MSMS
MICHIGAN STATE MEDICAL SOCIETY

2022
HOUSE OF DELEGATES

THE ONE HUNDRED FIFTY-SEVENTH
ANNUAL SESSION
April 30 - May 1, 2022
The Radisson, Kalamazoo

MSMS
MICHIGAN STATE MEDICAL SOCIETY

ORDER OF BUSINESS
2022 HOUSE OF DELEGATES
THE RADISSON HOTEL AND SUITES, KALAMAZOO

SATURDAY, April 30

8:00 am – 7:00 pm	Registration – Lower Level Foyer
8:30 – 9:30 am	Breakfast Meetings Kent/Ottawa/Kalamazoo County – Great Lakes 4 (Lower Level) Medical Student Section – Stone Theatre (Lower Level) Saginaw – Great Lakes 1 (Lower Level) Wayne – Great Lakes 3 (Lower Level)
9:00 – 10:00 am	Reference Committee on Ways and Means – The Prairies 6 (Lower Level)
9:00 – 10:00 am	Reference Committee C - Internal Affairs and Bylaws – The Prairies 4 (Lower Level)
10:00 am – 12:30 pm	Reference Committee Hearings Reference Committee A - Medical Care Delivery – The Glens 1 (Lower Level) Reference Committee B – Legislation – The Glens 2 (Lower Level) Reference Committee D - Public Health – The Glens 3 (Lower Level) Reference Committee E - Scientific and Education – The Prairies 5 (Lower Level)
12:00 – 12:30 pm	Reference Committee on Ways and Means – The Prairies 6 (Lower Level)
12:30 pm	Lunch – Arcadia Foyer (Lobby Level)
12:30 – 2:30 pm	First Meeting of the House – Arcadia Ballroom (Lobby Level) Call to Order Memorial Service for Deceased Delegates Address of the 2020 – 2021 President – S. "Bobby" Mukkamala, MD Address of the 2021 – 2022 President – Pino D. Colone, MD Candidate Forum – M. Salim U. Siddiqui, MD, PhD Report from the Chair of the Board – Mark C. Komorowski, MD Report from the Treasurer – John A. Waters, MD Report from the Chair of the MDPAC – Amit Ghose, MD Address of the President-Elect – Thomas J. Veverka, MD
2:30 – 3:30 pm	AMA Town Hall Meeting – Arcadia Ballroom (Lobby Level)
3:30 – 5:00 pm	President's Installation and Reception – Kalamazoo Ballroom (Lower Level)
5:00 – 6:00 pm	MDPAC 300 Club Reception – Great Lakes 2-3 (Lower Level)

SUNDAY, May 1

6:30 – 7:45 am	Breakfast Meetings AMA Delegation – The Glens (Lower Level) Ingham/Washtenaw – Great Lakes 5 (Lower Level) Kent/Ottawa/Kalamazoo County – Great Lakes 4 (Lower Level) Medical Student Section – Stone Theatre (Lower Level) Saginaw – Great Lakes 1 (Lower Level) Wayne – Great Lakes 3 (Lower Level)
8:00 am	Second Meeting of the House – Arcadia Ballroom (Lobby Level) Report of the Committee on Credentials and Tellers Nominations and Elections Reports of Reference Committees Ways and Means B – Legislation A – Medical Care Delivery E – Scientific and Educational Affairs C – Internal Affairs and Bylaws D – Public Health

Parliamentary Procedures

MSMS Speakers' Principles of Rules of Order

(Based on Sturgis)

1. Only one main motion
2. A motion may be amended only to second order
3. Motion stated affirmatively
4. Precedence of motion must be honored
5. A motion, once reiterated by Chair, belongs to assembly
6. Member may speak/vote against own motion
7. Any member may move for reconsideration
8. Unless otherwise stated, vote immediately applies only to immediately-pending issue
9. More than majority vote required when rights are limited
10. Requests are rights of member/assembly which may be asked for
11. On appeal, vote always on sustaining speaker or vice speaker
12. Nominations require no second
13. Presiding officer may vote
14. Presiding officer may not adjourn meeting

PRINCIPAL RULES GOVERNING MOTIONS

Order of precedence [1]	*Can interrupt?*	*Requires second?*	*Debat-able?*	*Amend -able?*	*Vote required?*	*Applies to what other motions?*	*Can have what other motions applied to it?*[4]
PRIVILEGED MOTIONS							
1. Adjourn	No	Yes	No[3]	Yes[3]	Majority	None	Amend
2. Recess	No	Yes	Yes[3]	Yes[3]	Majority	None	Amend[3]
SUBSIDIARY MOTIONS							
3. Postpone temporarily (Table)	No	Yes	No	No	Majority[2]	Main motion	None
4. Close debate	No	Yes	No	No	2/3	Debatable motions	None
5. Limit debate	No	Yes	Yes[3]	Yes[3]	2/3	Debatable motions	Amend[3]
6. Postpone to a certain time	No	Yes	Yes[3]	Yes[3]	Majority	Main motion	Amend[3], close debate, limit debate
7. Refer to committee	No	Yes	Yes[3]	Yes[3]	Majority	Main motion	Amend[3], close debate, limit debate
8. Amend	No	Yes	Yes	Yes	Majority	Rewordable motions	Close debate, limit debate, amend
MAIN MOTIONS							
9. a. The main motion	No	Yes	Yes	Yes	Majority	None	Restorative, subsidiary
b. Restorative main motions							
Amend a previous action	No	Yes	Yes	Yes	Majority	Main motion	Subsidiary, restorative
Ratify	No	Yes	Yes	Yes	Majority	Previous action	Subsidiary
Reconsider	Yes	Yes	Yes[3]	No	Majority	Main motion	Close debate, limit debate
Rescind	No	Yes	Yes	No	Majority	Main motion	Close debate, limit debate
Resume consideration	No	Yes	No	No	Majority	Main motion	None

INCIDENTAL MOTIONS

No order of precedence	*Can interrupt?*	*Requires second?*	*Debat-able?*	*Amend -able?*	*Vote required?*	*Applies to what other motions?*	*Can have what other motions applied to it?*
MOTIONS							
Appeal	Yes	Yes	Yes	No	Majority	Decision of chair	Close debate, limit debate
Suspend rules	No	Yes	No	No	2/3	None	None
Consider informally	No	Yes	No	No	Majority	Main	None
REQUESTS							
Question of privilege	Yes	No	No	No	None	None	None
Point of order	Yes	No	No	No	None	Any error	None
Parliamentary inquiry	Yes	No	No	No	None	All motions	None
Withdraw a motion	Yes	No	No	No	None	All motions	None
Division of question	No	No	No	No	None	Main motion	None
Division of assembly	Yes	No	No	No	None	Indecisive vote	None

[1] Motions are in order only if no motion higher on the list is pending.

[2] Requires two-thirds vote when it would suppress a motion without debate.

[3] Debatable if no other motion is pending.

[4] Withdraw may be applied to all motions.

PRINCIPAL PARLIAMENTARY MOTIONS GUIDE

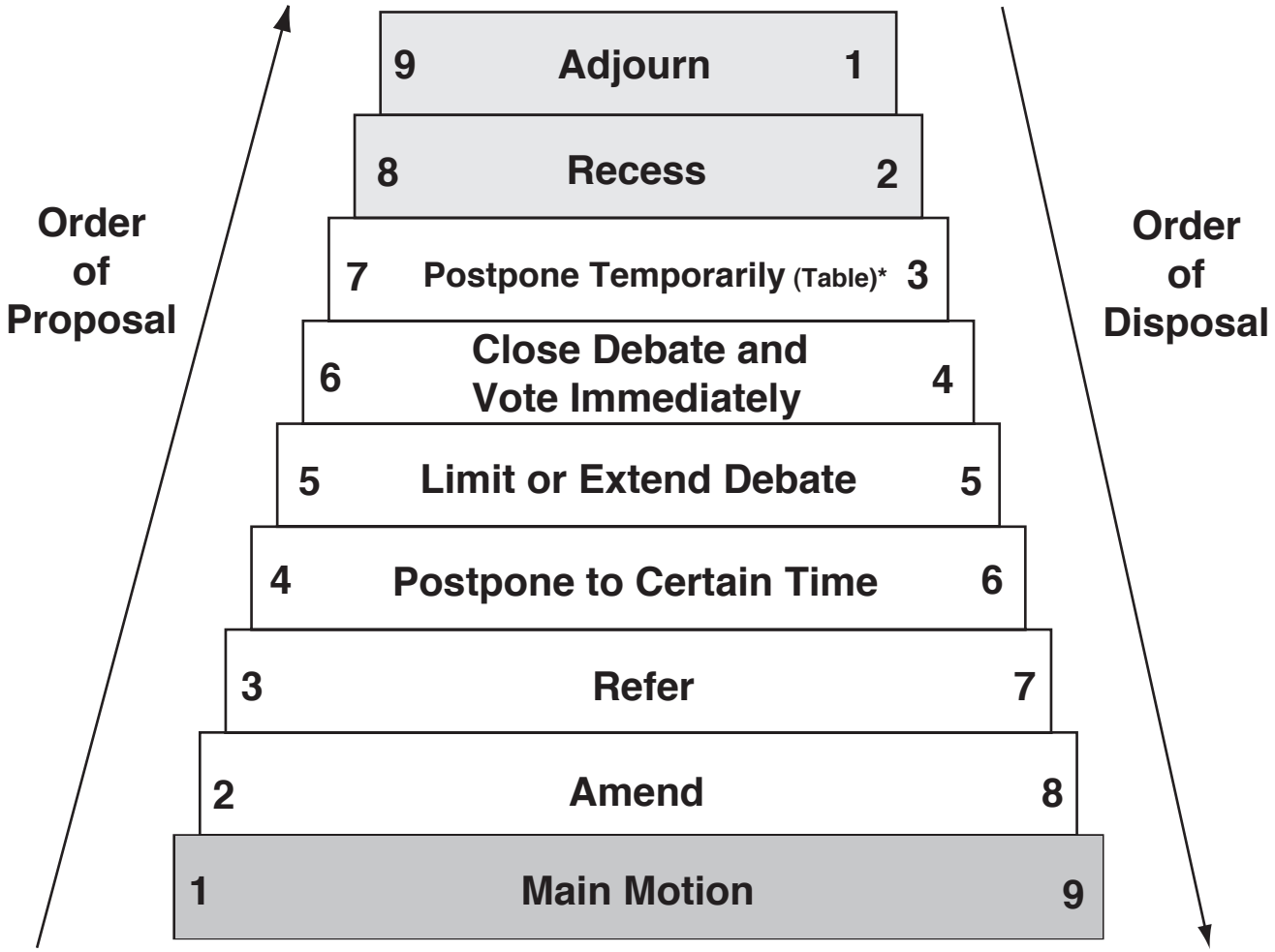
The Standard Code of Parliamentary Procedure, Sturgis, 4th ed.

What You Want To Accomplish, in order of precedence[1]	**What You Need To Say**
Close/adjourn the meeting	"I move that we adjourn"
Take a break/recess	"I move to recess until…"
Register a complaint/raise a question of privilege	"I rise to a question of privilege"
Postpone an item temporarily/Table[2]	"I move that we postpone/table the item temporarily"
Close debate and vote immediately[3]	"I move to close debate"
Limit or extend debate	"I move to limit debate of each speaker to…"
Postpone to a certain time	"I move to postpone the item until…"
Refer an item	"I move to refer this item to the Board"
Amend (by substitution, insertion, deletion)	"I would like to amend the resolution by…"
Bring business before assembly, i.e. main motion[4]	"I move that…"
Restorative Main Motions, no order of precedence. Introduce when nothing else is pending.	**What You Need to Say**
Amend a previous action	"I move to amend the motion that was…"
Reconsider an item previously votes upon	"I move to reconsider…"
Rescind a previously considered item	"I move to rescind…"
Resume consideration/take from the table	"I move to resume consideration of…"
Incidental Motions, no order of precedence	**What You Need to Say**
Disagree with the ruling of the Speaker	"I appeal the ruling of the chair"
Suspend rules	"I move to suspend the rules requiring…"
Enforce rules	"Point of order." State your point when recognized
Ask about parliamentary procedure	"Point of parliamentary inquiry"
Request to withdraw a motion	"I wish to withdraw the motion"
Divide an issue into individual resolved clauses	"I would like to divide the question"
Ask for a hand count of the assembly	"I call for a division of the assembly"

[1] Motions are in order only if no motion higher on the list is pending, e.g. if a motion to close debate is pending, a motion to amend would be out of order, but a motion to recess would be in order, since it outranks the pending motion.
[2] Tabling an item effectively results in killing the item and no action being taken unless the item is moved for reconsideration.
[3] Unless specifically stated, vote will be taken only on the pending item.
[4] Main motions are the resolutions submitted to the HOD.

STURGIS RULES OF ORDER

MOTIONS WITH PRECEDENCE AND THEIR RANK



Precedented Motions

Privileged Motions

Subsidiary Motions

Main Motion

***Postponing temporarily or tabling a motion means no action is taken & the motion dies.**

Candidates for Office

MSMS
MICHIGAN STATE MEDICAL SOCIETY

OFFICERS, 2021-2022

President	Pino D. Colone, MD	Genesee
President-Elect	Thomas J. Veverka, MD	Saginaw
Immediate Past President	S. Bobby Mukkamala, MD	Genesee
Secretary	T. Jann Caison-Sorey, MD, MSA, MBA	Wayne
Treasurer	John A. Waters, MD	Genesee
Speaker	Phillip G. Wise, MD	Kent
Vice Speaker	Bryan W. Huffman, MD	Ottawa
Chair	Mark C. Komorowski, MD	Bay
Vice Chair	Paul D. Bozyk, MD	Oakland
Ex-Officio	Dennis M. Ramus, MD	Macomb
Ex-Officio	F. Remington Sprague, MD	Muskegon

REGIONAL DIRECTORS

Talat Danish, MD, MPH, FAAP	1	Wayne	2023	Mark E. Meyer, MD	5	Kalamazoo	2024
Herbert C. Smitherman, Jr., MD, MPH	1	Wayne	2023	Nita M. Kulkarni, MD	6	Genesee	2022
Paul D. Bozyk, MD	2	Oakland	2022	P. Dileep Kumar, MD, MBA, FACP, CPE	6	St. Clair	2023
Daniel M. Ryan, MD	2	Macomb	2023	Mark C. Komorowski, MD	7	Bay	2023
Larry Junck, MD	3	Washtenaw	2022	Mildred J. Willy, MD	7	Saginaw	2022
Bradley J. Uren, MD	3	Livingston	2023	Eric L. Larson, MD	8	Kent	2024
Robert M. Doane, MD	4	Jackson	2023	Brian R. Stork, MD	8	Muskegon	2024
David T. Walsworth, MD	4	Ingham	2024	Melanie S. Manary, MD	9	Northern	2024
Belen Amat, MD	5	Barry	2024				

DESIGNATED DIRECTORS

At-Large Physician	Jayne E. Courts, MD, Kent	2023
Independent Small Practice Physician	Donald P. Condit, MD, MBA, Kent	2023
Physician Leader From Health System	Christopher J. Milback, MD, MBA, Oakland	2023
Physician Organization Leader	Paul S. Harkaway, MD, Washtenaw	2023
Physician Serving as DIO/Representing GME Training	Robert F. Flora, MD, MBA, MPH, Genesee	2023
Physician Serving In Government/Public Health Role	Thomas M. George, MD, Kalamazoo	2023

SECTION DIRECTORS

Young Physicians Section	Michael J. Redinger, MD	Kalamazoo
Residents And Fellows Section	Gunjan B. Malhotra, MD	Washtenaw
Medical Students Section	Tabitha E. Moses	Wayne

DELEGATION TO THE AMA

Delegates	**Term Expires**
Paul D. Bozyk, MD, Oakland	2022
Michael D. Chafty, MD, JD, Kalamazoo	2022
Betty S. Chu, MD, MBA, Oakland	2023
Pino D. Colone, MD, Genesee	2023
Jayne E. Courts, MD, Kent	2022
Mark C. Komorowski, MD, Bay	2023
Rose M. Ramirez, MD, Kent	2022
Venkat K. Rao, MD, Genesee	2022
Michael A. Sandler, MD Wayne	2023
Krishna K. Sawhney, MD, Wayne	2023
Richard E. Smith, MD, Wayne	2022
David T. Walsworth, MD, Ingham	2023
Kaitlyn Dobesh, MD, JD, Wayne, Resident	

Alternates (in order of seniority)	**Term Expires**
T. Jann Caison-Sorey, MD, MSA, MBA, Wayne	2022
Christie L. Morgan, MD, Oakland	2022
Amit Ghose, MD, Ingham	2022
John A. Waters, MD, Genesee	2022
Theodore B. Jones, MD, Wayne	2023
Patricia A. Kolowich, MD, Wayne	2023
M. Salim U. Siddiqui, MD, PhD, Wayne	2023
Kenneth Elmassian, DO, Ingham	2023
Edward C. Bush, MD, Wayne	2023
Courtland Keteyian, MD, Jackson	2022
Michael J. Redinger, MD, Kalamazoo	2022
Mara Darian, Medical Student	

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MICHIGAN STATE MEDICAL SOCIETY

Notification of Slate of Offices – 2022 House of Delegates

REGIONAL DIRECTORS *(Three-year term to 2025 House of Delegates)*

Region #2 – Macomb and Oakland
Paul D. Bozyk, MD, Oakland: completed one term

Region #3 – Lenawee, Livingston, Monroe, and Washtenaw
Larry Junck, MD, Washtenaw: completed one term

Region #6 – Genesee, Huron, Lapeer, Sanilac, Shiawassee, St. Clair, and Tuscola
Nita M. Kulkarni, MD, Genesee: completed one term

Region #7 – Arenac, Bay, Gladwin, Gratiot, Isabella-Clare, Midland, and Saginaw
Mildred J. Willy, MD, Saginaw: approved to fill the unexpired term of Doctor Veverka

Region #9 – See Enclosed Map with Counties
OPEN POSITION *(Candidate must be from a county located in the Upper Peninsula)*

SECTION REPRESENTATIVES: The ***MSMS Resident and Fellow Section*** and the ***MSMS Medical Student Section*** will elect one representative each to serve on the MSMS Board of Directors for a one-year term to the 2023 House of Delegates. The ***Young Physicians Section*** will elect one representative to serve on the MSMS Board of Directors for a two-year term to the 2024 House of Delegates.

OFFICERS *(One-year term to 2023 House of Delegates)*
Speaker: Phillip G. Wise, MD, Kent
Vice Speaker: Bryan W. Huffman, MD, Ottawa
President-elect Candidate to Date: M. Salim U. Siddiqui, MD, PhD, Wayne

MICHIGAN DELEGATION TO THE AMA *(Two-year term to 2024 House of Delegates)*

Delegates
Paul D. Bozyk, MD, Oakland
Michael D. Chafty, MD, JD, Kalamazoo
Jayne E. Courts, MD, Kent
Rose M. Ramirez, MD, Kent
Venkat K. Rao, MD, Genesee
Richard E. Smith, MD, Wayne

Alternate Delegates Incumbents:
T. Jann Caison-Sorey, MD, Wayne
Christie L. Morgan, MD, Oakland
Amit Ghose, MD, Ingham
John A. Waters, MD, Genesee
Courtland Keteyian, MD, Jackson
Michael J. Redinger, MD, Kalamazoo

Resident position will take a seat as an AMA Delegate and the Student position will take a seat as an AMA Alternate Delegate for the term 2022-2024.

In Memoriam

MSMS
MICHIGAN STATE MEDICAL SOCIETY

In Memory

The members of the Michigan State Medical Society remember with respect their colleagues who have passed away since our last annual meeting.

John Allen, DO
Henry Ancheta, MD
Ernie Balcueva, MD
Theodore Beals, MD
Daniel Benishek, MD
Virgilio Bonet, MD
Wayne Breece, MD
Robert Brouwer, MD
Arthur Brown, MD
Roger Byrd, DO
Nicanor Castedo, MD
Robert Cross, MD
Thomas Davis, MD
Sandra Dettmann, MD
Samuel Dismond, MD
Fred Doornbos, MD
Gary Farhat, MD
John Feilla, MD
W. Rodney Flanary, MD
Colin Forsyth, MD
Lori Fortner, MD
Bruce Genovese, MD
Norma Gilbert, MD
Scot Goldberg, MD, MBA
Robert Graham, DO
Stanley Greenberg, MD
Kenneth Gritter, MD
Robert Guild, DO
Carl Hammerstrom, MD
Alan Hendra, MD
Victor Hill, MD
Janet Holloway, DO
Harold Hommerson, MD
Jack Hunt, MD
Syed Husain-Hamzavi, MD
Robert Jongeward, MD
Azzam Kanaan, MD
John Karakitsos, MD
Thomas Kaye, MD
Zubeda Khan, MD
Jerome Kwartowitz, DO
Sandra Last, MD
Lawrence Lee, MD
Charles Lee, DO
Lloyd Lemmen, MD
James Letson, MD
Otto Linet, MD
Paul Linnell, MD
Diana Little, MD
Robert Martin, DO
Rodney McFarland, MD
Andre Michaud, MD
Andrew Michelakis, MD
Bipin Modi, MD
Earl Moehn, MD
Abboy Mohan, MD
Konda Mouli, MD
Iquo Nafiu, MD
Robert Packer, MD
Moon Pak, MD, PhD

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William Passinault, MD
Fred Patterson, MD, FACR
Ernesto Quiachon, MD
Robert Reed, MD
William Roth, MD
Earl Rudner, MD
Charles Seifert, MD
Jyotsna Shah, MD
Shiraz Shariff, MD
Rebekah Sharp, MD
Allen Silbergleit, MD, PhD
James Stanton, MD
K. Leslie Taylor, MD
William Tenhaaf, MD
Dennis Tibble, MD
Donald Tuckey, MD
Vincent Turcotte, MD
Prabhundha Vanasupa, MD
Joseph VanVliet, MD
Robert Weber, MD
Thomas Weeber, MD
Eugene Willoughby, MD
David Zalenski, MD
Charles Zimont, MD

Roster of Delegates and Alternates

MICHIGAN STATE MEDICAL SOCIETY
2022 HOUSE OF DELEGATES
April 30 - May 1, 2022
Roster of Delegates

OFFICERS:

Phillip	Wise	MD	Speaker
Bryan	Huffman	MD	Vice-Speaker
T. Jann	Caison-Sorey	MD, MSA, MBA	Secretary

County: Berrien

Dennis	Szymanski	MD	Delegate

County: Genesee

Khalid	Ahmed	MD	Delegate
Qazi	Azher	MD	Delegate
Edward	Christy	MD	Delegate
Paul	Kocheril	MD	Delegate
Venkat	Rao	MD	Delegate
Macksood	Aftab	DO	Alternate Delegate
Scott	Garner	MD	Alternate Delegate
Ethiraj	Raj	MD	Alternate Delegate
Rama	Rao	MD	Alternate Delegate
Sunilkumar	Rao	DO	Alternate Delegate
Brenda	Rogers-Gray	DO	Alternate Delegate

County: Grand Traverse - Leelanau - Benzie

Frederick	Brodeur, Jr.	MD	Delegate
Leah	Davis	DO	Delegate
Bradley	Goodwin	MD	Delegate
Kenneth	Musson	MD, MS, FACS	Delegate
Edward	Rutkowski	MD	Delegate
Richard	Schultz	MD	Delegate

County: Gratiot

Rakesh	Saxena	MD	Delegate

County: Ingham

Iftiker	Ahmad	MD	Delegate
Kenneth	Elmassian	DO	Delegate
Amit	Ghose	MD	Delegate
Ved	Gossain	MD	Delegate
Narasimha	Gundamraj	MD	Delegate
Raza	Haque	MD	Delegate
Richard	Honicky	MD	Delegate
Joseph	Wilhelm	MD	Delegate
Ronald	Horowitz	MD	Alternate Delegate

County: Jackson

Oluwaseyi	Adebekun	MD	Delegate
Janak	Bhavsar	MD	Delegate
Courtland	Keteyian	MD	Delegate
Jon	Lake	MD	Delegate

County: Kalamazoo

Janice	Werbinski	MD	Delegate

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County: Kent

Megan	Edison	MD	Delegate
Warren	Lanphear	MD, FACEP	Delegate
Gerald	Lee	MD	Delegate
Rose	Ramirez	MD	Delegate
Adam	Rush	MD	Delegate
John	VanSchagen	MD	Delegate
David	Whalen	MD	Delegate
Phillip	Wise	MD	Delegate
Anita	Avery	MD	Alternate Delegate
John	Beernink	MD, FACS	Alternate Delegate
Michelle	Condon	MD	Alternate Delegate
Karen	Leavitt	MD	Alternate Delegate
Herman	Sullivan	MD	Alternate Delegate

County: Macomb

Anthony	Baron	MD	Delegate
Terrence	Brennan	MD	Delegate
Burton	Engel	MD	Delegate
Lawrence	Handler	MD	Delegate
Jane	Krasnick	MD	Delegate
Ronald	Levin	MD	Delegate
Klaudia	Plawny-Lebenbom	MD	Delegate
Vincente	Redondo	MD	Delegate
Aaron	Sable	MD	Delegate
Adrian	Christie	MD	Alternate Delegate
Akash	Sheth	MD	Alternate Delegate

County: Muskegon

Wayne	Fuller	MD	Delegate
Blake	Miller	DO	Delegate

County: Oakland

Jaime	Aragones	MD	Delegate
Barry	Auster	MD	Delegate
George	Blum	MD	Delegate
Betty	Chu	MD, MBA	Delegate
Peter	Duhamel	MD	Delegate
Jay	Fisher	MD	Delegate
Ashok	Gupta	MD	Delegate
Sherwin	Imlay	MD	Delegate
Anil	Kumar	MD	Delegate
Kamalesh	Lahiri	MD	Delegate
David	Lee	MD	Delegate
Robert	Levine	MD	Delegate
Shahrokh	Mansoori	MD	Delegate
Steven	Newman	MD	Delegate
Donald	Peven	MD	Delegate
Theodore	Roumell	MD	Delegate
Manveen	Saluja	MD	Delegate
Raouf	Seifeldin	MD	Delegate
Karol	Zakalik	MD	Delegate

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Roster of Delegates

County: Ottawa

Bryan	Huffman	MD	Delegate
Todd	Van Heest	MD	Alternate Delegate

County: Saginaw

Christopher	Allen	MD	Delegate
Judy	Blebea	MD	Delegate
Elvira	Dawis	MD	Delegate
Karensa	Franklin	MD	Delegate
Elizabeth	Marshall	MD	Delegate
Miriam	Schteingart	MD	Delegate
Caroline	Scott	MD	Delegate
Julia	Walter	MD	Delegate
Anthony	Zacharek	MD	Delegate
Waheed	Akbar	MD	Alternate Delegate
Nicholas	Haddad	MD	Alternate Delegate
Mohammad	Khan	MD	Alternate Delegate
Kala	Ramasamy	MD	Alternate Delegate
Jennifer	Romeu	MD	Alternate Delegate

County: Shiawassee

Adriana	Raus	MD	Delegate

County: St. Clair

Sara	Liter-Kuester	DO	Delegate
Annette	Mercatante	MD, MPH	Delegate
John	Pelachyk	MD	Delegate

County: Washtenaw

Richard	Burney	MD	Delegate
Terence	Joiner	MD	Delegate
Charles	Koopmann, Jr.	MD	Delegate
James	Mitchiner	MD, MPH	Delegate
Joseph	Nnodim	MD, PhD, FACP	Delegate
Robert	Sain	MD	Delegate
James	Szocik	MD	Delegate
Barbara	Threatt	MD	Delegate
Jerry	Walden	MD	Delegate
Evelyn	Eccles	MD	Alternate Delegate
Alon	Weizer	MD	Alternate Delegate

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County: Wayne

Anthony	Adeleye	MD	Delegate
Susan	Adelman	MD, FACS	Delegate
Ghassan	Allo	MD	Delegate
Hassan	Amirikia	MD	Delegate
Charles	Barone	MD	Delegate
Joseph	Beals	MD	Delegate
Deloris	Berrien-Jones	MD	Delegate
E. Chris	Bush	MD	Delegate
Denise	Collins	MD	Delegate
Steven	Daveluy	MD	Delegate
Nicolas	Fletcher	MD	Delegate
Cheryl	Gibson Fountain	MD	Delegate
Holly	Gilmer	MD	Delegate
Sarah	Gorgis	MD	Delegate
Sara	Hegab	MD	Delegate
Aliya	Hines	MD, PhD	Delegate
Clara	Hwang	MD	Delegate
Anne-Mare'	Ice	MD	Delegate
Edward	Jankowski	MD	Delegate
Theodore	Jones	MD, FACOG	Delegate
Katherine	Joyce	MD	Delegate
Lauren	Keshishian	MD	Delegate
Sina	Khoshbin	MD	Delegate
Samer	Kirmiz	MD	Delegate
Patricia	Kolowich	MD	Delegate
Navid	Mahabadi	DO	Delegate
Federico	Mariona	MD, MHSA, FACS, FACOG	Delegate
Chandan	Mehta	MD	Delegate
Alireza	Meysami	MD, RhMSUS	Delegate
Ijeoma	Opara	MD	Delegate
Mohammed	Rehman	DO	Delegate
Katherine	Reyes	MD, MPH	Delegate
Latonya	Riddle-Jones	MD	Delegate
Michael	Sandler	MD	Delegate
Blake	Sanford	MD	Delegate
Krishna	Sawhney	MD	Delegate
George	Shade, Jr.	MD	Delegate
Mhd Tayseer	Shamaa	MD	Delegate
M Salim	Siddiqui	MD, PhD	Delegate
Emily	Smith	MD	Delegate
Richard	Smith	MD	Delegate
James	Sondheimer	MD	Delegate
Neelima	Thati	MD	Delegate
Bright	Thilagar	MD	Delegate
Theresa	Toledo	MD	Delegate
Donald	Tynes	MD, FACP	Delegate
Eunice	Yu	MD	Delegate
Lucia	Zamorano	MD	Delegate

County: Wexford-Missaukee

Martin	Dubravec	MD	Delegate

MICHIGAN STATE MEDICAL SOCIETY
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Roster of Delegates

Delegate-At-Large: Immediate Past President

S. Bobby	Mukkamala	MD	Delegate

Delegate-At-Large: Medical School Dean, Central Michigan University

George	Kikano	MD	Delegate

Delegate-At-Large: Medical School Dean, Michigan State University

Andrea	Amalfitano	DO, PhD	Delegate
Aron	Sousa	MD	Delegate

Delegate-At-Large: Medical School Dean, University of Michigan

Marschall	Runge	MD, PhD	Delegate

Delegate-At-Large: Medical School Dean, Oakland University

Duane	Mezwa	MD, FACR	Delegate

Delegate-At-Large: Medical School Dean, Wayne State University

Wael	Sakr	MD	Delegate

Delegate-At-Large: Medical School Dean, Western Michigan University

Paula	Termuhlen	MD	Delegate

Members-At-Large: MDHHS Chief Medical Officer

Natasha	Bagdasarian	MD	Delegate

Medical Student Section

Kumaran	Arivoli	Student Delegate
Samuel	Borer	Student Delegate
Mara	Darian	Student Delegate
Daniel	Domin	Student Delegate
Alyssa	Dsouza	Student Delegate
Vanessa	Elliott	Student Delegate
Sravya	Emmadi	Student Delegate
Mary	Finedore	Student Delegate
Katherine	Grayden	Student Delegate
Remonda	Khalil-Moawad	Student Delegate
Charlotte	Kreger	Student Delegate
Ashton	Lewandowski	Student Delegate
Darian	Mills	Student Delegate
Cloe	Nazeer	Student Delegate
Aarti	Patel	Student Delegate
Pragathi	Pathanjeli	Student Delegate
Emily	Ridge	Student Delegate
Yunjoo	Shin	Student Delegate
Simon	Zetuna	Student Delegate

MICHIGAN STATE MEDICAL SOCIETY
2022 HOUSE OF DELEGATES
April 30 - May 1, 2022
Roster of Delegates

International Medical Graduate Section
Vacant

Resident and Fellow Section

Kevin	Harris	MD	Delegate

Young Physician Section
Vacant

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Cara	Poland	MD, MEd	Specialty Society Alternate

Specialty Society: MI Allergy & Asthma Society

Lawrence	Hennessey	MD	Specialty Society Delegate

Specialty Society: MI Society of Anesthesiologists

Neeraja	Ravikant	MD	Specialty Society Delegate

Specialty Society: MI Society of Colon and Rectal Surgeons

Adewunmi	Adeyemo	MD	Specialty Society Delegate
Antonia	Henry	MD	Specialty Society Alternate

Specialty Society: MI Dermatological Society

Alice	Watson	MD	Specialty Society Delegate

Specialty Society: MI College of Emergency Physicians

Sara	Chakel	MD, FACEP	Specialty Society Delegate

Specialty Society: MI Society of Eye Physicians and Surgeons

Patrick	Droste	MD	Specialty Society Delegate

Specialty Society: MI Academy of Family Physicians

Loretta	Leja	MD	Specialty Society Delegate
Holli	Neiman-Hart	MD	Specialty Society Alternate

Specialty Society: MI Association of Medical Examiners

Carl	Hawkins	MD	Specialty Society Delegate

Specialty Society: MI Neurological Association

Amit	Sachdev	MD	Specialty Society Delegate

Specialty Society: MI Orthopaedic Society

Christopher	Betzle	MD	Specialty Society Delegate

Specialty Society: American College of Physicians, MI Chapter

Martha	Gray	MD	Specialty Society Delegate

Specialty Society: MI Academy of Plastic Surgeons

Steven	Haase	MD	Specialty Society Delegate

Specialty Society: MI Psychiatric Society

Carmen	McIntyre Leon	MD	Specialty Society Delegate
Denise	Gribbin	MD	Specialty Society Alternate

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Pamela	Hackert	MD, JD, MPH	Specialty Society Delegate
Catherine	Bodnar	MD	Specialty Society Alternate

Specialty Society: MI Radiological Society

Katharine	Scharer	MD	Specialty Society Delegate
Brent	Griffith	MD	Specialty Society Alternate

Specialty Society: MI Rheumatism Society

Joshua	June	DO	Specialty Society Delegate

Specialty Society: MI Academy of Sleep Medicine

Maria	Tovar Torres	MD	Specialty Society Delegate

Specialty Society: MI Chapter of the American College of Surgeons

Thomas	Thornton	MD	Specialty Society Delegate
Amanda	McClure	MD	Specialty Society Alternate

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Mark C. Komorowski, MD
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Jennifer L. Finney

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MICHIGAN STATE MEDICAL SOCIETY
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Board Advisors:
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John A. Waters, MD

Staff:
Lauchlin W. S. MacGregor

Miscellaneous Information

House of Delegates Conflict of Interest Policy

All members of the Michigan State Medical Society House of Delegates should declare any conflict of interest, including regulatory capture*, to the House of Delegates and its Reference Committees prior to testimony. The MSMS House of Delegates considers a potential conflict of interest to exist when a Delegate, Alternate Delegate, other physician member or a non-member testifying on the floor of the House of Delegates or in Reference Committee has a relationship, or engages in any activity, or has any personal financial or commercial interest that might impair his or her independence or judgment or inappropriately influence his or her decisions or actions concerning MSMS matters.

- Board Action Report #4, 2000 HOD, Res 10-HOD99A and Res 13-HOD99A -Edited 2017

*Regulatory capture refers to the corruption of the regulatory process such that public good is sacrificed in favor of the commercial interests of the regulated entity.

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Reaffirmation Calendar

MICHIGAN STATE MEDICAL SOCIETY
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REAFFIRMATION CALENDAR

RESOLUTION	DESCRIPTION
02-22 (07-20)	Mandatory Electronic Prescriptions in Michigan
35-22	Strengthen Laws to Curb Human Trafficking Aimed at People Who Buy Sex
49-22	Mandating a Health Systems Education in Medical School Curricula

RESOLUTION 02-22 (07-20)

Title: Mandatory Electronic Prescriptions in Michigan

Introduced by: Anup Lal, MD, for the St. Clair County Delegation

Original Author: Anup Lal, MD

Referred To: Reaffirmation Calendar

House Action:

Whereas, the Michigan Legislature is considering legislation to mandate electronic prescribing for all prescriptions with some exceptions and a waiver process, and

Whereas, proposed exceptions include, among others, an exception for temporary technological failure, cases where it is impractical for the patient to obtain the prescription drug in a timely manner, and when a prescription is orally prescribed, and

Whereas, a prescriber could seek a waiver from the Department of Licensing and Regulatory Affairs if he or she cannot meet the electronic prescribing requirement, and

Whereas, MSMS has testified in both Chambers expressing reservations with the bills, as currently written, and

Whereas, MSMS agrees adoption of e-prescribing should be encouraged, the concerns expressed centered on the existing barriers to adoption of electronic prescribing of controlled substances, including interoperability concerns and the often, prohibitive costs of the electronic prescribing of controlled substances software, and

Whereas, several states have adopted e-prescribing regulations, and others are considering the same, there is considerable variation as to scope, and penalties (or lack thereof) for lack of compliance (i.e., New York mandates e-prescribing for all medications, with penalties for noncompliance, while Oklahoma requires e-prescribing for schedule II-V controlled substances, with provisions for exemptions and waivers, and no penalties listed), and

Whereas, it is commonly assumed by its proponents that e-prescribing will reduce medication errors and costs and help reduce the impact of the opioid epidemic, and

Whereas, there is some evidence in favor of the former, but it is not conclusive, and lacking, especially in the outpatient setting, and

Whereas, it is still too early to estimate effect, if any, on the opioid epidemic, and

Whereas, mandatory e-prescribing could pose significant burden on the prescriber and patients, even without the circumstances detailed above. Some examples include, and are not limited to, prescribing after hours, when access to the patient's electronic health record (EHR) can be difficult under many circumstances and physicians covering for other practitioners who are not

part of the same group. Additional examples include the patient changing pharmacies without informing the prescriber or not being able to reach their preferred pharmacy during its working hours. Many EHR systems are still limited in their ability to prescribe customized schedules, such as steroid tapers, and

Whereas, lack of interoperability between EHR systems can significantly limit effectiveness in terms of communication between different providers and health systems; therefore be it

RESOLVED: That MSMS oppose the enactment of mandatory electronic prescribing for all prescriptions; and be it further

RESOLVED: That MSMS oppose legislation to mandate electronic prescribing for all prescriptions unless such legislation 1) includes suitable safeguards to reduce burden on the prescriber and patients; 2) includes sufficient exceptions and waivers; and 3) does not include penalties for "non-compliance."

WAYS AND MEANS COMMITTEE FISCAL NOTE: None

Relevant MSMS Policy:

MSMS Position
MSMS opposed the state legislation on mandatory electronic prescribing which was signed into law in 2020.

Mandating e-Prescribing
MSMS encourages the AMA to work with representatives of pharmacies, pharmacy benefits managers, and software vendors to expand the ability to electronically prescribe all medications.

Relevant AMA Policy:

Federal Roadblocks to E-Prescribing D-120.958
1. Our AMA will: work with the Centers for Medicare and Medicaid Services and states to remove or reduce barriers to electronic prescribing of both controlled substances and non-scheduled prescription drugs, including removal of the Medicaid requirement in all states that continue to mandate that physicians write, in their own hand, “brand medically necessary” or the equivalent on a paper prescription form.
2. It is AMA policy that physician Medicare or Medicaid payments not be reduced for non-adoption of e-prescribing.
3. Our AMA will work with the largest and nearly exclusive national electronic pharmacy network, all related state pharmacy regulators, and with federal and private entities to ensure universal acceptance by pharmacies of electronically transmitted prescriptions.
4. Our AMA will advocate for appropriate financial and other incentives to physicians to facilitate electronic prescribing adoption.
5. Our AMA will work to substantially reduce regulatory burdens so that physicians may successfully submit electronic prescriptions for controlled substances.
6. Our AMA will work with representatives of pharmacies, pharmacy benefits managers, and software vendors to expand the ability to electronically prescribe all medications.
7. Our AMA will work with the Centers for Medicare & Medicaid Services and the federal government to have all pharmacies, including government pharmacies, accept e-prescriptions for prescription drugs.

Electronic Prescribing D-120.972
1. Our AMA will (a) ask the Drug Enforcement Administration to accelerate the promulgation of digital certificate standards for direct electronic transmission of controlled substance prescriptions to support the

patient safety goals and other governmental initiatives; and (b) urge Congress to work towards unifying state prescription standards and standard vocabularies to facilitate adoption of electronic prescribing.
2. Our AMA will support national efforts to amend federal law and federal Drug Enforcement Administration regulations to allow for the e-prescribing of a medication, including a controlled substance, needed by a patient with a mental health or behavioral health diagnosis when a valid patient-physician relationship has been established through telemedicine and in accordance with state law and accepted standards of care.

Sources:

1. MSMS News, msms.org
2. Mdtoolbox.com, eprescribe-map
3. Syst Rev. 2014 Jun. The effectiveness of computerized order entry at reducing preventable adverse drug events and medication errors in hospital settings: a systematic review and meta-analysis. Nuckols TK1, Smith-Spangler C et al
4. Perspect Health Inf Manag. 2014 Spring; 11(Spring):Published online 2014 Apr 1. Electronic Prescribing: Improving the Efficiency and Accuracy of Prescribing in the Ambulatory Care Setting. Amber Porterfield, MS, et al

RESOLUTION 35-22

Title: Strengthen Laws to Curb Human Trafficking Aimed at People Who Buy Sex

Introduced by: Joseph M. Beals, MD, for the Wayne County Delegation

Original Author: Joseph M. Beals, MD

Referred To: Reaffirmation Calendar

House Action:

Whereas, there have been at least 11 laws passed in Michigan dealing with human trafficking including Public Act 328 of 2014 which imposes stricter penalties on individuals who engage or offer to engage minors in prostitution or who "recruit, entice, harbor, transport, provide, or obtain by any means a minor for commercial sexual activity, or for forced labor or services," and

Whereas, in spite of these stricter laws, human trafficking continues in Michigan because of lax enforcement of existing laws, the large profit that is obtained from human trafficking, and the failure of society to make people aware of the danger of buying sex, and

Whereas, in September 2021, the state of Texas passed House Bill 1540, which was signed into law by Governor Greg Abbott, to make the buying of sex a felony, subject to jail time and large fines-up to two years in prison and fines up to $10,000; therefore be it

RESOLVED: That MSMS advocate that the Michigan Legislature pass a law similar to the Texas statute which makes the buying of sex a felony punishable by prison time and a large monetary penalty.

WAYS AND MEANS COMMITTEE FISCAL NOTE: None

Relevant MSMS Policy:

Resolution 14-20 - Curb Human Trafficking
RESOLVED: That MSMS advocate for the passage of human trafficking legislation which toughens criminal and financial penalties for persons soliciting sexual activity for payment rather than the victims of trafficking.

The Recognition and Protection of Human Trafficking Victims
MSMS supports training medical students, residents, and physicians to understand their role in treating patients who are victims of human trafficking.

Human Trafficking Education and Awareness
MSMS encourages the State Board of Education, Michigan secondary schools and colleges, as well as other influential organizations to increase awareness of human trafficking and increase awareness of signs of human trafficking.

Relevant AMA Policy:

Commercial Exploitation and Human Trafficking of Minors H-60.912
Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

Physicians Response to Victims of Human Trafficking H-65.966
1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.

Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.

The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

The Polaris Project -
In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:
- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
a. An assessment tool for health care professionals
b. Online training in recognizing and responding to human trafficking in a health care context
c. Speakers and materials for in-person training
d. Links to local resources across the country

The Rescue & Restore Campaign -
The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.

RESOLUTION 49-22

Title: Mandating a Health Systems Education in Medical School Curricula

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: Neil Vaishampayan and Kumaran Arivoli

Referred To: Reaffirmation Calendar

House Action:

Whereas, knowledge on health policy, advocacy, and legislation is crucial for health professionals and trainees to better understand the greater context of the health care system, and

Whereas, this decade has seen the greatest number of health policy related legislation passed, affecting the physician-patient relationship through copayments, value-based care, access to care, and insurance coverage, and

Whereas, a majority of patients ranked their physician or nurse as their most trusted source for information on the Affordable Care Act, placing increased responsibility on health professionals to convey evidence-based health policy information, and

Whereas, less than 20 percent of practicing physicians described themselves as equipped to understand and impact the field of medicine through health policy, and

Whereas, almost half of U.S. medical students report inadequate training and instruction in health policy, and

Whereas, 70 percent of medical schools do not cover curriculum in any of the domains of clinical and public health systems, health services financing, health workforce, and health policy process, and

Whereas, it has been shown that comprehensive health policy training leads to medical students and residents that are (1) more focused on large scale health care solutions as opposed to acute care and (2) more invested in community health and public health initiatives; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to support the implementation of a standardized health policy and public health curriculum that is integrated into all medical schools; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to support an objective, evidence-based health policy curriculum that incorporates education on integrated health care systems, including but not limited to weekly lectures explaining how health policy is created in America, monthly seminars discussing current federal health care legislation, interactive sessions for students to learn how to best advocate for their patients on a legislative level.

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50 WAYS AND MEANS COMMITTEE FISCAL NOTE: None

Relevant MSMS Policy:

Advocacy Training in Medical Schools
MSMS encourages all Michigan and U.S. medical schools and residency programs to incorporate significant, more formalized training in health care policy and patient care advocacy into their curricula to aid in the development of our next generation of physician leaders. (Res55-13)

Relevant AMA Policy:

Medical Student, Resident and Fellow Legislative Awareness H-295.953
1. 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.
2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum.
3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.
4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows.

Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327
1. Our AMA encourages medical schools, schools of public health, graduate medical education programs, and key stakeholder organizations to develop and implement longitudinal educational experiences in public health for medical students in the pre-clinical and clinical years and to provide both didactic and practice-based experiences in public health for residents in all specialties including public health and preventive medicine.
2. Our AMA encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum.
3. Our AMA actively encourages the development of innovative models to integrate public health content across undergraduate, graduate, and continuing medical education.
4. Our AMA, through the Initiative to Transform Medical Education (ITME), will work to share effective models of integrated public health content.
5. Our AMA supports legislative efforts to fund preventive medicine and public health training programs for graduate medical residents.
6. Our AMA will urge the Centers for Medicare and Medicaid Services to include resident education in public health graduate medical education funding in the Medicare Program and encourage other public and private funding for graduate medical education in prevention and public health for all specialties.

