decision may be made to withhold or withdraw life-sustaining treatment. When life-sustaining treatment is withheld or withdrawn, comfort care must not be discontinued.
When an infant's prognosis is largely uncertain, as is often the case with extremely premature newborns, all life-sustaining and life-enhancing treatment should be initiated. Decisions about life-sustaining treatment should be made once the prognosis becomes more certain. It is not necessary to attain absolute or near absolute prognostic certainty before life-sustaining treatment is withdrawn, since this goal is often unattainable and risks unnecessarily prolonging the infant's suffering.
Physicians must provide full information to parents of seriously ill newborns regarding the nature of treatments, therapeutic options, and expected prognosis with and without therapy, so that parents can make informed decisions for their children about life-sustaining treatment. Counseling services and an opportunity to talk with persons who have had to make similar decisions should be available to parents. Ethics committees or infant review committees should also be utilized to facilitate parental decision making. These committees should help mediate resolutions of conflicts that may arise among parents, physicians, and others involved in the care of the infant. These committees should also be responsible for referring cases to the appropriate public agencies when it is concluded that the parents' decision is not a decision that could reasonably be judged to be in the best interests of the infant. (I, III, IV, V) Issued June 1994 based on the report "Treatment Decisions for Seriously Ill Newborns," adopted June 1992.

E-2.22 Do-Not-Resuscitate Orders

When a patient suffers cardiac or respiratory arrest, attempts should be made to resuscitate the patient, except when cardiopulmonary resuscitation (CPR) is not in accord with the patient's expressed desires or is clinically inappropriate.

All patients should be encouraged to express in advance their preferences regarding the extent of treatment after cardiopulmonary arrest, especially patients at substantial risk of such an event. During discussions regarding patients' preferences, physicians should include a description of the procedures encompassed by CPR. Patients' preferences should be documented as early as possible and should be revisited and revised as appropriate.

Advance directives stating patients' refusals of CPR should be honored whether patients are in or out of hospital. When patients refuse CPR, physicians should not permit their personal value judgments to obstruct implementation of the refusals.

If a patient lacks the ability to make or cannot communicate a decision regarding the use of CPR, a surrogate decision maker may make a decision based upon the previously expressed preferences of the patient. If such preferences are unknown, decisions should be made in accordance with the patient's best interests. If no surrogate decision maker is available, an attending physician contemplating a "Do Not Resuscitate" order (DNR) should consult another physician or a hospital ethics committee, if one is available. (See Opinion 8.081, "Surrogate Decision Making.")

If a patient (either directly or through an advance directive) or the patient's surrogate requests resuscitation that the physician determines would not be medically effective, the physician should seek to resolve the conflict through a fair decision-making process, when time permits. (See Opinion 2.037, "Medical Futility in End-of-Life Care.") In hospitals and other health care organizations, medical staffs or, in their absence, medical directors should adopt and disseminate policies regarding the form and function of DNR orders and a process for resolving conflicts.

DNR orders, as well as the basis for their implementation, should be entered by the attending physician in the patient's medical record.

DNR orders and a patient's advance refusal of CPR preclude only resuscitative efforts after cardiopulmonary arrest and should not influence other medically appropriate interventions, such as pharmacologic circulatory support and antibiotics, unless they also are specifically refused. (See Opinion 2.225, "Optimal Use of Orders-Not-to-Intervene and Advance Directives.") (I, IV, VIII)

Issued March 1992 based on the report "Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders," adopted December 1990 (JAMA. 1991; 265: 1868-1871).

Updated June 1994 and November 2005 based on the report "Universal Out-of-Hospital DNR Systems," adopted June 2005.

E-2.225 Optimal Use of Orders - Not - To - Intervene and Advance Directives

More rigorous efforts in advance care planning are required in order to tailor end-of-life care to the preferences of patients so that they can experience a satisfactory last chapter in their lives. There is need for better availability and tracking of advance directives, and more uniform adoption of form documents that can be honored in all states of the United States. The discouraging evidence of inadequate end-of-life decision-making indicates the necessity of several improvement strategies:
(1) Patients and physicians should make use of advisory as well as statutory documents. Advisory documents aim to accurately represent a patient's wishes and are legally binding under law. Statutory documents give physicians immunity from malpractice for following a patient's wishes. If a form is not available that combines the two, an advisory document should be appended to the state statutory form.
(2) Advisory documents should be based on validated worksheets, thus ensuring reasonable confidence that preferences for end-of-life treatment can be fairly and effectively elicited and recorded, and that they are applicable to medical decisions.
(3) Physicians should directly discuss the patient's preferences with the patient and the patient's proxy. These discussions should be held ahead of time wherever possible. The key steps of structuring a core discussion and of signing and recording the document in the medical record should not be delegated to a junior member of the health care team.
(4) Central repositories should be established so that completed advisory documents, state statutory documents, identification of a proxy, and identification of the primary physician can be obtained efficiently in emergency and urgent circumstances as well as routinely.
(5) Health care facilities should honor, and physicians use, a range of orders on the Doctor's Order Sheet to indicate patient wishes regarding avoidable treatments that might otherwise be given on an emergency basis or by a covering physician with less knowledge of the patient's wishes. Treatment avoidance orders might include, along with a Do Not Resuscitate (DNR) order, some of the following: Full Comfort Care Only (FCCO); Do Not Intubate (DNI); Do Not Defibrillate (DND); Do Not Leave Home (DNLH); Do Not Transfer (DNTransfer); No Intravenous Lines (NIL); No Blood Draws (NBD); No Feeding Tube (NFT); No Vital Signs (NVS); and so forth. One common new order, Do Not Treat (DNT), is specifically not included in this list, since it may unintentionally convey the message that no care should be given and the patient may lose the intense attention due to a dying person; FCCO serves the same purpose without the likely misinterpretation. As with DNR orders, these treatment avoidance orders should be revisited periodically to ensure their continued applicability. Active comfort care orders might include Allow Visitors Extended Hours (AVEH) and Inquire About Comfort (IAC) b.i.d. (twice daily). (I, IV) Issued June 1998 based on the report "Optimal Use of Orders - not - to - Intervene and Advance Directives," adopted June 1997 (Pyschology, Public Policy, and Law. 1998; 4: 668-75).

E-2.23 HIV Testing

Physicians' duties to promote patients' welfare and to improve the public's health are fostered by routinely testing their adult patients for HIV. Physicians must balance these obligations with their concurrent duties to their individual patients' best interest by following the guidelines below:

(1) Physicians should support routine HIV testing procedures in order to protect patients, avoid injury to third parties, and promote public health.

(2) While medical and social advances may have minimized the need for specific written consent prior to HIV testing, physicians should continue to seek patients' informed consent to undergo any form of medical treatment, including HIV testing. Patients' consent to HIV testing does not need to be documented in writing (unless required by law), although the conversation concerning testing should be documented in the patient's chart. It is justifiable to test patients without prior consent only in limited cases where the harms to individual autonomy are offset by significant benefits to known third parties. Such exceptions include testing for the protection of occupationally-exposed health care professionals or patients.

(3) Physicians must work to ensure that patients identified as being HIV positive receive appropriate follow-up care and counseling.

(4) Physicians must comply with all applicable disease reporting laws while taking appropriate measures to safeguard the confidentiality of patients' medical information to the extent possible.

(5) Physicians must honor their obligation to promote the public's health by working to prevent HIV-positive individuals from infecting third parties within the constraints of the law. If an HIV-positive individual poses a significant threat of infecting an identifiable third party, the physician should:

(a) notify the public health authorities, if required by law;

(b) attempt to persuade the infected patient to cease endangering the third party; and

(c) if permitted by state law, notify the endangered third party without revealing the identity of the source person. (I, IV, VII) Issued March 1992 based on the report "Ethical Issues Involved in the Growing AIDS Crisis," adopted December 1987 (JAMA. 1988; 259: 1360-61). Updated June 1994 and June 2008 based on the report "HIV Testing," adopted November 2007

E-2.24 Impaired Drivers and Their Physicians

The purpose of this report is to articulate physicians' responsibility to recognize impairments in patients' driving ability that pose a strong threat to public safety and which ultimately may need to be reported to the Department of Motor Vehicles. It does not address the reporting of medical information for the purpose of punishment or criminal prosecution.
(1) Physicians should assess patients' physical or mental impairments that might adversely affect driving abilities. Each case must be evaluated individually since not all impairments may give rise to an obligation on the part of the physician. Nor may all physicians be in a position to evaluate the extent or the effect of an impairment (eg, physicians who treat patients on a short-term basis). In making evaluations, physicians should consider the following factors:
(a) The physician must be able to identify and document physical or mental impairments that clearly relate to the ability to drive.
(b) The driver must pose a clear risk to public safety.
(2) Before reporting, there are a number of initial steps physicians should take. A tactful but candid discussion with the patient and family about the risks of driving is of primary importance. Depending on the patient's medical condition, the physician may suggest to the patient that he or she seek further treatment, such as substance abuse treatment or occupational therapy. Physicians also may encourage the patient and the family to decide on a restricted driving schedule. Efforts made by physicians to inform patients and their families, advise them of their options, and negotiate a workable plan may render reporting unnecessary.
(3) Physicians should use their best judgment when determining when to report impairments that could limit a patient's ability to drive safely. In situations where clear evidence of substantial driving impairment implies a strong threat to patient and public safety, and where the physician's advice to discontinue driving privileges is ignored, it is desirable and ethical to notify the Department of Motor Vehicles.
(4) The physician's role is to report medical conditions that would impair safe driving as dictated by his or her state's mandatory reporting laws and standards of medical practice. The determination of the inability to drive safely should be made by the state's Department of Motor Vehicles.
(5) Physicians should disclose and explain to their patients this responsibility to report.
(6) Physicians should protect patient confidentiality by ensuring that only the minimal amount of information is reported and that reasonable security measures are used in handling that information.
(7) Physicians should work with their state medical societies to create statutes that uphold the best interests of patients and community and that safeguard physicians from liability when reporting in good faith. (I, III, IV, VII) Issued June 2000 based on the report "Impaired Drivers and Their Physicians," adopted December 1999.

E-2.25 The Use of Quarantine and Isolation as Public Health Interventions

Quarantine and isolation to protect the population's health potentially conflict with the individual rights of liberty and self-determination. The medical profession, in collaboration with public health colleagues, must take an active role in ensuring that those interventions are based on science and are applied according to certain ethical considerations.

(1) To this end, the medical profession should:
(a) seek an appropriate balance of public needs and individual restraints so that quarantine and isolation use the least restrictive measures available that will minimize negative effects on the community through disease control while providing protections for individual rights;
(b) help ensure that quarantine and isolation are based upon valid science and do not arbitrarily target socioeconomic, racial, or ethnic groups;
(c) advocate for the highest possible level of confidentiality of personal health information whenever clinical information is transmitted in the context of public health reporting;
(d) advocate for access to public health services to ensure timely detection of risks and prevent undue delays in the implementation of quarantine and isolation;
(e) help to educate patients and the public about quarantine and isolation through the development of educational materials and participation in educational programs;
(f) advocate for the availability of protective and preventive measures for physicians and others caring for patients with communicable diseases.

(2) Individual physicians should participate in the implementation of appropriate quarantine and isolation measures as part of their obligation to provide medical care during epidemics (see Opinion E-9.067, "Physician Obligation in Disaster Preparedness and Response"). In doing so, advocacy for their individual patients' best interests remains paramount (see Opinion E-10.015, "The Patient-Physician Relationship"). Accordingly, physicians should:
(a) encourage patients to adhere voluntarily to scientifically grounded quarantine and isolation measures by educating them about the

nature of the threat to public health, the potential harm that it poses to the patient and others, and the personal and public benefits to be derived from quarantine or isolation. If the patient fails to comply voluntarily with such measures, the physician should support mandatory quarantine and isolation for the non-compliant patient;
(b) comply with mandatory reporting requirements and inform patients of such reports;
(c) minimize the risk of transmitting infectious diseases from physician to patient and ensure that they remain available to provide necessary medical services by using appropriate protective and preventive measures, seeking medical evaluation and treatment if they suspect themselves to be infected, and adhering to mandated public health measures.

(3) Frontline physicians have an increased ethical obligation to avail themselves of safe and effective protective and preventive measures (for example, influenza vaccine). (I, III, VI, VII, VIII) Issued June 2006 based on the report "The Use of Quarantine and Isolation as Public Health Interventions," adopted November 2005.

E-2.30 Information from Unethical Experiments

All proposed experiments using human subjects should undergo proper ethical evaluation by a human studies review board before being undertaken.
Responsibility for revealing that the data are from unethical experiments lies in the hands of authors, peer reviewers, and editors of medical texts that publish results of experimental studies. Each publication should adopt a standard regarding publication of data from unethical experiments.
If data from unethical experiments can be replaced by existing ethically sound data and achieve the same ends, then such must be done. If ethically tainted data that have been validated by rigorous scientific analysis are the only data of that nature available, and such data are necessary in order to save lives, then the utilization of such data by physicians and editors may be appropriate.
Should editors and/or authors decide to publish an experiment or data from an experiment that does not reach standards of contemporary ethical conduct, a disclaimer should be included. Such disclosure would by no means rectify unethical conduct or legitimize the methods of collection of data gathered from unethical experimentation. This disclaimer should: (1) clearly describe the unethical nature of the origin of any material being published; (2) clearly state that publication of the data is needed in order to save human lives; (3) pay respect to the victims; (4) avoid trivializing trauma suffered by the participants; (5) acknowledge the unacceptable nature of the experiments; and (6) endorse higher ethical standards.
Based on both scientific and moral grounds, data obtained from cruel and inhumane experiments, such as data collected from the Nazi experiments and data collected from the Tuskegee Study, should virtually never be published or cited. In the extremely rare case when no other data exist and human lives would certainly be lost without the knowledge obtained from use of such data, publication or citation is permissible. In such a case, the disclosure should cite the specific reasons and clearly justify the necessity for citation.
Certain generally accepted historical data may be cited without a disclaimer, though a disclosure of the ethical issues would be valuable and desirable. (II, V, VII) Issued December 1998 based on the report "Information from Unethical Experiments," adopted June 1998.

E-2.40 Radio Frequency ID Devices in Humans

Radio frequency identification (RFID) devices may help to identify patients, thereby improving the safety and efficiency of patient care, and may be used to enable secure access to patient clinical information. However, their efficacy and security have not been established. Therefore, physicians implanting such devices should take certain precautions:

(1) The informed consent process must include disclosure of medical uncertainties associated with these devices.

(2) Physicians should strive to protect patients' privacy by storing confidential information only on RFID devices with informational security similar to that required of medical records.

(3) Physicians should support research into the safety, efficacy, and potential non-medical uses of RFID devices in human beings. (I, III, V) Issued November 2007 based on the report "Radio Frequency ID Devices in Humans," adopted June 2007.

E-3.00 Opinions on Interprofessional Relations

E-3.01 Nonscientific Practitioners

It is unethical to engage in or to aid and abet in treatment which has no scientific basis and is dangerous, is calculated to deceive the patient by giving false hope, or which may cause the patient to delay in seeking proper care.
Physicians should also be mindful of state laws which prohibit a physician from aiding and abetting an unlicensed person in the practice of medicine, aiding or abetting a person with a limited license in providing services beyond the scope of his or her license, or undertaking the joint medical treatment of patients under the foregoing circumstances.
Physicians are otherwise free to accept or decline to serve anyone who seeks their services, regardless of who has recommended that the individual see the physician. (III, VI) Issued prior to April 1977; Updated June 1994 and June 1996.

E-3.02 Nurses

The primary bond between the practices of medicine and nursing is mutual ethical concern for patients. One of the duties in providing reasonable care is fulfilled by a nurse who carries out the orders of the attending physician. Where orders appear to the nurse to be in error or contrary to customary medical and nursing practice, the physician has an ethical obligation to hear the nurse's concern and explain those orders to the nurse involved. The ethical physician should neither expect nor insist that nurses follow orders contrary to standards of good medical and nursing practice. In emergencies, when prompt action is necessary and the physician is not immediately available, a nurse may be justified in acting contrary to the physician's standing orders for the safety of the patient. Such occurrences should not be considered to be a breakdown in professional relations. (IV, V) Issued June 1983; Updated June 1994.

E-3.03 Allied Health Professionals

Physicians often practice in concert with allied health professionals such as, but not limited to, optometrists, nurse anesthetists, nurse midwives, and physician assistants in the course of delivering appropriate medical care to their patients. In doing so, physicians should be guided by the following principles:
(1) It is ethical for a physician to work in consultation with or employ allied health professionals, as long as they are appropriately trained and duly licensed to perform the activities being requested.
(2) Physicians have an ethical obligation to the patients for whom they are responsible to ensure that medical and surgical conditions are appropriately evaluated and treated.
(3) Physicians may teach in recognized schools for the allied health professionals for the purpose of improving the quality of their education. The scope of teaching may embrace subjects which are within the legitimate scope of the allied health profession and which are designed to prepare students to engage in the practice of the profession within the limits prescribed by law.
(4) It is inappropriate to substitute the services of an allied health professional for those of a physician when the allied health professional is not appropriately trained and duly licensed to provide the medical services being requested. (I, V, VII) Issued December 1997.

E-3.04 Referral of Patients

A physician may refer a patient for diagnostic or therapeutic services to another physician, limited practitioner, or any other provider of health care services permitted by law to furnish such services, whenever he or she believes that this may benefit the patient. As in the case of referrals to physician-specialists, referrals to limited practitioners should be based on their individual competence and ability to perform the services needed by the patient. A physician should not so refer a patient unless the physician is confident that the services provided on referral will be performed competently and in accordance with accepted scientific standards and legal requirements. (V, VI) Issued prior to April 1977.

E-3.041 Chiropractic

It is ethical for a physician to associate professionally with chiropractors provided that the physician believes that such association is in the best interests of his or her patient. A physician may refer a patient for diagnostic or therapeutic services to a chiropractor permitted by law to furnish such services whenever the physician believes that this may benefit his or her patient. Physicians may also ethically teach in recognized schools of chiropractic. (V, VI) Issued March 1992.

E-3.05 Specialists

Deleted in June 1994.

E-3.06 Sports Medicine

Physicians should assist athletes to make informed decisions about their participation in amateur and professional contact sports which entail risks of bodily injury.
The professional responsibility of the physician who serves in a medical capacity at an athletic contest or sporting event is to protect the health and safety of the contestants. The desire of spectators, promoters of the event, or even the injured athlete that he or she not be removed from the contest should not be controlling. The physician's judgment should be governed only by medical considerations. (I, VII) Issued June 1983; Updated June 1994.

E-3.07 Teaching

Deleted in June 1994.

E-3.08 Sexual Harassment and Exploitation Between Medical Supervisors and Trainees

Sexual Harassment and Exploitation between Medical Supervisors and Trainees

Sexual harassment may be defined as sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when (l) such conduct interferes with an individual's work or academic performance or creates an intimidating, hostile, or offensive work or academic environment or (2) accepting or rejecting such conduct affects or may be perceived to affect employment decisions or academic evaluations concerning the individual. Sexual harassment is unethical.
Sexual relationships between medical supervisors and their medical trainees raise concerns because of inherent inequalities in the status and power that medical supervisors wield in relation to medical trainees and may adversely affect patient care. Sexual relationships between a medical trainee and a supervisor even when consensual are not acceptable regardless of the degree of supervision in any given situation. The supervisory role should be eliminated if the parties involved wish to pursue their relationship. (II, IV, VII) Issued March 1992 based on the report "Sexual Harassment and Exploitation Between Medical Supervisors and Trainees," adopted June 1989; Updated June 1994.

E-3.09 Medical Students Performing Procedures on Fellow Students

(1) In the context of learning basic clinical skills, medical students must be asked specifically to consent to procedures being performed by fellow students. The stringency of standards for ensuring the explicit and non-coerced informed consent increases as the invasiveness and intimacy of the procedure increase.
(2) Instructors should explain to students how the procedures will be performed, making certain that students are not placed in situations that violate their privacy or sense of propriety. The confidentiality, consequences, and appropriate management of a diagnostic finding should also be discussed.
(3) Students should be given the choice of whether to participate prior to entering the classroom and there should be no requirement that the students provide a reason for their unwillingness to participate.
(4) Students should not be penalized for refusal to participate. Thus instructors must refrain from evaluating students' overall performance in terms of their willingness to volunteer as "patients." (IV, V) Issued June 2000 based on the report "Medical Students Performing Procedures on Fellow Students," adopted December 1999.

E-4.00 Opinions on Hospital Relations

E-4.01 Admission Fee

Charging a separate and distinct fee for the incidental, administrative, non-medical service the physician performs in securing the admission of a patient to a hospital is unethical. Physicians should derive their income from medical services rendered, in keeping with the traditions of the American Medical Association. (IV) Issued prior to April 1977; Updated June 1994.

E-4.02 Assessments, Compulsory

It is improper to condition medical staff membership or privileges on compulsory assessments for any purpose. However, self-imposed assessments by vote of the medical staff are acceptable. (IV) Issued prior to April 1977; Updated June 1994.

E-4.03 Billing for Housestaff and Student Services

When a physician assumes responsibility for the services rendered to a patient by a resident or student, the physician may ethically bill the patient for services which were performed under the physician's direct personal observation, direction, and supervision. (II) Issued prior to April 1977; Updated June 1994.

E-4.04 Economic Incentives and Levels of Care

The primary obligation of the hospital medical staff is to safeguard the quality of care provided within the institution. The medical staff has the responsibility to perform essential functions on behalf of the hospital in accordance with licensing laws and accreditation requirements. Treatment or hospitalization that is willfully excessive or inadequate constitutes unethical practice. The organized medical staff has an obligation to avoid wasteful practices and unnecessary treatment that may cause the hospital needless expense. In a situation where the economic interests of the hospital are in conflict with patient welfare, patient welfare takes priority. (I, II, IV, V, VI) Issued June 1986.

E-4.05 Organized Medical Staff

The organized medical staff performs essential hospital functions even though it may often consist primarily of independent practicing physicians who are not hospital employees. The core responsibilities of the organized medical staff are the promotion of patient safety and the quality of care. Members of the organized medical staff may choose to act as a group for the purpose of communicating and dealing with the governing board and others with respect to matters that concern the interest of the organized medical staff and its members. This is ethical so long as there is no adverse effect on patient safety and the quality of care. (IV, VI) Issued July 1983; Updated June 1994 and June 2004.

E-4.06 Physician-Hospital Contractual Relations

There are various financial or contractual arrangements that physicians and hospitals may enter into and find mutually satisfactory. A physician may, for example, be a hospital employee, a hospital-associated medical specialist, or an independent practitioner with staff privileges. The form of the contractual or financial arrangement between physicians and hospitals depends on the facts and circumstances of each situation. A physician may be employed by a hospital for a fixed annual amount, for a certain amount per hour, or pursuant to other similar arrangements that are related to the professional services, skill, education, expertise, or time involved. (VI) Issued March 1981; Updated June 1994.

E-4.07 Staff Privileges

The mutual objective of both the governing board and the medical staff is to improve the quality and efficiency of patient care in the hospital. Decisions regarding hospital privileges should be based upon the training, experience, and demonstrated competence of candidates, taking into consideration the availability of facilities and the overall medical needs of the community, the hospital, and especially patients. Privileges should not be based on numbers of patients admitted to the facility or the economic or insurance status of the patient. Personal friendships, antagonisms, jurisdictional disputes, or fear of competition should not play a role in making these decisions. Physicians who are involved in the granting, denying, or termination of hospital privileges have an ethical responsibility to be guided primarily by concern for the welfare and best interests of patients in discharging this responsibility. (IV, VI, VII) Issued July 1983; Updated June 1994.

E-5.00 Opinions on Confidentiality, Advertising, and Communications Media Relations

E-5.01 Advertising and Managed Care Organizations

A physician may provide medical services to members of a prepaid medical care plan or to members of a health maintenance organization which seeks members or subscribers through advertising. Physicians practicing in prepaid plans or managed care organizations are subject to the same ethical principles as other physicians. Advertising which would lead prospective members or subscribers to believe that the services of a named physician who has a reputation for outstanding skill would be routinely available to all members or subscribers, if in fact this is not so, is deceptive. However, the publication by name of the roster of physicians who provide services to members, the type of practice in which each is engaged, and biographical and other relevant information is not a deceptive practice. (II, VI) Issued prior to April 1977; Updated June 1996.

E-5.015 Direct-to-Consumer Advertisements of Prescription Drugs

The medical profession needs to take an active role in ensuring that proper advertising guidelines are enforced and that the care patients receive is not compromised as a result of direct-to-consumer advertising. Since the Food and Drug Administration (FDA) has a critical role in determining future directions of direct-to-consumer advertising of prescription drugs, physicians should work to ensure that the FDA remains committed to advertising standards that protect patients' health and safety. Moreover, physicians should encourage and engage in studies regarding the effect of direct-to-consumer advertising on patient health and medical care. Such studies should examine whether direct-to-consumer advertising improves the communication of health information; enhances the patient-physician relationship; and contains accurate and reasonable information on risks, precautions, adverse reactions, and costs. Physicians must maintain professional standards of informed consent when prescribing. When a patient comes to a physician with a request for a drug he or she has seen advertised, the physician and the patient should engage in a dialogue that would assess and enhance the patient's understanding of the treatment. Although physicians should not be biased against drugs that are advertised, physicians should resist commercially induced pressure to prescribe drugs that may not be indicated. Physicians should deny requests for inappropriate prescriptions and educate patients as to why certain advertised drugs may not be suitable treatment options, providing, when available, information on the cost effectiveness of different options.

Physicians must remain vigilant to assure that direct-to-consumer advertising does not promote false expectations. Physicians should be concerned about advertisements that do not enhance consumer education; do not convey a clear, accurate, and responsible health education message; do not refer patients to their physicians for more information; do not identify the target population at risk; and fail to discourage consumer self-diagnosis and self-treatment. Physicians may choose to report these concerns directly to the pharmaceutical company that sponsored the advertisement.

