

2018-2019
PENNSYLVANIA MEDICAL SOCIETY
POLICY COMPENDIUM

PAMED MISSION STATEMENT

The Pennsylvania Medical Society (“PAMED” or “the Society”) is the voice of Pennsylvania’s physicians and the patients they serve. We advance quality patient care and the ethical practice of medicine. We promote physician leadership, education, professional satisfaction, practice sustainability, and the public’s health.

The 2018-2019 edition of the Policy Compendium represents a continuation of PAMED’s efforts to make its policies accessible. It contains policies enacted by the PAMED House of Delegates from 1965 through 2018.

TABLE OF CONTENTS

| | | |
|---------|--|----|
| 5.000 | Abortion | 4 |
| 10.000 | Accident Prevention | 4 |
| 15.000 | Accident Prevention: Motor Vehicles | 5 |
| 20.000 | Acquired Immunodeficiency Syndrome (AIDS)..... | 6 |
| 25.000 | Aging | 8 |
| 30.000 | Alcohol and Alcoholism | 9 |
| 35.000 | Allied Health Professions | 9 |
| 55.000 | Cancer | 12 |
| 60.000 | Children and Youth | 13 |
| 65.000 | Civil and Human Rights..... | 14 |
| 70.000 | Coding and Nomenclature | 15 |
| 80.000 | Crime | 15 |
| 85.000 | Death | 16 |
| 95.000 | Drug Abuse..... | 17 |
| 100.000 | Drugs | 20 |
| 110.000 | Drugs: Cost..... | 22 |
| 115.000 | Drugs: Labeling and Packaging | 23 |
| 120.000 | Drugs: Prescribing and Dispensing | 23 |
| 125.000 | Drugs: Substitution..... | 24 |
| 130.000 | Emergency Medical Services | 26 |
| 135.000 | Environmental Health..... | 27 |
| 140.000 | Ethics..... | 29 |
| 145.000 | Firearms: Safety and Regulation | 31 |
| 155.000 | Health Care Costs..... | 32 |
| 160.000 | Health Care Delivery | 33 |
| 165.000 | Health System Reform | 40 |
| 180.000 | Health Insurance..... | 45 |
| 185.000 | Health Insurance: Benefits and Coverage..... | 48 |
| 190.000 | Health Insurance: Claims Forms and Claims Processing | 53 |
| 195.000 | Health Maintenance Organizations | 54 |
| 200.000 | Health Workforce | 55 |
| 210.000 | Home Health Services | 55 |
| 215.000 | Hospitals | 55 |
| 225.000 | Hospitals: Medical Staff..... | 56 |
| 230.000 | Hospitals: Medical Staff - Credentialing and Privileges..... | 63 |
| 235.000 | Hospitals: Medical Staff - Organization | 65 |
| 240.000 | Hospitals: Reimbursement | 68 |
| 255.000 | International Medical Graduates | 68 |
| 260.000 | Laboratories..... | 68 |
| 270.000 | Legislation and Regulation..... | 69 |
| 275.000 | Licensure and Discipline | 73 |
| 280.000 | Long-Term Care..... | 78 |
| 285.000 | Managed Care | 79 |
| 290.000 | Medicaid | 89 |
| 295.000 | Medical Education..... | 90 |
| 305.000 | Medical Education: Financing and Support | 92 |
| 310.000 | Medical Education: Graduate | 92 |
| 315.000 | Medical Records | 93 |
| 320.000 | Medical Review..... | 94 |
| 330.000 | Medicare..... | 94 |
| 335.000 | Medicare: Carrier Review..... | 97 |

| | | |
|---------|---|-----|
| 335.998 | Medicare and Insurer Codes..... | 97 |
| 335.999 | Centers for Medicare and Medicaid Services Oversight of Carriers..... | 97 |
| 340.000 | Medicare: PRO | 97 |
| 345.000 | Mental Health..... | 97 |
| 350.000 | Minorities | 98 |
| 360.000 | Nurses and Nursing | 100 |
| 370.000 | Organ Donation and Transplantation | 102 |
| 375.000 | Peer Review | 102 |
| 385.000 | Physician Payment | 104 |
| 390.000 | Physician Payment: Medicare | 109 |
| 400.000 | Physician Payment: Medicare - RBRVS..... | 110 |
| 405.000 | Physicians..... | 110 |
| 425.000 | Preventive Medicine..... | 111 |
| 430.000 | Prisons..... | 112 |
| 435.000 | Professional Liability | 113 |
| 440.000 | Public Health..... | 118 |
| 445.000 | Public Relations | 123 |
| 450.000 | Quality of Care..... | 123 |
| 455.000 | Radiation and Radiology | 125 |
| 460.000 | Research | 125 |
| 470.000 | Sports and Physical Fitness..... | 126 |
| 475.000 | Surgery | 126 |
| 480.000 | Technology | 126 |
| 490.000 | Tobacco..... | 128 |
| 495.000 | Tobacco: Labeling and Warnings..... | 129 |
| 500.000 | Tobacco: Marketing and Promotion..... | 130 |
| 505.000 | Tobacco: Prohibitions on Sale and Use | 130 |
| 520.000 | War | 130 |
| 530.000 | PAMED: Administration and Organization..... | 130 |
| 535.000 | PAMED: Board of Trustees..... | 137 |
| 540.000 | PAMED: Councils and Committees..... | 138 |
| 545.000 | PAMED: House of Delegates..... | 138 |
| 555.000 | PAMED: Membership and Dues | 141 |
| 565.000 | PAMED: Political Action | 142 |

5.000 Abortion

5.998 Abortion

The Society has a policy of no position on abortion. (H-1980; Res. 202, H-1997; Report 3, Board of Trustees, H-1998)

5.999 Testifying Before State Legislature

Spokespersons shall not testify pro or con about abortion on behalf of the Society, but if a significant non-abortion issue is presented as part of legislation concerning abortion, members of the Board may testify representing the Society as to that issue and that issue alone. The Society is also to maintain a roster of physicians willing to testify individually pro or con on the issue of abortion and make that list available to legislators on request. (Res. 7, H-1982; revised, Res. 210, H-1996; reaffirmed, H-2016)

10.000 Accident Prevention

10.997 Motorcycle Helmet Law

The Society publicly endorses the wearing of protective cranial helmets by motorcycle drivers and passengers to reduce or eliminate the severity of potential injuries. It is a Society legislative objective to work with the Pennsylvania General Assembly to pursue re-enactment of a mandatory motorcycle helmet safety law to reduce the additional burden these injuries pose to Pennsylvania's beleaguered health care system. (Res. 419, H-2004)

10.998 Protective Head Gear for Equestrian Events

The Society recommends that educational programs be given to parents, riders, riding instructors, show organizers and managers outlining the risks of horseback riding and methods to minimize them. The Society also recommends that a satisfactory protective headgear which can pass standards for retention, penetration, absorption, and distribution of shock for each type of riding activity be worn when riding or preparing to ride. Finally, the Society urges riding schools, horse shows, rodeos, and other equestrian events to recommend that protective headgear be worn during the activities. (Res. 11, H-1984)

10.999 Farm Machine Injury Prevention for Low-Income Farmers

The Society is directed to ask the state to consider implementing a program to subsidize the retrofitting of rollover protection and safety shielding of older farm equipment used by farmers having an annual income of less than 150 percent of the federal poverty level. (Res. 23, H-1991)

15.000 Accident Prevention: Motor Vehicles

15.995 Mandatory Drivers' License Reexamination for Senior Citizens

The Society supports mandatory drivers' license reexamination by the Commonwealth of Pennsylvania for individuals 75 years of age or older; further, the Society shall contact stakeholders (i.e., AARP, etc.) to discuss this issue. (Report 2, Board of Trustees, H-2004)

15.996 Improving Pennsylvania's Child Occupant Protection Law

The Society shall use its power to encourage the Pennsylvania legislature to enact legislation that would more effectively protect children, including legislation directed at requiring that all children be restrained in all seating positions in motor vehicles and creating an age-appropriate back seat mandate for child passengers. Further, that the legislation shall eliminate the "safety belt shortage" exception, increase the fine for violators of the "Child Occupant Protection Law", establish a child occupant protection course for violators, and allow primary enforcement of the law. (Sub. Res. 202, H-2001)

15.997 Regulatory Reporting Requirement under Motor Vehicle Law

The Society shall continue to participate in the activities of the Pennsylvania Department of Transportation's Medical Advisory Board to address changes to the physical and mental conditions reporting criteria and related issues focused on driver safety. The Board is directed to report on its progress at the 2008 House of Delegates. (Report 8, Board of Trustees, H-2007)

The Society shall pursue changes to the Motor Vehicle Law and the Department of Transportation regulations to bring them into conformance with the Reporting of Driver Impairment Model Law of the American Association of Motor Vehicle Administrators. The Society will continue to work with the Department of Transportation to improve the reporting process and develop improved methods to evaluate driver physical condition and driving abilities. (Report 13, Board of Trustees/Res. 406, H-2009)

15.998 Mandatory Seat Belt Laws

The Society encourages physicians to educate patients about seat belts and the benefits of their use. (Res. 6, H-84; Retained in part by deleting second sentence calling for support of Pennsylvania mandatory seat belt law, H-1994)

15.999 Improve Pennsylvania's Safety Belt Law

The Society is committed to amend Act 82, the Pennsylvania Safety Belt Use Law, to include primary enforcement as a major provision in an effort to increase safety belt use among Pennsylvanians (Res. 11, H-1990)

20.000 Acquired Immunodeficiency Syndrome (AIDS)

20.982 Accidental Exposure

The Society shall work to streamline the procedures outlined in Act 148 for testing a source patient's blood for HIV when an accidental exposure to that patient's blood occurs. The expedited procedure will be designed to allow use of appropriate treatment of the exposed individual in a timely manner. The Commission on Public Health will pursue the matter further and consider the possibility of calling for a mandate that source patients be tested for HIV when a health care worker is accidentally exposed to that patient's blood. (Report 29, Board of Trustees, H-2001; Report 3, Board of Trustees, H-2002)

20.983 Written Consent Requirements

The Society shall seek amendments to Act 148 of 1990 to delete the requirements for written consent specific to HIV testing and allow for testing based upon verbal consent. (Report 29, Board of Trustees, H-2001)

The Society reaffirms its support for the elimination of a written consent, while emphasizing the importance of verbal consent, for HIV testing. (Res. 206, H-2008)

20.984 Unrestricted Testing

HIV testing should be carried out whenever, in a physician's clinical judgment, it is appropriate either for the care of the patient or to prevent the spread of HIV disease throughout the general population, including health care workers. Patients should be informed of the need for testing and give their verbal consent. (Report 29, Board of Trustees, H-2001)

20.985 HIV Education

The Society believes that HIV education must continue to be a priority. Physicians should strongly promote and participate in HIV education programs in Pennsylvania schools, hospitals, nursing homes, and other appropriate settings. (Report 29, Board of Trustees, H-2001)

20.986 Patient Counseling

The Society recognizes the value of appropriate pretest and post-test counseling. Patients who test negative for HIV should be counseled about effective strategies and behaviors for avoiding future HIV exposure. Individuals who test positive for HIV infection should be counseled about effective strategies and behaviors for the prevention of the spread of the virus and about methods for health protection in the instance of a compromised immune system. They should be advised to place themselves under the care of a physician with the resources to treat HIV infection. HIV-infected individuals should be counseled to alert sexual contacts, current and past (5-10 years), to be tested also. (Report 29, Board of Trustees, H-2001)

20.987 Voluntary Testing

The Society recommends voluntary testing for all pregnant women and newborns, persons considering marriage who have significant risk factors, and physicians who have high-risk behavior or who work in high-risk specialties. (Report 29, Board of Trustees, H-2001)

- 20.988 Action by the Medical Society**
The Medical Society supports the following concepts: (1) government efforts to develop anti-discrimination policies designed to protect the rights of those afflicted with AIDS or infected with HIV; (2) the Society will monitor the medical delivery system and respond as necessary to ensure that the system meets the medical needs of persons infected with HIV; and (3) every HIV-infected person, including those with AIDS, should have access to compassionate and competent medical care in Pennsylvania. (Report 29, Board of Trustees, H-2001)
- 20.989 Individual Physician Behavior toward HIV Infected Patients**
The Medical Society believes that physicians have an ethical obligation to: (1) treat HIV infected patients. The Society has endorsed the statements on AIDS by the AMA Council on Ethical and Judicial Affairs, the most important of which is that it is unethical for a physician to refuse to treat a patient solely because that patient is seropositive; (2) make appropriate referrals. Physicians who are unable to provide the services required by HIV infected patients should make referrals to those physicians or facilities equipped to provide such services; and (3) provide compassionate care. The Society affirms that physicians are dedicated to providing competent medical service with compassion and respect for human dignity. (Report 29, Board of Trustee, H-2001)
- 20.990 Government Funding**
The Society urges government officials to continue funding HIV testing, research, treatment, and counseling. In addition, the Society pledges to participate in government efforts to maintain cost-effective health care systems for HIV-infected patients in Pennsylvania. (Report 29, Board of Trustees, H-2001)
- 20.991 Mandatory HIV Testing**
The Society reaffirms its existing policies concerning HIV testing and renews its commitment to assuring that Act 148 is changed to be consistent with these policies. (Res. 205, H-1998)
- The Society believes that HIV testing in Pennsylvania should be voluntary and under general consent. (Sub. Res. 204, H-2003)
- 20.992 Student/Resident Exposure to Blood-Borne Pathogens**
The Society adopted the Student/Resident Exposure to Bloodborne Pathogens policy statement. (Report JJ, Board of Trustees, H-1993)
- 20.993 HIV Reporting**
The Society reaffirms the view that AIDS and HIV infection should be perceived as an infectious disease, and that every effort should be made by public health authorities to encourage compliance with regulations requiring reporting of such infectious diseases. (Res. 22, H-1993)
- 20.994 Reporting to Department of Health**
The Pennsylvania Medical Society is directed to urge the Pennsylvania State Health Advisory Board to require reporting of all confirmed HIV positivity to the appropriate health department. (Res. 38, H-1991; Res. 4, H-1992; Revised, Report 29, Board of Trustees, H-2001)

- 20.995 Physician with AIDS to Consult with Colleagues**
The Society asserts that a physician who has AIDS or who is seropositive should consult colleagues about which activities the physician can pursue without creating a risk to patients. (Task Force on AIDS, Report A, H-1987)
- 20.996 HIV/AIDS Patients Who Purposely Threaten Others**
The Society asserts that blatant disregard by an HIV-infected individual for the health of others should be subject to legal sanctions. (Report A, Task Force on AIDS, H-1987; Revised, Report 29, Board of Trustees, H-2001)
- 20.997 HIV Positives Reported to Public Health Officials**
The Society believes regulations should be established so that individuals testing positive for HIV infection could be reported to the appropriate public health officials or organizations in a confidential manner. (Report A, Task Force on AIDS, H-1987; Revised, Report 29, Board of Trustees, H-2001)
- 20.998 Contact Reporting Immunity for Physicians**
In the event that HIV-infected persons are unable or unwilling to reveal their test status to an intimate contact, Act 148 of 1990 allows physicians to warn unsuspecting third parties and provides liability protection for physicians who do not warn a third-party because, in their best judgment, circumstances make the warning unwise. The Society urges physicians to exercise their best judgment and warn third parties of the danger whenever action is warranted in accordance with the requirements of Act 148. (Report A, Task Force on AIDS, H-1987; Revised, Report 29, Board of Trustees, H-2001)
- 20.999 Certification of Significant Exposure**
The Society seeks revision of Section 6 (a) (1) of the Confidentiality of HIV-Related Information Act to allow a physician to certify his own exposure or that of any of his employees as a significant exposure for the purpose of testing the source patient's blood for HIV. (Res. 25, H-1991; Revised, Report 29, Board of Trustees, H-2001)
-

25.000 Aging

- 25.997 Depression in Older Adults**
PAMED shall support the widespread implementation of evidence-based treatment programs to improve treatment outcomes of depression in older adults. (Res. 206, H-2018)
- 25.998 Physician Membership in AARP**
The Society encourages eligible physicians to join the American Association of Retired Persons. (Board Report I, H-1989)
- 25.999 Adult Day Care Centers**
The Society (1) supports county medical societies acting as patient advocates to the local Area Agencies on Aging (AAA) by urging them to allocate appropriate levels of funding from their annual block grants for adult day care centers in their counties; (2) encourages member physicians to serve as patient/family advocates by educating families on the availability of adult day care centers, recommending their use as medically appropriate, and assisting them in seeking funding such as the Options Program and the Family Care Givers Support Program; (3) encourages the Pennsylvania legislature to provide incentives for the establishment and

operation of adult day care centers by the private sector, both for profit and nonprofit; (4) urges the legislature to provide start-up funds for those counties currently lacking adult day care centers; and (5) supports the transfer of Department of Transportation programs for the elderly from the Department of Transportation (DOT) to the Department of Aging. (Report AA, Board of Trustees, H-1991)

30.000 Alcohol and Alcoholism

30.997 Underage Drinking and Strict Enforcement of DUI

The Society supports state legislation and other initiatives aimed at reducing underage drinking and strict enforcement of the driving under the influence law. Further, the Society supports the need for increased education regarding alcohol abuse, underage drinking, and rehabilitation treatment services. (Board of Trustees, March 1997)

30.998 Identification and Rehabilitation of Drunk Drivers

The Society supports appropriate efforts by the PA General Assembly to identify and rehabilitate drunk drivers. (Res. 8, H-1990)

30.999 Community Hospitals Meet Needs

The Society encourages all community hospitals to meet the acute medical needs of alcoholics. (Res. 23, H-1969; Revised, H-1999)

35.000 Allied Health Professions

35.986 Medical Aestheticians

The Society shall work with the State Board of Medicine and the State Cosmetology Board to eliminate actions and procedures by aestheticians that exceed their scope of practice as set forth in existing state regulation. The Society shall also work to prohibit the use of the term "medical aesthetician" and require that aestheticians abide by truth in advertising in describing the services they can provide. (Res. 409, H-2012)

35.987 Supporting the Need for Physician Oversight/Defending the Physician-Patient Relationship

The Pennsylvania Medical Society (PAMED) recognizes, supports, and lobbies for the need for physician oversight, whether by direct supervision or a written collaborative agreement, of all non-physician practitioners under the guidance of physicians including, but not limited to, CRNPs, CRNAs, nurse midwives, and physician assistants. PAMED adopted the policy to oppose in any current or future federal or state health law legislation or act enabling regulations regarding any or all of the following provisions: 1) Any federal or state provision which requires or permits any licensed or non-licensed non-physician practitioner (whether certified or not) to practice medicine independently without licensed medical supervision or written collaborative agreement with a medical physician (MD/DO) licensed in the same state; 2) any federal or state provision which permits any licensed or non-licensed non-physician practitioner (whether certified or not) to prescribe drugs without licensed medical supervision or written collaborative agreement with a medical physician (MD/DO) licensed in the same state; and 3) payment to any licensed or non-licensed non-physician practitioner (whether certified or not) which

would be equal to or greater than any payment made to a licensed medical practitioner for the same service in the same payment area. PAMED directed its Pennsylvania Delegation to the AMA to submit this resolution to the 2010 AMA Interim Meeting. (Res. 407, H-2010)

The 2017 House of Delegates directed PAMED to strongly oppose current and future legislation which would establish independent practice for Nurse Practitioners, and also to reaffirm Policy Number 35.986 (now known as Policy Number 35.987 due to re-numbering as a result of the Policy Sunset process). (Reaffirmed, Res. 403, H-2017)

The 2018 House of Delegates directed PAMED to reaffirm both Policy No. 35.987 and Policy No. 270.974 entitled "Oppose Measures That Erode Physician Supervision of Physician Assistants" (formerly Policy No. 270.971 but re-numbered as a result of the Policy Sunset process). The House also directed that both PAMED policies shall appear in and be listed as Scope of Policy issues under the current section, 35.000 Allied Health Professions. Under Policy No. 270.974, PAMED is directed to oppose legislation that promotes physician assistant independent practice, and any legislation that erodes the supervisory role of the physician with or in relation to the physician assistant. (Reaffirmed as amended, Res. 406, H-2018)

35.988 Store-Based Health Clinics in Pennsylvania

The Board of Trustees approved the recommendation that it be the policy of the Pennsylvania Medical Society that any individual, company, or other entity that establishes and/or operates store-based health clinics should adhere to the following principles:

- a. Store-based health clinics must have a well-defined list of services, consistent with state scope of practice laws.
- b. Store-based health clinics must use standardized protocols derived from evidence-based practice guidelines to insure patient safety and quality of care.
- c. Store-based health clinics must establish prior arrangements by which their health care practitioners have direct access to physicians and other health care practitioners in accordance with state laws.
- d. Store-based health clinics must establish protocols for ensuring continuity of care with practicing physicians within the local community.
- e. Store-based health clinics must establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic.
- f. Store-based health clinics must clearly inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as any limitation in the types of illnesses that can be diagnosed and treated. Such qualifications must be within existing scopes of practice and not reflect an increase in independent practice.
- g. Store-based health clinics must establish appropriate sanitation and hygienic guidelines and facilities to insure the safety of patients.
- h. Store-based health clinics should be encouraged to use electronic health records (EHRs) as a means of communicating patient information and facilitating continuity of care.
- i. Store-based health clinics should encourage patient to establish a "medical home" to ensure continuity of care.