Sources:

1. Patel MS, Davis MM, Lypson ML. Advancing medical education by teaching health policy. N Engl J Med. 2011;364(8):695-697. doi:10.1056/NEJMp1009202
2. Patel MS, Lypson ML, Miller DD, Davis MM. A framework for evaluating student perceptions of health policy training in medical school. Acad Med. 2014;89(10):1375-1379. doi:10.1097/ACM.0000000000000408
3. Riegelman R. Commentary: Health systems and health policy: a curriculum for all medical students. Acad Med. 2006 Apr;81(4):391-2. doi: 10.1097/00001888-200604000-00014. PMID: 16565193.
4. Hearne SA. Practice-based teaching for health policy action and advocacy. Public Health Rep. 2008;123 Suppl 2(Suppl 2):65-70. doi: 10.1177/00333549081230S209. PMID: 18770919; PMCID: PMC2431098.

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6. Jacobsohn V, DeArman M, Moran P, Cross J, Dietz D, Allen R, Bachofer S, Dow-Velarde L, Kaufman A. Changing hospital policy from the wards: an introduction to health policy education. Acad Med. 2008 Apr;83(4):352-6. doi: 10.1097/ACM.0b013e3181667d6e. PMID: 18367894. Health policy training initiatives. Health Psychology. 2004; 2(15, Suppl).
7. Shortt SE, Hodgetts PG. A curriculum for the times: an experiment in teaching health policy to residents in family medicine. CMAJ. 1997;157(11):1567-1569.
8. Mills DA, Dane P, Cymet T. A curriculum on health policy for medical students. Md Med. 2012;13(2):21-2. PMID: 23252039.
9. Venkataramani AS, O'Brien R, Tsai AC. Declining Life Expectancy in the United States: The Need for Social Policy as Health Policy. JAMA. 2021;325(7):621-622. doi:10.1001/jama.2020.26339 Kaiser Health Tracking Poll: August 2013. (2013). Retrieved 8 January 2022, from https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-august-2013/
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Reference Committee A

MICHIGAN STATE MEDICAL SOCIETY
2022 HOUSE OF DELEGATES

RESOLUTIONS BY COMMITTEE

REFERENCE COMMITTEE A – MEDICAL CARE DELIVERY

RESOLUTION	DESCRIPTION
01-22 (02-20)	Improve Access to Pediatric Psychiatry
09-22 (24-20)	Prescription Medication Pill Size
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22-22	Clinical Laboratory Improvement Amendment Requirements
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51-22	Medicaid Funding to Address Social Determinants of Health
52-22	Pharmaceutical Equity for Pediatric Populations
57-22	Informed Consent for Pelvic Examinations on Patients Who Are Unconscious or Under Anesthesia
58-22	Resource Allocations to Hospital Social Workers
BOARD ACTION REPORT	**DESCRIPTION**
#1-22	Resolution 31-20 – "Bring Insurance Credentialing into Legal Compliance on Maintenance of Certification"

RESOLUTION 01-22 (02-20)

Title: Improve Access to Pediatric Psychiatry

Introduced by: Annette Mercatante, MD, for the St. Clair County Delegation

Original Author: Daniel Wilhelm, MD

Referred To: Reference Committee A

House Action:

Whereas, a recent study found that 17.6 percent of children and adolescents in Michigan have been diagnosed with one of the three disorders studied - depression, anxiety, and ADHD, and

Whereas, of those, approximately 100,000 kids and teens in the state (approximately 40 percent) were not getting mental health treatment, and

Whereas, the state had a total of just 239 psychiatrists trained to treat children and adolescents in 2017, according to the American Academy of Child and Adolescent Psychiatrists; which works out to just 11 psychiatrists for every 100,000 children across the state, and

Whereas, more than half of Michigan's counties, 65 in total, have zero child and adolescent psychiatrists, and

Whereas, the under treatment of these illnesses is likely catastrophic for a child's trajectory in life, and

Whereas, the shortage of child and adolescent psychiatrists means pediatricians and other primary care providers often end up being the ones treating children and teens for their mental health issues, and

Whereas, the Michigan Child Care Collaborative (MC3) provides psychiatry support to primary care providers in Michigan who are managing patients with mild to moderate behavioral health problems including children, adolescents, and young adults through age 26, and women who are contemplating pregnancy, pregnant, or postpartum with children up to a year, and

Whereas, psychiatrists are available through MC3 to offer guidance on diagnoses, medications, and psychotherapy interventions so that primary care providers can better manage patients in their practices, and

Whereas, such support is available through educational phone consultations to referring providers as well as remote psychiatric evaluation to patients and families through video telepsychiatry, and

Whereas, one study indicated that the percentage of children residing in states with statewide child psychiatric telephone access programs who received mental health services was

significantly higher than the percentage of children residing in states with no such programs; therefore be it

RESOLVED: That MSMS actively engage primary care providers to become familiar with and utilize Michigan Child Care Collaborative (a.k.a., MC3) services; and be it further

RESOLVED: That MSMS work with innovative programs and services to expand pediatric mental health capacity in the state.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000 for collaborative outreach efforts.

Relevant MSMS Policy:

Support for Mental Health Reform in Michigan
MSMS supports efforts to improve mental health services in Michigan, including those that address mental health disparities, promote interdepartmental coordination and shared accountability, and provide greater access to timely outpatient treatment, crisis intervention, specialty behavioral health services, inpatient psychiatric hospitalizations and other medically necessary related therapies.

Relevant AMA Policy:

Statement of Principles on Mental Health H-345.999
(1) Tremendous strides have already been made in improving the care and treatment of patients with psychiatric illness, 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 psychiatric 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.

Addressing the Shortage of Child and Adolescent Psychiatrists D-200.978
Our AMA will: (1) ask the Office of the Secretary of Health and Human Services and the Department of Health Resources and Services Administration to provide data on requests for National Health Service Corps deferments to allow completion of training in child and adolescent psychiatry; 2) call upon the Office of the Secretary of Health and Human Services and the Department of Health Resources and Services Administration to amend current policy to allow National Health Service Corps scholars to complete their training in the underserved specialty of child and adolescent psychiatry prior to the commencement of initial practice assignments; and (3) call upon the Office of the Secretary of Health and Human Services and the Department of Health Resources and Services Administration to amend current policy to allow National Health Service Corps scholars to complete their training in any specialty where there is a shortage of that specialty in designated Health Professional Shortage Areas prior to the commencement of initial practice assignments.

Sources:

1. Whitney DG, Peterson MD. US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. JAMA Pediatr. 2019;173(4):389-391.
2. Kim WJ, American Academy of Child and Adolescent Psychiatry Task Force on Workforce Needs. Child and adolescent psychiatry workforce: A critical shortage and national challenge. Acad Psychiatry. 2003;27:277â€"82.
3. https://mc3.depressioncenter.org/
4. A National Examination of Child Psychiatric Telephone Consultation Programs "Impact on Children" Mental Health Care Utilization. Stein, Bradley D. et al. Journal of the American Academy of Child & Adolescent Psychiatry, Volume 58, Issue 10, 1016 - 1019

RESOLUTION 09-22 (24-20)

Title: Prescription Medication Pill Size

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: David Whalen, MD

Referred To: Reference Committee A

House Action:

Whereas, dosing of medication frequently requires a patient to cut pills in half to achieve the proper dose recommended by their physician, and

Whereas, these medication types requiring alteration in pill tab size may be to limit the dose of controlled substances which is an advantage to many patients, and

Whereas, these dosage adjustments may be difficult for patients with limited dexterity to cut on their own; therefore be it

RESOLVED: That MSMS ask the Michigan Board of Pharmacy to pursue pill medication size to be no smaller than six mm in diameter or other size found by research to be best suited for pill cutting by elderly or disabled patients; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to request pharmaceutical companies to manufacture pills larger than five mm in diameter for medications most likely to be prescribed to elderly and disabled persons, especially those consisting of controlled substances, to better allow pill cutting to help control dosages, unless research shows this to be unnecessary in this group of patients.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000 to engage in outreach efforts.

Relevant MSMS Policy: None

Relevant AMA Policy: None

RESOLUTION 10-22 (25-20)

Title: Limit Copay on Emergency Department Visits

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Michelle M. Condon, MD, FACP

Referred To: Reference Committee A

House Action:

Whereas, some insurance products require a patient to pay an extra or larger co-pay or deductible if an emergency department evaluation does not lead to a hospital admission, and

Whereas, these patients may have waited to confer with their private physician until office hours are open, but are instructed by that physician to go to the emergency department for evaluation; therefore be it

RESOLVED: That MSMS advocate that insurance companies waive the imposition of higher co-pays or deductibles when a patient is directed by their primary care physician to seek treatment for an acute problem in the emergency department, even if the patient is not admitted to the hospital.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000 to engage in regulatory and industry advocacy.

Relevant MSMS Policy: None

Relevant AMA Policy: None

RESOLUTION 22-22

Title: Clinical Laboratory Improvement Amendment Requirements

Introduced by: David Whalen, MD, MPA, for the Kent County Delegation

Original Author: Gerald Lee, MD

Referred To: Reference Committee A

House Action:

Whereas, the Clinical Laboratory Improvement Amendment was designed to ensure quality and safety when testing human samples, and

Whereas, some manufacturers have sought legal protection by stating all tests need to be confirmed in a laboratory, and

Whereas, physicians are trying to make medical decisions based on the results of such tests at the time of appointment and/or for lower costs to the patient, and

Whereas, in-office testing should only be done by trained staff in accordance with manufacturer's directions, and

Whereas, physicians should use this information in accordance with the clinical history; therefore be it

RESOLVED: That MSMS adopt policy advocating that any confirmatory laboratory testing should be done at the discretion of the ordering physician with the best interests of the patient in mind.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new MSMS policy.

Relevant MSMS Policy:

Determination of Medical Necessity of Medical Case Management
The treating physician shall be the sole determinant of medical case management and medical necessity. MSMS believes that an insurer, a health care corporation or a government agency may not interfere with the patient/physician relationship by determining medical necessity or medical case management without a fair and reasonable appeals process and independent binding arbitration in a timely fashion. (Board Action Report #14, 1994 HOD, re Res121-93A)
– Reaffirmed (Sunset Policy 2021)

Relevant AMA Policy:

Clinical Laboratory Improvement Act of 1988 H-260.980
1. It is the policy of the AMA to (a) continue and intensify its efforts to seek appropriate and reasonable modifications in the proposed rules for implementation of the Clinical Laboratory Improvement Amendments

(CLIA) 88; (b) communicate to Congress and to the Centers for Medicare & Medicaid Services (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; (c) 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; (d) protest the reported high costs being considered for certification of laboratories and the limited number of laboratory categories proposed; (e) 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 (f) protest the very limited list of waivered tests.
2. Our AMA will send a letter to CMS stating that CLIA requirements regarding provider-performed microscopy procedures and annual competency assessments are overly burdensome for physicians and their practices.

Regulation of Clinical Laboratories H-260.982
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.

RESOLUTION 23-22

Title: Off-Label Policy

Introduced by: David Whalen, MD, MPA, for the Kent County Delegation

Original Author: Gerald Lee, MD

Referred To: Reference Committee A

House Action:

Whereas, "one size does not fit all" and a physician is in a unique position to discuss risk/benefits and evaluate a specific medication/dose for a specific individual, and

Whereas, physicians have the best interests of the individual at the forefront, education to evaluate studies, and the ability to move more quickly than official channels especially when profits are a determinant of such approval, and

Whereas, new data is constantly becoming available affecting new treatments, dosage, conditions, and situations, and

Whereas, the American Medical Association (AMA) policy, Patient Access to Treatments Prescribed by Their Physicians H-120.988, affirms the autonomous clinical decision-making authority of a physician and the ability of that a physician to lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; supports the need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices; supports the dissemination of generally available, unedited, independently derived, peer reviewed, scientifically sound, and truthful information about off-label uses by manufacturers to physicians; recognizes the obligations of physicians 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 off-label use); supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated; and, supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act; therefore be it

RESOLVED: That MSMS support AMA Policy, "Patient Access to Treatments Prescribed by Their Physicians H-120.988" as a basic medical right and responsibility of a physician to provide the best care available to our patients; and be it further

RESOLVED: That MSMS support the addition of dosage at a physician discretion as consistent with AMA Policy, "Patient Access to Treatments Prescribed by Their Physicians H-120.988."

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new MSMS policy.

Relevant MSMS Policy:

Unproven Therapeutic Substances
MSMS opposes substituting political considerations for scientific investigation and conclusions for therapeutic substances. However, if political considerations support unproven medical decisions and/or principles, they should be evaluated on an experimental basis following standard experimental drug protocol or as approved by the FDA.

Relevant AMA Policy:

Patient Access to Treatments Prescribed by Their Physicians H-120.988
1. Our 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 off-label indication when such use is based upon sound scientific evidence or 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 clinically appropriate 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.
2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.
3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.
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 off-label use).
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 supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.

RESOLUTION 24-22

Title: Medicare Prescription Drug Pricing

Introduced by: David Whalen, MD, MPA, for the Kent County Delegation

Original Author: Warren Lanphear, MD

Referred To: Reference Committee A

House Action:

Whereas, prescription drug prices in the United States are considerably more expensive in many cases than in similar developed countries worldwide, and

Whereas, the cost of prescription drugs to Medicare patients is therefore often quite burdensome and leads to noncompliance, and

Whereas, Federal law allows the government to negotiate Medicare drug prices only for veterans and Medicaid beneficiaries, and

Whereas, specifically, the 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA) noninterference provision prohibits the Secretary of Health and Human Services (HHS) from negotiating Medicare drug prices or establishing a preferred drug list, and

Whereas, instead, Medicare prescription drug prices are negotiated between prescription drug manufacturers and insurance companies that administer Part D plans, and

Whereas, low-income seniors eligible for Medicare and Medicaid are known as "dual-eligibles," and

Whereas, additionally, when Part D took effect, drug coverage for dual-eligibles switched from Medicaid to Medicare and drug manufacturer rebates were discontinued, which resulted in a significant increase in prescription drug costs for this population, and

Whereas, for several years, Congress has considered (1) removing the prohibition on negotiating Medicare drug prices and (2) requiring prescription drug rebates for dual-eligibles (such rebates are provided to Medicaid beneficiaries), but Congress did not pass this legislation, and

Whereas, the recent Build Back Better proposal would permit Medicare prescription drug price negotiation; therefore be it

RESOLVED: That MSMS strengthen its advocacy for federal legislation to permit Medicare to negotiate with pharmaceutical companies in order to lower the high cost of prescription drugs for this population; and be it further

RESOLVED: That MSMS make the lowering of Medicare prescription drug pricing one of its top legislative priorities.; and be it further

RESOLVED: That the Michigan Delegation to the American Medication Association (AMA) ask our AMA to make the lowering of Medicare prescription drug pricing one of its top legislative priorities.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000 for legislative advocacy.

Relevant MSMS Policy:

Prescription Coverage by Medicare
MSMS supports prescription coverage for patients in the Medicare program. (Res59-99A)

Pharmaceutical Cost Transparency
MSMS supports drug price and cost transparency legislation designed to encourage prescription drug price and cost transparency among pharmaceutical companies and pharmacy benefit managers. (Board-July2018)

Relevant AMA Policy:

Prescription Drug Prices and Medicare D-330.954
1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

Pharmaceutical Costs H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more

each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.

11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.

12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.

13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.

14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.

RESOLUTION 42-22

Title: Medicare-for-All

Introduced by: James Mitchiner, MD, for the Washtenaw County Delegation

Original Author: James Mitchiner, MD

Referred To: Reference Committee A

House Action:

Whereas, approximately 29 million people remain uninsured despite the Affordable Care Act, with an additional 44 million under-insured, and

Whereas, Medicare-for-All is an alternative financing mechanism for national health insurance that does not supplant the private practice of medicine, and preserves existing doctor-patient relationships, and

Whereas, Medicare-for-All is subject to myths and misconceptions, including the false belief that Medicare-for-All is "socialized medicine" and the false belief that physicians will be paid at the current Medicare fee schedule rate, and

Whereas, Medicare is a single-payer model that receives high patient satisfaction ratings, yet has much lower administrative costs, and

Whereas, Medicare-for-All has advantages to medical practices including simplicity in billing and administration, and

Whereas, Medicare-for-All can make American businesses more competitive by eliminating corporate responsibility for financing employee health care, and

Whereas, Medicare-for-All provides the opportunity to improve medical care according to themes of the 2006 MSMS Future of Medicine report, including "Universal Coverage," "Prevention and Wellness," and "Partnering with Patients;" therefore be it

RESOLVED: That MSMS create a Health Care Reform Task Force charged with thoughtful and evidence-based deliberations on Medicare-for-All, as well as alternatives, with at least three periodic meetings throughout the year, leading to recommendations on MSMS taking a definitive position (pro or con) on Medicare-for-All. This Task Force shall report its recommendations to the 2023 MSMS House of Delegates.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,500-$5,000 for physician outreach.

Relevant MSMS Policy:

National Health Care
MSMS supports voluntary, free-choice methods of medical and health care rather than a system dominated and controlled by the federal government.

Physician Input for National Health Care Programs
MSMS supports physician input at all levels in the development of any national health care programs.

Universal Coverage
MSMS supports comprehensive health system reform described in the MSMS Future of Medicine Report. *(See Addendum P "Guiding Principles for the Future of Medicine and Health Care" in website version)*

Relevant AMA Policy:

Educating the American People About Health System Reform H-165.844
Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system.

Health System Reform Legislation H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
    a. Health insurance coverage for all Americans
    b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
    c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
    d. Investments and incentives for quality improvement and prevention and wellness initiatives
    e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
    f. Implementation of medical liability reforms to reduce the cost of defensive medicine
    g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:

a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services

b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system

c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted

d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate

e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another

f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.

B. 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.

C. 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.

D. 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.

E. 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.

F. 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.
G. 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.
H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.
3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.
4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

Sources:

1. Tolbert J, Orgera K. Key facts about the uninsured population. Kaiser Family Foundation, Nov. 6, 2020. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/
2. Collins SR, Bhupal HK, Doty MM. Health insurance coverage eight years after the ACA: fewer uninsured Americans and shorter coverage gaps, but more underinsured (Commonwealth Fund, Feb. 2019), at: https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca
3. eHealth Insurance. Medicare Consumer Survey, February 2019. https://news.ehealthinsurance.com/_ir/68/20191/eHealth%20Medicare%20Consumer%20Survey%20February%202019.pdf

RESOLUTION 44-22

Title: Establishment of Periprocedural Committee in MSMS

Introduced by: Neeju Ravikant, MD, for the MI Society of Anesthesiologists

Original Author: Neeju Ravikant, MD

Referred To: Reference Committee A

House Action:

Whereas, specialties associated with procedures like anesthesiology, cardiology, gastroenterology, interventional radiology, and interventional pulmonology have different challenges than those with office-based procedures, and

Whereas, a forum for these specialties to discuss the full and unique scope of procedural care from clinical, operational, economic, and community perspectives would be beneficial to members, and

Whereas, a periprocedural effort would focus on patient care versus the procedure itself, this might include pre-procedure evaluation and optimization, patient safety, opioid sparing measures with surgery, neurocognition loss with anesthesia, transfusions and blood conservation in a national shortage, surgical site infections, unexpected admissions, covid safety with aerosol generating procedures, and MINS (myocardial injury after non-cardiac surgery), and

Whereas, this group could also focus on value-based reimbursement trends, sources of quality metrics, office based and ambulatory surgery center dynamics, hospital-based practice variables, efficiency and patient satisfaction, out of network and network pressures.; therefore be it

RESOLVED: That MSMS convene a multispecialty group, known as the MSMS Peri-procedural Committee to discuss the challenges and goals for specialties associated with procedures throughout the entire course of patient care.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000 for collaborative outreach efforts.

Relevant MSMS Policy: None

Relevant AMA Policy: None

RESOLUTION 51-22

Title: Medicaid Funding to Address Social Determinants of Health

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: Kumaran Arivoli and Neil Vaishampayan

Referred To: Reference Committee A

House Action:

Whereas, more than 80 percent of the factors that affect an individual's health are related to non-clinical socioeconomic, environmental, and behavioral factors called the social determinants of health, and

Whereas, socioeconomic income level is the strongest contributing factor to health disparities in America with those below the five percent percentile income level experiencing a 0.21 year decrease in life expectancy between 2001 and present day while those in the top five percent experienced a 2.5 year increase in life expectancy, and

Whereas, the lack of nutritious food options is correlated to a doubling risk of increased cardiovascular disease, obesity, renal disease, and chronic conditions, and

Whereas, individuals eligible for Medicaid, those below the 130 percent federal poverty line, are 2.5 times more likely to have fast food restaurants, six times less likely to have fresh produce, and seven times more likely to shop for food at convenience stores than those with income greater than 350 percent of the federal poverty line, and

Whereas, the ability to purchase important preventative health and hygiene products, such as condoms, face masks, tampons, and antibacterial hand soap is further decreased for patients that fall under the Medicaid eligible 130 percent federal poverty line contributing to a higher spread of COVID-19, sexually transmitted, and infectious disease within this population, and

Whereas, access to affordable housing options is associated with greater physical health, greater psychological health, decreased substance use, better effectiveness of health care, more children reaching their developmental milestones, better management of chronic conditions, and a reduction in emergency department visits, and

Whereas, the federal funding of Medicaid does not allow for expenditures on many non-medical services, states can utilize state plans and waiver authorities to add non-medical services to their benefits packages, and

Whereas, states can utilize the Medicaid Managed Care stipends to allocate funds for individuals who express a need for transportation services, access to nutritional foods, funds to purchase preventative care products, and/or assistance with rent or housing costs; therefore be it

RESOLVED: That MSMS support the use of Michigan Medicaid waivers to allocate federal Medicaid funding towards non-medical services that address social determinants of health, including services towards transportation costs, access to nutritious produce, housing expenditures, and the ability to purchase preventative care products; and be it further

RESOLVED: That MSMS advocate for the adoption of Michigan Medicaid Managed Care protocols that support the creation of stipends exclusively for Medicaid individuals who express a need for funding to improve their social determinants of health.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000 for regulatory and/or industry advocacy.

Relevant MSMS Policy:

Expand Medicaid Transportation to Include Healthy Grocery Destinations
MSMS supports the inclusion of supermarkets, food banks and pantries, and local farmers markets as destinations covered by Medicaid transportation policy. (Res29-19)

Relevant AMA Policy:

Affordable Care Act Medicaid Expansion H-290.965

1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3 Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.
12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.

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RESOLUTION 52-22

Title: Pharmaceutical Equity for Pediatric Populations

Introduced by: Mara Darian, for the Medical Student Section

Original Author: Camilla Cascardo

Referred To: Reference Committee A

House Action:

Whereas, legislation has aimed to increase the quality of evidence from clinical trials in children, 50 percent of pediatric drugs and an even greater portion of neonatal drugs are used “off-label," and

Whereas, there are significant discrepancies between the number of drugs developed and approved for use in children compared to adults, and

Whereas, the average start-up time for pediatric drug trials is 12-16 months compared to six months for adult drug trials and the average duration of a pediatric drug trial is 15 years compared to 8-10 years in adult trials, and

Whereas, there is an average lag time of 5-10 years between a drug’s approval for adults and the addition of pediatric-specific labeling information, and

Whereas, 60 percent of pediatric drug trials stall and 40 percent of pediatric drug trials fail, and

Whereas, historically off-label prescribing has had harmful effects on children, such as Verapamil causing hypotension and death, or Chloramphenicol causing circulatory collapse, also known as “gray baby syndrome,” and

Whereas, the Pediatric Research Equity Act and Best Pharmaceuticals Act for Children are designed to protect children, the exemption of necessitating pediatric trials for “orphan drugs,” which are those indicated for the treatment of diseases that affect fewer than 200,000 individuals creates a loophole for pharmaceutical companies that compromises the quantity and safety of available drugs that can be used in children, and

Whereas, the Institutional Review Board (IRB) is generally unlikely to approve clinical trials involving children if the drug of interest can be tested on adults; however, the physiologic differences between these groups can have a significant impact on pharmacokinetics and pharmacodynamics, and

Whereas, extrapolating efficacy from adult to pediatric populations can streamline pediatric drug development and help to increase the number of approvals for pediatric use, implicit extrapolation of data (i.e. off-label use, without investigation) can have harmful effects on children, and

Whereas, the Institute for Advanced Clinical Trials (I-ACT) for Children is an independent 501(c)(3) public-private collaboration, funded by membership, a Food and Drug Administration (FDA) U18 grant, and donations that is dedicated to improving the efficiency and success of pediatric drug trials, leading to the development of innovative therapeutic solutions and improvement in the health outcomes of children, and

Whereas, I-ACT for Children improves pharmaceutical equity for children by connecting pediatric experts, sites, and other resources needed to conduct efficient clinical trials to clinical trial sponsors and stakeholders, and

Whereas, in 2020, I-ACT for Children was able to design an adaptive platform trial for Duchenne Muscular Dystrophy allowing multiple potential drugs to be tested in parallel, advocated for the inclusion of adolescents in adult clinical trials and planned pediatric studies targeting development of COVID-19 vaccination and treatment, and

Whereas, I-ACT for Children holds collaboration agreements with sites across the United States, Central and South America, Saudi Arabia, South Africa, Australia, Europe, Canada, and Japan allowing for expansive patient recruitment so that trials can reach enrollment goals faster, accelerating study startup, and

Whereas, children's hospitals in Michigan belong to the I-ACT for Children network, including Beaumont Children's Hospital Royal Oak, Helen DeVos Children's Hospital Grand Rapids, and University of Michigan C.S. Mott Children's Hospital, and

Whereas, our American Medical Association (AMA) already supports policies regarding FDA surveillance of clinical trials to maintain proportional representation of women and minority groups, including consideration of pediatric and elderly populations; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to amend Policy H-100.987 "Insufficient Testing of Pharmaceutical Agents in Children," by addition to read as follows:

Insufficient Testing of Pharmaceutical Agents in Children H-100.987

1. 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.
2. **The AMA supports collaboration between stakeholders, including but not limited to the FDA, the American Academy of Pediatrics and nonprofit organizations such as the Institute for Advanced Clinical Trials for Children to improve the efficiency and safety of pediatric pharmaceutical trials in pursuit of pharmaceutical equity for pediatric populations.**

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for revised AMA policy.

Relevant MSMS Policy: None

Relevant AMA Policy:

Insufficient Testing of Pharmaceutical Agents in Children H-100.987
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.

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RESOLUTION 57-22

Title:	Informed Consent for Pelvic Examinations on Patients Who Are Unconscious or Under Anesthesia
Introduced by:	Mara Darian, for the Medical Student Section
Original Author:	Yu Rim Park
Referred To:	Reference Committee A
House Action:	

Whereas, several foundational studies demonstrated that a majority of medical students performed pelvic examinations without informed consent, the most recent data acquired from a 2019 magazine survey of 101 medical students from seven United States medical schools found that 92 percent had performed a pelvic examination on anesthetized female patients and, of this group, 61 percent performed this examination without informed consent, and

Whereas, forgoing the process of informed consent violates basic human rights, patient autonomy, and the patient's trust in medicine, and

Whereas, a single-center study showed that approximately 80 percent of women wanted to be told if a medical student would be present during their gynecological surgery, and more than 80 percent of patients undergoing gynecological surgery were unaware a medical student might conduct their pelvic exam, and

Whereas, a previous study indicated that 62 percent of women would agree to a medical student performing a pelvic examination under anesthesia for educational purposes, and

Whereas, according to the National Sexual Violence Resource Center, 81 percent of women and 43 percent of men reported experiencing sexual harassment and/or assault in their lifetime, and individuals with a history of sexual violence are especially at risk for anxiety and distress during intimate examinations, and

Whereas, research on trauma-informed care shows that physical exams without consent can retraumatize the patient leading to exacerbated trauma symptoms and decreased willingness of the patients to engage in health care treatment in the future, and

Whereas, to avoid re-traumatization in patients who have experienced sexual trauma, the AAFP advocates for taking extra care to obtain consent, ask patient preferences prior to beginning any physical exam, and describe invasive exams beforehand to the patient, and

Whereas, several studies show that many medical students feel uncomfortable conducting an intimate exam without patients' consent and express discomfort towards refusing their supervisor to conduct an intimate exam without consent, and

Whereas, the practice of non-consensual intimate exams may lead to a decline in student's perceived importance towards seeking informed consent, and

Whereas, the American College of Obstetricians and Gynecologists (ACOG) states that respect for patient autonomy requires that patients be allowed to choose not to be cared for or treated by learners when this is feasible, and

Whereas, ACOG states that pelvic examinations on anesthetized women that offer no personal benefit and are performed solely for teaching purposes should be performed only with their specific informed consent before surgery, and

Whereas, at least 20 states have outlawed intimate exams without express consent unless the exam is required for diagnostic purposes, treatment or sexual assault is suspected and evidence could be lost, and

Whereas, the Michigan House of Representatives is considering House Bill 4958 which prohibits pelvic examination on an anesthetized or unconscious patient unless there is informed consent obtained or the examination is necessary for preventative, diagnostic, or treatment purposes, and

Whereas, the American Medical Association (AMA) ethical and policy guidelines support respect for patient refusal of care by a trainee, and

Whereas, AMA Policy H-140.828 opposes performing unconsented physical exams on patients under anesthesia or on unconscious patients for solely educational purposes; therefore be it

RESOLVED: That MSMS support prohibition of unconsented pelvic examinations by medical trainees on patients who are unconscious or have been administered any form of sedation or anesthesia unless necessary for diagnostics and treatment.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new MSMS policy.

Relevant MSMS Policy: None

Relevant AMA Policy:

Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients H-140.828

Our AMA: (1) opposes performing physical exams on patients under anesthesia or on unconscious patients that offer the patient no personal benefit and are performed solely for teaching purposes without prior informed consent to do so; (2) encourages institutions to align current practices with published guidelines, recommendations, and policies to ensure patients are educated on pelvic, genitourinary, and rectal exams that occur under anesthesia; and (3) strongly opposes issuing blanket bans on student participation in educational physical exams.

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16. Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients H-140.828, Resolution 6, A-21. Adopted AMA Resolution- 2021.

RESOLUTION 58-22

Title: Resource Allocations to Hospital Social Workers

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: Vanessa Elliott, Malak Elshafei, and Jasdeep Kler

Referred To: Reference Committee A

House Action:

Whereas, social determinants of health, the circumstances in which people live and work, are estimated to have twice the impact of quality health care on the overall health of an individual, and

Whereas, social workers, as a profession, are positioned to play a critical role navigating multiple dimensions that influence health, including policy, community, health care settings, and family, and are considered an integral part of the U.S. health care system, and

Whereas, current evidence indicates that higher levels of social work services correlate to lower hospital charges, better patient medical adherence, decreased emergency department visits, and overall significant cost reduction in treatment than those who received less social work services, and

Whereas, there is still a lack of research evidence that further emphasizes the economic and health value of direct social work services on health outcomes across patient populations, and

Whereas, hospital social workers indicate that improved health outcomes in terms of readmission, coordination of care, and other social determinants of health, is possible if hospital resource gaps for social workers were narrowed and specialized discharge teams led by social workers were formed; therefore be it

RESOLVED: That MSMS support increased funding for research on the impact of social workers in health care settings; and be it further

RESOLVED: That MSMS should aim to increase resources to social workers by increasing fiscal budgets for the number of social workers within hospital settings, to improve social worker to patient ratios within health care settings, and to expand fiscal budgets for the resource needs for social workers.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000 for regulatory and/or industry advocacy.

Relevant MSMS Policy: None

Relevant AMA Policy: None

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ACTION REPORT #01-22 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 31-20
Bring Insurance Credentialing into Legal Compliance on Maintenance of Certification

REFERRED TO: Reference Committee A

HOUSE ACTION:

RECOMMENDATION: That the 2022 House of Delegates disapprove Resolution 31-20, "Bring Insurance Credentialing into Legal Compliance on Maintenance of Certification."

Resolution 31-20 was referred to the MSMS Board of Directors for study. The Board referred the resolution to the Health Care Delivery Department for review and recommendation.

Resolution 31-20 asked "that MSMS work with Michigan health insurance companies to change credentialing requirements to be in compliance with Public Act 487 of 2018, by requiring only initial board certification for the credentialing of in-network physicians specializing in family medicine, internal medicine, and pediatrics; and that MSMS pursue legal action against Michigan health insurance companies that refuse to work with MSMS to bring the health insurance company's credentialing requirements into legal compliance with Public Act 487 of 2018 and continue to discriminate against family medicine, internal medicine, and pediatric physicians for not participating in or purchasing a maintenance of certification product."

Resolution 31-20, authored by Megan Edison, MD, and submitted on behalf of the Kent County Delegation, was introduced to ensure that Michigan health insurance companies are complying with Public Act 487 of 2018.

Reference Committee A (Medical Care Delivery) considered Resolution 31-20 during the 2021 MSMS House of Delegates. Committee members supported the first Resolved but were concerned about the cost of legal action written in the second Resolved. Committee members recommended referral to the MSMS Board of Directors for further investigation.

Public Act 487 of 2018 (PA 487) states that an insurer or a health maintenance organization "shall not require as the sole condition precedent to the payment or reimburse of a claim under the policy or contract that an allopathic or osteopathic

(continued)

physician in the medical specialties of family practice, internal medicine or pediatrics maintain a national or regional certification, not otherwise specifically required for licensure under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838." MSMS contacted the major health insurance companies in Michigan. Of those that responded, each health insurance company does not use Maintenance of Certification (MOC) as the sole requirement for credentialing; therefore, they are not violating PA 487.
MSMS has received two complaints from physicians regarding an insurance company's denial of credentialing. When it was investigated further, it was found that both physicians had an alternative to MOC to be credentialed by the insurance company. Because MSMS received limited complaints, MSMS reached out to the specialty societies for family practice, internal medicine, and pediatrics asking if they had received complaints. None of the specialty societies responded to MSMS's inquiries.

Virginia Gibson, MSMS staff and Daniel Schulte, MSMS Legal Counsel, spoke with Doctor Edison to discuss the health insurance companies' policies. After the discussion, Doctor Edison agreed that they were complying with PA 487. Additionally, she understood that there was no need for legal action since they were complying.

As an additional point, MSMS Legal Counsel has also advised MSMS that there is no legal cause of action that MSMS can pursue against "Michigan health insurance companies that refuse to work with MSMS to bring the health insurance company's credentialing requirements into legal compliance with Public Act 487 of 2018." Instead, only physicians who have had adverse action taken against them by an insurer, HMO, or other entity subject to Public Act 487 of 2018 arising from its failure to follow that law would have such a cause of action.

Therefore, the second Resolved is not something that MSMS could pursue and the Health Care Delivery recommended disapproval of Resolution 31-20.

At its meeting on March 23, 2022, the MSMS Board of Directors approved the recommendation of the Health Care Delivery Department to disapprove Resolution 31-20.

Attachment
Resolution 31-20

RESOLUTION 31-20

Title: Bring Insurance Credentialing into Legal Compliance on Maintenance of Certification

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Megan Edison, MD

Referred To: Reference Committee A

House Action:

Whereas, Public Act 487 of 2018 became law on December 27, 2018, and

Whereas, this law was a direct result of resolutions adopted by the MSMS House of Delegates to end insurance company mandates to participate in or purchase maintenance of certification products in order to be accepted as an in-network provider eligible to care for patients, and

Whereas, the law states, "an insurer that delivers, issues for delivery, or renews in this state a health insurance policy issued under chapter 34 or a health maintenance organization that issues a health maintenance contract under chapter 35 shall not require as the sole condition precedent to the payment or reimbursement of a claim under the policy or contract that an allopathic or osteopathic physician in the medical specialties of family practice, internal medicine, or pediatrics maintain a national or regional certification not otherwise specifically required for licensure under article of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838," and

Whereas, despite passage of this law, there are insurance companies in Michigan ignoring the law by not changing credentialing policy and continuing to reject physicians solely for not maintaining American Board of Medical Specialties or the American Osteopathic Association board certification; therefore be it

RESOLVED: That MSMS work with Michigan health insurance companies to change credentialing requirements to be in compliance with Public Act 487 of 2018 by requiring only initial board certification for the credentialing of in-network physicians specializing in family medicine, internal medicine, and pediatrics; and be it further

RESOLVED: That MSMS pursue legal action against Michigan health insurance companies that refuse to work with MSMS to bring the health insurance company's credentialing requirements into legal compliance with Public Act 487 of 2018 and continue to discriminate against family medicine, internal medicine, and pediatric physicians for not participating in or purchasing a maintenance of certification product.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $50,000-$100,000 for legal intervention.

Relevant MSMS Policy:

Review Board Recertification and Maintenance of Certification Process
MSMS supports Maintenance of Certification (MOC) only under all of the following circumstances:
1. MOC must be voluntary.
2. MOC must not be a condition of licensure, hospital privileges, health plan participation, or any other function unrelated to the specialty board requiring MOC.

3. MOC should not be the monopoly of any single entity. Physicians should be able to access a range of alternatives from different entities.
4. The status of MOC should be revisited by MSMS if it is identified that the continuous review of physician competency is objectively determined to be a benefit for patients. If that benefit is determined to be present by objective data regarding value and efficacy, then MSMS should support the adoption of an evidence based process that serves only to improve patient care.

Relevant AMA Policy:

Continuing Board Certification D-275.954
Our AMA will:
1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a yearly report to the House of Delegates regarding the CBC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.

Reference Committee B

MICHIGAN STATE MEDICAL SOCIETY
2022 HOUSE OF DELEGATES

RESOLUTIONS BY COMMITTEE

REFERENCE COMMITTEE B – LEGISLATION

RESOLUTION	DESCRIPTION
04-22 (12-20)	Non-Stigmatizing Verbiage
07-22	Expanded Child Tax Credit
11-22 (29-20)	Enforce AMA Principles on Continuing Board Certification
16-22 (60-20)	Support of Michigan Mental Health Court System
17-22 (05-21)	Health Information Card
18-22 (19-21)	De-professionalization of the Medical Profession
19-22	Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use in Response to Recent Research
25-22	Fentanyl Patch for Patch Exchange Program
28-22	Retain Physician Assistant Professional Title
29-22	Transparency of Practice Agreements Between Physicians and Non-Physicians
32-22	Amending Michigan's No Fault Auto Insurance Law (Again)
38-22	NBPAS as Equivalent Certification for Health Insurers and Hospitals
46-22	Radiology Interpretation by Physicians

RESOLUTION 04-22 (12-20)

Title: Non-Stigmatizing Verbiage

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Sandy Dettmann, MD, DABAM, FASAM

Referred To: Reference Committee B

House Action:

Whereas, we are in the midst of the largest manmade epidemic in the history of the United States, and

Whereas, drug overdose is the most common cause of death in Americans under the age of 50, and

Whereas, addiction is a medical disease with effective, evidence-based medical treatment available, and

Whereas, persons who suffer from the disease of addiction are frequently referred to as "drug addicts," and

Whereas, the verbiage "drug addict" conjures up a somewhat horrific image in the minds of most people, and

Whereas, in reality, addiction is an "equal opportunity destroyer;" therefore be it

RESOLVED: That MSMS encourages the use of clinically accurate, non-stigmatizing terminology when referring to the disease of addiction and shall incorporate such terminology in future communications and publications, as well as update existing policies during the normal process of updating the MSMS Policy Manual; and be it further

RESOLVED: That MSMS recommends all physicians adopt the phrase "person with the disease of addiction" instead of “drug addict” or other stigmatizing verbiage when communicating about substance use and addiction.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new MSMS policy and revisions to existing policy.

Relevant MSMS Policy:

Communication, Documentation, and Professionalism
MSMS endeavors to educate physicians and other health care providers about the importance of careful and accurate verbal discussions and written documentation of care provided.

MSMS encourages physicians to demonstrate and maintain high ethical standards to avoid inadvertently discrediting other physicians or other health care providers; thereby, leading by example so that resident physicians and medical students can learn in a supportive environment while providing excellent care for our mutual patients.

Relevant AMA Policy:

Destigmatizing the Language of Addiction H-95.917
Our AMA will use clinically accurate, non-stigmatizing terminology (substance use disorder, substance misuse, recovery, negative/positive urine screen) in all future resolutions, reports, and educational materials regarding substance use and addiction and discourage the use of stigmatizing terms including substance abuse, alcoholism, clean and dirty.

Destigmatizing the Language of Addiction D-95.966
Our AMA and relevant stakeholders will create educational materials on the importance of appropriate use of clinically accurate, non-stigmatizing terminology and encourage use among all physicians and U.S. healthcare facilities.

RESOLUTION 07-22

Title: Expanded Child Tax Credit

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: Maria Chyz, Beena Haque, and Isabella Kunkel

Referred To: Reference Committee B

House Action:

Whereas, in 2020, 19.3 percent of individuals under the age of 18 in Michigan lived at or below the national poverty line, putting the state's average for childhood poverty more than three percent higher than the national average, and

Whereas, children across most other racial categories are more likely to experience poverty than their white counterparts and they are disproportionately represented among children in poverty, and

Whereas, child poverty negatively impacts children's physical, mental, and emotional health and development, and this effect continues into adulthood, and

Whereas, the American Heart Association notes mounting evidence that mitigation of child poverty improves cardiovascular outcomes in adulthood and recommends tax credits as one means of mitigation, and

Whereas, the existing child tax credit legislation detailed in the American Recovery and Rescue Plan of 2009 excludes roughly half of Latino and Black children because their parents earn too little income to receive full benefit of that policy, and

Whereas, the expanded child tax credit included in the American Rescue Plan Act of 2021 dramatically and quickly reduced child poverty rates in the United States, including significant reductions in poverty rates for Black and Latino children, and

Whereas, 91 percent of families with low incomes utilized funds provided through the expanded child tax credit for necessities, including food, clothing, shelter, utilities, or education, and

Whereas, the expanded child tax credit included in the American Rescue Plan Act of 2021 ended in December 2021, and

Whereas, Michigan is home to many of the groups most likely to be excluded by a federal child tax credit, including families of color and rural families, and struggles with many of the social issues addressed by an expanded child tax credit, including child health outcomes and educational outcomes, and

Whereas, seven states to date have successfully implemented a child tax credit to supplement and strengthen that offered by federal legislation; therefore be it

RESOLVED: That MSMS advocate for and support an amendment to Michigan law, seeking institution of a permanent expanded child tax credit; and be it further

RESOLVED: That MSMS support a bill such as Michigan Senate Bill 768, which creates an annual $500 child tax credit for each child under the age of 19; and be it further

RESOLVED: That our Michigan Delegation to the American Medical Association (AMA) ask our AMA to support the American Families Plan of 2021 and/or similar policies that aim to institute a permanent, expanded child tax credit at the federal level.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new MSMS and AMA policy.

Relevant MSMS Policy: None

Relevant AMA Policy: None

Sources:

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RESOLUTION 11-22 (29-20)

Title: Enforce AMA Principles on Continuing Board Certification

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Authors: Megan Edison, MD, and David Whalen, MD

Referred To: Reference Committee B

House Action:

Whereas, the American Medical Association (AMA) Principles on Continuing Board Certification have been developed through the democratic process of various states' Houses of Delegates and the AMA House of Delegates, reflecting the collective will of state and national medical societies and their physician members, and

Whereas, these longstanding principles clearly demand a continuing board certification process that is low cost, evidence-based, untied to insurance and hospital credentialing, and free of harm to the physician workforce, and

Whereas, the proprietary American Board of Medical Specialties (ABMS) and American Osteopathic Association (AOA) continuing board certification product continues to be high cost, high stress, without evidence over other forms of continuing medical education, required for insurance and hospital credentialing, and harmful to the physician workforce, and

Whereas, ABMS and AOA boards continue to ignore the AMA on nearly every aspect of the AMA policy handbook on continuing board certification, and

Whereas, this failure to protect physicians from recertification harm is having significant effects upon cost of care, physician burnout, and access to qualified physicians, and

Whereas, this failure to advocate successfully for these principles reflects poorly upon the ability of organized medicine to defend physicians and our right to care for patients; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to continue to actively work to enforce current AMA Principles on Continuing Board Certification; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to publicly report their work on enforcing AMA Principles on Continuing Board Certification at the Annual and Interim meetings of the AMA House of Delegates.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:

Review Board Recertification and Maintenance of Certification Process
MSMS supports Maintenance of Certification (MOC) only under all of the following circumstances:
1. MOC must be voluntary.
2. MOC must not be a condition of licensure, hospital privileges, health plan participation, or any other function unrelated to the specialty board requiring MOC.
3. MOC should not be the monopoly of any single entity. Physicians should be able to access a range of alternatives from different entities.
4. The status of MOC should be revisited by MSMS if it is identified that the continuous review of physician competency is objectively determined to be a benefit for patients. If that benefit is determined to be present by objective data regarding value and efficacy, then MSMS should support the adoption of an evidence based process that serves only to improve patient care.

Relevant AMA Policy:

Continuing Board Certification D-275.954
Our AMA will:
1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a yearly report to the House of Delegates regarding the CBC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.

13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's CBC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.

36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.
38. Our AMA, through its Council on Medical Education, will continue to work with the ABMS and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development of new, integrated standards for continuing certification programs by 2020 that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.
39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.

Continuing Board Certification H-275.924
Continuing Board Certification AMA Principles on Continuing Board Certification
1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.
4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit", American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. CBC should be used as a tool for continuous improvement.
15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing CBC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. CBC activities and measurement should be relevant to clinical practice.
19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.