To assist the FDA in enforcing existing law and tracking the effects of direct-to-consumer advertising, physicians should, whenever reasonably possible, report to them advertisements that (1) do not provide a fair and balanced discussion of the use of the drug product for the disease, disorder, or condition; (2) do not clearly explain warnings, precautions, and potential adverse reactions associated with the drug product; (3) do not present summary information in language that can be understood by the consumer; (4) do not comply with applicable FDA rules, regulations, policies, and guidelines as provided by the FDA; or (5) do not provide collateral materials to educate both physicians and consumers. (II, III) Issued June 1999 based on the report "Direct-to-Consumer Advertisement of Prescription Drugs," adopted December 1998 (Food and Drug Law Journal. 2000; 55: 119-24).

E-5.02 Advertising and Publicity

There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize him or herself as a physician through any commercial publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television, direct mail, or other advertising) provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive.

Because the public can sometimes be deceived by the use of medical terms or illustrations that are difficult to understand, physicians should design the form of communication to communicate the information contained therein to the public in a readily comprehensible manner. Aggressive, high-pressure advertising and publicity should be avoided if they create unjustified medical expectations or are accompanied by deceptive claims. The key issue, however, is whether advertising or publicity, regardless of format or content, is true and not materially misleading.

The communication may include (1) the educational background of the physician, (2) the basis on which fees are determined (including charges for specific services), (3) available credit or other methods of payment, and (4) any other nondeceptive information.

Nothing in this opinion is intended to discourage or to limit advertising and representations which are not false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act. At the same time, however, physicians are advised that certain types of communications have a significant potential for deception and should therefore receive special attention. For example, testimonials of patients as to the physician's skill or the quality of the physician's professional services tend to be deceptive when they do not reflect the results that patients with conditions comparable to the testimoniant's condition generally receive.

Objective claims regarding experience, competence, and the quality of physicians and the services they provide may be made only if they are factually supportable. Similarly, generalized statements of satisfaction with a physician's services may be made if they are representative of the experiences of that physician's patients.

Because physicians have an ethical obligation to share medical advances, it is unlikely that a physician will have a truly exclusive or unique skill or remedy. Claims that imply such a skill or remedy therefore can be deceptive. Statements that a physician has an exclusive or unique skill or remedy in a particular geographic area, if true, however, are permissible. Similarly, a statement that a physician has cured or successfully treated a large number of cases involving a particular serious ailment is deceptive if it implies a certainty of result and creates unjustified and misleading expectations in prospective patients.

Consistent with federal regulatory standards which apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, radio, or television, should determine in advance that the communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those which a reasonable, prudent advertiser should have discovered. Inclusion of the physician's name in advertising may help to assure that these guidelines are being met. (II) Issued prior to April 1977; Updated June 1996.

E-5.025 Physician Advisory or Referral Services by Telecommunication

Telecommunication advisory services, by way of phone, fax, or computer, distinct from an existing patient-physician relationship can be a helpful source of medical information for the public. Often, people are not sure where to turn for information of a general medical nature or do not have easy access to other sources of information. Individuals also may be embarrassed about directly bringing up certain questions with their physicians. Although telecommunication advisory services can provide only limited medical services, they can be a useful complement to more comprehensive services, if used properly.

Any telecommunication advisory service should employ certain safeguards to prevent misuse. For example, the physician responding to the call should not make a clinical diagnosis. Diagnosis by telecommunication is done without the benefit of a physician examination or even a face-to-face meeting with the caller. Critical medical data may be unavailable to the physician. Physicians who respond to callers should therefore act within the limitations of telecommunication services and ensure that callers understand the limitations of the services. Under no circumstances should medications be prescribed.

Physicians who respond to the calls should elicit all necessary information from the callers. When callers are charged by the minute, they may try to hurry their calls to limit their costs. As a result, important information may not be disclosed to the physician. Physicians should also ensure that callers do not incur large bills inadvertently or without understanding the billing system.

Physician referral services can also offer important information to the public. Referral services are often provided by medical societies, hospitals, and for-profit entities. To ensure that the service bases its recommendation on medically legitimate considerations rather than the likelihood of being paid by the physician, when the service charges physicians a fee to participate, physicians should not pay the service per referral. Also, callers should be told how the list is created. For example, callers should be informed whether the list includes physicians who pay a flat fee to be listed, members of a particular hospital staff or medical society, or physicians who meet some general quality-based criteria.

While these safeguards are described as applying primarily to telephone services, they should be considered equally applicable to any other communication media, such as radio or television, in which the physician and patient do not meet face-to-face. (I, IV, VI) Issued June 1994; Updated June 1996.

E-5.026 The Use of Electronic Mail

Electronic mail (e-mail) can be a useful tool in the practice of medicine and can facilitate communication within a patient-physician relationship. When communicating with patients via e-mail, physicians should take the same precautions used when sending faxes to patients. These precautions are presented in the following considerations:
(1) E-mail correspondence should not be used to establish a patient-physician relationship. Rather, e-mail should supplement other, more personal, encounters.
(2) When using e-mail communication, physicians hold the same ethical responsibilities to their patients as they do during other encounters. Whenever communicating medical information, physicians must present the information in a manner that meets professional standards. To this end, specialty societies can provide specific guidance as to the appropriateness of offering specialty care or advice through e-mail communication.
(3) Physicians should engage in e-mail communication with proper notification of e-mail's inherent limitations. Such notice should include information regarding potential breaches of privacy and confidentiality, difficulties in validating the identity of the parties, and delays in responses. Patients should have the opportunity to accept these limitations prior to the communication of privileged information. Disclaimers alone cannot absolve physicians of the ethical responsibility to protect patients' interests.
(4) Proper notification of e-mail's inherent limitations can be communicated during a prior patient encounter or in the initial e-mail communication with a patient. This is similar to checking with a patient about the privacy or security of a particular fax machine prior to faxing sensitive medical information. If a patient initiates e-mail communication, the physician's initial response should include information regarding the limitations of e-mail and ask for the patient's consent to continue the e-mail conversation. Medical advice or information specific to the patient's condition should not be transmitted prior to obtaining the patient's authorization. (I, IV, VI, VIII) Issued June 2003 based on the report "Ethical Guidelines for the Use of Electronic Mail between Patients and Physicians," adopted December 2002, (AJOB 2003; 3(3)).

E-5.027 Use of Health-Related Online Sites

As Internet prevalence and access rapidly increases, individuals turn to the Internet to find health-related information quickly and efficiently. Online users can access innumerable informational or interactive online sites, many of which are maintained by physicians or rely on their services. Physician involvement should be guided by the following considerations:
(1) Physicians responsible for the health-related content of an online site should ensure that the information is accurate, timely, reliable, and scientifically sound, and includes appropriate scientific references.
(2) The provision of diagnostic or therapeutic services through interactive online sites, including advice to online users with whom the physician does not have a pre-existing relationship or the use of decision-support programs that generate personalized information directly transmitted to users, should be consistent with general and specialty-specific standards. General standards include truthfulness, protection of privacy, principles of informed consent, and disclosures such as limitations inherent in the technology.
(3) When participating in interactive online sites that offer email communication, physicians should follow guidelines established in Opinion 5.026, "The Use of Electronic Mail."
(4) Physicians who establish or are involved in health-related online sites must minimize conflicts of interest and commercial biases. This can be achieved through safeguards for disclosure and honesty in funding and advertising. It also requires that physicians not place commercial interests ahead of patient health; therefore, physicians must not use health-related online sites to promote unnecessary services, refer patients to entities in which they have ownership interests, or sell products outside of established ethical guidelines. (See Opinions 2.19, "Unnecessary Services;" 8.032, "Conflicts of Interest: Health Facility Ownership by a Physician;" 8.062, "Sale of Non-Health-Related Goods from Physicians' Offices;" and 8.063, "Sale of Health-Related Products from Physicians' Offices"). Promotional claims on online sites must conform to Opinion 5.02, "Advertising and Publicity."
(5) Physicians who establish or are involved in health-related online sites that use patient-specific information must provide high-level security protections, as well as privacy and confidentiality safeguards. (I, II, IV, V, VI) Issued December 2003 based on the report "Use of Health-Related Online Sites," adopted June 2003, (AJOB 2003; 3(3)).

E-5.03 Communications Media: Press Relations

Issued prior to April 1977; Deleted in June 1996 and combined with Opinion 5.04.

E-5.04 Communications Media: Standards of Professional Responsibility

Physicians are ethically and legally required to protect the personal privacy and other legal rights of patients. When information concerning a specific patient is requested by the media, the physician must obtain the consent of the patient or an authorized representative before releasing such information. The physician may release only the authorized information or that which is public knowledge. The patient-physician relationship and its confidential nature must be maintained.
With these considerations in mind, the physician may assist the representatives of the media in every way possible. When the patient or authorized representative consents to the release of information, physicians should cooperate with the press to ensure that medical news is available more promptly and more accurately than would be possible without their assistance. Inasmuch as a diagnosis may be made only by a physician and may depend upon X-ray and laboratory studies, no statement regarding diagnosis should be made except by or on behalf of the attending physician. For the same reason, prognosis will be given only by the attending physician or at

the attending physician's direction.
Statements regarding the circumstances surrounding shootings, knifings, and poisonings are properly police matters, and questions whether they were accidental should be referred to the appropriate authorities.
Certain news that is part of the public record, such as deaths, may be made available without the consent of the patient or authorized representative. (IV) Issued prior to April 1977; Updated June 1994 and June 1996.

E-5.045 Filming Patients in Health Care Settings

The use of any medium to film, videotape, or otherwise record (hereafter film) patient interactions with health care providers requires the utmost respect for the privacy and confidentiality of the patient. The following guidelines are offered to help ensure that the rights of patients are protected when filming occurs. These guidelines specifically address filming with the intent of broadcast for public viewing. As such, they consider physicians' role in striving to deliver information to the public that is both complete and accurate. They do not address other uses such as filming for medical education (see Opinion 5.046), forensic or diagnostic filming, or the use of security cameras.

(1) Educating the public about the health care system should be encouraged, and filming of patients may be one way to accomplish this. This educational objective can be achieved ethically by filming only patients who can consent.

(2) Filming patients without consent is a violation of the patient's privacy. Consent is therefore an ethical requirement for both initial filming and subsequent broadcast for public viewing. Because filming cannot benefit a patient medically and may cause harm, filming should be done only if the patient being filmed can explicitly consent. When patients cannot consent, dramatic reenactments utilizing actors should be considered instead of violating patient privacy.

Consent by a surrogate medical decision-maker is not an ethically appropriate substitute for consent by the patient because the role of such surrogates is to make medically necessary decisions, and whether to film for public broadcast is not a medical decision. A possible exception exists when the person in question is permanently or indefinitely incapacitated (e.g. a patient in a persistent vegetative state) or is a minor child, in which case the consent should be obtained from a parent or legal guardian who has the authority to make non-medical decisions.

(a) Patients should have the right to have filming stopped upon request at any time and the film crew removed from the area. Also, persons involved in the direct medical care of the patient who feel that the filming may jeopardize patient care should request that the film crew be removed from the patient care area.

(b) The initial granting of consent does not preclude the patient from withdrawing consent at a later time. After filming has occurred, patients who have been filmed should have the opportunity to rescind their consent up until a reasonable time period before broadcast for public viewing. The consent process should include a full disclosure of whether the tape will be destroyed if consent is rescinded, and the degree to which the patient is allowed to view and edit the final footage before broadcast for public viewing.

(c) Due to the potential conflict of interest, informed consent should be obtained by a disinterested third party, and not a member of the film crew or production team.

(3) Information obtained in the course of filming medical encounters between patients and physicians is confidential. Persons who are not members of the health care team, but who may be present for filming purposes, must demonstrate that they understand the confidential nature of the information and are committed to respecting it. If possible, it is desirable for stationary cameras or health care professionals to perform the filming.

(4) Physicians retain their responsibility to maintain professional standards whenever medical or surgical encounters are filmed for public broadcast. They should be mindful that the educational content of the finished product may become marginalized, potentially distorting the portrayal of the patient-physician encounter and of the medical procedures. Physicians should accurately convey the risks, benefits, and alternatives of treatments to an audience of prospective patients, and should refuse to participate in programs that foster misperceptions or are otherwise misleading.

(5) Independent peer groups, such as medical specialty societies, also may help prevent misleading information from reaching the public by making themselves available to producers to assess the accuracy of program content. They may help dispel misperception by providing educational resources and, if necessary, taking corrective or disciplinary action.

(6) As advocates for their patients, physicians should not allow the care they provide or their advice to patients regarding participation in filming to be influenced by financial gain or promotional benefit to themselves, their patients, or their health care institutions.

(7) If a physician is compensated beyond services to the patient, the amount and conditions of compensation must be disclosed to the patient.

(8) To protect the best interests of patients, physicians should participate in institutional review of requests to film.

(9) Programs regarding various aspects of health care are commonly televised; therefore, physicians should recognize that their patients may have preformed expectations from public broadcasts that may need to be addressed. (I, IV, VII, VIII) Issued December 2001 based on the report "Filming Patients in Health Care Settings," adopted June 2001. Updated June 2006 based on the report "Ethics of Physician Participation in Reality Television for Entertainment," adopted November 2005.

E-5.046 Filming Patients for the Education of Health Professionals

It is important to recognize that filming patients for educational purposes has direct implications in relation to privacy, which itself has become the object of recent detailed federal regulations. Therefore, filming for educational purposes in the health care setting should comply with relevant laws and regulations. In addition, filming for educational purposes should be analyzed from the perspective of the ethics of the patient-physician relationship. In this regard, an important distinction can be drawn between filming for commercial purposes (see Opinion 5.045, "Filming Patients in Health Care Settings") and filming for educational purposes, since the latter is performed and viewed by members of the health care team, who are bound by ethical responsibilities regarding patient autonomy, privacy, and confidentiality. Specifically:
(1) Informed consent should be obtained before filming whenever possible. If it is not possible to obtain consent from the patient before filming, then consent must be obtained before the film is used for educational purposes. A surrogate decision-maker may give consent for filming only if the patient temporarily lacks capacity to give consent before the filming. When the patient regains decision-making capacity, his or her consent should be obtained before the film is used. In the case of minor children or permanently incompetent adults, consent may be obtained from the patient's parent or guardian (see Opinion 5.045, "Filming Patients in Health Care Settings").
(2) When obtaining consent, physicians should disclose information similar to that provided for other medical interventions, including an explanation of the educational purpose of film, potential benefits and harms (such as breaches of privacy and confidentiality), as well as a clear statement that participation in filming is voluntary and that the decision will not affect the medical care the patient receives. Moreover, physicians should be aware that filming may affect patient behavior during a clinical encounter. The patient should be given ample opportunity to discuss concerns about the film, before and after filming, and a decision to withdraw consent must be respected.
(3) Information contained in educational films must be held to the same standards of confidentiality as other patient information. If filming requires the presence of non-clinical persons, these persons must agree to protect the patient’s privacy and confidentiality. Viewing must be limited to health professionals, professionals-in-training, and students in the health professions, unless it has been disclosed to the patient that non-health professionals would view the film and the patient has consented to such viewing. If the film is to be distributed outside the institution in which it was produced, disclosure of the distribution must be made and explicit consent obtained.
(4) Films contain a record of personal patient information. Depending on its content, a film may or may not be considered part of the patient’s medical record, and may be protected under privacy law. Irrespective of these legal standards, films should be securely stored and final disposal should ensure that they are properly destroyed. (I, IV, V, VIII) Issued December 2003 based on the report "Filming Patients for Educational Purposes," adopted June 2003.

E-5.05 Confidentiality

The information disclosed to a physician by a patient should be held in confidence. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential information without the express consent of the patient, subject to certain exceptions which are ethically justified because of overriding considerations.

When a patient threatens to inflict serious physical harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, which may include notification of law enforcement authorities.

When the disclosure of confidential information is required by law or court order, physicians generally should notify the patient. Physicians should disclose the minimal information required by law, advocate for the protection of confidential information and, if appropriate, seek a change in the law. (III, IV, VII, VIII) Issued December 1983; Updated June 1994 and June 2007.

E-5.051 Confidentiality of Medical Information Postmortem

All medically related confidences disclosed by a patient to a physician and information contained within a deceased patient’s medical record, including information entered postmortem, should be kept confidential to the greatest possible degree. However, the obligation to safeguard patient confidences is subject to certain exceptions that are ethically and legally justifiable because of overriding societal considerations (Opinion 5.05, "Confidentiality"). At their strongest, confidentiality protections after death would be equal to those in force during a patient’s life. Thus, if information about a patient may be ethically disclosed during life, it likewise may be disclosed

after the patient has died.

Disclosure of medical information postmortem for research and educational purposes is appropriate as long as confidentiality is maintained to the greatest possible degree by removing any individual identifiers. Otherwise, in determining whether to disclose identified information after the death of a patient, physicians should consider the following factors:
(1) The imminence of harm to identifiable individuals or the public health
(2) The potential benefit to at-risk individuals or the public health (eg, if a communicable or inherited disease is preventable or treatable)
(3) Any statement or directive made by the patient regarding postmortem disclosure
(4) The impact disclosure may have on the reputation of the deceased patient
(5) Personal gain for the physician that may unduly influence professional obligations of confidentiality
When a family member or other decision maker has given consent to an autopsy, physicians may disclose the results of the autopsy to the individual(s) that granted consent to the procedure. (IV) Issued December 2000 based on the report "Confidentiality of Medical Information Postmortem," adopted June 2000. Updated December 2001 (Arch Pathol Lab Med. 2001; 125:1189-92).

E-5.055 Confidential Care for Minors

Physicians who treat minors have an ethical duty to promote the autonomy of minor patients by involving them in the medical decision-making process to a degree commensurate with their abilities.
When minors request confidential services, physicians should encourage them to involve their parents. This includes making efforts to obtain the minor's reasons for not involving their parents and correcting misconceptions that may be motivating their objections. Where the law does not require otherwise, physicians should permit a competent minor to consent to medical care and should not notify parents without the patient's consent. Depending on the seriousness of the decision, competence may be evaluated by physicians for most minors. When necessary, experts in adolescent medicine or child psychological development should be consulted. Use of the courts for competence determinations should be made only as a last resort.
When an immature minor requests contraceptive services, pregnancy-related care (including pregnancy testing, prenatal and postnatal care, and delivery services), or treatment for sexually transmitted disease, drug and alcohol abuse, or mental illness, physicians must recognize that requiring parental involvement may be counterproductive to the health of the patient. Physicians should encourage parental involvement in these situations. However, if the minor continues to object, his or her wishes ordinarily should be respected. If the physician is uncomfortable with providing services without parental involvement, and alternative confidential services are available, the minor may be referred to those services. In cases when the physician believes that without parental involvement and guidance, the minor will face a serious health threat, and there is reason to believe that the parents will be helpful and understanding, disclosing the problem to the parents is ethically justified. When the physician does breach confidentiality to the parents, he or she must discuss the reasons for the breach with the minor prior to the disclosure.
For minors who are mature enough to be unaccompanied by their parents for their examination, confidentiality of information disclosed during an exam, interview, or in counseling should be maintained. Such information may be disclosed to parents when the patient consents to disclosure. Confidentiality may be justifiably breached in situations for which confidentiality for adults may be breached, according to Opinion 5.05, "Confidentiality." In addition, confidentiality for immature minors may be ethically breached when necessary to enable the parent to make an informed decision about treatment for the minor or when such a breach is necessary to avert serious harm to the minor. (IV) Issued June 1994 based on the report "Confidential Care for Minors," adopted June 1992; Updated June 1996.

E-5.059 Privacy in the Context of Health Care

In the context of health care, emphasis has been given to confidentiality, which is defined as information told in confidence or imparted in secret. However, physicians also should be mindful of patient privacy, which encompasses information that is concealed from others outside of the patient-physician relationship.

Physicians must seek to protect patient privacy in all of its forms, including (1) physical, which focuses on individuals and their personal spaces, (2) informational, which involves specific personal data, (3) decisional, which focuses on personal choices, and (4) associational, which refers to family or other intimate relations. Such respect for patient privacy is a fundamental expression of patient autonomy and is a prerequisite to building the trust that is at the core of the patient-physician relationship.

Privacy is not absolute, and must be balanced with the need for the efficient provision of medical care and the availability of resources. Physicians should be aware of and respect the special concerns of their patients regarding privacy. Patients should be informed of any significant infringement on their privacy of which they may otherwise be unaware. (I, IV) Issued June 2002 based on the report "Privacy in the Context of Health Care," adopted December 2001.

E-5.0591 Patient Privacy and Outside Observers to the Clinical Encounter

Outside observers are individuals who are present during patient-physician encounters and are neither members of a health care team nor enrolled in an educational program for health professionals such as medical students.

Physicians are ethically and legally responsible for safeguarding patient privacy and, therefore, must inform outside observers about medical standards of confidentiality and require them to agree to these standards.

Outside observers may be present during the medical encounter only with the patient's explicit agreement. Physicians should avoid situations in which an outside observer's presence may negatively influence the medical interaction and compromise care. The presence of outside observers during encounters between physicians and patients who lack decision-making capacity should not be permitted, except under rare circumstances and with consent of the parent or legal guardian.

Physicians should not accept payment from outside observers because accepting such payment may undermine the patient-physician relationship. (I, IV, VIII) Issued November 2005 based on the report "Patient Privacy and Outside Observers to the Clinical Encounter," adopted June 2005.

E-5.06 Confidentiality: Attorney-Physician Relation

The patient's history, diagnosis, treatment, and prognosis may be discussed with the patient's lawyer with the consent of the patient or the patient's lawful representative.

A physician may testify in court or before a worker's compensation board or the like in any personal injury or related case. (IV) Issued prior to April 1977.

E-5.07 Confidentiality: Computers

The utmost effort and care must be taken to protect the confidentiality of all medical records, including computerized medical records.

The guidelines below are offered to assist physicians and computer service organizations in maintaining the confidentiality of information in medical records when that information is stored in computerized data bases:
(1) Confidential medical information should be entered into the computer-based patient record only by authorized personnel. Additions to the record should be time and date stamped, and the person making the additions should be identified in the record.
(2) The patient and physician should be advised about the existence of computerized data bases in which medical information concerning the patient is stored. Such information should be communicated to the physician and patient prior to the physician's release of the medical information to the entity or entities maintaining the computer data bases. All individuals and organizations with some form of access to the computerized data bases, and the level of access permitted, should be specifically identified in advance. Full disclosure of this information to the patient is necessary in obtaining informed consent to treatment. Patient data should be assigned a security level appropriate for the data's degree of sensitivity, which should be used to control who has access to the information.
(3) The physician and patient should be notified of the distribution of all reports reflecting identifiable patient data prior to distribution of the reports by the computer facility. There should be approval by the patient and notification of the physician prior to the release of patient-identifiable clinical and administrative data to individuals or organizations external to the medical care environment. Such information should not be released without the express permission of the patient.
(4) The dissemination of confidential medical data should be limited to only those individuals or agencies with a bona fide use for the data. Only the data necessary for the bona fide use should be released. Patient identifiers should be omitted when appropriate. Release of confidential medical information from the data base should be confined to the specific purpose for which the information is requested and limited to the specific time frame requested. All such organizations or individuals should be advised that authorized release of data to them does not authorize their further release of the data to additional individuals or organizations, or subsequent use of the data for other purposes.
(5) Procedures for adding to or changing data on the computerized data base should indicate individuals authorized to make changes, time periods in which changes take place, and those individuals who will be informed about changes in the data from the medical records.
(6) Procedures for purging the computerized data base of archaic or inaccurate data should be established and the patient and physician should be notified before and after the data has been purged. There should be no mixing of a physician's computerized patient records with those of other computer service bureau clients. In addition, procedures should be developed to protect against inadvertent mixing of individual reports or segments thereof.
(7) The computerized medical data base should be online to the computer terminal only when authorized computer programs requiring the medical data are being used. Individuals and organizations external to the clinical facility should not be provided online access to a computerized data base containing identifiable data from medical records concerning patients. Access to the computerized data base should be controlled through security measures such as passwords, encryption (encoding) of information, and scannable badges or other user identification.
(8) Back-up systems and other mechanisms should be in place to prevent data loss and downtime as a result of hardware or software failure.
(9) Security:
(a) Stringent security procedures should be in place to prevent unauthorized access to computer-based patient records. Personnel audit procedures should be developed to establish a record in the event of unauthorized disclosure of medical data. Terminated or former

employees in the data processing environment should have no access to data from the medical records concerning patients.
(b) Upon termination of computer services for a physician, those computer files maintained for the physician should be physically turned over to the physician. They may be destroyed (erased) only if it is established that the physician has another copy (in some form). In the event of file erasure, the computer service bureau should verify in writing to the physician that the erasure has taken place. (IV) Issued prior to April 1977; Updated June 1994 and June 1998.

E-5.075 Confidentiality: Disclosure of Records to Data Collection Companies

Data collection from computerized or other patient records for marketing purposes raises serious ethical concerns. In some cases, firms have sought to amass information on physicians' prescribing practices on behalf of pharmaceutical houses for marketing purposes. Often, physicians are offered incentives such as computer hardware and software packages in return for agreeing to such an arrangement. They may be told that data-collecting software does not capture patients' names.
These arrangements may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must give their permission after being fully informed about the purpose of such disclosures. If permission is not obtained, physicians violate patient confidentiality by sharing specific and intimate information from patients' records with commercial interests.
Arrangements of this kind may also violate Opinion 8.061, "Gifts to Physicians From Industry."
Finally, these arrangements may harm the integrity of the patient-physician relationship. The trust that is fundamental to this relationship is based on the principle that the physicians are the agents first and foremost of their patients. (I, II, IV) Issued June 1994; Updated June 1998.

E-5.08 Confidentiality: Insurance Company Representative

History, diagnosis, prognosis, and the like acquired during the physician-patient relationship may be disclosed to an insurance company representative only if the patient or a lawful representative has consented to the disclosure. A physician's responsibilities to patients are not limited to the actual practice of medicine. They also include the performance of some services ancillary to the practice of medicine. These services might include certification that the patient was under the physician's care and comment on the diagnosis and therapy in the particular case. See also Opinion 2.135, "Insurance Companies and Genetic Information." (IV) Issued prior to April 1977.

