

AMA DELEGATION

Walter J. Kahn, MD, Chair

Report to: Board of Trustees

Meeting: December 16, 2007

Subject: AMA Interim Meeting – November 9-13, 2007
Honolulu, Hawaii

Southeastern Delegation

Our delegation was warmly welcomed into the Southeastern Delegation. The Southeastern Delegation consists of Alabama, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, New Jersey, North Carolina, Puerto Rico, South Carolina, Tennessee, Virginia, and West Virginia. Members of the New Jersey delegation and MSNJ staff attended the Southeastern Delegation breakfast caucus on Monday, November 12.

Reference Committee on Amendments to the Constitution and Bylaws

- The House of Delegates referred to the Council on Ethical and Judicial Affairs (CEJA) ethics guidelines regarding health facility ownership by physicians. There was much discussion on this issue, and some of the controversy involved whether the physician should provide the patient with information regarding an alternative arrangement if available. The opinion of CEJA did not satisfy the House of Delegates and therefore was referred back.
- The Council on Ethical and Judicial Affairs recommended further wording to HIV testing which closely followed CDC guidelines.
- The Council's report on expedited partner therapy, especially in relation to sexually transmitted infections, became controversial because of legal and ethical concerns. The report was referred back to CEJA for further development with appropriate input from ACOG, CDC, and other relevant parties.
- A resolution concerning a physician's duty to report torture was not adopted by the House of Delegates.

Reference Committee F

- The House of Delegates voted to re-examine its role in implementing current policies related to school violence.

- The AMA voted to explore the barriers to primary care medicine as a career choice and the impact of these barriers on the profession of medicine as a whole and on access to health care throughout the country.
- The House of Delegates referred a resolution to the Board of Trustees to consider hosting a forum during the 2008 AMA Annual Meeting in June for the leading U.S. presidential candidates from all major parties in an effort to make the candidates' views about health care more available to physicians.
- A controversial resolution on maintaining the physician consortium for performance improvement as physician-led was hotly debated since apparently there is a desire by the Consortium to include non-MD and DO participants as full voting members. This resolution was referred for decision to the AMA Board of Trustees. Unfortunately, some on the Board are not that enthusiastic about keeping the Consortium totally physician-led and its referral for decision was a disappointment to many in the House of Delegates.

Reference Committee J

- A resolution on single payer was the most controversial resolution debated in the House of Delegates. After much discussion, the resolved that finally passed called on the AMA to “undertake a media campaign designed to educate the American people about AMA policy on health care system reform, emphasizing pluralism, individual ownership of health insurance and the insurance market reforms necessary to allow free market principles to function.” Amazingly, there is still a strong minority of physicians in our House of Delegates that favor the single-payer system.
- The House also approved policy that the American Medical Association support the use of appropriately structured and adequately funded tax credits as the most effective mechanism for enabling uninsured individuals to obtain health insurance coverage.
- A resolution passed at the meeting called on the AMA to continue to study combining Part A and B of the Medicare Trust Funds into a single program, and report back, clearly delineating the advantages and disadvantages of this action, including the effect on graduate medical education funding and of adding a means test to Medicare Part A.
- The House reaffirmed AMA policy which supports eliminating Medicare’s “limiting charge” for Medicare physicians and to permit balance billing.

- A resolution concerning health care as a fundamental societal obligation was referred. The Council on Ethical and Judicial Affairs is currently considering this issue.

Reference Committee K

Dr. Nancy L. Mueller, AMA Alternate Delegate, served on this reference committee.

A resolution on Principles for Strengthening the Physician-Hospital Relationship passed without controversy. This resolution was strongly supported by the Organized Medical Staff Section. MSNJ's Organized Medical Staff Section should disseminate these principles to all medical staffs in the state.

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 includes 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.

- The AMA reaffirmed policy supporting the principle that risk-related subsidies such as those for high-risk pools, reinsurance and risk adjustment, should be financed through general tax revenues rather than through strict community rating or premium surcharges. It also adopted a recommendation to support the principle that health insurance coverage of high-risk patients be funded through direct risk-based subsidies such as high-risk pools, reinsurance and risk adjustment, rather than through indirect methods that rely heavily on market regulation.
- The AMA resolved to advocate that all Joint Commission standards, including medication reconciliation standards, be consistently interpreted by its survey team members, hospitals and health care systems to improve patient safety.
- The AMA resolved to seek a full refundable federal tax credit or equivalent financial mechanism to indemnify physician practices for the cost of purchasing and implementing clinical information technology, including electronic medical record systems, e-prescribing and other clinical information technology tools, in compliance with applicable safe harbors.

Reference Committee L

- The AMA resolved to devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to introduce legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interferes with patient access to care. This legislation should be designed to pre-empt state laws that prohibit balance billing and prohibit the inappropriate inclusion of balance billing bans in insurance-physician contracts. The AMA also will develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician's right to balance bill any insured patient.
- After considerable and impassioned discussion, the AMA voted to oppose a resolution calling for reauthorization of the State Children's Health Insurance Program (SCHIP) for children only, and only for those at or below the 200 percent Federal Poverty Level, with a transition toward insurance coverage for those children through a system of tax subsidies and vouchers by 2010. The New Jersey Delegation had supported the resolution.

* * * * *

Appreciation is extended to Dr. Joseph H. Reichman, Vice-Chair of the Delegation, for his assistance during the AMA Interim Meeting.