RESOLUTION 16-22 (60-20)

Title: Support of Michigan Mental Health Court System

Introduced by: Mara Darian for the Medical Student Section

Original Authors: Kelly Fahey and Benjamin Malamet

Referred To: Reference Committee B

House Action:

Whereas, 18.5 percent of all United States adults reported at least one mental health disorder in 2017, and the prevalence in the criminal justice system is higher, as 37 percent of prisoners and 44 percent of jail inmates reported having been told they had a mental health illness by a professional, and

Whereas, mental health courts provide juveniles and adults who have been diagnosed with a serious mental illness, serious emotional disturbance, developmental disability, or a co-occurring disorder the opportunity to enroll in a treatment program to address their mental illness instead of being sentenced to lengthy prison or jail terms, and

Whereas, mental health courts offer comprehensive services such as medical treatment through local community health service providers, drug testing, referrals to community services such as housing or clothing resources, enrollment in educational classes, transportation, assistance with obtaining employment, and access to substance use disorder treatment, and

Whereas, medication adherence in the general population varies by disease state (major depressive disorder: 28-52 percent, bipolar disorder: 20-50 percent, schizophrenia: 20-72 percent and anxiety disorders: 57 percent), with many patients non-adherent overall, and

Whereas, medication adherence of those who successfully completed the mental health court system was significantly higher as 91 percent, 92 percent, and 77 percent of participants were fully compliant with medication in the adult circuit mental health court, adult district mental health court, and juvenile mental health court respectively, and

Whereas, mental health courts positively impacted the health and quality of life of participants, as of those who successfully completed the program reported upwards of 97 percent improvement in mental health and 96 percent improvement in the quality of life, and

Whereas, in a matched-pair analysis of those who completed the mental health court system and those who were not in the mental health court system, mental health court participants had lower rates of a new conviction within three years after their offense. In the adult circuit mental health court system, rates of reconviction were 15 percent compared to 36 percent of comparison members. In the adult district court system, rates of reconviction were 33 percent compared to 54 percent of comparison members. In the juvenile mental health court system, rates of reconviction were 31 percent compared to 45 percent of comparison members, and

Whereas, MSMS supports efforts to improve mental health services in the state of Michigan, and

Whereas, the American Medical Association supports "state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions," and

Whereas, there are only 33 mental health courts in the state of Michigan, and the creation of mental health courts requires grant funding and the development of proper resources; therefore be it

RESOLVED: That MSMS support continued expansion of Michigan's mental health court system.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new MSMS policy.

Relevant MSMS Policy:

Support of Mental Health Reform in Michigan
1.) That MSMS support efforts to improve mental health services in Michigan, including those that address mental health disparities in the state
2.) That MSMS shall advocate for legislation and governmental programs that support interdepartmental coordination and shared accountability, as well as greater access to timely outpatient treatment, crisis intervention, specialty behavioral health services, inpatient psychiatric hospitalizations and other medically necessary related therapies.

Relevant AMA Policy:

Maintaining Mental Health Services by States H-345.975
Our AMA:
1.) supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2.) supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3.) supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4.) supports enforcement of the Mental Health Parity Act at the federal and state level; and
5.) will take these resolves into consideration when developing policy on essential benefit services.

Statement of Principles on Mental Health H-345.999
1.) Tremendous strides have already been made in improving the care and treatment of patients with psychiatric illness, 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 psychiatric 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.

Sources:

1. FY 2018 Problem-Solving Courts Annual Report. Michigan Supreme Court Office of Public Information. https://courts.michigan.gov/Administration/SCAO/Resources/Documents/Publications/Reports/PSCAnnualReport.pdf.
2. Bronson J, Berzofsky M. Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12.
3. FY 2018 Problem-Solving Courts Annual Report. Michigan Supreme Court Office of Public Information. https://courts.michigan.gov/Administration/SCAO/Resources/Documents/Publications/Reports/PSCAnnualReport.pdf.
4. Ehret MJ, Wang M. How to increase medication adherence: What works? Mental Health Clinician. 2013;2(8):230-232. doi:10.9740/mhc.n132973.

RESOLUTION 17-22 (05-21)

Title: Health Information Card

Introduced by: Federico G. Mariona, MD, MBA, FACOG, FACS, for the Wayne County Delegation

Original Authors: Mirna Kaafarani and Federico Mariona, MD

Referred To: Reference Committee D

House Action:

Whereas, the SARS-CoV-2 novel coronavirus is the third highly transmissible pathogen in its class that has surfaced in the first 20 years of the 21st century and reached the level of a pandemic, causing the clinical disease known as Corona Virus Disease-19 (CoVid-19), and

Whereas, Covid-19 affects the health, society, education, economy, and security of the United States population, and

Whereas, accurate and consistent public information is of critical importance to identify, design, and implement programs and processes that are consistent with the needs of the state public health institutions to provide appropriate means to mitigate and implement statewide solutions to health crises and catastrophic events, and

Whereas, the public lacks confidence in the veracity and the consistency of the health information provided by the health authorities and the media, with conflicting and frequently changing advice increasing the health care, social, and economic uncertainty, and

Whereas, that a state Health Information Card should be implemented and equipped with programmed encrypted microchip technology to protect the identity of the holder. The card will allow for real time entry of health events and provide access to health information changes and contribute to build the state's public health system information network, assist in the implementation of strategic plans for public information, individual evidence-based treatment, guide public health advocacy, economic policies, national security integrity, and advanced planning, and

Whereas, a similar system has been tested, tried, and used in advanced industrialized countries in the world including the United States in Tennessee, and

Whereas, providing accurate information can be achieved, by the implementation of a system that allows for timely obtainment and recording of pertinent data gathering to construct epidemiological models avoiding poor methodology and variable definitions; therefore be it

RESOLVED: That MSMS encourage the state's public health authorities and the state legislature to work towards the implementation of a state Health Information Card, issued to each citizen in the state to contain the demographic and clinical information needed to allow for the

building of a standard system of health data collection and facilitate reporting of the state's population health status.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000 - $24,000 for regulatory and/or industry advocacy.

Relevant MSMS Policy: None

Relevant AMA Policy: None

Sources:

1. Statista, Cost Drivers where Mobile Health Will Have the Highest Positive Impact Worldwide in the Next Five Years, as of 2016. (accessed on 24 July 2020)]; Available online: https://www.statista.com/statistics/625219/mobile-health-global-healthcare-cost-reductions/
2. The pharmaceutical record in an emergency department: Assessment of its accessibility and its impact on the level of knowledge of the patient's treatment. Trinh-Duc A, et al. Ann Pharm Fr. 2016. PMID: 33096907 French. In France, the pharmaceutical record (PR) is a shared professional tool arising from the pharmacists lists of all drugs dispensed during the...
3. Derek M Griffith, Andrea R Semlow, Mike Leventhal, Clare Sullivan, The Tennessee Men's Health Report Card: A Model for Men's Health Policy Advocacy and Education. Am J mens health. Sept-October 2019. 13(5)

RESOLUTION 18-22 (19-21)

Title: De-professionalization of the Medical Profession

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Patrick J. Droste, MS, MD

Referred To: Reference Committee B

House Action:

Whereas, physicians attend medical school, complete an internship, and residency training before being credentialed as a fully licensed physician, and

Whereas, physicians complete a rigorous series of board examinations during medical school, internship, and residency to certify their ability to diagnosis and treat patients, and

Whereas, physicians are regarded as the legal entity that is ultimately responsible for patient care, and

Whereas, health care workers are encouraged to address physicians by their first name rather than doctor, in order to lessen the "authority gradient" related to patient safety, and

Whereas, physicians-in-training are being encouraged to perform as active team members in patient care and are not being recognized as medical students or resident physicians, which potentially leads to confusion about leadership and accountability within the team, and

Whereas, medical schools are utilizing Advanced Practice Professionals as educators for future physicians, implying that the training of Advanced Practice Professionals is equivalent to the training of physicians, and

Whereas, physicians are still held professionally and legally accountable for outcomes, including adverse outcomes, of team-based care due to the higher level of training involved and the role as the team leader; therefore be it

RESOLVED: That MSMS supports only the use of titles and descriptors that align with a physician or non-physician provider's state issued licenses or credentials; and be it further

RESOLVED: That MSMS actively oppose efforts to diminish the qualifications and training of physicians by hospital administrators, insurance companies, and governmental regulatory agencies who require physicians be referenced as medical providers, team members, health care providers, or any other reference in lieu of the legal title of physician or doctor; and be it further

RESOLVED: That MSMS seek legislation which provides that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained as follows:

1. Wear an identification badge which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc.), to differentiate between those who have achieved a Doctorate, and those with other types of credentials. The font size of their credentials shall be greater than the front size used for their name for the purpose of role definition and patient safety.
2. 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 has not 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, shall specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000 for legislative advocacy.

Relevant MSMS Policy:

Calling Physicians by their First Name
MSMS discourages policies that require physicians to be called by their first names in professional settings such as their workplace. (Res42-16)

Physician Not Labeled as Provider
MSMS opposes the current custom by government and insurance companies of labeling physicians as providers and encourages proper identification of physicians and/or surgeons.
MSMS supports physicians who request they be identified as “physicians” apart from other “providers” on any contracts or documents they are asked to sign. (Res38-90A) – Amended 1993 – Edited 1998 -Reaffirmed (Sunset Report 2020)

Relevant AMA Policy:

"Doctor" as a Title H-405.992
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.

Clarification of the Title "Doctor" in the Hospital Environment D-405.991
1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.

2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require 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 (H-405.969, ?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?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO,

RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. 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) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

RESOLUTION 19-22

Title:	Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use in Response to Recent Research
Introduced by:	Gunjan Malhotra, MD, for the Resident and Fellow Section
Original Author:	Gunjan Malhotra, MD
Referred To:	Reference Committee B
House Action:	

Whereas, led by the Society of Pediatric Radiology (SPR), the Image Gently Alliance was formed in late 2006 with the goal of "changing practice by raising awareness of the opportunities to lower radiation dose in the imaging of children," and

Whereas, the SPR recruited other organizations/members of the imaging team into the alliance in 2007 including the American College of Radiology (ACR), American Association of Physicists in Medicine (AAPM), and American Society of Radiologic Technologists (ASRT), and

Whereas, the practice of shielding reproductive organs and in utero fetuses began in the 1950s given concerns about the long-term effects of radiation and the potential for passing on genetic mutations through genetic inheritance, and

Whereas, in response to these concerns, state and federal laws and regulations have been created requiring the use of gonad shields in medical imaging studies, and

Whereas, through technological advances, medical physicists estimate the dose from routine diagnostic imaging to reproductive organs has been reduced by 95 percent without compromising diagnostic quality, and

Whereas, technological advances and optimization have resulted in marginal hereditary risk reduction from gonad shielding ranging from 1x10-6 in women and 5x10-6 in men, and

Whereas, research on radiation dosing has shown that routine diagnostic imaging does not produce harmful levels of radiation to patients and fetuses, and

Whereas, modern mechanisms to optimize imaging parameters such as automatic exposure control (AEC) are negatively affected by shielding, and

Whereas, the gonad shield results in decreased activity on the detector, triggering AEC to increase radiation output, which results in increased exposure and patient dose along with the degradation of image quality, and

Whereas, the gonad shield produces artifacts and can obscure relevant anatomy and diagnostic information, and

Whereas, non-diagnostic or obscured images may need to be repeated increasing patient dose when shields are used, and

Whereas, the gonad surface shield is ineffective at reducing internal scatter, and

Whereas, studies have shown that gonad shields are incorrectly placed for females in 91 percent of radiographs and for males in 66 percent of radiographs, rendering them ineffective, and

Whereas, on January 12, 2021, the National Council on Radiation Protection and Measurements (NCRP) issued a statement that the risks of utilizing gonad shields far outweigh the negligible benefits to reproductive organs and therefore they should not be routinely used, and

Whereas, similar statements opposing routine or mandatory use of gonadal shields were released by the ACR and the AAPM in 2019 and by the ASRT in 2021, and

Whereas, this resolution was presented at the 2021 MSMS Virtual House of Delegates Meeting, but no live testimony was heard on the subject, and

Whereas, the original resolution from 2021 was amended as follows: "That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to study whether the U.S. Food and Drug Administration should amend the code of federal regulations to remove language regarding the routine use of gonad shields in medical imaging," and

Whereas, the justification for the amended language rather supports the author's original language and intent to avoid legislative regulation of the practice of medicine, and

Whereas, if the authors in 2021 were able to provide testimony it could have been demonstrated that the research on this subject has already been performed and another AMA study of the topic would be unnecessary and costly, and

Whereas, the solution to this issue would be to remove the current regulatory control of the practice of medicine in regard to this topic, and

Whereas, this resolution and its original intent brought up in 2021 seeks to remove outdated government regulations and allow the practice of medicine to reside under the control of physicians; therefore be it

RESOLVED: That MSMS advocate for the removal of state and national legislation and regulations that mandate the routine use of gonad shields in medical imaging.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000 for regulatory and/or industry advocacy.

Relevant MSMS Policy:

Oppose Routine Use of Gonad Shields - Resolution 03-21 (Approved as Amended)
RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to study whether the U.S. Food and Drug Administration should amend the code of federal regulations to remove language regarding the routine use of gonad shields in medical imaging.

Relevant AMA Policy:

AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959
1. Our AMA opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.
2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:
A. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
B. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
C. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
D. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.

Sources:

1. https://www.imagegently.org/About-Us/Campaign-Overview
2. https://www.aappublications.org/news/2020/03/31/xrayshields040120
3. https://www.radiologyinfo.org/en/info.cfm?pg=safety-patient-shielding
4. https://www.ecfr.gov/cgi-bin/text-idx?SID=c6fd98dfc8955d41420798f3e5357c66&mc=true&node=se21.8.1000_150&rgn=div8
5. https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?fr=1000.50
6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7005227/
7. https://www.aapm.org/org/policies/details.asp?id=468&type=PP%C2%A4t=true
8. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3292647/
9. https://pubmed.ncbi.nlm.nih.gov/28437549/
10. https://ncrponline.org/wp-content/themes/ncrp/PDFs/Statement13.pdf
11. https://www.acr.org/Advocacy-and-Economics/Advocacy-News/Advocacy-News-Issues/In-the-June-8-2019-Issue/ACR-Endorses-AAPM-Position-on-Patient-Gonadal-and-Fetal-Shielding
12. https://www.asrt.org/main/news-publications/news/article/2021/01/12/asrt-statement-on-fetal-and-gonadal-shielding

RESOLUTION 25-22

Title: Fentanyl Patch for Patch Exchange Program

Introduced by: David Whalen, MD, MPA, for the Kent County Delegation

Original Authors: Cara Poland, MD, and Gerald Lee, MD

Referred To: Reference Committee B

House Action:

Whereas, fentanyl is a powerful synthetic opioid analgesic that is 50-100 times more potent than morphine, and

Whereas, fentanyl is a Schedule II prescription drug, and it is typically used to treat patients with severe pain or to manage pain after surgery, and

Whereas, approximately 28,400 people died from overdose of synthetic opiates, other than methadone, in 2017 alone, and

Whereas, Michigan's overdose rate of 21.2 per 100,000 is above the national average of 14.6 per 100,000, and

Whereas, synthetic opioids, mainly fentanyl, overdose deaths have increased in Michigan from 72 in 2012 to 1,368 in 2017, and

Whereas, Ontario, Canada, has instituted a successful patch for patch exchange program (P4P Program); therefore be it

RESOLVED: That MSMS propose a fentanyl "patch for patch" exchange program in the state of Michigan that includes the following provisions:

1. Require a new fentanyl prescription to be labeled as a first prescription (this will result in a one-time return of 9/10 patches);
2. Require old patches to be stuck to a sheet of paper and returned to the pharmacy when getting a new prescription;
3. Require the pharmacy receiving a prescription for fentanyl patches to contact the prescriber if the pharmacy does not collect all used patches or collects fewer than the quantity to be dispensed;
4. Require the pharmacist and prescriber to jointly make an assessment, consider the circumstances, and determine the best course of action and the quantity to be dispensed; and,
5. Require pharmacies to properly store and then dispose of used patches; and be it further

RESOLVED: That MSMS seek legislation to implement a fentanyl "patch for patch" exchange program in Michigan.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000 - $32,000 for legislative advocacy.

Relevant MSMS Policy:

Prescription Drug Abuse
MSMS supports the following AMA position on "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.

Relevant AMA Policy:

Curtailing Prescription Drug Abuse While Preserving Therapeutic Use - Recommendations for Drug Control Policy H-95.979 (see language above)

RESOLUTION 28-22

Title: Retain Physician Assistant Professional Title

Introduced by: David Whalen, MD, MPA, for the Kent County Delegation

Original Author: Megan Edison, MD

Referred To: Reference Committee B

House Action:

Whereas, in May 2021, the American Academy of Physician Assistants passed a resolution during their virtual annual meeting to change their title from "Physician Assistant" to "Physician Associate," and

Whereas, "Physician Associate" is already the terminology used by non-partner physicians in medical practice, and

Whereas, this rebranding and marketing change is confusing, and will further obfuscate non-physician credentials from patients who deserve clarity and transparency, and

Whereas, the American Medical Association opposes this proposed title change, citing issues relating to patient transparency and the understanding of the type of care they are receiving, and

Whereas, the American Osteopathic Association opposes this proposed title change, stating it is an attempt "to obfuscate their credentials through title misappropriation;" therefore be it

RESOLVED: That MSMS oppose the title change of Physician Assistant to Physician Associate.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new MSMS policy.

Relevant MSMS Policy: None

Relevant AMA Policy:

Non-Physician Title Misappropriation D-405.977
Our AMA will: (1) actively oppose the American Academy of Physician Assistants' (AAPA's) recent move to change the official title of the profession from "Physician Assistant" to "Physician Associate"; and (2) actively advocate that the stand-alone title "Physician" be used only to refer to doctors of allopathic medicine (MDs) and doctors of osteopathic medicine (DOs), and not be used in ways that have the potential to mislead patients about the level of training and credentials of non-physician health care workers.

RESOLUTION 29-22

Title:	Transparency of Practice Agreements Between Physicians and Non-Physicians
Introduced by:	David Whalen, MD, for the Kent County Delegation
Original Author:	Megan Edison, MD
Referred To:	Reference Committee B
House Action:	

Whereas, MSMS has long recognized the value of non-physician providers, including physician assistants and nurse practitioners, as an important part of the physician-led health care team, and

Whereas, Michigan law requires a practice agreement between physicians and non-physician providers, and

Whereas, this practice agreement is essential, and ensures that every non-physician practicing medicine has a licensed physician available for patient consultation and oversight should the patient issue be beyond the non-physician provider's scope of practice in education, training, or experience, and

Whereas, most Michigan physicians care for patients with non-physician providers in a professional, open, safe, patient-centered, physician-led manner with appropriate chart review and accessibility for consultation, some practice agreements are opaque without clear evidence of physician involvement, and

Whereas, transparency of non-physician provider credentials and easy identification of the physician who has entered into practice agreement with the non-physician provider is essential for patient autonomy, safety, and informed consent; therefore be it

RESOLVED: That MSMS support public transparency of practice agreements, or lack of such agreements, between physicians and non-physician providers (such as nurse practitioners and physician assistants), as a reflection of our professionalism and commitment to patient safety in a physician-led care model; and be it further

RESOLVED: That MSMS support state legislation to achieve transparency of practice agreements between physicians and non-physician providers, or lack of such agreements, in a manner easily accessible to patients, in the form of website and/or marketing material disclosures, so that patients may be informed of the credentials of their entire care team.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000 for legislative advocacy.

Relevant MSMS Policy:

Clear Identification of Health Worker Position/Title with ID Tags
MSMS supports that physicians, nurses and other health providers wear a clearly visible photo identification badge that states their credentials in large block letters with descriptions such as "physician," "nurse," "physician assistant," "nurse practitioner," and that the badges be worn at all times when in contact with patients. (Res50-11)

Relevant AMA Policy:

Practice Agreements Between Physicians and Advance Practice Nurses and the Physician to Advance Practice
Our AMA will: (1) continue to work with the Federation in developing necessary state advocacy resource tools to assist the Federation in: (a) addressing the development of practice agreements between practicing physicians and advance practice nurses, and (b) responding to or developing state legislation or regulations governing these practice agreements, and that the AMA make these tools available on the AMA Advocacy Resource Center Web site; and (2) support the development of methodologically valid research comparing physician-APRN practice agreements and their respective effectiveness.

Definition and Use of the Term Physician H-405.951
Our AMA:
1. Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
2. Will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:
a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician;
b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician; and
c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.
3. Urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.
4. Ensure that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.
5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.
6. 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 providers that is not otherwise covered by existing Journal of the American Medical Association (JAMA) Editorial Governance Plan, which protects the editorial independence of JAMA.
7. Actively supports the Scope of Practice Partnership in the Truth in Advertising campaign

Truth in Advertising H-405.964
1. 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.
2. Our AMA opposes any misappropriation of medical specialties' titles and work with state medical societies to advocate for states and administrative agencies overseeing nonphysician providers to authorize only the use of titles and descriptors that align with the nonphysician providers' state issued licenses.

Definition of a Physician H-405.969

1. 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.
2. 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.
3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.

Clarification of the Title "Doctor" in the Hospital Environment D-405.991

1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.
2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require 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 (H-405.969, ?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?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. 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) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

RESOLUTION 32-22

Title: Amending Michigan's No Fault Auto Insurance Law (Again)

Introduced by: Richard Burney, MD, for the Washtenaw County Delegation

Original Author: Richard Burney, MD

Referred To: Reference Committee B

House Action:

Whereas, in 2019 the Michigan Legislature passed, and the Governor signed, legislation amending Michigan's No Fault Auto Insurance law, and

Whereas, the new law imposed drastic reductions in reimbursement for medical care of victims of auto crash injury to take effect in 2021, and

Whereas, this reduction in reimbursement has led to catastrophic changes the availability of adequate medical care for persons that have suffered serious brain and spinal cord injuries, and

Whereas, the Michigan Legislature has failed to address this humanitarian problem by repealing or further amending the 2019 "reform;" therefore be it

RESOLVED: That MSMS redouble its current advocacy efforts in support of legislation to reestablish adequate reimbursement for care of catastrophically injured persons as intended by Michigan's original No Fault legislation.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000 for legislative advocacy.

Relevant MSMS Policy:

No-Fault Auto Insurance – Coordination of Benefits
MSMS supports the requirement that automobile insurance policies with a coordination of benefits clause pay reasonable charges for products, services and accommodations incurred by the insured that are not covered by his/her primary health care policy, if the services are provided by a qualified health care professional. (Board-July97)
– Reaffirmed (Sunset Policy 2021)

No-fault Health Insurance
MSMS supports the concept that health insurance carriers cover the cost of treatment for illness or injury until the responsible payer is identified in order to ensure continuity of care. (Res60-95A)
– Reaffirmed (Sunset Policy 2021)

Relevant AMA Policy: None

Source:
1. CPAN press release January 11, 2022, University of Michigan Poverty Solutions Policy Brief 12/ 2021 Brain Injury Association of Michigan/Michigan Public Health Institute report 12/2021

RESOLUTION 38-22

Title: NBPAS as Equivalent Certification For Health Insurers and Hospitals

Introduced by: David Whalen, MD, MPA, for the Kent County Delegation

Original Author: Megan Edison, MD

Referred To: Reference Committee B

House Action:

Whereas, MSMS and the AMA have longstanding policy opposing continuing board certification as a requirement for hospital privileges or insurance plan participation, and

Whereas, insurers and hospital systems continue to ignore this, citing their own corporate credentialing concerns, as "board certified physician" are a marker of quality as measured by the National Committee for Quality Assurance (NCQA), The Joint Commission (TJC), and Utilization Review Accreditation Commission (URAC), and

Whereas, previously, the credentialing language of NCQA, TJC, and URAC only allowed American Board of Medical Specialties (ABMS) and American Osteopathic Association (AOA) certification, leaving physicians no other option than to participate in ABMS or AOA recertification for hospital or insurance participation, and

Whereas, ABMS and AOA are no longer the only options for physicians, other organizations such as National Board of Physicians and Surgeons (NBPAS) provide board certification, and unlike ABMS and AOA, adhere firmly to the AMA Principles on Continuing Board Certification, and

Whereas, NCQA now recognizes board certification with NBPAS as equivalent to ABMS and AOA certification for insurance company credentialing, and

Whereas, TJC now recognizes board certification with NBPAS as equivalent to ABMS and AOA certification in the Joint Commission's glossary for the Ambulatory Care, Behavioral Health and Human Services, Critical Access Hospital, Hospital, and Office-Based Surgery accreditation manuals effective July 2022, and

Whereas, URAC now recognizes board certification with NBPAS as equivalent to ABMS and AOA certification in their accreditation standards for health care organizations, and

Whereas, MSMS policy on board recertification champions these options, stating "MOC should not be the monopoly of any single entity. Physicians should be able to access a range of alternatives from different entities," and

Whereas, official acceptance of NBPAS as equivalent to ABMS and AOA certification for NCQA, TJC, and URAC credentialing should leave no reason why insurers and hospitals should continue to require recertification by only ABMS and AOA; therefore be it

RESOLVED: That MSMS work expediently with Michigan insurance companies to update their board certification language to be in compliance with current National Committee for Quality Assurance and Utilization Review Accreditation Commission standards, recognizing board certification with National Board of Physicians and Surgeons as equivalent to American Board of Medical Specialties and American Osteopathic Association certification for physician participation; and be it further

RESOLVED: That MSMS support the efforts of physician members working to change their hospital bylaws to recognize National Board of Physicians and Surgeons as equivalent to American Board of Medical Specialties and American Osteopathic Association certification for hospital privileges; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask the AMA to bring the recent recognition of National Board of Physicians and Surgeons as equivalent to American Board of Medical Specialties and American Osteopathic Association certification for National Committee for Quality Assurance, The Joint Commission, and Utilization Review Accreditation Commission credentialing for the consideration of our AMA as an option for physicians nationwide to consider in their continuing certification needs.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000 for regulatory and/or industry advocacy.

Relevant MSMS Policy:

Review Board Recertification and Maintenance of Certification Process

MSMS supports Maintenance of Certification (MOC) only under all of the following circumstances:

1. MOC must be voluntary
2. MOC must not be a condition of licensure, hospital privileges, health plan participation, or any other function unrelated to the specialty board requiring MOC
3. MOC should not be the monopoly of any single entity. Physicians should be able to access a range of alternatives from different entities.
4. The status of MOC should be revisited by MSMS if it is identified that the continuous review of physician competency is objectively determined to be a benefit for patients. If that benefit is determined to be present by objective data regarding value and efficacy, then MSMS should support the adoption of an evidence based process that serves only to improve patient care. (Res73-15)

– Reaffirmed (Res10-19)

Relevant AMA Policy:

Continuing Board Certification D-275.954

Our AMA will:

1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a yearly report to the House of Delegates regarding the CBC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.

4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's CBC and associated processes.

26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.
36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.
38. Our AMA, through its Council on Medical Education, will continue to work with the ABMS and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development of new, integrated standards for continuing certification programs by 2020 that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.
39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.

Continuing Board Certification H-275.924
Continuing Board Certification AMA Principles on Continuing Board Certification
1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.

4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit", American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. CBC should be used as a tool for continuous improvement.
15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing CBC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. CBC activities and measurement should be relevant to clinical practice.
19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.

RESOLUTION 46-22

Title: Radiology Interpretation by Physicians

Introduced by: Leah Davis, DO, for the Michigan Radiological Society

Original Author: Leah Davis, DO

Referred To: Reference Committee B

House Action:

Whereas, the demand for competent, high quality delivery of health care services is increasing, particularly in rural and underserved areas in this state, and

Whereas, this increased demand for health care services is being used by non-physician groups as justification for an effort by them to expand their scope of practice, with documented strategic goals to "remove restrictive physician involvement," "eliminate the legal requirement for a specific relationship between physician assistants and physicians," and attain the "ability to supervise radiologic technologists," and

Whereas, Michigan nurse practitioners are advocating for passage of Senate Bill 680 which would allow them to have prescriptive authority, as well as authority to diagnose and "interpret laboratory and imaging studies" without proper training and education in these disciplines," and

Whereas, enactment of SB 680 would compromise patient safety and quality of patient care in order to expand the scope of practice for nurse practitioners to include the practice of medicine, and

Whereas, addressing the need for greater access to quality care can be done through the legislative enactment of incentives that encourage qualified physicians with the training and education necessary to render these services competently rather than legislating medical degrees for non-physicians; therefore be it

RESOLVED: That MSMS oppose legislation that would authorize non-physicians to practice medicine; and be it further

RESOLVED: That MSMS support that radiological image interpretation is performed only by physicians and may not be delegated to nurse practitioners in this state.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000 for legislative advocacy.

Relevant MSMS Policy:

Nursing: Scope of Practice
MSMS opposes the practice of medicine by independent nurse practitioners. MSMS supports the establishment of written protocols between the physician and nurse practitioner. (Res33-91A) – Edited 1998 – Reaffirmed (Board-Oct12)

Oppose Scope of Practice Expansion for Allied Health Care Professionals
MSMS opposes scope of practice changes for non-physician health care professionals that are not supported by their level of education and training. (Res89-16) – Amended (Res59-18)

Relevant AMA Policy:

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950
Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in 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.

Sources:

1. https://www.aana.com/docs/default-source/sga-aana-com-web-documents-(all)/state-legislative-and-regulatory-agenda-2021-2022---spreads.pdf?sfvrsn=4c7bfd1d_6
2. https://www.aapa.org/advocacy-central/optimal-team-practice/
3. https://legiscan.com/MI/bill/SB0680/2021

Reference Committee C

MICHIGAN STATE MEDICAL SOCIETY
2022 HOUSE OF DELEGATES

RESOLUTIONS BY COMMITTEE

REFERENCE COMMITTEE C – INTERNAL AFFAIRS, BYLAWS, AND RULES

RESOLUTION	DESCRIPTION
03-22 (10-20)	Inclusion of Northern Michigan in the Rotation for the HOD Meeting
08-22 (20-20)	Michigan State Medical Society Judicial Commission
30-22	Celebrate Michigan Physicians
40-22	MSMS Bylaws Revision to Codify Standard Practice for Members Joining or Transferring Membership
45-22	MSMS Committee on Membership Recruitment and Retention
48-22	Group Membership Recruitment
BOARD ACTION REPORTS	**DESCRIPTION**
#3-22	Resolution 04-21 – "Dissemination of Information to the County Medical Societies"
#4-22	Revisions to the MSMS Policy Manual and the 2022 Sunset Policy
2nd Reading	**DESCRIPTION**
#13-21	Upholding the Integrity and Vitality of the State and County Medical Societies
#20-21	Designated Directors Serving as Chair of the MSMS Board of Directors

RESOLUTION 03-22 (10-20)

Title: Inclusion of Northern Michigan in the Rotation for the HOD Meeting

Introduced by: David Whalen, MD, for the Ottawa County Delegation

Original Author: Bryan Huffman, MD

Referred To: Reference Committee C

House Action:

Whereas, MSMS traditionally rotates its annual House of Delegates (HOD) meeting between the east and west side of Michigan, but always holds its meeting in the southern quarter of the state, and

Whereas, MSMS represents physicians from the entire state of Michigan, and

Whereas, travel time for HOD meetings for delegates from the northern half of Michigan is always dramatically longer than that of physicians in the southern portion of the state, and

Whereas, this places a higher burden on delegates from northern Michigan which may impact their representation in the HOD, and

Whereas, the majority of Michigan's population is in the southeastern portion of the state, and

Whereas, while many counties in the northern portion of Michigan lack a facility large enough to hold a MSMS meeting, communities such as Traverse City and Mackinac Island have sufficient facilities, and

Whereas, Traverse City has previously hosted an MSMS HOD; therefore be it

RESOLVED: That MSMS continue to rotate the HOD meeting between the east and west side of the state, but at least once every 12 years, the western meeting shall take place in a northern county.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new MSMS policy.

Relevant MSMS Policy:

Bylaws 12.70 MEETINGS - ANNUAL SESSION—The House of Delegates shall meet at least annually at the time and place of the Annual Session of this Society and may hold such number of meetings as the House may determine or its business require, recessing from day to day as may be necessary to complete its business and specifying its own time for the holding of its meeting. The House of Delegates may also be called into session at any time by the Speaker upon a two-thirds vote of the Board of Directors, or on petition

of twenty-five percent of the Delegates. The purposes of such special session shall be stated in the notice of call and no other business shall be transacted.

Relevant AMA Policy:

Meetings of the House of Delegates. B-2.12
2.12.1 Regular Meetings of the House of Delegates. The House of Delegates shall meet twice annually, at an Annual Meeting and an Interim Meeting.

2.12.1.1 Business of Interim Meeting. The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting.

2.12.2 Special Meetings of the House of Delegates. Special Meetings of the House of Delegates shall be called by the Speaker on written or electronic request by one-third of the members of the House of Delegates, or on request of a majority of the Board of Trustees. When a special meeting is called, the Executive Vice President of the AMA shall mail a notice to the last known address of each member of the House of Delegates at least 20 days before the special meeting is to be held. The notice shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the meeting is called.

2.12.3 Locations. The House of Delegates shall meet in cities selected by the Board of Trustees.

2.12.3.1 Invitation from Constituent Association. A constituent association desiring a meeting within its borders shall submit an invitation in writing, together with significant data, to the Board of Trustees. The dates and the city selected may be changed by action of the Board of Trustees at any time, but not later than 60 days prior to the dates selected for that meeting.

2.12.4 Meetings.

2.12.4.1 Open. The House of Delegates may meet in an open meeting to which any person may be admitted. By majority vote of delegates present and voting, an open meeting may be moved into either a closed or an executive meeting.

2.12.4.2 Closed. A closed meeting shall be restricted to members of the AMA, and to employees of the AMA and of organizations represented in the House of Delegates.

2.12.4.3 Executive. An executive meeting shall be limited to the members of the House of Delegates and to such employees of the AMA necessary for its functioning.

RESOLUTION 08-22 (20-20)

Title: Michigan State Medical Society Judicial Commission

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Jayne E. Courts, MD, FACP

Referred To: Reference Committee C

House Action:

Whereas, the Judicial Commission serves to review any concern about the conduct of a physician member that is potentially in violation of the American Medical Association (AMA) Code of Ethics, and

Whereas, concerns may originate from patients or other people and may include, but are not limited to, inappropriate behavior, sexual harassment, or issues of gender identity, and

Whereas, the MSMS Judicial Commission serves as the disciplinary body within MSMS, and

Whereas, the Judicial Commission works through the component county medical societies, often in a slow and potentially inequitable process, and

Whereas, the Official Procedures of the Judicial Commission allow determination of appropriate disciplinary action of a physician member, including possible censure, suspension, or expulsion from MSMS membership, and

Whereas, clear and concise approaches to the judicial and disciplinary process would improve timeliness, consistency, equity, and protection due to standardized processes and expedited decisions; therefore be it

RESOLVED: That the MSMS Board of Directors consider making the Judicial Commission a Committee of the Board so the Committee may perform its function in a more efficient and equitable manner; and be it further

RESOLVED: That the MSMS Board of Directors study the structure and function of the Judicial Commission and recommend Constitution and Bylaws changes that will be brought to the 2021 MSMS House of Delegates for first reading.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,500 -$5,000 to engage in a Board directed study.

Relevant MSMS Policy:

15.00 THE JUDICIAL COMMISSION

15.10 COMPOSITION - QUALIFICATIONS—The Judicial Commission shall be composed of ten members, each of whom shall be a voting member of the Society in good standing. No member of the Judicial Commission shall, during tenure of office, hold any of the following offices or positions: Speaker or Vice-Speaker of the House of Delegates of this Society, or District Director of this Society. Any member of the governing board of a component society which serves in these capacities, shall not, as a Commissioner, participate in deliberations pertaining to a grievance involving a member of that component society or cast a vote in respect thereto.

15.20 JUDICIAL DISTRICTS—There shall be seven Judicial Districts formed by grouping component societies as follows:
District 1—Wayne
District 2—Macomb, Oakland. St. Clair
District 3—Ingham, Livingston, Monroe, Shiawassee, Washtenaw
District 4—Bay, Iosco-Arenac, Genesee, Gratiot, Huron, Isabella-Clare, Lapeer, Midland, Saginaw, Sanilac, Tuscola
District 5—Allegan, Berrien, Branch, Calhoun, Cass, Eaton, Hillsdale, Jackson, Kalamazoo, Lenawee, St. Joseph, Van Buren
District 6—Barry, Clinton, Ionia-Montcalm, Kent, Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana, Ottawa
District 7—Alpena-Alcona-Presque Isle, Chippewa-Mackinac, Delta, Dickinson-Iron, Gogebic, Grand Traverse-Leelanau-Benzie, Houghton-Baraga-Keweenaw, Luce, Manistee, Marquette-Alger, Menominee, North Central Counties (Crawford, Gladwin, Kalkaska, Montmorency, Otsego, Roscommon), Northern Michigan (Antrim, Charlevoix, Cheboygan, Emmett), Ogemaw-Oscoda, Ontonagon, Schoolcraft, Wexford-Missaukee

15.80 POWERS AND DUTIES—The Judicial Commission shall have:
15.81 Authority to make binding interpretations of the Constitution and Bylaws of this Society and of the several component societies as they pertain to matters of ethics, mediation, grievance and discipline.

15.82 Authority to make ethical interpretations and decisions in accordance with the standards of the American Medical Association.

15.83 Sole appellate powers at the state level in all matters relating to ethics, professional conduct, mediation and discipline of members of component societies.

15.84 The power to entertain and exercise original jurisdiction in matters pertaining to ethics, mediation, conduct of members or discipline of members when requested to do so by any component society or by any member in good standing of this Society.

15.85 The power and authority to make and promulgate from time to time, rules and regulations governing all procedures pertaining to ethics, grievances, mediation, professional conduct and discipline of members, which rules and regulations shall be binding upon all component societies.

15.86 The power and authority to appoint such committees and to adopt such rules, regulations and procedures as, in the sole judgment of the Commission, are deemed desirable in carrying out the functions and purposes of the Commission.

Relevant AMA Policy:

Conflicts of Interest H-140.967
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.

Source:

1. Michigan State Medical Society. Constitution and Bylaws, Supplement: Official Procedures for the MSMS Judicial Commission, 2015 edition.

RESOLUTION 30-22

Title: Celebrate Michigan Physicians

Introduced by: David Whalen, MD, MPA, for the Kent County Delegation

Original Author: Megan Edison, MD

Referred To: Reference Committee C

House Action:

Whereas, medicine is a unique calling, filled with incredible, unique physicians, and

Whereas, Michigan physicians have demonstrated publicly throughout this pandemic, the heroic efforts that have long been part of our profession, and

Whereas, extensive lobbying and public advertising campaigns by non-physician providers have blurred the lines between physician and non-physician providers, and

Whereas, often these advertising campaigns malign the compassion and "heart" of the physician, and

Whereas, there are no organizations truly championing who we are, as physicians, to the public; therefore be it

RESOLVED: That MSMS pursue a public awareness campaign celebrating how truly awesome Michigan physicians are and highlighting the diverse contributions of physicians to creating a better Michigan, as well as how the unique training as physicians prepares physicians to lead in education, research, public health, small business, philanthropy, and patient care.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $4,500-$9,000 for a messaging campaign.

Relevant MSMS Policy: None

Relevant AMA Policy:

Responses to News Reports and Articles H-445.995
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.

AMA Membership Moves Medicine™ - Advocating for patients and physicians
https://www.ama-assn.org/amaone/how-membership-moves-medicine

RESOLUTION 40-22

Title:	MSMS Bylaws Revision to Codify Standard Practice for Members Joining or Transferring Membership
Introduced by:	Joseph Wilhelm, MD, for the Ingham County Delegation
Original Author:	Joseph Wilhelm, MD
Referred To:	Reference Committee C
House Action:	

Whereas, Article III, Section 1 of the Michigan State Medical Society (MSMS) Constitution states: "DEFINITION---Component societies shall consist of those county medical societies which hold charters from this Society," and

Whereas, Article III, Section 2 of the MSMS Constitution states: "GEOGRAPHICAL SCOPE---Not more than one component society shall be chartered in any county of the State. The House of Delegates may, however, in its discretion, grant a charter to a component society comprising two or more counties," and

Whereas, Section 2.20 of the MSMS Bylaws states: "MEMBERSHIP PREREQUISITE-All members of the several component societies, when in good standing, are thereby and must be members of this Society. All members of this Society must be members of a component medical society or direct members through the Resident and Fellow Section or the Medical Student Section," and

Whereas, Section 2.30 of the MSMS Bylaws states: "ACTIVE MEMBERS-To be eligible for active membership in any component society, doctors of medicine must hold an unrevoked, permanent license that is not currently under suspension in Michigan, or if unlicensed, must be engaged in academic teaching, research or administration. To maintain active membership in any component society, doctors of medicine must maintain active membership in this Society and comply with all the provisions of the Bylaws of this Society and the component society," and

Whereas, Section 4.10 of the MSMS Bylaws states: "MEMBERSHIP AS PRIVILEGE-NOT RIGHT---Admission to membership in any component society is not a matter of right, but one of privilege, to be accorded or withheld at the sole discretion of such society. Each component society may determine the manner of electing its members and shall be the sole judge of the qualifications of applicants for membership therein. There shall be no discrimination on the basis of race, religion, sex, ethnic origin, or sexual orientation," and

Whereas, it is the practice of our county medical societies and our MSMS that new members to MSMS join the component medical society of the county where they either live or primarily work, and

Whereas, the MSMS website states, "When you become a member of MSMS, you also become a member of the county medical society in which you live or work," and

Whereas, any current member wishing to transfer membership to another county medical society must first receive a good standing certification from the former county medical society and approval from the new county medical society, and

Whereas, the county medical societies became aware in July 2020 of physician(s) and/or physician group(s) being allowed to join and/or to transfer membership to inactive counties (counties with no discernable county medical society leadership, structure, operations, or membership dues requirements) in which they did not live and/or primarily work, and

Whereas, MSMS staff did not notify the county medical societies when these members transferred membership, and

Whereas, the county medical societies initiated discussion about these aberrant situations with MSMS staff on July 20, 2020, and

Whereas, following that discussion, the MSMS Board of Directors considered and approved a motion at the October 2020 Board meeting re-interpreting the Bylaws stating, "that the MSMS Board of Directors acknowledge MSMS Legal Counsel's interpretation that the MSMS Bylaws do not expressly require a physician to live or work in a county in order to hold membership in that county medical society," and

Whereas, this practice of allowing physicians to join and/or transfer to counties in which they do not live and/or primarily work continues to occur since the October 2020 MSMS Board meeting, and

Whereas, this practice creates an incentive for physicians and/or physician groups regardless of where they live or work to join inactive counties without membership dues to reduce their cost, and

Whereas, this practice is disruptive and harmful to the integrity and vitality of the county medical societies and MSMS; therefore be it

RESOLVED: That the MSMS Bylaws be amended as follows. Deletions are indicated by ~~strikethroughs~~, additions are indicated in **bold type**.

2.20 MEMBERSHIP PREREQUISITE-All members of the several component societies, when in good standing, are thereby and must be members of this Society. All members of this Society must be members of a component medical society **where they live or primarily work** or direct members through the Resident and Fellow Section or the Medical Student Section.

4.10 MEMBERSHIP AS PRIVILEGE - NOT RIGHT---**A doctor of medicine may apply for component membership within the county of their residence or primary location of practice. Any exception would require written, mutual agreement between the physician and/or physician group, MSMS, and the respective county(ies).** Admission to membership in any component society is not a matter of right, but one of privilege, to be accorded or withheld at the sole discretion of such society. Each component society may determine the manner of electing its members

and shall be the sole judge of the qualifications of applicants for membership therein. There shall be no discrimination on the basis of race, religion, sex, ethnic origin, or sexual orientation.

5.10 CHANGE OF LOCATION - PROCEDURE---When a member of a component society, by reason of change of **residence or primary practice** location, desires to transfer membership to another component society, such member shall make application thereto accompanied by tender of dues for the remaining half of the current year (any major fraction of a half being regarded as a full half and any minor fraction being disregarded). Thereupon, the secretary of the society to which application is made shall request certification of standing from the Society from which the member desires to transfer and upon receipt of such request the secretary of the latter Society shall supply certification of good standing, provided the following requirements have been met:

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new MSMS policy.

Relevant MSMS Policy: None

Relevant AMA Policy: None

Sources:

1. https://connect.msms.org/Membership/Join
2. Source: January 14, 2021, MSMS Board of Directors Meeting Packet The Saginaw County Medical Society has approved also submitting this resolution on their behalf.

RESOLUTION 45-22

Title:	MSMS Committee on Membership Recruitment and Retention
Introduced by:	Narasimha Gundamraj, MD, for the Barry, Ingham, Jackson, Kent, Saginaw, and Wayne County Delegations
Original Author:	Narasimha Gundamraj, MD
Referred To:	Reference Committee C
House Action:	

Whereas, MSMS was established in 1866 as a professional membership organization with the purpose of bringing together ethical, licensed, Michigan physicians, and

Whereas, MSMS has the responsibility of collecting and disbursing membership dues on behalf of its component societies, and

Whereas, the MSMS Committee on Membership Recruitment and Retention, composed of MSMS staff, component society leaders, and component society staff, used to meet regularly to collaborate with MSMS staff on membership recruitment and retention activities but was disbanded several years ago, and

Whereas, the elimination of the MSMS Committee on Membership Recruitment and Retention led to the loss of component society input on the membership recruitment and retention plans and processes for their own members, and

Whereas, MSMS refocused membership resources on large group membership solicitation activities over the past several years, and

Whereas, MSMS and its component societies have continued to lose members over the past few years, including several large groups, and

Whereas, after group membership has lapsed, current MSMS policy is that individual members must renew at the full dues rate unless exception is granted by the MSMS Board of Directors under pilot program authority, and

Whereas, recruitment efforts for regaining a majority of these individual members back have not been successful, and

Whereas, this loss of membership, on a proportional basis, has even more severely impacted the operating budgets of the individual component medical societies; and

RESOLVED: That MSMS re-establish the Member Committee with the following criteria:

a. Committee meetings to occur no less than six times a year;

b. Committee membership to be composed of MSMS leadership and staff, as well as not more than one leader and one staff member from each of the component societies for which MSMS is responsible for collecting dues;
c. The Committee is to have a significant role in developing and adjusting the annual membership recruitment and retention plan; and
d. The Committee is to develop a membership report for the 2023 MSMS House of Delegates that includes dues rates from other state and county medical societies for all membership categories to determine if a new dues rate structure is needed; state and component society membership benefits to determine if changes or enhancements are needed; the short- and long-term impact of COVID-19 on membership; and any other significant membership information that the Committee requests.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000 – $2,000 for basic reporting.