E-5.09 Confidentiality: Industry-Employed Physicians and Independent Medical Examiners

Where a physician's services are limited to performing an isolated assessment of an individual's health or disability for an employer, business, or insurer, the information obtained by the physician as a result of such examinations is confidential and should not be communicated to a third party without the individual's prior written consent, unless required by law. If the individual authorized the release of medical information to an employer or a potential employer, the physician should release only that information which is reasonably relevant to the employer's decision regarding that individual's ability to perform the work required by the job.
When a physician renders treatment to an employee with a work-related illness or injury, the release of medical information to the employer as to the treatment provided may be subject to the provisions of worker's compensation laws. The physician must comply with the requirements of such laws, if applicable. However, the physician may not otherwise discuss the employee's health condition with the employer without the employee's consent or, in the event of the employee's incapacity, the appropriate proxy's consent. Whenever statistical information about employees' health is released, all employee identities should be deleted. (IV) Issued July 1983; Updated June 1994; updated June 1996; updated December 1999 based on the report "Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations," adopted June 1999.

E-6.00 Opinions on Fees and Charges

E-6.01 Contingent Physician Fees

If a physician's fee for medical service is contingent on the successful outcome of a claim, such as a malpractice or worker's compensation claim, there is the ever-present danger that the physician may become less of a healer and more of an advocate or partisan in the proceedings. Accordingly, a physician's fee for medical services should be based on the value of the service provided by the physician to the patient and not on the uncertain outcome of a contingency that does not in any way relate to the value of the medical service.
A physician's fee should not be made contingent on the successful outcome of medical treatment. Such arrangements are unethical because they imply that successful outcomes from treatment are guaranteed, thus creating unrealistic expectations of medicine and false promises to consumers. (VI) Issued prior to April 1977; Updated June 1994.

E-6.02 Fee Splitting

Payment by or to a physician solely for the referral of a patient is fee splitting and is unethical.
A physician may not accept payment of any kind, in any form, from any source, such as a pharmaceutical company or pharmacist, an

optical company, or the manufacturer of medical appliances and devices, for prescribing or referring a patient to said source.
In each case, the payment violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed. (II) Issued prior to April 1977; Updated June 1994.

E-6.021 Financial Incentives to Patients for Referrals

Physicians should not offer financial incentives or other valuable considerations to patients in exchange for recruitment of other patients. Such incentives can distort the information that patients provide to potential patients, thus distorting the expectations of potential patients and compromising the trust that is the foundation of the patient-physician relationship. (I, II, VIII) Issued December 2004 based on the report "Financial Incentives to Patients for Referrals," adopted June 2004.

E-6.03 Fee Splitting: Referrals to Health Care Facilities

Clinics, laboratories, hospitals, or other health care facilities that compensate physicians for referral of patients are engaged in fee splitting which is unethical.
Health care facilities should not compensate a physician who refers patients there for the physician's cognitive services in prescribing, monitoring, or revising the patient's course of treatment. Payment for these cognitive services is acceptable when it comes from patients, who are the beneficiaries of the physician's services, or from the patient's designated third party payer.
Offering or accepting payment for referring patients to research studies (finder's fees) is also unethical. (II) Issued prior to April 1977; Updated June 1994 and updated June 1996 based on the report "Finder's Fees: Payment for the Referral of Patients to Clinical Research Studies," adopted December 1994.

E-6.04 Fee Splitting: Drug or Device Prescription Rebates

"Fee Splitting: Drug or Device Prescription Rebates," issued March 1980, was deleted in June 2002 and combined with Opinion 8.07, "Gifts to Physicians:Offers of Indemnity" and Opinion 8.06, "Drugs and Devices:Prescribing," into the current Opinion 8.06, "Prescribing and Dispensing Drugs and Devices."

E-6.05 Fees for Medical Services

A physician should not charge or collect an illegal or excessive fee. For example, an illegal fee occurs when a physician accepts an assignment as full payment for services rendered to a Medicare patient and then bills the patient for an additional amount. A fee is excessive when after a review of the facts a person knowledgeable as to current charges made by physicians would be left with a definite and firm conviction that the fee is in excess of a reasonable fee. Factors to be considered as guides in determining the reasonableness of a fee include the following:
(1) The difficulty and/or uniqueness of the services performed and the time, skill, and experience required
(2) The fee customarily charged in the locality for similar physician services
(3) The amount of the charges involved
(4) The quality of performance
(5) The experience, reputation, and ability of the physician in performing the kind of services involved (II) Issued prior to April 1977; Updated June 1994.

E-6.06 Fees: Group Practice

The previous Opinion 6.06, "Fees: Group Practice," issued in March 1981, was deleted in June 1994.

E-6.07 Insurance Form Completion Charges

The attending physician should complete without charge the appropriate "simplified" insurance claim form as a part of service to the patient to enable the patient to receive his or her benefits. A charge for more complex or multiple forms may be made in conformity with local custom. (II) Issued prior to April 1977; Updated June 1994.

E-6.08 Interest Charges and Finance Charges

Although harsh or commercial collection practices are discouraged in the practice of medicine, a physician who has experienced problems with delinquent accounts may properly choose to request that payment be made at the time of treatment or add interest or other reasonable charges to delinquent accounts. The patient must be notified in advance of the interest or other reasonable finance or service charges by such means as the posting of a notice in the physician's waiting room, the distribution of leaflets describing the office billing practices, and appropriate notations on the billing statement. The physician must comply with state and federal laws and regulations applicable to the imposition of such charges. Physicians are encouraged to review their accounting/collection policies to

ensure that no patient's account is sent to collection without the physician's knowledge. Physicians who choose to add an interest or finance charge to accounts not paid within a reasonable time are encouraged to use compassion and discretion in hardship cases. (II) Issued prior to April 1977; Updated June 1994.

E-6.09 Laboratory Bill

When it is not possible for the laboratory bill to be sent directly to the patient, the referring physician's bill to the patient should indicate the actual charges for laboratory services, including the name of the laboratory, as well as any separate charges for the physician's own professional services. (II) Issued prior to April 1977.

E-6.10 Services Provided by Multiple Physicians

Each physician engaged in the care of the patient is entitled to compensation commensurate with the value of the service he or she has personally rendered.
No physician should bill or be paid for a service which is not performed; mere referral does not constitute a professional service for which a professional charge should be made or for which a fee may be ethically paid or received.
When services are provided by more than one physician, each physician should submit his or her own bill to the patient and be compensated separately, if possible. A physician should not charge a markup, commission, or profit on the services rendered by others.
It is ethically permissible in certain circumstances, however, for a surgeon to engage other physicians to assist in the performance of a surgical procedure and to pay a reasonable amount for such assistance, provided the nature of the financial arrangement is made known to the patient. This principle applies whether regardless of the assisting physician is the referring physician. (II) Issued prior to April 1977; Updated June 1994.

E-6.11 Competition

Competition between and among physicians and other health care practitioners on the basis of competitive factors such as quality of services, skill, experience, miscellaneous conveniences offered to patients, credit terms, fees charged, etc, is not only ethical but is encouraged. Ethical medical practice thrives best under free market conditions when prospective patients have adequate information and opportunity to choose freely between and among competing physicians and alternate systems of medical care. (VII) Issued July 1983.

E-6.12 Forgiveness or Waiver of Insurance Co-payments

Under the terms of many health insurance policies or programs, patients are made more conscious of the cost of their medical care through co-payments. By imposing co-payments for office visits and other medical services, insurers hope to discourage unnecessary health care. In some cases, financial hardship may deter patients from seeking necessary care if they would be responsible for a co-payment for the care. Physicians commonly forgive or waive co-payments to facilitate patient access to needed medical care. When a co-payment is a barrier to needed care because of financial hardship, physicians should forgive or waive the copayment.
A number of clinics have advertised their willingness to provide detailed medical evaluations and accept the insurer's payment but waive the co-payment for all patients. Cases have been reported in which some of these clinics have conducted excessive and unnecessary medical testing while certifying to insurers that the testing is medically necessary. Such fraudulent activity exacerbates the high cost of health care, violates Opinion 2.19, "Unnecessary Services," and is unethical.
Physicians should be aware that forgiveness or waiver of co-payments may violate the policies of some insurers, both public and private; other insurers may permit forgiveness or waiver if they are aware of the reasons for the forgiveness or waiver. Routine forgiveness or waiver of co-payments may constitute fraud under state and federal law. Physicians should ensure that their policies on copayments are consistent with applicable law and with the requirements of their agreements with insurers. (II) Issued June 1993.

E-6.13 Professional Courtesy

Professional courtesy refers to the provision of medical care to physician colleagues or their families free of charge or at a reduced rate. While professional courtesy is a long-standing tradition in the medical profession, it is not an ethical requirement. Physicians should use their own judgment in deciding whether to waive or reduce their fees when treating fellow physicians or their families. Physicians should be aware that accepting insurance payments while waiving patient co-payments may violate Opinion 6.12, "Forgiveness or Waiver of Insurance Copayments." (II, IV) Issued June 1994.

E-7.00 Opinions on Physician Records

E-7.01 Records of Physicians: Availability of Information to Other Physicians

The interest of the patient is paramount in the practice of medicine, and everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who have served or are serving the patient. A physician who formerly treated a patient

should not refuse for any reason to make records of that patient promptly available on request to another physician presently treating the patient. Proper authorization for the use of records must be granted by the patient. Medical reports should not be withheld because of an unpaid bill for medical services. (IV) Issued prior to April 1977.

E-7.02 Records of Physicians: Information and Patients

Notes made in treating a patient are primarily for the physician's own use and constitute his or her personal property. However, on request of the patient, a physician should provide a copy or a summary of the record to the patient or to another physician, an attorney, or other person designated by the patient.
Most states have enacted statutes that authorize patient access to medical records. These statutes vary in scope and mechanism for permitting patients to review or copy medical records. Access to mental health records, particularly, may be limited by statute or regulation. A physician should become familiar with the applicable laws, rules, or regulations on patient access to medical records.
The record is a confidential document involving the patient-physician relationship and should not be communicated to a third party without the patient's prior written consent, unless required by law or to protect the welfare of the individual or the community.
Medical reports should not be withheld because of an unpaid bill for medical services. Physicians may charge a reasonable fee for copying medical records. (IV) Issued prior to April 1977; Updated June 1994.

E-7.025 Records of Physicians: Access by Non-Treating Medical Staff

Physicians who use or receive information from medical records share in the responsibility for preserving patient confidentiality and should play an integral role in the designing of confidentiality safeguards in health care institutions. Physicians have a responsibility to be aware of the appropriate guidelines in their health care institution, as well as the applicable federal and state laws.
Informal case consultations that involve the disclosure of detailed medical information are appropriate in the absence of consent only if the patient cannot be identified from the information.
Only physicians or other health care professionals who are involved in managing the patient, including providing consultative, therapeutic, or diagnostic services, may access the patient's confidential medical information. All others must obtain explicit consent to access the information.
Monitoring user access to electronic or written medical information is an appropriate and desirable means for detecting breaches of confidentiality. Physicians should encourage the development and use of such monitoring systems.
This opinion focuses on the issue of access to medical records by medical staff not involved in the treatment or diagnosis of patients. It does not address the need to access medical records for clinical research, epidemiological research, quality assurance, or administrative purposes. (IV) Issued December 1999 based on the report "Records of Physicians: Access by Non-Treating Medical Staff," adopted June 1999.

E-7.03 Records of Physicians upon Retirement or Departure from a Group

A patient's records may be necessary to the patient in the future not only for medical care but also for employment, insurance, litigation, or other reasons. When a physician retires or dies, patients should be notified and urged to find a new physician and should be informed that upon authorization, records will be sent to the new physician. Records which may be of value to a patient and which are not forwarded to a new physician should be retained, either by the treating physician, another physician, or such other person lawfully permitted to act as a custodian of the records.
The patients of a physician who leaves a group practice should be notified that the physician is leaving the group. Patients of the physician should also be informed of the physician's new address and offered the opportunity to have their medical records forwarded to the departing physician at his or her new practice location. It is unethical to withhold such information upon request of a patient. If the responsibility for notifying patients falls to the departing physician rather than to the group, the group should not interfere with the discharge of these duties by withholding patient lists or other necessary information. (IV) Issued prior to April 1977; Updated June 1994, June 1996 and February 2002.

E-7.04 Sale of a Medical Practice

A physician or the estate of a deceased physician may sell the elements that comprise his or her practice, such as furniture, fixtures, equipment, office leasehold, and goodwill. In the sale of a medical practice, the purchaser is buying not only furniture and fixtures, but also goodwill, ie, the opportunity to take over the patients of the seller. A patient's records may be necessary to the patient in the future not only for medical care but also for employment, insurance, litigation, matriculation, or other reasons. Therefore, the transfer of records of patients is subject to the following:
(1) The physician (or the estate) must ensure that all medical records are transferred to another physician or entity who is held to the same standards of confidentiality and is lawfully permitted to act as custodian of the records.
(2) All active patients should be notified that the physician (or the estate) is transferring the practice to another physician or entity who will retain custody of their records and that at their written request, within a reasonable time as specified in the notice, the records (or copies) will be sent to another physician or entity of their choice.
(3) A reasonable charge may be made for the cost of locating, duplicating, and mailing records. (IV) Issued July 1983; Updated June 2000.

E-7.05 Retention of Medical Records

Physicians have an obligation to retain patient records which may reasonably be of value to a patient. The following guidelines are offered to assist physicians in meeting their ethical and legal obligations:
(1) Medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes and chemotherapy records should always be part of the patient's chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether a physician would want the information if he or she were seeing the patient for the first time.
(2) If a particular record no longer needs to be kept for medical reasons, the physician should check state laws to see if there is a requirement that records be kept for a minimum length of time. Most states will not have such a provision. If they do, it will be part of the statutory code or state licensing board.
(3) In all cases, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice claims. The statute of limitations may be three or more years, depending on the state law. State medical associations and insurance carriers are the best resources for this information.
(4) Whatever the statute of limitations, a physician should measure time from the last professional contact with the patient.
(5) If a patient is a minor, the statute of limitations for medical malpractice claims may not apply until the patient reaches the age of majority.
(6) Immunization records always must be kept.
(7) The records of any patient covered by Medicare or Medicaid must be kept at least five years.
(8) In order to preserve confidentiality when discarding old records, all documents should be destroyed.
(9) Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity. (IV, V) Issued June 1994.

E-8.00 Opinions on Practice Matters

E-8.01 Appointment Charges

A physician may charge a patient for a missed appointment or for one not cancelled 24 hours in advance if the patient is fully advised that the physician will make such a charge. (VI) Issued prior to April 1977; Updated June 1994.

E-8.02 Ethical Guidelines for Physicians in Administrative or Other Non-clinical Roles

The practice of medicine focuses primarily on diagnosis and treatment of disease and injury, but its concerns extend broadly to include human experiences related to health and illness. Throughout their formal education and their practice of medicine, physicians profess and are therefore held to standards of medical ethics and professionalism, such as those expressed in the AMA Code of Medical Ethics. Complying with these standards enables physicians to earn the trust of their patients and the general public. Trust is essential to successful healing relationships and, therefore, to the practice of medicine.

The ethical obligations of physicians are not suspended when a physician assumes a position that does not directly involve patient care. Rather, these obligations are binding on physicians in non-clinical roles to the extent that they rely on their medical training, experience, or perspective. When physicians make decisions in non-clinical roles, they should strive to protect the health of individuals and communities. (I, V, VII) Issued June 1994 based on the report "Ethical Guidelines for Medical Consultants," adopted December 1992; Updated June 1998; Revised November 2007.

E-8.021 Ethical Obligations of Medical Directors

Assuming a title or position that removes the physician from direct patient-physician relationships does not override professional ethical obligations. The term "medical directors," as used here, refers to physicians who are employed by third party payers in the health care delivery system (ie, insurance companies, managed care organizations, self-insured employers) or by entities that perform medical appropriateness determinations on behalf of payers. These types of medical directors have specific functions, such as making coverage determinations, which go beyond mere administrative responsibility. The following stem from this understanding.
Whenever physicians employ professional knowledge and values gained through medical training and practice, and in so doing affect individual or group patient care, they are functioning within the professional sphere of physicians and must uphold ethical obligations, including those articulated by the AMA's Code of Medical Ethics.
Medical directors acting within the professional sphere, such as when making decisions regarding medical appropriateness, have an overriding ethical obligation to promote professional medical standards. Adherence to professional medical standards includes:
(1) Placing the interests of patients above other considerations, such as personal interests (eg, financial incentives) or employer business interests (eg, profit). This entails applying the plan parameters to each patient equally and engaging in neither discrimination nor favoritism.
(2) Using fair and just criteria when making care-related determinations. This entails contributing professional expertise to help craft plan guidelines that ensure fair and equal consideration of all plan enrollees. In addition, medical directors should review plan policies and guidelines to ensure that decision-making mechanisms are objective, flexible, and consistent, and apply only ethically appropriate

criteria, such as those identified by the Council in Opinion 2.03, "Allocation of Limited Medical Resources."
(3) Working towards achieving access to adequate medical services. This entails encouraging employers to provide services that would be considered part of an adequate level of health care, as articulated in Opinion 2.095, "The Provision of Adequate Health Care." (I, III, VII) Issued December 1999 based on the report "Ethical Obligations of Medical Directors," adopted June 1999.

E-8.03 Conflicts of Interest: Guidelines

Under no circumstances may physicians place their own financial interests above the welfare of their patients. The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient, prescribe a drug, or conduct diagnostic tests for the physician's financial benefit is unethical. If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit. (II) Issued July 1986; Updated June 1994.

E-8.031 Conflicts of Interest: Biomedical Research

Avoidance of real or perceived conflicts of interest in clinical research is imperative if the medical community is to ensure objectivity and maintain individual and institutional integrity. All medical centers should develop specific guidelines for their clinical staff on conflicts of interest. These guidelines should include the following rules: (1) once a clinical investigator becomes involved in a research project for a company or knows that he or she might become involved, she or he, as an individual, cannot ethically buy or sell the company's stock until the involvement ends and the results of the research are published or otherwise disseminated to the public; (2) any remuneration received by the researcher from the company whose product is being studied must be commensurate with the efforts of the researcher on behalf of the company; and (3) clinical investigators should disclose any material ties to companies whose products they are investigating, including financial ties, participation in educational activities supported by the companies, participation in other research projects funded by the companies, consulting arrangements, and any other ties. The disclosures should be made in writing to the medical center where the research is conducted, organizations that are funding the research, and journals that publish the results of the research. An explanatory statement that discloses conflicts of interest should accompany all published research. Other types of publications, such as a letters to the editor, should also include an explanatory statement that discloses any potential conflict of interest.
In addition, medical centers should form review committees to examine disclosures by clinical staff about financial associations with commercial corporations. (II, IV) Issued March 1992 based on the report "Conflicts of Interest in Biomedical Research," adopted December 1989 (JAMA. 1990; 263: 2790-2793); Updated June 1999 based on the report "Conflicts of Interest: Biomedical Research," adopted December 1998.

E-8.0315 Managing Conflicts of Interest in the Conduct of Clinical Trials

As the biotechnology and pharmaceutical industries continue to expand research activities and funding of clinical trials, and as increasing numbers of physicians both within and outside academic health centers become involved in partnerships with industry to perform these activities, greater safeguards against conflicts of interest are needed to ensure the integrity of the research and to protect the welfare of human subjects. Physicians should be mindful of the conflicting roles of investigator and clinician and of the financial conflicts of interest that arise from incentives to conduct trials and to recruit subjects. In particular, physicians involved in clinical research should heed the following guidelines:
(1) Physicians should agree to participate as investigators in clinical trials only when it relates to their scope of practice and area of medical expertise. They should have adequate training in the conduct of research and should participate only in protocols which they are satisfied are scientifically sound.
(2) Physicians should be familiar with the ethics of research and should agree to participate in trials only if they are satisfied that an Institutional Review Board has reviewed the protocol, that the research does not impose undue risks upon research subjects, and that the research conforms to government regulations.
(3) When a physician has treated or continues to treat a patient who is eligible to enroll as a subject in a clinical trial that the physician is conducting, the informed consent process must differentiate between the physician's roles as clinician and investigator. This is best achieved when someone other than the treating physician obtains the participant's informed consent to participate in the trial. This individual should be protected from the pressures of financial incentives, as described in the following section.
(4) Any financial compensation received from trial sponsors must be commensurate with the efforts of the physician performing the research. Financial compensation should be at fair market value and the rate of compensation per patient should not vary according to the volume of subjects enrolled by the physician, and should meet other existing legal requirements. Furthermore, according to Opinion 6.03, "Fee Splitting: Referral to Health Care Facilities," it is unethical for physicians to accept payment solely for referring patients to research studies.
(5) Physicians should ensure that protocols include provisions for the funding of subjects' medical care in the event of complications associated with the research. Also, a physician should not bill a third party payer when he or she has received funds from a sponsor to cover the additional expenses related to conducting the trial.
(6) The nature and source of funding and financial incentives offered to the investigators must be disclosed to a potential participant as part of the informed consent process. Disclosure to participants also should include information on uncertainties that may exist regarding funding of treatment for possible complications that may arise during the course of the trial. Physicians should ensure that

such disclosure is included in any written informed consent.
(7) When entering into a contract to perform research, physicians should ensure themselves that the presentation or publication of results will not be unduly delayed or otherwise obstructed by the sponsoring company. (II, V) Issued June 2001 based on the report "Managing Conflicts of Interest in the Conduct of Clinical Trials," adopted December 2000 (JAMA. 2002; 287: 78-84).

E-8.04 Consultation

Physicians should obtain consultation whenever they believe that it would be medically indicated in the care of the patient or when requested by the patient or the patient's representative. When a patient is referred to a consultant, the referring physician should provide a history of the case and such other information as the consultant may need, calling to the attention of the consultant any specific questions about which guidance is sought, and the consultant should advise the referring physician of the results of the consultant's examination and recommendations. (V) Issued prior to April 1977; Updated June 1992 and June 1996.

E-8.041 Second Opinions

Physicians should recommend that a patient obtain a second opinion whenever they believe it would be helpful in the care of the patient. When recommending a second opinion, physicians should explain the reasons for the recommendation and inform their patients that patients are free to choose a second-opinion physician on their own or with the assistance of the first physician. Patients are also free to obtain second opinions on their own initiative, with or without their physician's knowledge.
With the patient's consent, the first physician should provide a history of the case and such other information as the second-opinion physician may need, including the recommendations about management. The second-opinion physician should maintain the confidentiality of the evaluation and should report to the first physician if the consent of the patient has been obtained.
After evaluating the patient, a second-opinion physician should provide the patient with a clear understanding of the opinion, whether or not it agrees with the recommendations of the first physician.
When a patient initiates a second opinion, it is inappropriate for the primary physician to terminate the patient-physician relationship solely because of the patient's decision to obtain a second opinion.
In some cases, patients may ask the second-opinion physician to provide the needed medical care. In general, second-opinion physicians are free to assume responsibility for the care of the patient. It is not unethical to enter into a patient-physician relationship with a patient who has been receiving care from another physician. By accepting second-opinion patients for treatment, physicians affirm the right of patients to have free choice in the selection of their physicians.
There are situations in which physicians may choose not to treat patients for whom they provide second opinions. Physicians may decide not to treat the patient in order to avoid any perceived conflict of interest or loss of objectivity in rendering the requested second opinion. However, the concern about conflicts of interest does not require physicians to decline to treat second-opinion patients. This inherent conflict in the practice of medicine is resolved by the responsible exercise of professional judgment.
Physicians may agree not to treat second-opinion patients as part of their arrangements with insurers or other third party payers. Physicians who enter into such contractual agreements must honor their commitments.
Physicians must decide independently of their colleagues whether to treat second-opinion patients. Physicians may not establish an agreement or understanding among themselves that they will refuse to treat each others' patients when asked to provide a second opinion. Such agreements compromise the ability of patients to receive care from the physicians of their choice and are therefore not only unethical but also unlawful. (IV, V) Issued June 1992; Updated June 1996.

E-8.043 Ethical Implications of Surgical Co-Management

For the purpose of this report, the term "surgical co-management" refers to the practice of allotting specific responsibilities of patient care to designated caregivers. The following guidelines stem from this understanding:
(1) Physicians should engage in co-management arrangements only to assure the highest quality of care.
(2) When surgical co-management arrangements are made between duly licensed physicians, their responsibilities should be delineated according to the scope of the physicians' expertise. Likewise, when physicians enter into surgical co-management arrangements with allied health professionals, each caregiver's responsibility should correspond to his or her qualifications.
(3) Even though different caregivers will be responsible for rendering specific portions of the patient's care, a single physician should be ultimately responsible for ensuring that the care is delivered in a coordinated and appropriate manner. Other caregivers should support this obligation by communicating with this physician.
(4) The treating physicians are responsible for ensuring that the patient has consented not only to take part in the surgical co-management arrangement but also to the services that will be provided within the arrangement. In addition to disclosing medical facts to the patient, the patient should also be informed of other significant aspects of the surgical co-management arrangement such as the credentials of the other caregivers, the specific services each will provide, and the billing arrangement.
(5) Physicians should ensure that their surgical co-management arrangements do not violate the ethical or legal restrictions on self-referral.
(6) Referrals to another caregiver should be based only on that caregiver's skill and ability to meet the patient's needs and not on expected further referrals or other self-serving bases. Physicians who participate in surgical co-management arrangements must avoid such financial agreements as fee-splitting, which are both unethical and illegal.

Physicians who participate in surgical co-management arrangements should employ appropriate safeguards to ensure that confidential information is protected. (I, II, IV, V, VI) Issued June 2000 based on the report "Ethical Implications of Surgical Co-Management," adopted December 1999.

E-8.045 Direct-to-Consumer Diagnostic Imaging Tests

Diagnostic imaging services that have not been scientifically validated for screening purposes are being offered without prior referral by a personal physician. Examples include total body scanning, electron beam computed tomography (CT) for determining coronary artery calcification, spiral CT for lung cancer screening, and CT colonography for colon cancer screening. Physicians and relevant specialty societies should advocate for the conduct of appropriate trials aimed at determining the predictive power of the tests, and their sensitivity and specificity for target abnormalities. When adequate data regarding a screening diagnostic imaging service become available, the profession has a responsibility to develop suitable guidelines, as has been done for mammography.