The Society shall continue to monitor the effects of store-based health clinics on both the delivery of patient care and on the health care marketplace in Pennsylvania. The Society opposes expansion of the scope of service of store-based health clinics into chronic disease management based on concerns for patient safety, continuity of care and confidentiality. Chronic disease management should be coordinated only by a physician. (Board of Trustees, October 2006; revised, Res. 202, H-2010)

35.989 Advertising by Non-Physician Health Care Providers

The Society shall monitor and pursue sanctions against non-physician health care providers that utilize fraudulent or deceptive advertising to the public in order to enhance their business and intentionally misrepresent their scope of practice and ability to diagnose, manage and treat patients. (Res. 412, H-2006; reaffirmed, H-2016)

35.990 Restrictions of Medical Use of Lasers

The Society advocates for legislation or regulation to limit the use of lasers for medical purposes to physicians and podiatrists. (Res. 412, H-2005)

The Society shall seek to define the medical use of lasers, intense pulse light devices, microwave energy, electrical impulses, thermal destruction chemical application, particle sanding, botulinum toxins, neurotoxins, and foreign or natural substances by injection or insertion as the practice of medicine and/or surgery, and require that through appropriate regulation or legislation that these services must be performed by qualified and licensed physicians or qualified and licensed non-physicians under the supervision of a physician. (Res. 401, H-2011)

35.991 Scope of Practice of Dentistry

The Society opposes any practice by oral and maxillofacial surgeons without a license as a medical doctor or doctor of osteopathy that goes beyond the scope of practice defined by the Dental Practice Act and shall inform directors of dental training programs of this policy. The Society shall inform the public of the differences between dental and medical practices. (Res. 202, H-2004)

35.992 Physician Delegation Regulations

The Society continues to support the State Board of Medicine physician delegation regulations. The Society shall assist in the education of physicians as to their responsibilities as they relate to the delegation, supervision and direction of non-physician health care services. (Report 11, Board of Trustees, H-2002)

35.993 Scope of Practice Reform

The Society continues to work to affect scope of practice reform that is substantive, eases access to appropriate medical care, treats non-physician providers with the proper respect due their training, and keeps the practice of medicine under the direction of the physician. (Recommendation 6(d) of the President-Elect, H-2000)

35.994 Limited Licensed Practitioners

The Society reaffirms its policies regarding limited licensed practitioners and opposes the expansion of the scope of practice for limited licensed practitioners, such as optometrists and podiatrists. (Board of Trustees, March 2000)

35.995 Scope of Psychological Practice in the Hospital Setting

The Society adopted the following positions regarding the scope of psychological practice in the hospital setting:

1. A psychologist with clinical duties may, with the concurrence of any psychiatric member of the medical staff, recommend patients for admission. The attending psychiatrist shall assume responsibility and authority for the care of the patient throughout the hospital stay, including the collaborative participation of the recommending psychologist. The extent and nature of the collaboration should be determined by the bylaws of the individual hospital in accordance with existing regulations;
2. Psychologists should be included as voting members on committees where appropriate and not in conflict with the bylaws of the individual hospital;
3. "Psychologists" in this regard shall be defined as licensed, clinical, doctoral-level psychologists operating within the scope of their license; and
4. Efforts to enlarge upon the role of psychologists in hospitals beyond these areas shall be opposed by the Society as not in the interest of the best health care for the citizens of Pennsylvania. (Res. 1, H-1991)

35.996 Physician Non-Physician Relationships

The Society reiterated its 1979 policy on relationships with non-physician providers, directed that the policy be broadly circulated, and that it be provided to the state Department of Public Welfare and other state agencies for the purpose of influencing future regulations regarding medical and mental health services and programs. (Res. 38, H-1980)

35.997 PA Society of American Association of Medical Assistants

The Society supports the Pennsylvania Society of the American Association of Medical Assistants and encourages similar support by county societies and other state societies. (Council on Public Service, H-1971)

35.998 Oppose Primary Eye Care by Optometrists

The Society vigorously opposes the concept of allowing non-medical persons to practice medicine. The Society specifically opposes the further expansion of the practice of optometry into the practice of medicine. (Res. 29, H-1975)

35.999 Direct Reimbursement of Nurse Anesthetists

The Society opposes any statute, regulation, or similar action which provides for direct reimbursement of certified registered nurse anesthetists. (Res. 40, H-1986; reaffirmed, H-2016)

55.000 Cancer

55.998 Screening for Early Lung Cancer

The Society supports the position that monies from the tobacco settlement be used to investigate screening methods for early lung cancer. (Res. 202, H-2000; revised, H-2010)

55.999 Colorectal Cancer Surveillance

The Society endorses the concept of colorectal cancer surveillance and strongly urged reimbursement for such colorectal cancer surveillance in health care and health insurance reform legislation as it evolves in the Pennsylvania legislature and the United States Congress, as recommended by the Interspecialty Section. (Board of Trustees, March 1995)

60.000 Children and Youth**60.989 School Resource Officer Training Standards**

The Pennsylvania Medical Society (PAMED) is directed to strongly and urgently advocate for minimum standards of training for School Resource Officers (SRO) to include childhood development, conflict de-escalation and resolution, restorative justice, crime awareness, implicit/explicit biases, diversity inclusion, cultural competency, and individual and institutional safety, and that this initiative be a priority to protect the health and safety of the schoolchildren, teachers, and school staff of the Commonwealth of Pennsylvania. (Res. 403, H-2018)

60.990 Adverse Childhood Experience (ACE) Screenings

PAMED shall encourage primary care providers to recognize the correlation between adverse childhood experiences and chronic disease to appropriately tailor care to the unique needs of the patient. (Res. 208, H-2018)

60.991 Routine Immunization of Older Adolescents

PAMED shall promote American Academy of Family Physicians (AAFP) and/or Pennsylvania Academy of Family Physicians (PAFP) outreach campaigns to educate health care providers about current Centers for Disease Control and Prevention (CDC) guidelines for routine immunizations at age 16. (Res. 18-202, H-2018)

60.992 Baby Boxes as a Safe Sleeping Space for Infants in PA

PAMED shall encourage the research of safe sleeping environments which could include the study of the safety, efficacy, and methods of implementation of boxes for babies to sleep in as a potential initiative to decrease the incidence of sudden unexpected infant death in Pennsylvania. (Res. 206, H-2017)

60.993 Teen Health Week

The Pennsylvania Medical Society (PAMED) shall actively promote Teen Health Week and encourage county and specialty associations across the state to join with their local schools to adopt, promote, and participate in Teen Health Week. Also, the Pennsylvania Delegation to the American Medical Association (AMA) is directed to present this resolution to the upcoming interim meeting of the AMA (I-2016) for national adoption. (Res. 207, H-2016)

The 2017 House of Delegates adopted the following reaffirmation of Policy Number 60.992: PAMED shall actively promote Teen Health Week and encourage its component county and specialty associations to also work with their local schools to adopt Teen Health Week. (Res. 202, H-2017)

60.994 Eliminating Barriers to Children Possessing and Using Sunscreen in School

The Centers for Disease Control and Prevention believe that school policies that prohibit hats or student possession of sunscreen can create barriers to the use of important sun protection methods. Even one blistering sunburn during childhood or adolescence can nearly double a person's chance of developing melanoma later in life, while 5 or more blistering sunburns in late adolescence increases one's

melanoma risk by 80 percent and non-melanoma risk by 68 percent. No published studies show that sunscreens that meet FDA standards are toxic to humans or hazardous to human health, and the incidence of skin cancer can be reduced by the use of sunscreen and sun-protective clothing. The Society shall lobby to allow students to bring and possess sunscreen and sun-protective clothing, including hats, at school and youth camps without requiring physician authorization. (Res. 204, H-2016)

60.995 Proper Passenger Restraints on Airlines for Children

The Society directed its AMA Delegation to request the AMA to lobby the appropriate authorities to have five-point restraints available on passenger airplanes for children over two years of age and under four feet tall and 80 pounds. (Res. 204, H-2012)

60.996 Use of FDA Approved Adult Medications in Pediatric Care

The Society shall lobby insurers to update and amend their formularies to include medications which are at this time only FDA approved for adults and not yet for children, if the medication is commonly recognized and used by physicians for the treatment of pediatric patients. (Res. 304, H-2010)

60.997 Periodic Preventive Health Exams for Children and Adolescents

The Society supports existing guidelines from national professional medical organizations, i.e., AAP, AAFP, ACOFP, etc., for periodic preventive health examinations for children and adolescents, and supports adequate reimbursement for those physicians who choose to follow these guidelines. (Res. 205, H-2004)

60.998 More Stringent Vaccinations

The Society supports legislation to 1) establish a parental duty to immunize their children in a complete and timely manner; and 2) mandate Pennsylvania public health clinics provide all recommended immunizations as recommended by the Centers for Disease Control Advisory Committee on Immunization Practices (specifically Hepatitis B vaccine). (Res. 4, H-1993; Revised, H-2013)

60.999 Health Passport

The Society urged all physicians and other health care professionals who treat children to consider using immunization records in their practices, including participation in computerized immunization tracking systems. (Res. 32, H-1979; Revised, H-1999)

65.000 Civil and Human Rights

65.999 Limited English Proficiency Policy Guidance Document

The Society shall seek from the Department of Health and Human Services Office of Civil Rights clarification of the Limited English Proficiency Policy Guidance document and resolution of the document's ambiguities and inconsistencies. (Res. 301, H-2002)

70.000 Coding and Nomenclature

70.996 Billing Modifiers

The Society shall seek legislation that requires standardized billing processing including modifiers and further, that all codes be reimbursed in compliance with accepted Current Procedural Terminology (CPT) practices for Pennsylvania insurers. A CPT code or modifier that is reimbursed zero dollars or otherwise not properly reimbursed should be considered as an uncovered, billable service. The Pennsylvania Delegation to the AMA is directed to forward this resolution to the AMA for action. (Res. 305, H-2005)

70.997 Multiple Procedure Modifier Reimbursement

The Society shall seek legislation and/or regulation to require all health insurers doing business in Pennsylvania and the Department of Public Welfare to reimburse for all Current Procedural Terminology Codes, as published, including multiple procedure modifiers. (Sub. Res. 304, H-2001)

70.998 CPT Code Modifiers

The Society supports legislation to ensure that all insurance companies and group payers recognize and pay for all published CPT codes, including modifiers that the payer has agreed to compensate as outlined in the contract language, and that all third-party payers disclose the components of, and clinical justification for, bundled CPT codes. If carriers persist in combining published CPT codes in a manner that results in inappropriate bundling of services, then legislative and legal remedies should be pursued. The Society shall ask the Pennsylvania Delegation to the AMA to carry the contents of this resolution forward to the American Medical Association. (Res. 310, H-1999)

70.999 Revision of Evaluation and Management Codes

The Society is directed to request the CPT Department of Coding and Nomenclature to develop policy, rules, and guidelines to handle unusual situations (i.e., multiple small problems at one visit, one extraordinary component, incomplete initial visit) that the rigid definitions of Evaluation and Management Services has created, so that unusual visits can be easily coded; and was further directed to ask the AMA to do likewise. (Res. 506, H-1995)

80.000 Crime

80.998 Sexual Harassment

The Society adopted the policies suggested in the AMA Guidelines for Establishing Sexual Harassment Prevention Procedures. The Society is directed to review any future AMA Guidelines for possible adoption. (Report H, Board of Trustees, H-1992)

80.999 Confidentiality of Rape Counselors' Files

The Society supports appropriate legal protection from public access of records of alleged rape patients retained by qualified rape counselors. (Res. 44, H-1980)

85.000 Death

85.992 Providing a “Home” for the POLST Program

The Society shall expeditiously convene stakeholders with an interest in promoting the Pennsylvania Physician Orders for Life-Sustaining Treatment (POLST) program, with the goal of developing a proper home for a quality POLST program, and to assess the need for legislative or regulatory initiatives to resolve the inability of EMS personnel to follow orders on a properly executed Pennsylvania POLST form. (Res. 201, H-2012)

85.993 Advance Directives

The Society shall seek innovative ways to expand the use of advance directives. (Res. 412, H-2007)

85.994 Financial Incentives for Autopsies

The Society affirms the importance of autopsies and opposes the use of any financial incentives for physicians who acquire autopsy clearance. (Res. 204, H-1995)

85.995 Right to Die Legislation

As a matter of high priority, the Society supports and encourages the development of right to die legislation in the Commonwealth that protects patient, family, and physicians’ decisions. (Res. 30, H-85)

The Society believes that the traditional physician/patient framework for decision-making is still the desired approach for treatment decisions concerning the incompetent patient, which calls upon physicians to:

1. Identify the goals of medical treatment based on the medical facts, the medical indications, and the potential consequences.
2. Identify the patient’s preferences in consultation with family, friends, and religious leaders, if available. In this application of substituted judgment, someone other than the patient makes the treatment decision, but the goal is to act in harmony with the patient’s moral, ethical, and religious values using any available written or verbal expression or instructions of the patient. Any previous discussion the physician may have had with the patient would be important.
3. Consider the patient’s previously expressed viewpoint on quality of life; understand the medical, professional, and human values of all individuals involved; and identify major value conflicts.
4. Explore applicable external factors, such as cost, legal issues, etc. The Society acknowledges, however, that instances occur where outside decision-making assistance should be sought. The guidance of the hospital’s ethics committee is one source of guidance. In some cases, a second opinion from another physician might be sought. In rare instances, a physician may want to petition the local court for guidance. As an example, a physician must consider this avenue when the patient is unable to make treatment decisions and no surrogate decision-maker is available. In such instances, the court could appoint a guardian who would have the responsibility of making treatment decisions for the patient. (Report K, Board of Trustees, H-1992)

85.996

Pronouncement of Death in Nursing Homes

Physicians should be urged to cooperate in the pronouncement and certification of death of nursing home residents so that there is not an unreasonable delay in the removal of a body. (Report F, Board of Trustees, H-1979; Revised, H-1999)

85.997

Hospice Programs

The Society endorses in principle hospice programs as an appropriate mode of care and seeks changes in policies of health insurers to include subscriber coverage by third-party payers for hospice programs. (Res. 30, H- 79)

85.998

Euthanasia

The Society believes that:

1. The decision to withhold or to withdraw extraordinary forms of medical therapy, when there is sound evidence that biologic death is inevitable, is the prerogative of the patient or the closest relative with proper medical consultation by the attending physician.
2. The use of euthanasia, that is, the active termination of life through the administration of a lethal drug or the use of a lethal instrument, is unjustifiable taking of human life and exceeds proper medical practice. (Res. 5, H-1973)

Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment, even though it may foreseeably hasten death. (Revised, H-2003)

85.999

Death Certificate Guidelines

The Society supports the development of statewide guidelines beyond the standard nomenclature that are intended to assist physicians in the accurate completion of death certificates. The Society also urges each hospital to perform in-house, periodic review of all death certificates completed over a defined period of no more than three (3) months for the purpose of evaluation and education of medical trainees and staff. The Society further urges all physicians responsible for the completion of death certificates to regularly consult with their region's medical examiner prior to the determination of problematic causes and manners of death. (Res. 74, H-1990; Reaffirmed current system, Report V, Board of Trustees, H-1991)

The Society once again urges all hospital medical staffs to perform in-house periodic reviews of death certificates for the purpose of evaluation and education of medical trainees and staff. The Society continues to urge all physicians responsible for the completion of death certificates to regularly consult with their region's medical examiner and/or coroner prior to the determination of problematic causes and manners of death. (Res. 207, H-2005)

95.000

Drug Abuse

95.992

SAMHSA Hotline for Opioid Abuse

PAMED shall continue to promote awareness of the Substance Abuse and Mental Health Services Administration (SAMHSA) national helpline, which is available 24/7

for use by patients, families, and care providers to find counseling and care. (Res. 204, H-2018)

95.993 Promoting Medication-Assisted Treatment for Substance Abuse Disorders
PAMED shall coordinate public and professional education campaigns and programs to promote more widespread use of the safe and effective medication-assisted treatments in coordination with counseling and evidence-based therapies which are available and shall promote training programs for those Pennsylvania physicians interested in becoming medication-assisted treatment providers. (Res. 203, H-2017)

95.994 Further Addressing the Overdose Crisis
The use and abuse of prescription medications, primarily opioids, benzodiazepines, antidepressants and other illegal drugs have become so pervasive as to be considered a public health epidemic. The Society has taken a leadership role in education and advocacy to address this crisis. However, many very significant barriers continue to exist for patients who are in need of appropriate and sometimes immediate treatment. The Society shall work together with other statewide stakeholders to identify and rectify existing barriers for patients seeking care for addiction and shall work with the county medical societies to identify and rectify barriers at the local level. (Res. 202, H-2016)

95.995 Education on Overdose Prevention/Naloxone Prescribing
The Society (1) promotes overdose prevention education to patients and their families; (2) promotes physician education on naloxone prescribing, including risk assessment of patients, resources available to learn more about available programs, and how best to proceed when the decision is made to prescribe;(3) will expand the Pain Management Work Group to include expertise on overdose prevention and naloxone prescribing;(4) advocates to expand the mission of the Pennsylvania Pain Coalition to include physician and public overdose education goals, and continue to work with the coalition and other nonprofit organizations to develop patient education materials about naloxone use as part of a public education program. This program should focus on appropriate pain management therapies and their adverse side effects, as well as the importance of having realistic expectations for pain control; and (5) will continue to monitor research on naloxone prescribing, including the Lazarus Project. (Report 4, Board of Trustees, H-2009)

95.996 Use of Medical Marijuana
The Society adopted AMA policy H-1995.952 as the policy of the Pennsylvania Medical Society with respect to the use of cannabis for medical purposes: (1) 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) 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) urges the National Institutes of Health (NIH) to implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research into the medical utility of marijuana. This effort should include: a) disseminating specific

information for researchers on the development of safeguards for marijuana clinical research protocols and the development of model informed consent on marijuana for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of marijuana for clinical research purposes; c) confirming that marijuana of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the Drug Enforcement Agency who are conducting bona fide clinical research studies that receive Food and Drug Administration approval, regardless of whether or not the NIH is the primary source of grant support; and (4) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and the discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. (Board of Trustees, February 2-3, 2010)

Medical Use of Cannabinoids

The Society opposes broad-based legalization of cannabis for medical use and adopted the following principles:

1. The Pennsylvania Medical Society 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. The Pennsylvania Medical Society 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. The Pennsylvania Medical Society urges the National Institutes of Health (NIH) to implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research into the medical utility of marijuana. This effort should include: a) disseminating specific information for researchers on the development of safeguards for marijuana clinical research protocols and the development of model informed consent on marijuana for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of marijuana for clinical research purposes; c) confirming that marijuana of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the Drug Enforcement Agency who are conducting bona fide clinical research studies that receive Food and Drug Administration approval, regardless of whether or not the NIH is the primary source of grant support.
4. The Pennsylvania Medical Society believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and the discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions.
5. The Pennsylvania Medical Society supports trials using cannabidiol oil to treat children with seizure disorders, funding for the trials, and a patient registry.