Relevant MSMS Policy: None

Relevant AMA Policy: None

RESOLUTION 48-22

Title: Group Membership Recruitment

Introduced by: Steve Daveluy, MD, FAAD, for the Barry, Ingham, Jackson, Kent, Saginaw, and Wayne County Delegations

Original Author: Steve Daveluy, MD, FAAD

Referred To: Reference Committee C

House Action:

Whereas, MSMS and its component societies are unified in membership but are separate 501(c)(6) organizations, and

Whereas, MSMS has retained the responsibility of collecting the unified membership dues on behalf of the component societies, and

Whereas, MSMS has refocused membership resources on large group membership solicitation activities over the past several years, and

Whereas, MSMS regularly solicits and negotiates for group membership without input or collaboration from component societies, and

Whereas, without input or collaboration, component societies are deprived of input into membership activities directly impacting their operating budgets, and

Whereas, MSMS has failed to do due diligence in obtaining the home and/or primary work address for each of the individual members joining under a group membership, and

Whereas, MSMS and its component societies have lost several of these large groups over the past several years, and

Whereas, re-engagement recruitment efforts for regaining a majority these former group members back individually have not been successful, and

Whereas, this loss of membership, has had a severe impact on the operating budgets of the individual component societies; therefore be it

RESOLVED: That MSMS report any group membership solicitation plans to the impacted component societies; and be it further

RESOLVED: That MSMS include the impacted component societies in the group solicitation and negotiations; and be it further

RESOLVED: That MSMS requires a written contract for any group membership over 50 members and shares the roster and contract with the impacted component societies in advance of finalizing contracts; and be it further

RESOLVED: That MSMS obtain the home and/or primary work address of each individual member under the group bill, whether from the group contact or through research by MSMS.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000 - $24,000 for extensive reporting.

Relevant MSMS Policy: None

Relevant AMA Policy: None

ACTION REPORT #03-22 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 04-21
Dissemination of Information to the County Medical Societies

REFERRED TO: Reference Committee C

HOUSE ACTION:

RECOMMENDATION: That the 2022 House of Delegates take no action on Resolution 04-21, "Dissemination of Information to County Medical Societies," since a solution to this resolution has already been identified in collaboration with county medical society staff and has been implemented.

Resolution 04-21 was referred to the MSMS Board of Directors for study. The Board referred the resolution to the MSMS Executive Committee for review and recommendations.

Resolution 04-21 asked "that MSMS amend its Website Privacy Policy Information Sharing and Disclosure policy to affirm the County Medical Societies as component societies, and continue the transparent process of providing member and nonmember information to the Secretary and Executive Director/Administrator, if applicable, of the duly chartered County Medical Societies as requested without regard to the members' or nonmembers' county of origin; and that any membership or information sharing policy shall be discussed and approved with the County Medical Societies and/or the House of Delegates before implementation or finalization moving forward."

Resolution 04-21, authored by Christopher Allen, MD, and submitted on behalf of the Ingham, Saginaw, and Washtenaw County Delegations, was introduced to ensure that the County Medical Societies gain access to all member or non-member information regardless of county of origin. The key issue was providing information that allowed county medical societies to determine if physicians were assigned to the correct county without compromising some of the personal data that is in the member record. Each county has access, through the MSMS member database portal, to the entire member record, but due to the confidentiality provisions of MSMS, that record cannot be shared with other counties. Basic identifying information is available on the MSMS website through the physician directory, but it is cumbersome for county staff to use since they

(continued)

have to search county by county to determine if a member has moved or been reassigned to a different county.

Reference Committee C (Internal Affairs and Bylaws) considered Resolution 04-21 during the 2021 MSMS House of Delegates. The Reference Committee had a lengthy and thoughtful discussion about this resolution. After reviewing legal counsel's recommendation and reflecting upon general privacy sharing information from their own professional and personal lives, the Committee believed the current information available to the county medical societies via their individual portals and the physician directory is appropriate. Committee members were sensitive to the online comments from delegates and appreciates this is an issue that would most benefit from an in-person House where respectful debate and questions could be more directly addressed.

Legal Counsel's recommendation, based on this resolution, is to share first name, last name, and county information only with the county medical societies. This information is available now at http://MSMS.org/PhysicianDirectory.

Julie Novak and Kevin McFatridge, MSMS staff, met with Angela Kemppainen (Ingham and Washtenaw staff) and Patricia Dalton (Kent, Ottawa, and Kalamazoo staff) on January 20, 2022, to discuss ways the State and County information sharing could meet the needs of the County Medical Societies. There was agreement reached which then went to a County Medical Society meeting between MSMS staff and County staff on February 24, 2022. The agreement indicates that MSMS staff will share a quarterly report to the County staffs that reflects what is currently made public in the online Physician Directory in an Excel document on a quarterly basis. Information to include first name, middle initial, last name, credentials, full work address, work phone, employer, email, county, county chapter, and join date. The county executives participating in the February 24 meeting agreed that this quarterly report would provide the information they needed and appropriately resolved the issue that led to the resolution. As of this writing, the first report is in production and should be available to the county executives in early April 2022.

MSMS and the County Medical Societies have agreed on an appropriate solution to better meet their informational needs and altering the privacy policy could have legal ramifications; therefore, it is unnecessary. The Finance Committee approved the recommendation to take no action on Resolution 04-21.

At its meeting on March 23, 2022, the MSMS Board of Directors approved the recommendation of the MSMS Executive Committee to take no action on Resolution 04-21.

MSMS staff affirmed to the County Medical Society staff at their March 24, 2022, meeting that the recommendation of no action would be forwarded to the House of Delegates in light of the consensus around the alternate solution.

Attachment
Resolution 04-21

RESOLUTION 04-21

Title: Dissemination of Information to County Medical Societies

Introduced by: Joseph Wilhelm, MD, for the Ingham County Delegation, Christopher J. Allen, MD, for the Saginaw County Medical Society, and Evelyn Eccles, MD, for the Washtenaw County Delegation

Original Author: Christopher J. Allen, MD

Referred To:

House Action:

Whereas, the County Medical Societies (CMS) are duly chartered component societies of MSMS, and membership is required in CMS and MSMS, and

Whereas, over time, MSMS has retained the statewide database of members and nonmembers (including nonpaid members, physicians who have moved, and the deceased) as it hosts the online membership platform and database, CRM, and

Whereas, the CMS are tasked with maintaining a roster of members, but the majority of CMS do not maintain an independent electronic database of members and nonmembers as MSMS hosts a comprehensive, statewide version, and

Whereas, the CMS have previously used this shared information exclusively for official membership business including the verification of membership and to aid MSMS in recruitment and retention efforts, and

Whereas, CMS and MSMS work hand-in-hand in providing services to their physician and medical student members, and

Whereas, MSMS ceased providing statewide membership information to CMS stating the practice was not in compliance with MSMS Bylaws and policies beginning in October 2020, and

Whereas, MSMS began citing a Website Privacy Policy Information Sharing and Disclosure policy in February 2021, noting the prohibition of the release of this information to CMSs moving forward, and

Whereas, the Information and Sharing Disclosure states “the Michigan State Medical Society is committed to protecting your personal information. We will not disclose your personally identifiable information to third parties without your consent,” and

Whereas, the newly cited MSMS policy suggests CMS are “third parties” and not component partners in unified membership efforts; therefore be it

RESOLVED: That MSMS amend its Website Privacy Policy Information Sharing and Disclosure policy to affirm the County Medical Societies as component societies, and continue the transparent process of providing member and nonmember information to the Secretary and Executive Director/Administrator, if applicable, of the duly chartered County Medical Societies as requested without regard to the members' or nonmembers' county of origin; and be it further

RESOLVED: That any membership or information sharing policy shall be discussed and approved with the County Medical Societies and/or the House of Delegates before implementation or finalization moving forward.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

STATEMENT OF URGENCY: The Saginaw, Ingham, and Washtenaw County Medical Society Delegations and Boards of Directors affirm this resolution is important and needs immediate action by the House of Delegates. In order for the county medical societies to survive, thrive and serve their members, it is imperative the county medical societies receive the requested information from MSMS which has been available to the county medical societies in the past, but has been withheld by MSMS for various unsubstantiated reasons as dictated by MSMS. The county medical societies are trusted partners, not third parties, and work hand-in-hand with MSMS to provide services to our dual members. The requested information is also needed to maintain and ensure the integrity and transparency of both the county medical societies and MSMS. The 2018 and 2019 HOD voted to maintain unification of MSMS and the county medical societies, therefore, the HOD needs to address the issue of MSMS staff withholding necessary information from the counties which is needed to maintain that unification.

Relevant MSMS Policy:
Over the past year, MSMS has deployed several strategies to address issues raised by county medical societies regarding state society operations and procedures relative to membership, advocacy, communications and the House of Delegates. Those strategies include weekly (spring 2020) and then bi-weekly (summer 2020) virtual meetings between the MSMS CEO and county society staff, monthly meetings between MSMS departmental heads and county society staff (which have been ongoing since 2010), and a facilitator-led series of meetings to research state and county perspectives and host a series of meetings to work through how various issues will be handled going forward. The consultant work is ongoing, and the topic raised in this resolution has been part of that process. In addition, county concerns have been discussed broadly at MSMS Board meetings, the Chair and Vice Chair hosted a virtual meeting with Regional Directors representing five counties raising concerns, and the MSMS Executive Committee has also met to support strategies to establish best practices between state and county going forward.

MSMS Website Privacy Policy: At the Michigan State Medical Society, we believe anyone who uses the Internet should be fully aware of how their information is used, and are committed to doing business with the highest ethical standards. The following Privacy Policy outlines how the Michigan State Medical Society gathers and utilizes various sources of information obtained during your visit to www.msms.org, and handles your data.

Definitions: "Non-Personal Information" is information that is in no way personally identifiable and that is obtained automatically through your use of the Site with a Web browser. "Personally Identifiable Information" is non-public information that is personally identifiable and obtained in connection with providing a product or service to you. It may include information such as name and address.

Information collected: When you enter the Site, we collect Non-Personal Information, such as your browser type and IP address. Likewise, in order to offer you meaningful products and services and for other reasons, we may collect personally identifiable Information about you from the following sources: Information you give us on applications or other forms on the Site; or Information you send us via any medium, including, but not limited to email, telephone, and social media interaction. If you are a non-registered visitor to the Site, the only information we collect will be Non-Personal Information through the use of cookies and/or pixels. Information you provide to third-party websites is not within the control of the Michigan State Medical Society and you provide such information at your own risk. The terms and conditions of use and the privacy policies of those websites that you provide information to will govern their use of such information.

Cookies & Pixels: The Site may send a "cookie" to your computer. A cookie, or pixel, is a small piece of data that is sent to your browser from a Web server and stored on your computer's hard drive. A cookie or pixel cannot read data off your hard disk or read cookie and pixel files created by other sites. Cookies and pixels do not damage your system. Cookies and pixels allow us to recognize you as a user when you return to the Michigan State Medical Society website using the same computer and Web browser. We use cookies and pixels to identify which areas of our site you have visited, so the next time you visit the site, those pages may be readily accessible. We may also use this information to better personalize the content that you see on the Site. In the course of optimizing service to our users, we may allow authorized third parties to recognize a unique cookie or pixel on your browser. Any information provided to third parties through cookies or pixels will not be personally identifiable, but may provide general segment information for the enhancement of your user experience by providing more relevant advertising. The Michigan State Medical Society uses third-party vendor re-marketing tracking cookies and pixels, through sites like Facebook and Google. This means we have the ability to show ads to you on Facebook, or other websites across the Internet. As always, we respect your privacy and are not collecting any identifiable information through Facebook, or any other third-party remarketing system. The third-party vendors, including Facebook, whose services we use, will place cookies on Web browsers in order to serve ads based on past visits to our website. Third party vendors, including Facebook, use cookies to serve ads based on a user's prior visits to your website. This type of advertising is designed to provide you with a selection of products and offers based on what you're viewing on www.msms.org, and allows us to make special offers and continue to market our services to those who have shown interest in our service.

Managing Cookies: Most browser software can be set to reject cookies. If you'd prefer to restrict, block or delete cookies from www.msms.org or any other website, you can use your browser to do this. Each browser is different; so check the 'Help' menu of your particular browser to learn how to change your Cookie preferences. Alternatively, you can opt out of a third-party vendor's use of cookies by visiting the Network Advertising Initiative opt-out page. Please keep in mind that if cookies aren't enabled, certain functionality on the Site may not work properly and your experience may be limited.

Information Sharing And Disclosure: The Michigan State Medical Society is committed to protecting your personal information. We will not disclose your personally identifiable information to third parties without your consent.

Relevant AMA Policy:
None

ACTION REPORT #04-22 OF THE BOARD OF DIRECTORS

SUBJECT: Revisions to the MSMS Policy Manual and the 2022 Sunset Policy

REFERRED TO: Reference Committee C

HOUSE ACTION:

RECOMMENDATION: That the 2022 MSMS House of Delegates approve the revisions to the MSMS Policy Manual and the 2022 Sunset report. Upon House approval, the reviions will be placed in the Policy Manual on the MSMS website.

The MSMS Policy Manual Review Committee met virtually on December 20, 2021; January 11, 2022; and February 22, 2022, to review existing policy slated for review pursuant to the MSMS sunset policy; reviewed the 2021 House of Delegates Resolutions and Board Action Reports, as well as the MSMS Board Actions from January through October 2021.

At its virtual meeting on March 23, 2022, the MSMS Board of Directors approved the revisions to the MSMS Policy Manual and the 2022 Sunset Report and that upon House approval the updates will be placed in the Policy Manual on the MSMS website.

Attachments
- MSMS Policy Manual Updates
- 2022 Sunset Report
- Addendum H

MICHIGAN STATE MEDICAL SOCIETY

Policy Manual
Addendum to the 2021 Edition

CERTIFICATION AND MAINTENANCE OF CERTIFICATION

Review Board Recertification and Maintenance of Certification Process

MSMS supports Maintenance of Certification (MOC) only under all of the following circumstances:

1. MOC must be voluntary
2. MOC must not be a condition of licensure, hospital privileges, health plan participation, or any other function unrelated to the specialty board requiring MOC
3. MOC should not be the monopoly of any single entity. Physicians should be able to access a range of alternatives from different entities.
4. The status of MOC should be revisited by MSMS if it is identified that the continuous review of physician competency is objectively determined to be a benefit for patients. If that benefit is determined to be present by objective data regarding value and efficacy, then MSMS should support the adoption of an evidence-based process that serves only to improve patient care. (Res73-15)

- Reaffirmed (Res10-19)
- Reaffirmed (Res30-20)

CHILDREN AND YOUTH

Prevention and Screening

Depression Screening in Adolescents after Sport-Related Concussion

MSMS supports the screening of student athletes participating in Michigan High School Athletic Association sports for depression after concussion, and prior to return to activity, by physicians, physician assistants, or nurse practitioners using a validated screening tool*. (Res46-20)

* Example: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7963018/.

Routine ACE Screening in Pediatric Appointments

MSMS supports screening and health plan reimbursement for screening for adverse childhood experiences in annual pediatric appointments. (Board Action Report #2, 2019 HOD, re Res29-18)

- Reaffirmed (Res36-21)

CONTINUING MEDICAL EDUCATION

Opposition to Compulsory Content of Mandated Continuing Medical Education

MSMS opposes any attempt to introduce compulsory content of mandated Continuing Medical Education (CME) in the state of Michigan. (Res67-07A)
- Reaffirmed (Sunset Report 2020)
- Reaffirmed (Res01-21)

HEALTH CARE DELIVERY

Medical and Dental Care for Prisoners

MSMS believes persons who are incarcerated should have access to a timely and transparent review process comprised of correctional officials and clinicians to address concerns regarding access to and receipt of necessary medical and dental treatment. (Res18-21)

HEALTH CARE INSURANCE

Coverage and Billing of LARC Services

MSMS supports access to Long-Acting Reversible Contraceptives for populations with barriers to contraceptive access. Any legislative or regulatory proposals must be consistent with the clinical management guidelines provided by the American College of Obstetricians and Gynecologists in order to ensure clinical best practices and standards of care are promoted.

MSMS supports AMA policy H-75.984, Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraceptive Placement, in effect on April 29, 2018, which recognizes efficacy of postpartum long-acting reversible contraceptives placement as a way of reducing future unintended pregnancies and the need to increase availability and coverage by Medicaid, Medicare, and private insurers, as well as to bill and pay these devices separately from the obstetrical global fee. (Res43-18)
- Reaffirmed (49-20)
- Edited 2022

HEALTH CLINICIANS OTHER THAN PHYSICIANS

Licensure of Dietitians and Nutritionists

MSMS supports the licensure of dietitians and nutritionists. (Board-July2021)

HEALTH INFORMATION TECHNOLOGY

Electronic Prescribing Waiver for Michigan's Free Clinics

MSMS supports a waiver or other exemption for non-profit charitable medical clinics from Michigan's requirement that all non-controlled substances be electronically prescribed. (Res15-21)

IMMUNIZATIONS

COVID-19 Vaccine Distribution

MSMS supports efforts to increase convenient access to COVID-19 and other vaccines for individuals experiencing homelessness including, but not limited to, the provision of vaccines at shelters, food distribution centers, and community centers. (Res35-21)

Vaccine Outreach to Minority Communities

MSMS supports community-centered strategies for disease specific (e.g., COVID-19) and annual vaccination efforts, including influenza and childhood vaccine outreach. Utilization of evidence-based, community-driven interventions such as collaboration with faith and school-based leaders, for education and dissemination of information, can help to build trust in minority populations disproportionately impacted by longstanding historical violations of trust. (Res24-21)

MATERNAL AND INFANT HEALTH

Michigan Maternal Health, Safety, and Quality Care Initiatives

MSMS shall participate with other stakeholders involved in the care of pregnant women to advance statewide initiatives to improve maternal health outcomes including, but not limited to, Maternal Levels of care at birthing centers. (Res24-14)
- Reaffirmed (Res06-21)

MEDICAID

Medicaid Dialysis Policy for Undocumented Patients

MSMS encourages the state of Michigan to cover scheduled outpatient maintenance dialysis for undocumented patients with end stage kidney disease under Emergency Medicaid. (Res16-21)

Opposition to Medicaid Work Requirements (p. 24)

MSMS opposes work requirements as a criterion for Medicaid eligibility. (Res22-19)
-Reaffirmed (Res01-20)

MEDICAL EDUCATION AND TRAINING

Financial Aid for Medical Students

Adequate financial aid systems should be available for financially needy medical students. (Prior to 1990)
- Reaffirmed (Res59-20)

Medical Student Debt Crisis

MSMS supports the adoption and pursuit of state and federal policies that provide immediate medical student debt relief, as well as long-term novel solutions to the medical student debt crisis. (Res46-08)
- Reaffirmed (Res59-20)

Opioid Education in Medical Schools

MSMS strongly supports the development and implementation of evidence-based opioid and related substance use disorder training programs and education resources in medical school curriculums. MSMS encourages the inclusion of education on prescribing medications to treat opioid use disorders in such curricula. (Res59-19)
- Amended (Res22-21)

ORGAN DONATION AND TRANSPLANTATION

Payment for Organs

MSMS opposes payment in any form to the donor, the donor's family members, or the donor's agents for organs used for transplant. Payment does not mean provisions for donation-related expenses incurred by a living organ donor including, but not limited to medical expenses related to the donation or expenses incurred after the donation as a consequence of donation. (Board-July96)
- Amended (Res11-21)

HIV-Positive Organ Transplantation

MSMS endorses the ability to transplant organs from HIV-positive donors into HIV-positive recipients pursuant to appropriate evidence-based protocols including the recipient's informed consent. (Res11-21)

PRACTICE SAFETY

Physician Health Programs

MSMS believes the design, policies, and actions of Physician Health Programs should be motivated by humanitarian concerns and provide for the following:

- A confidential resource for physicians and medical students whose capacity to function professionally is at risk of impairment or has been impaired by addictive, psychiatric, medical, behavioral, or other potentially debilitating conditions.
- A therapeutic alternative to disciplinary action since the best current evidence indicates none of these conditions are voluntarily acquired or "self-inflicted."
- A confidential mechanism for self-referral prior to impairment.
- The opportunity to receive effective and affordable clinical care for mental, physical, and substance use disorders, including easy access to a variety of clinical interventions and treatment programs, to aid in their recovery and encourage safe and ethical return to clinical practice.
- Individualized decision-making inclusive of all treatment options appropriate for physicians or medical students who are actively engaged in, or planning to return to, clinical work.
- Oversight of a participant's progress and compliance with treatment and/or continuing care recommendations. (Prior to 1990)

– Edited 1998, 2016
– Amended (Res13-18)
- Amended (Res09-20)

PUBLIC HEALTH

*(Subcategories: Collaboration; Communicable Disease; Disaster Planning; Education; Environmental Health Issues; General; Healthy Choices; Physical Fitness and Nutrition; Screening; **Social Determinants of Health**)*

Social Determinants of Health

Availability of Medical Respite Centers

MSMS supports policies that increase the availability of medical respite centers and programs for use by individuals experiencing homelessness. Additionally, MSMS recognizes that local stakeholders must be able to secure adequate funding for medical respite programs, including, but not limited to, the expansion of current facilities in urban areas with large populations of individuals who are homeless. (Res31-21)

Reduce Harm in Encampment Removals or Relocations

MSMS encourages the collaborative efforts of local governments, public health departments, social service organizations, and other stakeholders to develop a comprehensive plan to address the health care and social needs of individuals experiencing homelessness who would be impacted by the removal or relocation of an encampment in which they have been living. In the event of a public health recommendation of encampment clearance, the plan should establish procedures to safely and humanely remove or relocate encampments. (Res25-21)

QUALITY ASSURANCE AND PATIENT SAFETY

9-1-1 Dispatcher Telephone CPR Training

MSMS encourages 9-1-1 dispatchers to receive training on how to provide telephone cardiopulmonary resuscitation for out-of-hospital cardiac arrests. (Res61-20)

SAFETY AND ACCIDENT PREVENTION

Firearm Safety

Firearm-Related Injury and Death: Adopt A Call to Action (p. 39)
MSMS endorses the specific recommendations made in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms. (Res13-16)
- Reaffirmed (Res78-19 AND Res80-19)
- Reaffirmed (Res27-20)

Firearm Regulations

MSMS opposes the liberalization of concealed gun laws and efforts to weaken current laws regarding the manufacture, importation, and/or ownership of assault weapons and/or handguns. MSMS supports policies that 1) prohibit acquisition of firearms by high-risk persons; 2) require firearm owners to have firearm safety certification which includes but is not limited to basic education in the care and handling of firearms; 3) limit ownership and use of assault weapons; and, 4) ban the sale of assault weapons and large-capacity ammunition magazines. (Res37-96A)

- Amended (Res 44-18)
- Reaffirmed (Res78-19 AND Res80-19)
- Reaffirmed (Sunset Report 2019)
- Reaffirmed (Res27-10)

SUBSTANCE USE AND ADDICTION

Eliminate the X Waiver

MSMS supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder. (Res22-21)

Expand Access to Medication for the Treatment of Opioid Use Disorder

MSMS recommends the removal of legislative, regulatory, and other barriers to the use of medications for opioid use disorder. (Res22-21)

Resentencing for Individuals Convicted of Marijuana-Based Offenses

MSMS supports the expungement, destruction, or sealing of criminal records for marijuana offenses committed prior to Michigan's adult-use marijuana law adopted by ballot initiative in 2018 and now considered legal. Additionally, MSMS supports the elimination of violations or other penalties for persons under parole, probation, pre-trial, or criminal supervision for marijuana offenses committed prior to Michigan's adult-use marijuana law adopted by ballot initiative in 2018 and now considered legal. (Res54-20)

TAXES

Essential Services Tax

MSMS vigorously opposes any sales or use tax on essential needs of Michigan citizens, including, but not limited to education, food items, prescriptions, medical services, feminine hygiene products, and also oppose any provider tax. (Res19-07A)
– Reaffirmed (Board-Oct2009)
- Amended (Board-July2021)

WOMEN'S HEALTH

*(Subcategories: Abortion; Contraception; **General;** Prevention and Screening)*

Contraception

Behind the Counter Hormonal Contraception Devices

MSMS supports the American College of Obstetricians and Gynecologists Committee policy to allow contraceptive vaginal rings and contraceptive patches to be available behind the counter. (Res30-21)

General

Access to Menstrual Products in Correctional Facilities

MSMS supports access to free menstrual products at all Michigan state and local correctional facilities, regardless of an institution's private, state, or federal funding source. (Res28-21)

Sunset Report to 2022 MSMS House of Delegates

At its 2018 Annual Meeting, the Michigan State Medical Society (MSMS) House of Delegates (HOD) established a sunset mechanism for House policies (Resolution 14-18, "Sunset Mechanism MSMS Policy"). Pursuant to this mechanism, a policy established by the HOD ceases to be viable after 10 years unless action is taken by the HOD to retain it.

The objective of the sunset mechanism is to help ensure the MSMS Policy Manual is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of MSMS to communicate and promote its policy positions, as well as contributes to the efficiency and effectiveness of HOD deliberations.

The MSMS Committee to Review the MSMS Policy Manual recommends that the House of Delegates policies listed in this report be acted upon in the manner indicated and the remainder of the report be filed.

Index	Policy	Year	Recommendation
ADVERTISING	**Inclusion of Professional Title and License Type in Advertising** MSMS supports requiring that all health care advertising include the professional title and license type.	Res51-11	***Retain, policy is still relevant.***
AUTOPSIES	**Maternal Mortality and Autopsies** MSMS supports that an autopsy be performed when a death occurs that meets the Michigan state criteria for a pregnancy related death.	Board Action Report #1, 2011 HOD, re Res2-10A	***Retain, policy is still relevant.***
CONTINUING MEDICAL EDUCATION	**Required Training for Appointed County Medical Examiners** MSMS supports a requirement for fundamental medicolegal death investigation training applicable to all county medical examiners and deputy medical examiners.	Res21-11	***Retain, policy is still relevant.***
CREDENTIALING	**Insurance Companies Increasing the Limits of Liability for Credentialing** MSMS opposes mandating increased limits of professional liability insurance coverage at the time of re-credentialing.	Res41-11	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
CREDENTIALING	**Release of Physician's Personal Medical Record for Hospital Credentialing** MSMS opposes any credentialing process that forces a physician to release his/her personal medical record.	Res38-11	***Retain, policy is still relevant.***
END OF LIFE CARE	**Public Awareness of Terminally Ill Treatments** MSMS should continue and expand its campaign to bring to public attention the efforts by physicians to treat the terminally ill so that assisted suicide is not considered a necessary alternative to continued medical care.	Res77-93A	***Sunset policy.*** ***Rationale:*** *This campaign no longer exists.*
ETHICS	**Developing Due Process Standards for Institutional Ethics Committees in Michigan** MSMS supports that Institutional Ethics Committees in Michigan facilitate due process into their deliberations concerning extraordinary or unusual patient care questions by including the patient or a patient advocate unrelated to the patient, hospital, or physicians(s).	Board-Oct11	***Retain, policy is still relevant.***
HEALTH CARE DELIVERY	**Continuity of Prenatal Care** All providers of prenatal care in Michigan are obligated to provide continuity of care for labor and delivery.	(Prior to 1990) – Edited 1998	***Retain, policy is still relevant; however, modify by inserting "for" after "provide".*** ***Continuity of Prenatal Care*** *All providers of prenatal care in Michigan are obligated to provide for continuity of care for labor and delivery.* ***Rationale:*** *Care provided in outpatient and inpatient settings is often by different clinicians. This slight language change seeks to ensure current standard of care is advocated.*
HEALTH CARE DELIVERY	**Post-operative Care** MSMS supports the position that post-operative care should be provided by the operating surgeon or by a licensed physician trained in post-operative care.	Board Action Report #1, 1993 HOD, re Res29-91A	***Retain, policy is still relevant.***
HEALTH CARE INSURANCE	**Accountability of Repricing Networks** MSMS supports a physician's right to withdraw participation from any insurance company that mandates participation in repricing networks or all products clauses.	Res4-11	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
HEALTH CARE INSURANCE	**Non-payment of "Authorized" Medical Services** MSMS supports that an insurer's authorization for specific service(s) is associated with payment for services rendered; that reimbursement for services rendered is received within 30 days; and that services with "authorization" cannot be denied retrospectively with request for return payment.	Res79-11	***Retain, policy is still relevant.***
HEALTH CLINICIANS OTHER THAN PHYSICIANS	**Physician Assistants (PAs): Prescribing Controlled Substances** MSMS supports changing the Board of Medicine administrative rules so physician assistants (PAs) can write orders for controlled substances in the hospital setting upon verbal order of his or her collaborating physician.	Res59-97A	***Sunset policy.*** ***Rationale:*** *The applicable Administrative Rules, R 338.3153a of the Board of Pharmacy - Controlled Substances, currently permit this activity.*
HOSPITAL-PHYSICIAN RELATIONS	**Medical Staff Self-rule** All hospital medical staffs should have the right to formulate and implement their constitution, bylaws, rules and regulations with the understanding that they are subject to the hospital corporate body.	Prior to 1990 – Edited 1998	***Retain, policy is still relevant.***
HOSPITAL-PHYSICIAN RELATIONS	**National Practitioner Data Bank** MSMS supports repeal of the National Practitioner Data Bank.	Res7-90A – Amended 1993 – Edited 1998	***Retain, policy is still relevant.***
LABORATORY MEDICINE	**Signatures for Diagnostic Laboratory Test Requisitions Creates Inefficiency, Increased Costs and Patient Safety Risks** MSMS opposes requiring signatures for diagnostic laboratory test requisitions.	Res39-11	***Retain, policy is still relevant.***
MANAGED CARE	**Cesarean Section Rates** MSMS opposes the C-section rate as the only measure of quality.	Res127-99A	***Retain, policy is still relevant.***
MANAGED CARE	**Gag Orders and Hold Harmless Clauses** MSMS opposes any form of gag orders, hold harmless clauses and pejorative treatments arising out of contractual stipulations.	Res10-96A	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
MANAGED CARE	**Guidelines for Managed Care** MSMS advocates the following managed care guidelines: 1. Medical facilities must be physician-oriented and their medical services be physician-directed. 2. Physicians' services must be clearly differentiated and separated from hospital services. 3. The patient's physician should be free of controls and restrictions that interfere with providing the highest quality of medical care. 4. The physician-patient relationship is the keystone to good medical practice, which means that each patient must have freedom of choice of physician and each physician freedom of choice of patient. 5. Frequency of use and criteria for medical care are and must continue to be the responsibility of physicians. 6. Governmental agencies may provide medical service and/or medical facilities only when they cannot be purchased or are not available from private sources.	Prior to 1990 – Edited 1998	***Retain, policy is still relevant.***
MANAGED CARE	**Health Maintenance Organizations** MSMS reaffirms its support of a pluralistic health care and reimbursement system and opposes the domination of the HMO industry by any one financial entity. MSMS will continue to carefully monitor the ownership, development and growth of HMOs within Michigan.	Prior to 1990	***Retain, policy is still relevant.***
MANAGED CARE	**Long-Term Psychotherapy** MSMS opposes arbitrary establishment of the number of long-term psychotherapy sessions a patient may receive.	Res93-95A	***Retain, policy is still relevant.***
MANAGED CARE	**Managed Care Contract Panel** MSMS supports elimination of medical staff membership/privileges as a requirement for participation in a managed care contract panel, as long as the organization has in place a process of providing continuity of care.	Res11-97A	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
MANAGED CARE	**Medical Director Oversight** MSMS supports Board of Medicine jurisdiction over health plan medical directors. MSMS opposes using medical liability as a legal remedy against medical directors of health maintenance organizations.	Board-Jan99 – Edited 2005	***Retain, policy is still relevant.***
MANAGED CARE	**Non-physician Gatekeepers Pre-empting Medical and Treatment Plans of Emergency Room Physicians** MSMS opposes protocols that allow non-physician gatekeepers to pre-empt the medical decisions and treatment plan of emergency medical situations.	Res58-94A	***Retain, policy is still relevant.***
MANAGED CARE	**Periodic Interim Payments for Prenatal Care** MSMS supports a system for periodic interim payments from major managed care companies and other third-party payers for prenatal care.	Res15-90A – Edited 1998	***Retain, policy is still relevant.***
MANAGED CARE	**Responsibility to Explain Health Care Contracts** MSMS supports requiring all health insurance and managed care plans to explain in clear and familiar terms all pertinent information about the health plan to prospective purchasers and enrollees.	Res14-97A	***Retain, policy is still relevant.***
MATERNAL AND INFANT HEALTH	**Alcohol, Tobacco and Other Drugs (ATOD) Screening of Pregnant Women by Primary Physicians** MSMS encourages physicians to conduct alcohol, tobacco and other drug (ATOD) assessment of pregnant women as a health initiative in Michigan.	Res101-97A	***Retain, concept behind policy is still relevant; however, modify policy to read as follows:*** ***Alcohol, Tobacco and Substance Use Disorder Screening of Pregnant Women by Primary Physicians*** *MSMS encourages physicians to routinely inquire about alcohol, tobacco, and other substance use in the course of providing prenatal care.* ***Rationale:*** *The edits remove the reference to a health initiative as this is a common practice.*

Index	Policy	Year	Recommendation
MATERNAL AND INFANT HEALTH	**Drive-through Deliveries** MSMS supports post-delivery, inpatient hospital services for a mother and her newly born child for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section, unless determined otherwise by the mother, her physician or other health care provider.	Res49-96A	***Retain, the concept behind the policy is still relevant; however, modify the title and text to read as follows:*** ***Post-partum Inpatient Care*** *MSMS supports health insurance coverage of post-delivery, inpatient hospital services for a mother and her newly born child for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section, unless determined otherwise by the mother, her physician or other health care provider.* ***Rationale:*** *The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) is a federal law that affects the length of time a mother and newborn child are covered for a hospital stay in connection with childbirth. In general, group health plans and health insurance issuers that are subject to NMHPA may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The mother and her physicians may choose a shorter stay if that is the patient's choice and medically appropriate.*
MATERNAL AND INFANT HEALTH	**Free-Standing Birth Centers** MSMS opposes freestanding birth centers in Michigan.	Res34-99A	***Retain, policy is still relevant.***
MATERNAL AND INFANT HEALTH	**Vaginal Birth After Cesarean (VBAC) Safety** MSMS is opposed to mandatory trials of labor for all women with previous cesarean births.	Res126-99A	***Retain, policy is still relevant.***
MEDICAID	**Equitable Medicaid Reimbursement** MSMS opposes all cuts in Medicaid reimbursement budgets and supports an increase in payments to a level that covers physician and hospital costs.	Res99-91A – Amended 1993 – Edited 1998	***Retain, policy is still relevant.***
MEDICAID	**Medicaid Funding** The state of Michigan should fund abortions for Medicaid patients deemed necessary by a physician.	Prior to 1990) – Edited Board Action Report #5, re Res63-11	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
MEDICAID	**Uniform Statewide Medicaid Rules** MSMS supports implementation of uniform statewide Medicaid contract rules.	Board-Sept97	***Retain, policy is still relevant.***
MEDICAID	**Preventive Services** Preventive health services such as physical examinations, well-baby visits, necessary immunizations and family planning services should be included in the Medicaid program.	Prior to 1990 – Edited 1998	***Retain, the policy concept is still relevant, but modify to read as follows:*** ***Preventive Services*** *MSMS supports the inclusion of preventive health services including, but not limited to, physical examinations, well-baby visits, necessary immunizations, and family planning services in the Medicaid program.* ***Rationale:*** *Medicaid currently covers preventive health services.*
MEDICAL EDUCATION & TRAINING	**American Citizens Enrolled in Medical Schools Abroad** MSMS opposes freestanding clinical education by hospitals in our state for American citizens enrolled in medical schools abroad. For the purposes of this policy, "freestanding" is defined as a clinical education offered without the supervision of a medical school in the United States or Canada.	Prior to 1990 – Edited 2005	***Retain, policy is still relevant.***
MEDICAL EDUCATION & TRAINING	**Automatic Eligibility for Licensure Limited to Graduates from Medical Schools which Meet LCME Standards** Only graduates from medical schools which meet standards established by the Liaison Committee for Medical Education should be automatically eligible for licensure as medical doctors in Michigan.	Prior to 1990	***Retain, policy is still relevant; however, modify to read as follows:*** ***Automatic Eligibility for Licensure Limited to Graduates from Medical Schools which Meet LCME Standards*** *Only graduates from medical schools which meet standards established by the Liaison Committee on Medical Education should be automatically eligible for licensure as medical doctors in Michigan.* ***Rationale:*** *The entity name needs to be corrected to "Liaison Committee on Medical Education."*

Index	Policy	Year	Recommendation
MEDICAL EDUCATION & TRAINING	**Defense of Diversity in Medical Education** MSMS supports the American Medical Association policies that promote increasing the number of minority applicants to medical schools.	Res42-04A	***Retain, policy is still relevant; however, update language to read as follows:*** ***Defense of Diversity in Medical Education*** *MSMS supports the American Medical Association policies that promote increasing the number of underrepresented groups to medical schools.* ***Rationale:*** *This language more accurately reflects current AMA policy.*
MEDICAL EDUCATION & TRAINING	**Diversity and Equality of Opportunity in Admissions to Michigan's Medical Colleges** MSMS supports and encourages Michigan's medical colleges to consider the socioeconomic status of applicants when evaluating and deciding admissions to academic programs.	Res54-07A	***Retain, policy is still relevant.***
MEDICAL EDUCATION & TRAINING	**Exploring Options to Protect Medical Students from Potential Future Unexpected Mid-Year and Retroactive Tuition Increases** MSMS opposes mid-year or retroactive increases in tuition for students of medical and related health professional schools in the state of Michigan.	Res50-03A	***Retain, policy is still relevant.***
MEDICAL EDUCATION & TRAINING	**Financial Aid for Medical Students** Adequate financial aid systems should be available for financially needy medical students.	Prior to 1990	***Retain, policy is still relevant.***
MEDICAL EDUCATION & TRAINING	**Medical School Curriculum** MSMS supports medical school facilities educating medical students on the management of stress, exercise and nutrition.	Res29-90A) – Edited 1998	***Retain, policy is still relevant.***
MEDICAL EDUCATION & TRAINING	**Medical School Debt Forgiveness** MSMS supports the principle of debt forgiveness for students of Michigan medical schools in return for service in primary care in the state of Michigan.	Res90-10A	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
MEDICAL EDUCATION & TRAINING	**New Medical Schools in Michigan** MSMS urges the state of Michigan to perform a thorough prospective study on the effect of proposed medical schools on existing medical schools before any new medical schools are founded in Michigan and urges state officials to conduct a study on the impact of current and new medical schools, existing residency training positions, and the effect on international medical graduates on the future supply of physicians in Michigan.	Res89-08A	***Retain, policy is still relevant.***
MEDICAL EDUCATION & TRAINING	**Opposition to Centralized Postgraduate Medical Education** MSMS supports a pluralistic system of postgraduate medical education for house officer training and opposes the mandatory centralization of postgraduate medical training under the auspices of the nation's only to accredited medical schools.	Prior to 1990	***Retain, but modify to read as follows:*** ***Opposition to Centralized Postgraduate Medical Education*** *MSMS opposes mandatory centralization of postgraduate medical training only to accredited medical schools.* ***Rationale:*** *The language was updated to simplify the policy with more current verbiage.*
MEDICAL EDUCATION & TRAINING	**Residency Review Committee Representation** Community hospital physician-educators should be represented on residency review committees.	Prior to 1990	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Arbitration Support** MSMS supports arbitration as a means of resolving medical liability disputes.	Prior to 1990 – Edited 2005	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Attorneys Not Immune** Attorneys should not be immune from civil suits arising from non-meritorious medical liability lawsuits.	Prior to 1990 – Edited 2005	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Ceiling on Awards for Pain and Suffering** MSMS believes actual damages should be awarded in a proven medical liability case. Ceilings on awards for pain and suffering should be maintained.	Prior to 1990 – Edited 1998, 2005	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Continuous Study of Medical Liability** MSMS and Michigan's medical liability insurance carriers should monitor the current and evolving medical liability situation and study alternatives to the tort system.	Prior to 1990 – Edited 1998, 2005	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
MEDICAL LIABILITY	**Court Costs and Legal Fees in Non-meritorious Suits** MSMS supports court rules that would award all legal and court costs together with punitive damages of the defendant in non-meritorious suits against physicians, hospital and significant others.	Prior to 1990 – Edited 1998	***Retain, policy is still relevant. However, modify to read as follows:*** ***Court Costs and Legal Fees in Non-meritorious Suits*** *MSMS supports court rules that would award all legal and court costs together with punitive damages of the defendant in non-meritorious suits against physicians, hospitals, and significant others.* ***Rationale:*** *Technical change - "hospital" to "hospitals,".*
MEDICAL LIABILITY	**Driving Recommendations in Patients with Epilepsy** MSMS supports protection for physicians from any civil or criminal liability for their opinions and recommendations to the Michigan Secretary of State regarding patients with epilepsy.	Res57-11	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Exempt Physicians Providing Pro Bono Health Care to Uninsured Patients from Legal Action and Insurance Penalties** MSMS supports the exemption of physicians providing pro bono health care to uninsured patients at their practice sites from legal action, including medico-legal and criminal charges stemming from the care of pro bono-treated patients.	Res82-10A	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
MEDICAL LIABILITY	**Expert Plaintiffs Witness Testimony Review Service** MSMS supports policies that permit the use of peer review of expert witness testimony with the expectation that deliberately false, fraudulent, or deceptive testimony be appropriately sanctioned by MSMS, the respective specialty society, and the Board of Medicine.	Res15-06A	***Retain, policy is still relevant, and modify to read as follows to reflect the fact that the MSMS and other professional associations have no jurisdiction over non-members and that DOs are regulated by the Board of Osteopathic Medicine and Surgery:*** ***Expert Plaintiffs Witness Testimony Review Service*** *MSMS supports policies that permit the use of peer review of expert witness testimony with the expectation that deliberately false, fraudulent, or deceptive testimony be appropriately sanctioned by MSMS and the respective specialty society, if applicable, and the Board of Medicine or Board of Osteopathic Medicine and Surgery.*
MEDICAL LIABILITY	**Expert Witness Monitoring** In an attempt to assure competency of expert medical witnesses, the appropriate component medical society and/or specialty society will be requested to monitor the testimony or review the deposition and render a written report to MSMS on the quality of the testimony for its subsequent review and appropriate action.	Prior to 1990	***Sunset policy.*** ***Rationale:*** *This practice no longer exists, component and specialty societies are unlikely to have the capacity to monitor and report on depositions, and MSMS does not have a mechanism in place to accept or act on such reports.*
MEDICAL LIABILITY	**Expert Witness Qualifications in All Courts** MSMS supports the position that the qualifications for an expert witness established in Public Act 78 of 1993 be used in all legal proceedings against health care professionals.	Res115-00A	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Good Samaritan Protection** MSMS supports legal protection for doctors, nurses, and para-medical personnel who assist travelers experiencing medical problems.	Prior to 1990	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Gross Negligence Standard for EMTALA Related Care** MSMS supports a standard of gross negligence on all Emergency Medical Treatment and Active Labor Act related care.	Res61-11	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
MEDICAL LIABILITY	**Hospital Requirements for Medical Liability Insurance** It is appropriate that practicing physicians carry medical liability insurance for themselves and their patients. MSMS opposes unilateral arbitrary hospital governing board edicts that mandate medical liability coverage as a requirement of hospital staff membership when these edicts are passed without medical staff approval or acceptance. The decision to require medical liability insurance as a requisite for hospital medical staff privileges and the limits of such insurance coverage should be a decision mutually agreed upon by the hospital medical staff and the hospital board of trustees. Physicians who are unable to obtain medical liability insurance and who are otherwise in good standing with the Michigan Board of Medicine, hospital and medical staff should not automatically be denied hospital privileges.	Prior to 1990 – Edited 1998, 2005	***Retain, policy is still relevant; however, modify to read as follows:*** ***Hospital Requirements for Medical Liability Insurance*** *It is appropriate that practicing physicians carry medical liability insurance for themselves and their patients.* *MSMS opposes unilateral arbitrary hospital governing board edicts that mandate medical liability coverage as a requirement of hospital staff membership when these edicts are passed without medical staff approval or acceptance.* *The decision to require medical liability insurance as a requisite for hospital medical staff privileges and the limits of such insurance coverage should be a decision mutually agreed upon by the hospital medical staff and the hospital board of trustees.* *Physicians who are unable to obtain medical liability insurance and who are otherwise in good standing with the Michigan Board of Medicine or the Michigan Board of Osteopathic Medicine and Surgery, hospital and medical staff should not automatically be denied hospital privileges.* ***Rationale:*** *The proposed edit adds "or Michigan Board of Osteopathic Medicine and Surgery" after "Michigan Board of Medicine". Michigan has separate Boards for allopathic and osteopathic physicians, which this policy should recognize.*