The following ethical guidelines apply to physicians providing screening imaging services that have not been scientifically validated, without referral from another physician:

(1) Performance of a diagnostic imaging test at the request of an individual is justifiable only if, in the judgment of the physician, the potential benefits of the service outweigh the risks.

(2) Once a physician agrees to perform the test, a patient-physician relationship is established with all the obligations such a relationship entails. (See Opinion 10.01, "Fundamental Elements of the Patient-Physician Relationship" and Opinion 10.015, "The Patient-Physician Relationship.")

In the absence of a referring physician who orders the test, the testing physician assumes responsibility for relevant clinical evaluation, as well as pre-test and post-test counseling concerning the test, its results, and indicated follow-up. Post-test counseling may also be accomplished through referral to an appropriate physician who accepts the patient.

In obtaining the patient's informed consent (see Opinion 8.08, "Informed Consent"), the testing physician should discuss, in a manner the patient can understand, the usual elements of informed consent as well as:
(a) the inaccuracies inherent in the proposed test,
(b) the possibility of inconclusive results,
(c) false positives or false negatives, and
(d) circumstances which may require further assessment and additional costs.

(3) Physicians who hold financial interests in imaging facilities must not place those interests above the welfare of their patients, as stated in Opinions 8.03, "Conflicts of Interest: Guidelines" and 8.032, "Conflicts of Interest: Health Facility Ownership by a Physician." Moreover, physicians who advertise diagnostic imaging services should ensure that advertisements are truthful and not misleading or deceptive. (I, II, V, VIII) Issued November 2005 based on the report "Direct-to-Consumer Diagnostic Imaging Tests," adopted June 2005.

E-8.047 Industry Representatives in Clinical Settings

Manufacturers of medical devices may facilitate their use through industry representatives who can play an important role in patient safety and quality of care by providing information about the proper use of the device or equipment as well as technical assistance to physicians.

Because of their obligation to protect their patients, physicians must strive to prevent industry representatives from breaching patient privacy and confidentiality, and seek to verify that they are properly credentialed and do not exceed the bounds of their training. Physicians may fulfill these obligations by satisfying themselves that the facility has suitable mechanisms in place to accomplish these functions.

Physicians or their designees must disclose to patients the anticipated presence and roles of industry representatives during clinical encounters, and obtain patients' approval. This requires neither disclosure of the representative's specific identity nor a formal informed consent process. (I, IV, V) Issued November 2007 based on the report "Industry Representatives in Clinical Settings," adopted June 2007.

E-8.05 Contractual Relationships

The contractual relationships that physicians assume when they join or affiliate with group practices or agree to provide services to the patients of an insurance plan are varied.
Income arrangements may include hourly wages for physicians working part time, annual salaries for those working full time, and share of group income for physicians who are partners in groups that are somewhat autonomous and contract with plans to provide the

required medical care. Arrangements also usually include a range of fringe benefits, such as paid vacations, insurance, and pension plans.
Physicians may work directly for plans or may be employed by the medical group or the hospital that has contracted with the plan to provide services. In the operation of such plans, physicians should not be subjected to lay interference in professional medical matters and their primary responsibility should be to the patients they serve. (VI) Issued prior to April 1977; Updated June 1994 and June 1996.

E-8.0501 Professionalism and Contractual Relations

Physicians are free to enter into a wide range of contractual arrangements. However, physicians should not sign contracts containing provisions that may undermine their ethical obligation to advocate for patient welfare. Therefore, before entering into contractual agreements to provide services that directly or indirectly impact patient care, physicians should negotiate the removal of any terms, such as financial incentives or administrative conditions, that are known to compromise professional judgment or integrity. Particularly, when contractual compensation varies according to performance (see Opinion E-8.054, "Financial Incentive and the Practice of Medicine"), physicians should beware of incentives that may adversely impact patient care. (VI, VIII) Issued June 2004 based on the report "Professionalism and Contractual Relations," adopted December 2003.

E-8.051 Conflict of Interest Under Capitation

The application of capitation to physicians' practices can result in the provision of cost-effective, quality medical care. It is important to note, however, that the potential for conflict exists under such systems. Physicians who contract with health care plans should attempt to minimize these conflicts and to ensure that capitation is applied in a manner consistent patients' interests.
(1) Physicians have an obligation to evaluate a health plan's capitation payments prior to contracting with that plan to ensure that the quality of patient care is not threatened by inadequate rates of capitation. Physicians should advocate that capitation payments be calculated primarily on the basis of relevant medical factors, available outcomes data, the costs associated with involved providers, and consensus-oriented standards of necessary care. Furthermore, the predictable costs resulting from existing conditions of enrolled patients should be considered when determining the rate of capitation. Different populations of patients have different medical needs and the costs associated with those needs should be reflected in the per member per month payment. Physicians should seek agreements with plans that provide sufficient financial resources for all care that is the physician's obligations to deliver and should refuse to sign agreements that fail in this regard.
(2) Physicians must not assume inordinate levels of financial risk and should therefore consider a number of factors when deciding whether or not to sign a provider agreement. The size of the plan and the time period over which the rate is figured should be considered by physicians evaluating a plan as well as in determinations of the per member per month payment. The capitation rate for large plans can be calculated more accurately than for smaller plans because of the mitigating influence of probability and the behavior of large systems. Similarly, length of time will influence the predictability of the cost of care. Therefore, physicians should advocate for capitation rates calculated for large plans over an extended period of time.
(3) Stop-loss plans can prevent the potential of catastrophic expenses from influencing physician behavior. Physicians should ensure that such arrangements are finalized prior to signing an agreement to provide services in a health plan.
(4) Physicians must be prepared to discuss with patients any financial arrangements which could impact patient care. Physicians should avoid reimbursement systems that, if disclosed to patients, could negatively affect the patient-physician relationship. (II, III, VI) Issued December 1997 based on the report "The Ethical Implications of Capitation," adopted June 1997; updated June 2002.

E-8.052 Negotiating Discounts for Specialty Care

Patients are entitled to all the benefits outlined in their insurance plan. Therefore, it is unethical for a referring physician to restrict the referral options of patients who have chosen a plan that provides for access to an unlimited or broad selection of specialist physicians. It is also unethical to base the referral of these patients on a discount for the capitated patients in a primary care physician's practice. (II) Issued December 1997 based on the report "Ethical Issues in Negotiating Discounts for Specialty Care," adopted June 1996.

E-8.053 Restrictions on Disclosure in Health Care Plan Contracts

Despite ethical requirements demanding full disclosure of treatment options regardless of limitations imposed by plan coverage, some health care plans include clauses in their employment contracts that directly inhibit the ability of physicians to keep their patients fully informed. These types of contract clauses erect inappropriate barriers to necessary communications between physicians and patients, labeled "gag clauses" by some observers. Restrictive clauses of this type impact the ability of physicians to provide information to their patients and to act effectively as a patient advocate. They also threaten to undermine individual and public trust in the profession of medicine.
(1) Health care plans have the right to protect proprietary information. However, physicians should oppose any such protection that inhibits them from disclosing relevant information to patients. For this reason, physicians should advocate for the elimination of contract clauses that could prevent them from raising or discussing matters relevant to patients' medical care.
(2) The right of patients to be informed of all pertinent medical information must be reaffirmed by the medical profession, and individual physicians must continue to uphold their ethical obligation to disclose such information.

(3) Physicians, individually or through their representative, should review their contracts carefully to ensure that they are able to fulfill their ethical obligations to patients. (II, III, VI) Issued June 1998 based on the report "Restrictions on Disclosure in Managed Care Contracts," adopted June 1996; updated June 2002.

E-8.054 Financial Incentives and the Practice of Medicine

In order to achieve the necessary goals of patient care and to protect the role of physicians as advocates for individual patients, the following statement is offered for the guidance of physicians:
(1) Although physicians have an obligation to consider the needs of broader patient populations within the context of the patient-physician relationship, their first duty must be to the individual patient. This obligation must override considerations of the reimbursement mechanism or specific financial incentives applied to a physician's clinical practice.
(2) Physicians, individually or through their representatives, should evaluate the financial incentives associated with participation in a health plan before contracting with that plan. The purpose of the evaluation is to ensure that the quality of patient care is not compromised by unrealistic expectations for utilization or by placing that physician's payments for care at excessive risk. In the process of making judgments about the ethical propriety of such reimbursement systems, physicians should refer to the following general guidelines:
(a) Monetary incentives may be judged in part on the basis of their size. Large incentives may create conflicts of interest that can in turn compromise clinical objectivity. While an obligation has been established to resolve financial conflicts of interest to the benefit of patients, it is important to recognize that sufficiently large incentives can create an untenable position for physicians,
(b) The proximity of large financial incentives to individual treatment decisions should be limited in order to prevent physicians' personal financial concerns from creating a conflict with their role as individual patient advocates. When the proximity of incentives cannot be mitigated, as in the case of fee-for-service payments, physicians must behave in accordance with prior Council recommendations limiting the potential for abuse. This includes the Council's prohibitions on fee-splitting arrangements, the provision of unnecessary services, unreasonable fees, and self-referral. For incentives that can be distanced from clinical decisions, physicians should consider the following factors in order to evaluate the correlation between individual act and monetary reward or penalty:
(i) In general, physicians should favor incentives that are applied across broad physician groups. This dilutes the effect any one physician can have on his or her financial situation through clinical recommendations, thus allowing physicians to provide those services they feel are necessary in each case. Simultaneously, however, physicians are encouraged by the incentive to practice efficiently.
(ii) The size of the patient pool considered in calculations of incentive payments will affect the proximity of financial motivations to individual treatment decisions. The laws of probability dictate that in large populations of patients, the overall level of utilization remains relatively stable and predictable. Physicians practicing in plans with large numbers of patients in a risk pool therefore have greater freedom to provide the care they feel is necessary based on the likelihood that the needs of other plan patients will balance out decisions to provide extensive care.
(iii) Physicians should advocate for the time period over which incentives are determined to be long enough to accommodate fluctuations in utilization resulting from the random distribution of patients and illnesses. For example, basing incentive payments on an annual analysis of resource utilization is preferable to basing them on monthly review.
(iv) Financial rewards or penalties that are triggered by specific points of utilization may create enormous incentives as a physician's practice approaches the established level. Therefore, physicians should advocate that incentives be calculated on a continuum of utilization rather than a bracketed system with tiers of widely varied bonuses or penalties.
(v) Physicians should ascertain that a stop-loss plan is in place to prevent the costs associated with unusual outliers from significantly impacting the reward or penalty offered to a physician.
(3) Physicians also should advocate for incentives that promote efficient practice, but are not be designed to realize cost savings beyond those attainable through efficiency. As a counterbalance to the focus on utilization reduction, physicians also should advocate for incentives based on quality of care and patient satisfaction.
(4) Patients must be informed of financial incentives that could impact the level or type of care they receive. Although this responsibility should be assumed by the health plan, physicians, individually or through their representatives, must be prepared to discuss with patients any financial arrangements that could impact patient care. Physicians should avoid reimbursement systems that, if disclosed to patients, could negatively affect the patient-physician relationship. (II, III) Issued June 1998 based on the report "Financial Incentives and the Practice of Medicine," adopted December 1997; updated June 2002.

E-8.055 Retainer Practices

Individuals are free to select and supplement insurance for their health care on the basis of what appears to them to be an acceptable tradeoff between quality and cost. Retainer contracts, whereby physicians offer special services and amenities (such as longer visits, guaranteed availability by phone or pager, counseling for healthy lifestyles, and various other customized services) to patients who pay additional fees distinct from the cost of medical care, are consistent with pluralism in the delivery and financing of health care. However, they also raise ethical concerns that warrant careful attention, particularly if retainer practices become so widespread as to threaten access to care.
(1) When entering into a retainer contract, both parties must be clear about the terms of the relationship and must agree to them. Physicians must present the terms of the contract in an honest manner, and must not exert undue pressure on patients to agree to the arrangement. If a physician has knowledge that the patient's health care insurance coverage will be compromised by the retainer

contract, the information must be discussed with the patient before reaching an agreement on the terms of the retainer contract. Also, patients must be able to opt out of a retainer contract without undue inconveniences or financial penalties.
(2) Concern for quality of care the patient receives should be the physician's first consideration. However, it is important that a retainer contract not be promoted as a promise for more or better diagnostic and therapeutic services. Physicians must always ensure that medical care is provided only on the basis of scientific evidence, sound medical judgment, relevant professional guidelines, and concern for economic prudence. Physicians who engage in mixed practices, in which some patients have contracted for special services and amenities and others have not, must be particularly diligent to offer the same standard of diagnostic and therapeutic services to both categories of patients. All patients are entitled to courtesy, respect, dignity, responsiveness, and timely attention to their needs.
(3) In accord with medicine's ethical mandate to provide for continuity of care and the ethical imperative that physicians not abandon their patients, physicians converting their traditional practices into retainer practices must facilitate the transfer of their non-participating patients, particularly their sickest and most vulnerable ones, to other physicians. If no other physicians are available to care for non-retainer patients in the local community, the physician may be ethically obligated to continue caring for such patients.
(4) Physicians who enter into retainer contracts will usually receive reimbursement from their patients' health care plans for medical services. Physicians are ethically required to be honest in billing for reimbursement, and must observe relevant laws, rules, and contracts. It is desirable that retainer contracts separate clearly special services and amenities from reimbursable medical services. In the absence of such clarification, identification of reimbursable services should be determined on a case-by-case basis.
(5) Physicians have a professional obligation to provide care to those in need, regardless of ability to pay, particularly to those in need of urgent care. Physicians who engage in retainer practices should seek specific opportunities to fulfill this obligation. (I, II, VI, VIII, IX) Issued December 2003 based on the report "Retainer Practices," adopted June 2003.

E-8.056 Physician Pay-for-Performance Programs

Physician pay-for-performance (PFP) compensation arrangements should be designed to improve health care quality and patient safety by linking remuneration to measures of individual, group, or organizational performance. To uphold their ethical obligations, physicians who are involved with PFP programs must take appropriate measures to promote patients' well-being.

(1) Physicians who are involved in the design or implementation of PFP programs should advocate for:
(a) incentives that are intended to promote health care quality and patient safety, and are not primarily intended to contain costs;
(b) program flexibility that allows physicians to accommodate the varying needs of individual patients;
(c) adjustment of performance measures by risk and case-mix in order to avoid discouraging the treatment of high-risk individuals and populations;
(d) processes to make practice guidelines and explanations of their intended purposes and the clinical findings upon which they are based available to participating physicians.

(2) Practicing physicians who participate in PFP programs while providing medical services to patients should:
(a) maintain primary responsibility to their patients and provide competent medical care, regardless of financial incentives;
(b) support access to care for all people and avoid selectively treating healthier patients for the purpose of bolstering their individual or group performance outcomes;
(c) be aware of evidence-based practice guidelines and the findings upon which they are based;
(d) always provide care that considers patients' individual needs and preferences, even if that care conflicts with applicable practice guidelines;
(e) not participate in PFP programs that incorporate incentives that conflict with physicians' professional values or otherwise compromise physicians' abilities to advocate for the interests of individual patients. (I, II, VI, VIII, IX) Issued June 2006 based on the report "Physician Pay-for-Performance Programs," adopted November 2005.

E-8.06 Prescribing and Dispensing Drugs and Devices

(1) Physicians should prescribe drugs, devices, and other treatments based solely upon medical considerations and patient need and reasonable expectations of the effectiveness of the drug, device or other treatment for the particular patient.
(2) Physicians may not accept any kind of payment or compensation from a drug company or device manufacturer for prescribing its products. Furthermore, physicians should not be influenced in the prescribing of drugs, devices, or appliances by a direct or indirect financial interest in a firm or other supplier, regardless of whether the firm is a manufacturer,
distributor, wholesaler, or repackager of the products involved.
(3) Physicians may own or operate a pharmacy, but generally may not refer their patients to the pharmacy. Exceptionally, a physician may refer patients to his or her pharmacy in accord with guidelines established in Opinion 8.032, "Conflicts of Interest: Health Facility Ownership by a Physician." Physicians may dispense drugs within their office practices provided such dispensing primarily benefits the patient.
(4) In all instances, physicians should respect the patient's freedom of choice in selecting who will fill their prescriptions as they are in the choice of a physician and, therefore, have the right to have a prescription filled wherever they wish. (See Opinions 9.06, "Free Choice," and 8.03, "Conflicts of Interest: Guidelines.") Physicians should not urge patients to fill prescriptions from an establishment which has entered into a business or other preferential arrangement with the physician with respect to the filling of the physician's

prescriptions.
(5) A third party's offer to indemnify a physician for lawsuits arising from the physician's prescription or use of the third party's drug, device, or other product, introduces inappropriate incentives into medical decision making. Such offers, regardless of their limitations, therefore constitute unacceptable gifts. This does not address contractual assignments of liability between employers or in research arrangements, nor does it address government indemnification plans.
(6) Patients have an ethically and legally recognized right to prompt access to the information contained in their individual medical records. Since a prescription is part of the patient's medical record, the patient is entitled to a copy of the physician's prescription for drugs or devices, including eyeglasses and contact lenses. Therefore, physicians should not discourage patients from requesting a written copy of a prescription. (II, III, IV, V) Issued June 2002. This opinion is a consolidation of previous Opinions 6.04, "Fee Splitting:Drug or Device Prescription Rebates;" 8.06, "Drugs and Devices: Prescribing;" and 8.07, "Gifts to Physicians:Offers of Indemnity."

E-8.061 Gifts to Physicians from Industry

Many gifts given to physicians by companies in the pharmaceutical, device, and medical equipment industries serve an important and socially beneficial function. For example, companies have long provided funds for educational seminars and conferences. However, there has been growing concern about certain gifts from industry to physicians. Some gifts that reflect customary practices of industry may not be consistent with the Principles of Medical Ethics. To avoid the acceptance of inappropriate gifts, physicians should observe the following guidelines:
(1) Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted. The use of drug samples for personal or family use is permissible as long as these practices do not interfere with patient access to drug samples. It would not be acceptable for non-retired physicians to request free pharmaceuticals for personal use or use by family members.
(2) Individual gifts of minimal value are permissible as long as the gifts are related to the physician's work (eg, pens and notepads).
(3) The Council on Ethical and Judicial Affairs defines a legitimate "conference" or "meeting" as any activity, held at an appropriate location, where (a) the gathering is primarily dedicated, in both time and effort, to promoting objective scientific and educational activities and discourse (one or more educational presentation(s) should be the highlight of the gathering), and (b) the main incentive for bringing attendees together is to further their knowledge on the topic(s) being presented. An appropriate disclosure of financial support or conflict of interest should be made.
(4) Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a subsidy directly to a physician by a company's representative may create a relationship that could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor who in turn can use the money to reduce the conference's registration fee. Payments to defray the costs of a conference should not be accepted directly from the company by the physicians attending the conference.
(5) Subsidies from industry should not be accepted directly or indirectly to pay for the costs of travel, lodging, or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging, and meal expenses. Token consulting or advisory arrangements cannot be used to justify the compensation of physicians for their time or their travel, lodging, and other out-of-pocket expenses.
(6) Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution. Carefully selected educational conferences are generally defined as the major educational, scientific or policy-making meetings of national, regional, or specialty medical associations.
(7) No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and materials should belong to the organizers of the conferences or lectures. (II)

Issued June 1992 based on the report "Gifts to Physicians from Industry," adopted December 1990 (JAMA. 1991; 265: 501); Updated June 1996 and June 1998.

Clarification of Opinion 8.061

Scope
Opinion 8.061, "Gifts to Physicians from Industry," is intended to provide ethical guidance to physicians. Other parties involved in the health care sector, including the pharmaceutical, devices, and medical equipment industries and related entities or business partners, should view the guidelines as indicative of standards of conduct for the medical profession. Ultimately, it is the responsibility of individual physicians to minimize conflicts of interest that may be at odds with the best interest of patients and to access the necessary information to inform medical recommendations.

The guidelines apply to all forms of gifts, whether they are offered in person, through intermediaries, or through the Internet. Similarly, limitations on subsidies for educational activities should apply regardless of the setting in which, or the medium through which, the educational activity is offered.

General Questions
(a) Do the guidelines apply only to pharmaceutical, device, and equipment manufacturers?

"Industry" includes all "proprietary health-related entities that might create a conflict of interest."

Guideline 1
Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted. The use of drug samples for personal or family use is permissible as long as these practices do not interfere with patient access to drug samples. It would not be acceptable for non-retired physicians to request free pharmaceuticals for personal use or for use by family members.

(a) May physicians accept gram stain test kits, stethoscopes, or other diagnostic equipment?

Diagnostic equipment primarily benefits the patient. Hence, such gifts are permissible as long as they are not of substantial value. In considering the value of the gift, the relevant measure is not the cost to the company of providing the gift. Rather, the relevant measure is the cost to the physician if the physician purchased the gift on the open market.

(b) May companies invite physicians to a dinner with a speaker and donate $100 to a charity or medical school on behalf of the physician?

There are positive aspects to the proposal. The donations would be used for a worthy cause, and the physicians would receive important information about patient care. There is a direct personal benefit to the physician as well, however. An organization that is important to the physician-and one that the physician might have ordinarily felt obligated to make a contribution to-receives financial support as a result of the physician’s decision to attend the meeting. On balance, physicians should make their own judgment about these inducements. If the charity is predetermined without the physician’s input, there would seem to be little problem with the arrangement.

(c) May contributions to a professional society’s general fund be accepted from industry?

The guidelines are designed to deal with gifts from industry which affect, or could appear to affect, the judgment of individual practicing physicians. In general, a professional society should make its own judgment about gifts from industry to the society itself.

(d) When companies invite physicians to a dinner with a speaker, what are the relevant guidelines?

First, the dinner must be a modest meal. Second, the guideline does allow gifts that primarily benefit patients and that are not of substantial value. Accordingly, textbooks and other gifts that primarily benefit patient care and that have a value to the physician in the general range of $100 are permissible. When educational meetings occur in conjunction with a social event such as a meal, the educational component must have independent value, such as a presentation by an authoritative speaker other than a sales representative of the company. Also, the meal should be a modest one similar to what a physician routinely might have when dining at his or her own expense. In an office or hospital encounter with a company representative, it is permissible to accept a meal of nominal value, such as a sandwich or snack.

(e) May physicians accept vouchers that reimburse them for uncompensated care they have provided?

No. Such a voucher would result directly in increased income for the physician.

(f) May physicians accumulate "points" by attending several educational or promotional meetings and then choose a gift from a catalogue of education options?

This guideline permits gifts only if they are not of substantial value. If accumulation of points would result in physicians receiving a substantial gift by combining insubstantial gifts over a relatively short period of time, it would be inappropriate.

(g) May physicians accept gift certificates for educational materials when attending promotional or educational events?

The Council views gift certificates as a grey area which is not per se prohibited by the guidelines. Medical textbooks are explicitly approved as gifts under the guidelines. A gift certificate for educational materials, ie, for the selection by the physician from an

exclusively medical textbook catalogue, would not seem to be materially different. The issue is whether the gift certificate gives the recipient such control as to make the certificate similar to cash. As with charitable donations, preselection by the sponsor removes any question. It is up to the individual physician to make the final judgment.

(h) May physicians accept drug samples or other free pharmaceuticals for personal use or use by family members?

The Council's guidelines permit personal or family use of free pharmaceuticals (i) in emergencies and other cases where the immediate use of a drug is indicated, (ii) on a trial basis to assess tolerance, and (iii) for the treatment of acute conditions requiring short courses of inexpensive therapy, as permitted by Opinion 8.19, "Self-Treatment or Treatment of Immediate Family Members." It would not be acceptable for physicians to accept free pharmaceuticals for the long-term treatment of chronic conditions.

(i) May companies invite physicians to a dinner with a speaker and offer them a large number of gifts from which to choose one?

In general, the greater the freedom of choice given to the physician, the more the offer seems like cash. A large number of gifts presented to physicians who attend a dinner would therefore be inappropriate.

There is no precise way of deciding an appropriate upper limit on the amount of choice that is acceptable. However, it is important that a specific limit be chosen to ensure clarity in the guidelines. A limit of eight has been chosen because it permits flexibility but prevents undue freedom of choice. Each of the choices must have a value to the physicians of no more than $100.

(j) May physicians charge for their time with industry representatives or otherwise receive material compensation for participation in a detail visit?

Guideline 1 states that gifts in the form of cash payments should not be accepted. Also, Guideline 6 makes clear that, in the context of the industry-physician relationship, only physicians who provide genuine services may receive reasonable compensation. When considering the time a physician spends with an industry representative, it is the representative who offers a service, namely the presentation of information. The physician is a beneficiary of the service. Overall, these guidelines do not view that physicians should be compensated for the time spent participating in educational activities, nor for time spent receiving detail information from an industry representative.

Guideline 2
Individual gifts of minimal value are permissible as long as the gifts are related to the physician's work (eg, pens and notepads).

(a) May physicians, individually or through their practice group, accept electronic equipment, such as hand held devices or computers, intended to facilitate their ability to receive detail information electronically?

Although Guideline 2 recognizes that gifts related to a physician' s practice may be appropriate, it also makes clear that these gifts must remain of minimal value. It is not appropriate for physicians to accept expensive hardware or software equipment even though one purpose only may pertain to industry-related activities of a modest value.

Guideline 3
The Council on Ethical and Judicial Affairs defines a legitimate "conference" or "meeting" as any activity, held at an appropriate location, where (a) the gathering is primarily dedicated, in both time and effort, to promoting objective scientific and educational activities and discourse (one or more educational presentation(s) should be the highlight of the gathering), and (b) the main incentive for bringing attendees together is to further their knowledge on the topic(s) being presented. An appropriate disclosure of financial support or conflict of interest should be made.

Guideline 4
Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a subsidy directly to a physician by a company's sales representative may create a relationship which could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor who in turn can use the money to reduce the conference's registration fee. Payments to defray the costs of a conference should not be accepted directly from the company by the physicians attending the conference.

(a) Are conference subsidies from the educational division of a company covered by the guidelines?