(Res. 403, H-2015)

95.997 Access to Treatment for Addiction

The Society shall provide public and expert support for any community effort to expand safe and appropriately supervised access to comprehensive therapy for opiate addiction, including methadone and buprenorphine. The Society encourages its members to function as advocates for and providers of therapies to treat opiate addiction within federal and state guidelines. (Res. 202, H-2005)

95.998 Prescription Drug Monitoring Legislation

The Society shall actively pursue legislation that would allow the Commonwealth to develop a prescription drug monitoring program that would immediately identify and intervene with those individuals that are receiving scheduled drugs from multiple physicians and pharmacies. The prescription drug monitoring database for the program should be available to provide physicians with information for purposes of minimizing further distribution of non-medical use of prescription medication. (Res. 213, H-2004)

95.999 Decriminalization of Illicit Drugs

The Society adopted a white paper on decriminalization of illicit drugs which included the following recommendations:

1. The Society should support the American Society of Addiction Medicine's definition which states that addiction is a disease.
 2. The Society should advocate:
 - a. Primary prevention
 - b. Early identification
 - c. Expanded research
 - d. Increased access to a full complement of treatments for addiction
 3. The Society should work to assure that medical insurance benefits for the treatment of addiction are available to all citizens, thus providing access to the most effective and cost-efficient treatments to all who desire help.
 4. The Society should support an educational program for physicians and the public on all aspects of substance abuse, including the multiple issues of decriminalization.
 5. The Society urges a continual exploration of this complex issue.
 6. In view of the numerous unanswered questions, the Society should not endorse decriminalization at this time; instead it should encourage a continuing discussion among physicians to evaluate current and future proposals for decriminalization. (Report UU, Board of Trustees, H-1991; Revised, H-2001)
-

100.000 Drugs

100.994 One Fee, One Number

The Society is directed to send a letter to the AMA, asking that they continue to pursue the actions outlined in AMA Policy D-100.975: (1) Our AMA will work with the Drug Enforcement Administration (DEA) and Congress to move toward a system in which individual physician DEA registration numbers are person-specific rather than site-specific within a state. Additionally, the AMA will work with the DEA to ensure that the full DEA registration fee is paid only once, when the provider initially registers. Following the initial registration, provider should only pay a small re-registration fee every three years to fund the work of the Diversion Control Program; (2) our AMA will work with the DEA, Congress and state licensing boards to explore changes to the DEA registration system so that a single DEA registration number can be used by physicians who prescribe, dispense, and/or administer

controlled substances in multiple states. Our AMA will explore the possible development of a national DEA standard which would be greater than or equal to the most stringent state requirements for controlled substances. Providers could choose whether they would like to apply for the national DEA standard, or, more likely for those practicing in a single state, remain registered with the DEA under their single state requirements; and (3) our AMA continues to monitor implementation of the National Provider Identifier (NPI) system and work with physicians and payers to ensure proper and prompt payment for physician claims. Additionally, the AMA will monitor physician privacy concerns associated with the public consumption of the NPI database. (Report 2, Board of Trustees, H-2014)

100.995

Safe Disposal of Prescription and Over-the-Counter Drugs

The Society is directed to produce guidelines on Medication Clean-up programs for physicians and medical practices, and to seek ways to partner with interested government agencies and organizations to expand the Medication Clean-up program to counties beyond the pilot areas of Pittsburgh, Harrisburg, and Philadelphia. (Res. 204, H-2010)

100.996

Appropriate Unused Medication Disposal

The Society shall work with interested organizations and appropriate state agencies to promote education regarding the storage and disposal of unused medications. The Society shall urge the office of the Governor to convene a task force to resolve the jurisdictional issues that impede progress in addressing this safety issue of appropriate unused medication disposal. The Society is directed to take this issue to the AMA House of Delegates. (Res. 202, H-2009)

100.997

Establishment of a Registry for Clozapine Users with Benign Ethnic Neutropenia

The Society adopted the following policy statement and shall communicate it to the U.S. Food and Drug Administration: "The Pennsylvania Medical Society supports the establishment of a national registry for patients who are being treated with clozapine for schizophrenia and other serious conditions and have benign ethnic neutropenia. This registry, to be established by the Food and Drug Administration, could prevent interruption of therapy. Prescription refills of clozapine should not be refused by the pharmacist until it is determined that the patient does not have benign ethnic neutropenia. Clozapine is considered the best antipsychotic for treatment resistant schizophrenia and other serious conditions. Currently, pharmacists are required to refuse clozapine prescriptions when blood tests of clozapine patients indicate low white cell counts. However, patients of African or Mediterranean descent may normally have low white cell counts. The refusal of refills by the pharmacist interrupts therapy and may result in behavioral issues that put patients and their families at risk of injury or even death." (Report 26, Board of Trustees, H-2009)

100.998

Use of Drug Enforcement Agency (DEA) Numbers

The Society adopted the policy statement on DEA numbers which included the following: The Society (1) believes that the U.S. Drug Enforcement Agency issues DEA numbers for the specific purpose of governing the distribution of controlled substances; (2) considers that the expansion of the use of these numbers for other purposes, such as serving as a physician identifier for third-party prescription programs, is not conducive to the practice of good medicine, can be detrimental to the physician-patient relationship, and can result in the diversion of controlled substances for illicit purposes; (3) encourages physicians to limit their use of DEA numbers to only those instances prescribed by the DEA and opposes any

additional usage; and (4) recommends that any third-party identification system use another universal number, such as medical license number, UPIN number, Employer Identification Number, etc. (Report CC, Board of Trustees, H-1993; Revised, H-2003)

100.999 Use of Anorexiants for Treatment of Obesity

The key to medically-safe treatment of obesity continues to center on sound nutrition and adequate exercise. These concepts, which combine reduced food intake and increased energy output, offer what appears to be the most effective way to control obesity on a long-range basis. Sensible weight reduction is a slow process which may require some individuals to restrict caloric intake lifelong. Crash or fad diets, while they have an appeal based on gimmicks or seemingly fast results, may fail to address the underlying problem causing obesity or overweight.

1. It is the position of the Pennsylvania Medical Society that treatment of obesity is a medical matter;
2. Obesity is best treated in connection with the patient's physical, social, and emotional conditions;
3. Proper diagnosis and treatment of obesity can be accomplished through continued efforts to inform and educate;
4. The public should be protected against an irrational therapy, including inappropriate use of drugs or other selected methods of weight loss such as dietary supplements, which enjoy sudden and brief popularity but often lack any medical soundness. (Res. 21, H-1977)

110.000 Drugs: Cost

110.997 Physician Education on Pharmacy Benefits

The Society believes physicians should be educated about medications that are available to patients through Medicare Part B and are not subject to the "donut hole", including respiratory medications (e.g., nebulizer medications) and injectable medications (e.g., Reclast); and over-the-counter alternatives which may also lower total Medicare total Rx costs, and to more easily recognize a true pre-certification for a medication from other medication change requests. The Society is directed to take this issue to the AMA for action by way of a resolution. (Res. 303, H-2009)

110.998 Pharmacy Benefit Plans

The Society is committed to overseeing the modification of Pharmacy Benefit Plans with potential associated inefficient and overly burdensome methods. The Society shall be actively involved in finding more effective solutions to rising drug costs that do not unfairly burden physicians or their offices or expose patients to additional risks. (Res. 316, H-2000; revised, H-2010)

110.999 Costs for Prescriptions

The Society lends its full support toward appropriate measures which can be instituted for substantial price reductions on prescription drugs. (Res. 22, H-1992)

115.000 Drugs: Labeling and Packaging**115.998 Prescription Drug Expiration Dates**

The Society is directed to approach the State Board of Pharmacy to change the current labeling practice and begin to place the expiration date specified by the pharmaceutical manufacturer on the prescription drugs. The specifications should state that the product should be stored under reasonable conditions. (Res. 409, H-2006; reaffirmed, H-2016)

115.999 Consistent Prescription Medication Outdating

The Society requests the State Pharmacy Board to pass regulations for consistent medication outdating equal to the pharmaceutical manufacturers' stock dating. (Res. 401, H-2005)

120.000 Drugs: Prescribing and Dispensing**120.991 Oppose Mandate to Mandated E-Prescribing**

Many organizations are moving to support and encourage electronic prescribing ("e-prescribing"), while many physicians prefer to be able to write prescriptions using paper and pen. Mandating electronic prescriptions may create undue pressure and concern for many physicians and a reliance on e-prescribing may present logistical difficulties when there are problems with the underlying technology. The Society is directed to actively preserve the ability of physicians to physically write prescriptions and oppose any mandate that requires all prescribing in Pennsylvania be done electronically. (Res. 401, H-2016)

120.992 Geriatric Prescribing

The Society shall develop a brief list of credible websites available to physicians regarding geriatric prescribing to be published in a member newsletter and on the Society's website. (Res. 203, H-2012)

120.993 Safe and Appropriate Medication Dosages for Geriatric Patients

The Society is directed to ask the AMA to collaborate with those specialty societies involved with the care of the geriatric patient and lobby the appropriate federal agencies to research and develop recommendations for the safe and appropriate dosages of medications used by the elderly. (Res. 206, H-2009)

120.994 Prescription Pad Theft

The Society shall prepare and disseminate a guide of action steps for physicians to complete when they discover the theft of their prescription pads, unauthorized use of electronic prescribing, or the unauthorized use of their DEA numbers. (Res. 403, H-2009)

120.995 Pharmaceuticals Administered by Physician Practices

The Society shall work with the Pennsylvania Society of Oncology and Hematology and other affected organizations to set up meetings with health insurance companies to discuss the practice of indirect, unsupervised acquisition, handling, preparation and disposal of pharmaceuticals administered by physician practices ("brown bagging"). The Society shall join the Pennsylvania Society of Oncology and Hematology and other organizations in meetings with the Bureau of Managed Care

under the Department of Health to discuss patient safety concerns associated with the practice of “brown bagging.” (Res. 309, H-2004; revised, H-2014)

120.996 Use of FDA Approved Drug Product/Medical Device

The Society adopted the policy that a physician may lawfully use a Federal Drug Administration (FDA) approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion; and affirms the position that when the prescription of a drug or use of a device represents safe and effective therapy, third-party payers should consider the intervention reasonable and necessary medical care, irrespective of labeling, and should fulfill their obligation to their beneficiaries by covering such therapy. (Res. 301, H-2003)

The Society renews its policy to encourage health plans across the state to include “off-label” uses on their list of “covered prescription drugs.” The Society shall develop an appropriate definition of “sound scientific evidence” and/or “sound medical opinion” as raised in the Medical Directors Forum. The Society shall also develop and promote appropriate legislative remedies which would require health insurance companies in Pennsylvania to cover the appropriate use of “off-label” drugs. (Res. 306, H-2004)

120.997 Pharmaceutical Companies’ Access to Physician Prescribing

The Society shall pursue ways, through regulatory and legislative efforts, to stop pharmaceutical companies’ access to physicians’ prescribing patterns, and shall request the AMA to take steps in preventing this practice on a national basis. (Res. 208, H-1998)

120.998 Prescription Drugs for Indigent Patients

The Society (1) compliments the Pharmaceutical Manufacturers Association (PMA) on its programs for indigent patients and encourages the PMA to develop a universal application process and eligibility criteria to facilitate enrollment of patients and physicians in all the programs providing pharmaceuticals to indigent patients that are provided by pharmaceutical manufacturers; and (2) encourages the PMA to provide information to physicians and hospital medical staffs about the members of PMA that provide pharmaceuticals to indigent patients. (Sub. Res. 202, H-1994)

120.999 Prepaid Prescription Plans and Unsound Medical Practices

The Society recommends that prepaid prescription plans allow participants to receive prescriptions in quantities smaller than three months’ supply at a time. The State Drug Device and Cosmetic Board has been notified of this policy. (Res. 38, H-1990)

125.000 Drugs: Substitution

125.991 Requirement of Formulary Equivalent Alternatives from Denying Insurers

PAMED shall seek through legislation or regulation the requirement that all insurers or their agents provide formulary alternates with similar mechanism of action at the time of prescription denial. (Res. 405, H-2017)

125.992 Informed Substitution of Anticonvulsant Drugs

The Society opposes the practice of substitution for anticonvulsant drugs (brand name to generic or generic to generic) for patients with epilepsy at the point-of-sale

without the express consent of the prescribing physician and notification of the patient in writing; further, the Society supports legislation that prohibits this practice. (Res. 211, H-2007)

125.993 Pharmacy Scope of Practice

The Society shall work in a collaborative manner with the Pennsylvania Pharmacists Association to develop guidelines for pharmacists that (a) limit their advice to information that is found in standard references; (b) recommend that pharmacists contact prescribing physicians directly about specific treatment concerns or prescription modification; and (c) assure that pharmacists recommend that patients contact their treating physicians to discuss questions or concerns or any refusal to dispense medication. The Society continues to recognize the valuable contributions made by pharmacists in protecting patients from adverse drug events such as drug interactions. The Society shall investigate reports from physicians about pharmacists' interventions which appear to exceed the scope of pharmacy practice and develop an action plan to address areas where such behaviors are occurring. (Res. 211, H-2005)

125.994 Pharmacy Benefits and Prescription Changes

The Society shall work with The Hospital and Health System Association of Pennsylvania, third-party payers, and pharmacy benefit managers in the interests of patients' safety to establish an effective mechanism to (1) coordinate inpatient formularies with patients' pharmacy benefit formularies in order to avoid otherwise unnecessary medication changes after discharge; (2) assure that requests for therapeutic changes (in their interest of cost savings) be approved by both the primary care physician and the hospital-based physician(s) responsible for the care of the patient; (3) establish that pharmacy benefit managers assume the responsibility and costs of ascertaining that the physicians and patients completely understand their requested changes in order to avoid patient noncompliance and therapeutic errors; and (4) to provide for a third-day transitional period to allow for continuation of coverage of medications prescribed at discharge. (Res. 308, H-2000)

125.995 Non-Generic Drugs

The Society is directed to influence insurance companies and prescription programs to provide reimbursement to patients for medications that are not yet available in generic form. (Res. 312, H-2000)

125.996 Coverage for All Dosage Strengths in Formulary Approved Products

The Society encourages managed care organizations with drug formularies to authorize payment for all manufactured dosage strengths of products already approved for their formulary. (Res. 309, H-1998)

125.997 Changes in Medications Prescribed by Physicians

The Society seeks to have prescription plan formularies' preferred medications evaluated and continuously reviewed by physicians to assure these are acceptable therapeutic substitutions. The Society also seeks to have a simple and timely appeal and reversal process available to physicians in instances where the physician believes the therapeutic substitution is not as effective in treating the patient as was the original regimen, or if the therapeutic substitution represents a significant risk to patient care. The Society shall pursue legislative or regulatory efforts to prohibit pharmacists and health plans to seek therapeutic substitutions in an attempt to receive direct rebates or rewards offered by pharmaceutical companies. (Res. 209, H-1998)

125.998 **Changes in Medications Ordered by Physicians**
The Society opposes the practice by pharmacists or other third parties of communicating with patients, suggesting changes in medications ordered by their treating physicians. (Board of Trustees, January 1998)

125.999 **Information on Generic Drugs**
The Society believes that (1) due to the quantity of data available on generic drugs and their general safety and efficacy, it is not practical, necessary, or cost-effective to provide every physician with bioavailability and bioassay data on every generic drug; (2) a concerned physician can readily request such data on an individual, case-by-case basis directly from the FDA; and (3) additional information on methodology and guidance where bioequivalence may be an issue are available from the U.S. Pharmacopoeia. (Report 2, Board of Trustees, H-1994)

130.000 **Emergency Medical Services**

130.994 **Continued Improvement of Emergency Response**
The Society shall work with the Department of Emergency Medical Services and other agencies to seek continued improvement to emergency response and to identify best practices in the delivery of emergency care. (Report 7, Board of Trustees, H-2011)

130.995 **Emergency Department Crowding**
The Work Group on Emergency Department Crowding is directed to continue its efforts to develop a white paper on emergency department crowding and work with the new administration and other stakeholders to address the problem. (Report 2, Board of Trustees, H-2010)

130.996 **Utilizing Emergency Department to Connect Victims of Violence to Community Resources**
The Society supports the introduction and passage of legislation, as has been proposed and passed in other states, which supports funding of an Injury Prevention Coordinator in emergency departments of state trauma centers where such need exists. (Res. 408, H-2007)

130.997 **Bioterrorism**
The Society encourages public health organizations throughout the Commonwealth to educate physicians on the history and manifestations of acts of bioterrorism. The Society adopts and shall disseminate the following AMA policy 130.949, "Organized Medicine's Role in the National Response to Terrorism", as an informational and educational tool in the physician's office to better prepare the practicing physician for the detection and treatment of bioterrorism: Our AMA: (1) and the Federation of Medicine will work with appropriate public health, law enforcement, hospital, and emergency response agencies and associations, as well as the pharmaceutical industry and media, to develop coordinated plans and strategies that identify the specific needs, roles, contributions, and participation of organized medicine and individual physicians in disaster planning and emergency response to terrorist attacks and identify procedures for the rapid detection, early reporting, and medical management of affected individuals; and (2) urges medical schools and residency programs to develop curricula and training programs for medical students and residents regarding medical and public health aspects of biological and chemical

terrorism, as well as community disaster planning and emergency response procedures in the event of such terrorism. (Res. 209, H-2000)

130.998 Care Delivered by On-Call Physicians

The Society seeks a requirement that health plans be mandated to cover the cost of care delivered by on-call physicians which is needed to stabilize patients presenting to the emergency department. The Society shall work together with organizations, such as the Pennsylvania Chapter of the American College of Emergency Physicians and The Hospital and Healthcare Association of Pennsylvania, to educate physicians, hospitals and other interested parties regarding the Emergency Medical Treatment and Active Labor Act (EMTALA), including the issue of responsibility of on-call physicians. (Res. 314, H-1998)

130.999 Prudent Layperson Definition of an Emergency

The Society adopted the following “prudent layperson” definition of emergency services: “Emergency services are health care services provided to evaluate and treat medical conditions of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent and/or unscheduled medical care is required.” Further, the Society is directed to incorporate this definition into its position statements regarding health care and to seek legislation requiring health insurance entities to use this definition in determining reimbursement for emergency services. (Res. 307, H-1995)

135.000 Environmental Health

135.993 Radon Policy

1. The Society believes that environmental radon gas and daughter radionuclide represent a significant public health concern.
2. The Society supports efforts aimed at remediation of homes found to contain high levels of radon gas.
3. It supports ongoing educational efforts aimed at publicizing the nature, extent, prevention and remediation of the problem.
4. The Society supports longitudinal health monitoring aimed at ascertaining actuarial risks of pulmonary carcinoma related to radon.
5. The Society advocates limited public sector support for testing and for remediation of highly contaminated homes (200pci/L).
6. The Society supports further study of the health effects of radon-contaminated drinking water. (Board of Trustees, May 1988)

135.994 Acid Rain Policy Adopted

The Society policy regarding acid rain states: “Atmosphere pollutants in ambient air concentrations do produce adverse effects on human health. The lungs and airways are primarily affected. Secondary effects, due to groundwater and game contamination, are less well studied and documented, but are nonetheless important.” The Pennsylvania Medical Society recommends the following:

- I. Organization Actions
 - A. Learn about pending legislation at state and national levels and support reasonable bills that will insure both quality of health and quality of lifestyle.
 - B. Urge compliance with established federal, state and local air pollutant levels in monitored urban areas.