Index	Policy	Year	Recommendation
MEDICAL LIABILITY	**Immunity for Disaster Relief** MSMS supports model legislation in Michigan for physicians engaged in disaster relief that provides immunity from civil liability except in instances of willful misconduct and gross negligence.	Res53-09A	***Retain, policy is still relevant; however, modify to read as follows:*** ***Immunity for Disaster Relief*** *MSMS supports the provision of immunity from civil liability, except in instances of willful misconduct and gross negligence, for physicians engaged in disaster relief.* ***Rationale:*** *Reference to model legislation is removed. Michigan's Good Samaritans Act provides immunity for rendering emergency care at the scene of an emergency. Michigan's Emergency Management Act includes immunity provisions for disaster relief efforts.*
MEDICAL LIABILITY	**Immunity – Uncompensated Care** MSMS supports limiting the liability of physicians who provide uncompensated care to patients.	Board-Mar93 – Reaffirmed (Res38-01A)	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Indemnification** MSMS supports indemnifying physicians against medical liability suits arising from the provision of indigent care or the care of Medicaid patients and indemnifying physicians and hospitals when they consent to treat patients in a charitable setting.	Res32-90A, Res49-90A, Res108-91A, & Res29-92A – Amended 1993 – Edited 1998, 2005	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Indemnification for Physicians Treating Indigent Obstetrical Patients** MSMS supports indemnifying medical liability to physicians who care for indigent obstetrical patients.	Prior to 1990) – Amended 1993 – Edited 1998	***Sunset policy.*** ***Rationale:*** *See MSMS policy, Indemnification, above. This policy already includes all patients who are indigent.*
MEDICAL LIABILITY	**Indemnification of Physician Hospital Agents** Hospital administrators and board of trustees should be required to indemnify physicians against civil liability when such physicians are acting as agents for the hospital.	Prior to 1990) – Amended 1993 – Edited 1998	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
MEDICAL LIABILITY	**Insurance Premiums** Premium schedules for medical liability insurance should be based on the actual cost and risk. Physicians' insurance premiums should not be raised merely for their having been named in a medical liability suit.	Prior to 1990	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Liability Immunity/Correctional Facilities** MSMS believes health care workers employed by, or acting under contract, in a state correctional facility, county jail or local police lock-up, should be immune from tort liability for injuries to persons or damages to property caused by the employee in the course of employment or volunteer service while acting on behalf of a governmental agency.	Board-July95	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Mandatory Medical Liability Insurance** MSMS opposes mandatory medical liability insurance for physicians.	Res35-HOD91A – Amended 1993 – Edited 1998, 2005	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Medical Liability Coverage for Medicaid Obstetrical Care** MSMS supports a plan for the Michigan Department of Community Health to assume responsibility for all medical liability for obstetrical care for the Medicaid population.	Prior to 1990) – Edited 1998, 2005	***Retain, policy is still relevant; however, modify to read as follows:*** ***Medical Liability Coverage for Medicaid Obstetrical Care*** *MSMS supports the Michigan Department with jurisdiction over the state's Medicaid program assuming responsibility for all medical liability for obstetrical care for persons enrolled in Medicaid.* ***Rationale:*** *Removes the name of the department as this changes over time and uses first person language.*
MEDICAL LIABILITY	**Medical Liability Demonstration Project** MSMS supports the practice parameters and risk management protocols as an affirmative defense in medical liability cases and requiring medical liability insurers to report claims data related to physician participation.	Board-March93	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
MEDICAL LIABILITY	**Medical Liability: Sporting Events** MSMS supports the exemption of physicians and other health care personnel from liability under certain circumstances related to sporting events.	Board-July95	***Retain, policy is still relevant; however, modify the language to read as follows:*** ***Medical Liability: Sporting Events*** *MSMS supports the exemption of physicians and other health care personnel from liability related to sporting events except acts or omissions that amount to gross negligence or willful and wanton misconduct and except acts or omissions that are outside the scope of the license held by the physician or other health care personnel.* ***Rationale:*** *Language is updated to reflect what's in Michigan's statute.*
MEDICAL LIABILITY	**Monitoring the Judiciary** MSMS supports monitoring decisions at all levels of the state judiciary regarding medical liability.	Prior to 1990) – Edited 1998, 2005	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Permit Annuity Payments of Medical Liability Awards** Payments could be made over a period of time, for corrective/rehabilitative services, as an alternative to lump sum payments when medical liability suits are settled in a court of law as are currently allowed by Michigan's Arbitration Law.	Prior to 1990 – Edited 2005	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Physicians in Health Facilities/Agencies Partial Medical Liability Insurance Reimbursement** MSMS opposes establishment of a state fund from which physicians in medical service entities will be reimbursed for a portion of their medical liability insurance premium that equals the percentage of all medical services rendered for which they received minimal compensation from Medicaid.	Board-July95 – Edited 2005	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Physician Liability Coverage for Mandatory Hospital Clinic and Emergency Department Service** MSMS supports hospitals providing liability coverage for the physicians rendering services to unattended patients in hospital outpatient clinics and emergency departments who are not part of the physician's practice.	Res65-95A	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
MEDICAL LIABILITY	**Premium Notices** MSMS supports the promulgation of rules by the Michigan Insurance Commission to demand premium notification to policyholders at least thirty (30) days prior to renewal date for medical liability insurance policies.	Res10-90A – Edited 2005	***Retain, policy is still relevant; however, modify to read as follows:*** ***Premium Notices*** *MSMS supports premium notification to policyholders at least thirty (30) days prior to renewal date for medical liability insurance policies.*
MEDICAL LIABILITY	**State of Michigan Medical Liability Coverage for Volunteer Physicians** MSMS supports the concept that the state of Michigan should provide medical liability insurance coverage for physicians who volunteer their professional services.	Res67-95A	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Statistical Disclosure of Medical Liability** All insurers including self-insured hospitals should disclose pertinent statistical information on claims, settlement and judgment. Such information should be available for public review.	Prior to 1990 – Edited 2005	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Subrogation Lien Rights** MSMS supports banning subrogation lien rights by third party health insurers.	Res71-91A – Edited 1998	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Support for Physicians' Counter Suits in Nuisance Claims** MSMS should support physicians who are considering counter suits against a plaintiff or attorney, or both, following medical liability cases totally without merit. As MSMS cannot itself bring such a suit, it could assist the physician and his attorney by providing expert medical and legal review and research to support and encourage aggrieved defendant physicians in bringing counter actions.	Prior to 1990 – Edited 2005	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Tort Reform and the Tobacco Industry** MSMS opposes the exclusion of tobacco companies or tobacco products from liability.	Res1-95A	***Retain, policy is still relevant.***
MEDICAL LIABILITY	**Voluntary and Binding Arbitration** There should be multiple systems for handling medical liability claims by mediation, binding arbitration, and courtroom litigation.	Prior to 1990 – Edited 2005	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
MEDICAL RECORDS, CONFIDENTIALITY, AND PRIVILEGED COMMUNICATION	**Patients' Rights to Medical Records** MSMS supports the Michigan Attorney General Opinion No. 5125 in the matter of patients' rights to medical records which states that patients have the right to have a copy of their medical record, but not the original at a reasonable charge.	Board Action Report #5, 2000 HOD, re Res11-99A	***Retain, policy is still relevant.***
MEDICAL RECORDS, CONFIDENTIALITY, AND PRIVILEGED COMMUNICATION	**Physician-Patient Relationship Confidential** MSMS, believing the confidential physician-patient relationship is essential for proper diagnosis and medical treatment, opposes changes in court rules or statutes to waive this privilege when a lawsuit is initiated.	Prior to 1990	***Retain, policy is still relevant.***
MEDICAL RECORDS, CONFIDENTIALITY, AND PRIVILEGED COMMUNICATION	**Privileged Communications** MSMS believes in the confidentiality of medical histories and records held by physicians and hospitals and will work to strengthen Michigan laws and court rules to safeguard this.	Prior to 1990	***Retain, policy is still relevant.***
MEDICAL RECORDS, CONFIDENTIALITY, AND PRIVILEGED COMMUNICATION	**Release of Medical Records and Privacy of Medical Examiner Records** MSMS supports the exemption of the Medical Examiner autopsy reports from the Michigan Freedom of Information Act so as to more evenly balance the privacy of a deceased individual and his/her family against the public's right to examine autopsy documents, and to ensure confidentiality of such records.	Res44-94A	***Retain, policy is still relevant.***
MEDICAL RECORDS, CONFIDENTIALITY, AND PRIVILEGED COMMUNICATION	**Privacy and Confidentiality of Medical Records** MSMS supports the confidentiality and security of patient medical records.	Res18-95A	***Retain, policy is still relevant.***
MEDICARE	**Center for Health Outcomes and Evaluation** MSMS supports in principle the Center for Health Outcomes and Evaluation and recommends MSMS work intensively to impact the organization and process of the Center as it applies to the Medicare practice of Michigan physicians.	Board-Jan93	***Sunset policy.*** ***Rationale:*** *The Center for Health Outcomes and Evaluation no longer exists.*
MEDICARE	**Medicare Fraud and Abuse Law** MSMS opposes the private use of qui tam plaintiff provisions.	Res41-99A	***Retain, policy is still relevant.***

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MEDICARE	**Medicare Payment for Diagnostic Medical Tests** MSMS supports allowing payment for diagnostic tests at a frequency deemed necessary by a beneficiary's personal physician and within the boundaries of generally accepted standards of practice set by the medical profession.	Res2-97A	***Retain, policy is still relevant.***
MEDICARE	**Outpatient Reimbursement Parity** MSMS opposes co-payments by beneficiaries (Medicare patients) to hospital outpatient departments and hospital-owned physician practices above those the beneficiaries would have to pay at a private practitioner's office.	Res79-98A	***Retain, policy is still relevant.***
MEDICARE	**Payment of Medicare Deductible and Coinsurance Amount** MSMS advocates requiring any insurer, health maintenance organization, third party administrator and network manager in the state of Michigan to pay the coinsurance and deductible amounts up to the Medicare fee schedule.	Res104-97A	***Retain, policy is still relevant.***
MEDICARE	**Prescription Coverage by Medicare** MSMS supports prescription coverage for patients in the Medicare program.	Res59-99A	***Retain, policy is still relevant.***
MEDICARE	**Reduction of Physician Payment and Participation by CMS** MSMS opposes the Centers for Medicare & Medicaid Services (CMS) proposals that threaten to reduce physician payment and participation with the Medicare program.	Board-July97 – Edited 2005	***Retain, policy is still relevant, but modify to read as follows:*** ***Reduction of Physician Payment and Participation under Medicare*** *MSMS opposes proposals that threaten to reduce physician payment and participation with the Medicare program.*
MEMBERSHIP	**Advise Physicians Regarding the Importance of Organized Medicine** MSMS advocates educating Michigan physicians regarding the value of membership in their respective county medical societies, MSMS and the AMA.	Res17-96A	***Retain, policy is still relevant.***
MEMBERSHIP	**AMA Statement of Collaborative Intent** MSMS endorses the AMA Statement of Collaborative Intent. (See Addendum K in website version)	Board-Sep97	***Retain, policy is still relevant; however, Addendum K needs to be updated to reflect the current Statement of Collaborative Intent G-620.030.***

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MEMBERSHIP	**Designation of State and County Medical Society for Retired Physician Membership** MSMS permits a retired physician member of the federation of medicine to designate the county and state medical society where the physician last belonged as the tally and credit site for membership regardless of the physician's retirement address.	Res53-96A	***Retain, policy is still relevant.***
MEMBERSHIP	**MDPAC** MSMS supports MDPAC and recommends that its annual dues billing be separately identified on the dues billing form.	Res112-91A – Edited 1993	***Retain, policy is still relevant.***
MEMBERSHIP	**Unified Membership** MSMS supports the concept of unified membership in MSMS, the component society and the AMA.	Prior to 1990	***Retain, policy is still relevant.***
MENTAL HEALTH	**Director of MDCH Mental Health Agency** MSMS supports the requirement that the Director of the Mental Health Agency of the Michigan Department of Community Health be a physician who is licensed in the state of Michigan.	Res96-95A – Edited 1998	***Retain, policy is still relevant; however, modify to read as follows:*** ***Director of Michigan's Mental Health Services*** *MSMS supports the requirement that the individual serving as the Director of the state agency or division charged with the oversight of mental health services in Michigan be a physician who is licensed in the state of Michigan.* ***Rationale:*** *The specific department name is removed to avoid having to update policy each time a department or agency name is changed.*
MENTAL HEALTH	**Increasing Funding for Mental Health Hospitals** MSMS supports restoration of budget cuts and increased expenditures in the public mental health hospital system so that quality care again may be provided by upgrading staff levels to recommended requirements. MSMS supports increased state funding for psychiatric research so as to develop more efficacious treatment for the mentally ill. MSMS supports efforts to assure adequate treatment in Michigan Department of Community Health mental health facilities as required by state law.	Prior to 1990	***Retain, as policy concept is still relevant; however, modify to read as follows:*** ***Funding for Mental Health Hospitals*** *MSMS supports actuarily sound funding of Michigan's public mental health hospital system to ensure the delivery of quality care and appropriate staff levels. Additionally, MSMS supports increased state funding for psychiatric research so as to develop more efficacious treatment for persons with mental illness.*

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MENTAL HEALTH	**Needs of Dementia Patients** MSMS supports public funding for diagnostic and assessment services, a registry and a post-mortem examination program to meet the needs to patients with dementia and their families.	Res95-90A – Edited 1998	***Retain, policy is still relevant; however, modify to read as follows:*** ***Needs of Dementia Patients*** *MSMS supports public funding for diagnostic and assessment services, a registry and a post-mortem examination program to meet the needs of patients with dementia and their families.* ***Rationale:*** *Technical change - "the needs to" to "the needs of".*
MENTAL HEALTH	**Parity for Mental Health** MSMS encourages covering the treatment of mental illness to the same limits applied to the treatment of all other non-psychiatric diagnoses.	Res86-96A – Reaffirmed Res19-02A	***Retain, policy is still relevant.***
MENTAL HEALTH	**Requirements for Reporting or Hospitalizing Suicidal Patients** MSMS supports using the same requirements for reporting or hospitalizing suicidal patients as the Michigan law for patients who have the intent of inflicting physical violence and who have the ability to carry out that treat in the foreseeable future.	Res91-95A	***Retain, policy is still relevant; however, modify to read as follows:*** ***Requirements for Reporting or Hospitalizing Patients Who Attempt Suicide*** *MSMS supports using the same requirements for reporting or hospitalizing patients who attempt suicide as the Michigan law for patients who have the intent of inflicting physical violence and who have the ability to carry out that threat in the foreseeable future.* ***Rationale:*** *Technical changes - incorporate person-first language and correct a spelling error.*

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MENTAL HEALTH	**Requiring Physician Visits for a Patient in Seclusion or Restraints** MSMS supports the concept that assessment and management of hospitalized patients in seclusion or restraints requires no more than once daily face-to-face assessment by the patient's physician unless individual conditions warrant additional visits.	Res63-97A	**Retain, but modify to read as follows to reflect minimum expected standards:** ***Requiring Physician Visits for a Patient in Seclusion or Restraints*** *MSMS believes that assessment and management of hospitalized patients in seclusion or restraints requires at least once daily face-to-face assessment by the patient's physician, who may determine the individual's condition warrants additional visits.* ***Rationale:*** *See AMA Code of Ethics "1.2.7 Use of Restraints" and AMA policy CMS Interim Final Rule on the Use of Seclusion and Restraints H-280.952.*
NUTRITION	**Banning the Use of Trans Fats in Restaurants and Bakeries in the U.S.** MSMS opposes the use of trans fats in restaurants and bakeries in Michigan.	Res49-08A	***Retain, policy is still relevant.***
NUTRITION	**Enhancing Public Safety Relation to the Food Industry** MSMS supports, where appropriate, Michigan-based community health initiatives or educational programs that promote public awareness of food safety and the source of food products available to consumers.	Res36-10A	***Retain, policy is still relevant.***
NUTRITION	**Hazards of Energy Beverages, Their Abuse and Regulation** MSMS supports the regulation of the sale and distribution of energy beverages to protect the public from their deleterious effects.	Res42-11	***Retain, policy is still relevant.***
NUTRITION	**Junk Food in Schools** MSMS supports working toward the total elimination of selling junk food as defined by the USDA in elementary, middle, and high schools in the state of Michigan.	Res44-06A	***Retain, policy is still relevant.***
NUTRITION	**Nutrition Information Availability in Restaurants** MSMS supports requiring that clear nutrition information be provided for items sold in restaurants in Michigan.	Res72-10A	***Retain, policy is still relevant.***

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NUTRITION	**Nutritional Label Education** MSMS supports nutrition education programs that would promote the involvement of parents in their children's nutrition education.	Res52-07A	***Retain, policy is still relevant.***
ORGAN DONATION AND TRANSPLANT	**"Mandated Choice" Policy** MSMS supports a "mandated choice" policy requiring people to indicate whether or not they consent to be organ donors when they renew a driver's license, file a tax return or perform other tasks required by the state.	Res58-00A	***Retain, policy is still relevant.***
ORGAN DONATION AND TRANSPLANT	**Organ Donations** MSMS supports efforts which 1) make it easier to donate body parts upon one's death and require individuals to make a deliberate decision to donate their body parts or not to donate their body parts upon their death, 2) appropriately address the issue of parental consent for minors who wish to be organ donors and 3) ensure that recognized national and state procurement societies are utilized for organ donation and recipient selection.	Board-July96	***Retain, policy is still relevant.***
ORGAN DONATION AND TRANSPLANT	**Organ Salvage Programs** MSMS supports permitting medical examiner systems to participate in organ salvage programs.	Prior to 1990 – Edited 1998	***Retain, policy is still relevant.***
PAIN MANAGEMENT	**Pain Management Education and CME Credit** MSMS supports the concept of requiring physicians to be educated in pain management techniques but opposes mandating this type of education through CME credit.	Board-March94 – Reaffirmed (Board-Oct05)	***Retain, policy is still relevant.***

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PATIENT'S BILL OF RIGHTS	**Statement of Patient's Rights** 1. Each patient must have freedom of choice of physician and each physician must be free to offer his/her services to all patients. 2. The patient's physician must be free of controls and restrictions that interfere with providing the highest quality of medical care. 3. The freedoms we believe necessary for patients and physicians should apply to all aspects of medical care. 4. The quality of a patient's medical care must be judged by practicing physicians, responsible only to their own hospital staffs and medical association. 5. The primacy of a physician's responsibility to his patient cannot be delegated or usurped by a hospital or other corporation. 6. Any plan for financing medical costs must recognize variables in cost of provision, and kinds of service; and must not interfere with the individual patient-physician contract. 7. The principle of reciprocal doctor-patient responsibility must be preserved.	Prior to 1990	***Retain, policy is still relevant.***
PEER REVIEW	**Accountability of Utilization Review Firms** Utilization review firms employed by insurance companies should be held accountable for medical decisions based on their review.	Res14-92A	***Retain, policy is still relevant.***
PEER REVIEW	**Medicare Peer Review** A Michigan-based physician-directed organization should operate as the Medicare peer review organization, if administratively and financially feasible.	Prior to 1990	***Retain, policy is still relevant.***
PEER REVIEW	**Opposition to Release of Peer Review Records** Peer review records should not be released under the Freedom of Information Act.	Prior to 1990	***Retain, policy is still relevant.***
PEER REVIEW	**Peer Review – Physicians Held Harmless** Physicians should be held harmless as they meet their peer review responsibilities. Hospitals should be advised to introduce "hold harmless" language into their bylaws.	Prior to 1990 – Edited 1998	***Retain, policy is still relevant.***

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PEER REVIEW	**Peer Review Protection for Physician Organizations (POs) and Group Practices** MSMS believes physician organizations (POs) and group practices peer review should have the same protection afforded hospital medical staff peer review, and state and county (local) medical societies.	Res65-97A	***Retain, policy is still relevant.***
PEER REVIEW	**Professional Review Organization Peer Review** MSMS recommends that professional review organizations accept national medical specialty society guidelines or parameters for review processes, where they exist, and that critiques be by peers in the same specialty.	Res19-97A	***Retain, policy is still relevant.***
PEER REVIEW	**Scrutiny of MPRO Review and Denial Process** MSMS supports interaction between county societies and local hospital medical staffs in monitoring Michigan Peer Review Organization (MPRO) activities at the county level. MSMS supports member participation as physician reviewers in all peer review activities.	Prior to 1990 – Edited 1998	***Retain, policy is still relevant.***
PEER REVIEW	**Utilization Review in the Practice of Medicine** MSMS advocates that only licensed practicing physicians in the same specialty may perform utilization review for health plans.	Res29-97A	***Retain, policy is still relevant.***
PENSION PLANS	**Exemption from Bankruptcy Proceedings** MSMS supports legal exemption of pension/profit-sharing plans from bankruptcy proceedings.	Prior to 1990	***Retain, policy is still relevant.***
PHARMACY AND PHARMACEUTICALS	**Ban Lindane** MSMS supports the ban of lindane in the state of Michigan.	Res33-05A	***Retain, policy is still relevant.***
PHARMACY AND PHARMACEUTICALS	**Closed Drug Formulary** No state agency should be empowered to develop a closed drug formulary that makes unavailable to the indigent any medication that is available to the rest of the population.	Prior to 1990	***Retain, policy is still relevant; however, modify to read as follows:*** ***Closed Drug Formulary*** *No state agency should be empowered to develop a closed drug formulary that makes any medications that are available to the rest of the population, but unavailable to persons who are publicly insured.* ***Rationale:*** *Technical change to use person-first and less stigmatizing language.*

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PHARMACY AND PHARMACEUTICALS	**Food and Drug Administration Approval of Generic Biologics** MSMS supports Food and Drug Administration approval of generic biologics.	Board Action Report #2, 2011 HOD, re Res3-10A	***Retain, policy is still relevant.***
PHARMACY AND PHARMACEUTICALS	**Guidelines for Drug Screening in the Workplace** MSMS adopts the guidelines for "Drug Screening in the Workplace" prepared by the American Occupational Medical Association. (See Addendum C in website version)	Prior to 1990 – Reaffirmed 1998	***Retain, policy is still relevant, and modify to read as follows:*** ***Guidelines for Drug Screening in the Workplace*** *MSMS adopts the American College of Occupational and Environmental Medicine Position Statement on the Ethical Aspects of Drug Testing.* **Update Addendum C to:** https://acoem.org/acoem/media/PDF-Library/Position-Statement-Ethical-Aspects-Drug-Testing-2019.pdf ***Rationale:*** *Changes necessary to recognize updated guidelines and organization name.*
PHARMACY AND PHARMACEUTICALS	**Marijuana for Medical Use** MSMS supports the use of cannabinoids by routes other than smoking for medical uses, for which scientific evidence supports efficacy equal or superior to established therapies and encourages further research to elucidate the efficacy of cannabinoids in various medical conditions and its optimal dosage and route of delivery.	Res59-08A	***Retain, policy is still relevant.***
PHARMACY AND PHARMACEUTICALS	**Misuse of DEA Numbers** MSMS opposes any use of the DEA number except when in prescribing controlled substances.	Prior to 1990	***Retain, policy is still relevant.***
PHARMACY AND PHARMACEUTICALS	**Oncology Advisory Panel** MSMS supports the establishment of an oncology advisory panel to advise all health insurance carriers about the efficacy, appropriateness and routes of administration for off-label indications of U.S. Food and Drug Administration-approved drugs used in anti-neoplastic therapy.	Board-July95	***Retain, policy is still relevant.***

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PHARMACY AND PHARMACEUTICALS	**Out-of-State Prescriptions** MSMS supports the concept of prohibiting a pharmacist, a dispensing prescriber, or any other person from dispensing or repackaging expired medication. MSMS supports the concept of allowing pharmacists in Michigan to fill prescriptions for drugs, other than controlled substances, written by a physician in another state.	Board-Nov95	***Retain, policy is still relevant.***
PHARMACY AND PHARMACEUTICALS	**Pharmacy: Medication Information** MSMS supports the efforts of pharmacies to educate patients and prevent medication-induced problems.	Res110-97A	***Retain, policy is still relevant.***
PHARMACY AND PHARMACEUTICALS	**Privacy of Physician Prescriber Data** MSMS supports prohibiting pharmacies from providing physician-specific prescribing data to pharmaceutical companies and other non-regulatory entities that are not involved in an individual patient's care.	Res67-10A	***Retain, policy is still relevant.***
PHARMACY AND PHARMACEUTICALS	**Purity and Safety Homeopathic/Naturopathic Products** MSMS supports the oversight of homeopathic/naturopathic products by the Food and Drug Administration or other appropriate agencies, especially with regards to purity and safety.	Res57-10A	***Retain, policy is still relevant.***
PHARMACY AND PHARMACEUTICALS	**Redistribution of Unused Sealed Medications** MSMS supports the return of sealed, unused, unexpired medications to a collection site for distribution to those in need of the medication and are unable to pay for the medications.	Res25-05A	***Retain, policy is still relevant.***
PHARMACY AND PHARMACEUTICALS	**Require Prescription for Ephedrine and Pseudoephedrine** MSMS supports limiting the availability of ephedrine and pseudoephedrine for illicit purposes while maintaining legitimate patient and physician access to this medication.	Res9-11	***Retain, policy is still relevant.***
PHARMACY AND PHARMACEUTICALS	**Right of Physician to Dispense** MSMS actively supports the right of physicians to dispense medication.	Prior to 1990	***Retain, policy is still relevant.***

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PHARMACY AND PHARMACEUTICALS	**Unproven Therapeutic Substances** MSMS opposes substituting political considerations for scientific investigation and conclusions for therapeutic substances. However, if political considerations support unproven medical decisions and/or principles, they should be evaluated on an experimental basis following standard experimental drug protocol or as approved by the FDA.	Prior to 1990 – Edited 1998	***Retain, policy is still relevant.***

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PHYSICIAN BUSINESS AND LEGAL RELATIONS	**Physician-Business Coalition Recommendations** MSMS supports the following physician and business coalition initiatives: ● Facilitate physician-business dialogue and interaction. ● Encourage and promote effective physician participation in business/health planning coalition activities. ● Encourage the formation of business coalitions to allow physicians to concentrate their efforts with local businesses to discuss issues such as direct contracting, quality measures, and local control of health care delivery. ● Develop effective MSMS staff interaction with the staffs of business/health planning coalitions. ● Serve as a resource center for physicians involved in dialogue with employers. ● Educate physicians on the importance of effective communication between physicians and employers. ● Establish contacts with business leaders that can be utilized by developing physician organizations, facilitate discussions between them and offer the resources of the management services organization where appropriate. Designate the MSMS Advisory Committee on Medical Economics as the appropriate body to provide physician input, monitor ongoing activities and identify future needs.	Board-Sep96	***Retain, policy is still relevant; however, modify to read as follows:*** ***Physician-Business Collaboration Recommendations*** *MSMS supports initiatives to support physician and business collaboration, as follows:* ● *Facilitate physician-business dialogue and interaction.* ● *Encourage and promote effective physician participation in business/health planning activities.* ● *Encourage the formation of business coalitions to allow physicians to concentrate their efforts with local businesses to discuss issues such as direct contracting, quality measures, and local control of health care delivery.* ● *Develop effective MSMS staff interaction with the staffs of business/health planning organizations and coalitions.* ● *Serve as a resource center for physicians involved in dialogue with employers.* ● *Educate physicians on the importance of effective communication between physicians and employers.* ● *Establish contacts with business leaders that can be utilized by developing physician organizations, facilitate discussions between them and offer the resources of the management services organization where appropriate.* ***Rationale:*** *Coalition mentioned throughout policy is no longer active. However, the concepts expressed in the policy are still relevant, so it was modified to be more focused to general physician-business collaboration rather than a specific coalition. Also, the last bullet is removed because that committee non longer exists.*

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PHYSICIAN BUSINESS AND LEGAL RELATIONS	**Principles Between Physicians and Lawyers** MSMS endorses the Principles between Physicians and Lawyers. (See Addendum I in website version)	Prior to 1990	***Retain, policy is still relevant.***
PHYSICIAN FEES AND REIMBURSEMENT	**Automobile No-fault Insurance** MSMS opposes the use of the Workers Compensation fee schedule, or other governmental mandated fee schedule, for auto insurance health care services.	Res14-90A and Res86-91A – Edited 1998	***Retain, policy is still relevant.***
PHYSICIAN FEES AND REIMBURSEMENT	**Criteria-based Retrospective Reviews** MSMS supports the following: 1. Any guidelines used by third-party payers must be shared with physicians in an educational mode. 2. Physician input, through MSMS and specialty society representatives, must be included in development of a utilization management program. 3. Guidelines must be based on medical evidence and specialty society guidelines. 4. If prior authorization is obtained from the payer, no retrospective payment denial or recovery should be used. Criteria-based retrospective review for the purpose of denial or recovery of payment is neither cost-effective nor a productive model for improvement.	Substitute Res28-00A, for Res28, 32 & 74-00A	***Retain, policy is still relevant.***
PHYSICIAN FEES AND REIMBURSEMENT	**Direct Patient Financial Participation** Patients should pay a portion of the cost of their medical care.	Prior to 1990 – Edited 1998	***Retain, policy is still relevant.***
PHYSICIAN FEES AND REIMBURSEMENT	**Equal Fee for Equal Service** MSMS upholds the principle of equal fee for equal service.	Prior to 1990	***Retain, policy is still relevant.***
PHYSICIAN FEES AND REIMBURSEMENT	**Equal Payments for Hospital Satellite Clinics and Physicians' Offices** Equal payments should be made for services delivered by hospital free-standing satellite facilities and by physicians' offices.	Prior to 1990 – Edited 1998	***Retain, policy is still relevant.***

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PHYSICIAN FEES AND REIMBURSEMENT	**Exempt Physicians Providing Pro Bono Health Care to Uninsured Patients from Legal Action and Insurance Penalties** MSMS supports allowing physicians to provide pro bono health care to uninsured patients at their practice sites without a subsequent denial of payment for treatment of insured patients.	Res82-10A	***Retain, policy is still relevant.***
PHYSICIAN FEES AND REIMBURSEMENT	**Facility Fee** Third party payers should pay an additional fee for increased overhead expenses for procedures performed in freestanding non- hospital-based ambulatory settings or in the physician's office.	Prior to 1990	***Retain, policy is still relevant.***
PHYSICIAN FEES AND REIMBURSEMENT	**Fee Schedules** MSMS, when appropriate, will actively participate in the development or modification of reimbursement methodologies and governmental fee schedules. MSMS opposes government fee schedules and reimbursement methodologies that were developed without appropriate physician input which limit patient access to quality medical care or unfairly reimburse physicians.	Res65-93A	***Retain, policy is still relevant.***
PHYSICIAN FEES AND REIMBURSEMENT	**Fees for Out-of-State Patients** MSMS supports reimbursement to Michigan physicians for services to out-of-state patients at the fee schedule of their home state.	Res90-95A	***Retain, policy is still relevant.***
PHYSICIAN FEES AND REIMBURSEMENT	**Involuntary Garnishment of Reimbursement by HMOs and Third-Party Carriers** MSMS opposes garnishment of reimbursement or other fees without physician opportunity to first respond to audit questions or allegations before health maintenance organizations or third-party payers decide to impose financial sanctions.	Res97-98A	***Retain, policy is still relevant.***

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PHYSICIAN FEES AND REIMBURSEMENT	**Physician's Right to Bill** Every physician, hospital-based included, has the right to bill patients for the professional component of services irrespective of where those services were rendered. In addition, MSMS supports physicians who strive to preserve the right to establish their own fees without hospital interference, regulation or threat of loss of contract privileges.	Res18-92A – Amended 1993 – Edited 1998	***Retain, policy is still relevant.***
PHYSICIAN FEES AND REIMBURSEMENT	**Reimbursement for Emergency Procedures** MSMS advocates increased reimbursement for procedures done as emergencies because of the increased risk and complications involved in emergency procedures.	Res2-94A	***Retain, policy is still relevant.***
PHYSICIAN FEES AND REIMBURSEMENT	**Retroactive Recovery of Funds Research** MSMS supports equity in the time frames for both the provider community in submitting a health insurance claim and the insurance carriers in seeking retroactive recovery of payments for services rendered.	Res44-11	***Retain, policy is still relevant.***
PHYSICIAN FEES AND REIMBURSEMENT	**Retrospective Revenue Recovery by Third Party Payers** MSMS opposes the policy of third-party payers' retrospective revenue recovery by developing an inventory to collect physician complaints, review policies, and unfavorable appeals to present to legislators and the Insurance Commissioner.	Res39-07A	***Retain, policy is still relevant.***
PHYSICIAN FEES AND REIMBURSEMENT	**Separate Reimbursement for Consultation Fees** MSMS affirms that consultations are services separate from any care rendered thereafter and, therefore, consultation fees are legitimate charges in their own right, whether or not a procedure with a fee occurs afterward, and that consultations should be reimbursed separately from procedure.	Res84-97A	***Retain, policy is still relevant.***
PHYSICIAN FEES AND REIMBURSEMENT	**Suggested Guidelines for Determining Medical/Legal Fees** MSMS endorses the "Suggested Guidelines for Determining Medical/Legal Fees." (See Addendum H in website version)	Prior to 1990	***Retain, policy is still relevant; however, update Addendum H (attached).*** ***Rationale:*** *MSMS Legal Counsel recommended language in Addendum H be updated and redundant language deleted.*

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PHYSICIAN FEES AND REIMBURSEMENT	**Timely Payment for Physicians** MSMS supports legislation promoting timely payment of physicians in a fair and reasonable manner, including payments from all health care insurance companies, HMOs, third-party administrators and other similar entities.	Res49-00A	***Retain, policy is still relevant, and modify to read as follows:*** ***Timely Payment for Physicians*** *MSMS supports timely payment of physicians in a fair and reasonable manner.* ***Rationale:*** *Legislation has passed on this policy, but MSMS still supports the concept.*
PRACTICE SAFETY	**Assaults in Emergency Departments** MSMS supports the vigorous prosecution of assaults upon health care workers during the conduct of their duty regardless of setting and work with the Michigan Health and Hospital Association, individual hospitals, the Michigan Nurses Association and the Michigan Chapter of the American College of Emergency Physicians to implement policies to accomplish this objective.	Board Action Report #6, 2003 HOD, re Res35-02A	***Retain, policy is still relevant.***
PUBLIC HEALTH	**Organized Medicine's Liaison with Public Health** MSMS encourages its component medical societies to develop liaison committees with their local public health departments and participate in local community assessment and improvement programs.	Board-Mar97	***Retain, policy is still relevant.***
PUBLIC HEALTH	**Availability of Latex Condoms in Schools** MSMS is in favor of schools being permitted to dispense devices to prevent sexually transmitted diseases.	Res81-95A	***Retain, policy is still relevant.***
PUBLIC HEALTH	**Confidentiality of HIV Blood Test Results** MSMS supports safeguards to protect the confidentiality of HIV test results.	Res61-97A	***Retain, policy is still relevant.***
PUBLIC HEALTH	**Confirmed HIV Positivity as Sexually Transmitted Disease** HIV positivity, if confirmed, indicates a disease that can be sexually transmitted and should be reported as a sexually transmitted disease.	Prior to 1990 – Edited 1998	***Retain, policy is still relevant.***

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PUBLIC HEALTH	**HIV Testing for Women** MSMS supports the Michigan Department of Community Health's efforts to inform the public about the risks of perinatal HIV transmission and recommends HIV testing for all pregnant women and those considering pregnancy.	Res125-93A	***Retain, policy is still relevant, and modify to read as follows:*** ***HIV Testing in Pregnancy and Pre-conception Care*** *MSMS supports efforts to inform the public about the risks of perinatal HIV transmission and recommends HIV testing for all pregnant women and those considering pregnancy.* *Rationale:*
PUBLIC HEALTH	**Increase Sexually Transmitted Diseases (STDs) Counseling of Adolescents** MSMS encourages physicians, when counseling adolescents, to include counseling on sexually transmitted diseases and AIDS in their interactions.	Res53-93A	***Retain, policy is still relevant.***
PUBLIC HEALTH	**Routine Premarital HIV Testing** MSMS supports premarital HIV testing.	Res58-97A	***Retain, policy is still relevant.***
PUBLIC HEALTH	**Routine Testing for HIV in Medical Care Settings** MSMS supports, promotes, and participates in the establishment and utilization of guidelines for routine HIV testing in medical settings, including the necessary alterations in current Michigan law that will facilitate this step.	Res68-07A	***Retain, policy is still relevant.***

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PUBLIC HEALTH	**Stressing Abstinence to Prevent Sexually Transmitted Diseases (STDs)** MSMS encourages public health departments at local and state levels to stress abstinence as a part of STD prevention programs.	Res56-94A	***Retain, policy is still relevant; however, modify to read as follows:*** ***Stressing Abstinence to Prevent Sexually Transmitted Diseases (STDs)*** *MSMS encourages public health departments at local and state levels to stress abstinence as the best method to prevent STDs while also teaching about contraceptive choices and less dangerous sex as part of STD prevention programs.* ***Rationale:*** *Modified to reflect current best practice. Language modeled after AMA policy, Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968.*
PUBLIC HEALTH	**Biological Disaster Plans** MSMS encourages the inclusion of biological and chemical disaster preparation plans in hospitals.	Res88-00A	***Retain, policy is still relevant.***
PUBLIC HEALTH	**Education of Students on the Hazards of Ultraviolet Radiation (Tanning Rays)** MSMS supports the education of students about the hazards of ultraviolet radiation.	Res124-93A	***Retain, policy is still relevant.***
PUBLIC HEALTH	**Health Education in Public Schools** MSMS supports health education classes in all public schools starting at the elementary level and encourages physician involvement at the local level in the development and implementation of health education curricula.	Res77-95A	***Retain, policy is still relevant.***
PUBLIC HEALTH	**"Safe Sex" a Deadly Misnomer** MSMS supports the wording "less dangerous sex" when referring to sex using latex condoms in all educational and public health materials.	Res39-93A	***Retain, policy is still relevant.***
PUBLIC HEALTH	**Teaching Life-Saving Skills in Schools** MSMS supports the inclusion of basic first aid and age-appropriate life-saving skills in school curricula.	Res51-00A	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
PUBLIC HEALTH	**Ban Bath Salts** MSMS opposes the sale of bath salts and other products containing a significant quantity of methylenedioxypyrovalerone or mephedrone in Michigan.	Res5-11	***Retain, policy is still relevant; however, modify to read as follows:*** ***Ban Bath Salts*** *MSMS opposes the sale of synthetic drugs referred to as "bath salts," containing methylenedioxypyrovalerone (MDPV), mephedrone, and related substances.* ***Rationale:*** *Updated language.*
PUBLIC HEALTH	**Endorse Environmental Protection Agency (EPA) Air Quality Standards** MSMS supports the updated July 17, 1997, Environmental Protection Agency (EPA) air quality standards for ozone, nitrogen oxides, and particulates.	Board Action Report #6, 1998 HOD, re Res92-97A	***Retain, policy is still relevant; however, modify to read as follows:*** ***Endorse Environmental Protection Agency (EPA) Air Quality Standards*** *MSMS supports the current Environmental Protection Agency (EPA) air quality standards for ozone, nitrogen oxides, and particulates.* *Rationale: These standards are reviewed every five years. Therefore, by including a specific date, MSMS is supporting outdated standards.*
PUBLIC HEALTH	**Establishment of the Epidemiology of Elevated Blood Lead Level in Michigan** MSMS supports the requirement that cases of elevated blood lead levels in Michigan be reported to the Michigan Department of Community Health.	Res95-93A	***Sunset policy.*** ***Rationale:*** *Policy is no longer necessary as Public Act 219 of 1998 requires all blood lead level tests conducted in Michigan to be reported to the department.*
PUBLIC HEALTH	**Fluoridation** MSMS supports the current public health guidelines for water fluoridation.	Res2-11	***Retain, policy is still relevant***
PUBLIC HEALTH	**Great Lakes Toxins** MSMS supports the 1995 House of Delegates resolution on "Great Lakes Toxins." (See Addendum D in website version).	Board Action Report #3, 1995 HOD, re Res5-94A & Res92-94A	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
PUBLIC HEALTH	**Medical Waste Disposal Costs** MSMS supports reimbursement for the costs incurred of medical waste disposal programs.	Res87-90A – Edited 1998	***Retain, policy is still relevant.***
PUBLIC HEALTH	**Nuclear Power in Michigan** MSMS advocates a public policy of cautious and reasoned development of nuclear power in Michigan.	Prior to 1990 – Edited 1998	***Retain, policy is still relevant.***
PUBLIC HEALTH	**Statewide Policy on Storage of High-Level Radioactive Waste** MSMS supports development of a statewide policy on storage of high-level radioactive waste.	Res114-93A	***Sunset policy.*** ***Rationale:*** *"The Nuclear Regulatory Commission (NRC) has regulatory authority over storage and disposal of all commercially-generated nuclear wastes in the United States, as well as disposal of spent fuel and high-level wastes generated by the Department of Energy."*
PUBLIC HEALTH	**Definition of Public Health** MSMS supports the Precise Definition of Public Health and the Proper Role of a Public Health Department. (See Addendum M in website version)	Prior to 1990 – Reaffirmed Res31-11	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
PUBLIC HEALTH	**Physical Fitness Programs** MSMS, through public relations, will cooperate with recognized health and physical fitness programs. MSMS supports the provision of traffic lanes and trails open to public use for the purposes of biking, hiking and jogging. In addition, MSMS encourages the appropriate state and local governmental agencies to convert unused railroad beds for such uses.	Prior to 1990 Res64-92A – Amended 1993 – Edited 1998	***Retain, policy is still relevant, and modify to read as follows:*** ***Physical Fitness Programs*** *MSMS supports the provision of traffic lanes and trails open to public use for the purposes of biking, hiking and jogging. In addition, MSMS encourages the appropriate state and local governmental agencies to convert unused railroad beds for such uses.* ***Rationale:*** *The first paragraph is no longer necessary. MSMS has policy that would support engagement in a future public awareness campaign:* ● ***Support of Healthy Lifestyle*** *MSMS supports a healthy lifestyle related to nutrition and exercise and the avoidance of alcohol and tobacco.* ● ***Incentives for Regular Physical Exercise*** *MSMS encourages initiatives that positively incentivize regular physical exercise as a means of improving health.*
PUBLIC HEALTH	**Screening for Sickle Cell Trait and Rubella** MSMS supports screening for the following: sickle cell trait and rubella.	Prior to 1990 – Edited 1998	***Retain, policy is still relevant.***
PUBLIC HEALTH	**Unnecessary Health Screenings** MSMS supports that marketing of preventive health screening directly to the public should include information on risks and benefits of screening; disclose whether the screening is recommended by the U.S. Preventive Services Task Force or other well recognized specialty societies. MSMS supports that those performing the screenings and reviewing the results of the tests be appropriately credentialed. MSMS supports that those performing the screenings and reviewing the results of the tests be appropriately credentialed.	Board-Oct04 Board-Oct04	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
QUALITY ASSURANCE AND PATIENT SAFETY	**Guidelines for Quality Assurance Programs** MSMS insists that any quality assurance program, whether by hospitals, third party payers or managed care programs, include physician input in the development of quality guidelines; and that each program must include due process for the physician indicating the right of appeal. MSMS encourages medical staff to work with their local third-party carrier or managed care organization to share data, provide adequate safeguards for due process, develop proper protocols and assist in setting educational programs.	Res19-93A	***Retain, policy is still relevant.***
QUALITY ASSURANCE AND PATIENT SAFETY	**Payment for Medical Staff Quality Assurance by Hospitals to Medical Staff Organizations** MSMS encourages hospitals to reimburse the medical staff organization for quality assurance and leadership functions performed.	Res29-01A	***Retain, policy is still relevant.***
QUALITY ASSURANCE AND PATIENT SAFETY	**Prevention of Medical Errors** MSMS supports actions that will encourage the prevention of medical errors on the state and local level.	Board-Jan01	***Retain, policy is still relevant.***
QUALITY ASSURANCE AND PATIENT SAFETY	**Oversight of Office Invasive Procedures and Sedation** MSMS supports the Michigan Quality Improvement Consortium (MQIC) Guideline on Office-Based Surgery; supports dialogue with the health plans and the Michigan Department of Community Health to determine if the Michigan Quality Improvement Consortium (MQIC) Guideline on Office-based Surgery is used; and supports consideration of other options to promote adherence to the guideline including quality and safety collaborative to address office-based surgery or potential changes to the Public Health Code.	Board Action Report #5, 2010 HOD, re Res107-09A	***Retain, policy is still relevant; however, modify to read as follows:*** ***Oversight of Office Invasive Procedures and Sedation*** *MSMS supports the Michigan Quality Improvement Consortium (MQIC) Guideline on Office-Based Surgery; supports dialogue with the health plans and state agencies to determine if the Michigan Quality Improvement Consortium (MQIC) Guideline on Office-based Surgery is used; and supports consideration of other options to promote adherence to the guideline including quality and safety collaborative to address office-based surgery or potential changes to the Public Health Code.* ***Rationale:*** *Removed reference to any specific department since department names change.*

Index	Policy	Year	Recommendation
SAFETY AND ACCIDENT PREVENTION	**Opposition to Use of Infant Walkers** MSMS discourages the use of infant walkers and asks physicians to counsel parents of the significant risk of injury from infant walkers.	Prior to 1990	***Retain, policy is still relevant.***
SAFETY AND ACCIDENT PREVENTION	**Anti-violence Public Education** MSMS encourages the news media to actively participate in sending out a strong message against violence, urges educating children at the elementary level regarding the pitfalls of violence, and encourages schools to include discussions on resolving conflict and solving problems without resorting to violence at parent/teacher conferences.	Res105-95A	***Retain, policy is still relevant.***
SAFETY AND ACCIDENT PREVENTION	**Secure Environment for Care for Rape Victims** MSMS supports specialized care for rape victims in a secure, dedicated environment.	Res9-94A	***Retain, policy is still relevant.***
SAFETY AND ACCIDENT PREVENTION	**Auto Safety** MSMS encourages: 1) stricter enforcement of existing laws relative to driving while drunk and imposition of more serious penalties for violations thereof; 2) detection and prosecution of the reckless or careless driver; and 3) provision for a more careful and appropriate interval examination of all drivers.	Prior to 1990 – Edited 1998	***Retain, policy is still relevant.***
SAFETY AND ACCIDENT PREVENTION	**Automobile Seat Belts and other Restraints** MSMS supports the mandatory use of automobile seat belts. MSMS supports the use of appropriate restraining devices and protection for any person riding in the back of a pickup truck.	Prior to 1990 Res53-92A – Amended 1993 – Edited 1998	***Retain, policy is still relevant.***
SAFETY AND ACCIDENT PREVENTION	**Ban Hand-Held Cell Phone and Hand-Held Communication Device Use While Driving** MSMS endorses legislation that would ban the use of hand-held cell phones and hand-held communication devices while driving.	Res89-09A	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
SAFETY AND ACCIDENT PREVENTION	**Bicycle Helmets** MSMS endorses the use of American National Standards Institute (ANSI) or Snell Foundation approved helmets for all bicycle riders and passengers.	Prior to 1990	***Retain, policy is still relevant, and modify to read as follows:*** **Bicycle Helmets** MSMS endorses the use of American Society for Testing and Materials (ASTM) or Snell Foundation approved helmets for all bicycle riders and passengers. ***Rationale:*** *ANSI standards are no longer used, instead ANSI adopted the ASTM standards.*