Yes. When the Council says "any subsidy," it would not matter whether the subsidy comes from the sales division, the educational division, or some other section of the company.

(b) May a company or its intermediary send physicians a check or voucher to offset the registration fee at a specific conference or a

conference of the physician's choice?

Physicians should not directly accept checks or certificates which would be used to offset registration fees. The gift of a reduced registration should be made across the board and through the accredited sponsor.

Guideline 5
Subsidies from industry should not be accepted directly or indirectly to pay for the costs of travel, lodging, or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging, and meal expenses. Token consulting or advisory arrangements cannot be used to justify the compensation of physicians for their time or their travel, lodging, and other out-of-pocket expenses.

(a) If a company invites physicians to visit its facilities for a tour or to become educated about one of its products, may the company pay travel expenses and honoraria?

This question has come up in the context of a rehabilitation facility that wants physicians to know of its existence so that they may refer their patients to the facility. It has also come up in the context of surgical device or equipment manufacturers who want physicians to become familiar with their products.

In general, travel expenses should not be reimbursed, nor should honoraria be paid for the visiting physician's time since the presentations are analogous to a pharmaceutical company's educational or promotional meetings. The Council recognizes that medical devices, equipment, and other technologies may require, in some circumstances, special evaluation or training in proper usage which can not practicably be provided except on site. Medical specialties are in a better position to advise physicians regarding the appropriateness of reimbursement with regard to these trips. In cases where the company insists on such visits as a means of protection from liability for improper usage, physicians and their specialties should make the judgment. In no case would honoraria be appropriate and any travel expenses should be only those strictly necessary.

(b) If the company invites physicians to visit its facilities for review and comment on a product, to discuss their independent research projects, or to explore the potential for collaborative research, may the company pay travel expenses and an honorarium?

If the physician is providing genuine services, reasonable compensation for time and travel expenses can be given. However, token advisory or consulting arrangements cannot be used to justify compensation.

(c) May a company hold a sweepstakes for physicians in which five entrants receive a trip to the Virgin Islands or airfare to the medical meeting of their choice?

No. The use of a sweepstakes or raffle to deliver a gift does not affect the permissibility of the gift. Since the sweepstakes is not open to the public, the guidelines apply in full force.

(d) If a company convenes a group of physicians to recruit clinical investigators or convenes a group of clinical investigators for a meeting to discuss their results, may the company pay for their travel expenses?

Expenses may be paid if the meetings serve a genuine research purpose. One guide to their propriety would be whether the National Institute of Health (NIH) conducts similar meetings when it sponsors multi-center clinical trials. When travel subsidies are acceptable, the guidelines emphasize that they be used to pay only for "reasonable" expenses. The reasonableness of expenses would depend on a number of considerations. For example, meetings are likely to be problematic if overseas locations are used for exclusively domestic investigators. It would be inappropriate to pay for recreation or entertainment beyond the kind of modest hospitality described in this guideline.

(e) How can a physician tell whether there is a "genuine research purpose?"

A number of factors can be considered. Signs that a genuine research purpose exists include the facts that there are (1) a valid study protocol, (2) recruitment of physicians with appropriate qualifications or expertise, and (3) recruitment of an appropriate number of physicians in light of the number of study participants needed for statistical evaluation.

(f) May a company compensate physicians for their time and travel expenses when they participate in focus groups?

Yes. As long as the focus groups serve a genuine and exclusive research purpose and are not used for promotional purposes, physicians may be compensated for time and travel expenses. The number of physicians used in a particular focus group or in multiple

focus groups should be an appropriate size to accomplish the research purpose, but no larger.

(g) Do the restrictions on travel, lodging, and meals apply to educational programs run by medical schools, professional societies, or other accredited organizations which are funded by industry, or do they apply only to programs developed and run by industry?

The restrictions apply to all conferences or meetings which are funded by industry. The Council drew no distinction on the basis of the organizer of the conference or meeting. The Council felt that the gift of travel expenses is too substantial even when the conference is run by a non-industry sponsor. (Industry includes all "proprietary health-related entities that might create a conflict of interest.")

(h) May company funds be used for travel expenses and honoraria for bona fide faculty at educational meetings?

This guideline draws a distinction between attendees and faculty. As was stated, "[i]t is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses."

Companies need to be mindful of the guidelines of the Accreditation Council on Continuing Medical Education. According to those guidelines, "[f]unds from a commercial source should be in the form of an educational grant made payable to the CME sponsor for the support of programming."

(i) May travel expenses be reimbursed for physicians presenting a poster or a "free paper" at a scientific conference?

Reimbursement may be accepted only by bona fide faculty. The presentation of a poster or a free paper does not by itself qualify a person as a member of the conference faculty for purposes of these guidelines.

(j) When a professional association schedules a long-range planning meeting, is it appropriate for industry to subsidize the travel expenses of the meeting participants?

The guidelines are designed to deal with gifts from industry which affect, or could appear to affect, the judgment of individual practicing physicians. In general, a professional society should make its own judgment about gifts from industry to the society itself.

(k) May continuing medical education conferences be held in the Bahamas, Europe, or South America?

There are no restrictions on the location of conferences as long as the attendees are paying their own travel expenses.

(l) May travel expenses be accepted by physicians who are being trained as speakers or faculty for educational conferences and meetings?

In general, no. If a physician is presenting as an independent expert at a CME event, both the training and its reimbursement raise questions about independence. In addition, the training is a gift because the physician’s role is generally more analogous to that of an attendee than a participant. Speaker training sessions can be distinguished from meetings (See 5d) with leading researchers, sponsored by a company, designed primarily for an exchange of information about important developments or treatments, including the sponsor’s own research, for which reimbursement for travel may be appropriate.

(m) What kinds of social events during conferences and meetings may be subsidized by industry?

Social events should satisfy three criteria. First, the value of the event to the physician should be modest. Second, the event should facilitate discussion among attendees and/or discussion between attendees and faculty. Third, the educational part of the conference should account for a substantial majority of the total time accounted for by the educational activities and social events together. Events that would be viewed (as in the succeeding question) as lavish or expensive should be avoided. But modest social activities that are not elaborate or unusual are permissible, eg, inexpensive boat rides, barbecues, entertainment that draws on the local performers. In general, any such events which are a part of the conference program should be open to all registrants.

(n) May a company rent an expensive entertainment complex for a evening during a medical conference and invite the physicians attending the conference?

No. The guidelines permit only modest hospitality.

(o) If physicians attending a conference engage in interactive exchange, may their travel expenses be paid by industry?

No. Mere interactive exchange would not constitute genuine consulting services.

(p) If a company schedules a conference and provides meals for the attendees that fall within the guidelines, may the company also pay for the costs of the meals for spouses?

If a meal falls within the guidelines, then the physician's spouse may be included.

(q) May companies donate funds to sponsor a professional society's charity golf tournament?

Yes. But it is sensible if physicians who play in the tournament make some contribution themselves to the event.

(r) If a company invites a group of consultants to a meeting and a consultant brings a spouse, may the company pay the costs of lodging or meals of the spouse? Does it matter if the meal is part of the program for the consultants?

Since the costs of having a spouse share a hotel room or join a modest meal are nominal, it is permissible for the company to subsidize those costs. However, if the total subsidies become substantial, then they become unacceptable.

Guideline 6
Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution. Carefully selected educational conferences are generally defined as the major educational, scientific, or policy-making meetings of national, regional, or specialty medical associations.

(a) When a company subsidizes the travel expenses of residents to an appropriately selected conference, may the residents receive the subsidy directly from the company?

Funds for scholarships or other special funds should be given to the academic departments or the accredited sponsor of the conference. The disbursement of funds can then be made by the departments or the conference sponsor.

(b) What is meant by "carefully selected educational conferences?"

The intent of Guideline 6 is to ensure that financial hardship does not prevent students, residents, and fellows from attending major educational conferences. For example, we did not want to deny cardiology fellows the opportunity to attend the annual scientific meeting of the American College of Cardiology or orthopedic surgery residents the opportunity to attend the annual scientific meeting of the American Academy of Orthopedic Surgeons. However, it was not the intent of the guideline to permit reimbursement of travel expenses in other circumstances, such as when conferences or symposia are designed specifically for students, residents, or fellows.

Funds are limited to travel and lodging expenses for attendance at major educational, scientific, or policy-making meetings of national, regional, or specialty medical associations.

Guideline 7
No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and materials should belong to the organizers of the conferences or lectures.

(a) May companies send their top prescribers, purchasers, or referrers on cruises?

No. There can be no link between prescribing or referring patterns and gifts. In addition, travel expenses, including cruises, are not permissible.

(b) May the funding company itself develop the complete educational program that is sponsored by an accredited continuing medical education sponsor?

No. The funding company may finance the development of the program through its grant to the sponsor, but the accredited sponsor must have responsibility and control over the content and faculty of conferences, meetings, or lectures. Neither the funding company nor an independent consulting firm should develop the complete educational program for approval by the accredited sponsor.

(c) How much input may a funding company have in the development of a conference, meeting, or lectures?

The guidelines of the Accreditation Council on Continuing Medical Education on commercial support of continuing medical education address this question.

Issued 1992. Updated December 2000, June 2002, and June 2004 (Food and Drug Law Journal, 2001;56(1):27-40).

E-8.062 Sale of Non-Health-Related Goods from Physicians' Offices

The sale of non-health-related goods by physicians presents a conflict of interest and threatens to erode the primary obligation of physicians to serve the interests of their patients before their own. Furthermore, this activity risks placing undue pressure on the patient and risks demeaning the practice of medicine.
Physicians should not sell non-health-related goods from their offices or other treatment settings, with the exception noted below. Physicians may sell low-cost non-health-related goods from their offices for the benefit of community organizations, provided that (1) the goods in question are low-cost; (2) the physician takes no share in profit from their sale; (3) such sales are not a regular part of the physician's business; (4) sales are conducted in a dignified manner; and (5) sales are conducted in such a way as to assure that patients are not pressured into making purchases. (I, II)

Issued June 1998 based on the report "Sale of Non-Health-Related Goods from Physicians' Offices," adopted December 1997. (JAMA1998 Aug 12;280(6):563.)

Clarification of Opinion 8.062

Do the guidelines discussing the sale of health-related products (8.063) and the sale of non-health-related goods (8.062) apply to physicians' practice Web-sites?

Yes. The physician who provides or sells products to patients must follow the above guidelines regardless of whether the products are provided in the physician's office or through a practice Web-site.

Adopted December 2000 as "Addendum III: Council on Ethical and Judicial Affairs Clarification on Sale of Products from Physicians' Offices (E-8.062 and E-8.063)

E-8.063 Sale of Health-Related Products from Physicians' Offices

"Health-related products" are any products that, according to the manufacturer or distributor, benefit health. "Selling" refers to the activity of dispensing items that are provided from the physician's office in exchange for money and also includes the activity of endorsing a product that the patient may order or purchase elsewhere that results in direct remuneration for the physician. This Opinion does not apply to the sale of prescription items which is already addressed in Opinion 8.06, "Prescribing and Dispensing Drugs and Devices."
Physicians who engage in in-office sales practices should be aware of the related guidelines presented in Opinion 8.062, "Sale of Non-Health-Related Goods from Physicians' Offices;" Opinion 8.06, "Prescribing and Dispensing Drugs and Devices;" Opinion 8.032, "Conflicts of Interest: Health Facility Ownership by a Physician;" Opinion 3.01, "Nonscientific Practitioners;" Opinion 8.20, "Invalid Medical Treatment;" as well as the reports from which these opinions are extracted.
In-office sale of health-related products by physicians presents a financial conflict of interest, risks placing undue pressure on the patient, and threatens to erode patient trust and undermine the primary obligation of physicians to serve the interests of their patients before their own.
(1) Physicians who choose to sell health-related products from their offices should not sell any health-related products whose claims of benefit lack scientific validity. When judging the efficacy of a product, physicians should rely on peer-reviewed literature and other unbiased scientific sources that review evidence in a sound, systematic, and reliable fashion.
(2) Because of the risk of patient exploitation and the potential to demean the profession of medicine, physicians who choose to sell health-related products from their offices must take steps to minimize their financial conflicts of interest. The following guidelines apply:
(a) In general, physicians should limit sales to products that serve the immediate and pressing needs of their patients. For example, if traveling to the closest pharmacy would in some way jeopardize the welfare of the patient (eg, forcing a patient with a broken leg to travel to a local pharmacy for crutches), then it may be appropriate to provide the product from the physician's office. These conditions are explained in more detail in the Council's Opinion 8.06, "Prescribing and Dispensing Drugs and Devices," and are analogous to situations that constitute exceptions to the permissibility of self-referral.
(b) Physicians may distribute other health-related products to their patients free of charge or at cost, in order to make useful products readily available to their patients. When health-related products are offered free or at cost, it helps to ensure removal of the elements of personal gain and financial conflicts of interest that may interfere, or appear to interfere, with the physician's independent medical judgment.
(3) Physicians must disclose fully the nature of their financial arrangement with a manufacturer or supplier to sell health-related products. Disclosure includes informing patients of financial interests as well as about the availability of the product or other equivalent products elsewhere. Disclosure can be accomplished through face-to-face communication or by posting an easily understandable written notification in a prominent location that is accessible by all patients in the office. In addition, physicians should, upon request, provide patients with understandable literature that relies on scientific standards in addressing the risks, benefits, and limits of knowledge regarding the health-related product.
(4) Physicians should not participate in exclusive distributorships of health-related products which are available only through physicians' offices. Physicians should encourage manufacturers to make products of established benefit more fairly and more widely

accessible to patients than exclusive distribution mechanisms allow. (II)

Issued December 1999 based on the report "Sale of Health-Related Products from Physicians' Offices," adopted June 1999.

Clarification of Opinion 8.063

Do the guidelines discussing the sale of health-related products (8.063) and the sale of non-health-related goods (8.062) apply to physicians' practice Web-sites?

Yes. The physician who provides or sells products to patients must follow the above guidelines regardless of whether the products are provided in the physician's office or through a practice Web-site.

Adopted December 2000 as "Addendum III: Council on Ethical and Judicial Affairs Clarification on Sale of Products from Physicians' Offices (E-8.062 and E-8.063)

E-8.07 Expedited Partner Therapy

Expedited Partner Therapy (EPT) is the practice of treating the sex partners of patients with sexually transmitted diseases via patient-delivered partner therapy without the partner receiving a medical evaluation or professional prevention counseling. While this practice is presently recommended by the Centers for Disease Control and Prevention for use in very limited circumstances (for gonorrhea or chlamydial infection in heterosexual men and women), EPT may be recommended for additional applications in the future.

Although EPT has been demonstrated to be effective at reducing the burden of certain diseases, it also has ethical implications. EPT potentially abrogates the standard informed consent process, compromises continuity of care for patients' partners, encroaches upon the privacy of patients and their partners, increases the possibility of harm by a medical or allergic reaction, leaves other diseases or complications undiagnosed, and may violate state practice laws. The following guidelines are offered for use in establishing whether EPT is appropriate:

(1) Physicians should determine the need for EPT by engaging in open discussions with patients to ascertain their partners' abilities to access medical services. Only if the physician reasonably believes that a patient's partner(s) will be unwilling or unable to seek treatment within the context of a traditional patient-physician relationship should the use of EPT be considered.

(2) Prior to initiating EPT, physicians are advised to seek the guidance of public health officials, as well as determine the legal status of EPT in their state.

(3) If the physician chooses to initiate EPT, he or she must provide patients with appropriate instructions regarding EPT and its accompanying medications and answers to any questions that they may have.

(4) Physicians must provide patients with educational material to share with their partners that encourages the partners to consult a physician as a preferred alternative to EPT, and that discloses the risk of potential adverse drug reactions and the possibility of dangerous interactions between the patient-delivered therapy and other medications that the partner may be taking. The partner should also be informed that he or she may be affected by other STDs that may be left untreated by the delivered medicine.

(5) The treating physician should also make reasonable efforts to refer a patient's partner(s) to appropriate health care professionals (VII). Issued November 2008 based on the report "Expedited Partner Therapy," adopted June 2008.

E-8.08 Informed Consent

E-8.08 Informed Consent

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice. The patient should make his or her own determination about treatment. The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a basic policy in both ethics and law that physicians must honor, unless the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent. In special circumstances, it may be appropriate to postpone disclosure of information, (see Opinion E-8.122, "Withholding Information from Patients").

Physicians should sensitively and respectfully disclose all relevant medical information to patients. The quantity and specificity of this information should be tailored to meet the preferences and needs of individual patients. Physicians need not communicate all information at one time, but should assess the amount of information that patients are capable of receiving at a given time and present

the remainder when appropriate. (I, II, V, VIII)
Issued March 1981. Updated June 2006, based on the Report "Withholding Information from Patients (Therapeutic Privilege)."

E-8.081 Surrogate Decision-Making

Competent adults may formulate, in advance, preferences regarding a course of treatment in the event that injury or illness causes severe impairment or loss of decision-making capacity. These preferences generally should be honored by the health care team out of respect for patient autonomy. Patients may establish an advance directive by documenting their treatment preferences and goals in a living will or by designating a health care proxy (durable power of attorney for health care) to make health care decisions on their behalf.

In some instances, a patient with diminished or impaired decision-making capacity can participate in various aspects of health care decision-making. The attending physician should promote the autonomy of such individuals by involving them to a degree commensurate with their capabilities.

If a patient lacks the capacity to make a health care decision, a reasonable effort should be made to identify a prior written expression of values such as a pertinent living will, or a health care proxy. When reasonable efforts have failed to uncover relevant documentation, physicians should consult state law. Physicians should be aware that under special circumstances (for example, reproductive decisions for individuals who are incompetent), state laws may specify court intervention. In the absence of state law specifying either appropriate surrogate decision-makers or a process to identify them, the patient's family, domestic partner, or close friend should become the surrogate decision-maker. When there is no family, domestic partner, or close friend, persons who have some relevant knowledge of the patient should participate in the decision-making process. In all other instances, a physician may wish to consult an ethics committee to aid in identifying a surrogate decision-maker or to facilitate sound decision-making.

When there is evidence of the patient's preferences and values, decisions concerning the patient's care should be made by substituted judgment. This entails considering the patient's advance directive (if any), the patient's views about life and how it should be lived, how the patient has constructed his or her identity or life story, and the patient's attitudes towards sickness, suffering, and certain medical procedures.

If there is no reasonable basis on which to interpret how a patient would have decided, the decision should be based on the best interests of the patient, or the outcome that would best promote the patient's well-being. Factors that should be considered when weighing the harms and benefits of various treatment options include the pain and suffering associated with treatment, the degree of and potential for benefit, and any impairments that may result from treatment. Any quality of life considerations should be measured as the worth to the individual whose course of treatment is in question, and not as a measure of social worth. One way to ensure that a decision using the best interest standard is not inappropriately influenced by the surrogate's own values is to determine the course of treatment that most reasonable persons would choose for themselves in similar circumstances.

Physicians should recognize the proxy or surrogate as an extension of the patient, entitled to the same respect as the competent patient. Physicians should provide advice, guidance, and support; explain that decisions should be based on substituted judgment when possible and otherwise on the best interest principle; and offer relevant medical information as well as medical opinions in a timely manner. In addition to the physician, other hospital staff or ethics committees are often helpful to providing support for the decision-makers.

In general, physicians should respect decisions that are made by the appropriately designated surrogate and based on the standard of substituted judgment or best interest. In cases where there is a dispute among family members, physicians should work to resolve the conflict through mediation. Physicians or an ethics committee should try to uncover the reasons that underlie the disagreement and present information that will facilitate decision-making. When a physician believes that a decision is clearly not what the patient would have decided, could not be reasonably judged to be within the patient's best interests, or primarily serves the interest of a surrogate or a third party, an ethics committee should be consulted before requesting court intervention.

Physicians should encourage their patients to document their treatment preferences or to appoint a health care proxy with whom they can discuss their values regarding health care and treatment in advance. Because documented advance directives are often not available in emergency situations, physicians should emphasize to patients the importance of discussing treatment preferences with individuals who are likely to act as their surrogates. (I, III, VIII) Issued December 2001 based on the report "Surrogate Decision-Making," adopted June 2001; updated December 2004.

E-8.082 Withholding Information from Patients

The practice of withholding pertinent medical information from patients in the belief that disclosure is medically contraindicated is known as "therapeutic privilege." It creates a conflict between the physician's obligations to promote patients' welfare and respect for their autonomy by communicating truthfully. Therapeutic privilege does not refer to withholding medical information in emergency situations, or reporting medical errors (see E-8.08, "Informed Consent," and E-8.121, "Ethical Responsibility to Study and Prevent

Error and Harm").

Withholding medical information from patients without their knowledge or consent is ethically unacceptable. Physicians should encourage patients to specify their preferences regarding communication of their medical information, preferably before the information becomes available. Moreover, physicians should honor patient requests not to be informed of certain medical information or to convey the information to a designated proxy, provided these requests appear to genuinely represent the patient's own wishes.

All information need not be communicated to the patient immediately or all at once; physicians should assess the amount of information a patient is capable of receiving at a given time, delaying the remainder to a later, more suitable time, and should tailor disclosure to meet patients' needs and expectations in light of their preferences.

Physicians may consider delaying disclosure only if early communication is clearly contraindicated. Physicians should continue to monitor the patient carefully and offer complete disclosure when the patient is able to decide whether or not to receive this information. This should be done according to a definite plan, so that disclosure is not permanently delayed. Consultation with patients' families, colleagues, or an ethics committee may help in assessing the balance of benefits and harms associated with delayed disclosure. In all circumstances, physicians should communicate with patients sensitively and respectfully. (I, III, V, VIII) Issued November 2006 based on the report "Withholding Information from Patients (Therapeutic Privilege)," adopted June 2006.

E-8.083 Placebo Use in Clinical Practice

A placebo is a substance provided to a patient that the physician believes has no specific pharmacological effect upon the condition being treated. In the clinical setting, the use of a placebo without the patient's knowledge may undermine trust, compromise the patient-physician relationship, and result in medical harm to the patient.

Physicians may use placebos for diagnosis or treatment only if the patient is informed of and agrees to its use. A placebo may still be effective if the patient knows it will be used but cannot identify it and does not know the precise timing of its use. A physician should enlist the patient's cooperation by explaining that a better understanding of the medical condition could be achieved by evaluating the effects of different medications, including the placebo. The physician need neither identify the placebo nor seek specific consent before its administration. In this way, the physician respects the patient's autonomy and fosters a trusting relationship, while the patient still may benefit from the placebo effect.

A placebo must not be given merely to mollify a difficult patient, because doing so serves the convenience of the physician more than it promotes the patient's welfare. Physicians can avoid using a placebo, yet produce a placebo-like effect through the skillful use of reassurance and encouragement. In this way, the physician builds respect and trust, promotes the patient-physician relationship, and improves health outcomes (I, II, VIII). Issued June 2007 based on the report "Placebo Use in Clinical Practice," adopted November 2006.

E-8.085 Waiver of Informed Consent for Research in Emergency Situations

The current state of emergency medicine and research has resulted in the application of standard treatments that often have not been scientifically evaluated for safety and effectiveness and may render unsatisfactory outcomes. Given the insufficiency of standard treatment alternatives, it is appropriate, in certain situations and with special safeguards, to provide experimental treatments without obtaining the informed consent of the subject. However, in order to protect the rights and welfare of the subjects, several conditions must be met:
(1) This type of research is limited to emergency, life-threatening situations, and may involve only experimental treatments that are ready for trials involving human subjects.
(2) The subject must lack the capacity to give informed consent for participation in the research.
(3) The window of opportunity for intervention must be so narrow as to make obtaining surrogate consent unfeasible.
(4) Obtaining prospective informed consent for the protocol must not be feasible (ie, the life threatening emergency situation could not have been anticipated).
(5) The experimental treatment must have a realistic probability of benefit equal to or greater than standard care.
(6) The risks associated with the research should be reasonable in light of the critical nature of the conditions and the risks associated with standard treatment.
(7) Where informed consent is waived, subjects or their representatives must be informed as soon as possible about inclusion in the study and asked to consent to further participation. Subjects, or their representatives, may choose to discontinue participation at any time after being fully informed about the possible consequences. Additionally, if the patient dies while participating in the research protocol, the patient's family or representative must be informed that the patient was involved in an experimental protocol.
(8) Community input should be sought prior to approval of the protocol, and public disclosure should be made of study results. Fair randomization of research subjects should be given thorough consideration. Moreover, an independent data monitoring board should be established to oversee the ongoing trial. (I, V) Issued December 1997 based on the report "Waiver of Informed Consent for Research in Emergency Situations," adopted June 1997.

E-8.087 Medical Student Involvement in Patient Care

(1) Patients and the public benefit from the integrated care that is provided by health care teams that include medical students. Patients should be informed of the identity and training status of individuals involved in their care and all health care professionals share the responsibility for properly identifying themselves. Students and their supervisors should refrain from using terms that may be confusing when describing the training status of students.
(2) Patients are free to choose from whom they receive treatment. When medical students are involved in the care of patients, health care professionals should relate the benefits of medical student participation to patients and should ensure that they are willing to permit such participation. Generally, attending physicians are best suited to fulfill this responsibility.
(3) In instances where the patient will be temporarily incapacitated (eg, anesthetized) and where student involvement is anticipated, involvement should be discussed before the procedure is undertaken whenever possible. Similarly, in instances where a patient may not have the capacity to make decisions, student involvement should be discussed with the surrogate decision-maker involved in the care of the patient whenever possible. (V, VII) Issued June 2001 based on the report "Medical Student Involvement in Patient Care," adopted December 2000 (J Clin Ethics. 2001; 12 :111-15).

E-8.088 Resident Physicians' Involvement in Patient Care

Residents and fellows have dual roles as trainees and caregivers. First and foremost, they are physicians and therefore should always regard the interests of patients as paramount. To facilitate both patient care and educational goals, physicians involved in the training of residents and fellows should ensure that the health care delivery environment is respectful of the learning process as well as the patient's welfare and dignity.

(1) In accordance with graduate medical education standards such as those promulgated by the Accreditation Council for Graduate Medical Education (ACGME), training must be structured to provide residents and fellows with appropriate faculty supervision and availability of faculty consultants, and with graduated responsibility relative to level of training and expertise.