- C. Encourage medical attention to the human health effects of air pollutants through the use of press releases, radio public service announcements and television health interest reports on news programs.
- D. Endorse the research and development of alternative energy sources and waste management.
- E. Endorse cooperation with selected organizations in order to gain additional expertise concerning atmospheric pollutants.
- II. Professional Actions
 - A. Educate yourself about the health effects of pollutants.
 - B. Identify the at-risk population in your practice which may include: Elderly greater than 65 years, children less than 8 years, patients with pulmonary disease such as COPD and asthma, pregnant women and post-myocardial infarction patients.
 - C. Consider the diagnosis of pollutant induced ill health or exacerbation of an existing disease.
 - D. Treatment of air pollutant induced ill health: Avoid exposure (stay indoors), reduce physical activity, air purification, medical treatment if necessary.
 - E. Counsel at risk patients to be alert to broadcast air quality reports and discover for themselves how it affects their health.
 - F. Document suspicion of pollutant induced illness in medical records.
- III. Personal Strategies
 - A. Educate yourself and then educate others about the facts of pollutant induced ill health.
 - B. Be an example:
 - Office waste management
 - Reduce fossil fuel consumption
 - Avoid using leaded gas
 - Avoid use of fluorocarbon aerosol propellants
 - Review investment portfolio - consider investments in environmentally minded corporations. (Board of Trustees, June 1990)

135.995

Acid Rain

The Society supports efforts to reduce air pollution and improve air quality. The Society encourages vigilance in monitoring problems with air quality. (Res. 8, H-1981; Revised, H-2001)

135.996

Pesticides and Herbicides

The Society adopted the policy statement on pesticides and herbicides, which included the following: The Society (1) recognizes the value to society, both global and nationally, of most of the diverse chemicals described on herbicides and pesticides; (2) is aware that such substances present an acute or chronic human health hazard and that abuse and misuse of any of these substances may occur and advocates responsible and informed use of all agents for any use; (3) acknowledges that information available about herbicides and pesticides varies in terms of quality and accuracy and endorses the objective and reasonable interpretation of peer reviewed data; (4) notes that data and the conclusions drawn from those data are not uniform; rigidly dogmatic conclusions are rarely warranted; (5) recognizes that many agents have potential health effects under appropriate circumstances and that these effects can be acute, chronic, or idiosyncratic; (6) endorses the education of physicians, both at the training and postgraduate levels, about the diagnosis and treatment of toxic effects from these agents; this can be accomplished by direct education or by accessing widely available and high quality data bases; and (7) is aware that numerous laws and regulations regarding these

chemicals have been promulgated; these reflect society's concern about the safety and health effects of these agents. (Report I, Board of Trustees, H-1993)

135.997 Future Policies on Environmental Issues

The Society adopted the following provisions of the policy statement "Guidelines for Policy Making on Environmental Issues: Experience of the Pennsylvania Medical Society, 1984-1993": The Society (1) continues to be active in environmental health issues; (2) bases its positions on the best science available; (3) avoids being politicized or choosing sides; and (4) keeps in clear focus the dual role of its members: watchdog of the public health and generator/user of hazardous materials. (Report DD, Board of Trustees, H-1993)

135.998 Air Pollution

The Society will keep its membership informed about bills involving air pollution control in order that members may send letters of support for such legislation to appropriate members of the state legislature. (Res. 17, H-1969; Revised, H-1999)

135.999 Air Pollution

The Society supports air pollution programs which receive continuing review and approval by professional consultants in the medical field. (Res. 10, H-1966; reaffirmed, H-2016)

140.000 Ethics

140.992 Analysis of American Board of Internal Medicine (ABIM) Finances

The American Board of Internal Medicine (ABIM), a 501-C3 organization, used \$56 million of diplomates' money to form another 501(c)(3) corporation known as the ABIM Foundation. The ABIM Foundation uses the income of the \$56 million for internal salaries, dubious research which consistently publishes data in support of MOC, and approximately \$500,000 a year for high-end retreats at the country's most expensive resorts. There may well be many more undiscovered excessive expenses at the ABIM, the Society is directed to petition the AMA, through its delegation to the AMA, to analyze the finances of the ABIM and its Foundation and to request that the results of this analysis be shared with our AMA House of Delegates and our membership-at-large. (Res. 503, H-2016)

140.993 Restrictive Covenants in Physician Contracts

The Society shall, as a high priority item, seek legislation prohibiting non-compete restrictive covenants in employment contracts. Said prohibition would not preclude a contract provision permitting an employer to recoup reasonable expenses incurred in recruiting the physicians and establishing the physician's patient base. (Res. 402, H-2012)

140.994 Physician Advertising

The Society reaffirms its support of the AMA's "Code of Medical Ethics", particularly with regard to Section 5.02 on Advertising and Publicity. The Society shall study mechanisms by which members can bring potentially inappropriate physician advertising to the Society's attention and mechanisms for appropriate action on such advertising and shall make such mechanisms available as a member service when and if our Board deems them feasible. (Res. 504, H-2006; reaffirmed, H-2016)

140.995 Confidentiality of Genetic Testing

The Medical Society, working with the Pennsylvania Bar Association and other organizations as appropriate, shall continue to monitor legislation as it is introduced, and work toward developing a policy statement which will list all of the caveats important to genetic testing confidentiality. (Report 5, Board of Trustees, H-2001; revised, H-2011)

140.996 Treatment of Chronic Pain

The Society shall work with the Pennsylvania State Board of Medicine to clarify, revise and refine the "Guidelines for the Use of Controlled Substances in the Treatment of Pain" as necessary to address physician concerns. The Society shall also work with the Pennsylvania State Board of Medicine to publicize the Medical Board's position on this matter. If it appears that the Medical Board's statement is not sufficient to allay physicians' fears or the Medical Society discovers that other state agencies are pursuing a different course, the Medical Society will seek appropriate legislation. (Report 23, Board of Trustees, H-2000)

140.997 Non-compete Clauses in Physician Contracts

The Society opposes non-compete restrictive covenant provisions in physician contracts and seeks state legislation banning those contract clauses. (Res. 316, H-1998, adopted in lieu of 1999 Board Report 13)

140.998 Restrictive Covenants in Medicine

The Society adopted as policy that physicians, singly and in organized groups, shall not be party to nor participate in a corporate, partnership, or employment agreement with another physician or organization that restricts the right of the physician to practice medicine after termination of a relationship created by the agreement, and that reasonable cost-based payments that are part of a separation agreement are not unprofessional, unethical restrictions on the right to practice medicine or on professional autonomy or on patient access. The Society opposes the use of restrictive covenants as a condition for physicians entering into training programs. (Report 6, Board of Trustees, H-1996; reaffirmed, H-2016)

The Society shall seek legislation prohibiting employers from requiring a physician to sign a restrictive covenant that precludes the physician from competing with the employer. This requirement would not preclude a buyout clause that requires the physician to reimburse the employer for reasonable expenses incurred in recruiting the physician and establishing the physician's patient base. (Res. 408, H-2008)

140.999 Joint Venture Contracts

The Society asserts that the patient should be informed of any economic relationship which may exist between a referral source and an entity to which the patient is referred for evaluation or treatment. The medical staffs of hospitals should be encouraged to establish oversight committees to review all joint venture contracts between the hospital or its subsidiaries and any members of its medical staff which encompass the provision of professional physician services. (Res. 39, H-1987; revised, H-2007)

145.000 Firearms: Safety and Regulation**145.994 Firearms Safety Education for Physicians**

PAMED is directed to explore partnerships with other stakeholders to provide physicians with a comprehensive educational resource on firearms safety. (Res. 205, H-2018)

145.995 Support Closing Pennsylvania's Private Sale Loophole for Long Guns by Requiring Background Checks for All Firearms Transfers

The Society shall reaffirm support for HB 1010 or similar legislation that closes Pennsylvania's private sale loophole for long guns by requiring background checks for all firearms transfers. (Res. 409, H-2016)

145.996 Gun Violence

The Society is directed to (1) issue a statement recognizing gun violence as a significant public health problem, and urge politicians and the public to support further research into the epidemiology of risks related to gun violence in the state of Pennsylvania; and (2) present, in writing, its position statement recognizing gun violence as a significant public health concern and its support of research into the epidemiology of risks related to gun violence in the state of Pennsylvania to the Pennsylvania Department of Health, Violence, and Injury Prevention for consideration. The Pennsylvania Delegation to the AMA is directed submit a resolution to the AMA House of Delegates, urging U.S. legislators to support further research into the epidemiology of risks related to gun violence on a national level. (Res. 206, H-2013)

145.997 Promotion of Firearms Safety

The Society shall partner with other stakeholders in an effort to promote firearms safety. (Res. 406, H-2007)

145.998 Firearms Safety Programs for Children

The Society supports AMA Policy 145.990: Prevention of Firearm Accidents in Children which (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearms safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; and (2) encourages state medical societies to work with other organizations to increase public education about firearm safety.

The Society also supports recently adopted AMA policy encouraging "organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children." (Report 2, Board of Trustees, H-2000)

145.999 Health Consequences of Firearms

The Society advocates funding of scientific research on firearm related injury and death by appropriate national groups, like the Centers for Disease Control. (Res. 50, H-1986; reaffirmed, H-2016)

155.000 Health Care Costs**155.992 Advocacy on Drug Prices and Shortages**

The Pennsylvania Medical Society (PAMED) is directed to support evidence-based collaborative policy to address drug shortages and drug prices; to advocate for effective implementation of legislation to prohibit pharmacist gag clauses, thereby helping to ensure that patients are informed of the least-costly payment method for drug purchase; to advocate for increased supply chain transparency and pharmacy choice; and to NOT take a position regarding the Anti-Kickback Statute Safe Harbor for Group Purchasing Organizations (GPOs) or Pharmacy Benefit Managers (PBMs) until data exists that specifically examines the effect of the Safe Harbor on drug shortages and drug prices. (Res. 309, H-2018)

155.993 Pharmaceutical Safe Harbors

PAMED is directed to educate its members on the issue of Safe Harbors in pharmaceutical sales. (Res. 304, H-2018)

155.994 Informing Public of Hospital Revenue Per Inpatient Day of Care

PAMED is asked to continue to work with the Pennsylvania Department of Health (DOH) and the Pennsylvania Health Care Cost Containment Council (PHC4) to inform patients and families of the average daily cost of hospitalization at each hospital (Net Patient Revenue per Inpatient Day of Care); to work to have the PHC4 publish an addendum to their 2014 Financial Analysis that reports Net Patient Revenue per Inpatient Day of Care for each hospital each hospital and region, and include Net Patient Revenue per Inpatient Day of Care in all future annual Financial Analysis reports; and to work with the DOH to establish policy that requires each hospital to post prominently its most recent Average Daily Cost for Hospitalization (Net Patient Revenue per Inpatient Day of Care), along with the averages for the state and region. (Report 3, Board of Trustees, H-2016)

155.995 Costs of Highmark Automatic Audits

The Society is directed to analyze the practices of reimbursement agencies that consume health care resources and explore avenues to reduce the consumption of these resources. (Res. 309, H-2007)

155.996 Cost of Disposable Equipment

The Society shall request the Insurance Commissioner of the Commonwealth of Pennsylvania to address the problem of insurer failure to pay for the user cost of disposable equipment in addition to the DRG payment. (Res. 313, H-1999)

155.997 Reporting of Advertising Expenditures

The Society shall request, through appropriate regulatory or legislative means, the reporting and public availability of advertising expenditures as a line item disclosure in yearly financial statements by all facilities licensed and operating in the Commonwealth of Pennsylvania. (Res. 404, H-1998)

155.998 Pennsylvania Health Care Cost Containment Council

The Society directed the Board of Trustees to continue monitoring the activities of and cooperating with the Pennsylvania Health Care Cost Containment Council to assure the provision of valid health care cost and quality data. (Res. 63, H-1993)

155.999 Tax Exemption of Health Care Expenses

The Society endorses the concept of equal tax exemption for all health care expenses, regardless of the form of employment, and regardless of whether health insurance is used to pay for it. The Society is working for the adoption of this policy at the AMA; and seeks, to the best of its ability, to execute legislative implementation. (Res. 45, H-1992; reaffirmed, Res. 21, H-1993)

160.000 Health Care Delivery**160.974 Refocusing the Care Centered Collaborative**

The Care Centered Collaborative (CCC) is directed to continue exploring and providing updates on additional innovative, free-market based concepts including, but not limited to, Association Health Plans, Direct Primary Care, Reference-Based Pricing Models, Chronic Disease Management, etc. that can set PAMED apart as a leader of grassroots innovation in healthcare delivery and payment models. (Res. 509, H-2018)

160.975 Corporate Practice of Medicine in Pennsylvania

PAMED is directed to commission a study to:

- 1) determine the current extent of corporate ownership of physician practices in the Commonwealth of Pennsylvania;
- 2) determine the nature of all corporate entities involved;
- 3) determine the pattern of such corporate ownership within the state as it relates to geography and/or physician specialty; and
- 4) compile physician and patient feedback regarding various models of corporate ownership of physician practices.

PAMED is directed to report the findings of the above-referenced study at the 2019 meeting of the House of Delegates. (Res. 303, H-2018)

160.976 Support Physician-Driven, Free Market-Based Healthcare Payment Model Creation and the Restoration of the Patient-Physician Relationship through Innovative Consumer-Driven Healthcare Financing and Delivery Solutions

The Board of Trustees' Report 6 (2017) recommended that fostering the development of one or more clinically integrated networks (CINs) would offer a more realistic alternative to eschewing traditional insurance and market realities because it seeks a commensurate level of risk transfer that will be to the benefit of both patients and physicians. The Board recommended that Report 6 be adopted in lieu of Resolution 16-506, and the House confirmed the recommendation. (Board of Trustees, Report 6, H-2017; adopted in lieu of Res. 16-506)

160.977 Support of Direct Primary Care Model

PAMED shall provide a written description of the Direct Primary Care model to its members for the purpose of educating on alternative practice models. The Society is also directed to submit and publish a press release outlining its support of the Direct Primary Care model, and to work with State legislators to support the practice of Direct Primary Care models. (Res. 302; H-2017)

160.978 Practice Options Initiative Concept and Funding

The Society's Board of Trustees voted at their August 16, 2016 meeting (by the required simple majority) to support the concept of the PAMED Practice Options

Initiative. The Board of Trustees voted at their October 21, 2016 meeting (by the required super-majority vote of 75 percent) to recommend to the House of Delegates their approval to withdraw up to \$15 million from the \$115 million principle to be used to develop the PAMED Practice Options Initiative.

The PAMED Board of Trustees is committed to transparency and responsible fiscal stewardship of endowment funds. Future business plans shall include a list of deliverables, dates for updates to the membership, and performance metrics. Regular communication to the Society's membership, including the House of Delegates, will provide updates on the PAMED Practice Options Initiative including, but not limited to, when the business plan is approved and a quarterly report.

With the assistance of legal counsel, the PAMED Practice Options Initiative will explore collaboration among physician-led networks, including specialty networks, and enable engagement by physicians of all practice types.

The PAMED House of Delegates authorizes the PAMED Board of Trustees to access up to \$15 million from the PAMED Endowment Fund principle of \$115 million to be used to actualize the PAMED Practice Options Initiative. (Res. COW, H-2016)

160.979 Reducing Healthcare Disparities for Lesbian, Gay, Bisexual and Transgender (LGBT) Patients

The Society shall advocate to expand access and eliminate healthcare disparities for Lesbian, Gay, Bisexual and Transgender (LGBT) Pennsylvanians, and for future research efforts that are specifically designed to investigate LGBT health issues. Further, the Society shall make information on LGBT health issues available to Pennsylvania physicians. (Res. 206, H-2015)

160.980 Universal Patient Transfer Form

The Society shall work with work with the appropriate government agencies and legislative bodies to develop a simple, straightforward Universal Patient Transfer Form (UPTF) in the Commonwealth of Pennsylvania, and shall work with hospitals, the Hospital and Healthsystem Association of Pennsylvania (HAP), and the appropriate government agencies on a memorandum of understanding with regards to a UPTF. (Res. 405, H-2014)

160.981 Prompt Communication of Medical Information from Urgent Care Clinics

The Society shall work to educate urgent care and retail clinics on the importance of transmission of point of service patient medical records to primary care physicians and specialists and shall investigate any complaints of non-disclosure of medical records by a facility due to alleged financial and network associations. (Res. 304, H-2014)

160.982 Preserving Patient Access and Physician Choice of Practice

The Society shall act to ensure that the private practice of medicine remains a tenable choice for physicians and patients in Pennsylvania, and continue to support physicians within all practice environments in the state of Pennsylvania; investigate the legal implications of the trends in referral patterns directed by hospitals or health system arrangements, and provide information and education to physicians about these implications; and ensure that the doctor-patient relationship is preserved. (Res. 303, H-2011)

160.983 Reporting Forms

The Society's policy requires simplification and standardization of reporting forms, whether electronic, paper or verbal, for all governmental, insurance, or other regulatory bodies. Further, the requirements for "quality standards" are to be data-driven in collaboration with the Pennsylvania Medical Society and specialty societies, rather than imposed by governmental, insurance, or other regulatory bodies. (Res. 302, H-2008)

160.984 Health Care Services to the Underserved

The Society shall 1) continue its active participation in efforts to expand access to affordable, quality health care coverage for all Pennsylvanians; 2) express its strong support for the efforts of Pennsylvania's new Office of Health Equity to eliminate health care disparities within our system; and 3) serve as a resource for information on existing health care services available to the underserved. (Report 6, Board of Trustees, H-2006; reaffirmed, H-2016)

160.985 Access to Health Care

The Society shall work with the Pennsylvania legislature to increase access to care for both adults and children in Pennsylvania by finding creative ways to incentivize physicians to participate in the care of Medical Assistance, uninsured, and indigent patients. (Res. 403, H-2006; reaffirmed, H-2016)

160.986 Acceptable Standards of Treatment for Specific Disease Entities

The Society formally opposes any attempt of the legislature to define acceptable standards of treatment for specific disease entities. (Res. 407, H-2005)

160.987 Sharing of Patient Health Information

The Society shall explore the issues related to health plans and pharmacy benefits companies' sharing of patient health information with treating physicians, within the boundaries of state and federal regulations, including the development of guidelines for information sharing, and if deemed appropriate, encourage the development of initiatives to improve the sharing of this information. (Res. 313, H-2002)

160.988 Corporate Practice of Medicine Doctrine

The Society adopted the following principles relating to the corporate practice of medicine:

I. The Society shall pursue the following activities to protect patients from inappropriate lay interference in physician clinical decision-making:

(1) Corporate Practice of Medicine Doctrine—Support reaffirmation and stringent enforcement of the corporate practice of medicine legal doctrine, consistent with the following principles:

- As a general rule, no corporation or other legal entity, other than an authorized physician "corporate" entity such as a physician professional corporation or partnership, should be permitted to provide physician care or otherwise exercise control over the delivery of physician care.
- Arrangements generally restricted by the doctrine should include: employment of physicians, contracts to deliver physician services, billing for physician services, and fee splitting.
- Entities should be excepted from a corporate practice of medicine restriction only if there are adequate safeguards to ensure that the physicians are free, both under the terms of the arrangement and in

practice, to exercise their independent clinical judgment and to provide care that is in the best interests of their patients.