Index	Policy	Year	Recommendation
SAFETY AND ACCIDENT PREVENTION	**Drunk Driving** MSMS supports the following measures to reduce drunk driving: 1. The establishment of a blood alcohol concentration of 0.05 as per se illegal for driving in Michigan. 2. Administrative license revocation upon arrest for operating under the influence. 3. Mandatory blood alcohol testing for any driver involved in a motor vehicle accident that result in personal injury. 4. Establishment of a color-coded operator's license for persons under 21 years of age. 5. Mandatory alcohol treatment and counseling for repeat violators of drunk driving laws. 6. MSMS supports activities to educate the public and physicians to secure their cooperation in the stringent enforcement of drunk driving laws. To do: Staff – research rationale for AMA's .04 recommendation.	Prior to 1990	***Retain, policy is still relevant, and modify to read as follows:*** ***Drunk Driving*** *MSMS supports the following measures to reduce drunk driving:* *1. The establishment of a blood alcohol concentration of 0.05 as per se illegal for driving in Michigan.* *2. Administrative license revocation upon arrest for operating under the influence.* *3. Mandatory blood alcohol testing for any driver involved in a motor vehicle accident that result in personal injury.* *4. Differentiation of operator's license for persons under 21 years of age such as color-coding or vertical orientation.* *5. Screening of all drivers convicted of first and multiple DUI offenses and referral and treatment when indicated.* *6. Mandatory alcohol treatment and counseling, when medically indicated, for all convicted DUI offenders.* *7. MSMS supports activities to educate the public and physicians to secure their cooperation in the stringent enforcement of drunk driving laws.* ***Rationale:*** *This policy was written before licenses were vertical for those under 21. Therefore, bullet #4 was updated to reflect changes in Michigan law. Also, bullet #5 was split into bullets #5 and #6 using verbiage from AMA policy, Prevention of Impaired Driving H-30.936).*
SAFETY AND ACCIDENT PREVENTION	**Designated Driver Promotion** MSMS encourages establishments serving alcohol to promote the identification of a designated driver.	Res40-95A	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
SAFETY AND ACCIDENT PREVENTION	**Driver Capabilities** MSMS reaffirms its offer to assist the Legislature and the Secretary of State in an advisory capacity to develop means whereby a fair evaluation of driver capabilities may be accomplished to permit restriction or withdrawal of driving privileges from those judged to be physically or mentally incapable.	Prior to 1990	***Retain, policy is still relevant.***
SAFETY AND ACCIDENT PREVENTION	**Driver License Suspensions** MSMS supports the development of guidelines for the assessment of a driver's competence because of medical illness, an emotional disorder, medications and/or alcohol or illicit drug use which include due process to protect individuals' driving privileges and ensure that persons' health records are not made public.	Res34-96A	***Retain, policy is still relevant.***
SAFETY AND ACCIDENT PREVENTION	**Drivers with Suspended Licenses** MSMS supports impounding and/or confiscation of motor vehicles being operated by individuals with suspended licenses. MSMS supports the confiscation of privately owned vehicles used by drivers with suspended licenses while driving under the influence of alcohol.	Board Action Report #4, 1997 HOD, re Res31-96A & Res35-96A	***Retain, policy is still relevant.***
SAFETY AND ACCIDENT PREVENTION	**Motor Vehicle and Bicycle Safety** MSMS supports the lack of safety belt use being designated a "primary enforcement offense." MSMS supports helmet usage by riders of motorcycles and other motorized and non-motorized vehicles and bicycles.	Res46-95A	***Retain, policy is still relevant.***
SAFETY AND ACCIDENT PREVENTION	**Provide Transportation for the Alcohol Impaired Driver** MSMS supports the availability of year-round safe transportation home for intoxicated persons.	Res35-95A	***Retain, policy is still relevant.***
SAFETY AND ACCIDENT PREVENTION	**Redefinition of Automobile Manufactures' Responsibility** MSMS considers part of the responsibility of automobile manufacturers is to manufacture safer vehicles.	Res79-97A	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
SAFETY AND ACCIDENT PREVENTION	**Rented or Leased Unsafe Automobiles** MSMS opposes the rental or leasing of vehicles with uncorrected safety defects within the state of state of Michigan.	Res111-97A	***Retain, policy is still relevant, and modify by correcting typo to read as follows:*** **Rented or Leased Unsafe Automobiles** MSMS opposes the rental or leasing of vehicles with uncorrected safety defects within the state of Michigan.
SAFETY AND ACCIDENT PREVENTION	**Safety and Driver Capabilities** MSMS endorses the report on drivers and dementia for senior citizens. (See Addendum O in website version)	Board-Nov98	***Retain, policy is still relevant.***
SAFETY AND ACCIDENT PREVENTION	**Support Standard Enforcement of Safety Belt and Child Restraint** MSMS supports standard enforcement of seat belt and child restraint usage.	Res89-97A	***Retain, policy is still relevant.***
SAFETY AND ACCIDENT PREVENTION	**Ban Look-alike Toy Guns** MSMS supports a ban on look-alike toy guns.	Prior to 1990	***Retain, policy is still relevant***
SAFETY AND ACCIDENT PREVENTION	**Firearm Education** MSMS supports a basic course in care and handling of firearms. MSMS supports age- and developmentally-appropriate gun safety education.	Res79-94A Res33-01A	***Retain, policy is still relevant.***
SAFETY AND ACCIDENT PREVENTION	**Runners Encouraged to Wear Reflective Clothing** MSMS supports Michigan physicians to educate their patients who run or jog to wear brightly colored, lighted, or reflective clothing while in the street when appropriate.	Res97-10A	***Retain, policy is still relevant.***
SAFETY AND ACCIDENT PREVENTION	**Snowboarding and Skiing Helmets** MSMS recommends that all snowboarders and skiers wear proper helmets and encourages public education regarding the safety of this issue.	Res27-05	***Retain, policy is still relevant.***
SAFETY AND ACCIDENT PREVENTION	**Snowmobile Helmets and Safety** All snowmobile drivers and passengers should be required to wear helmets, and children should be adequately and appropriately supervised.	Res47-98A	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
SAFETY AND ACCIDENT PREVENTION	**Snowmobile Speed Limit Policy** MSMS supports reasonable snowmobile speed limits and appropriate law enforcement.	Res65-94A, Res55-96A	***Retain, policy is still relevant.***
SCOPE OF PRACTICE	**Clear Identification of Health Worker Position/Title with ID Tags** MSMS supports that physicians, nurses and other health providers wear a clearly visible photo identification badge that states their credentials in large block letters with descriptions such as "physician," "nurse," "physician assistant," "nurse practitioner," and that the badges be worn at all times when in contact with patients.	Res50-11	***Retain, policy is still relevant.***
SPORTS	**Athletic Medicine Units** Every school should establish an "athletic medicine unit" and medical schools should train such personnel.	Prior to 1990	***Retain, policy is still relevant.***
SPORTS	**Emergency Services at Sports Arenas and Other Facilities** MSMS advocates facilities providing adequate emergency services, including the latest technical medical equipment and trained personnel, at large gatherings.	Res36-90A – Edited 1998	***Retain, policy is still relevant.***
SPORTS	**Limits on Weight Loss for Wrestlers** MSMS supports the adoption of a policy by the Michigan High School Athletic Association to limit the amount of weight a wrestler can lose.	Res59-92A	***Sunset policy.*** ***Rationale:*** *This policy is no longer necessary as the Michigan High School Athletic Association has set lowest minimum weight standards based on 7 percent body fat for males and 12 percent for females required for all senior high schools to determine the lowest weight class a wrestler may compete.*
SPORTS	**National Athletic Trainers' Association** MSMS recommends that schools utilize certified athletic trainers.	Prior to 1990	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
SPORTS	**Opposition to Boxing** MSMS supports the American Medical Association's position opposing boxing.	Prior to 1990	***Retain, policy is still relevant; however, modify as follows:*** **Opposition to Boxing** MSMS supports the American Medical Association's policies opposing boxing - Boxing as a Health Hazard H-470.983 and Boxing as an Olympic Sport H-470.973. ***Rationale:*** *Updated to identify current related AMA policies.*
SPORTS	**Prohibition of Ultimate Fighting (Barbaric and Blood Sports)** MSMS opposes ultimate fighting (barbaric and blood sports) competitions in the state of Michigan.	Res89-96A	***Retain, policy is still relevant.***
SUBSTANCE USE AND ADDICTION	**Addiction a Disease** MSMS consider drug intoxication and addiction as diseases.	Prior to 1990	***Retain, policy is still relevant; however, modify to read as follows:*** **Addiction a Disease** MSMS recognizes drug addiction as a disease. ***Rationale:*** *Policy update recognizing the full spectrum of drug addiction.*
SUBSTANCE USE AND ADDICTION	**Alcohol During Pregnancy** MSMS opposes the use of alcohol by pregnant women.	Res71-95A	***Retain, policy is still relevant.***
SUBSTANCE USE AND ADDICTION	**Drug Educational Programs** Drug educational programs by public agencies should be expanded and all medical schools, hospitals and medical societies should establish such programs, with particular attention paid to programs treating pregnant women and teenagers.	Res43-90A – Amended 1993 – Edited 1998	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
SUBSTANCE USE AND ADDICTION	**Forfeiture of Property** MSMS supports forfeiture of real property used in committing a violation of the substance abuse act and allocating 50 percent of forfeiture proceeds for community-based educational and substance abuse treatment programs.	Prior to 1990 – Edited 1998	***Retain, policy is still relevant; however, modify to read as follows:*** ***Forfeiture of Property*** *MSMS supports the allocation of at least 50 precent of proceeds from forfeiture of real property obtained due to illegal substance use activity to community-based educational and substance use treatment programs.* ***Rationale:*** *Reference to the Substance Abuse Act was removed as it appears it is no longer in existence.*
SUBSTANCE USE AND ADDICTION	**Hospital Treatment** Hospitals should provide treatment and rehabilitation facilities for substance use.	Res43-90A – Amended 1993 – Edited 1998	***Retain, policy is still relevant.***
SUBSTANCE USE AND ADDICTION	**Pathological Gambling** MSMS advocates treatment for gambling addiction.	Res99-98A	***Retain, policy is still relevant.***
TAXES	**Provider Taxes** MSMS is opposed to a provider tax in any form.	Res43-94A	***Retain, policy is still relevant.***
TAXES	**Repeal or Revision of Single Business Tax** The Single Business Tax statute should be repealed or otherwise amended, so as to exempt service professions from this tax.	Prior to 1990 – Edited 1998	***Sunset policy.*** ***Rationale:*** *This policy is no longer necessary as Public Act 325 of 2006 repealed the Single Business Tax after December 31, 2007.*
TAXES	**Tax Credits for Provision of Free Medical Care** MSMS supports the concept that physicians receive tax credits for the provision of free medical care at both the state and federal taxing authority levels.	Res87-97A – Reaffirmed Res32-10A	***Retain, policy still relevant.***
TOBACCO AND SMOKING	**Federal Assistance to the Tobacco Industry** MSMS opposes federal government financial assistance to the tobacco industry. (Prior to 1990) – Reaffirmed (Res116-98A)	Prior to 1990 – Reaffirmed Res116-98A	***Retain, policy still relevant.***

Index	Policy	Year	Recommendation
TOBACCO AND SMOKING	**Investment in Tobacco Holdings** When feasible, MSMS will refrain from making financial investments in tobacco holdings.	Res94-92A – Reaffirmed Res116-98A	***Retain, policy is still relevant; however, combine this policy with MSMS policy, Removal of Tobacco Stocks from MSMS Portfolio, to read as follows:*** ***Investment in Tobacco Holdings and Stocks*** *MSMS should not hold stock in companies that sell tobacco products. When feasible, MSMS will refrain from making financial investments in tobacco holdings.* ***Rationale:*** *The two policies addressed the same issue so; it makes sense to combine them.*

Index	Policy	Year	Recommendation
TOBACCO AND SMOKING	**MSMS Position/Program of Action re: Smoking-Health** 1. MSMS encourages its members to reflect their knowledge of the hazards of smoking by personally stopping smoking; 2. MSMS asks its members to encourage their individual employees and hospital staff members to stop smoking; 3. MSMS is opposed to the use of tobacco products in all hospitals and health facilities; 4. MSMS urges its members to avail themselves of all opportunities to lead or participate in the dissemination of information regarding the hazards of smoking, cooperating with existing agencies with like goals. 5. MSMS is opposed to smoking in enclosed public places except in designated smoking areas. MSMS encourages members to record on death certificates the use of tobacco, drugs or alcohol as a contributing factor to deaths.	Prior to 1990 – Edited 1998 – Reaffirmed Res116-98A	***Retain, policy still relevant, and modify to read as follows:*** ***MSMS Position/Program of Action re: Smoking-Health*** 1. MSMS encourages its members to reflect their knowledge of the hazards of smoking by personally stopping smoking; 2. MSMS asks its members to encourage their individual employees and hospital staff members to stop smoking; 3. MSMS is opposed to the use of tobacco products in all hospitals and health facilities; 4. MSMS urges its members to avail themselves of all opportunities to lead or participate in the dissemination of information regarding the hazards of smoking, cooperating with existing agencies with like goals. 5. MSMS is opposed to smoking in public places. 6. MSMS encourages members to record on death certificates the use of tobacco, exposure to environmental tobacco smoke, drugs or alcohol, and other risk factors as a contributing factor to deaths. ***Rationale:*** *Bullet #5 is updated to reflect current MSMS policy - Ban on Smoking in Public Places. For formatting purposes, the last paragraph is bulleted in #6 and "exposure to environmental tobacco smoke," was added to be consistent with AMA policy: Improving Death Certification Accuracy and Completion H-85.953*
TOBACCO AND SMOKING	**Prohibit Tobacco Promotion** Tobacco promotion should be illegal.	Prior to 1990 – Edited 1998 – Reaffirmed Res116-98A	***Retain, policy still relevant.***

Index	Policy	Year	Recommendation
TOBACCO AND SMOKING	**Removal of Tobacco Stocks from MSMS Portfolio** MSMS should not hold stock in companies that sell tobacco products.	Res35-97A – Reaffirmed Res116-98A	***Sunset policy.*** ***Rationale:*** *This policy has been combined with MSMS policy, Investment in Tobacco Holdings, above.*
TOBACCO AND SMOKING	**Restricting Alcohol and Tobacco Advertising** MSMS opposes alcohol and tobacco advertising on billboards or buildings within the immediate vicinity of schools and hospitals. MSMS opposes alcohol and tobacco advertising during family and children television programs.	Res116-98A	***Retain, policy still relevant.***
TOBACCO AND SMOKING	**Smokeless Marijuana Treatments** MSMS supports a smokeless society and replacing smoked marijuana with tablets or oral spray manufactured by a reputable and licensed company and available only by prescription.	Res87- 10A	***Retain, policy is still relevant.***
TOBACCO AND SMOKING	**Tobacco Free Michigan Active Doctors (TFMAD) and Tobacco Free Michigan Coalition (TFMAC) Health Care Campaign** MSMS supports the Tobacco Free Michigan Active Doctors and the Tobacco Free Michigan Action Coalition health care campaign.	Board-March94 – Reaffirmed Res116-98A	***Sunset policy.*** ***Rationale:*** *This policy is no longer relevant as the Tobacco Free Michigan Active Doctors is no longer active, and the Tobacco Free Michigan Coalition Health Care Campaign has ended.*
TOBACCO AND SMOKING	**Tobacco Related Ordinances** MSMS supports local units of government passing tobacco related ordinances that are more restrictive than state law.	Board-Jan99	***Retain, policy is still relevant.***
UTILIZATION REVIEW	**Principles for Utilization Management and Medical Review** MSMS supports the Principles for Utilization Management and Medical Review. (See Addendum N in website version).	Board -March 95	***Retain, policy is still relevant.***
WAR	**Ban on Land Mines** MSMS is opposed to the manufacture, trade and use of all land mines.	Res51-97A	***Retain, policy is still relevant.***
WAR	**Global Nuclear Disarmament** MSMS encourages global nuclear disarmament.	Prior to 1990 – Edited 1998	***Retain, policy is still relevant.***
WOMEN'S HEALTH	**No Constitutional Prohibition** There should be no amendment to the Constitution of the United States that would prohibit abortion.	Prior to 1990	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
WOMEN'S HEALTH	**Abortion as Medical Procedure** Abortion is a medical procedure and should be performed only by a licensed physician in conformance with standards of good medical practice and the Public Health Code of the state of Michigan.	Prior to 1990	***Retain, policy is still relevant.***
WOMEN'S HEALTH	**Anti-abortion Coercion** Patients have the right to be free from coercion in determining when and if they will submit to medical procedures such as sterilization and abortion.	Prior to 1990	***Retain, policy is still relevant.***
WOMEN'S HEALTH	**Abortion Clinic Access** MSMS endorses the concept of allowing civil action suits to be brought against individuals who interfere with access to health care facilities.	Board-Sept93	***Retain, policy is still relevant.***
WOMEN'S HEALTH	**Gender Selection** MSMS opposes prohibiting physicians from performing abortions for women who want to terminate their pregnancy based on the gender of the fetus because MSMS opposes infringement upon the physician/patient relationship.	Board-May 94	***Retain, policy is still relevant***
WOMEN'S HEALTH	**Over the Counter Contraception (The Morning After Pill)** MSMS supports the concept of making the "morning after" contraceptive pill an over-the-counter medication. (Res6-06A)	Res6-06A	***Retain, policy is still relevant.***
WOMEN'S HEALTH	**Pap Smear Screening** MSMS supports the current American Cancer Society guidelines for average-risk women that recommend that: "Cervical cancer screening should begin at age 21 years. Women aged younger than 21 years should not be screened regardless of the age of sexual initiation or other risk factors." The frequency of screenings should follow the screening recommendations for their respective age groups.	Board Action Report #10, 1998 HOD, re Res97-97A – Edited 2016	***Sunset policy.*** ***Rationale:*** *The current American Cancer Society policy of screening beginning at age 25 is an outlier. The ACOG, ASCCP, SGO, and USPSTF all support screening at age 21, which is consistent with the intent of the original resolution. Screening beginning at age 21 is current practice. Therefore, instead of updating to an outlier position promoted by the ACS or adding other recommendations that may become outdated, sunsetting the policy is recommended.*

Index	Policy	Year	Recommendation
WORKERS' COMPENSATION	**Health Service Rules** MSMS policy on the Workers' Compensation Health Service Rules and fee schedule is as follows: 1. MSMS opposes use of budget neutrality as a guiding consideration in changing the fee schedule for workers compensation health services. 2. MSMS supports movement to a single conversion factor for all categories of service and proposes raising the conversion factors for medicine and radiology services to the same conversion factor as surgery services, through a three-year phase in. When increases are applied selectively during the phase in period, the conversion factor for medicine services should have priority. 3. MSMS supports use of a single statewide fee schedule, accomplished through a blend of the geographic practice cost indices for southeast Michigan and the rest of the state. 4. MSMS urges adoption of methodology that will update the fee schedule annually, regardless of changes to relative value units. It urges use of the Medicare Economic Index, and that the index be applied retroactively for four years, during which time the fee schedule has been frozen. 4. MSMS supports immediate efforts to examine the unique 5. nature of health services to injured workers. Specific issues that need to be addressed differently for injured workers than for Medicare patients are office visits, follow up days and the relative values for hand surgery procedures. 6. MSMS encourages inclusion in the rules of measures to address the administrative complexity associated with treatment of injured workers.	Board-March98	***Retain, policy is still relevant.***

Index	Policy	Year	Recommendation
WORKERS' COMPENSATION	**Use of Current Procedural Terminology (CPT) Codes and Reimbursement by Workers Compensation** MSMS supports the utilization of Current Procedural Terminology (CPT) by the Workers Compensation program.	Res73-96A	***Retain, policy is still relevant***

Addendum H

(Revised ___, 2022)

Suggested Guidelines for Determining Medical/Legal Fees

A. Fees for Furnishing Existing Records: The costs that may be charged for furnishing copies of medical records are regulated by applicable law and rules. Applicable laws and rules may include, for example, HIPAA, the Michigan Medical Records Access Act (including the annual fee schedule promulgated thereunder), workers' compensation rules, etc.

B. Fees for a Narrative Report: A narrative report is a report prepared by a physician in response to an inquiry for patient information, containing a review of the patient's history, initial examination, diagnosis, course of treatment, prognosis and, if requested, relationship to incident or event. It is reasonable to charge on either an hourly or flat rate basis for the preparation of a report. In determining the hourly rate to be used, the physician should consider the fact that the time spent repairing narrative reports need not conflict with hospital, surgical or patient examining time(v). Many physicians prefer to charge a flat fee for a narrative report, rather than compute a precise fee based on time spent(vi). This practice is reasonable, provided that:

    1. The flat fee is arrived at by determining the amount of time spent for the preparation of a typical narrative report multiplied by a reasonable hourly rate; and,
    2. Where the actual time spent on a report is far in excess or below the average, the flat fee may be adjusted accordingly.

C. Fees for Conferences: When an attorney wishes to meet with a physician, it is reasonable for the physician to charge for that conference on a reasonable hourly rate basis or on a fixed fee basis (vii).

D. Fees for Deposition Testimony: Depositions impose greater demands upon the time and scheduling convenience of the physician than do narrative reports(viii). Deposition charges may include travel time, research, and pre-deposition conference time. It is common and reasonable for a physician to charge a stated amount for the deposition which includes the first hour of time with an additional hourly charge for depositions that run beyond the first hour.

    A cancellation fee is reasonable where notice of the cancellation policy is given in advance. A cancellation fee should not be charged if notice of cancellation is given sufficiently in advance to allow the physician to reschedule the time in a productive manner.

E. Fees for Courtroom Testimony: Courtroom testimony will frequently involve a serious disruption to a physician's practice. Where a physician can be placed on call, and can continue daily business until actually needed in court, waiting time should not incur additional charges. If an attorney requests that a physician come to court and wait to testify, or where a physician's schedule must be cleared in anticipation of being called, it is reasonable that the physician be paid for waiting time as well as testimony time.

F. Agreement in Advance: Misunderstandings and disputes over fees can usually be avoided if fees and cancellation charges are agreed upon in advance between the physician and the attorney.

RESOLUTION 13-21

Title:	Upholding the Integrity and Vitality of the State and County Medical Societies
Introduced by:	Narasimha Gundamraj, MD, for the Ingham County Delegation, Christopher J. Allen, MD, for the Saginaw County Delegation, and Evelyn Eccles, MD, for the Washtenaw County Delegation
Original Author:	Evelyn Eccles, MD
Referred To:	Reference Committee C
House Action:	

Whereas, MSMS and county medical societies are and always have been interdependent, but supported by separate dues structures, and

Whereas, the health of MSMS depends in large part on the health of the county medical societies, which provide grassroots input, mentorship, coordination, education, leadership, and

Whereas, physician and medical student members are best served when linked to leaders within their respective local, component society communities, and

Whereas, physicians that live in areas where there is no active, staffed county medical society have been allowed to become members of MSMS, and

Whereas, this practice could create an incentive for physicians and/or medical students and/or physician groups regardless of where they live or work to join unstaffed counties or counties without membership dues to reduce their cost, and

Whereas, this option is potentially disruptive and harmful to the integrity and vitality of the county medical societies and MSMS, and

Whereas, the 2019 MSMS House of Delegates overwhelmingly approved continued membership unification between MSMS and the county medical societies via the amended Final MSMS Organizational Remodeling Recommendations, as well as disapproval of Resolution 63-19, and

Whereas, the MSMS Board of Directors considered and approved a motion at the October 2020, Board meeting interpreting the bylaws stating, "that the MSMS Board of Directors acknowledge MSMS Legal Counsel's interpretation that the MSMS Bylaws do not expressly require a physician to live or work in a county in order to hold membership in that county medical society," and

Whereas, the county medical societies have become aware of physician(s) and/or physician group(s) that belong to counties in which they potentially do not live and/or work prior to the October 2020, MSMS Board or Directors motion and approval and subsequently since, and

Whereas, the county medical societies have requested and received membership roster(s) within their districts and/or regions previously, but have been informed by MSMS that this is not in accordance with MSMS Bylaws and policies since October 2020; therefore be it

RESOLVED: That the county medical societies and MSMS work as committed partners to uphold the county medical societies and MSMS shared integrity and vitality, as previously approved by the House of Delegates; and be it further

RESOLVED: That the current MSMS state-wide membership roster shall be audited and the results shall be distributed to the county medical societies and the 2022 MSMS House of Delegates to evaluate the extent of the October 2020 bylaws interpretation; and be it further

RESOLVED: That any recruitment and/or retention practice by MSMS, vendors and/or support subsidiaries, and/or county medical societies supported by the October 2020 bylaws interpretation that serves to undermine the integrity and vitality of the medical societies end; and be it further

RESOLVED: That moving forward, all physician and medical student members join the county where they live or work, unless there is written agreement due to mutually agreed upon exception between the medical student, physician and/or physician group, MSMS, and the respective county(ies).

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

STATEMENT OF URGENCY: The membership practice was considered and approved within the last year and the consequences are currently unknown. The HOD should review and remedy this practice before the 2022 membership dues cycle begins.

Relevant MSMS Policy:
Over the past year, MSMS has deployed several strategies to address issues raised by county medical societies regarding state society operations and procedures relative to membership, advocacy, communications and the House of Delegates. Those strategies include weekly (spring 2020) and then bi-weekly (summer 2020) virtual meetings between the MSMS CEO and county society staff, monthly meetings between MSMS departmental heads and county society staff (which have been ongoing since 2010), and a facilitator-led series of meetings to research state and county perspectives and host a series of meetings to work through how various issues will be handled going forward. The consultant work is ongoing, and the topic raised in this resolution has been part of that process. In addition, county concerns have been discussed broadly at MSMS Board meetings, the Chair and Vice Chair hosted a virtual meeting with Regional Directors representing five counties raising concerns, and the MSMS Executive Committee has also met to support strategies to establish best practices between state and county going forward.

Advise Physicians Regarding the Importance of Organized Medicine
MSMS advocates educating Michigan physicians regarding the value of membership in their respective county medical societies, MSMS and the AMA. (Res17-96A)

Relevant AMA Policy:
None

Sources:

1. https://www.msms.org/About-MSMS/News-Media/overview-of-the-2019-msms-house-of-delegates
2. https://www.msms.org/hodresolutions/2019/63.pdf
3. Source: January 14, 2021 MSMS Board of Directors Meeting Packet

RESOLUTION 20-21

Title: Designated Directors Serving as Chair of the MSMS Board of Directors

Introduced by: Betty S. Chu, MD, MBA

Original Author: Betty S. Chu, MD, MBA

Referred To: Reference Committee C

House Action:

Whereas, the MSMS House of Delegates amended its bylaws in 2019 to create a new category of representatives on the MSMS Board of Directors, titled Designated Directors, and

Whereas, the purpose of the Designated Director was to represent specific physician constituencies and perspectives based on current physician demographics, and

Whereas, the House of Delegates overwhelmingly supported the addition of these seats to complement the Regional Directors that constitute the vast majority of seats on the MSMS Board of Directors, and

Whereas, the House of Delegates forms a Nominating Committee, composed of delegates from each of the nine regions, to review candidates for each of the Designated Director categories to ensure the candidates presented are the most qualified and reflect the diversity of the Society's membership, and

Whereas, the House of Delegates has the final authority to elect candidates for the Designated Director, and

Whereas, the current Designated Directors approved by the House of Delegates include representatives from a physician organization, health system, independent small practice, government/public health, designated institutional officer/graduate medical education, and an at-large member, and

Whereas, the contribution of these House-elected Designated Directors has already proven to be beneficial to the work of the MSMS Board, and

Whereas, allowing Designated Directors to be candidates to chair MSMS Board Committees, which are elected by the Board annually, would expand the choice of qualified candidates that could serve in Board leadership; therefore be it

RESOLVED: That the MSMS Bylaws be amended as follows. Deletions are indicated by ~~strikethroughs~~, additions are indicated in **bold type**.

14.10 ORGANIZATION—The Board of Directors is the executive body of the Society. Subject only to the following, it shall determine the times and places of its meetings. At its first meeting immediately following the Annual Session of the House of

Delegates, the Board of Directors shall elect Secretary and Treasurer, who shall serve for a term of office of one year or until a successor is elected and takes office. At the same meeting, the Board of Directors shall elect a Chair, a Vice-Chair, a Chair of the Finance Committee, a Chair of the Health Care Delivery Committee, a Chair of the Legislative Policy Committee, and a Chair of the Scientific and Educational Affairs Committee, who shall be duly elected Regional Directors **or Designated Directors**, each to take office immediately and to serve for a term of one year or until a successor is elected and takes office.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

Reference Committee D

MICHIGAN STATE MEDICAL SOCIETY
2022 HOUSE OF DELEGATES

RESOLUTIONS BY COMMITTEE

REFERENCE COMMITTEE D – PUBLIC HEALTH

RESOLUTION	DESCRIPTION
05-22	CPS Involvement in Cases of Maternal Cannabis Use
12-22 (37-20)	Waiting Period for Gun Purchase
15-22 (57-20)	Safe Sex Education at Senior Living Facilities
26-22	Recognizing the Contribution of the Clinical Laboratory Workforce in Combating COVID-19 in Michigan
27-22	Strengthen Support for Local Health Department Medical Directors and the Medical Health Officer Role
33-22	Repeal of Michigan's Abortion Law
34-22	Prohibit Persons from Carrying Firearms and Explosive Devices in Public Spaces
41-22	MSMS Efforts to Mitigate the COVID-19 Pandemic
47-22	Protect Freedom of Speech, Diversity of Thought, and Open Scientific Inquiry for Physicians
50-22	Pictorial Health Warnings on Alcoholic Beverages
54-22	Oppose Michigan's Parental Consent Law MCL 722.903
55-22	Continuity of Care Upon Release from Correctional Systems
60-22	Eliminate Medical Co-Payments in Prisons and Jails

RESOLUTION 05-22

Title: CPS Involvement in Cases of Maternal Cannabis Use

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: Taylar Dickson, Caitlin Heenan, Jessyca Judge, Isabella Kunkel, and Veronica Stafford

Referred To: Reference Committee D

House Action:

Whereas, as of February 2022, 37 states allow for medical use of cannabis and 18 allow for its recreational use, and

Whereas, in Michigan, cannabis became legal for medical use for adults in 2008 and for recreational use for adults in 2018, and

Whereas, the number of women using cannabis during pregnancy has been increasing in Michigan; as of 2019 roughly one in fifteen pregnant people used cannabis, and

Whereas, there is some evidence that there are long term effects to the baby during childhood such as problems with problem-solving, attention span, and visual analysis, and

Whereas, much of the available evidence is inconsistent and subject to confounding, reporting, and recall bias, and

Whereas, the American College of Obstetricians and Gynecologists (ACOG) does not recommend cannabis use during pregnancy, largely because the evidence is unclear on the effects and safety profile, and

Whereas, providers do not consistently initiate discussion on cannabis use in pregnancy, and when it is discussed, patients report hearing conflicting recommendations, and

Whereas, in Michigan and other states, Children's Protective Services (CPS) must be notified whenever it is known that cannabis is being used by a pregnant person, and

Whereas, while tobacco use during pregnancy is associated with significant risks to mother and baby, use of tobacco does not require reporting to CPS, and

Whereas, the fear of being reported to CPS inhibits patients from discussing cannabis use with their providers, and is a barrier to comprehensive care, and

Whereas, involvement with CPS and the potential of losing a child is a serious source of stress, anxiety, and depression for mothers, and

Whereas, even in states where cannabis is legal, mothers have been placed on child abuse registries and engaged in lengthy legal battles with CPS to keep their child, and

Whereas, parents of Color are reported to the criminal legal system and CPS and have their parental rights taken away at higher rates than their white peers, and

Whereas, ACOG has made it clear that seeking prenatal care should not put a woman at risk of criminal penalties for cannabis use; therefore be it

RESOLVED: That MSMS advocate for the need for research during pregnancy on the impacts of recreational cannabis use on the fetus, and be it further

RESOLVED: That MSMS encourage professional education efforts for prenatal care providers to be able to provide consistent recommendations on cannabis use in pregnancy; and be it further

RESOLVED: That MSMS support the review and revision of Child Protective Services (CPS) policies to remove the mandated referral of pregnant patients to CPS solely for cannabis use.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000 for regulatory and/or industry advocacy.

Relevant MSMS Policy:

Marijuana for Medical Use
MSMS supports the use of cannabinoids by routes other than smoking for medical uses, for which scientific evidence supports efficacy equal or superior to established therapies and encourages further research to elucidate the efficacy of cannabinoids in various medical conditions and its optimal dosage and route of delivery. (Res59-08A)

Research on the Personal and Public Health Effects of Recreational Marijuana
RESOLVED: That MSMS encourages further research into the personal and public health impacts of recreational marijuana use. (In lieu of Resolution 58-19, the following policies will be reaffirmed: • Marijuana • Publish the Contents of Cannabis • Dangers of Adolescent Access to Marijuana (Resolution 63-18)

Oppose Legalized Marijuana
RESOLVED: That MSMS actively oppose legislation and/or ballot initiatives that seek to legalize recreational marijuana in the State of Michigan; and be it further
RESOLVED: That MSMS adopt policy opposing the legalization of recreational marijuana in the State of Michigan. Edited 1998 Amended 2019 (Res46-18 AND 70-18)

Oppose Recreational Marijuana Use
RESOLVED: That MSMS opposes legalization of marijuana for general recreational use; and be it further
RESOLVED: That MSMS collaborate with other stakeholders to oppose the legalization of marijuana for general recreational use. Edited 1998 Amended 2019 (Res46-18 AND 70-18)

Relevant AMA Policy:

Cannabis and Cannabinoid Research H-95.952

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 urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.
3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.
4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.
5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.
6. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.
7. Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.

Cannabis Legalization for Medicinal Use D-95.969
Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; (5) 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; (6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians; and (7) encourages hospitals and health systems to: (a) not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use; and (b) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.

Medical Marijuana License Safety D-95.959
1. Our AMA supports efforts to include medical cannabis license certification in states' prescription drug monitoring programs when consistent with AMA principles safeguarding patient privacy and confidentiality.
2. Our AMA will continue its monitoring of state legislation relating to the inclusion of cannabis and related information in state PDMPs.

3. Our AMA will review existing state laws that require information about medical cannabis to be shared with or entered into a state prescription drug monitoring program. The review should address impacts on patients, physicians and availability of information including types, forms, THC concentration, quantity, recommended usage, and other medical cannabis details that may be available from a dispensary.

Treatment Versus Criminalization - Physician Role in Drug Addiction During Pregnancy H-420.970
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.

Sources:

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2. Michigan - Adult-use stores continue to open; expungement bill awaits Senate action. Marijuana Policy Project. https://www.mpp.org/states/michigan/. Published January 13, 2020. Accessed February 18, 2022
3. Haak P. Michigan PRAMS 2019 Birth Year Maternal and Infant Health Tables Executive Summary. Michigan Pregnancy Risk Assessment Monitoring System. https://www.michigan.gov/documents/mdhhs/2021-05-14_MI_PRAMS_2019_Annual_Tables_-_Exec_Summary_725442_7.pdf. Published May 14, 2021. Accessed February 18, 2022
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8. Tobacco and nicotine cessation during pregnancy. American College of Obstetricians and Gynecologists. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/05/tobacco-and-nicotine-cessation-during-pregnancy. Published May 2020. Accessed February 18, 2022
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11. Edwards F, Wakefield S, Healy K, Wildeman C. Contact with child protective services is pervasive but unequally distributed by race and ethnicity in large US counties. Proceedings of the National Academy of Sciences. 2021;118(30). doi:10.21428/cb6ab371.a855067a

RESOLUTION 12-22 (37-20)

Title: Waiting Period for Gun Purchase

Introduced by: John Pelachyk, MD, for the St. Clair County Delegation

Original Author: Raj Makim, MD

Referred To: Reference Committee D

House Action:

Whereas, a waiting period law requires a certain number of days to lapse between the purchase of a firearm and when the buyer can actually take possession, and

Whereas, by delaying immediate access to firearms, waiting periods create an important "cooling off" period that can help prevent impulsive acts of gun violence, including gun homicides and suicides, and

Whereas, many studies suggest that most suicide survivors contemplated their actions for only a brief period of time, "often less than 24 hours" before making a suicide attempt. Similarly, studies suggest that some of the factors that incite violence against others, such as anger and rage, can be short-lived, and

Whereas, studies suggest that waiting period laws are associated with reduced rates of firearm suicide. By one estimation, waiting period laws may reduce firearm suicide rates by 7-11 percent, and

Whereas, waiting period laws also appear to reduce gun homicide rates. One study found that waiting period laws that delay the purchase of firearms by a few days can reduce gun homicides by roughly 17 percent, and

Whereas, waiting periods can also give law enforcement agencies additional time to complete background checks that sometimes cannot be completed within the three-day window provided by the federal law, and

Whereas, each year, approximately 3,800 ineligible people acquire firearms through so-called "default proceed" sales, in which a dealer completes a sale without a completed background check after three business days, as is allowed under federal law, and

Whereas, Federal Bureau of Investigation experts have recommended extending the time to complete background checks to reduce the number of prohibited people, "like people subject to domestic violence restraining orders," able to purchase firearms by default proceeds; therefore be it

RESOLVED: That MSMS recommend to the Michigan Legislature the establishment of a waiting period for all firearm purchases in Michigan.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000 for legislative advocacy.

Relevant MSMS Policy:

Firearm Regulations
MSMS opposes the liberalization of concealed gun laws and efforts to weaken current laws regarding the manufacture, importation, and/or ownership of assault weapons and/or handguns. MSMS supports policies that 1) prohibit acquisition of firearms by high-risk persons; 2) require firearm owners to have firearm safety certification which includes but is not limited to basic education in the care and handling of firearms; 3) limit ownership and use of assault weapons; and, 4) ban the sale of assault weapons and large-capacity ammunition magazines.

Firearm-Related Injury and Death: Adopt A Call to Action
MSMS endorses the specific recommendations made in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms.

Relevant AMA Policy:

Waiting Period Before Gun Purchase H-145.992
The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Sources:

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6. Ann Givens and Andrew Knapp, "FBI to Add Major Law Enforcement Database to Gun Background Check System," The Trace, July 10, 2018, https://www.thetrace.org/2018/07/fbi-background-check-system-nics-ndex-charleston https://lawcenter.giffords.org/gun-laws/state-law/50-state-summaries/waiting-periods-state-by-state/

RESOLUTION 15-22 (57-20)

Title: Safe Sex Education at Senior Living Facilities

Introduced by: Mara Darian for the Medical Student Section

Original Authors: Nicholas Ang, Kaylie Bullock, Maryam Hermez, Eric James, and Manraj Sekhon

Referred To: Reference Committee D

House Action:

Whereas, sexual activity is commonplace amongst residents of senior living facilities, and

Whereas, the engagement in sexual activity in late life is a core aspect of identity and is associated with decreased tension, improved mental health, and increased affirmation of one's body, its functioning, and security, and

Whereas, the incidence of HIV/AIDS is faster growing amongst people over the age of 50 than in any other age group; the prevalence of sexually transmitted infections (STIs) such as syphilis, gonorrhea, and chlamydia has been increasing amongst seniors, and the prevalence of HIV has been increasing amongst senior living facility residents, and

Whereas, the population of U.S. citizens aged 65 years and older was 38,613,000 as of the 2010 U.S. Census and is expected to increase to more than 73,000,000 citizens by the time of the 2020 U.S. Census, suggesting an increase in the number of at risk-individuals in senior living facilities, and

Whereas, condom usage amongst seniors is low – reported in one study of self-reported sexually active seniors as only 20 percent of men and 24 percent of women used a condom in their most recent sexual encounter, and

Whereas, poor communication with health-care professionals contributes to lower levels of counseling and education about sexual risk - reported in one study as 90 percent of seniors not receiving information about HIV/AIDS and 80 percent not receiving education about STIs, and

Whereas, California State University Los Angeles and USC found that knowledge of STIs and availability of sex education for seniors is limited, but perceived as important to this community, and

Whereas, MSMS already recognizes sexual education should be complementary at all school levels as a comprehensive sexual education program including condom usage, and that such programs be supported by public funding, and

Whereas, the American Medical Association (AMA) opposes abstinence only education and supports the integration of dating violence prevention, conversations about consent, and the

development of evidence-based, best practices curricula for sexual education produced by physicians and other interested parties, and

Whereas, the AMA supports that state and local agencies should include comprehensive health education with standards for sex education and sexual responsibility, taught by qualified and competent instructors; therefore be it

RESOLVED: That MSMS work with the Michigan Department of Health and Human Services Office of Services to the Aging to support an assessment of the availability of educational programs focused on sexual health of seniors in senior living communities; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to support the utilization of current evidence-based research of literature and policy for the implementation of sexual education programs for residents in senior living communities specifically.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000 for collaborative outreach effort and $1,000-$2,000 for new AMA policy.

Relevant MSMS Policy:

Define 'Medically Accurate' in Sex Education Program Requirements
MSMS supports "medically accurate" information in sex education programs to be defined as information that satisfies all of the following:
1. Relevant to informed decision-making based on the weight of scientific evidence.
2. Consistent with generally recognized scientific theory, conducted under accepted scientific methods.
3. Published in peer-reviewed journals with findings replicated by subsequent studies.
4. Recognized as accurate and objective information by mainstream professional organizations such as AMA, American College of Obstetricians and Gynecologists, American Public Health Association, and American Academy of Pediatrics; government agencies such as Center for Disease Control, Food and Drug Administration, and National Institutes of Health; and, scientific advisory groups such as the Institute of Medicine and the Advisory Committee on Immunization Practices.

Statement on Sex Education
Public schools should be required to teach medically accurate, age appropriate, comprehensive sex education at all school levels with the option for parental opt out. Sex education programs should 1) be part of an overall health education program; 2) be presented in a manner commensurate with the maturation level of the students; 3) include age-appropriate training on how to give and withhold consent (based on the definition of consent as the unambiguous and voluntary agreement between all participants in each physical act within the course of interpersonal relationships, including respect for personal boundaries); 4) have professionally developed curricula; 5) include ample opportunities to involve parents and other concerned members of the community; and 6) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training.

Educational Activities Addressing Needs of the Elderly
MSMS supports, through existing MSMS committees and programs, educational activities addressing the special medical, social and economic needs of the elderly.

Relevant AMA Policy:

A Guide for Best Health Practices for Seniors Living in Retirement Communities H-25.987
Our AMA, in collaboration with other interested parties, such as the public health community, geriatric specialties, and organizations working to advocate for seniors, will create a repository of available resources for physicians to guide healthy practices for seniors who reside in independent living communities.

Senior Care H-25.993
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.

Health Information and Education H-170.986
(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.

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968

(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 at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) 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; (d) 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; (e) 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; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, 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;

(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and

(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

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12. America Counts Staff. 2020 Census Will Help Policymakers Prepare for the Incoming Wave of Aging Boomers. United States Census Bureau. December 10, 2019.
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RESOLUTION 26-22

Title:	Recognizing the Contribution of the Clinical Laboratory Workforce in Combating COVID-19 in Michigan
Introduced by:	Gaurav Sharma, MD, for the Wayne County Delegation
Original Author:	Gaurav Sharma, MD
Referred To:	Reference Committee D
House Action:	

Whereas, the global pandemic of COVID-19 has impacted billions of human lives across all nations, and

Whereas, the diagnosis and management of this transmissible disease relies on timely, accurate, and dependable clinical laboratory diagnostic methods, and

Whereas, in the absence of such laboratory testing, clinicians and public health agencies are unable to identify and control the spread of the pandemic, and

Whereas, despite significant headwinds in available staffing, supply-chain shortages, and overwhelming demand for testing driven by novel SARS-COV-2 variants, clinical laboratory testing for COVID-19 was sustained across the state of Michigan without any significant and prolonged outage, and

Whereas, as of late-February 2022, laboratory testing has helped diagnose more than two million cases of COVID-19 in Michigan, and

Whereas, this achievement in testing volumes comes with an intangible cost to the laboratory workforce whose work-life balance has been swayed by the 24x7 shifts needed to support COVID-19 testing, supply chain shortages, and reduced staffing due to post-exposure home quarantines, and

Whereas, one-third of the clinical laboratory workforce is age 55 years or older and thus at a higher risk of complications from COVID-19, and

Whereas, the technical nature of the laboratory work does not lend itself to work-from-home, rather it is a job that requires hours of focused and precise work each day of the ongoing pandemic; therefore be it

RESOLVED: That MSMS acknowledge, and encourage pathologists and others in Michigan's medical community to acknowledge, the challenges faced by the clinical laboratory workforce in setting up unprecedented COVID-19 testing capabilities in the state of Michigan; and be it further

RESOLVED: That MSMS recognize that paramount professionalism was demonstrated by the clinical laboratory workforce in ensuring that Michiganders maintained access to COVID-19 testing throughout the COVID-19 pandemic.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for basic reporting or communications.

Relevant MSMS Policy: None

Relevant AMA Policy: None

Sources:

1. Where We Stand With Covid-19, retrieved 02/25/22 Coronavirus - Coronavirus (michigan.gov).
2. Edna Garcia, MPH, Iman Kundu, MPH, Melissa Kelly, PhD, Ryan Soles, MS, Lotte Mulder, EdM, Geoffrey A Talmon, MD, MEd, The American Society for Clinical Pathology's Job Satisfaction, Well-Being, and Burnout Survey of Laboratory Professionals, American Journal of Clinical Pathology, Volume 153, Issue 4, April 2020, Pages 470-486, https://doi.org/10.1093/ajcp/aqaa008.