(2) Residents' and fellows' interactions with patients must be based on honesty. Accordingly, residents and fellows should clearly identify themselves as members of a team that is supervised by the attending physician.

(3) If a patient refuses care from a resident or fellow, the attending physician should be notified. If after discussion, a patient does not want to participate in training, the physician may exclude residents or fellows from that patient's care or, if appropriate, transfer the patient's care to another physician or non-teaching service, or to another health care facility.

(4) Residents and fellows should participate fully in established mechanisms for error reporting and analysis in their training programs and hospital systems. They should cooperate with attending physicians in the communication of errors to patients. (See Opinion E-8.121, "Ethical Responsibility to Study and Prevent Error and Harm.")

(5) Residents and fellows are obligated, as are all physicians, to monitor their own health and level of alertness so that these factors do not compromise their ability to care for patients safely. (See Opinion E-9.035, "Physician Health and Wellness.") Residents and fellows should recognize that providing patient care beyond time permitted by their programs (for example, "moonlighting") might be potentially harmful to themselves and patients. Other activities that interfere with adequate rest during off-hours might be similarly harmful.

(6) Residency and fellowship programs must offer means to resolve educational or patient care conflicts that can arise in the course of training. All parties involved in such conflicts must continue to regard patient welfare as the first priority. Conflict resolution should not be punitive, but should aim at assisting residents and fellows to complete their training successfully. When necessary, higher administrative authorities or the relevant Residency Review Committee (RRC) should be involved, as articulated in ACGME guidelines. (I, II, V, VIII) Issued November 2005 based on the report "Resident Physicians' Involvement in Patient Care," adopted June 2005.

E-8.09 Laboratory Services

(1) A physician should not misrepresent or aid in the misrepresentation of laboratory services performed and supervised by a non-physician as the physician's professional services. Such situations could involve a laboratory owned by a physician who directs and manages its financial and business affairs with no professional medical services being provided; laboratory work being performed by technicians and directly supervised by a medical technologist with no participation by the physician; or the physician's name being used in connection with the laboratory so as to create the appearance that it is owned, operated, and supervised by a physician when this is not so.
(2) If a laboratory is owned, operated, and supervised by a non-physician in accordance with state law and performs tests exclusively for physicians who receive the results and make their own medical interpretations, the following considerations would apply:
The physician's ethical responsibility is to provide patients with high quality services. This includes services that the physician performs personally and those that are delegated to others. A physician should not utilize the services of any laboratory, irrespective of

whether it is operated by a physician or non-physician, unless she or he has the utmost confidence in the quality of its services. A physician must always assume personal responsibility for the best interests of his or her patients. Medical judgment based upon inferior laboratory work is likewise inferior. Medical considerations, not cost, must be paramount when the physician chooses a laboratory. The physician who disregards quality as the primary criterion or who chooses a laboratory solely because it provides low-cost laboratory services on which the patient is charged a profit, is not acting in the best interests of the patient. However, if reliable, quality laboratory services are available at lower cost, the patient should have the benefit of the savings. As a professional, the physician is entitled to fair compensation for his or her services. A physician should not charge a markup, commission, or profit on the services rendered by others. A markup is an excessive charge that exploits patients if it is nothing more than a tacked on amount for a service already provided and accounted for by the laboratory. A physician may make an acquisition charge or processing charge. The patient should be notified of any such charge in advance. (I, II, III, IV, V) Issued prior to April 1977; Updated June 1994.

E-8.095 Reporting Clinical Test Results: General Guidelines

To alleviate patients' anxieties, physicians should report clinical test results to patients within a reasonable time frame. Since many variables contribute to the urgency of a particular situation, physicians should use their best professional judgment when determining what length of time is reasonable for the particular situation at hand. Anticipated delays should be explained to patients at the time of testing.

Physicians should adopt a consistent reporting policy that accommodates the demands of their practice while at the same time being considerate of patients' anxieties. The reporting policy should be disclosed to patients, for instance when tests are administered, so patients know what to expect. Reporting policies should take into consideration under what circumstances (eg, all results, only abnormal results) and by whom (eg, the laboratory or the physician) test results are appropriately reported to the patient. Any anticipated inconsistencies should be disclosed to patients as soon as they are discovered.

Physicians should provide test results in language understandable to the patient and in the manner deemed most appropriate by the physician. Any information gathered from test results that would be necessary for patients to make intelligent medical decisions and give informed consent on future medical treatments must be disclosed to them.

Physicians should take all appropriate precautions to ensure the confidentiality of test results. Such precautions may include, but are not limited to, not leaving test results on an answering machine, on voice mail, or with a third party unless previously given permission to do so by the patient, not delivering test results via electronic mail, and not sending test results through the mail in any form other than a sealed envelope. (II, IV, V) Issued December 1998 based on the report "Reporting Clinical Test Results: General Guidelines," adopted June 1998.

E-8.10 Lien Laws

In states where there are lien laws, a physician may file a lien as a means of assuring payment of his or her fee provided the fee is fixed in amount and not contingent on the amount of settlement of the patient's claim against a third party. (I, VI) Issued prior to April 1977.

E-8.11 Neglect of Patient

Physicians are free to choose whom they will serve. The physician should, however, respond to the best of his or her ability in cases of emergency where first aid treatment is essential. Once having undertaken a case, the physician should not neglect the patient. (I, VI) Issued prior to April 1977; Updated June 1996.

E-8.115 Termination of the Physician-Patient Relationship

Physicians have an obligation to support continuity of care for their patients. While physicians have the option of withdrawing from a case, they cannot do so without giving notice to the patient, the relatives, or responsible friends sufficiently long in advance of withdrawal to permit another medical attendant to be secured. (I, VI) Issued June 1996 (formerly included in Opinion 8.11).

E-8.12 Patient Information

It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions. Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed decisions regarding future medical care.

Ethical responsibility includes informing patients of changes in their diagnoses resulting from retrospective review of test results or any other information. This obligation holds even though the patient's medical treatment or therapeutic options may not be altered by the new information.

Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient. (I, II, III, IV) Issued March 1981; Updated June 1994.

E-8.121 Ethical Responsibility to Study and Prevent Error and Harm

In the context of health care, an error is an unintended act or omission, or a flawed system or plan, that harms or has the potential to harm a patient. Patient safety can be enhanced by studying the circumstances surrounding health care errors. This can best be achieved through a legally protected review process, which is essential for reducing health care errors and preventing patient harm.
(1) Because they are uniquely positioned to have a comprehensive view of the care patients receive, physicians must strive to ensure patient safety and should play a central role in identifying, reducing, and preventing health care errors. This responsibility exists even in the absence of a patient-physician relationship.
(2) Physicians should participate in the development of reporting mechanisms that emphasize education and systems change, thereby providing a substantive opportunity for all members of the health care team to learn. Specifically, physicians should work with other relevant health care professionals to:
(a) Establish and participate fully in an effective, confidential, and protected error-reporting mechanism
(b) Develop means for objective review and analysis of reports regarding errors, and to conduct appropriate investigations into the causes of harm to a patient
(c) Ensure that the investigation of causes of harm, and the review and study of error reports result in preventive measures that are conveyed to all relevant individuals
(d) Identify and promptly report impaired and/or incompetent colleagues so that rehabilitation, retraining or disciplinary action can occur in order to prevent harm to patients
(3) Physicians must offer professional and compassionate concern toward patients who have been harmed, regardless of whether the harm was caused by a health care error. An expression of concern need not be an admission of responsibility. When patient harm has been caused by an error, physicians should offer a general explanation regarding the nature of the error and the measures being taken to prevent similar occurrences in the future. Such communication is fundamental to the trust that underlies the patient-physician relationship, and may help reduce the risk of liability.
(4) Physicians have a responsibility to provide for continuity of care to patients who may have been harmed during the course of their health care. If, because of the harm suffered under the care of a physician, a patient loses trust in that physician, the obligation may best be fulfilled by facilitating the transfer of the patient to the care of another physician.
(5) Physicians should seek changes to the current legal system to ensure that all errors in health care can be safely and securely reported and studied as a learning experience for all participants in the health care system, without threat of discoverability, legal liability, or punitive action. (I, II, III, IV, VIII) Issued December 2003 based on the report "Ethical Responsibility to Study and Prevent Error and Harm in the Provision of Health Care,' adopted June 2003.

E-8.13 Managed Care

The expansion of managed care has brought a variety of changes to medicine including new and different reimbursement systems for physicians with complex referral restrictions and benefits packages for patients. Some of these changes have raised concerns that a physician's ability to practice ethical medicine will be adversely affected by the modifications in the system. In response to these concerns, the following points were developed to provide physicians with general guidelines that will assist them in fulfilling their ethical responsibilities to patients given the changes heralded by managed care.
(1) The duty of patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the system of health care delivery. Physicians must continue to place the interests of their patients first.
(2) When health care plans place restrictions on the care that physicians in the plan may provide to their patients, physicians should insist that the following principles be followed:
(a) Any broad allocation guidelines that restrict care and choices--which go beyond the cost/benefit judgments made by physicians as a part of their normal professional responsibilities--should be established at a policy-making level so that individual physicians are not asked to engage in bedside rationing.
(b) Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for any care they believe will materially benefit their patients.
(c) Physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Health care plans should create structures similar to hospital medical staffs that allow physicians to have meaningful input into the plan's development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis and updated to reflect advances in medical knowledge and changes in relative costs.
(d) Adequate appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in unfair denials of care, ie, denial of care that, in the physician's judgment, would materially benefit the patient. In such cases, the physician's duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise when a health plan has an allocation guideline that is generally unfair in its operations. In such cases, the physician's duty as patient advocate requires not only a challenge to any denials of treatment from the guideline but also advocacy at the health plan's policy-making level to seek an elimination or modification of the guideline. Physicians should assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient's best interests.
(e) Health care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information. Full disclosure requires that health care plans inform potential subscribers of limitations or restrictions on the benefits package when

they are considering entering the plan.
(f) Physicians also should continue to promote full disclosure to patients enrolled in health care plans. The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's health care plan. Full disclosure includes informing patients of all of their treatment options, even those that may not be covered under the terms of the health care plan. Patients may then determine whether an appeal is appropriate, or whether they wish to seek care outside the plan for treatment alternatives that are not covered.
(g) Physicians should not participate in any plan that encourages or requires care below minimum professional standards.
(3) When physicians are employed or reimbursed by health care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians' personal financial interests and the needs of their patients. Efforts to contain health care costs should not place patient welfare at risk. Thus, physicians should accept only those financial incentives that promote the cost-effective delivery of health care and not the withholding of medically necessary care.
(a) Physicians should insist that any incentives to limit care must be disclosed fully to patients by plan administrators upon enrollment and at least annually thereafter.
(b) Physicians should advocate that limits be placed on the magnitude of fee withholds, bonuses, and other financial incentives to limit care and that incentive payments be calculated according to the performance of a sizable group of physicians rather than on an individual basis.
(c) Physicians should advocate that health care plans or other groups develop financial incentives based on quality of care. Such incentives should complement those based on the quantity of services used.
(4) Physicians should encourage both that patients be aware of the benefits and limitations of their health care coverage and that they exercise their autonomy by public participation in the formulation of benefits packages and by prudent selection of health care coverage that best suits their needs. (I, II, III, V) Issued June 1996 based on the report "Ethical Issues in Managed Care," adopted June 1994 (JAMA. 1995; 273: 330-35); Updated June 2002.

E-8.132 Referral of Patients: Disclosure of Limitations

Physicians should always make referral decisions based on the best interests of their patients, regardless of the financing and delivery mechanisms or contractual agreements between patients, health care practitioners and institutions, and third party payers. When physicians agree to provide treatment, they assume an ethical obligation to treat their patients to the best of their ability. If a physician knows that a patient's health care plan or other agreement does not cover referral to a non-contracting medical specialist or to a facility that the physician believes to be in the patient's best interest, the physician should so inform the patient to permit the patient to decide whether to accept the outside referral.

Physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward, or the avoidance of financial penalties. Because patients must have the necessary information to make informed decisions about their care, physicians have an obligation to disclose medically appropriate treatment alternatives. Physicians should also promote an effective program to monitor and improve the quality of the patient care services within their practice settings.

Physicians must ensure disclosure of any financial incentives that may limit appropriate diagnostic and therapeutic alternatives that are offered to patients or that may limit patients' overall access to care. This obligation may be satisfied if the health care plan or other agreement makes adequate disclosure to enrolled patients. (II, IV) Issued June 1986; Updated June 1994 based on the report "Financial Incentives to Limit Care: Ethical Implications for HMOs and IPAs," adopted June 1990; updated June 2002; updated November 2007.

E-8.135 Cost Containment Involving Prescription Drugs in Health Care Plans

When health care plans, whether publicly or privately financed, establish drug formulary systems, physicians are obligated to advocate for formularies that meet the medical needs of their patients.
(1) Physicians should maintain awareness of plan decisions about drug selection by staying informed, where appropriate, about pharmacy and therapeutics (P&T) committee actions and by ongoing personal review of formulary composition. P&T committee members should include independent physician representatives. Mechanisms should be established for ongoing peer review of formulary policy. Physicians who perceive inappropriate influences on formulary development should notify the proper regulatory authorities.
(2) When scientifically based evidence is available, physicians are ethically required to advocate for changes to the formulary that would benefit the patient. Physicians also should advocate for exceptions to the formulary on a case-by-case basis when justified by the health care needs of particular patients. Mechanisms to appeal formulary exclusions should be established. Other cost-containment mechanisms, including prescription caps and prior authorization, should not unduly burden physicians or patients in accessing optimal drug therapy. Quality improvement rather than cost containment should be the primary determinant for formulary exclusions. In order to be cost efficient, however, physicians should select the lowest cost medication of equal efficacy for their patients.
(3) Physicians should advocate that limits be placed on the extent to which health care plans use incentives or pressures to lower prescription drug costs. Financial incentives are permissible when they promote cost-effectiveness, not when they require withholding medically necessary care. Physicians should not be made to feel that they jeopardize their compensation or participation in a health care plan if they prescribe drugs that are necessary for their patients but that may also be costly. There should be limits on the

magnitude of financial incentives, which should be calculated according to the practices of a sizeable group of physicians rather than on an individual basis, and incentives based on quality of care rather than cost of care should be used. Prescriptions should not be changed without the physician's knowledge and authorization. This affords the physician the opportunity to discuss the change with the patient.
(4) Physicians should encourage health care plans to develop mechanisms to educate and assist physicians in cost-effective prescribing practices, including the availability of clinical pharmacists. Such initiatives are preferable to financial incentives or pressures by health care plans or hospitals, which can be ethically problematic.
(5) Physicians should advocate that methods to limit prescription drug costs within health care plans in which they participate be disclosed to patients. In particular, they should encourage health care plans to inform patients upon enrollment concerning:
(i) the existence of formularies
(ii) provisions for cases in which the physician prescribes a drug that is not included in the formulary
(iii) incentives or other mechanisms used to encourage formulary compliance by physicians
(iv) relationships with pharmaceutical benefit management companies or pharmaceutical companies that could influence the composition of the formulary

If physicians exhaust all avenues to secure a formulary exception for a significantly advantageous drug, they are still obligated to disclose the option of the more beneficial drug to the patient, so that the patient can consider whether to obtain the medication out-of-plan. Under circumstances in which the health care program will not subsidize the drug, physicians should help patients by identifying alternative forms of financial assistance, such as those available through pharmaceutical companies' assistance programs. (III) Issued June 1996 based on the report "Managed Care Cost Containment Involving Prescription Drugs," adopted June 1995 (Food and Drug Law Journal. 1998; 53: 25-34); updated June 2002.

E-8.137 Restrictions on Disclosure in Managed Care Contracts

The previous Opinion 8.137, "Restrictions on Disclosure in Managed Care Contracts," issued June 1997, was deleted in June 2000 and combined with Opinion 8.053, "Restrictions on Disclosure in Managed Care Contracts."

E-8.14 Sexual Misconduct in the Practice of Medicine

Sexual contact that occurs concurrent with the patient-physician relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well-being.
If a physician has reason to believe that non-sexual contact with a patient may be perceived as or may lead to sexual contact, then he or she should avoid the non-sexual contact. At a minimum, a physician's ethical duties include terminating the physician-patient relationship before initiating a dating, romantic, or sexual relationship with a patient.
Sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship. (I, II, IV) Issued December 1989; Updated March 1992 based on the report "Sexual Misconduct in the Practice of Medicine," adopted December 1990 (JAMA. 1991; 266: 2741-2745).

E-8.145 Sexual or Romantic Relations Between Physicians and Key Third Parties

Patients are often accompanied by third parties who play an integral role in the patient-physician relationship. The physician interacts and communicates with these individuals and often is in a position to offer them information, advice, and emotional support. The more deeply involved the individual is in the clinical encounter and in medical decision making, the more troubling sexual or romantic contact with the physician would be. This is especially true for the individual whose decisions directly impact on the health and welfare of the patient. Key third parties include, but are not limited to, spouses or partners, parents, guardians, and proxies.

Physicians should refrain from sexual or romantic interactions with key third parties when it is based on the use or exploitation of trust, knowledge, influence, or emotions derived from a professional relationship. The following factors should be considered when considering whether a relationship is appropriate: the nature of the patient's medical problem, the length of the professional relationship, the degree of the third party's emotional dependence on the physician, and the importance of the clinical encounter to the third party and the patient. (I, II) Issued December 1998 based on the report "Sexual or Romantic Relations between Physicians and Key Third Parties," adopted June 1998.

E-8.15 Substance Abuse

It is unethical for a physician to practice medicine while under the influence of a controlled substance, alcohol, or other chemical agents which impair the ability to practice medicine. (I) Issued December 1986.

E-8.16 Substitution of Surgeon without Patient's Knowledge or Consent

A surgeon who allows a substitute to operate on his or her patient without the patient's knowledge and consent is deceitful. The patient is entitled to choose his or her own physician and should be permitted to acquiesce to or refuse the substitution.
The surgeon's obligation to the patient requires the surgeon to perform the surgical operation: (1) within the scope of authority granted by the consent to the operation; (2) in accordance with the terms of the contractual relationship; (3) with complete disclosure of facts relevant to the need and the performance of the operation; and (4) utilizing best skill.
It should be noted that it is the operating surgeon to whom the patient grants consent to perform the operation. The patient is entitled to the services of the particular surgeon with whom he or she contracts. The operating surgeon, in accepting the patient, is obligated to utilize his or her personal talents in the performance of the operation to the extent required by the agreement creating the physician-patient relationship. The surgeon cannot properly delegate to another the duties which he or she is required to perform personally.
Under the normal and customary arrangement with patients, and with reference to the usual form of consent to operation, the operating surgeon is obligated to perform the operation but may be assisted by residents or other surgeons. With the consent of the patient, it is not unethical for the operating surgeon to delegate the performance of certain aspects of the operation to the assistant provided this is done under the surgeon's participatory supervision, ie, the surgeon must scrub. If a resident or other physician is to perform the operation under non-participatory supervision, it is necessary to make a full disclosure of this fact to the patient, and this should be evidenced by an appropriate statement contained in the consent. Under these circumstances, it is the resident or other physician who becomes the operating surgeon. (I, II, IV, V) Issued prior to April 1977; Updated June 1994.

E-8.17 Use of Restraints

All individuals have a fundamental right to be free from unreasonable bodily restraint. Physical and chemical restraints should therefore be used only in the best interest of the patient and in accordance with the following guidelines:
(1) The use of restraints, except in emergencies, may be implemented only upon the explicit order of a physician, in conformance with reasonable professional judgment.
(2) Judgment should be exercised in issuing pro re nata (PRN) orders for the use of physical or chemical restraints, and the implementation of such orders should be frequently reviewed and documented by the physician.
(3) The use of restraints should not be punitive, nor should they be used for convenience or as an alternative to reasonable staffing.
(4) Restraints should be used only in accordance with appropriate clinical indications.
(5) As with all therapeutic interventions, informed consent by the patient or surrogate decision maker is a key element in the application of physical and chemical restraints, and should be incorporated into institutional policy.
(6) In certain limited situations, it may be appropriate to restrain a patient involuntarily. For example, restraints may be needed for the safety of the patient or others in the area. When restraints are used involuntarily, the restraints should be removed when they are no longer needed. (I, IV) Issued March 1992 based on the report "Guidelines for the Use of Restraints in Long Term Care Facilities," adopted June 1989.

E-8.18 Informing Families of a Patient's Death

Disclosing the death of a patient to the patient's family is a duty which goes to the very heart of the patient-physician relationship and should not be readily delegated to others by the attending physician. The emotional needs of the family and the integrity of the physician-patient relationship must at all times be given foremost consideration.
Physicians in residency training may be asked to participate in the communication of information about a patient's death, if that request is commensurate with the physician's prior training or experience and previous close personal relationship with the family.
It would not be appropriate for the attending physician or resident to request that a medical student notify family members of a patient's death. Medical students should be trained in issues of death and dying, and should be encouraged to accompany attending physicians when news of a patient's death is conveyed to the family members. (I, IV) Issued March 1992 based on the report "Informing Families of a Patient's Death: Guidelines for the Involvement of Medical Students," adopted December 1989; Updated June 1994.

E-8.181 Performing Procedures on the Newly Deceased for Training Purposes

Physicians should work to develop institutional policies that address the practice of performing procedures on the newly deceased for purposes of training. Any such policy should ensure that the interests of all the parties involved are respected under established and clear ethical guidelines. Such policies should consider rights of patients and their families, benefits to trainees and society, as well as potential harm to the ethical sensitivities of trainees, and risks to staff, the institution, and the profession associated with performing procedures on the newly deceased without consent. The following considerations should be addressed before medical trainees perform procedures on the newly deceased:
(1) The teaching of life-saving skills should be the culmination of a structured training sequence, rather than relying on random opportunities. Training should be performed under close supervision, in a manner and environment that takes into account the wishes and values of all involved parties.
(2) Physicians should inquire whether the deceased individual had expressed preferences regarding handling of the body or procedures performed after death. In the absence of previously expressed preferences, physicians should obtain permission from the family before

performing such procedures. When reasonable efforts to discover previously expressed preferences of the deceased or to find someone with authority to grant permission for the procedure have failed, physicians must not perform procedures for training purposes on the newly deceased patient.
In the event post-mortem procedures are undertaken on the newly deceased, they must be recorded in the medical record. (I, V)
Issued December 2001, based on the report, "Performing Procedures on the Newly Deceased for Training Purposes," adopted June 2001, (Acad. Med. 2002; 77:1212-1216).

E-8.19 Self-Treatment or Treatment of Immediate Family Members

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.
Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.
It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members. (I, II, IV) Issued June 1993.

E-8.191 Peers as Patients

The opportunity to care for a fellow physician is a privilege and may represent a gratifying experience and serve as a show of respect or competence. In emergencies or isolated or rural settings when options for care by other physicians are limited or where there is no other qualified physician available, physicians should not hesitate to treat peers. There are, however, a number of ethical considerations to weigh before undertaking the care of a colleague.

(1) Physicians who provide care to a peer should be alerted to the possibility that their professional relationship with the patient may affect their ability to exercise objective professional judgment and make unbiased treatment recommendations. They must also recognize that the physician-patient may be reluctant to disclose sensitive information or permit an intimate examination.

(2) Physicians providing care to a professional colleague have an obligation to respect informational and physical privacy of physician-patients as they would for any patient. Treating physicians should consider, and possibly discuss with the physician-patient, how to respond appropriately to the inquiries about the physician-patient's medical care from other physicians or medical staff. Treating physicians should also recognize that special measures may be required to ensure that the physician-patient's physical privacy is respected.

(3) Physicians providing care to a colleague should respect the physician-patient's right to participate in informed decision-making. Treating physicians should make no assumptions about the physician-patient's knowledge about her or his medical condition and should provide information to enable the physician-patient to make voluntary, fully informed decisions about care.

(4) Physicians-in-training and medical students face unique challenges when asked to provide or participate in care for peers given the circumstances of their roles in medical schools and residency programs. Except in emergency situations or when other care is not available, physicians-in-training should not be required to care for fellow trainees, faculty members, or attending physicians if they are reluctant to do so. (VI) Issued November 2008 based on the report "Peers as Patients," adopted June 2008.

E-8.20 Invalid Medical Treatment

The following general guidelines are offered to serve physicians when they are called upon to decide among treatments:
(1) Treatments which have no medical indication and offer no possible benefit to the patient should not be used (Opinion 2.035, "Futile Care").
(2) Treatments which have been determined scientifically to be invalid should not be used (Opinion 3.01, "Nonscientific

Practitioners").
(3) Among the treatments that are scientifically valid, medically indicated, and offer a reasonable chance of benefit for patients, some are regulated or prohibited by law; physicians should comply with these laws. If physicians disagree with such laws, they should seek to change them.
(4) Among the various treatments that are scientifically valid, medically indicated, legal, and offer a reasonable chance of benefit for patients, the decision of which treatment to use should be made between the physician and patient. (I, III, IV) Issued June 1998 based on the report "Invalid Medical Treatment," adopted December 1997.

E-8.21 Use of Chaperones During Physical Exams

From the standpoint of ethics and prudence, the protocol of having chaperones available on a consistent basis for patient examinations is recommended. Physicians aim to respect the patient's dignity and to make a positive effort to secure a comfortable and considerate atmosphere for the patient; such actions include the provision of appropriate gowns, private facilities for undressing, sensitive use of draping, and clear explanations on various components of the physical examination. A policy that patients are free to make a request for a chaperone should be established in each health care setting. This policy should be communicated to patients, either by means of a well-displayed notice or preferably through a conversation initiated by the intake nurse or the physician. The request by a patient to have a chaperone should be honored.
An authorized health professional should serve as a chaperone whenever possible. In their practices, physicians should establish clear expectations about respecting patient privacy and confidentiality to which chaperones must adhere.
If a chaperone is to be provided, a separate opportunity for private conversation between the patient and the physician should be allowed. The physician should keep inquiries and history-taking, especially those of a sensitive nature, to a minimum during the course of the chaperoned examination. (I, IV) Issued December 1998 based on the report, "Use of Chaperones During Physical Exams," adopted June 1998.