- Hospitals and other licensed health care facilities, including state facilities, should be permitted to employ physicians and to deliver physician services under the direction of an organized medical staff which has responsibility for the quality of all medical care provided to patients and for the ethical conduct and practice of its members.
- Non-profit corporations, such as community health clinics, may employ physicians and deliver physician services under the direction of an organized medical staff which has responsibility for the quality of all medical care provided to patients and for the ethical conduct and practice of its members. The corporation must also qualify for a federal tax exemption or other criteria designed to assure that the corporation's activities further legitimate non-profit purposes and do not financially benefit insiders or for-profit enterprises.
- Health maintenance organizations (HMOs), hospital and professional health service plans (the Blues), preferred provider organizations (PPOs), and integrated delivery systems (IDSs) may provide physician services through their physician networks under the direction of an organized medical staff for the quality of all medical care provided to patients and for the ethical conduct and practice of its members.

(2) Employment Safeguards—Seek adoption of the following safeguards for physician employment arrangements:

- The employer should not be permitted to interfere in medically appropriate diagnostic or treatment decisions.
- The employer should not be permitted to restrict referrals in a manner that adversely affects the welfare of a patient.
- The employer should be required to provide a mechanism, such as an organized medical staff, through which the physicians can participate in “management” decisions that affect patient care.
- The employer should not be permitted to require a physician to sign a restrictive covenant that precludes the physician from competing with the entity. (This requirement would not preclude a “buyout” clause that requires the physician to reimburse the entity for reasonable expenses incurred in establishing the physician’s patient base.)

(3) Decision-Matrix—Encourage employed physicians and those physicians who are involved in an IDS to develop with their employer/system a decision matrix, such as the matrix recommended by the California Medical Association (and attached to 1997 Board Report 35).

(4) Managed Care Safeguards—Continue to advocate for managed care safeguards, such as prohibitions on gag clauses, peer reviewer qualifications, and utilization and credentialing due process; and

(5) Upstream Liability—Continue to advocate that managed care organizations should be held legally accountable when their negligence harms a patient and should not be permitted to transfer that liability to provider through an indemnification clause or otherwise.

- II. The Society shall develop a strategy for advocating our positions on the corporate practice of medicine and employment safeguards in appropriate forums.

(Report 16, Board of Trustees, H-1999)

160.989 Access to Quality Medical Care

The Society shall work closely with the AMA, public health agencies, the Pennsylvania legislature, and the Pennsylvania Department of Public Welfare to assure continuing access to quality medical care for the medically indigent, medically underserved, and Medicaid recipients in Pennsylvania. (Res. 508, H-1996; reaffirmed, H-2016)

160.990 Health Care Delivery Models

The Society shall continue to participate in AMA efforts to coordinate information-sharing among states related to evolving health care delivery models. Information and opinions related to the effectiveness of the models shall be communicated to the membership. The Society is very engaged in value-based health care delivery models and is making efforts to educate physicians on these as well as business opportunities to further assist physicians in succeeding in these new models. (Report 3, Board of Trustees, H-1996; reaffirmed, H-2016)

160.991 Public Education, Importance of Continuity of Care by Personal Physician

The Society supports free choice of physician or system of care by all individuals and encourages employers to: (a) offer employees a choice of several health insurance plans which allow the free choice of source of care, and (b) provide clear and comparable information on alternative plans offered.

The Society recognizes the need for multiple methods of delivering medical services and encourages and participates in efforts to develop them. In the interest of attracting the most highly qualified candidates to the field of medicine, the Society supports making every effort simultaneously to maintain and create incentives in medical practice. Among these incentives are a multiplicity of practice options, maximum professional independence, and freedom of choice for both physicians and patients. (Res. 522, H-1994)

160.992 Timely, Humane Care for the Medically Indigent

The Society is committed to assuring timely, humane, appropriate, and necessary care to the medically indigent of the Commonwealth and encourages its members to render service to the underinsured at fees commensurate with insurance coverage and/or family income and to the uninsured whose family income is below poverty level at no charge. (Res. 77, H-1988; reaffirmed, Report 11, Board of Trustees, H-2009)

160.993 Third-Party Interference with Patient Management

The Society reaffirms its commitment to the importance of the physician/patient relationship. To preserve the physician/patient relationship, Society members should resist any and all attempts by third-party payers to dictate the type and quality of care provided their patients. (Res. 23, H-1978)

The Society opposes third-party interference with patient management. It asserts that third-party interference with clinical decision-making will result in reduced quality care and increased patient jeopardy. Prospective and retrospective chart review must not supersede onsite physician judgment. (Res. 42, H-1985)

160.994 Support for Multiple Approaches to Delivery and Financing

The Society reiterates its support of the concept of multiple approaches to the delivery and financing of medical services. The Society, the AMA, and others should use their resources to preserve competitive systems. (Res. 20, H-1979; Revised, H-1999)

160.995 Prioritization of Health Care Resources

The Society adopted the following policy statement on prioritization of health care resources:

1. All citizens of the Commonwealth of Pennsylvania should have access to basic health care but, for various reasons, do not always receive such care.
2. Prioritization of health care is a process that rank orders medical services, categories of services, and/or treatment options on the basis of value.
 - a. Currently, some form of implicit (primarily subjective evaluation) prioritization of health care exists in all facets of the practice of medicine. This appears in the form of cost containment, outcome research, age discrimination, access limitations, practice standards, and medical indigence, among others. Such prioritization will probably continue and likely increase, but every effort must be made to base such future decisions on objective available data.
 - b. Organized medicine seeks to actively participate in the development of any explicit method of health care prioritization. It is recognized, however, that the duty of the individual physician is to serve the best interests of his or her patient.
 - c. Value is derived from the non-economic and economic benefits obtained from a medical service, category of service, and/or a treatment option. Examples could include quality of life, cost-effectiveness, equity, longevity, personal responsibility, and the greatest good for the greatest number, among many others. Society as a whole must determine which value or combinations of values should serve as the basis for prioritization of health care.
3. On the other hand, rationing is a process that restricts the application of resources to those medical services, categories of services, and/or treatment options ranked higher on a priority list and denies access to others by, in effect, drawing a line.
 - a. Rationing within the health care system is the responsibility of society as a whole, not organized medicine. Organized medicine should provide information and consultation to society for subsequent rationing as society so determined.
 - b. Any rationing should align value and cost in a way that is acceptable to society, but implementation of rationing will require universal acceptance of the consequences of society's choices. (Report N, Board of Trustees, H-1992)

160.996 Preserving Physician/Patient Relationship

The Society advises physicians to continue in their traditional way to preserve life when possible, to improve the quality of life when feasible, and to provide comfort and support to those whose life is ebbing. At the same time the Society opposes

any attempt by government to dictate by rules and regulation any change in this time-honored physician/patient relationship. (Res. 33, H-1983)

160.997 Health Care Case Management

The Society recommends that individuals assigned as case managers collaborate with the patient's attending physician. Case manager decisions must be within the scope of the case manager's license and must be decisions for which the case manager can be held accountable. This policy extends to both public and private programs and to the care of the mentally ill. (Res. 63, H-1988)

160.998 Competition

The Society reaffirmed its policy supporting a free and competitive health care market which allows the development of alternative delivery and financing systems and increases price consciousness among consumers and cost consciousness among physicians, but which maintains safeguards that ensure that quality of care and access to care are optimal under conditions of their own choice. (Board of Trustees Report D, H-1983)

The House adopted a policy statement on quality of care which contained the following recommendation:

Quality concerns associated with the use of new technology (FDA approved) and procedures with potential life-threatening risks requiring immediate appropriate back-up emergency care (e.g., cardiac catheterization) should be addressed through appropriate facility licensure standards. The licensure standards should include quality assurance requirements recognized by national medical organizations such as volume-based criteria, when appropriate. Periods between re-licensure should not exceed three (3) years and should include evidence of an appropriate functioning quality assurance program. Facility licensure standards utilized by the Department of Health, when appropriate, should utilize quality assurance processes consistent with existing nationally recognized organizations such as the American Association for Accreditation of Ambulatory Plastic Surgery Facilities, Inc. (AAAAPSF), the Accreditation Association for Ambulatory Health Care (AAHC), or other peer review organizations. An added value would be that the licensee, not the Commonwealth, would bear the cost of review. A competitive marketplace should eliminate the unnecessary duplication of existing services provided certain non-competitive legislated economic advantages such as the current pass-through charges are eliminated. Facilities serving a disproportionate share of the medically indigent and/or under-subsidized public health care programs such as Medicaid should receive special consideration for government incentives to assure access. (Report CC, Board of Trustees, H-1992, revised H-2002)

160.999 Choice of Physicians vs. Non-Physicians in Managed Care

The Society recommends that alternative health care delivery systems inform their enrollees of the difference between physician and non-physician health care provider so that the patient may make a free and educated choice between physician and non-physician health care providers. (Res. 1, H-1984; Retained in part, H-1994)

The Society (1) reaffirms existing policy which emphasizes patients' freedom of choice of physicians or health care delivery systems, and (2) is committed to the education of the public on these multiple delivery systems as an integral part of the AMA's public awareness program. Freedom of choice should include those patients

whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system. (Res. 522, H-1994)

165.000 Health System Reform

165.982 Act 70 Ambulatory Surgery Center (ASC) Compliance Challenges

The Pennsylvania Medical Society (PAMED) is directed to actively engage with appropriate stakeholders, such as the Pennsylvania Ambulatory Surgery Association (PASA), the Department of Health, and legislative committees of purview to ensure that Act 70 of 2017 is executed as originally intended by the legislature. In the event further clarification is not achieved, PAMED shall seek a legislative remedy that specifically states that 28 PA Code §553.21 is inconsistent with Act 70 of 2017 and is, therefore, abrogated. (Res. 401, H-2018)

165.983 Repealing MIPS and Regulatory Burdens

PAMED shall support the repeal of MIPS (Merit-Based Incentive Payment System) and petition the American Medical Association (AMA) to support the repeal of MIPS. Upon repeal of MIPS, PAMED shall petition the AMA to oppose any federal efforts to implement any pay-for-performance programs unless such programs add no significant regulatory or paperwork burdens to the practice of medicine and have been shown, by evidence-based research, to improve the quality of care for those served. (Res. 306, H-2018)

165.984 Health Insurance Carriers Canceling Coverage for Thousands of Pennsylvania Patients

The Society shall work with the Governor, state legislators and the Insurance Commissioner to assure that individuals enrolled in individual plans, and other subscribers who may experience similar cancellations in Pennsylvania, be able to renew or otherwise extend their existing insurance contracts until such time that affordable comparable replacements are available through the Exchanges or within the private market. Further, the Pennsylvania Delegation to the AMA is directed to take this issue forward to the AMA Interim Meeting this November, asking the AMA work with the President, legislators, and Centers for Medicare and Medicaid Services so that subscribers who are enrolled in individual plans, and other subscribers who may experience similar cancellations throughout the nation, be able to renew or otherwise extend their existing insurance contracts until such time that affordable and comparable replacements are available through the Exchanges or within the private market. (Res. 305, H-2013)

165.985 Health Care Affordability Act of 2010

The Society adopted the following, seeking a major change in direction for PAMED to assist physicians in dealing with rapidly accelerating changes in health care delivery as a result of the adoption of the Health Care Affordability Act of 2010:

The Society shall define the new skill sets that will be needed as the practice of medicine evolves, in order to ensure the success of all members, and to develop the curricula and means to educate physicians. (Recommendation 1, President-Elect, H-2010)

The Society shall be, in a proactive fashion, open, collaborative as well as agile on all levels as we seek the common ground with other health care stakeholders. (Recommendation 2, President-Elect, H-2010)

The Society must position physicians to lead and shape health care delivery to assure that the evolving system provides quality and value to patients and the community. (Strategic Goal on Physician Leadership in Quality/Value, H-2010)

Filed the “Blueprint” document as amended, which contained the following principles the Society will use to guide its advocacy for physician engagement in this era of change:

Principles for Physician Engagement

1. **Physicians must be engaged in shaping the evolving health care delivery system:** Physicians cannot be relegated to the sidelines. Physicians must respond with flexible, innovative strategies that will implement our vision of the future.
2. **Physicians have a responsibility to promote both quality and value:** The goal of the health care delivery system must be to deliver care that is safe, timely, effective, efficient, equitable and patient-centered. This requires that we, as physicians, accept our responsibility to use resources wisely to the extent feasible within the constraints of our practice environment (see Principle 9).
3. **Physician engagement is critical for true quality and value:** Physicians must be involved, through their participation and leadership, at the core of strategic decision-making that impacts patient care. Our engagement is essential to assure a changed clinical and business culture that supports quality and value:
 - Effective change requires physician knowledge and expertise:** Physicians not only directly influence cost and utilization when delivering and ordering care, we have the knowledge and experience to drive the design of clinical and administrative processes that will improve quality and value.
 - a. **Physicians are advocates for quality:** Because of our clinical expertise, ethical responsibility to patients, professional values, and central role within the health care team, physicians are uniquely qualified and positioned to promote quality patient care.
 - b. **Physician involvement is necessary for credible data and measures:** Physician input is required to develop scientifically accurate data and measures that will allow meaningful comparison and have credibility to physicians for self-evaluation and practice changes.
4. **Physician engagement must be real and meaningful:** For decisions that are imbued with clinical care significance, it is imperative that physicians have substantial and direct participation with real power to influence the outcome. In many cases, this requires that we lead the initiative.
5. **Physician engagement is essential across all organizational structures:** Physicians must be engaged in the decisions and processes that drive the quality and value of the health care provided to their patients, regardless of the structure of the organization that provides the care or the nature of their relationship with the organization.

6. **Physician engagement in the future is dependent on student engagement now:** Investments in mentorship, leadership development, participation and educational opportunities for students are essential for their future ability to lead and shape health care delivery.
7. **Multiple clinical collaboration and integration models can be effective:** The focus of clinical integration and collaboration should be to provide a platform for physicians to engage with hospitals and other health care providers to align incentives, coordinate care, and implement other measures to maximize quality and value. A variety of clinical integration and collaboration models should have the opportunity to thrive.
8. **Members of the health care team must accept mutual responsibilities for effective physician engagement:** Physicians must be collaborative and accountable. Other stakeholders involved in health care delivery, such as health system governing boards, must accept and promote meaningful and independent physician involvement, regardless of the setting or organizational structure.
9. **Multiple stakeholders play a role in improving quality and value:** Other key stakeholders include patients, other health care professionals and providers, certification organizations, regulators, legislators, insurers, and employers.
 - a. **All stakeholders must work together to achieve our common goal:** Physicians and other stakeholders must communicate in a collaborative and transparent manner to assist each other as they perform their roles in improving the quality and value of health care.
 - b. **Professional liability and other reforms must be adopted to eliminate barriers to quality and value:** There are limitations to what physicians and other health care providers can accomplish without changes in the practice environment. Professional liability reform is necessary to reduce defensive medicine. Counterproductive administrative hassles and payment disparities must also be addressed. (H-2010)

Filed as amended the elements for consideration in the “Blueprint” implementation plan, which are to include but not limited to: 1) develop a comprehensive communications plan; 2) seek physician consensus on the definition of engagement, leadership, value, and quality; 3) identify the knowledge and skill sets required to lead clinical integration; 4) assure that the implementation plan includes all practice settings and all physician groups, including new physicians, residents, students, women, and minorities; 5) consider utilizing the expertise of the American Medical Association, as well as state and national specialty societies; 6) seek to identify local leaders within medical staffs, county medical societies, and local/regional physician groups and organizations to facilitate the engagement of other physicians; 7) provide education on utilizing data for practice assessment and improvements; 8) educate physicians and students on the importance of involvement in the political process; and 9) seek ongoing feedback from our members and continually apprise them of our progress. (H-2010)

165.986

Pennsylvania Medical Society’s Guiding Principles of Health System Reform

The Society is directed to ask the AMA to incorporate the State Society’s eight guiding principles of health system reform in any policy for health system reform which may be proposed or adopted. (Res. 507- H-2009)

- 165.987 Access to Quality Health Care**
The Society shall continue to advocate for patients and their access to quality health care as health system reform is debated. (Report 11, Board of Trustees, H-2009)
- 165.988 Anti-Trust Exemptions for Insurance Companies**
The Society and the AMA shall pursue all necessary means, including legislation and community education, to end the anti-trust exemption afforded the insurance industry. (Res. 308, H-1998)
- 165.989 National Health Insurance Pilot Program**
If a national health insurance program is approved by the Congress, the Society urges that before full implementation, it be tested on a pilot project basis. (Res. 1, H-1979)
- 165.990 For-Profit Conversions of Health Care Organizations**
The Society adopted the policy of the American Medical Association as expressed in the Council on Medical Service Report 8 (A-97): (a) representatives of state government (e.g., state attorney general, state insurance commissioner) should oversee all for-profit conversions of health care organizations; (b) public notice and subsequent public hearings should be required prior to the approval of a for-profit conversion; (c) the health care organization converting to for-profit status should be required to obtain an independent appraisal of its assets prior to the conversion. This appraisal should be made available to the representatives of state government (e.g., state attorney general, state insurance commissioner) overseeing the for-profit conversion; (d) for-profit conversions should be structured to prohibit private inducement from officers, directors and key employees of the converting health care organization, as well as private benefit from other individuals; (e) if the establishment of a charitable foundation is required as part of the for-profit conversion, the mission of the foundation, as well as its proposed program agenda, should be determined and offered for public comment prior to the completion of the conversion; (f) the mission of a charitable foundation resulting from a for-profit conversion should closely reflect the original mission of the not-for-profit health care organization; (g) a designated proportion of the members serving on the board of directors of a charitable foundation should be new, independent members not previously affiliated with the converting organization, who are selected based on their experience relative to the mission of the foundation; (h) the level of compensation received by members serving on the board of directors of a charitable foundation should be consistent with that received by board members of similar types and sizes of foundations; (i) representatives of state government (e.g., state attorney general state insurance commissions) should approve the mission and governance of any charitable foundation established as a result of for-profit conversions; and (j) once a charitable foundation has been established as a result of a for-profit conversion. ongoing community liaison with the foundation should occur on a regular basis (e.g., community advisory committees, periodic public reports). The Society's Board of Trustees shall (a) evaluate the impact of mergers and other consolidations of major health care institutions on health care availability, health care and quality, health care cost and physician autonomy, and (b) develop Pennsylvania Medical Society policy for physician and public review and input into these decisions. (Amended Sub. Res. 408, H-1997)
- 165.991 ERISA Limitations on Utilization Review Accountability**
The Society will attempt to ensure that any health system reform proposal includes language that will change the relevant components of ERISA laws to ensure that

utilization review companies and managed care companies involved in self-insured plans have the same responsibility and liability for their decisions as other health care providers. (Report 24, Board of Trustees, H-1995)

165.992 ERISA Limitations on Utilization Review Accountability and Physician Liability

The Society will: (1) develop and support federal legislation that would modify ERISA to hold self-insured, employee health benefits plans accountable for negligent UR decisions and ensure meaningful remedies and fair compensation to patients who are injured as a result of such a decision; and (2) advocate that federal health system reform include appropriate modifications to ERISA, including a provision to hold self-insured, employee health benefits plans accountable for negligent UR decisions. (Report 24, Board of Trustees, H-1995)

165.993 Safeguards for Physicians in Health Care Plans

The Society endorses as policy positions and will work to incorporate in all health system reform legislation the following AMA policies: (1) all managed care plans and medical delivery systems must include significant physician involvement in their health care delivery policies similar to those of self-governing medical staffs in hospitals (Report 12, Board of Trustees, H-1994); and (2) physicians participating in these plans (and no physicians should be arbitrarily excluded) 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. (Report 28, Board of Trustees, H-1994)

165.994 Patient Access to Specialty Care in Managed Care Systems

The Society: (1) urges managed care plans to provide patients, on an ongoing basis, with the right to select a new primary physician from the panel of physicians contracting with that managed care plan, and appeal to the plan when the patient is dissatisfied with his/her present primary physician; and (2) encourages medical specialty societies, through appropriate channels, to conduct further research to define the circumstances better when patient self-referrals to specialists of their choice are appropriate and cost-effective; (Res. 522, H-1994; revised, H-2014)

The Society reiterated this policy and continues to seek legislative and regulatory solutions which embody this policy in lieu of legislation/regulation addressing access to specific providers. (Board of Trustees, September 1998)

165.995 Development of General Health Care Plan Policy

The Society is directed to concentrate on developing a general health care plan policy rather than responding to each and every one of the myriads of individual proposals that have and will be floated. A general policy is favored because of the fluidity of the legislative process. (Report 11, Board of Trustees, H-1994)

165.996 Any Willing Facility

The Society is directed to study the following policy and request the AMA do likewise: "That any willing credentialed facility be given the opportunity to apply to any health plan or network and have that application approved if it conforms with the fee schedule and quality mechanisms set forth by the plan." (Res. 518, H-1994)

165.997 Managed Competition

(1) The Society adopts the following policy position: Health system reform proposals that unfairly concentrate the market power of payers are 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 Society. Reform proposals should balance fairly the market power between payers and physicians or be opposed.