RESOLUTION 27-22

Title:	Strengthen Support for Local Health Department Medical Directors and the Medical Health Officer Role
Introduced by:	Annette Mercatante, MD, MPH, for the Michigan Association of Preventive Medicine and Public Health
Original Author:	Annette Mercatante, MD, MPH
Referred To:	Reference Committee D
House Action:	

Whereas, public health is defined as the science of protecting the safety and improving the health of communities through education, policy making, and research for disease and injury prevention, and

Whereas, the three fundamentals in the philosophy of public health are scientific method, analysis, and synthesis which are core skills of physician training and practice, and

Whereas, during the COVID-19 pandemic, where the science is emerging and rapidly evolving, the skills of physicians trained in scientific method, analysis, and synthesis have been even more profoundly important and have illustrated the value of physicians being at the decision-making table, and

Whereas, Michigan's Public Health Code, MCL 333.2428, addresses the appointment, qualifications, and powers and duties of local health officers and includes the following:
"(1) A local health department shall have a full-time local health officer appointed by the local governing entity or in case of a district health department by the district board of health. The local health officer shall possess professional qualifications for administration of a local health department as prescribed by the department.
(2) The local health officer shall act as the administrative officer of the board of health and local health department and may take actions and make determinations necessary or appropriate to carry out the local health department's functions under this part or functions delegated under this part and to protect the public health and prevent disease," and

Whereas, Michigan Administrative Rule, R 325.13001, states that "A health officer shall be a medical health officer or administrative health officer. If the health officer is not a physician, a medical director shall also be employed who is responsible to the health officer for medical decisions," and

Whereas, the expectations for the leadership role of the medical director are not defined in the Public Health Code, with the unintended consequence that some Medical Directors act as an advisor rather than part of the leadership team; therefore be it

RESOLVED: That MSMS work with the Michigan Association of Local Public Health and the Michigan Association of Preventive and Public Health Physicians in addition to other state agencies

and medical specialty groups to identify common goals and objectives for improved synergy and advancement of physician leadership roles in local and state health departments; and be it further

RESOLVED: That MSMS advocate for strong physician leadership within governmental public health as to support and enhance the voice of physicians for the benefit of population health; and be it further

RESOLVED: That MSMS work with the Michigan Association of Local Public Health and the Michigan Association of Preventive and Public Health Physicians as a liaison with other health care stakeholders including, but not limited to, third party payers and the Michigan Health & Hospital Association.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $4,500-$9,000 for messaging campaign.

Relevant MSMS Policy:

Organized Medicine's Liaison with Public Health
MSMS encourages its component medical societies to develop liaison committees with their local public health departments and participate in local community assessment and improvement programs. (Board-Mar97)

Definition of Public Health
MSMS supports the Precise Definition of Public Health and the Proper Role of a Public Health Department. (See Addendum M in website version) (Prior to 1990)
– Reaffirmed (Res31-11)

Establish and Maintain Stand-Alone Michigan Department of Public Health
MSMS supports the establishment and maintenance of a standalone Michigan Department of Public Health that is organized in a way to ensure that an effective structure is in place to prioritize, meet, and respond to the public health needs of Michigan residents. (Res62-16)

Require MDHHS Director to be a Physician
MSMS supports a requirement that the director of the Michigan Department of Health and Human Services be a physician licensed in the state of Michigan. (Board Action Report #13, 2000 HOD, re Res112-99A)
– Edited 2016

Relevant AMA Policy:

Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems D-440.922
Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; (2) develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress; (3) work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials; and (4) advocate for (a) consistent, sustainable funding to support our public health infrastructure, (b) incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff, (c) public health data

modernization and data governance efforts as well as efforts to promote interoperability between health care and public health; and (d) efforts to ensure equitable access to public health funding and programs.

Organized Medicine and Public Health Collaboration H-440.960
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, including representatives from governmental public health, and those representing physicians in private practice, employed in health systems, employed in academic medicine, and working in other clinical settings; (3) actively supports promoting and contributing to increased attention to public health issues in its programs in medical science and education; (4) encourages public health agencies to focus on assessment of problems, assurance of healthy living conditions, policy development, and other related activities; (5) 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; and (6) encourages state and local health agencies to communicate directly with physicians licensed in their jurisdiction about the status of the population's health, the health needs of the community, and opportunities to collectively strengthen and improve the health of the public.

Public Health Leadership H-440.888
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;
(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;
(3) encourages the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation Council for Graduate Medical Education (ACGME) to highlight public/population health leadership learning opportunities to all learners, but especially encourage dissemination to women physician groups and other groups typically underrepresented in medicine; and
(4) encourages public health leadership programs to evaluate the effectiveness of various leadership interventions.

RESOLUTION 33-22

Title: Repeal of Michigan's Abortion Law

Introduced by: Richard Burney, MD, for the Washtenaw County Delegation

Original Author: Richard Burney, MD

Referred To: Reference Committee D

House Action:

Whereas, the Michigan Penal Code, Act 328 of 1931, Sections 750.14 and 7650.15 make it illegal to provide abortion services of any kind, including medically induced abortions, and

Whereas, it is possible that the U. S. Supreme Court will reverse the Roe v. Wade decision making abortion legal, overruling state laws, and

Whereas, should this happen, Michigan's 1931 law would become effective, preventing abortion services except in the first trimester, and

Whereas, this would significantly impair women's freedom, health, and well-being; therefore be it

RESOLVED: That MSMS advocate to repeal Act 328 of 1931, regardless of the outcome of the current case before the Supreme Court.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000 for legislative advocacy.

Relevant MSMS Policy:

No Constitutional Prohibition
There should be no amendment to the Constitution of the United States that would prohibit abortion. (Prior to 1990)

Abortion as Medical Procedure
Abortion is a medical procedure and should be performed only by a licensed physician in conformance with standards of good medical practice and the Public Health Code of the state of Michigan. (Prior to 1990)

Relevant AMA Policy:

Policy on Abortion H-5.990
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.

Abortion H-5.995
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.

Right to Privacy in Termination of Pregnancy H-5.993
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.

4.2.7 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.

Source:
1. Section 750.14 (of the law) held unconstitutional as relating to abortions in the first trimester of a pregnancy as authorized by the pregnant woman's attending physician in the exercise of his medical judgment. People v Bricker, 389 Mich 524; 208 NW2d 172 (1973). Whether this ruling would be affected by reversing Roe is not known.

RESOLUTION 34-22

Title:	Prohibit Persons from Carrying Firearms and Explosive Devices in Public Spaces
Introduced by:	Robert Sain, MD, for the Washtenaw County Delegation
Original Author:	Robert Sain, MD
Referred To:	Reference Committee D
House Action:	

Whereas, Michigan citizens experienced the deliberate lethal threat against our neighbors and public officials by persons carrying firearms and/or explosive devices in the Michigan State Capitol on April 30, 2020, and in various instances since, and

Whereas, members of the group(s) who invaded Michigan's Capitol in April and threatened our elected officials and public servants were among those who went on to threaten to kidnap and harm various elected leaders, including Governor Gretchen Whitmer and Attorney General Dana Nessel, and

Whereas, private unauthorized militias are illegal in Michigan, and

Whereas, the Armed Conflict Location & Event Data Project states that far-right groups have taken an increasing part in demonstrations against the election result, demonstrations are more likely to turn violent if militia members are present, and these groups have not just started attending more protests, they are also ramping up training and recruitment events, and

Whereas, members of Michigan militant groups are known to have participated in the insurrection attempt at the U.S. Capitol in Washington, DC on January 6, 2021, making it clear that violence against the U.S., its people, and its institutions may just be beginning, and

Whereas, the act of threatening and intimidating with firearms, and/or explosive devices through open carry in the Michigan State Capitol only became expressly prohibited in January 2021, but concealed carry is still permissible, and

Whereas, there is increasing bipartisan support from lawmakers on banning the open carry of firearms in the Michigan legislature, and

Whereas, the latest U.S. public opinion on carrying firearms in public places from the *American Journal of Public Health* shows that fewer than one in three U.S. adults supported gun carrying in any of the specified venues, and support for carrying in public was lowest for schools (19%; 95% confidence interval [CI] = 16.7, 21.1), bars (18%; 95% CI = 15.9, 20.6), and sports stadiums (17%; 95% CI = 15.0, 19.5), and

Whereas, carrying firearms has been used to threaten individuals and impose physiologic and psychological harm to persons exposed making this a medical issue worthy of consideration by our medical societies, and

Whereas, in Michigan, those who carry firearms and explosive devices in public incite unnecessary fear, stress, and safety risks to fellow citizens and public officials; therefore be it

RESOLVED: That MSMS advocate that firearms and explosive devices of all kinds, with a carry exception for law enforcement officials, be prohibited from state government buildings and public spaces.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new MSMS policy.

Relevant MSMS Policy:

Address Gun Violence Using a Public Health Approach
MSMS supports physicians working with local and state public health agencies, law enforcement agencies, and other community organizations and leaders to identify, develop and evaluate strategies to increase firearm safety and prevent firearm injury and death.

Firearm Regulations
MSMS opposes the liberalization of concealed gun laws and efforts to weaken current laws regarding the manufacture, importation, and/or ownership of assault weapons and/or handguns. MSMS supports policies that 1) prohibit acquisition of firearms by high-risk persons; 2) require firearm owners to have firearm safety certification which includes but is not limited to basic education in the care and handling of firearms; 3) limit ownership and use of assault weapons; and, 4) ban the sale of assault weapons and large-capacity ammunition magazines.

Firearm-Related Injury and Death: Adopt A Call to Action
MSMS endorses the specific recommendations made in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms.

Handgun Control and Education
MSMS recommends effective controls on the assembly, manufacture, distribution and possession of handguns.

MSMS supports distribution of educational materials to firearm purchasers. The materials should address the use of lock boxes, trigger locks, childproof safety catches and loading indicators.

Oppose Imposition of Penalties on Local Units of Government and/or Officials and Staff
MSMS opposes the prohibition of local units of government and/or their elected or appointed officials or staff from imposing restrictions on the ownership, registration, purchase, sale, transfer, transportation, or possession of guns within their area of jurisdiction and/or punishment for the imposition of such restrictions.

Relevant AMA Policy:

AMA Campaign to Reduce Firearm Deaths H-145.988
The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.

Firearm Related Injury and Death: Adopt a Call to Action H-145.973
Our AMA endorses the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
1. 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:
(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(B) 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;
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(D) 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;
(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(F) 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; and
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

Sources:

1. https://www.nytimes.com/2021/01/09/us/politics/michigan-state-capitol.html
2. https://www.nytimes.com/2020/10/08/us/gretchen-whitmer-michigan-militia.html
3. https://www.law.georgetown.edu/icap/wp-content/uploads/sites/32/2020/09/Michigan.pdf?fbclid=IwAR0IaVjyucWn93MRZj-MJfTfkO-vzLehfIBqK7ZLG8jhezk8qNvfVWJYT4M
4. https://www.bbc.com/news/world-us-canada-55638579
5. https://www.bbc.com/news/world-us-canada-56174168
6. https://www.detroitnews.com/story/news/local/michigan/2021/01/11/commission-consider-open-carry-ban-state-capitol/6620997002/

7. https://www.detroitnews.com/story/news/politics/2021/01/07/michigan-capitol-temporarily-closed-because-a-threat/6578215002/
8. https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.303712
9. https://www.drsforamerica.org/issues/gun-violence-prevention/
10. https://giffords.org/lawcenter/gun-laws/policy-areas/guns-in-public/open-carry/

RESOLUTION 41-22

Title: MSMS Efforts to Mitigate the COVID-19 Pandemic

Introduced by: James Mitchiner, MD, for the Washtenaw County Delegation

Original Author: James Mitchiner, MD

Referred To: Reference Committee D

House Action:

Whereas, the COVID-19 pandemic is now entering its third year, with more than 2.3 million cases in Michigan and 34,000 COVID-related deaths reported to date, and

Whereas, efforts to reduce the spread of COVID by government, industry, academic institutions, health systems, public health departments, and school districts are ongoing and well-publicized, and

Whereas, multiple studies have proven the value of COVID vaccinations to protect the public in general, and at-risk populations in particular, from hospitalizations and mortality related to COVID, and

Whereas, multiple medical organizations, including the American Medical Association, the American College of Physicians, the American Academy of Pediatrics, and the American Academy of Family Physicians, among others, have issued public statements supporting mandatory vaccinations for health care workers, and

Whereas, there are multiple reports of irresponsible physicians disseminating misinformation and disinformation through public speeches and social media, about the alleged dangers of vaccinations and the ineffectiveness of masking, and touting so-called "therapies" against COVID, in the absence of peer-reviewed scientific data to support their opinions, and

Whereas, MSMS's efforts to combat COVID to date have been lukewarm at best, with no known town halls, press conferences, public service announcements, or published opinions promoting mandatory health care worker vaccinations or castigating physicians who promote unscientific recommendations; therefore be it

RESOLVED: That MSMS takes a more assertive position in favor of mandatory COVID-19 vaccinations for health care workers (with legitimate exceptions), using all available public mediums to do so; and be it further

RESOLVED: That MSMS supports the reporting to the Michigan Boards of Medicine and Osteopathic Medicine and Surgery of any Michigan physician who publicly spreads false and/or misleading information against well-established scientific evidence about COVID vaccinations, masking, or ineffective treatments.

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50 WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new MSMS policy.

Relevant MSMS Policy:

"Our fight against COVID-19 and its effects continues. Many have been vaccinated, and we have made great progress bringing life back to the way it was early last year. Still, COVID is not gone. In fact, it is changing and spreading and right now infecting an increasing number of people who, in most cases, have yet to be vaccinated.

As we have throughout this pandemic, Michigan physicians stand with our colleagues throughout our state's health and hospital systems, and we support their efforts to protect their staff and patients by requiring health system staff to be vaccinated.

The vaccine is safe, it works, and is needed to protect both patients and vital medical staff." – MSMS Board, July 2021

Relevant AMA Policy:

"We stand with the growing number of experts and institutions that support the requirement for universal vaccination of health workers. While we recognize some workers cannot be vaccinated because of identified medical reasons and should be exempted from a mandate, they constitute a small minority of all workers. Employers should consider any applicable state laws on a case-by-case basis." – July 2021, AMA Press Release

Sources:

1. Morse S (editor). AMA urges Supreme Court to uphold vaccination mandates. Healthcare Finance (January 3, 2022). https://www.healthcarefinancenews.com/news/ama-urges-supreme-court-uphold-vaccination-mandates.
2. American College of Physicians, et al. Joint statement in support of COVID-19 vaccine mandates for all workers in health and long-term care. Joint Statement in Support of COVID-19 Vaccine Mandates for All Workers in Health and Long-Term Care (acponline.org)
3. Rubin R. When physicians spread unscientific information about COVID-19. JAMA. Published online February 16, 2022. doi:10.1001/jama.2022.1083

RESOLUTION 47-22

Title:	Protect Freedom of Speech, Diversity of Thought, and Open Scientific Inquiry for Physicians
Introduced by:	David Whalen, MD, MPA, for the Kent County Delegation
Original Author:	Megan Edison, MD
Referred To:	Reference Committee D
House Action:	

Whereas, the AMA Principles of Medical Ethics, in their nine sections, have been adopted by the MSMS as its own policy, and

Whereas, the third AMA Principle of Medical Ethics encourages political action when it states, "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," and

Whereas, the fourth AMA Principle of Medical Ethics implores us to respect the rights of our patients and colleagues when it states, "A physician shall respect the rights of patients, colleagues, and of other health professionals," and

Whereas, the fifth AMA Principle of Medical Ethics requires us to continually seek truth and share that truth when it states, "A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public," and

Whereas, something has happened over these past few years of political and medical upheaval, worsened by uncertainty, fear and isolation, where we have lost sight of the importance of these principles, and

Whereas, the second AMA Principle of Medical Ethics stating, "A physician shall uphold 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," has taken an unprecedented life of its own, the threshold for reportable behavior being mere political disagreement or previously normal scientific skepticism, and

Whereas, history is full of heroic disruptive physicians who challenged the settled science, ushering in astonishing life-saving breakthroughs in medicine, a fact that should humble us all, and

Whereas, the science around one virus, SARS-CoV-2, has changed dramatically over the past two years, a fact that should humble us all, and

Whereas, a rush to judge, "report," and "cancel" fellow physicians, actions encouraged by our specialty boards, for simply expressing political, social, or medical opinions that may not be popular at the time, has become a means to silence physicians and our necessary scientific debate, and

Whereas, many states are pursuing legislation to either limit or protect physician free speech, and,

Whereas, progress in medicine requires open debate and questioning the status quo, and

Whereas, humanity in medicine requires us all to be allowed our own political, social, and religious beliefs and to express those beliefs publicly in a lawful manner, without fear of losing our ability to practice medicine; therefore be it

RESOLVED: That MSMS examine the language of the AMA Code of Medical Ethics as adopted by MSMS as its own code of ethics, to assure our rights to free speech, diversity of thought, and open scientific inquiry are protected and encouraged within the language of the document, reporting back suggested amending language to the 2023 House of Delegates if the document is found lacking; and be it further

RESOLVED: That MSMS study the complicated issue of censored speech, "cancelling" of physicians for expressing unpopular opinions, and how we may balance physician rights and due process with professionalism, reporting back with proposed policy to the 2023 House of Delegates.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,500-$5,000 for board study.

Relevant MSMS Policy:

MSMS supports the AMA 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, but also 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."

(AMA Current Opinions, 2001) (Prior to 1990)
– Reaffirmed 1998
– Reaffirmed (Res30-14)
– Edited 2016

Relevant AMA Policy: See above.

Source:
https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-of-medical-ethics.pdf

RESOLUTION 50-22

Title:	Pictorial Health Warnings on Alcoholic Beverages
Introduced by:	Mara Darian, for the Medical Student Section
Original Authors:	Taania Girgla, Jessyca Judge, Jasdeep Kler, Bryan Rangel Alvarez, Abdulmalik Saleem, Neil Vaishampayan, and Rosa Maria Vasquez
Referred To:	Reference Committee D
House Action:	

Whereas, excessive alcohol use is responsible for more than 95,000 deaths annually, making it a leading cause of preventable death in the U.S., and

Whereas, more than half of alcohol related deaths are linked to a rising number of life-threatening medical conditions, such as liver cirrhosis, cancer, cardiovascular disease, and stroke with prolonged use of excessive alcohol linked to dementia and neuropathy, and use of excessive alcohol during pregnancy linked to fetal alcohol syndrome, the leading cause of intellectual disability in the U.S., and

Whereas, nationally, excessive alcohol use leads to a shortened lifespan by approximately 29 years, for a total of 2.8 million years of potential life lost, and in Michigan, excessive alcohol use results in 2,945 deaths and 84,215 years of potential life lost each year, and

Whereas, the economic burden of alcohol misuse is significant, costing the U.S. $249 billion in 2010 alone of which, three-quarters of the total cost was related to binge drinking and in Michigan, excessive alcohol use cost $8.2 billion, or $2.10 per drink, in 2010 alone of which, three-quarters of the total cost was related to binge drinking, and

Whereas, in 2018, 5.8 percent of adults ages 18 and older nationally had alcohol use disorder, 26.45 percent of people ages 18 or older reported that they engaged in binge drinking in the past month, and 6.6 percent reported that they engaged in heavy alcohol use in the past month, and

Whereas, binge drinking specifically is responsible for more than half the deaths and two-thirds of the years of potential life lost, and in Michigan, 19.7 percent of adults and 17.8 percent of high school students reported binge drinking in 2011, and

Whereas, in Michigan, the alcohol-induced crude mortality rates have been steadily increasing for the last 40 years, and

Whereas, these numbers remain so despite a congressional "Alcoholic Beverage Labeling Act" (ABLA) passed in 1988 requiring health warning statements in text to appear on the labels of all containers of alcohol beverages for sale or distribution in the U.S., and

Whereas, only 35 percent of all adults in the summer of 1991 reported having seen the warning label, signifying that these labels have done little to reduce rates of alcohol-related risky behaviors, rates of consumption, or alcohol-related poor health outcomes during this period, and

Whereas, MSMS current policy supports requiring a text-only warning statement on all advertising for alcoholic beverages regarding fetal alcohol syndrome, and

Whereas, from 1988-1995, studies repeatedly showed that (1) larger pictorial and symbolic health warnings on tobacco packaging were both more effective at reducing tobacco use than smaller text-only warnings and (2) a mixture of health-related and social-related graphic health warnings on tobacco packaging were most effective at reducing tobacco use, and

Whereas, experts have recommended, and studies have shown that the use of pictorial health warnings on alcoholic beverages lead to improve health outcomes, and

Whereas, in the past decade several studies have predicted and proven that negative pictorial health warnings are associated with significantly increased perceptions of the health risks of consuming alcohol as well as greater intentions to reduce and quit alcohol consumption compared to the control, and

Whereas, though critics cite the somatic benefits of alcohol in moderation and question the need for health warnings on alcoholic beverages, research shows that there are adverse effects related to cancer at any level of alcohol consumption, and though critics argue that alcohol can still be consumed in bars and pubs without drinkers seeing the packaging, research actually shows that alcohol purchased from supermarkets is more than twice the level of alcohol consumed in bars/pubs, and

Whereas, MSMS supports a healthy lifestyle related to nutrition and exercise and the avoidance of alcohol and tobacco; therefore be it

RESOLVED: That MSMS will advocate for the implementation of pictorial health warnings on alcoholic beverages for sale in containers in Michigan, including but not limited to images such as a cirrhotic liver and dilated cardiomyopathy secondary to excessive alcohol use, a car crash, or an animation of a baby in the womb; and be it further

RESOLVED: That MSMS will amend current MSMS policy, titled Fetal Alcohol Syndrome, Board-May94, to read: MSMS supports pictorial fetal alcohol syndrome warning statements on all advertising for alcoholic beverages; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to advocate for the implementation of pictorial health warnings on alcoholic beverages.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new MSMS and AMA policy.

Relevant MSMS Policy:

Fetal Alcohol Syndrome
MSMS supports fetal alcohol syndrome warning statements on all advertising for alcoholic beverages. (Board-May94)
- Amended (Sunset Report 2020)

Support of Healthy Lifestyle
MSMS supports a healthy lifestyle related to nutrition and exercise and the avoidance of alcohol and tobacco. (Res36-93A)
– Reaffirmed (Res34-14)

Relevant AMA Policy:

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

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RESOLUTION 54-22

Title: Oppose Michigan's Parental Consent Law MCL 722.903

Introduced by: Mara Darian, for the Medical Student Section

Original Author: Alangoya Tezel

Referred To: Reference Committee D

House Action:

Whereas, according to the Michigan Department of Community Health, 8,143 minors aged 15-19 were pregnant in Michigan in 2019 and, out of these individuals, 2,212 (27.2percent) received an abortion, and

Whereas, Michigan's Parental Consent Law MCL 722.903 requires unemancipated, unmarried minors to obtain written consent from one parent or legal guardian before receiving an abortion, and

Whereas, 13 states do not require any parental involvement in minors' decisions to have an abortion, and

Whereas, Michigan is one of the 36 states to require parental involvement and offer a judicial bypass procedure, a process described as costly, time-intensive, and humiliating for minors, particularly for minors from marginalized groups, and

Whereas, a survey of more than 200 courts in three states found that laws on the judicial bypass procedure for minors seeking abortions were inconsistently applied by judges and/or often ignored altogether, and

Whereas, currently, 16 states waive the parental approval rule in cases of abuse, assault, incest, or neglect; however, Michigan is not one of these states, and

Whereas, limited parental involvement in the abortion process is often motivated by circumstances that may be harmful, restrictive, or unhelpful to minors seeking an abortion, and

Whereas, alternatives to abortion often include self-inflicted abdominal and bodily trauma, ingestion of dangerous chemicals, self-medication with a variety of drugs, and reliance on unqualified abortion providers, and

Whereas, these alternatives collectively lead to minors seeking delayed care or inducing self-harm, resulting in maternal and infant mortality, outcomes which are greatest for minors from marginalized groups who face disproportionate stress and discrimination from a teen pregnancy and disproportionate access to maternal care, and

Whereas, the burden of cost of treating major complications from unsafe abortions is estimated at $553 million annually, and

Whereas, after parental consent for abortions by minors was mandated in Missouri, the proportion of second-trimester abortions increased by an estimated 17 percent, and

Whereas, the average cost of an abortion increases with each additional week in the second trimester, jumping from $470 on average during the first trimester to $1,500 on average at 20 weeks, and

Whereas, in Michigan, minors are able to receive care regarding their sexual health without required parental consent, including birth control, sexually transmitted infections, pregnancy testing, and prenatal care, and

Whereas, the AMA's Code of Medical Ethics Opinion 2.2.3 states: "When an unemancipated minor requests abortion services, physicians should: (a) Strongly encourage the patient to discuss the pregnancy with her parents (or guardian). (b) Explore the minor patient's reasons for not involving her parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve parents. If the patient is unwilling to involve her parents, encourage her to seek the advice and counsel of adults in whom she has confidence, including professional counselors, relatives, friends, teachers, or the clergy. (c) Explain to the minor patient under what circumstances the minor's confidentiality will be abrogated, including: (i) life-threatening emergency; or (ii) when parental notification is required by applicable law. (d) Try to ensure that the minor patient carefully considers the issues involved and makes an informed decision. (e) Not feel or be compelled to require a minor patient to involve her parents before she decides whether to undergo an abortion;" therefore be it

RESOLVED: That MSMS advocate for an amendment to Michigan's Parental Consent Law MCL 722.903 to offer exemptions in cases of abuse, assault, incest, or neglect; and be it further

RESOLVED: That MSMS advocate for the codification of AMA's Code of Medical Ethics Opinion 2.2.3 into state law.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000 for legislative advocacy.

Relevant MSMS Policy:

Prenatal Health Care for Minors
Pregnant minors should be allowed to consent to prenatal and other pregnancy-related medical care. (Prior to 1990) – Amended (Sunset Report 2020)

Relevant AMA Policy:

2.2.2 Confidential Health Care for Minors
Physicians who treat minors have an ethical duty to promote the developing autonomy of minor patients by involving children in making decisions about their health care to a degree commensurate with the child's abilities. A minor's decision-making capacity depends on many factors, including not only chronological age, but also emotional maturity and the individual's medical experience. Physicians also have a responsibility to protect the confidentiality of minor patients, within certain limits.
In some jurisdictions, the law permits minors who are not emancipated to request and receive confidential services relating to contraception, or to pregnancy testing, prenatal care, and delivery services. Similarly,

jurisdictions may permit unemancipated minors to request and receive confidential care to prevent, diagnose, or treat sexually transmitted disease, substance use disorders, or mental illness.
When an unemancipated minor requests confidential care and the law does not grant the minor decision making authority for that care, physicians should:
(a) Inform the patient (and parent or guardian, if present) about circumstances in which the physician is obligated to inform the minor's parent/guardian, including situations when:
(i) involving the patient's parent/guardian is necessary to avert life- or health- threatening harm to the patient;
(ii) involving the patient's parent/guardian is necessary to avert serious harm to others;
(iii) the threat to the patient's health is significant and the physician has no reason to believe that parental involvement will be detrimental to the patient's well- being.
(b) Explore the minor patient's reasons for not involving his or her parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve parents.
(c) Encourage the minor patient to involve his or her parents and offer to facilitate conversation between the patient and the parents.
(d) Inform the patient that despite the physician's respect for confidentiality the minor patient's parents/guardians may learn about the request for treatment or testing through other means (e.g., insurance statements).
(e) Protect the confidentiality of information disclosed by the patient during an exam or interview or in counseling unless the patient consents to disclosure or disclosure is required to protect the interests of others, in keeping with ethical and legal guidelines.
(f) Take steps to facilitate a minor patient's decision about health care services when the patient remains unwilling to involve parents or guardians, so long as the patient has appropriate decision-making capacity in the specific circumstances and the physician believes the decision is in the patient's best interest. Physicians should be aware that states provide mechanisms for unemancipated minors to receive care without parental involvement under conditions that vary from state to state.
(g) Consult experts when the patient's decision-making capacity is uncertain.
(h) Inform or refer the patient to alternative confidential services when available if the physician is unwilling to provide services without parental involvement.

Confidential Health Services for Adolescents H-60.965
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 parent. 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;
(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;
(10) encourages physicians to recognize the unique confidentiality concerns of adolescents and their parents associated with telehealth visits; and
(11) encourages physicians in a telehealth setting to offer a separate examination and counseling apart from others and to ensure that the adolescent is in a private space.

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

Health Care Rights of Pregnant Minors H-60.907
Our AMA will: (1) work with appropriate stakeholders to support legislation allowing pregnant minors to consent to related tests and procedures from the prenatal stage through postpartum care; and (2) oppose any law or policy that prohibits a pregnant minor from consenting to prenatal and other pregnancy related care, including, but not limited to, prenatal genetic testing, epidural block, pain management, Cesarean section, diagnostic imaging, procedures, and emergency care.

2.2.3 Mandatory Parental Consent to Abortion
In many jurisdictions, unemancipated minors are not permitted to request or receive abortion services without their parents' knowledge and consent. Physicians should ascertain the law in their state on parental involvement to ensure that their practices are consistent with their legal obligations. In many places, the issue of confidentiality for minors who seek an abortion implicates competing ethical concerns apart from the abortion issue itself.
When an unemancipated minor requests abortion services, physicians should:
(a) Strongly encourage the patient to discuss the pregnancy with her parents (or guardian).
(b) Explore the minor patient's reasons for not involving her parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve parents. If the patient is unwilling to involve her parents, encourage her to seek the advice and counsel of adults in whom she has confidence, including professional counselors, relatives, friends, teachers, or the clergy.
(c) Explain to the minor patient under what circumstances the minor's confidentiality will be abrogated, including:
(i) life-threatening emergency; or
(ii) when parental notification is required by applicable law.
(d) Try to ensure that the minor patient carefully considers the issues involved and makes an informed decision.
(e) Not feel or be compelled to require a minor patient to involve her parents before she decides whether to undergo an abortion.

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RESOLUTION 55-22

Title: Continuity of Care Upon Release from Correctional Systems

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: Kumaran Arivoli, Neil Vaishampayan, Jasdeep Kler, Bryan Rangel Alvarez, Jessyca Judge, Rosa Maria Vasquez, and Abdulmalik Saleem

Referred To: Reference Committee D

House Action:

Whereas, the rate of recidivism, or the re-entry of formerly incarcerated people, is 70 percent in the United States of America, and more than 50 percent of those incarcerated have been incarcerated more than once, and

Whereas, roughly 20-25 percent of those incarcerated have a severe mental illness with up to 90 percent reporting consistently poor mental health, and

Whereas, mental health problems are by far the most significant cause of morbidity and the vast majority of mental health conditions are not detected upon release, and

Whereas, the general American population has a substance abuse rate of approximately seven percent, people who are incarcerated have a substance abuse rate of approximately 38 percent and are found to relapse approximately 50 percent of the time post-release, and

Whereas, incarcerated people with major psychiatric disorders are at an increased risk of multiple incarcerations, and risk factors such as certain psychiatric disorders, substance abuse, and lack of treatment adherence are risk factors for recidivism within the correctional system, and

Whereas, for formerly incarcerated people, the mental and substance abuse services they receive post-release are critical but inconsistent or inadequate, and

Whereas, assertive and continuous post-release social work, consisting of frequent mental health check-ins and referrals to addiction support groups significantly showed more post-release connections to mental health services as well as a significant reduction in reincidence, and

Whereas, only 28 percent of county jails screen inmates for Medicaid eligibility after release, and in the U.S., 16 states have no formal procedure to enroll people in Medicaid post-release, which serves as a barrier to crucial health care services, and

Whereas, these barriers not only lead to worsened and more costly health outcomes, it also increases the rates of recidivism, and

Whereas, recidivism rates have been shown to fall when newly-released incarcerated people have assistance in accessing medications, their medical records, and primary and specialty care, and

Whereas, in a national study of 1,434 ex-prisoners, 31.7 percent had three or more emergency department (ED) visits compared with only 6.5 percent of adults in the general population having two or more ED visits, and

Whereas, individuals with recent criminal justice involvement represent only 4.2 percent of the population, but they make up 8.5 percent of all emergency department (ED) expenditures, which translates to an additional $5.2 billion in annual spending across the health care sector, and

Whereas, when inmates in Rhode Island received medications for opioid use disorder while incarcerated, post-release emergency department visits were decreased, and similarly when inmates leaving prisons in California received transitional care (including medication refills and expedited primary care appointments), they had half as many annual emergency department visits, and

Whereas, in Ohio the Medicaid Pre-Enrollment Reentry program resulted in 30 percent of newly enrolled individuals participating in substance use treatment and 38 percent of individuals reporting the cost relief by Medicaid reduced their odds of recidivism, and

Whereas, in 2020, Maryland's Returning Citizens HealthLink Program worked with 3,453 inmates and determined that 86.8 percent qualified for Medicaid; of those that qualified, 89 percent were enrolled prior to release; therefore be it

RESOLVED: That MSMS advocates for consistent, longitudinal assistance spanning two years to newly-released people from correctional facilities; and be it further

RESOLVED: That MSMS advocate for a protocol wherein everyone released from prison or jail be connected to a health linkage program or health enrollment official from the responsible municipality who helps: a) apply/re-enroll/unsuspend individuals into a health insurance plan before release and b) provide comprehensive review of individual health status before release; and be it further

RESOLVED: That MSMS supports assistance from social workers, health care workers, and other staff to provide newly-released people from correctional facilities frequent mental health check-ins, referrals to substance abuse services, insurance eligibility screenings, and connections to primary and specialty health providers; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to amend AMA policy H-430.986 - Health Care While Incarcerated (AMA) to read as follows: 1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community. 2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system. 3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated. 4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive

an eligibility determination for Medicaid. 5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community. 6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons. 7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered. 8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum. 9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities. 10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; [and (c) the provision of longitudinal care from state supported social workers to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people to support their employment, education, housing, healthcare, and safety]. **11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention. 12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.**

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new AMA policy.

Relevant MSMS Policy: None

Relevant AMA Policy: See above.

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RESOLUTION 60-22

Title: Eliminate Medical Co-Payments in Prisons and Jails

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: Luca Borah, Hannah Catzen, Sarosh Irani, Charlotte Kreger, and Tiffany Loh

Referred To: Reference Committee D

House Action:

Whereas, prior to their incarceration, individuals in jails and prisons earned 41 percent less than their non-incarcerated counterparts, and

Whereas, people of color comprise 37 percent of the U.S. population, but 67 percent of the prison population, and

Whereas, incarcerated individuals are more at risk for chronic conditions and infectious diseases due to crowding, malnutrition, stress, and trauma, and

Whereas, as of December of 2020, at least 275,000 incarcerated individuals have been infected with COVID-19, 1700 have died; in Michigan, 52.4 percent of the prison population has been infected with COVID compared to only 4.8 percent in the state overall, and

Whereas, The American Journal of Preventive Medicine recommends eliminating copayments during the pandemic because such fees "prevent the timely identification, isolation, treatment and referral of cases," and

Whereas, in the state of Michigan the minimum wage for labor performed by incarcerated individuals is $0.14/hour and the average copay to receive necessary medical care in jails and prisons is $5, which is equivalent to over 35 hours of work from a minimum wage prison job, and

Whereas, copayments serve as a barrier to accessing care, resulting in incarcerated patients delaying or foregoing necessary medical care due to costs, which has been shown to delay diagnosis and treatment, worsen health conditions, and result in more expensive health care, and

Whereas, untreated infections among incarcerated patients spread rapidly due to space limitations and poor environmental and hygienic conditions, and

Whereas, the state of Michigan collects only $190,000 a year on medical copays, offsetting only 0.06 percent of the state's prison health care annual budget of $300 million, and

Whereas, the financial burden associated with administering copays ultimately costs more than copays recover, and

Whereas, thirteen states in the U.S. have elected to provide medical care to incarcerated individuals without copays; therefore be it

RESOLVED: That MSMS will support the elimination of medical copayments in prisons and jails across the state of Michigan; and be it further

RESOLVED: That MSMS will support research into how copayments impact utilization patterns and health outcomes in incarcerated settings.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000 for regulatory and/or industry advocacy.

Relevant MSMS Policy: None

Relevant AMA Policy:

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.

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Reference Committee E

MICHIGAN STATE MEDICAL SOCIETY
2022 HOUSE OF DELEGATES

RESOLUTIONS BY COMMITTEE

REFERENCE COMMITTEE E – SCIENTIFIC AND EDUCATIONAL AFFAIRS

RESOLUTION	DESCRIPTION
06-22 (17-20)	Balancing Supply and Demand for Physicians by 2030
13-22 (40-20)	Tuition Cost Transparency
14-22 (53-20)	Mental Health First Aid Training
20-22	Ending Early School Start Times in Michigan
21-22	Bedside Nursing and Health Care Staff Shortages
31-22	Amend CME Rules to Align with ABMS Policy Changes
36-22	Limit the Pornography Viewing by Minors Over the Internet
37-22	"Equality Model" for Survivors of Human Trafficking
39-22	Expedited Immigrant Green Card for J-1 Visa Waiver Physicians Serving in Underserved Areas
43-22	Risks of Substance Use Linked to a Child's Early Years
53-22	Standards in Cultural Humility Training within Medical Education
56-22	Universal K-12 Mental Health Screenings in Michigan Public Schools
59-22	Improving and Standardizing Pregnancy and Lactation Accommodations for Medical Board Examinations
BOARD ACTION REPORT	**DESCRIPTION**
#2-22	Resolution 02-21 – "Vision Qualifications for Driver's License"

RESOLUTION 06-22 (17-20)

Title: Balancing Supply and Demand for Physicians by 2030

Introduced by: Martha Gray, MD, for the Washtenaw County Delegation

Original Author: Martha Gray, MD

Referred To: Reference Committee E

House Action:

Whereas, current demographics predict growth of an aging population of people over age 65 by 55 percent, and

Whereas, projected shortfalls in primary care physicians ranges between 7,300 and 43,000 by 2030, and

Whereas, if current underserved populations utilize health care at the same rate as other patient populations, even higher demand is projected for primary care physicians, and

Whereas, current proportion of internal medicine residents completing training and going into primary care practice has fallen below 10 percent, and

Whereas, lifestyle, medical student debt, complex patient care demands, silos of care, electronic health record overload, and burnout all work against primary care physician recruitment; therefore be it

RESOLVED: That MSMS take action on all fronts to pursue and implement remedies that will rebalance the supply and demand equation for primary care physicians by 2030; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to take action on all fronts to pursue and implement remedies that will rebalance the supply and demand equation for primary care physicians by 2030.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new MSMS and AMA policy; $12,000-$24,000 for regulatory and industry advocacy.

Relevant MSMS Policy:

New Medical Schools in Michigan
MSMS urges the state of Michigan to perform a thorough prospective study on the effect of proposed medical schools on existing medical schools before any new medical schools are founded in Michigan and urges state officials to conduct a study on the impact of current and new medical schools, existing residency training positions, and the effect on international medical graduates on the future supply of physicians in Michigan.

Relevant AMA Policy:

US Physician Shortage H-200.954
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;
(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

Revisions to AMA Policy on the Physician Workforce H-200.955
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.
(8) Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agencys physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.
(9) Our AMA will consider physician retraining during all its deliberations on physician workforce planning.

Primary Care Physicians in Underserved Areas H-200.972
1. Our AMA should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
(a) Encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care.
(b) Encourage the affiliation of these family health clinics with local medical schools and teaching hospitals.
(c) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.
(d) Encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence.
(e) Urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations.
(f) 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 help meet the needs of underserved patient populations.
(g) Urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.

2. Our AMA supports efforts to: (a) expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and (b) increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that:
A. 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.
B. 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.
C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
D. 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.
E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
F. 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.
G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.

H. 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.
I. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
J. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.

3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.

4. Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.

Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy D-305.958
1. Our AMA will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform.
2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US.
3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997.
4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages.
5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians.
6. Our AMA will work with key organizations, such as the US Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to: (A) support development of reports on the economic multiplier effect of each residency slot by geographic region and specialty; and (B) investigate the impact of GME funding on each state and its impact on that state's health care workforce and health outcomes.

Sources:

1. Complexities of Physician supply and Demand 2017 Association of American Medical Colleges; IHS Markit report 2019 update
2. Trends in Career Paths of Internal Medicine Residents. Internal Medicine In-Training Exam Survey of interest to disclose.

RESOLUTION 13-22 (40-20)

Title: Tuition Cost Transparency

Introduced by: Mara Darian for the Medical Student Section

Original Authors: Awais Ahmed, Kaylie Bullock, Amy Cox, Kelly Fahey, Eric James, Benjamin Malamet, Ramiz Memon, Grace Peterson, Stephanie Wong

Referred To: Reference Committee E

House Action:

Whereas, in 2018, the Association of American Medical Colleges (AAMC) reported that 76 percent of medical students graduated with a median loan debt of $200,000. Compared to the median medical student debt of $50,000 in 1992, there is an approximate 220 percent increase in medical school debt, even after accounting for the rate of inflation, and

Whereas, the capitalizing interest rates of Stafford Subsidized loans increased from 1.87 percent prior to 2006, to a current fixed rate of 6.87 percent, thereby exacerbating the rising debt of medical students, and

Whereas, MSMS policy advocates for a variety of means in order to decrease medical student debt in the short-term and long-term, and

Whereas, higher levels of medical school debt are associated with worse academic outcomes in undergraduate medical education, negative effects on mental well-being, and higher levels of stress, and

Whereas, higher medical school debt influences the way medical students approach major life choices; students with higher aggregate amounts of debt were more likely to delay marriage or having children and disagree that they would choose to become a physician again, and

Whereas, medical students with higher debt compared to their peers were more likely to choose a specialty with a higher annual income, were less likely to choose primary care, and less likely to plan to practice in underserved locations, and

Whereas, the number of graduate medical students exceeds the number of available post graduate year positions. The increasing number of students not matching, and the increase in medical student debt can make medical school seem more of a financial risk, and

Whereas, the American Medical Association (AMA) supports continued assessment of the value of graduate medical education (GME) and transparency of federal funding, which is received by GME institutions, and

Whereas, undergraduate medical students are not provided specific breakdowns of tuition costs or reasons for tuition increases, and

Whereas, the AMA supports improving the systematic reporting of undergraduate medical student expenditures to determine which items are included and the ranges of costs; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to collaborate with organizations such as the Association of American Medical Colleges in creating transparency in tuition costs of undergraduate medical education institutions; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to collaborate with the Association of American Medical Colleges in systematic reporting of itemized tuition cost of undergraduate medical education annually thereby releasing an annual public report; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to work with other national organizations to support the responsible use of tuition funds by undergraduate medical institutions to improve the affordability of medical education.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000–$2,000 for new or revised AMA policy.

Relevant MSMS Policy:

Medical School Debt Forgiveness
MSMS supports the principle of debt forgiveness for students of Michigan medical schools in return for service in primary care in the state of Michigan.

Medical School Debt: Resolution 17-12
RESOLVED: That MSMS encourage legislation that would address the burden of medical school debt of future physicians through city, county, or regional purchase of tuition costs of medical students in return for service in these communities upon completion of training; and be it further

RESOLVED: That MSMS seek employment opportunities for medical students with area health systems and/or hospitals affiliated with medical schools to work during breaks, with wages that may be used to significantly reduce the debt burden of medical students.

Medical Student Debt Crisis: Resolution 46-08
RESOLVED: That MSMS pursue immediate debt relief for medical students at the statewide level by advocating for tuition freezes upon matriculation at state medical schools, pursuing scholarship and loan repayment options for students who stay to train and practice in the state, and continue to advocate at the state and national level for medical student debt relief; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to pursue long-term solutions to the student debt crisis by hiring an economic consulting firm to analyze the feasibility of novel solutions1 including; 1) competency-based curriculums that shorten the length of undergraduate education and medical school, 2) work-study opportunities, 3) paid rotating internships for fourth-year students who have passed initial licensing exams and have the training equivalents of mid-level providers, 4) financial investment funds that match parental savings, 5) relief for dual degrees not covered by the National Institute of Health, 6) pursuit of government Medicare funding for undergraduate medical education funding, and 7) implementing international medical student tuition models, among other viable options.

Relevant AMA Policy:

Cost and Financing of Medical Education and Availability of First-Year Residency Positions H-305.988

Our 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 compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.