E-9.00 Opinions on Professional Rights and Responsibilities

E-9.01 Accreditation

Physicians who engage in activities that involve the accreditation, approval, or certification of institutions, facilities, and programs that provide patient care or medical education or certify the attainment of specialized professional competence have the ethical responsibility to apply standards that are relevant, fair, reasonable, and nondiscriminatory. The accreditation of institutions and facilities that provide patient care should be based upon standards that focus upon the quality of patient care achieved. Standards used in the accreditation of patient care and medical education, or the certification of specialized professional attainment should not be adopted or used as a means of economic regulation. (II, IV, VII) Issued December 1982.

E-9.011 Continuing Medical Education

Physicians should strive to further their medical education throughout their careers, for only by participating in continuing medical education (CME) can they continue to serve patients to the best of their abilities and live up to professional standards of excellence. Fulfillment of mandatory state CME requirements does not necessarily fulfill the physician's ethical obligation to maintain his or her medical expertise.

Attendees. Guidelines for physicians attending a CME conference or activity are as follows:
(1) The physician choosing among CME activities should assess their educational value and select only those activities which are of high quality and appropriate for the physician's educational needs. When selecting formal CME activities, the physician should, at a minimum, choose only those activities that (a) are offered by sponsors accredited by the Accreditation Council for Continuing Medical Education (ACCME), the American Academy of Family Physicians (AAFP), or a state medical society; (b) contain information on subjects relevant to the physician's needs; (c) are responsibly conducted by qualified faculty; (d) conform to Opinion 8.061, "Gifts to Physicians from Industry."
(2) The educational value of the CME conference or activity must be the primary consideration in the physician's decision to attend or participate. Though amenities unrelated to the educational purpose of the activity may play a role in the physician's decision to participate, this role should be secondary to the educational content of the conference.
(3) Physicians should claim credit commensurate with only the actual time spent attending a CME activity or in studying a CME enduring material.
(4) Attending promotional activities put on by industry or their designees is not unethical as long as the conference conforms to Opinion 8.061, "Gifts to Physicians from Industry," and is clearly identified as promotional to all participants.

Faculty. Guidelines for physicians serving as presenters, moderators, or other faculty at a CME conference are as follows:
(1) Physicians serving as presenters, moderators, or other faculty at a CME conference should ensure that (a) research findings and therapeutic recommendations are based on scientifically accurate, up-to-date information and are presented in a balanced, objective manner; (b) the content of their presentation is not modified or influenced by representatives of industry or other financial contributors, and they do not employ materials whose content is shaped by industry. Faculty may, however, use scientific data

generated from industry-sponsored research, and they may also accept technical assistance from industry in preparing slides or other presentation materials, as long as this assistance is of only nominal monetary value and the company has no input in the actual content of the material.
(2) When invited to present at non-CME activities that are primarily promotional, faculty should avoid participation unless the activity is clearly identified as promotional in its program announcements and other advertising.
(3) All conflicts of interest or biases, such as a financial connection to a particular commercial firm or product, should be disclosed by faculty members to the activity's sponsor and to the audience. Faculty may accept reasonable honoraria and reimbursement for expenses in accordance with Opinion 8.061, "Gifts to Physicians from Industry."

Sponsors. Guidelines for physicians involved in the sponsorship of CME activities are as follows:
(1) Physicians involved in the sponsorship of CME activities should ensure that (a) the program is balanced, with faculty members presenting a broad range of scientifically supportable viewpoints related to the topic at hand; (b) representatives of industry or other financial contributors do not exert control over the choice of moderators, presenters, or other faculty, or modify the content of faculty presentations. Funding from industry or others may be accepted in accordance with Opinion 8.061, "Gifts to Physicians from Industry."
(2) Sponsors should not promote CME activities in a way that encourages attendees to violate the guidelines of the Council on Ethical and Judicial Affairs, including Opinion 8.061, "Gifts to Physicians from Industry," or the principles established for the AMA's Physician Recognition Award. CME activities should be developed and promoted consistent with guideline 2 for Attendees.
(3) Any non-CME activity that is primarily promotional must be identified as such to faculty and participants, both in its advertising and at the conference itself.
(4) The entity presenting the program should not profit unfairly or charge a fee which is excessive for the content and length of the program.
(5) The program, content, duration, and ancillary activities should be consistent with the ideals of the AMA CME program. (I, V) Issued December 1993; Updated June 1996.

E-9.012 Physicians' Political Communications with Patients and Their Families

Physicians enjoy the rights and privileges of free political speech shared by all Americans. It is laudable for physicians to run for political office; to lobby for political positions, parties or candidates; and in every other way to exercise the full scope of their political rights as citizens. These rights may be exercised individually or through involvement with organizations such as professional societies and political action committees.
In addition, physicians have a responsibility to work for the reform of, and to press for the proper administration of, laws that are related to health care. Physicians should keep themselves well-informed as to current political questions regarding needed and proposed changes to laws concerning such issues as access to health care, quality of health care services, scope of medical research, and promotion of public health.
It is natural that in fulfilling these political responsibilities, physicians will express their views to patients or their families. However, communications by telephone or other modalities with patients and their families about political matters must be conducted with the utmost sensitivity to patients' vulnerability and desire for privacy. Conversations about political matters are not appropriate at times when patients or families are emotionally pressured by significant medical circumstances. Physicians are best able to judge both the intrusiveness of the discussion and the patient's level of comfort. In general, when conversation with the patient or family concerning social, civic, or recreational matters is acceptable, discussion of items of political import may be appropriate.
Under no circumstances should physicians allow their differences with patients or their families about political matters to interfere with the delivery of high-quality professional care. (I, VII) Issued June 1999 based on the report "Physicians' Political Communications with Patients and Their Families," adopted December 1998.

E-9.02 Restrictive Covenants and the Practice of Medicine

Covenants-not-to-compete restrict competition, disrupt continuity of care, and potentially deprive the public of medical services. The Council on Ethical and Judicial Affairs discourages any agreement which restricts the right of a physician to practice medicine for a specified period of time or in a specified area upon termination of an employment, partnership, or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients' choice of physician. (VI, VII) Issued prior to April 1977; Updated June 1994 and June 1998.

E-9.021 Covenants-Not-to-Compete for Physicians-in-Training

It is unethical for a teaching institution to seek a non-competition guarantee in return for fulfilling its educational obligations. Physicians-in-training (residents in programs approved by the Accreditation Council for Graduate Medical Education [ACGME], fellows in ACGME-approved fellowship programs, and fellows in programs approved by one of the American Board of Medical Specialties specialty boards) should not be asked to sign covenants-not-to-compete as a condition of their entry into any residency or fellowship program. (III, IV, VI) Issued December 1997 based on the report "Covenants-Not-to-Compete for Physicians-in-Training," adopted June 1997 (JAMA. 1997; 278: 530).

E-9.025 Advocacy for Change in Law and Policy

Physicians may participate in individual acts, grassroots activities, or legally permissible collective action to advocate for change, as provided for in the AMA's *Principles of Medical Ethics.* Whenever engaging in advocacy efforts, physicians must ensure that the health of patients is not jeopardized and that patient care is not compromised.

Formal unionization of physicians, including physicians-in-training, may tie physicians' obligations to the interests of workers who may not share physicians' primary and overriding commitment to patients. Physicians should not form workplace alliances with those who do not share these ethical priorities.

Strikes and other collective action may reduce access to care, eliminate or delay necessary care, and interfere with continuity of care. Each of these consequences raises ethical concerns. Physicians should refrain from the use of the strike as a bargaining tactic. In rare circumstances, individual or grassroots actions, such as brief limitations of personal availability, may be appropriate as a means of calling attention to needed changes in patient care. Physicians are cautioned that some actions may put them or their organizations at risk of violating antitrust laws. Consultation with legal counsel is advised.

Physicians and physicians-in-training should press for needed reforms through the use of informational campaigns, non-disruptive public demonstrations, lobbying and publicity campaigns, and collective negotiation, or other options that do not jeopardize the health of patients or compromise patient care.

Physicians are free to decide whether participation in advocacy activities is in patients' best interests. Colleagues should not unduly influence or pressure them to participate nor should they punish them, overtly or covertly, for deciding whether or not to participate. (I, III, VI)
Issued December 1998 based on the report "Collective Action and Patient Advocacy," adopted June 1998. Updated June 2005 based on the report "Amendment to Opinion E-9.025, 'Collective Action and Patient Advocacy,'" adopted December 2004.

E-9.03 Civil Rights and Professional Responsibility

Opportunities in medical society activities or membership, medical education and training, employment, and all other aspects of professional endeavors should not be denied to any duly licensed physician because of race, color, religion, creed, ethnic affiliation, national origin, sex, sexual orientation, gender identity, age, or handicap. (IV) Issued prior to April 1977. Updated June 1994 and June 2008 based on the report "Modification of Ethics Policy to Ensure Inclusion for Transgender Physicians, Medical Students, and Patients," adopted November 2007

E-9.0305 Physician Health and Wellness

To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, construed broadly as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress. When health or wellness is compromised, so may the safety and effectiveness of the medical care provided. When failing physical or mental health reaches the point of interfering with a physician's ability to engage safely in professional activities, the physician is said to be impaired.

In addition to maintaining healthy lifestyle habits, every physician should have a personal physician whose objectivity is not compromised. Physicians whose health or wellness is compromised should take measures to mitigate the problem, seek appropriate help as necessary, and engage in an honest self-assessment of their ability to continue practicing.

Those physicians caring for colleagues should not disclose without the physician-patient's consent any aspects of their medical care, except as required by law, by ethical and professional obligation (Opinion E-9.031), or when essential to protect patients from harm. Under such circumstances, only the minimum amount of information required by law or to preserve patient safety should be disclosed.

The medical profession has an obligation to ensure that its members are able to provide safe and effective care. This obligation is discharged by:

- promoting health and wellness among physicians;
- supporting peers in identifying physicians in need of help;
- intervening promptly when the health or wellness of a colleague appears to have become compromised, including the offer of encouragement, coverage or referral to a physician health program;
- establishing physician health programs that provide a supportive environment to maintain and restore health and wellness;
- establishing mechanisms to assure that impaired physicians promptly cease practice;
- assisting recovered colleagues when they resume patient care;
- reporting impaired physicians who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations. This may entail reporting to the licensing authority. (I, II) Issued June 2004 based on the report

"Physician Health and Wellness," adopted December 2003.

E-9.031 Reporting Impaired, Incompetent, or Unethical Colleagues

Physicians have an ethical obligation to report impaired, incompetent, and/or unethical colleagues in accordance with the legal requirements in each state and assisted by the following guidelines:

Impairment. Physicians' responsibilities to colleagues who are impaired by a condition that interferes with their ability to engage safely in professional activities include timely intervention to ensure that these colleagues cease practicing and receive appropriate assistance from a physician health program (see Opinion E-9.0305, "Physician Health and Wellness"). Ethically and legally, it may be necessary to report an impaired physician who continues to practice despite reasonable offers of assistance and referral to a hospital or state physician health program. The duty to report under such circumstances, which stems from physicians' obligation to protect patients against harm, may entail reporting to the licensing authority.

Incompetence. Initial reports of incompetence should be made to the appropriate clinical authority who would be empowered to assess the potential impact on patient welfare and to facilitate remedial action. The hospital peer review body should be notified where appropriate. Incompetence that poses an immediate threat to the health and safety of patients should be reported directly to the state licensing board. Incompetence by physicians without a hospital affiliation should be reported to the local or state medical society and/or the state licensing or disciplinary board.

Unethical conduct. With the exception of incompetence or impairment, unethical behavior should be reported in accordance with the following guidelines and, considering, as necessary, the right to privacy of any patients involved:

Unethical conduct that threatens patient care or welfare should be reported to the appropriate authority for a particular clinical service. Unethical conduct that violates state licensing provisions should be reported to the state licensing board. It is appropriate to report unethical conduct that potentially violates criminal statutes to law enforcement authorities. All other unethical conduct should be reported to the local or state professional medical organization.

When the inappropriate conduct of a physician continues despite the initial report(s), the reporting physician should report to a higher or additional authority. The person or body receiving the initial report should notify the reporting physician when appropriate action has been taken. Physicians who receive reports of inappropriate behavior, including reports submitted anonymously, have an ethical duty to critically, objectively, and confidentially evaluate the reported information and assure that identified deficiencies are either remedied or further reported to a higher or additional authority. Information regarding reports or investigations of impairment, or of incompetent or unethical behavior should be held in confidence until the matter is resolved. (II) Issued March 1992 based on the report "Reporting Impaired, Incompetent, or Unethical Colleagues," adopted December 1991 (J Miss St Med Assoc. 1992; 33: 176-77); updated June 1994; updated June 1996; and updated June 2004, based on the report "Physician Health and Wellness," adopted December 2003.

E-9.032 Reporting Adverse Drug or Device Events

A physician who suspects the occurrence of an adverse reaction to a drug or medical device has an obligation to communicate that information to the broader medical community, (eg, through submitting a report or letter to a medical journal or informing the manufacturer of the suspect drug or device). In the case of a serious adverse event, the event should be reported to the Food and Drug Administration (FDA). Spontaneous reports of adverse events are irreplaceable as a source of valuable information about drugs and medical devices, particularly their rare or delayed effects, as well as their safety in vulnerable patient populations. Although premarketing and mandated postmarketing studies provide basic safeguards for the public health, they suffer from inherent deficiencies that limit their ability to detect rare or unexpected consequences of drug or medical device use. Physicians who prescribe and monitor the use of drugs and medical devices constitute the group best able to observe and communicate information about resulting adverse events.
Serious adverse events, such as those resulting in death, hospitalization, or medical or surgical intervention, are the most important to report and are the only adverse events for which the FDA desires a report. Certainty, or even reasonable likelihood, of a causal relationship between the drug or medical device and the serious adverse event will rarely exist and is not required before reporting the event to the FDA. Suspicion of such a relationship is sufficient to give rise to an obligation to participate in the reporting system. (I, V, VII) Issued June 1993 based on the report "Reporting Adverse Drug and Medical Device Events," adopted June 1993; Updated June 1994 (Food & Drug Law J. 1994; 49: 359-66).

E-9.035 Gender Discrimination in the Medical Profession

Physician leaders in medical schools and other medical institutions should take immediate steps to increase the number of women in leadership positions as such positions become open. There is already a large enough pool of female physicians to provide strong candidates for such positions. Also, adjustments should be made to ensure that all physicians are equitably compensated for their work. Women and men in the same specialty with the same experience and doing the same work should be paid the same

compensation.
Physicians in the workplace should actively develop the following: (1) retraining or other programs which facilitate the re-entry of physicians who take time away from their careers to have a family; (2) on-site child care services for dependent children; and (3) policies providing job security for physicians who are temporarily not in practice due to pregnancy or family obligations.
Physicians in the academic medical setting should strive to promote the following: (1) extension of tenure decisions through "stop the clock" programs, relaxation of the seven year rule, or part-time appointments that would give faculty members longer to achieve standards for promotion and tenure; (2) more reasonable guidelines regarding the appropriate quantity and timing of published material needed for promotion or tenure that would emphasize quality over quantity and that would encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research; and (3) fair distribution of teaching, clinical, research, administrative responsibilities, and access to tenure tracks between men and women. Also, physicians in academic institutions should consider formally structuring the mentoring process, possibly matching students or faculty with advisors through a fair and visible system.
Where such policies do not exist or have not been followed, all medical workplaces and institutions should create strict policies to deal with sexual harassment. Grievance committees should have broad representation of both sexes and other groups. Such committees should have the power to enforce harassment policies and be accessible to those persons they are meant to serve.
Grantors of research funds and editors of scientific or medical journals should consider blind peer review of grant proposals and articles for publication to help prevent bias. However, grantors and editors will be able to consider the author's identity and give it appropriate weight. (II, VII) Issued June 1994 based on the report "Gender Discrimination in the Medical Profession," adopted June 1993 (Women's Health Issues. 1994; 4: 1-11)

E-9.037 Signing Bonuses to Attract Graduates of U.S. Medical Schools

Signing bonuses or compensation should not be offered or denied to a resident based on the country where the resident attended or graduated from medical school. (II, III, IV, VI) Issued June 2000 based on the report, "Signing Bonuses to Attract Graduates of U.S. Medical School," adopted December 1999.

E-9.04 Discipline and Medicine

Incompetence, corruption, or dishonest or unethical conduct on the part of members of the medical profession is reprehensible. In addition to posing a real or potential threat to patients, such conduct undermines the public's confidence in the profession. A physician should expose, without fear or loss of favor, incompetent or corrupt, dishonest, or unethical conduct on the part of members of the profession. Questions of such conduct should be reported and reviewed in accordance with Opinion 9.031, "Reporting Impaired, Incompetent, or Unethical Colleagues."
Violation of governmental laws may subject the physician to civil or criminal liability. Expulsion from membership is the maximum penalty that may be imposed by a medical society upon a physician who violates the ethical standards involving a breach of moral duty or principle. However, medical societies have a civic and professional obligation to report to the appropriate governmental body or state board of medical examiners credible evidence that may come to their attention involving the alleged criminal conduct of any physician relating to the practice of medicine.
Although a physician charged with allegedly illegal conduct may be acquitted or exonerated in civil or criminal proceedings, this does not discharge a medical society from its obligation to initiate a disciplinary proceeding against a member with reference to the same conduct where there is credible evidence tending to establish unethical conduct.
The Council cannot pass judgment in advance on a situation that may later come before it on appeal. The Council cannot be an attorney for a society or a member thereof and later judge in the same factual situation. The local medical society has the initial obligation of determining all the facts and whether or not disciplinary action is indicated. Questions asking for a review of a proposed course of action or an evaluation of an existing factual situation should be presented to the appropriate official of the physician's local society. (II, III, VII) Issued prior to April 1977; Updated June 1994.

E-9.045 Physicians with Disruptive Behavior

This Opinion is limited to the conduct of individual physicians and does not refer to physicians acting as a collective, which is considered separately in Opinion 9.025, "Collective Action and Patient Advocacy."
(1) Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.) However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior.
(2) Each medical staff should develop and adopt bylaw provisions or policies for intervening in situations where a physician's behavior is identified as disruptive. The medical staff bylaw provisions or policies should contain procedural safeguards that protect due process. Physicians exhibiting disruptive behavior should be referred to a medical staff wellness-or equivalent-committee.
(3) In developing policies that address physicians with disruptive behavior, attention should be paid to the following elements:
(a) Clearly stating principal objectives in terms that ensure high standards of patient care and promote a professional practice and work environment.
(b) Describing the behavior or types of behavior that will prompt intervention.

(c) Providing a channel through which disruptive behavior can be reported and appropriately recorded. A single incident may not be sufficient for action, but each individual report may help identify a pattern that requires intervention.
(d) Establishing a process to review or verify reports of disruptive behavior.
(e) Establishing a process to notify a physician whose behavior is disruptive that a report has been made, and providing the physician with an opportunity to respond to the report.
(f) Including means of monitoring whether a physician's disruptive conduct improves after intervention.
(g) Providing for evaluative and corrective actions that are commensurate with the behavior, such as self-correction and structured rehabilitation. Suspension of responsibilities or privileges should be a mechanism of final resort. Additionally, institutions should consider whether the reporting requirements of Opinion 9.031, "Reporting Impaired, Incompetent, or Unethical Colleagues," apply in particular cases.
(h) Identifying which individuals will be involved in the various stages of the process, from reviewing reports to notifying physicians and monitoring conduct after intervention.
(i) Providing clear guidelines for the protection of confidentiality.
(j) Ensuring that individuals who report physicians with disruptive behavior are duly protected. (I, II, VIII) Issued December 2000 based on the report "Physicians With Disruptive Behavior," adopted June 2000.

E-9.05 Due Process

The basic principles of a fair and objective hearing should always be accorded to the physician or medical student whose professional conduct is being reviewed. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right of a hearing, the opportunity to be present and to rebut the evidence, and the opportunity to present a defense. These principles apply when the hearing body is a medical society tribunal, medical staff committee, or other similar body composed of peers. The composition of committees sitting in judgment of medical students, residents, or fellows should include a significant number of persons at a similar level of training.
These principles of fair play apply in all disciplinary hearings and in any other type of hearing in which the reputation, professional status, or livelihood of the physician or medical student may be negatively impacted.
All physicians and medical students are urged to observe diligently these fundamental safeguards of due process whenever they are called upon to serve on a committee which will pass judgment on a peer. All medical societies and institutions are urged to review their constitutions and bylaws and/or policies to make sure that these instruments provide for such procedural safeguards. (II, III, VII) Issued prior to April 1977; Updated June 1994.

E-9.055 Disputes Between Medical Supervisors and Trainees

Clear policies for handling complaints from medical students, resident physicians, and other staff should be established. These policies should include adequate provisions for protecting the confidentiality of complainants whenever possible. Confidentiality of complainants should be protected when doing so does not hinder the subject's ability to respond to the complaint. Access to employment and evaluation files should be carefully monitored to remove the possibility of tampering. Resident physicians should be permitted access to their employment files and also the right to copy the contents thereof, within the provisions of applicable federal and state laws.
Medical students, resident physicians, and other staff should refuse to participate in patient care ordered by their supervisors in those rare cases in which they believe the orders reflect serious errors in clinical or ethical judgment, or physician impairment, that could result in a threat of imminent harm to the patient or to others. In these rare cases, the complainant may withdraw from the care ordered by the supervisor, provided withdrawal does not itself threaten the patient's immediate welfare. The complainant should communicate his or her concerns to the physician issuing the orders and, if necessary, to the appropriate persons for mediating such disputes.
Mechanisms for resolving these disputes, which require immediate resolution, should be in place. Third-party mediators of such disputes may include the chief of staff of the involved service, the chief resident, a designated member of the institutional grievance committee, or, in large institutions, an institutional ombudsperson largely outside of the established hospital staff hierarchy.
Retaliatory or punitive actions against those who raise complaints are unethical and are a legitimate cause for filing a grievance with the appropriate institutional committee. (II, III, VII) Issued June 1994 based on the report "Disputes Between Medical Supervisors and Trainees," adopted December 1993 (JAMA. 1994; 272: 1861-65).

E-9.06 Free Choice

Free choice of physicians is the right of every individual. One may select and change at will one's physicians, or one may choose a medical care plan such as that provided by a closed panel or group practice or health maintenance or service organization. The individual's freedom to select a preferred system of health care and free competition among physicians and alternative systems of care are prerequisites of ethical practice and optimal patient care.
In choosing to subscribe to a health maintenance or service organization or in choosing or accepting treatment in a particular hospital, the patient is thereby accepting limitations upon free choice of medical services.
The need of an individual for emergency treatment in cases of accident or sudden illness may, as a practical matter, preclude free choice of a physician, particularly where there is loss of consciousness.
Although the concept of free choice assures that an individual can generally choose a physician, likewise a physician may decline to

accept that individual as a patient. In selecting the physician of choice, the patient may sometimes be obliged to pay for medical services which might otherwise be paid by a third party. (VI) Issued prior to April 1977.

E-9.065 Caring for the Poor

Each physician has an obligation to share in providing care to the indigent. The measure of what constitutes an appropriate contribution may vary with circumstances such as community characteristics, geographic location, the nature of the physician's practice and specialty, and other conditions. All physicians should work to ensure that the needs of the poor in their communities are met. Caring for the poor should be a regular part of the physician's practice schedule.
In the poorest communities, it may not be possible to meet the needs of the indigent for physicians' services by relying solely on local physicians. The local physicians should be able to turn for assistance to their colleagues in prosperous communities, particularly those in close proximity.
Physicians are meeting their obligation, and are encouraged to continue to do so, in a number of ways such as seeing indigent patients in their offices at no cost or at reduced cost, serving at freestanding or hospital clinics that treat the poor, and participating in government programs that provide health care to the poor. Physicians can also volunteer their services at weekend clinics for the poor and at shelters for battered women or the homeless.
In addition to meeting their obligation to care for the indigent, physicians can devote their energy, knowledge, and prestige to designing and lobbying at all levels for better programs to provide care for the poor. (I, VII) Issued June 1994 based on the report "Caring for the Poor," adopted December 1992 (JAMA. 1993; 269: 2533-2537).

E-9.067 Physician Obligation in Disaster Preparedness and Response

National, regional, and local responses to epidemics, terrorist attacks, and other disasters require extensive involvement of physicians. Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This ethical obligation holds even in the face of greater than usual risks to their own safety, health or life. The physician workforce, however, is not an unlimited resource; therefore, when participating in disaster responses, physicians should balance immediate benefits to individual patients with ability to care for patients in the future.

In preparing for epidemics, terrorist attacks, and other disasters, physicians as a profession must provide medical expertise and work with others to develop public health policies that are designed to improve the effectiveness and availability of medical care during such events. These policies must be based on sound science and respect for patients. Physicians also must advocate for and, when appropriate, participate in the conduct of ethically sound biomedical research to inform these policy decisions. Moreover, individual physicians should take appropriate advance measures to ensure their ability to provide medical services at the time of disasters, including the acquisition and maintenance of relevant knowledge. (V, VI, VII, VIII) Issued December 2004 based on the report "Physician Obligation in Disaster Preparedness and Response," adopted June 2004.

E-9.07 Medical Testimony

In various legal and administrative proceedings, medical evidence is critical. As citizens and as professionals with specialized knowledge and experience, physicians have an obligation to assist in the administration of justice.

When a legal claim pertains to a patient the physician has treated, the physician must hold the patient's medical interests paramount, including the confidentiality of the patient's health information, unless the physician is authorized or legally compelled to disclose the information.

Physicians who serve as fact witnesses must deliver honest testimony. This requires that they engage in continuous self-examination to ensure that their testimony represents the facts of the case. When treating physicians are called upon to testify in matters that could adversely impact their patients' medical interests, they should decline to testify unless the patient consents or unless ordered to do so by legally constituted authority. If, as a result of legal proceedings, the patient and the physician are placed in adversarial positions it may be appropriate for a treating physician to transfer the care of the patient to another physician.