- (2) The Society continues to support a pluralistic health care system, with no preferential treatment by government that gives a competitive advantage to any form of health insurance/health care delivery organization. In particular, integrated systems should be given no competitive advantage.
- (3) The Society will propose and support legislative or regulatory action requiring employers to offer a benefit payment schedule plan, in addition to other plans.
- (4) The Society will continue to advocate strongly to Congress, the Department of Justice, and the Federal Trade Commission the need for changes in relevant antitrust laws to allow physicians and physician organizations to engage in group negotiations with collective purchasers, managed care plans, insurers, and other payers.
- (5) Society support for any “managed competition” proposal is contingent, in part, on:
 - (a) relief from existing antitrust laws with respect to the right of physicians and physician organizations to engage in group negotiation; and
 - (b) modifications to ERISA to ensure that any rules and negotiation requirements apply equally to self-insured and insured health benefit plans. (Res. 522, H-1994)

165.998 Health System Reform

The Society authorized the Board of Trustees to use whatever resources necessary to address all issues concerning health system reform and directed that the assistance of the Pennsylvania Osteopathic Medical Association (POMA) be enlisted in this effort. (Res. 78, H-1993)

165.999 Any Willing Provider

The Society is directed to include in its health system reform proposal the concept that any willing health care provider/supplier be permitted to participate in health care networks/alliances provided they meet basic quality assurance criteria. (Res. 53, H-1993)

180.000 Health Insurance

180.983 Out-of-Network Balance Billing

PAMED is directed to support state legislation to “get patients out of the middle” of billing disputes between insurers and providers that result from surprise insurance gaps, out of network emergency services or other situations where patients do not have the ability to select their provider. In doing so, PAMED will use resources to ensure that any legislation follows PAMED and AMA principles and includes:

1. a framework that will truly “get the patient out of the middle” of billing disputes between insurers and providers not under contract, including

elimination of restrictive assignment of benefit and similar insurer payment practices;

2. a simple, uniform billing process for physicians not under contract with an insurer that is both transparent and subject to prompt payment requirements;
3. a benchmark or default payment rate for services provided by non-contracting physicians that is market driven, based on a national reference claims database which is conflict free and not affiliated with or controlled by either providers or insurers; and
4. a fair and transparent independent dispute resolution process administered by the Pennsylvania Insurance Department that is streamlined, efficient, and targeted only on the net amount in dispute.

In addition, PAMED shall use advocacy resources to oppose any legislative or regulatory initiative that bases the benchmark or default payment rate for non-contracted physician services on Medicare rates or methodology including engaging in discussions with any legislative and governmental representatives, as well as leadership in other advocacy organizations that propose using Medicare rates, to emphasize the negative consequences of this approach.

PAMED is also directed to work with appropriate state agencies, the legislature, and other stakeholder groups to conduct a comprehensive review of the statutory and regulatory framework governing limits on health insurance benefits, provider network adequacy standards for managed care organizations, PPOs, other forms of health care coverage, and access to out-of-network emergency services

Finally, PAMED shall make the appropriate resolution of out-of-network balance billing issues a priority in its advocacy agenda for 2019. (Res. 307, H-2018)

180.984 Requiring Insurer Contracts with Hospitals

The Society is directed to evaluate issues of patient access to care when limited competition exists in a marketplace for health insurance and providers and shall consider support of legislation such as House Bills 1621 and 1622 of the 2013-2014 session of the General Assembly that would provide for contracts between insurers and networks to assure access to care with a level of insurance coverage for patients. (Res. 404, H-2014)

180.985 Independent Practice Access to Facilities and Insurance Program Participation

The Society supports and shall seek legislation that will provide access to participation in insurance networks and hospital facilities for independent physicians that meet the accepted quality measures that are critical to physicians' ability to provide appropriate care. (Res. 403, H-2014; reaffirmed, H-2015)

180.986 Out-of-Network Rate Calculation Methodologies

The Society shall continue to monitor health plan out-of-network rate calculation methodologies and to report irregularities to regulators and other necessary parties and shall publicize the FAIR Health consumer web site through PAMED's patient advocacy programs. (Report 4, Board of Trustees, H-2011)

- 180.987 Proper Payment Under Assignment of Benefits**
The Society opposes the practice of health plans and other administrators of health claims of directly paying the patient when authorized to directly pay the provider. The Society shall seek legislation in order to prevent or discontinue the practice of health plans and other payers of directly paying the patient when authorized to directly pay the provider. (Res. 306, H-2007)
- 180.988 Insurance Company Reminders of Appropriateness of Care**
The Society adopted the policy that reminders sent by insurance companies to physicians regarding current standards of treatment should be sent with regard to the patient's best health interests, as opposed to strictly cost-saving considerations, or they should be withheld altogether. (Res. 308, H-2007)
- 180.989 Appropriate Reimbursement for Professional Services**
The Society is directed to develop a more proactive approach toward assuring appropriate reimbursement for professional services, particularly for services provided in critical care or emergent situations, where the physician is obligated to provide service even though he/she knows that they will receive little to no reimbursement. (Res. 304, H-2007)
- 180.990 Reimbursement for Services Related to Obesity Diagnosis**
The Society urges insurance companies to provide reimbursement for services related to the diagnosis of obesity. (Res. 306, H-2006; reaffirmed, H-2016)
- 180.991 Reimbursement for Services Related to Tobacco Abuse Diagnosis**
The Society urges insurance companies to provide reimbursement for services related to the diagnosis of tobacco abuse. (Res. 305, H-2006; reaffirmed, H-2016)
- 180.992 Payment Delays for Physicians' Services**
The Society encourages health insurers to (1) timely update enrollees' cards data with suggestions that patients show new cards at their next physician visit, (2) provide phone numbers without hindrances of multiple phone prompts for direct access to claims agents, (3) reduce the on-hold time to access a claims agent, and (4) timely update enrollees' data utilizing web-based technology and make access to such data available to physicians electronically. (Res. 302, H-2003)
- 180.993 Participation by Physicians in Health Insurance Programs**
The Society supports legislation allowing any properly qualified physician to participate in any health insurance program available in their community. (Res. 319, H-2000)
- 180.994 Due Process in Contracts between Physician and Hospital**
The Society, through the legislative and/or regulatory processes, seeks the mandatory inclusion of due process provisions in contracts between physicians and hospitals, health systems, and contract groups. (Res. 406, H-1999)
- 180.995 Universal Physician/Insurance Carrier Credentialing**
The Society shall pursue through legislative and regulatory efforts a low-cost universal credentialing and re-credentialing form which would be mandated by the state for insurers to market their products. The Society shall continue its efforts to administer this service with a low-cost competitive credential clearinghouse. (Res. 327, H-1998)

The Society reaffirms its commitment to the Pennsylvania Standard Application as a universally accepted credentialing and re-credentialing form for physicians in Pennsylvania. The Society shall work toward legislation and regulation mandating acceptance of the Pennsylvania Standard Application by all insurers, health systems, managed care organizations and other third-party payers for health care operating in Pennsylvania. (Res. 311, H-2004)

180.996 Diversion of Insurance Premiums

The Society is directed to contact the Insurance Commissioner to review and challenge the use of health care dollars being diverted from direct health care for which they are paid. (Res. 521, H-1994)

180.997 Blue Cross/Blue Shield Tax Status

The Society believes a challenge to the tax-exempt status of the Blues should not be pursued at this time. (Report X, Board of Trustees, H-1992)

180.998 Physician Qualification for Insurer Programs

The Society is directed to lobby for enactment of state and federal legislation to mandate that criteria used by insurance companies for physician/hospital applicants be available on request; that rejected applicants be informed if/when any or all economic criteria have been applied; and that any and all rejected applicants be provided with the opportunity to satisfy said criteria and thereby qualify for involvement in said insurance program. (Res. 23, H-1993)

180.999 Remove Special Status of Blue Shield and Blue Cross

The Society has determined to seek legislation which would remove the special status of Blue Shield and Blue Cross and have these companies treated in the same manner as all other health insurers operating in the Commonwealth. (Res. 3, H-85) If the Blues are to receive special status for social mission, they should be expected to carry out that mission. (Revised, H-2005)

185.000 Health Insurance: Benefits and Coverage

185.968 Comprehensive Health Insurance Coverage

PAMED is directed to advocate for essential health benefits and to seek legislation to ensure that Pennsylvania consumers are protected. PAMED is further directed to ask the Pennsylvania Insurance Department to provide information and resources to help guide consumers to secure comprehensive health insurance. (Res. 305, H-2018)

185.969 Support for VA Health Services for Women Veterans

PAMED shall recognize the disparity in access to care for women veterans and shall encourage research to address this population's specific needs to improve patient outcomes. The Pennsylvania Delegation to the American Medical Association shall present this issue to the upcoming interim meeting of the AMA (I-2017) for national adoption. (Res. 205, H-2017)

185.970 Universal Access for Vaccinations in Pennsylvania

The Society shall advocate that all insurers should be required to pay for appropriate vaccines regardless of the point of service. Further, that when a vaccination is administered to an adult or minor, a record of this vaccination is

registered in the Pennsylvania state vaccine registry and that communication of administration is passed back to the primary care providers. (Res. 205, H-2015)

185.971 Insurance Coverage of Psychiatric Consultations in Medical-Surgical Hospitals

The Society recognizes the clinical importance and economic value of psychiatric consultations provided in medical-surgical hospitals. The Society, in collaboration with the Pennsylvania Psychiatric Society, the Pennsylvania Society of Addiction Medicine, the Regional Council of the American Academy of Child and Adolescent Psychiatry and other interested parties, shall ask the appropriate state agency to require that psychiatric consultations provided in medical-surgical hospitals are included as “covered services” payable under all health insurance products offered in the Commonwealth of Pennsylvania. (Res. 302, H-2012)

185.972 Mandating Contraceptive Coverage by Pennsylvania Health Insurers

The Society shall develop, support, and lobby for legislation, such as Senate Bill 427, mandating that all general health insurance benefit policies offered in Pennsylvania be required to provide contraceptive coverage as a preventative service for any prescription drug/device approved by the FDA if such policy covers other medical prescription drugs/devices, as well as covering the outpatient medical or counseling services needed for the safe utilization of these methods. (Res. 402, H-2011)

185.973 Health Plan Payment Policies

The Society shall continue to monitor health plan payment policies to ensure that health plans are not inappropriately applying patient cost sharing amounts toward preventive service payment rates. (Report 5, Board of Trustees, H-2011)

185.974 Establishment of Payments for the Management of Chronic Medical Conditions

The Society shall work with insurers to establish payments to appropriately compensate physicians for the provision of initial management and ongoing care for patients with common chronic illnesses consistent with models such as the patient-centered medical home and the Governor’s Chronic Care Commission. (Res. 301, H-2010)

185.975 Maintenance Medications

The Society shall continue ongoing study and discussion to determine the feasibility of: (1) seeking a pharmacy benefits policy in Pennsylvania that would require insurer to provide the current medication and not force patients to change maintenance medications when either the insurer’s formulary changes and/or the patient changes to a new insurance carrier; (2) urging insurers to adopt a standard, expeditious review process for physicians advocating for patients for continued coverage of a currently used medication; (3) asking insurers to make available an in-state physician medical director with the authority to authorize coverage 24-hours a day, seven days a week; and (4) legislative versus regulatory means to accomplish the above. (Report 8, Board of Trustees, H-2009)

185.976 Evidence-Based Guidelines for Reimbursement for Medical Necessity Decisions

The Society is directed to undertake an initiative to ensure that insurance companies follow evidence-based guidelines as established by specialty societies when making medical necessity decisions. (Res. 305, H-2007)

- 185.977 Legality of Fining Physicians**
The Society shall investigate insurers' policies of fining physicians if a patient utilizes out-of-network labs or other services, and shall advocate through legislation, regulation, or other appropriate measures to eliminate these policies. (Res. 307, H-2007)
- 185.978 Reimbursement for HPV Vaccination**
The Society promotes adequate and timely insurance reimbursement for the HPV vaccination for patients with all forms of health insurance in the Commonwealth. (Res. 309, H-2006; reaffirmed, H-2016)
- 185.979 Access to Affordable Health Insurance**
The Society shall continue both its legislative and public education efforts on the issues of access to affordable health insurance and promoting healthy lifestyles. (Report 8, Board of Trustees, H-2005)
- 185.980 Physician Phone Appeals for Denied Procedures**
The Society requires insurers to accept the reason provided for a diagnostic study as written on the request constitutes medical necessity and further, the Society opposes pre-authorization of medically relevant tests. The Society shall study and seek legal definition of physicians' and third-party payers' legal responsibility and shall create a means to assess the negative impact such pre-authorization policies have in areas of patient satisfaction, diagnosis delay, and increased emergency department usage. The results of these efforts will be reported to physicians and third-party payers as soon as available. (Res. 303, H-2005; reaffirmed, H-2006; reaffirmed, H-2016)
- 185.981 Non-Sedating Antihistamines**
The Society shall petition the Pennsylvania Health Department to require all insurance plans to offer at least one non-sedating antihistamine in their prescription benefit plans. (Res. 302, H-2005)
- 185.982 Differences in Restrictive Formularies**
The Society shall take all necessary means to ensure that patients on established medication regimens (of greater than six months' duration) who change from one insurance plan to another be permitted to continue on the established regimens, and that the continued regimens be paid for by the patient at the same "tier rate" co-payment as the comparable formulary drug. (Res. 308, H-2004)
- 185.983 Obesity as a Treatable Disorder**
The Society shall work with the state legislature and third-party reimbursors to define and reimburse for prevention and treatment of obesity. (Sub. Res. 204, H-2002; revised, H-2012)
- 185.984 Disclosure of Health Care Benefits by Insurers**
The Society shall use all means appropriate to ensure that insurers provide adequate information to consumers regarding their health plan coverage and its limitations. The Society shall continue to monitor and participate whenever possible in patient and subscriber education. (Res. 314, H-2002)
- 185.985 Health Care Coverage for Uninsured and Underinsured**
The Society shall continue its efforts to support expansion of health insurance coverage through existing programs with increased funding and newly developed plans for coverage and shall continue to monitor efforts at the state and federal

levels to identify uninsured or underinsured populations and to support inclusion of these populations under existing and newly developed plans of coverage. (Report 14, Board of Trustees, H-2001)

- 185.986 Use of Oral Contraceptives in Non-Contraceptive Medical Conditions**
The Society shall exert its influence with managed care companies to ensure that prescriptions for hormonal treatments that are otherwise used for contraception, when prescribed, be reimbursable. (Res. 313, H-2000)
- 185.987 Contraceptive Coverage**
The Society shall actively pursue, through legislative or regulatory means, coverage for contraceptive medications in those insurance plans that provide pharmaceutical benefits. (Res. 401, H-2000)
- 185.988 Employer Medical Coverage**
The Society strongly recommends to employers that they notify employees far in advance about the proposed changes in healthcare coverage in order to help maintain patient-physician relationships; and that employers be encouraged to include employees in the development of such proposed changes in healthcare coverage prior to implementation. (Res. 304, H-2000)
- 185.989 Abnormal Pap Smears for Uninsured Women**
The Society shall study payment alternatives to make evaluation and treatment of abnormal pap smears a covered service for all women in Pennsylvania. (Res. 210, H-2000)
- 185.990 Timing of Screening Examinations**
The Society supports the principle that subscribers who are eligible for benefits screening examinations which are regimented by chronological constraints be able to receive these examinations within a reasonable grace period. Efforts shall be initiated to seek enactment of appropriate legislation in the Commonwealth of Pennsylvania if insurers are not positively responsive to this policy. (Res. 217, H-1998)
- 185.991 Diagnostic Imaging Tests by Insurers**
The Society, in concert with the AMA, seeks relief from inappropriate pre-authorization requirements of emergency and urgent diagnostic imaging procedures by insurers and imposition of monetary penalties by insurers against physicians who perform such diagnostic imaging procedures and are unable to obtain pre-authorization. (Res. 312, H-1998)
- 185.992 Denials by Insurers**
The Society shall:
- 1) Work in cooperation with the Pennsylvania chapter of the American College of Emergency Physicians to resolve issues associated with payment for emergency care.
 - 2) Educate physicians, physicians' staff, and patients on how to access and effectively utilize insurer grievance mechanisms to dispute coverage decisions made by insurers.
 - 3) Continue efforts to enact legislation requiring insurers to disclose coverage limitations and exclusions to purchasers and patients.

- 4) Educate employers who have experience-rated benefit plans about how to interpret their utilization data to determine if they provide adequate coverage.
- 5) Work with the media and various entities to educate the public about how the definition of medical necessity can vary and about how insurers influence their treatment as a result of these varying interpretations.
- 6) Take appropriate action requiring insurers to disclose to the public the clinical guidelines and other criteria (“Black Box Algorithms”) they utilize to determine if a service is medically necessary.
- 7) Advocate that (a) all denials of care resulting from precertification and concurrent utilization review be performed by licensed physicians. (Medical Doctors and Doctors of Osteopathy); and (b) all retrospective utilization reviews resulting in denials on the grounds of medical necessity and all appeals be performed by physicians licensed by the Commonwealth who are in active clinical practice (defined as an average of at least 20 hours per week in the treatment of patients; in the same specialty as the practitioner under review or of the specialty which normally managed the form of care under review).
- 8) Promote the tenet that when payment is denied by an insurer because the services are deemed “not medically necessary”, this equates to a clinical decision made by the insurer about what health care services are medically necessary.
- 9) Promote statements from the American Medical Association’s Code of Medical Ethics related to the allocation of limited resources (E-2.03) such as, “A physician has a duty to do all that he or she can for the benefit of the individual patient” and “Physicians have a responsibility to participate and to contribute their professional expertise in order to safeguard the interests of patients in decisions made at the social level regarding the allocation or rationing of health resources.”
- 10) Review various issues associated with requiring insurers to maintain a record of all payment denials based on the determination that the care was not medically necessary and with disclosing this information to the public.