10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

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RESOLUTION 14-22 (53-20)

Title: Mental Health First Aid Training

Introduced by: Mara Darian for the Medical Student Section

Original Authors: Nona Bhatia, Miriam Dow, Jamarie Geller, Maryssa Gilbert, Gabrielle Guzzardo, Alivia Knol, Adjoa Kusi-Appiah, Enrique Rodriquez-Fhon, Vikramjeet Saraan, and Manisha Verma

Referred To: Reference Committee E

House Action:

Whereas, the American Medical Association endorses that all licensed physicians should become proficient in cardiopulmonary resuscitation for medical emergencies, yet there is no such equivalent policy for mental health crisis or substance use emergencies, and

Whereas, Mental Health First Aid (MHFA) is a course that teaches the identification, understanding, and appropriate response to signs of mental illnesses and substance use disorders, providing the skills needed to reach out and provide initial help and support persons who may be developing a mental health or substance use problem or experiencing a crisis, and

Whereas, there are an estimated 46.6 million adults (about 1 in 5 Americans aged 18 or older) with a mental illness, and more than 20 percent (about 1 in 5) of children have had a seriously debilitating mental disorder, and

Whereas, suicide is the tenth leading cause of death overall in the U.S. and the second leading cause of death among people aged 15-34, and

Whereas, mood disorders are the third most common cause of hospitalization in the U.S. for youth and adults aged 18-44, and

Whereas, there are 65.9 million physician office visits with mental disorders as the primary diagnosis annually, and

Whereas, United Kingdom medical students who underwent the eLearning course of MHFA showcased the potential to improve students' mental health first aid skills and confidence in helping others, and

Whereas, 27.2 percent of medical students show signs and symptoms of depression and of them, 11.1 percent are suicidal, yet only 16 percent of those screening positive for depression seek psychiatric treatment, and

Whereas, online and face-to-face versions of MHFA have shown to improve outcomes for medical and nursing students with mental health problems such as preventing high failure rates and discontinuation of study, and the knowledge from the training was shown to potentially help them with their future careers, and

Whereas, in a survey of 2,000 U.S. physicians, approximately 50 percent believed they at one point met criteria for a mental health disorder but did not seek treatment, and

Whereas, MHFA training programs in the U.S. have been shown to increase knowledge of prevalence rates, cardinal signs and symptoms of common mental health diagnoses, and confidence in being able to apply interventional skills, and

Whereas, in a MHFA pre-survey, health care providers reported the same level of confidence when dealing with mental health as compared to the general public, and

Whereas, current performance in the management of mental illness in primary care settings is described by the rule of diminishing halves: "only half the patients with a threshold disorder are recognized; only half of those recognized are treated; and only half of those treated are effectively treated," and

Whereas, a meta-analysis of 90 independent reports demonstrated that mental health intervention programs amongst higher education students showed significant improvement of social-emotional skills, self-perception, and academic and behavior performance, especially when combined with supervised skills practice, and

Whereas, the number of behavior and mental health-related visits in the Emergency Department (ED) has seen a 44.1 percent increase over the last decade and has now reached an estimated one in every six ED visits; and despite this increase, there still remains a lack of compensatory mental health education to meet the new demand, and

Whereas, Emergency Medicine (EM) residents care for 1-2 patients per day with psychiatric or behavioral health complaints, yet more than half (55 percent) of them report their perception of involvement to be minimal-to-none in the management and care of these patients (beyond medical clearance), and 84 percent of them report they are more comfortable with treating a patient's physical illness than their mental illness, and

Whereas, fifty-nine percent of surveyed EM residents across the U.S. believed that their program should have offered more psychiatric education in order to better equip them with tools about how to handle psychiatric emergencies of all kinds, as only 13 percent reported "well prepared" to do so, and

Whereas, rates of mental health disorders are rising, and in many cases, the need far exceeds the resources available, and

Whereas, the national shortage of psychiatrists is linked to a lack of exposure to clinical psychiatry in medical school curricula, and

Whereas, psychiatry enrichment activities in medical school are shown to increase student interest in and understanding of the specialty, and

Whereas, MHFA has shown to decrease negative attitudes and stigma, and increase supportive behaviors towards people struggling with mental health, and

Whereas, mental health education programs for health professionals: general practitioners, psychiatrists, junior medical staff, psychologists, nurses, and social workers, led to an increase in perceived knowledge of mental illness and improvements in attitude toward mental illness, and

Whereas, many treatments are available to reduce the symptoms and disabilities of mental illness, yet stigma discourages patients to pursue care as a means to avoid potential discrimination, and

Whereas, primary care providers who endorsed stigmatizing ideas surrounding mental illness were found to be less likely to refer patients to needed follow-up services for comorbid physical conditions, and

Whereas, first year medical students who received additional mental health education revealed favorable attitudinal changes in terms of psychiatric services, human rights of the mentally ill, patients' independence in social life, and causes and characteristics of mental illness, and

Whereas, after four years of medical education medical students associated mental illness with stigma, stereotypes, and stress, in contrast to their initial interest in psychiatry before beginning their clinical curriculum, and

Whereas, a study of fourth year medical students showed that exposure to patients with mental illnesses during psychiatric clerkship did not improve their attitudes towards mental illness and psychiatric conditions as compared to before the clerkship, suggesting more educational training is needed, and

Whereas, fourth year medical students who successfully completed their psychiatry clerkship and showed interest in pursuing psychiatry, endorsed that stigma, stereotypes, and stress adversely affected their attitude toward mental illness and willingness to care for patients with mental illness, and

Whereas, a meta-analysis of randomized controlled trials concerning the incorporation of mental health interventions into higher education showed evidence of long-term sustainability, and

Whereas, the International Association of Medical Colleges and World Federation for Medical Education require that medical schools incorporate into the curriculum contributions of medical psychology that would enable effective communication, clinical decision-making and ethical practice, and

Whereas, in the “Mental Health Competencies for Pediatric Practice” Policy Statement, the American Academy of Pediatrics recommends that “pediatricians pursue quality improvement and maintenance of certification activities that enhance their mental health practice, prioritizing suicide prevention” and “advocate for innovations in medical school education, residency and fellowship training, and continuing medical education activities to increase the knowledge base and skill level for future pediatricians in accordance with mental health competencies,” and

Whereas, the 114th U.S. Congress HR 1877/S711 bill proposes authorization of $20 million for Mental Health First Aid Training programs to primary care professionals, students, emergency services personnel, police officers, and others with the goal of improving Americans' mental health,

reducing stigma around mental illness, and helping people who may be at risk for suicide or self-harm and referring them to appropriate treatment; therefore be it

RESOLVED: That MSMS encourage physician acquisition of Mental Health First Aid skills by offering education courses for physicians, fellows, residents, and medical students; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to encourage physician acquisition of Mental Health First Aid skills by offering education courses for physicians, fellows, residents, and medical students.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000 for physician outreach efforts and $1,000-$2,000 for new AMA policy.

Relevant MSMS Policy:

Suicide Awareness and Intervention Training Programs
MSMS supports training programs in the use of integrated multidisciplinary approaches to suicide awareness and intervention for health care professionals including physicians, advanced practice nurses, physician assistants, registered nurses, and mental health professionals.

Suicide Awareness Training
MSMS supports the implementation of evidence-based suicide awareness and training programs in health care systems and communities throughout Michigan.

Suicide Prevention Awareness and Education
MSMS supports efforts to raise awareness about the rising rate and devastating toll of suicide; to increase suicide prevention education for all physicians, residents, medical students, and allied health professionals; to encourage active engagement in suicide prevention awareness with their patients and colleagues; to increase research associated with suicides; and to reduce liability for those who provide suicide prevention care.

Relevant AMA Policy:

Increasing Detection of Mental Illness and Encouraging Education (D-345.994)
Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

Awareness, Diagnosis, and Treatment of Depression and other Mental Illnesses (H-345.984)
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 and other mental illnesses, either as the chief complaint or 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 and other mental illnesses 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. 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 and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings. Our AMA recognizes the impact of violence and social determinants on women's mental health.

Statement of Principles on Mental Health (H-345.999)
Tremendous strides have already been made in improving the care and treatment of patients with psychiatric illness, 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 psychiatric illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive. 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. The AMA will be more active in encouraging physicians to become leaders in community planning for mental health. -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.

Access to Confidential Health Services for Medical Students and Physicians H-295.858
Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to: -Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means; -Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees; -Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and -Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle. -Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety. -Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would: be available to all medical students on an opt-out basis; ensure anonymity, confidentiality, and protection from administrative action; provide proactive intervention for identified at-risk students by mental health and addiction professionals; and inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation. -Our AMA: (a) encourages state medical

boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior. -Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education. -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. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education. -Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

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RESOLUTION 20-22

Title: Ending Early School Start Times in Michigan

Introduced by: Maria Tovar, MD, for the Michigan Academy of Sleep Medicine

Original Author: Virginia Skiba, MD

Referred To: Reference Committee E

House Action:

Whereas, insufficient sleep in adolescents can lead to poor academic performance and tardiness; poor mental health including depression, anxiety and suicidal ideation; sleepiness; a myriad of physical health issues including risk of obesity; as well as public health consequences such as drowsy driving and increased vehicular crash rates, and

Whereas, the American Academy of Sleep Medicine recommends 8-10 hours of sleep for adolescents, the prevalence of short sleep duration among high school students in the national Youth Risk Behavior Survey in 2015 was 72.7 percent, and

Whereas, the sleep/wake cycle is delayed in adolescents due to alterations in the two processes that regulate sleep: the circadian rhythm with development of a more evening-type circadian phase preference and the homeostatic process with slower accumulation of sleep pressure in adolescents; and around the time of pubertal onset, children experience a physiologically delayed sleep phase of about two hours compared to their prior sleep schedule, and

Whereas, these circadian and homeostatic changes contribute to later sleep onset and later morning awakening, with teenagers typically struggling to fall asleep before 11:00 p.m., so a teenager who goes to bed around 11:00 p.m. would need to sleep until 7:30 a.m. or later to obtain sufficient sleep; and therefore, adolescents with early school start times suffer not only from sleep deprivation but also from circadian misalignment, and

Whereas, the American Medical Association, American Academy of Sleep Medicine, and Society of Behavioral Medicine have put out statements to start middle and high school classes no earlier than 8:30 a.m., and the American Academy of Pediatrics put out a statement urging high school and middle schools to aim for start times that would allow students the opportunity to achieve optimal levels of sleep, and

Whereas, in 2019 the state of California passed SB-328 requiring high schools to begin no earlier than 8:30 a.m. and middle schools no earlier than 8:00 a.m., four other states have passed laws to study healthy school start times, and thirteen other states have introduced legislation to either study, encourage, or mandate later start times, and

Whereas, in 2015 the Centers for Disease Control and Prevention published school start times for middle and high school students in the United States, and in Michigan only 7.9 percent of schools had start times of 8:30 a.m. or later, and

Whereas, later middle and high school start times and earlier elementary start times have minimal impact on younger students while benefiting older students with more sleep time and less sleepiness; for example, a 2-year follow-up of a school district that changed to have high schools start 70 minutes later and elementary school times 60 minutes earlier showed an increase in sleep duration of 45 minutes for high school students and a reduction in daytime sleepiness of 11.6 percent, with minimal negative impact on elementary school students, and

Whereas, later high school start times lead to a reduction in car crashes; in one district in Virginia crashes decreased from 31.6 to 29.6 events per 1,000 with main decrease related to fewer distraction-related incidents and in another district in Kentucky the average crash rate for teenage drivers decreased by 16.5 percent, while the state as a whole increased by 7.8 percent in the same time period, and

Whereas, implementing delayed school start times is shown to increase sleep duration, improve sleepiness and overall perception of sleep, improve concentration and attention, decrease depression mood scores, lower frequency of headaches, decrease tardiness, presenteeism and falling asleep in class and not adversely impact students being involved in sports and other extracurricular activities, and

Whereas, several districts in the state of Michigan have implemented later start times and noted students feeling more rested and refreshed, improved academic performance, decrease in tardiness, increased effectiveness of first period, fewer absences, fewer accidents, and lower rates of depression and suicide; therefore be it

RESOLVED: That MSMS encourage the Michigan Department of Education to educate school districts, caregivers, and students on the harms of insufficient sleep and the benefits of later school starts; and be it further

RESOLVED: That MSMS believes the state of Michigan should mandate that high schools start no earlier than 8:30 a.m. to provide students the opportunity to obtain the physiologically required amount of sleep; thereby, resulting in scholastic, psychological, and health benefits.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000 for regulatory and/or industry advocacy.

Relevant MSMS Policy: None

Relevant AMA Policy:

Insufficient Sleep in Adolescents H-60.930

1. Our AMA identifies adolescent insufficient sleep and sleepiness as a public health issue and supports education about sleep health as a standard component of care for adolescent patients.
2. Our AMA: (a) encourages school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep; (b) encourages physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the biologic sleep needs of adolescents; and (c) encourages continued research on the impact of sleep on adolescent health and academic performance.

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RESOLUTION 21-22

Title: Bedside Nursing and Health Care Staff Shortages

Introduced by: Anthony M. Zacharek, MD, for the Saginaw County Delegation

Original Author: Julia M. Walter, MD

Referred To: Reference Committee E

House Action:

Whereas, there is a national shortage of bedside nurses, and a shortage of bedside nurses in Michigan hospitals, and

Whereas, hospitals pay less for nursing salaries than nurses receive when working for travel companies, and some hospitals have had their nurses poached by other organizations, and

Whereas, experienced nurses are leaving bedside nursing jobs and choosing nonclinical careers, and

Whereas, nursing students often wait to finish their education due to a lack of clinical sites or nursing educator availability, and

Whereas, hospitals have reduced numbers of ancillary staff, and

Whereas, there is a shortage of emergency medical services providers, and

Whereas, working in a hospital is physically demanding, requires working long shifts, and may require mandated overtime, and

Whereas, working in a hospital and other health care jobs pay lower wages than less demanding occupations, and

Whereas, many nurses, physicians, ancillary staff, and physician assistants are suffering from moral injury and burnout related to the COVID-19 pandemic, and

Whereas, many patients require transfer to tertiary care hospitals for more definitive care, and

Whereas, many Michigan hospitals have been on diversion due to staff shortages causing delays in care and the delay in care, crowding and boarding, and increased hospital length of stays lead to increased morbidity and mortality for patients, and

Whereas, hospital administrators are not openly disclosing any strategies or solutions to address the shortage of all hospital staff, and hospitals, national news, and local news have been relatively silent on the bedside nursing and staff shortages, and

Whereas, hospitals had nursing and staff shortages before the COVID-19 pandemic and hospitals have been receiving federal financial assistance during the pandemic, and

Whereas, hospitals have not developed systematic long-term strategies to (1) improve staffing models which address the bedside nursing and health care worker shortages or (2) address wellness among their staff to improve career longevity, and

Whereas, physicians are the leaders of the health care team, and

Whereas, those who continue to work in hospitals are doing so under more duress due to shortages in staffing and delays in patient care; therefore be it

RESOLVED: That MSMS contact appropriate stakeholders such as the Michigan Health & Hospital Association and officially request the opportunity to collaborate on short and long-term strategies and solutions for addressing the nursing and health care staff shortages which promote a stable work force and career longevity; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to contact appropriate stakeholders such as the American Hospital Association and offer to collaborate on short and long-term strategies and solutions for addressing the nursing and health care staff shortages which promote a stable work force and career longevity.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000 for collaborative outreach efforts.

Relevant MSMS Policy: None

Relevant AMA Policy:

The Growing Nursing Shortage in the United States D-360.998
Our AMA: (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields;
(2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients;
(3) encourages hospitals and other health care facilities to collect and analyze data on the relationship between staffing levels, nursing interventions, and patient outcomes, and to use this data in the quality assurance process;
(4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions;
(5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care.

Revisions to AMA Policy on the Physician Workforce H-200.955
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.
(8) Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agency's physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.
(9) Our AMA will consider physician retraining during all its deliberations on physician workforce planning.

RESOLUTION 31-22

Title: Amend CME Rules to Align with ABMS Policy Changes

Introduced by: Richard Burney, MD, for the Washtenaw County Delegation

Original Author: Richard Burney, MD

Referred To: Reference Committee E

House Action:

Whereas, continuing medical education (CME) provisions in the Michigan Administrative Code (R 338.2443 and R 338.143) specify that specialty board certification or recertification may count for 50 hours of CME in the year in which it is achieved, and

Whereas, these rules are based on the premise that such board recertification is contingent on an examination that is taken at intervals of five to ten years, as prescribed by the applicable specialty board, and

Whereas, the Federation of State Medical Boards (FSMB) supports the use of, and encourages state boards to recognize, a licensee's participation in an American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC) and/or American Osteopathic Association Bureau of Osteopathic Specialists Osteopathic Continuous Certification (AOA BOS OCC) program as an acceptable means of meeting CME requirements for license renewal, and

Whereas, the ABMS has adopted new policies regarding renewal of specialty certification moving from "maintenance of certification" done at five to ten-year intervals to a "continuing certification" model in which to maintain board certification the diplomate will be actively and continuously engaged with the specialty board CME program, and

Whereas, this new model of formative continuing medical education is superior to the present summative model, and

Whereas, the current Rules in the Michigan Administrative Code do not align with this new ABMS CME model; therefore be it

RESOLVED: That MSMS work with the Michigan Boards of Medicine and Osteopathic Medicine and Surgery to amend the Michigan Administrative Code, Rules 338.2443 and 338.143, to align with the new American Board of Medical Specialties' Standards for Continuing Certification such that active participation in specialty continuing certification constitutes evidence of substantial compliance with continuing medical education (CME) requirements and an acceptable means of meeting CME requirements for license renewal.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000 for regulatory and/or industry advocacy.

Relevant MSMS Policy:

Maintenance of Certification versus CME and Lifelong Commitment to Learning
MSMS opposes discrimination by hospitals and any employer, the Michigan Board of Medicine, insurers, Medicare, Medicaid, and other entities, which might restrict a physician's right to practice medicine without interference (including economic discrimination by varying fee schedules) due to lack of participation in prescribed corporate programs including Maintenance of Certification or expiration of time limited board certification. (Res85-13)

Review Board Recertification and Maintenance of Certification Process
MSMS supports Maintenance of Certification (MOC) only under all of the following circumstances:
1. MOC must be voluntary
2. MOC must not be a condition of licensure, hospital privileges, health plan participation, or any other function unrelated to the specialty board requiring MOC
3. MOC should not be the monopoly of any single entity. Physicians should be able to access a range of alternatives from different entities.
4. The status of MOC should be revisited by MSMS if it is identified that the continuous review of physician competency is objectively determined to be a benefit for patients. If that benefit is determined to be present by objective data regarding value and efficacy, then MSMS should support the adoption of an evidence based process that serves only to improve patient care. (Res73-15)
– Reaffirmed (Res10-19)

Relevant AMA Policy:

Continuing Board Certification H-275.924
AMA Principles on Continuing Board Certification
1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.
4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit", American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."

10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. CBC should be used as a tool for continuous improvement.
15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing CBC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. CBC activities and measurement should be relevant to clinical practice.
19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.

Continuing Board Certification D-275.954
Our AMA will:
1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a yearly report to the House of Delegates regarding the CBC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review CBC issues.

3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Continue to assist physicians in practice performance improvement.

25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's CBC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.
36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.
38. Our AMA, through its Council on Medical Education, will continue to work with the ABMS and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development of new, integrated standards for continuing certification programs by 2020 that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.
39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.

Sources:

1. Federation of State Medical Boards Public Policy Compendium, 2021-22, 120.2 Participation in ABMS MOC and AOA BOS OCC Programs to Meet CME Requirements for License Renewal - https://www.fsmb.org/siteassets/advocacy/policies/public-policy-compendium.pdf
2. ABMS Standards for Continuing Certification - https://www.abms.org/board-certification/board-certification-standards/standards-for-continuing-certification/

RESOLUTION 36-22

Title: Limit the Pornography Viewing by Minors Over the Internet

Introduced by: Joseph M. Beals, MD, for the Wayne County Delegation

Original Author: Joseph M. Beals, MD

Referred To: Reference Committee E

House Action:

Whereas, the pornography industry has developed at a fast-pace secondary to Internet accessibility, and

Whereas, explicit material is readily available on the internet, and

Whereas, the number of pornography consumers is steadily increasing, mostly represented by men and young adults below the age of 34, and

Whereas, 70 percent of adult U.S. citizens age 18-30 admit to watching online pornography at least once per month, and

Whereas, 60 percent of college students admit to viewing pornography once per week, and

Whereas, 59-96 percent of adolescents in countries such as Taiwan and Sweden view pornography, and

Whereas, while pornography has a long history, new technology offers unlimited sexual diversity via free-of-charge online websites, and

Whereas, long term use of pornography correlates with erectile dysfunction, decreased libido, and lower sexual and relationship satisfaction, and has a negative effect on the quality of social relationships, and

Whereas, while the incidence of pornographic use is mostly in the male population, the incidence of women using pornography is increasing, and

Whereas, frequent use of pornography leads to increased incidence of buying sex; therefore be it

RESOLVED: That MSMS seek ways to limit the access of pornography to minors on the Internet, mobile applications, as well as, through in person retailers; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to seek ways to limit the access of pornography to minors on the internet, mobile applications, as well as, through in person retailers.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new MSMS and AMA policy.

Relevant MSMS Policy: None

Relevant AMA Policy:
H-60.934: Internet Pornography Protecting Children and Youth Who Use the Internet and Social Media
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 and social media use. (5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.

RESOLUTION 37-22

Title: "Equality Model" for Survivors of Human Trafficking

Introduced by: Joseph M. Beals, MD, for the Wayne County Delegation

Original Author: Joseph M. Beals, MD

Referred To: Reference Committee E

House Action:

Whereas, Sweden pioneered the "Equality Model" in 1999, and

Whereas, legalization of the sex trade creates a greater demand for sex workers, and

Whereas, pimps and traffickers meet the demand by increasing the supply of more men, women, and children, and

Whereas, sex buyers have higher scores of hostility and less empathy for women in sex work than do non-sex buyers, and

Whereas, in the Equality Model, persons bought and sold in the sex trade would not be arrested and incarcerated, but the sex buyers and pimps would be held accountable, and

Whereas, since 1999, eight countries have enacted the Equality Model with survivors offered counseling, medical care, legal aid, financial assistance, and economic empowerment, and

Whereas, as a result of the Equality Model being enacted, the size of the sex trade with violence, abuse, and sex trafficking has diminished, and

Whereas, Peter Qualliotine, in 2012, launched a 10-week sex buyers intervention program in Seattle, Washington that engaged men in deep conversation that was meant to change the way they think about their personal relationships in general and prostitution specifically, and

Whereas, while these programs are difficult to evaluate, they have been successful and are ongoing around the country; therefore be it

RESOLVED: That the Michigan Legislature be encouraged to enact the Equality Model in the state of Michigan where survivors of the sex trade are given assistance, but the buyers of sex are prosecuted; and be it further

RESOLVED: That Michigan law enforcement agencies and prosecutors be encouraged to conduct sex buyer classes for persons arrested for buying sex.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new AMA policy.

Relevant MSMS Policy:

Resolution 14-20: Curb Human Trafficking
That MSMS advocate for the passage of human trafficking legislation which toughens criminal and financial penalties for persons soliciting sexual activity for payment rather than the victims of trafficking.

Resolution 41-14: Human Trafficking
That MSMS support efforts to increase health care provider awareness of the prevalence, symptoms and signs of human trafficking in Michigan; and that MSMS support legislation providing access to, and payment for, health care services for victims of human trafficking regardless of their citizenship status.

The Recognition and Protection of Human Trafficking Victims
MSMS supports training medical students, residents, and physicians to understand their role in treating patients who are victims of human trafficking.

Human Trafficking Education and Awareness
MSMS encourages the State Board of Education, Michigan secondary schools and colleges, as well as other influential organizations to increase awareness of human trafficking and increase awareness of signs of human trafficking.

Relevant AMA Policy:

Commercial Exploitation and Human Trafficking of Minors H-60.912
Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

Physicians Response to Victims of Human Trafficking H-65.966
1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.

Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.

The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

The Polaris Project -
In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:
- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
a. An assessment tool for health care professionals
b. Online training in recognizing and responding to human trafficking in a health care context
c. Speakers and materials for in-person training
d. Links to local resources across the country

The Rescue & Restore Campaign -

The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.

RESOLUTION 39-22

Title:	Expedited Immigrant Green Card for J-1 Visa Waiver Physicians Serving in Underserved Areas
Introduced by:	Venkat K. Rao, MD, for the Genesee County Delegation
Original Author:	Venkat K. Rao, MD
Referred To:	Reference Committee E
House Action:	

Whereas, J-1 visa IMG resident physicians sign up for serving in underserved areas for three years to become eligible to stay in the U.S. as a permanent resident instead of a mandatory return to their native countries as required per J-1 visa regulation, and

Whereas, their service is extremely helpful in improving the health of U.S. citizens, especially low income and rural communities, and

Whereas, substantial care to COVID-19 patients was provided by these J-1 visa waiver physicians and they saved lives, and

Whereas, the waiting period for getting the Green Card Visa for physicians of certain countries is longer than 10 years at present due to a per country limit of seven percent of H-1B to immigrant (Green Card) availability, and the J-1 visa waiver physicians have to join the end of the very long queue of 1.2 million applicants for certain countries, and their children are becoming status less at age 18, and

Whereas, these J-1 visa waiver physicians provided great national service to US citizens, and deserve priority in visa allotment; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to lobby U.S. Congress and the U.S. Administration that the J-1 visa waiver physicians serving in underserved areas be given highest priority in visa conversion to green cards upon completion of their service commitment obligation and be exempted from the per country limitation of H-1B to green card visa conversion.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new AMA policy.

Relevant MSMS Policy:

Eliminate Cap on J-1 Visa Waiver Slots for Each State
MSMS supports eliminating the cap on J-1 Visa Waiver slots each state is allowed to sponsor. (Board Action Report #7, 2013 HOD, re Res68-12)

Relevant AMA Policy:

J-1 Visas and Waivers D-255.993
1. Our AMA shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program.
2. If the USDA does not continue in its role as an interested government agency (IGA), the AMA encourage HHS to expand its J-1 visa waiver program.
3. Our AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians? service requirements through the J-1 waiver and Conrad-30 programs with a report back at A-03.
4. Our AMA will work towards regulation and/or legislation to allow physicians on H-1B visas for their J-1 visa waiver, who are limited to serving in medically underserved areas, to continue to care for their patients who require hospitalization in the closest appropriate medical facility which may not be in the underserved area.
5. Our AMA will work with state medical societies to study and report back on the feasibility of having a national data repository of J-1 Visa Waiver statistics so that J-1 Visa Waiver unoffered positions can be transferred to states as needed to treat underserved communities and to monitor the success of this program.

Conrad 30 - J-1 Visa Waivers D-255.985
1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.
3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.
4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.
5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.

Source:
https://www.cato.org/publications/immigration-research-policy-brief/backlog-skilled-immigrants-tops-1-million-over#employment-based-green-card-backlog

RESOLUTION 43-22

Title: Risks of Substance Use Linked to a Child's Early Years

Introduced by: Robert Sain, MD, for the Washtenaw County Delegation

Original Author: Robert Sain, MD

Referred To: Reference Committee E

House Action:

Whereas, opioid deaths in Michigan continue to surge, from 500 deaths in 1999 to more than 2,000 deaths in 2018, and

Whereas, current government and private responses to persons with opioid addiction have also increased; however, these efforts will not catch up with the increase of opioid deaths without early interventions before dependence, and

Whereas, current critical treatments have improved including but not limited to the use of medication for opioid use disorder (MOUD), and

Whereas, these treatments are enhanced by effective psychiatric efforts (e.g. trauma focused psychotherapy), and

Whereas, deaths from overdose mostly occur during and after adolescence, and

Whereas, this presumes that our understanding of a child's experience before dependence is key to our understanding of later opioid dependence, and

Whereas, referrals to child psychiatrists and other mental health professionals who understand the relationship of deprivation (of love) and trauma to subsequent depression and substance dependence are critical after recognition of the risks; therefore be it

RESOLVED: That MSMS support and encourage the implementation of screening tools such as the Rapid Adolescent Prevention Screener (RAPS), the PHQ9, and the GAD-7 to detect high risk behaviors and mental health conditions such as substance use, smoking, and vaping in adolescent patients aged 12 to 20; and be it further

RESOLVED: That MSMS support and encourage the continuing education of all physicians treating very young children (0-5 years of age and older) who suffer from deprivation (of love) and adolescents who are already using addictive substances (marijuana, alcohol, opioids, including heroin), and cocaine.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000 for physician outreach.

Relevant MSMS Policy:

Routine ACE Screening in Pediatric Appointments
MSMS supports screening for adverse childhood experiences in annual pediatric appointments. (Board Action Report #2, 2019 HOD, re Res29-18)

Relevant AMA Policy:

Adverse Childhood Experiences and Trauma-Informed Care H-515.952
1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
2. Our AMA supports:
a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life; and
f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.
3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.

RESOLUTION 53-22

Title: Standards in Cultural Humility Training within Medical Education

Introduced by: Mara Darian, for the Medical Student Section

Original Author: Anthony Mufarreh

Referred To: Reference Committee E

House Action:

Whereas, cultural humility within medicine is defined as "the lifelong commitment to self-evaluation and self-critique to redressing the power imbalances in patient-physician dynamic," and

Whereas, cultural humility is a skill that is beneficial for students and physicians to understand how their culture and identity influences patient encounters to become more culturally-sensitive doctors, minimizing the risk of subconscious bias of personal beliefs onto a patient, and

Whereas, cultural humility is distinct from cultural competence, as competency implies achievement of proficiency, while humility includes constant self-reflection and learning, focuses on the clinicians ability to connect on multiple levels to patients, and fosters cultural respect, and

Whereas, the Liaison Committee on Medical Education (LCME) introduced standards for cultural competency for all medical students upon graduation, yet medical schools are not explicitly required to have standards for cultural humility education within their curriculum, and

Whereas, there is existing literature outlining techniques to implement tools and coaching of cultural humility in the healthcare field, such as simulated teaching interventions, the 5R's approach of developing humility (reflection, respect, regard, relevance, and resiliency), and self-reflective courses, and

Whereas, the population of Michigan encompasses a diverse set of identities, including but not limited to race, ethnicity, religion/spirituality, gender identity, sexual orientation, migration status, age, language, and systems of belief, perpetuating a need for cultural training among healthcare providers, and

Whereas, several cultural minority groups experience barriers in receiving quality health care and have worse mortality and morbidity outcomes across various chronic diseases, and

Whereas, training health care professionals in cultural humility is associated with higher scores on accountability, improved health care experiences, and increased empathy towards patients; therefore be it

RESOLVED: That MSMS supports initiatives for Michigan Medical Schools to organize and endorse cultural humility training for medical students; including but not limited to integrating cultural humility within didactic and experiential learning across medical school curricula; and be it further

RESOLVED: That Michigan Delegation to the American Medical Association (AMA) ask our AMA to support the development of national standards for cultural humility training in the medical school curricula.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000 for new MSMS and AMA policy.

Relevant MSMS Policy:

Cultural Competence in Standardized Patient Programs within Medical Education
MSMS supports initiatives by Michigan's medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills. (Res88-17)

Relevant AMA Policy:

Enhancing the Cultural Competence of Physicians H-295.897
1. Our AMA continues 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. Our AMA continues to support research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.

Sources:

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RESOLUTION 56-22

Title: Universal K-12 Mental Health Screenings in Michigan Public Schools

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: Kumaran Arivoli, Brianna Kuperus, and Neil Vaishampayan

Referred To: Reference Committee E

House Action:

Whereas, the first onset of the majority of mental disorders occurs during childhood and adolescence, with half of all lifetime mental disorders starting by the age of 14, and

Whereas, an early age of onset of mental disorders has been associated with worse clinical and functional outcomes, as well as a longer duration of untreated illness, and this longer duration of untreated illness also leads to lower treatment response, and

Whereas, the prevalence of mental illness is significant in younger populations, with a national sample of children ages 8-15 showing that 13.1 percent met DSM-IV criteria for at least one mental health disorder in the last 12 months, and

Whereas, this significant prevalence of mental health disorders among the youth has steadily increased over the years, with studies showing a 47 percent increase in mental health presentations at pediatric emergency departments from the years 2002-2012, and

Whereas, suicide continues to be the second leading cause of death among adolescents, and the rate of suicide, and more specifically, adolescent suicide has risen steadily in the U.S., and

Whereas, the current COVID-19 pandemic has further exacerbated mental illness within the youth population, with a 24 percent increase for children aged 5-11 and a 31 percent increase for adolescents aged 12-17 in mental health-related emergency department visits between March of 2020 and October of 2020, and

Whereas, early intervention in youth mental illness has been shown to improve symptoms, decrease hospital admissions and readmissions, and increase patient satisfaction, and early intervention specifically with depression is considered to be a preferred model of care, and

Whereas, the cost benefits of early mental health intervention proves to be significant, with every $1 spent on early treatment and prevention programs resulting in $2-$10 savings in health care costs, criminal justice costs, and lost productivity costs, and

Whereas, mental health screening and initial diagnosis is an important first step in the prevention and early intervention of mental illness, and

Whereas, previous multitiered systematic screening programs in schools have been shown to be completed at high rates, universal mental health screening programs have shown a

significant increase in identifying and referring youth with mental disorders to school and community-based mental health services they otherwise may not have been connected with; therefore be it

RESOLVED: That MSMS will advocate to the Michigan Department of Education for the implementation of annual, voluntary K-12 mental health screening that is evidence-based and age appropriate within all Michigan Public Schools that will serve to effectively identify and refer youth to needed mental health services.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000 for regulatory and/or industry advocacy.

Relevant MSMS Policy: None

Relevant AMA Policy:

Improving Pediatric Mental Health Screening H-345.977
Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.

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RESOLUTION 59-22

Title: Improving and Standardizing Pregnancy and Lactation Accommodations for Medical Board Examinations

Introduced by: Mara Darian, for the Medical Student Section

Original Author: Erin Currey

Referred To: Reference Committee E

House Action:

Whereas, there are known complications of pregnancy, including but not limited to, carpal tunnel syndrome, gestational diabetes, gastroesophageal reflux, morning sickness including hyperemesis gravidarum, urinary tract or bladder infections, chronic migraines, and pelvic and back pain, that can be disruptive to women's ability to complete workplace responsibilities, and

Whereas, complications of pregnancy qualify as disabilities under the American Disability Act, which requires employers to provide appropriate accommodations, and

Whereas, 53 percent of pregnant, working women felt the need to modify job requirements, and

Whereas, 70 percent of women report morning sickness in the first trimester, and

Whereas, in 2019, women accounted for 50.5% of all matriculating medical students, and

Whereas, medical student parents face unique barriers to coordinating medical school graduation requirements, and

Whereas, the majority of medical schools have scheduled licensing exam study periods and deadlines by which students must complete testing with relative inflexibility in timing, and

Whereas, the Prometric testing sites for the USMLE exam provide minimal pregnancy accommodations, limited to a trackball computer mouse, pillows for physical comfort, and private testing rooms, and

Whereas, the Prometric testing sites for the USMLE exam provide minimal lactation accommodations, limited to curtains or a pop-up tent for privacy during nursing or pumping, and

Whereas, the Personal Item Exceptions (PIEs) list of pre-approved items allowed within the secure testing area provides limited pregnancy comfort aids, including glucose tablets, non-electric heating pads, ice packs, pillow/lumbar support, and stools for limb elevation, and

Whereas, neither the National Board of Medical Education (NBME) nor the contracted Prometric Testing sites have a public, unified list of common pregnancy accommodations for the

USMLE exams, leaving candidates to find and cite multiple webpages to identify previously approved accommodations for the USMLE, and

Whereas, the state of California provides graduate students in their public institutions the same accommodations and support services to pregnant students and those recovering from childbirth-related conditions as it would to other students with temporary medical conditions, and

Whereas, the American Board of Internal Medicine considers pregnancy and breastfeeding to be medical conditions worthy of accommodation for board exams and offers a core set of accommodations offered to all pregnant or nursing examinees, including extra break time and the opportunity to take the exam over two days, and

Whereas, basic guidelines for lactation support at standardized testing centers have already been recognized by academic journals, including a private space for milk expression and storage of breastmilk ("lactation station") that is close to the testing site with furniture to support lactation including a chair to sit on while pumping, a power outlet, a sink for washing hands and/or cleaning pump parts, and a refrigerator and freezer to store expressed milk; therefore be it

RESOLVED: That MSMS supports expanded pregnancy and lactation accommodations for medical students and physicians taking required licensure examinations, as well as additional flexibility in medical school and residency curriculums to accommodate scheduling around pregnancy and lactation; and be it further

RESOLVED: That MSMS will advocate for contracted testing centers (i.e., Prometric) to provide cold storage space to store expressed milk during testing and provide private spaces for partners and babies to wait for testers to breastfeed on breaks; and be it further

RESOLVED: That MSMS will advocate for fee-waivers for pregnant students with documented medical complications of pregnancy that would impact their ability to complete and who need to reschedule their United States Medical Licensing Examination exam; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to advocate for the implementation of 60 minutes of additional, scheduled break time for medical students and residents who have pregnancy complications and/or lactation needs for all NBME administered examinations, consistent with American Board of Internal Medicine accommodations; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to advocate for the addition of pregnancy comfort aids, including but not limited to, ginger teas, saltines, wastebaskets, and antiemetics, to the USMLE pre-approved list of Personal Item Exemptions (PIEs) permitted in the secure testing area for pregnant individuals.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000 for regulatory and/or industry advocacy.

Relevant MSMS Policy:

Promote Designated Breastfeeding and/or Breast Pumping Areas in Places of Public Accommodation
MSMS encourages places of public accommodation to provide designated breastfeeding areas to breastfeeding mothers in order to enhance the goals supported by Michigan's Public Act 197 of 2014, "Breastfeeding Anti-Discrimination Act." (Res10-16)

Relevant AMA Policy:

AMA Support for Breastfeeding H-245.982
1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals 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 bottle-feeding 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.
3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.
4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).
5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.

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ACTION REPORT #02-22 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 02-21
Vision Qualifications for Driver's License

REFERRED TO: Reference Committee E

HOUSE ACTION:

RECOMMENDATION: That the 2022 House of Delegates approve Resolution 02-21, "Vision Qualifications for Driver's License," as amended to read:

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) urge our AMA to engage with stakeholders including, but not limited to, the American Academy of Ophthalmology, National Highway Traffic Safety Commission, and interested state medical societies, to make recommendations on standardized vision requirements for unrestricted and restricted driver's licensing privileges; and be it further

RESOLVED: That MSMS work with the American Medical Association (AMA) in any efforts by our AMA to seek stakeholder engagement to address standardized vision requirements for unrestricted and restricted driver's licensing privileges. MSMS shall communicate any resulting recommendations to the Michigan Secretary of State legislative liaison, Michigan legislators serving on committees with oversight of transportation issues, and other stakeholders as appropriate.

Resolution 02-21 was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Committee on State Legislation and Regulations for review and recommendation.

Resolution 02-21 asked, "that the Michigan Delegation to the American Medical Association (AMA) urge our AMA to engage with stakeholders including, but not limited to, the American Academy of Ophthalmology, National Highway Traffic Safety Commission, and interested state medical societies, to make recommendations on standardized vision requirements and cognitive testing, when applicable, for unrestricted and restricted driver's licensing privileges; and that MSMS work with the American Medical Association (AMA) in any efforts by our AMA to seek stakeholder engagement to address standardized vision requirements and cognitive testing, when applicable, for unrestricted and restricted driver's licensing privileges. MSMS shall

(continued)

communicate any resulting recommendations to the Michigan Secretary of State legislative liaison, Michigan legislators serving on committees with oversight of transportation issues, and other stakeholders as appropriate.”

Resolution 02-21 was introduced in an effort to update vision qualifications for operating motor vehicles.

Reference Committee E (Scientific and Educational Affairs) considered Resolution 02-21 during the 2021 MSMS House of Delegates. Although Committee members found the testimony by delegates useful and compelling, they believed additional evidence-based research to support potential changes to the standards and additional information about the referenced cognitive testing was needed.

The Committee on State Legislation and Regulations was initially briefed on the Resolution at its September meeting; however, action was delayed until the December meeting so that the Resolution’s author could participate.

Doctor Droste joined the Committee on State Legislation and Regulations meeting on December 1, 2021. Doctor Droste explained that current standards are outdated and not based on medical evidence and that there is national momentum for change. This is problematic as the denial or loss of a driver’s license often results in loss of independence, depression, decreased access to health care, increased risk for long term care, increased mortality, and increased health care costs. The Michigan Society of Eye Physicians and Surgeons joined with nine other state and subspecialty societies to address outdated legislative inequities and state-by-state inconsistencies in the licensure system. Through the submission of Council Advisory Recommendation (CAR: 21-03) to the American Academy of Ophthalmology, they are encouraging state ophthalmologic societies to approach their legislators to advocate for updated visual acuity/visual field requirements for driver’s licensing.

The Committee engaged in thoughtful discussion of the issue. Following questions and answers, members agreed with provisions in the Resolved statements that ask the AMA to convene appropriate stakeholders to reassess the data and make recommendations related to unrestricted and restricted driving privileges based on objective science, and to subsequently share those recommendations at the state level. However, there was concern about the clause related to cognitive testing and whether it was necessary. Doctor Droste offered that he was supportive of removing the reference – “and cognitive testing, when applicable,” – from the Resolved statements. Committee members agreed and amended the resolution by striking the language. Therefore, the

Committee on State Legislation and Regulations unanimously supported Resolution 02-21, as amended

At its meeting on January 19, 2022, the MSMS Board of Directors approved the recommendation of the Committee on State Legislation and Regulations to approve Resolution 02-21, as amended.

Attachment
Resolution 02-21

RESOLUTION 02-21

Title: Vision Qualifications for Driver's License

Introduced by: Patrick J. Droste, MD, for the Michigan Society of Eye Physicians & Surgeons

Original Author: Patrick J. Droste, MD

Referred To:

House Action:

Whereas, current vision qualifications for operating motor vehicles were derived by various states in the 1920s and 1930s, and

Whereas, the American Medical Association (2003) in its Physician's Guide to Assessing and Counseling Older Drivers stated, "Although many states currently require far visual acuity of 20/40 for an unrestricted license, current research indicates that there is no scientific basis for this cut-off. In fact, studies undertaken in some states have demonstrated that there is no increased crash risk between 20/40 and 20/70 resulting in several new state requirements," and

Whereas, good data exists to recommend reconsideration of visual acuity standards in many states, and

Whereas, it has been well known that some persons with reduced acuity continue to drive safely, and

Whereas, persons with significant visual field defects that violate state licensure requirements can be taught to drive safely, and

Whereas, tests for cognitive well-being are generally not used in motor vehicle licensure testing protocols in most states, and

Whereas, denying drivers licensure without evidence to support that denial frequently causes isolation, depression, and increased expenses for ill-advised and unnecessary medical visits, and

Whereas, crash avoidance systems, unimagined one century ago, are routinely incorporated in automotive and roadway systems, and

Whereas, autonomous vehicle technology is in advanced stages of development and has been supported by MSMS, the AMA, and the National Highway Traffic and Safety Administration (NHTSA), and

Whereas, it is well known that a large proportion of mortality involved auto crashes are accompanied by "driver error," and

Whereas, studies have been performed that show that drivers with the visual acuity less than 20/50 can be safe and competent drivers, and

Whereas, the Michigan Society of Eye Physicians and Surgeons (MiSEPS) has submitted a Council Advisory Recommendation (CAR: 21-03) to the American Academy of Ophthalmology (AAO) urging state ophthalmologic societies to approach their legislators to consider reviewing, perhaps relaxing, the visual acuity / visual field requirements for licensure while simultaneously advocating for simple appropriate tests where cognitive decline is suspected; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) urge our AMA to engage with stakeholders including, but not limited to, the American Academy of Ophthalmology, National Highway Traffic Safety Commission, and interested state medical societies, to make recommendations on standardized vision requirements and cognitive testing, when applicable, for unrestricted and restricted driver's licensing privileges; and be it further

RESOLVED: That MSMS work with the American Medical Association (AMA) in any efforts by our AMA to seek stakeholder engagement to address standardized vision requirements and cognitive testing, when applicable, for unrestricted and restricted driver's licensing privileges. MSMS shall communicate any resulting recommendations to the Michigan Secretary of State legislative liaison, Michigan legislators serving on committees with oversight of transportation issues, and other stakeholders as appropriate.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

STATEMENT OF URGENCY: The Michigan Society of Eye Physicians and Surgeons (MiSEPS) has submitted a Council Advisory Recommendation (CAR: 21-03) to the American Academy of Ophthalmology (AAO) urging state ophthalmologic societies to approach their legislators to consider reviewing, perhaps relaxing, the visual acuity/visual field requirements for licensure while simultaneously advocating for simple appropriate tests where cognitive decline is suspected. Timing is everything. Waiting a year to introduce this resolution could be detrimental to harnessing the momentum that could put Michigan at the forefront of addressing this important national health and safety issue. Current vision qualifications for operating motor vehicles were derived with no firm scientific underpinnings by the various states in the 1920s and 1930s and are outdated. This CAR was cosponsored by 10 state and subspecialty societies showing national momentum and support for this effort. At the state level, legislation to update vision qualifications for operating motor vehicles serves the public good. It also offers a good opportunity for stronger relations, increased credibility and capacity building to be better prepared to stand up to potential threats to medically led vision care including the strong potential of a scope challenge by optometry.

Relevant MSMS Policy:
None

Relevant AMA Policy:

8.2 Impaired Drivers & Their Physicians

A variety of medical conditions can impair an individual's ability to operate a motor vehicle safely, whether a personal car or boat or a commercial vehicle, such as a bus, train, plane, or commercial vessel. Those who operate a vehicle when impaired by a medical condition pose threats to both public safety and their own well-being. Physicians have unique opportunities to assess the impact of physical and mental conditions on patients' ability to drive safely and have a responsibility to do so in light of their professional obligation to protect public health and safety. In deciding whether or how to intervene when a patient's medical condition may impair driving, physicians must balance dual responsibilities to promote the welfare and confidentiality of the individual patient, and to protect public safety.

Not all physicians are in a position to evaluate the extent or effect of a medical condition on a patient's ability to drive, particularly physicians who treat patients only on a short-term basis. Nor do all physicians necessarily have appropriate training to identify and evaluate physical or mental conditions in relation to the ability to drive. In such situations, it may be advisable to refer a potentially at-risk patient for assessment.

To serve the interests of their patients and the public, within their areas of expertise physicians should: (a) Assess at-risk patients individually for medical conditions that might adversely affect driving ability, using best professional judgment and keeping in mind that not all physical or mental impairments create an obligation to intervene. (b) Tactfully but candidly discuss driving risks with the patient and, when appropriate, the family when a medical condition may adversely affect the patient's ability to drive safely. Help the patient (and family) formulate a plan to reduce risks, including options for treatment or therapy if available, changes in driving behavior, or other adjustments. (c) Recognize that safety standards for those who operate commercial transportation are subject to governmental medical standards and may differ from standards for private licenses. (d) Be aware of applicable state requirements for reporting to the licensing authority those patients whose impairments may compromise their ability to operate a motor vehicle safely. (e) Prior to reporting, explain to the patient (and family, as appropriate) that the physician may have an obligation to report a medically at-risk driver: (i) when the physician identifies a medical condition clearly related to the ability to drive; (ii) when continuing to drive poses a clear risk to public safety or the patient's own well-being and the patient ignores the physician's advice to discontinue driving; or (iii) when required by law.(f) Inform the patient that the determination of inability to drive safely will be made by other authorities, not the physician. (g) Disclose only the minimum necessary information when reporting a medically at-risk driver, in keeping with ethics guidance on respect for patient privacy and confidentiality.

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Late Resolutions

MSMS
MICHIGAN STATE MEDICAL SOCIETY

Instructions for Accessing the Annual Financial Report

The Annual Financial Report is an attachment to the PDF of the handbook. Click on the Ways and Means instruction page on a computer or laptop, click on the paper clip on the left side of the screen. The report is password protected. The password for delegates and alternates is included in the April 1, 2022 email to delegates. If you need assistance, please email Rebecca Blake at rblake@msms.org or 517-336-5729.

Message from Ways and Means Committee Chair, Dennis Szymanski, MD

The Ways and Means Committee discusses financial "policy" of MSMS at the annual House of Delegates meeting. If anyone has "bookkeeping" type questions on the MSMS Annual Financial Report, please email your questions prior to the meeting to Lauchlin MacGregor, Chief Financial Officer at lmacgregor@msms.org. Reponses to these questions will be given prior to the meeting. This will allow the Ways and Means Committee meeting to be more efficient and effective with its time Saturday morning by focusing its discussion on the financial policy of MSMS. Thank you.

Reference Committee Reports