When physicians choose to provide expert testimony, they should have recent and substantive experience or knowledge in the area in which they testify, and be committed to evaluating cases objectively and to providing an independent opinion. Their testimony should reflect current scientific thought and standards of care that have gained acceptance among peers in the relevant field. If a medical witness knowingly provides testimony based on a theory not widely accepted in the profession, the witness should characterize the theory as such. Also, testimony pertinent to a standard of care must consider standards that prevailed at the time the event under review occurred.

All physicians must accurately represent their qualifications and must testify honestly.
Physician testimony must not be influenced by financial compensation; for example, it is unethical for a physician to accept compensation that is contingent upon the outcome of litigation.

Organized medicine, including state and specialty societies, and medical licensing boards can help maintain high standards for medical witnesses by assessing claims of false or misleading testimony and issuing disciplinary sanctions as appropriate. (II, IV, V, VII) Issued December 2004 based on the report "Medical Testimony," adopted June 2004.

E-9.08 New Medical Procedures

In the ethical tradition expressed by Hippocrates and continuously affirmed thereafter, the role of the physician has been that of a healer who serves patients, a teacher who imparts knowledge of skills and techniques to colleagues, and a student who constantly seeks to keep abreast of new medical knowledge.
Physicians have an obligation to share their knowledge and skills and to report the results of clinical and laboratory research. Both positive and negative studies should be included even though they may not support the author's hypothesis. This tradition enhances patient care, leads to the early evaluation of new technologies, and permits the rapid dissemination of improved techniques.
The intentional withholding of new medical knowledge, skills, and techniques from colleagues for reasons of personal gain is detrimental to the medical profession and to society and is to be condemned.
Prompt presentation before scientific organizations and timely publication of clinical and laboratory research in scientific journals are essential elements in the foundation of good medical care. (I, II, V, VII) Issued December 1984; Updated June 1994.

E-9.09 Patent for Surgical or Diagnostic Instrument

A physician may patent a surgical or diagnostic instrument he or she has discovered or developed. The laws governing patents are based on the sound doctrine that one is entitled to protect one's discovery. (V, VII) Issued prior to April 1977.

E-9.095 The Use of Patents and Other Means to Limit Availability of Medical Procedures

Physicians have ethical responsibilities not only to learn from but also, when possible, to contribute to the total store of scientific knowledge. Physicians should strive to advance medical science and make their achievements known through publication or other means of disseminating such information. This encourages physicians to innovate and to share ensuing advances.

The use of patents, trade secrets, confidentiality agreements, or other means to limit the availability of medical procedures places significant limitation on the dissemination of medical knowledge, and is therefore unethical. (V, VII) Issued June 1996 based on the report "Ethical Issues in the Patenting of Medical Procedures," adopted June 1995 (Food & Drug Law J. 1998; 53: 341-57). Updated June 2008 based on the report "Trademarks, Patents, Copyrights, and Other Legal Restrictions on Medical Procedures," adopted November 2007.

E-9.10 Peer Review

Medical society ethics committees, hospital credentials and utilization committees, and other forms of peer review have been long established by organized medicine to scrutinize physicians' professional conduct. At least to some extent, each of these types of peer review can be said to impinge upon the absolute professional freedom of physicians. They are, nonetheless, recognized and accepted. They are necessary, and committees performing such work act ethically as long as principles of due process (Opinion 9.05, "Due Process") are observed. They balance the physician's right to exercise medical judgment freely with the obligation to do so wisely and temperately. (II, III, VII) Issued prior to April 1977; Updated June 1994.

E-9.11 Ethics Committees in Health Care Institutions

The following guidelines have been developed to aid in the establishment and functioning of ethics committees in hospitals and other health care institutions that may choose to form such committees.
(1) Ethics committees in health care institutions should be educational and advisory in purpose. Generally, the function of the ethics committee should be to consider and assist in resolving unusual, complicated ethical problems involving issues that affect the care and treatment of patients within the health care institution. Recommendations of the ethics
committee should impose no obligation for acceptance on the part of the institution, its governing board, medical staff, attending physician, or other persons. However, it should be expected that the recommendations of a dedicated ethics committee will receive serious consideration by decision makers.
(2) The size of the committee should be consistent with the needs of the institution but not so large as to be unwieldy. Committee members should be selected on the basis of their concern for the welfare of the sick and infirm, their interest in ethical matters, and their reputation in the community and among their peers for integrity and mature judgment. Experience as a member of hospital or medical society committees concerned with ethical conduct or quality assurance should be considered in selecting ethics committee members. Committee members should not have other responsibilities that are likely to prove incompatible with their duties as members of the ethics committee. Preferably, a majority of the committee should consist of physicians, nurses, and other health care providers. In hospitals, medical staff bylaws should delineate the functions of the committee, general qualifications for membership, and manner of selection of members, in accordance with these guidelines.
(3) The functions of the ethics committee should be confined exclusively to ethical matters. The Code of Medical Ethics of the

American Medical Association is recommended for the guidance of ethics committees in making their own recommendations. The matters to be considered by the committee should consist of ethical subjects that a majority of its members may choose to discuss on its own initiative, matters referred to it by the executive committee of the organized medical staff or by the governing board of the institution, or appropriate requests from patients, families, or health care providers.
(4) In denominational health care institutions or those operated by religious orders, the recommendations of the ethics committee may be anticipated to be consistent with published religious tenets and principles. Where particular religious beliefs are to be taken into consideration in the committee's recommendations, this fact should be publicized to physicians, patients, and others concerned with the committee's recommendations.
(5) In its deliberations and communication of recommendations, the procedures followed by the ethics committee should comply with institutional and ethical policies for preserving the confidentiality of information regarding patients.
(6) Committee members should be prepared to meet on short notice and to render their recommendations in a timely and prompt fashion in accordance with the demands of the situation and the issues involved. (II, IV, VII) Issued June 1994 based on the report "Guidelines for Ethics Committees in Health Care Institutions," adopted December 1984 (JAMA. 1985; 253: 2698-2699).

E-9.115 Ethics Consultations

Ethics consultations may be called to clarify ethical issues without reference to a particular case, facilitate discussion of an ethical dilemma in a particular case, or resolve an ethical dispute. The consultation mechanism may be through an ethics committee, a subset of the committee, individual consultants, or consultation teams. The following guidelines are offered with respect to these services:
(1) All hospitals and other health care institutions should provide access to ethics consultation services. Health care facilities without ethics committees or consultation services should develop flexible, efficient mechanisms of ethics review that divide the burden of committee functioning among collaborating health care facilities.
(2) Institutions offering ethics consultation services must appreciate the complexity of the task, recognizing the potential for harm as well as benefit, and act responsibly. This includes true institutional support for the service.
(3) Ethics consultation services require a serious investment of time and effort by the individuals involved. Members should include either individuals with extensive formal training and experience in clinical ethics or individuals who have made a substantial commitment over several years to gain sufficient knowledge, skills, and understanding of the complexity of clinical ethics. A wide variety of background training is preferable, including such fields as philosophy, religion, medicine, and law.
(4) Explicit structural standards should be developed and consistently followed. These should include developing a clear description of the consultation service's role and determining which types of cases will be addressed, how the cases will be referred to the service, whether the service will provide recommendations or simply function as a forum for discussion, and whether recommendations are binding or advisory.
(5) Explicit procedural standards should be developed and consistently followed. These should include establishing who must be involved in the consultation process and how notification, informed consent, confidentiality and case write-ups will be handled.
(6) In general, patient and staff informed consent may be presumed for ethics consultation. However, patients and families should be given the opportunity, not to participate in discussions either formally, through the institutional process, or informally.
(7) In those cases where the patient or family has chosen not to participate in the consultation process, the final recommendations of the consultant(s) should be tempered.
(8) In general, ethics consultation services, like social services, should be financed by the institution.
(9) A consultation service should be careful not to take on more than it can handle, ie, the complexity of the role should correspond to the level of sophistication of the service and the resources it has available. As a result, some services may offer only information and education, others a forum for discussion but not advice, others might serve a mediation role, and some might handle even administrative or organizational ethics issues. (IV, V) Issued June 1998 based on the report "Ethics Consultation," adopted December 1997.

E-9.12 Patient-Physician Relationship: Respect for Law and Human Rights

The creation of the patient-physician relationship is contractual in nature. Generally, both the physician and the patient are free to enter into or decline the relationship. A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination. Furthermore, physicians who are obligated under pre-existing contractual arrangements may not decline to accept patients as provided by those arrangements. (I, III, V, VI) Issued July 1986. Updated June 1994 and June 2008 based on the report "Modification of Ethics Policy to Ensure Inclusion for Transgender Physicians, Medical Students, and Patients," adopted November 2007.

E-9.121 Racial and Ethnic Health Care Disparities

Differences in treatment that are not directly attributable to variances in clinical needs or patient preferences constitute disparities in health care. Among racial and ethnic minority populations, such disparities may contribute to health outcomes that are considerably worse than those of majority populations. This represents a significant challenge for physicians who ethically are called upon to serve patients without regard to medically irrelevant personal characteristics. The following guidelines are intended to help reduce racial

and ethnic disparities in health care.

(1) Physicians must strive to offer the same quality of care to all their patients irrespective of personal characteristics such as race or ethnicity. The provision of care should be customized to meet patient needs and preferences.

(2) Physicians must learn to recognize racial and ethnic health care disparities and should examine their own practices to ensure that inappropriate considerations do not affect clinical judgment.

(3) Physicians should work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients. Inappropriate discrimination toward any patient or group of patients must not be permitted.

(4) Participatory decision making should be encouraged with all patients. This requires trust, which in turn requires effective communication. Physicians should seek to gain greater understanding of cultural or ethnic characteristics that can influence patients' health care decisions. Physicians should not rely upon stereotypes; they should customize care to meet the needs and preferences of individual patients.

(5) Physicians should recognize and take into account linguistic factors that affect patients' understanding of medical information. In particular, language barriers should be minimized so that information is exchanged in a manner that both parties can understand.

(6) Increasing the diversity of the physician workforce may be an important step in reducing racial and ethnic health care disparities. Physicians should therefore participate in efforts to encourage diversity in the profession.

(7) Physicians should help increase awareness of health care disparities by engaging in open and broad discussions about the issue in medical school curricula, in medical journals, at professional conferences, and as part of professional peer review activities. Research should continue to investigate health care disparities, including the development of quality measures. (I, VII, VIII, IX)
Issued March 1992 based on the report "Black-White Disparities in Health Care," adopted December 1989 (JAMA. 1990; 263: 2344-46).
Updated June 1994 and November 2005 based on the report "Racial and Ethnic Health Care Disparities," adopted June 2005.

E-9.122 Gender Disparities in Health Care

A patient's gender plays an appropriate role in medical decision making when biological differences between the sexes are considered. However, some data suggest that gender bias may be playing a role in medical decision making. Social attitudes, including stereotypes, prejudices, and other evaluations based on gender role expectations, may play themselves out in a variety of subtle ways. Physicians must ensure that gender is not used inappropriately as a consideration in clinical decision making. Physicians should examine their practices and attitudes for influence of social or cultural biases which could be inadvertently affecting the delivery of medical care.
Research on health problems that affect both genders should include male and female subjects, and results of medical research done solely on males should not be generalized to females without evidence that results apply to both sexes. Medicine and society in general should ensure that resources for medical research should be distributed in a manner which promotes the health of both sexes to the greatest extent possible. (I, IV) Issued March 1992 based on the report "Gender Disparities in Clinical Decision Making," adopted December 1990 (JAMA. 1991; 266: 559-62); Updated June 1994.

E-9.123 Disrespect and Derogatory Conduct in the Patient-Physician Relationship

The relationship between patients and physicians is based on trust and should serve to promote patients' well-being while respecting their dignity and rights. Trust can be established and maintained only when there is mutual respect.

Derogatory language or actions on the part of physicians can cause psychological harm to those they target. Also, such language or actions can cause reluctance in members of targeted groups to seek or to trust medical care and thus create an environment that strains relationships among patients, physicians, and the health care team. Therefore, any such conduct is profoundly antithetical to the Principles of Medical Ethics.

Patients who use derogatory language or otherwise act in a prejudicial manner toward physicians, other health care professionals, or others in the health care setting, seriously undermine the integrity of the patient-physician relationship. Such behavior, if unmodified, may constitute sufficient justification for the physician to arrange for the transfer of care. (I, II, VI, IX) Issued December 2003 based on the report "Disrespect and Derogatory Conduct in the Patient-Physician Relationship," adopted June 2003.

E-9.13 Physicians and Infectious Diseases

A physician who knows that he or she has an infectious disease, which if contracted by the patient would pose a significant risk to the patient, should not engage in any activity that creates a significant risk of transmission of that disease to the patient. The precautions

taken to prevent the transmission of a contagious disease to a patient should be appropriate to the seriousness of the disease and must be particularly stringent in the case of a disease that is potentially fatal. (I, IV) Issued August 1989; Updated June 1996 and June 1999.

E-9.131 HIV-Infected Patients and Physicians

A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive for HIV. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice.
When physicians are unable to provide the services required by an HIV-infected patient, they should make appropriate referrals to those physicians or facilities equipped to provide such services.
A physician who knows that he or she is seropositive should not engage in any activity that creates a significant risk of transmission of the disease to others. A physician who has HIV disease or who is seropositive should consult colleagues as to which activities the physician can pursue without creating a risk to patients. (I, II, IV) Issued March 1992 based on the report "Ethical Issues in the Growing AIDS Crisis," adopted December 1987 (JAMA. 1988; 259: 1360-1361); Updated June 1996 and June 1998.

E-9.132 Health Care Fraud and Abuse

The following guidelines encourage physicians to play a key role in identifying and preventing fraud:
(1) Physicians must renew their commitment to Principle II of the American Medical Association's Principles of Medical Ethics which states that "a physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character, competence, or who engage in fraud or deception."
(2) Physicians should make no intentional misrepresentations to increase the level of payment they receive or to secure non-covered health benefits for their patients. (II) Issued June 1998 based on the report "Health Care Fraud and Abuse," adopted December 1997 (J. Okla. St. Med. Assoc. 1998; 91: 408-09).

E-10.00 Opinions on the Patient-Physician Relationship

E-10.01 Fundamental Elements of the Patient-Physician Relationship

From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance. Physicians can best contribute to this alliance by serving as their patients' advocate and by fostering these rights:
(1) The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.
(2) The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.
(3) The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.
(4) The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.
(5) The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.
(6) The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care. Physicians should advocate for patients in dealing with third parties when appropriate. (I, IV, V, VIII, IX) Issued June 1992 based on the report "Fundamental Elements of the Patient-Physician Relationship," adopted June 1990 (JAMA. 1990; 262: 3/33); Updated 1993.

E-10.015 The Patient-Physician Relationship

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering.

A patient-physician relationship exists when a physician serves a patient's medical needs, generally by mutual consent between physician and patient (or surrogate). In some instances the agreement is implied, such as in emergency care or when physicians

provide services at the request of the treating physician. In rare instances, treatment without consent may be provided under court order (see Opinion 2.065, "Court-Initiated Medical Treatments in Criminal Cases"). Nevertheless, the physician's obligations to the patient remain intact.

The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare.

Within the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount. (I, II, VI, VIII) Issued December 2001 based on the report "The Patient-Physician Relationship," adopted June 2001.

E-10.016 Pediatric Decision-Making

Medical decision-making for pediatric patients should be based on the child's best interest, which is determined by weighing many factors, including effectiveness of appropriate medical therapies, the patient's psychological and emotional welfare, and the family situation. When there is legitimate inability to reach consensus about what is in the best interest of the child, the wishes of the parents should generally receive preference.

Physicians treating pediatric patients generally must obtain informed consent from a parent or a legal guardian. Certain classes of children, such as emancipated or mature minors, may provide consent to their own medical care.

Physicians should give pediatric patients the opportunity to participate in decision-making at a developmentally appropriate level. The physician should seek the patient's assent, or agreement, by explaining the medical condition, its clinical implications, and the treatment plan. If the patient does not or cannot assent, physicians should still explain the plan of care and tell him or her what to expect, without deception. In the case of an adolescent patient who has decision-making capacity, the physician should encourage the patient's active participation in decision-making. The use of force such as with using physical restraints to carry out a medical intervention in adolescent patients who do not assent should be a last resort.

Parents and physicians may disagree about the course of action that best serves the pediatric patient's interests. When disagreements occur, institutional policies for timely conflict resolution should be followed, including consultation with an ethics committee, pastoral service, or other counseling resource. If a health care facility does not have policies for resolving conflicts in a timely manner, physicians should encourage their development. Physicians should treat reversible life-threatening conditions regardless of any persistent disagreement. Resolution of disagreements in the courts should be pursued only as a last resort. (IV, VIII) Issued June 2008 based on the report "Pediatric Decision-Making," adopted November 2007.

E-10.017 Gifts from Patients

Gifts that patients offer to physicians are often an expression of appreciation and gratitude or a reflection of cultural tradition, and can enhance the patient-physician relationship.

Some gifts signal psychological needs that require the physician's attention. Some patients may attempt to influence care or to secure preferential treatment through the offering of gifts or cash. Acceptance of such gifts is likely to damage the integrity of the patient-physician relationship. Physicians should make clear that gifts given to secure preferential treatment compromise their obligation to provide services in a fair manner.

There are no definitive rules to determine when a physician should or should not accept a gift. No fixed value determines the appropriateness or inappropriateness of a gift from a patient; however, the gift's value relative to the patient's or the physician's means should not be disproportionately or inappropriately large. One criterion is whether the physician would be comfortable if acceptance of the gift were known to colleagues or the public.

Physicians should be cautious if patients discuss gifts in the context of a will. Such discussions must not influence the patient's medical care.

If, after a patient's death, a physician should learn that he or she has been bequeathed a gift, the physician should consider declining the gift if the physician believes that its acceptance would present a significant hardship (financial or emotional) to the family.

The interaction of these various factors is complex and requires the physician to consider them sensitively. (I, II) Issued December 2003 based on the report "Gifts from Patients," adopted June 2003.

E-10.018 Physician Participation in Soliciting Contributions from Patients

Donations play an important role in supporting and improving a community's health care. Physicians are encouraged to participate in

fundraising and other solicitation activities while protecting the integrity of the patient-physician relationship, including patient privacy and confidentiality, and ensuring that all donations are fully voluntary. In particular:

(1) Appropriate means of soliciting contributions include making information available in a reception area and speaking at fundraising events. Physicians should avoid directly soliciting their own patients, especially at the time of a clinical encounter. They should reinforce the trust that is the foundation of the patient-physician relationship by being clear that patients' welfare is the primary priority and that patients need not contribute in order to continue receiving the same quality of care.

(2) The greater the separation between the request and the clinical encounter, the more acceptable the solicitation is likely to be.

(3) When physicians participate in solicitation efforts as members of the general community, they should seek to minimize perceptions of overlap with their professional roles.

(4) Physicians in institutions that rely on fundraising personnel for donation requests should work to protect privacy and confidentiality of patient information. In particular physicians should ensure that any patient information used for solicitation activities reveals only basic demographic data, not personal health information. When the medical service delivered or the diagnosis is identifiable by the nature of the physician's practice or the physician's specialty, permission from the patient should be obtained prior to divulging any information to third parties.

(5) When patients initiate requests to contribute, physicians should refer them to appropriate sources of information or fundraising personnel. (IV, VII, VIII) Issued December 2004 based on the report "Physician Participation in Soliciting Contributions from Patients," adopted June 2004.

E-10.02 Patient Responsibilities

It has long been recognized that successful medical care requires an ongoing collaborative effort between patients and physicians. Physician and patient are bound in a partnership that requires both individuals to take an active role in the healing process. Such a partnership does not imply that both partners have identical responsibilities or equal power. While physicians have the responsibility to provide health care services to patients to the best of their ability, patients have the responsibility to communicate openly, to participate in decisions about the diagnostic and treatment recommendations, and to comply with the agreed-upon treatment program. Like patients' rights, patients' responsibilities are derived from the principle of autonomy. The principle of patient autonomy holds that an individual's physical, emotional, and psychological integrity should be respected and upheld. This principle also recognizes the human capacity to self-govern and choose a course of action from among different alternative options. Autonomous, competent patients assert some control over the decisions which direct their health care. With that exercise of self-governance and free choice comes a number of responsibilities.
(1) Good communication is essential to a successful patient-physician relationship. To the extent possible, patients have a responsibility to be truthful and to express their concerns clearly to their physicians.
(2) Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness, and other matters relating to present health.
(3) Patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.
(4) Once patients and physicians agree upon the goals of therapy and a treatment plan, patients have a responsibility to cooperate with that treatment plan and to keep their agreed-upon appointments. Compliance with physician instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.
(5) Patients generally have a responsibility to meet their financial obligations with regard to medical care or to discuss financial hardships with their physicians. Patients should be cognizant of the costs associated with using a limited resource like health care and try to use medical resources judiciously.
(6) Patients should discuss end-of-life decisions with their physicians and make their wishes known. Such a discussion might also include writing an advance directive.
(7) Patients should be committed to health maintenance through health-enhancing behavior. Illness can often be prevented by a healthy lifestyle, and patients should take personal responsibility when they are able to avert the development of disease.
(8) Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that unreasonably places the health of others at risk. Patients should inquire as to the means and likelihood of infectious disease transmission and act upon that information which can best prevent further transmission.
(9) Participation in medical education is to the mutual benefit of patients and the health care system. Patients are encouraged to participate in medical education by accepting care, under appropriate supervision, from medical students, residents, and other trainees. Consistent with the process of informed consent, the patient or the patient's surrogate decision maker is always free to refuse care from any member of the health care team.
(10) Patients should discuss organ donation with their physicians and, if donation is desired, make applicable provisions. Patients who are part of an organ allocation system and await needed transplant should not try to go outside of or manipulate the system. A fair system of allocation should be answered with public trust and an awareness of limited resources.

(11) Patients should not initiate or participate in fraudulent health care and should report illegal or unethical behavior by physicians and other providers to the appropriate medical societies, licensing boards, or law enforcement authorities. (I, IV, VI) Issued June 1994 based on the report "Patient Responsibilities", adopted June 1993; Updated June 1998, December 2000, and June 2001.

E-10.03 Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations

When a physician is responsible for performing an isolated assessment of an individual's health or disability for an employer, business, or insurer, a limited patient-physician relationship should be considered to exist. Both "Industry Employed Physicians" (IEPs), who are employed by businesses or insurance companies for the purpose of conducting medical examinations, and Independent Medical Examiners" (IMEs), who are independent contractors providing medical examinations within the realm of their specialty, may perform such medical examinations.

Despite their ties to a third party, the responsibilities of IEPs and IMEs are in some basic respects very similar to those of other physicians. IEPs and IMEs have the same obligations as physicians in other contexts to:
(1) Evaluate objectively the patient's health or disability. In order to maintain objectivity, IEPs and IMEs should not be influenced by the preferences of the patient-employee, employer, or insurance company when making a diagnosis during a work-related or independent medical examination.
(2) Maintain patient confidentiality as outlined by Opinion 5.09, "Industry Employed Physicians and Independent Medical Examiners."
(3) Disclose fully potential or perceived conflicts of interest. The physician should inform the patient about the terms of the agreement between himself or herself and the third party as well as the fact that he or she is acting as an agent of that entity. This should be done at the outset of the examination, before health information is gathered from the patient-employee. Before the physician proceeds with the exam, he or she should ensure to the extent possible that the patient understands the physician's unaltered ethical obligations, as well as the differences that exist between the physician's role in this context and the physician's traditional fiduciary role.

IEPs and IMEs are responsible for administering an objective medical evaluation but not for monitoring patients' health over time, treating patients, or fulfilling many other duties traditionally held by physicians. Consequently, a limited patient-physician relationship should be considered to exist during isolated assessments of an individual's health or disability for an employer, business, or insurer.

The physician has a responsibility to inform the patient about important health information or abnormalities that he or she discovers during the course of the examination. In addition, the physician should ensure to the extent possible that the patient understands the problem or diagnosis. Furthermore, when appropriate, the physician should suggest that the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care. (I) Issued December 1999 based on the report "Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations," adopted June 1999.

E-10.05 Potential Patients

(1) Physicians must keep their professional obligations to provide care to patients in accord with their prerogative to choose whether to enter into a patient-physician relationship.

(2) The following instances identify the limits on physicians' prerogative:

(a) Physicians should respond to the best of their ability in cases of medical emergency (Opinion 8.11, "Neglect of Patient").

(b) Physicians cannot refuse to care for patients based on race, gender, sexual orientation, gender identity, or any other criteria that would constitute invidious discrimination (Opinion 9.12, "Patient-Physician Relationship: Respect for Law and Human Rights"), nor can they discriminate against patients with infectious diseases (Opinion 2.23, "HIV Testing")

(c) Physicians may not refuse to care for patients when operating under a contractual arrangement that requires them to treat (Opinion 10.015, "The Patient-Physician Relationship"). Exceptions to this requirement may exist when patient care is ultimately compromised by the contractual arrangement.

(3) In situations not covered above, it may be ethically permissible for physicians to decline a potential patient when:

(a) The treatment request is beyond the physician's current competence.
(b) The treatment request is known to be scientifically invalid, has no medical indication, and offers no possible benefit to the patient (Opinion 8.20, "Invalid Medical Treatment").
(c) A specific treatment sought by an individual is incompatible with the physician's personal, religious, or moral beliefs.

(4) Physicians, as professionals and members of society, should work to assure access to adequate health care (Opinion 10.01, "Fundamental Elements of the Patient-Physician Relationship"). Accordingly, physicians have an obligation to share in providing charity care (Opinion 9.065, "Caring for the Poor") but not to the degree that would seriously compromise the care provided to

existing patients. When deciding whether to take on a new patient, physicians should consider the individual's need for medical service along with the needs of their current patients. Greater medical necessity of a service engenders a stronger obligation to treat. (I, VI, VIII, IX) Issued December 2000 based on the report "Potential Patients, Ethical Considerations," adopted June 2000. Updated December 2003 and June 2008 based on the report "Modification of Ethics Policy to Ensure Inclusion for Transgender Physicians, Medical Students, and Patients," adopted November 2007. * Considerations in determining an adequate level of health care are outlined in Opinion 2.095, "The Provision of Adequate Health Care."