(Report 13, Board of Trustees, H-1997)

185.993

Denial of Care

The Society shall seek regulation or legislation requiring health care insurance entities to keep a detailed record of all denials of approval for any medical care by providers or other representatives of the entity and requiring a review of such detailed records to be part of the oversight of health care insurance entities conducted by the Commonwealth of Pennsylvania and to have the results of the review made available to the public. (Res. 510, H-1996; reaffirmed, H-2016)

185.994

Emergency Room Precertification

The Society shall seek legislation and regulations that require all emergency room precertification programs providing coverage in the state to have a physician-based screening and appeals program that is meaningful and requires decisions based on patient care issues and not fiscal goals. The Society shall contact the appropriate agencies to enforce legislation and regulations that require that HMOs may not

establish programs that are different for their Medicaid-based programs and their non-Medicaid-based programs. (Res. 403, H-1996; reaffirmed, H-2016)

185.995 Modification of Waiver of ERISA

The Society will develop and support federal legislation that would modify ERISA to prevent employers from retroactively changing health care benefits, including monetary policy limitations, after an employee has already contracted a particular illness or condition. (Report 24, Board of Trustees, H-1995)

185.996 Precertification Process

The Society determined to set policy and propose legislation to ensure the following: (1) third-party payers that authorize a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care services in good faith and pursuant to the authorization; (2) if a third-party payer grants preauthorization, and services are rendered in good faith and pursuant to preauthorization, the third-party payer is responsible for timely reimbursement for those services provided. (Res. 509, H-1995; reaffirmed, Res. 313, H-1997)

The Society supports physician charges for the time spent in providing and obtaining authorizations for tests, certifications and procedures for patients. (Res. 301, H-2012)

185.997 Department of Public Welfare—Explanation of Medical Benefits

The Society requests a change in the Department of Public Welfare's policy so as to include the compensation payment with the Explanation of Medical Benefits (EOMB); further, the Society shall investigate and request any other insurance carrier to adjust to a similar policy. (Res. 502, H-1995)

185.998 Psychiatric Insurance Benefit Carve-Outs

The Society is directed to take all appropriate steps to reverse the carve-out of psychiatric treatment in the new Personal Choice product of Independence Blue Cross and Pennsylvania Blue Shield. (Res. 59, H-1993)

185.999 Child Health Insurance

The Society agreed to join the Pennsylvania Chapter of the American Academy of Pediatrics in supporting legislation to require coverage of health supervision services to children in all health insurance policies sold in Pennsylvania as a mandated benefit. (Res. 21, H-1987)

190.000 Health Insurance: Claims Forms and Claims Processing

190.996 Use of Interoperable Systems in Deployment of Health Information Technology

The Society shall continue its participation with CAQH CORE initiatives and discussions and also in the monitoring of smart card technology initiatives through national organizations such as the AMA and MGMA. The Society shall also pursue opportunities to engage in any and all activities that will assist its members in improving and enhancing their delivery of health care services to their patients to include use of interoperable systems in deployment of health information technology. (Report 4, Board of Trustees, H-2013)

190.997 Release of Medical Record Information to Third-Party Payers
The Society advocates for legislation that: (1) third-party payers do not have an automatic legal right to unlimited access to medical record information; (2) physicians should not release health care information to third-party payers without specific and contemporaneous patient authorization or court order when required; and (3) a medical records release authorization to third-party payers should be in writing and include (a) the name of the patient; (b) a statement that the physician is authorized to release the patient's medical records (or designated portions thereof) as provided in the release; (c) the name and address of the person or entity to whom the records should be released; (d) the scope of the release (the full medical record or designated portions); (e) the date; (f) the expiration date of the authorization; (g) the name and signature of the person authorizing the release; and (h) if the person authorizing the release is not the patient, the relationship of that person to the patient. (Report 17, Board of Trustees, H-2005; revised, H-2015)

190.998 Patient Confidentiality by Third-Party Payers
The Society advocates for the imposition of sanctions against third-party payers that breach the confidentiality of patient information provided to them by a treating or consulting physician. Sanctions should be legally imposed against third-party payers that demand, for approval of or payment for medical services, the provision of information that would conflict with HIPAA regulations. Additional penalties should be imposed against a third-party payer that inflicts onerous actions or sanctions against a provider who has declined to submit information that would violate HIPAA regulations. (Res. 410, H-2005)

190.999 Electronic Billing
The Society seeks through CMS to ensure that for electronic billing, hardware be a matter of personal choice or preference for physician users; that software packages provided by carriers be compatible with multiple operating systems and user friendly; that third parties provide updates of software to physicians operating within their system; and that a consistency of quality be maintained in software development and use for all. (Res. 48, H-1992; revised, H-2010)

195.000 Health Maintenance Organizations

195.998 Involuntary Assignment to HMO Panels
The Society strongly opposes the practice of managed care organizations involuntarily assigning physicians to new products, new panels, and new services without the express written consent of the physician in advance; further, that there be no coercion, such as being dropped from a panel if the physician fails to join a different or new panel or organization or product. (Res. 305, H-1995)

The Society reaffirms its policy against the use of "all products clauses" and other unfair business practices and seeks any and all appropriate remedies to eradicate these practices.

The Society is directed to approach this as a high priority issue. (Res. 309, H-2001)

195.999 Unfair Business Practice Regarding Inpatient Care
The Society shall help its physicians inform the public that if they are enrolled in certain HMO products, their primary care physicians may be pressured by improper

third-party payers' financial incentives not to provide their inpatient care. (Res. 312, H-2001; revised, H-2011)

The Society strongly supports change in the state HMO laws and regulations to allow non-admitting physicians to join HMOs as providers of health care. (Res. 76, H-1993)

200.000 Health Workforce

200.998 Training of Family Physicians a Concern of Medicine

The Society considers the training of physicians in family practice to be a proper role for Pennsylvania medical schools; and further, it encourages the state-related and state-assisted medical schools of the Commonwealth to develop and execute training programs geared to producing family physicians. (Res. 23, H-1973)

200.999 Society Support for Family Medicine

The Society embraces and actively supports the specialty of family medicine and the Pennsylvania Academy of Family Physicians. (Res. 3, H-1990; retained in part, H-2000; revised, H-2010)

210.000 Home Health Services

210.999 Medicare Physician Reimbursement for Home Health Visits

It is the policy of the Society to: (1) urge Congress and HCFA to adjust reimbursement for physician home visits so that the payment made to physicians is consistent with the services involved in treating patients at home; and (2) that the physician reimbursement should appropriately reflect the relative differences in the training and skill of physicians and other home health care providers. (Sub. Res. 511, H-1994)

215.000 Hospitals

215.998 Hospital Protocols for Patient Transfers

The Society shall work with The Hospital and Healthsystem Association of Pennsylvania and other concerned organizations to adopt a standard protocol for the transfer of patients and the patient's record and promote the adoption of a standard protocol among the hospitals, nursing, and long-term care facilities as appropriate. (Res. 202, H-2012)

215.999 Pennsylvania Act 13 of 2002 (Mcare Act) Enforcement

The Society is directed to communicate to the Pennsylvania Department of Health (DOH) the need for their inspectors to receive from DOH clear written guidelines and that these guidelines of what constitute a serious event be available to hospital administrators, employees, and medical staffs. (Res. 411, H-2005)

225.000 Hospitals: Medical Staff**225.989 Effects of Hospital/Health System Consolidations on Healthcare**

The Society is directed to provide financing to develop and execute a physician member survey in 2019 to assess actions taken by hospitals, health systems and/or insurers in limiting or restricting medical staff membership and/or insurer networks within the Commonwealth. In addition, the Pennsylvania delegation to the American Medical Association (AMA) shall present a resolution at the next appropriate AMA meeting to direct the AMA to lobby federal legislators, the IRS, and/or other appropriate federal officials to investigate and review whether non-profit hospitals and other applicable health systems are meeting the provisions of the Internal Revenue Code relating to their tax-exempt status when they restrict or otherwise limit medical staff privileges or maintain closed medical staffs, and to take appropriate action to ensure that non-profit hospitals and other applicable health systems continue to meet charitable purposes as required under applicable sections of the Internal Revenue Code. (Board Report 4, H-2018)

225.990 Preserving Medical Staff Members' Rights

The Society endorses and recommends to all members and to all Pennsylvania healthcare institution medical staffs that they consider including the AMA's model language in medical staff bylaws and employment contracts, protecting the rights of physicians to exercise their personal and professional judgment in voting, speaking and advocating for patients and/or medical staff matters. (Res. 504, H-2012)

225.991 Hospital Imposed Exclusivity Restrictions for Medical Staff Members

The Society shall aggressively seek resolution with the Pennsylvania Department of Health, of the issues of alleged fraud and abuse associated with hospital-imposed exclusivity policies. (Res. 501, H-2001; revised, H-2011)

225.992 Medical Staff Development Plans

The Society adopted the following principles and shall communicate them to the president and chair of the board of The Hospital and Healthsystem Association of Pennsylvania, and recommend that county medical societies establish a dialogue regarding medical staff development plans with their local hospitals:

- (a) The medical staff and hospital/health system leaders have a mutual responsibility to (1) cooperate and work together to meet overall health and medical needs of the community and preserve quality patient care; (2) acknowledge the constraints imposed on the two by limited financial resources; (3) recognize the need to preserve the hospital/healthsystem's economic viability; and (4) respect the autonomy, practice prerogatives, and professional responsibilities of physicians.
- (b) The medical staff and its elected leaders must be involved in the hospital/healthsystem's leadership function, including the process to develop a mission that is reflected in the long range, strategic, and operational plans; service design; resource allocation; and organizational policies.
- (c) Medical staffs must insure that quality patient care is not harmed by economic motivations.
- (d) The medical staff should review and make recommendations to the governing body prior to any decision to close the medical staff and/or a clinical department.

- (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges.
- (f) The medical staff must be responsible for professional/quality criteria related to appointment/reappointment to the medical staff and granting/renewing clinical privilege. The professional/quality criteria should be based on commonly known, objective standards.
- (g) The medical staff should be consulted in establishing and instituting institutional/community criteria. Institutional/community criteria should not be used inappropriately to prevent a practitioner or group of practitioners from gaining access to staff membership.
- (h) Staff privileges for physicians should be based only on training, experience, demonstrated competence, and adherence to medical staff bylaws. Additionally, there shall be a requirement in hospital bylaws for an appropriate appeal and due process mechanism.
- (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of patients, and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles must be made available to the subject physician at regular intervals. (Report 8, Board of Trustees, H-1999)

225.993 PA Department of Health Position on Verbal Order Regulations

The Society seeks regulations or legislation that the absolute time requirement for signing verbal orders be removed and replaced with language that allows individual medical staffs to determine when these orders are signed. (Res. 210, H-1999)

The Society seeks the elimination of the regulatory requirement in Pennsylvania that a physician's verbal orders be signed within 24 hours. The Society shall work with the Pennsylvania Department of Health to create a protocol for hospitals to establish standardized policies with respect to verbal orders directed towards ensuring patient safety. (Res. 206, H-2004)

225.994 Model Medical Staff Code of Conduct

The Society adopted the following AMA Model Medical Staff Code of Conduct (2010) as the Society's Model Medical Staff Code of Conduct:

AMA MODEL MEDICAL STAFF CODE OF CONDUCT

To encourage a culture of safety and quality, organized medical staffs are encouraged to adopt a Code of Conduct as part of their medical staff bylaws. The medical staff bylaws, of which this Code of Conduct is a part, shall be the exclusive means for review and disciplining medical staff members for inappropriate or disruptive behavior.

I. APPLICABLE DEFINITIONS:

"Appropriate behavior" means any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized medical staff, or to engage in professional practice including practice that may be in competition with the hospital. Criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior.¹ Appropriate behavior is not subject to discipline under these bylaws.

"Disruptive behavior" is characteristically a chronic or habitual pattern of behavior that creates a hostile environment, the effects of which have serious implications on the quality of patient care and patient safety.² Disruptive behavior means any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised. Personal conduct

whether verbal or physical, that affects or that potentially may affect patient care negatively constitutes disruptive behavior.³

“Sexual or other harassment” means conduct toward others based on their race, religion, sex, sexual identity or orientation, nationality or ethnicity, physical or mental disability, or marital status which has the purpose or direct effect of unreasonably interfering with a person’s work performance or which creates an offensive, intimidating or otherwise hostile work environment. Sexual harassment includes unwelcome verbal or physical conduct of a sexual or gender-based nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings or posters). Sexual harassment includes conduct that creates and/or perpetrates an intimidating, hostile, or offensive environment.

“Inappropriate behavior” means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as “disruptive behavior.”

“Medical staff member” means physicians and others granted membership on the Medical Staff and, for purposes of this Code, includes individuals with temporary clinical privileges.

II. TYPES OF CONDUCT

1 CEJA Ethical Opinion E-9.045

2 Russ C, et al. Report of the Special Committee on Professional Conduct and Ethics. Federation of State Medical Boards of the United States. 2000.

3 CEJA Ethical Opinion E-9.045

© 2010 American Medical Association. All rights reserved.

Authors: Barney I. Cohen, Esq., American Medical Association, and Elizabeth A. Snelson, Esq., Legal Counsel for the Medical Staff, PLLC. This document may only be copied, modified, or disseminated for non-commercial purposes. It is for informational purposes only and not intended to replace or serve as legal advice. The laws of individual states will vary. Users with questions are encouraged to consult with a knowledgeable attorney. To get an electronic copy of this document or the Physician’s Guide to Medical Staff Organization Bylaws or to learn how the American Medical Association Organized Medical Staff Section can serve as a voice for your medical staff, visit www.ama-assn.org/go/omss or call (312) 464-4761.

A. APPROPRIATE BEHAVIOR

Medical staff members cannot be subject to discipline for appropriate behavior. Examples of appropriate behavior include, but are not limited to, the following:

- Advocacy on patient care matters;
- Recommendations or criticism communicated in a reasonable manner and offered in good faith with the aim of improving patient care and safety;
- Encouraging clear communication;
- Expressions of concern about a patient’s care and safety;
- Expressions of dissatisfaction with policies through appropriate grievance channels or other civil non-personal means of communication;
- Use of cooperative approach to problem resolution;
- Constructive criticism conveyed in a respectful and professional manner, without blame or shame for adverse outcomes;
- Professional comments to any professional, managerial, supervisory, or administrative staff, or members of the Board of Directors about patient care or safety provided by others;
- Fulfilling duties of medical staff membership or leadership;

- Active participation in medical staff and hospital meetings (i.e., comments made during or resulting from such meetings cannot be used as the basis for a complaint under this Code of Conduct, referral to the Health and Wellbeing Committee, economic sanctions, or the filing of an action before a state or federal agency);
- Exercising rights granted under the medical staff bylaws, rules and regulations or policies;
- Engaging in legitimate business activities, while being mindful of contractual commitments;
- Membership on other medical staffs; and
- Seeking legal advice or the initiation of legal action for cause.

B. INAPPROPRIATE BEHAVIOR

Inappropriate behavior by medical staff members is discouraged. Persistent inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as “disruptive behavior.” Examples of inappropriate behavior include, but are not limited to, the following:

- Belittling or berating statements;
- Name calling;
- Use of profanity;
- Inappropriate comments written in the medical record;
- Blatant failure to respond to patient care needs or staff requests;
- Deliberate lack of cooperation without good cause;
- Deliberate refusal to return phone calls, pages, or other messages concerning patient care or safety; and
- Intentionally degrading or demeaning comments regarding patients and their families; nurses, physicians, hospital personnel and/or the hospital.

C. DISRUPTIVE BEHAVIOR

Disruptive behavior by medical staff members is prohibited. Examples of disruptive behavior include, but are not limited to, the following:

- Physical or verbal intimidation or challenge, including disseminating threats or pushing, grabbing or striking another person involved in the hospital;
- Physically threatening language directed at anyone in the hospital including physicians, nurses, other medical staff members, or any hospital employee, administrator or member of the Board of Directors;
- Physical contact with another individual that is threatening or intimidating;
- Throwing instruments, charts or other things;
- Threats of violence or retribution; and
- Sexual or other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation.

D. INTERVENTIONS

Interventions should initially be non-adversarial in nature, if possible, with the focus on restoring trust, placing accountability on and rehabilitating the offending medical staff member, and protecting patient care and safety. The medical staff supports tiered, non-confrontational intervention strategies, starting with informal discussion of the matter with the appropriate section chief or department chairperson. Further interventions can include an apology directly addressing the problem, a letter of admonition, a final written warning, or corrective action pursuant to the medical staff bylaws, if the behavior is or becomes

disruptive. The use of summary suspension should be considered only where the physician's disruptive behavior presents an imminent danger to the health of any individual. Rehabilitation may be recommended at any time. If there is reason to believe inappropriate or disruptive behavior is due to illness or impairment, the matter may be evaluated and managed confidentially according to the established procedures of the medical staff's Health and Wellbeing Committee (or equivalent committee).

II. PROCEDURE

Complaints about a member of the medical staff regarding allegedly inappropriate or disruptive behavior should be in writing, signed and directed to the President of the medical staff or, if the President of the medical staff is the subject of the complaint, to the Vice President of the medical staff, and include to the extent feasible:

1. the date(s), time(s) and location of the inappropriate or disruptive behavior;
2. a factual description of the inappropriate or disruptive behavior;
3. the circumstances which precipitated the incident;
4. the name and medical record number of any patient or patient's family member who was involved in or witnessed the incident;
5. the names of other witnesses to the incident;
6. the consequences, if any, of the inappropriate or disruptive behavior as it relates to patient care or safety, or hospital personnel or operations; and
7. any action taken to intervene in, or remedy, the incident, including the names of those intervening.

At the discretion of the President of the medical staff (or Vice President if the President of the medical staff is the subject of the complaint), the duties here assigned to the President of the medical staff can, from time to time, be delegated to another elected member of the medical staff ("designee"). The complainant will be provided a written acknowledgement of the complaint.

In all cases, the medical staff member subject of the complaint shall be provided a copy of this Code of Conduct and a copy of the complaint in a timely fashion, as determined by the organized medical staff, but in no case more than 30 days from receipt of the complaint by the President or Vice President of the medical staff. The medical staff member will be notified that attempts to confront, intimidate, or otherwise retaliate against the complainant is a violation of this Code of Conduct and may result in corrective action against the medical staff member. An ad hoc committee, none of the members of which may be economic competitors of the medical staff member, consisting of the President or Vice President of the medical staff, or designee, and at least two additional elected members of the medical executive committee, one of whom shall be the medical staff member's department chairperson, provided the chairperson is not the subject of the complaint, shall make such investigation as appropriate in the circumstances which may include seeking to interview the complainant, any witnesses and the subject of the complaint. The subject medical staff member shall be provided an opportunity to respond in writing to the complaint.

The ad hoc committee will make a determination of the authenticity and severity of the complaint. The ad hoc committee shall dismiss any unfounded complaint and may dismiss any complaint if it is not possible to confirm its authenticity or severity, and will notify both the complainant and the subject of the complaint of the decision reached.

If the ad hoc committee determines the complaint is well founded, the complainant and the subject of the complaint will be informed of the decision, and the complaint will be addressed as follows:

1. If this is the first incident of inappropriate behavior, the appropriate section chief, or chairperson of the offending medical staff member's assigned department, shall discuss the matter with the offending medical staff member, and emphasize that the behavior is inappropriate and must cease. The offending medical staff member may be asked to apologize to the complainant. The approach during this initial intervention should be collegial and helpful.
2. Further isolated incidents that do not constitute persistent, repeated inappropriate behavior will be handled by providing the offending medical staff member with notification of each incident, and a reminder of the expectation the individual complies with this Code of Conduct.
3. If the ad hoc committee determines the offending medical staff member has demonstrated persistent, repeated inappropriate behavior, constituting harassment (a form of disruptive behavior), or has engaged in disruptive behavior on the first offense, a letter of admonition will be sent to the offending medical staff member, and, as appropriate, a rehabilitation action plan developed by the ad hoc committee, with the advice and counsel of the medical executive committee.
4. If, in spite of this admonition and intervention, disruptive behavior recurs, the ad hoc committee shall meet with and advise the offending medical staff member such behavior must immediately cease or corrective action will be initiated. This "final warning" shall be sent to the offending medical staff member in writing.
5. If after the "final warning" the disruptive behavior recurs, corrective action (including suspension or termination of privileges) shall be initiated pursuant to the medical staff bylaws of which this Code of Conduct is a part, and the offending medical staff member shall have all of the due process rights set forth in the medical staff bylaws.
6. If a single incident of disruptive behavior or repeated incidents of disruptive behavior constitute an imminent danger to the health of an individual or individuals, the offending medical staff member may be summarily suspended as provided in the medical staff bylaws. The medical staff member shall have all of the due process rights set forth in the medical staff bylaws.
7. If no corrective action is taken pursuant to the medical staff bylaws, a confidential memorandum summarizing the disposition of the complaint, along with copies of any written warnings, letters of apology, and written responses from the offending medical staff member, shall be retained in the medical staff member's credentials file for two (2) years, and then must be expunged if no related action is taken or pending. Informal rehabilitation, a written apology, issuance of a warning, or referral to the Health and Wellbeing Committee (or equivalent committee) will not constitute corrective action.
8. At any time during this procedure the medical staff member has a right to personally retain and be represented by legal counsel.

IV. INAPPROPRIATE OR DISRUPTIVE BEHAVIOR AGAINST A MEDICAL STAFF MEMBER

Inappropriate or disruptive behavior which is directed against the organized medical staff or directed against a medical staff member by a hospital employee, administrator, board member, contractor, or other member of the hospital community shall be reported by the medical staff member to the hospital pursuant to hospital policy or code of conduct, or directly to the hospital governing board, the state or federal government, or relevant accrediting body, as appropriate.

V. ABUSE OF PROCESS

Threats or actions directed against the complainant by the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation by medical staff members against complainants will give rise to corrective action pursuant to the medical staff bylaws. Individuals who falsely submit a complaint shall be subject to corrective action under the medical staff bylaws or hospital employment policies, whichever applies to the individual.

VI. PROMOTING AWARENESS OF CODE OF CONDUCT

The medical staff shall, in cooperation with the hospital, promote continuing awareness of this Code of Conduct among the medical staff and the hospital community, by:

1. sponsoring or supporting educational programs on disruptive behavior to be offered to medical staff members and hospital employees;
2. disseminating this Code of Conduct to all current medical staff members upon its adoption and to all new applicants for membership to the medical staff.
3. encouraging the Health and Wellbeing Committee (or equivalent committee) to assist members of the medical staff exhibiting inappropriate or disruptive behavior to obtain education, behavior modification, or other treatment to prevent further infractions.
4. informing the members and the hospital staff of the procedures the medical staff and hospital have put into place for effective communication to hospital administration of any medical staff member's concerns, complaints and suggestions regarding hospital personnel, equipment, and systems. (Report 8, Board of Trustees, H-2011)

© 2010 American Medical Association. All rights reserved.

225.995 Medical Executive Committee Investigation

The Society adopted the following policy as stated in the Society's Model Medical Staff Bylaws: (1) Practitioners under investigation by the hospital medical executive committee shall be promptly notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon the terms as the investigating individual or body deems appropriate. The investigating individual or body shall interview the practitioner if requested; (2) medical staff quality improvement committees shall arrange for external review of care when appropriate; and (3) medical executive committee investigations shall be conducted in an expeditious manner and shall be focused on the issue(s) which initiated the investigation. The Society was also directed to ask the AMA to enact the same policies. (Res. 305, H-1994)

225.996 Review of Hospital Bylaws by Executive Committee

The Society encourages hospital medical executive committees and/or their legal counsel to regularly examine the hospital/corporate bylaws, rules, regulations, or practices. The Society also recommends that hospital medical executive committees request their boards of trustees/directors to notify them of any proposed or impending changes in the hospital corporate bylaws. Hospital medical executive committees should advise members/ applicants of the medical staff of the effect of these hospital /corporate bylaws, rules, and regulations. (Res. 68, H-1988)

225.997 Due Process Rights

The Society holds that hospital notification of possible loss of medical staff membership must be sent by certified mail, return receipt requested, and that this procedure should be part of the Society's Model Medical Staff Bylaws; that appropriate due process rights be assured to a physician who has received an

adverse recommendation regarding medical staff membership or privileges; and that such due process rights shall include: (1) an appeal conducted by an impartial body consisting of physicians who did not participate in the previous recommendation, and (2) if a negative action is taken by the physician hearing committee, a hearing be held by a committee of the hospital governing body. The Society has notified all Pennsylvania hospital medical staffs of the aforementioned procedure, as contained in the revised Joint Commission standards. (Amended Sub. Res. 52, H-1991; revised, H-2011)

225.998 Doctors on Governing Boards

The Society states that at least one representative of the medical staff shall serve as a voting member on each hospital governing board. (Res. 29, H-1972)

225.999 Control of Medical Staff Funds

The Society encourages hospital medical staffs to state in their bylaws that the medical staff is solely responsible for the collection, use, and expenditure of medical staff funds. (Res. 71, H-1988)

230.000 Hospitals: Medical Staff - Credentialing and Privileges

230.989 Patient Access to Experienced Physicians

PAMED is directed to advocate that physician credentialing by insurance companies be based on professional training and licensure rather than solely on employment status and/or hospital affiliation. In addition, PAMED shall advocate to payers that, once credentialed, all physicians must be listed as equal-tiered providers to those employed by the hospital or health insurer. (Res. 301, H-2018)

230.990 Eliminate the Preferential Treatment of Physicians with Hospital Privileges in Pennsylvania

The Pennsylvania Medical Society (PAMED) shall work with the Pennsylvania Legislature, the Pennsylvania Department of Health, the Pennsylvania Insurance Department, and other appropriate agencies to establish legislation or regulation that any physician who is not practicing in a hospital may not be required to maintain hospital privileges by any entity including, but not limited to, a health insurance company, malpractice insurance company, surgery center, or outpatient facility. Additionally, PAMED shall work with the Pennsylvania Legislature, the Pennsylvania Department of Health, the Pennsylvania Insurance Department, and other appropriate agencies to establish legislation or regulation that no insurance company may grant or deny preferred or in-network status to physicians according to the presence or absence of their hospital privileges. (Res. 401, H-2017)

230.991 Private Physician Health Care Network Relationships

The Society shall aggressively pursue legislation concerning the enforcement of the Community Benefit Standard in Pennsylvania; research ways to provide legal support to aid PAMED member physicians who are impacted by hospitals' exclusionary tactics that not only violate Internal Revenue Service Ruling 56-185, but also adversely affect quality patient care; and work to maintain continued private physician health care network relationships in order to preserve the physician-patient relationship. (Res. 401, H-2014; reaffirmed, H-2015)

230.992 Unfair Discrimination in Medical Staff Application/Selection Process

The Society shall clearly state in its policies that preferential selection processes favoring physician applicants for medical staff membership and clinical privileges

who are employed by the hospital or hospital-related organizations (i.e., foundations, PHO, etc.) over physician applicants who are independent practitioners or members of independent practice groups constitute unfair discrimination. (Res. 318, H-1997)

230.993 Linkage of Academic Privileges and Hospital Privileges

The Society continues to monitor actions related to granting of academic privileges and will take appropriate action to preclude academic organizations from linking the granting of academic privileges and hospital medical staff credentials. (Res. 402, H-1996; revised, H-2006; reaffirmed, H-2016)

230.994 Effect of Changes in Hospital Character Upon Medical Staff Credentialing.

The Society shall develop a policy on merger or acquisitions between hospitals and/or changes in services which will ensure due process when physician privileges and credentials are affected. The Society shall institute educational efforts to make medical staffs aware of these policies and shall support the medical staff with appropriate assistance in these efforts. (Res. 616, H-1996; reaffirmed, H-2016)

230.995 Selective Contracting

The Society endorses the AMA's Patient Protection Act, and adopts the following policies: (1) If, under the principle of self-governance, a medical staff determines that productivity, as it has a direct relationship to quality of care, is a reasonable criterion to use in its consideration of reappointment, it should be permitted to do so; however, the Society does not believe that economic productivity should be a factor in medical staff reappointment; and (2) criteria for hospital clinical privileges should be developed by the medical staff and criteria for hospital clinical privileges should be separate and can be different than criteria for managed care organization participation. Additionally, medical staffs and hospitals should be alert to and try to prevent attempts by managed care organizations to tie hospital clinical privileges and managed care organization participation together. The Society also adopted the following policy for distribution statewide: (1) A hospital should not deny, restrict, revoke, or terminate the medical staff membership or clinical privileges of a physician on the basis that the physician did not participate in the hospital's PHO; (2) in establishing PHOs, hospitals should not deprive physicians involved in the PHO of the right to separately contract with managed care organizations or other third-party insurance entities except during the brief period of active negotiations between the PHO and a particular HMO, when unity of voice may be essential for success; (3) PHOs should not restrict physicians who have clinical privileges at more than one hospital from joining other PHOs; and (4) the physicians should own the physician component of the PHO contract. (Report 26, Board of Trustees, H-1995)

230.996 Criteria for Hospital Medical Staff Privileges and Credentialing

The Society asserts that medical staff privileges should be granted on the basis of education, training, experience, and interest of individual physicians (Res. 21, H-1980; revised, H-2010), and that hospital credentialing should be based upon the professional qualifications of the physician to deliver medical care of excellence. The Society opposes the use of cost patterns as a sole criterion for hospital credentialing, since it does not address the issue of quality of patient care. (Res. 64, H-1990; revised, H-2010) The Society asserts that medical staff privileges should be granted on the basis of education, training, experience, and interest of individual physicians. (Res. 21, H-1980; revised, H-2010)

230.997 Economic Credentialing

The Society opposes economic credentialing as the sole or primary criterion for determining hospital medical staff privileges. (Res. 71, H-1993)

230.998 Protocol for Hospital Medical Staff Credentials Files

The Society recommends that the following guidelines be used for establishing, maintaining, and accessing hospital medical staff credentials files:

1. A single credentials file should be kept for each medical staff member.
2. The credentials files should be kept in the medical staff office.
3. The credentials files should contain information directly related to quality of care and ethical issues information mandated by state or federal statute or regulation, as well as information related to other issues deemed necessary by the medical staff to carry out review and credentialing functions.
4. Access to credentials files should be carefully monitored, and definite rules should be established by the hospital medical staff covering the conditions under which individuals (including the individual practitioner) may review the files and insert and delete information; written rules concerning confidentiality should be formulated and put in writing.

The Society urges medical staffs to establish and incorporate into their medical staff bylaws policies covering the management and maintenance of credentials files. It also encourages development of credentials files policies that are suited to the specific conditions prevailing at each individual hospital. (Res. 69, H-1988)

230.999 Exclusive Contracts

The Society supports the principle that the granting of clinical privileges to medical staff members should include a full right of access to hospital resources (including, but not limited to, equipment, facilities, and hospital personnel) which are necessary to exercise effectively those privileges, and that the right of access should not be taken away for other than demonstrable reasons directly related to quality patient care and not without due process. The Society takes no position with regard to exclusive contracts; however, in those individual situations where an exclusive contract appears to be either desirable or unavoidable: (1) the hospital and its medical staff should explore the reasons for entering into the exclusive contract to determine whether the arrangement is justified or whether the situation could be addressed through less restrictive alternatives; (2) the hospital and its medical staff should consider the practical effects that entering into such an arrangement may have on present and future medical staff members; and (3) the hospital should agree to indemnify the physician contractor(s) against any claims against them arising from the exclusive arrangement. Any physician entering into an exclusive arrangement should have the contract reviewed by an attorney experienced in exclusive contracts and antitrust law prior to its execution. The Society encourages those physicians who have experienced curtailment of their right to practice by reason of a hospital's decision to award an exclusive contract, to contact the Society. (Hospital Medical Staff Section Report, H-1986; reaffirmed, H-2016)

235.000 Hospitals: Medical Staff - Organization

235.988 Updating PAMED Medical Staff Bylaws Handbook (DVD)

The Society is directed to update its "Medical Staff Bylaws Handbook" (DVD) with information germane to Pennsylvania. This reference should be updated as needed and made available virtually at reasonable cost to physicians and hospital medical staffs in Pennsylvania. (Res. 501, H-2014)

235.990 Medical Staff Self-Governance and Independence

The Society is directed to prepare legislative and regulatory language to ensure the independence and self-governance of a hospital medical staff. The Society advocates with the Department of Health to include this language in the hospital regulations when the Department opens the appropriate sections for stakeholder review and seeks opportunities to insert this language in an appropriate legislative vehicle. (Report 9, Board of Trustees, H-2005)

235.991 Physician Review of Medical Staff Activities

The Society adopted the following policies: (1) Copies of minutes of all medical staff committees, except minutes concerning peer review or corrective action information, should be made available to all medical staff members; and (2) all policies which emanate from committee meetings where peer review issues are discussed and which affect medical staff members must be approved by the appropriate department and/or the medical executive committee and communicated to the medical staff. (Report 4, Board of Trustees, H-1995; Revised, H-2005)

235.992 Medical Staff Self-Governance

The Society adopted the policy that voting members of a hospital's medical executive committee must, themselves, have been elected by either the medical staff or by a subset thereof (such as a department). (Res. 304, H-1994)

235.993 The Role of the Hospital Medical Director

The Society supports the following guidelines regarding the role of the hospital medical director:

- (1) The hospital governing body, management, and medical staff should jointly determine if there is a need to employ a medical director; establish the purpose, duties, and responsibilities of this position; establish the qualifications for this position; and provide a mechanism for medical staff input into the selection, evaluation, and termination of the hospital medical director;
- (2) The purpose, duties, and responsibilities of the medical director should be included in the medical staff and hospital corporate bylaws;
- (3) The organized medical staff should maintain overall responsibility for the quality of the professional services provided by individuals with clinical privileges and should have the responsibility of reporting to the governing body;
- (4) The chief elected officer of the medical staff should represent the medical staff to the administration, governing body, and external agencies;
- (5) Government regulations which would mandate a hospital medical director who would have authority over the medical staff should be opposed; and
- (6) The hospital medical director shall be a physician. (Res. 303, H-1994)

235.994 Right to Meet in Executive Session

The Society supports the right of any hospital medical staff committee to meet in executive session with only voting members of the medical staff present in order to permit open and free discussion of issues such as peer review and to maintain confidentiality. Further, the Society encourages medical staffs to incorporate provisions into their medical staff bylaws to accomplish these objectives. (Res. 66, H-1988)

235.995 Non-Interference in Hospital Medical Staff Elections

The Society supports the concept of medical staff self-governance, including the process of electing and seating medical staff officers. The Society opposes

improper interference by the hospital governing body in the medical staff election process. (Res. 67, H-1988)

235.996 Medical Staffs Participate in Hospital Governance

The Society supports assisting medical staffs to participate on hospital boards of directors and board committees. (President-Elect's Address, H-1979)

235.997 Medical Staff Self-Governance

The Society recommends the following guidelines to describe the responsibilities and functions of the hospital, its governing board, and the medical staff:

1. The hospital has corporate responsibility for maintaining the necessary facilities, a safe environment, and a mechanism for the prudent selection of those who treat patients within the institution.
2. The governing board is responsible for the operation and management of the hospital and for fulfilling its corporate responsibilities.
3. The organized medical staff and its members should carry out their professional medical responsibilities through (a) the efficient operation of medical staff committees; (b) the objective recommendation of professionally qualified members of the organized medical staff and disciplinary functions relating to their competent performance; and (c) functioning as a self-governing body in promoting quality patient care within the hospital.
4. Members of the organized medical staff may likewise deal collectively with the hospital and its governing board with respect to professional matters, involving their own interests, as distinguished from the functions the organized medical staff performs on behalf of the hospital. (Res. 64, H-1988)

235.998 Medical Staff Bylaws

The Society advises hospital medical staffs that:

1. Medical staff bylaws, rules, and regulations shall be initiated and adopted by the medical staff and shall establish a framework for self-government;
2. The medical staff shall govern itself by these bylaws, rules, and regulations that shall:
 - a) be approved by the governing body, whose approval shall not be unreasonably withheld;
 - b) be reviewed and revised as necessary to reflect current medical staff practices; and
 - c) define the executive committee of the medical staff whose members are selected in accordance with criteria and standards established by the medical staff;
3. The medical staff shall have the authority to approve or disapprove all proposed amendments to medical staff bylaws, rules, and regulations;
4. The medical staff bylaws, when adopted by the hospital medical staff and formally approved by a hospital governing board, shall be mutually and equally binding on both the governing board and the medical staff; and
5. The medical staff bylaws, rules and regulations may not be unilaterally amended by the hospital corporate board or administration. (Res. 65, H-1988)

235.999 Explicit Medical Staff Bylaws

The Society encourages medical staffs to be specific in their bylaws, rules, and regulations and not to incorporate other documents by reference. (Res. 70, H-1988)

240.000 Hospitals: Reimbursement

255.000 International Medical Graduates

255.997 State Regulations on Moonlighting Privileges for IMGs

The Society seeks regulatory and/or legislative change to allow international medical graduates to obtain an interim limited license provide that they: (1) have passed the United States Medical Licensure Examination (USMLE) Step 1, Step 2, and Step 3 and the English exam; (2) are Educational Commission for Foreign Medical Graduates (ECFMG) certified; (3) have undergone a one-year training program as do graduates of accredited medical schools; and (4) have obtained the written approval of their program director. (Res. 206, H-1999)

255.998 Discrimination Against International Medical Graduates

The Society will continue to work with the International Medical Graduates (IMG) Section to review application of licensure requirements to IMGs. (Res. 47, H-1990; policy retained in part, H-2000)

255.999 Clinical Clerkships

The Society strongly objects to the practice of substituting clinical experiences provided by United States institutions for the core clinical curriculum of foreign medical schools. The Society also strongly disapproves of any legislative or regulatory measures requiring the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine. (Res. 18, H-1986; reaffirmed, H-2016)

260.000 Laboratories

260.996 Pennsylvania State Laboratory Regulations

The Society encourages and works for reform of the Pennsylvania state laboratory regulations to be consistent with the CLIA standards, especially with regard to performing waived testing by physicians in their offices. (Res. 201, H-1994)

The Society endorses the accreditation program for office laboratories of the Commission on Office Laboratory Accreditation (COLA) and strongly encourages the Pennsylvania Department of Health to grant the COLA deeming authority under the state laboratory law. The Society is directed to publicize information about COLA and encourage all physicians to seek clinical laboratory accreditation through COLA in lieu of federal certification. (Res. 35, H-1993)

260.997 Specimen Handling Fee

The Society supports a reasonable drawing and handling fee that would be reimbursed by all health insurance programs including those operated by the state and federal governments. (Res. 6, H-1986; reaffirmed, H-2016)

260.998 Resident Education in Laboratory Utilization
The Society endorses the concept of practicing physicians devoting a set period of time with first-year residents for chart reviews focusing on appropriate test ordering in patient care. (Res. 7, H-1990; revised, H-2010)

260.999 Physicians' Office Laboratories
Physicians should be permitted to perform quality laboratory tests in their own offices on their own patients provided they are willing to voluntarily participate in appropriate quality assurance and quality control programs. (Res. 33, H-1985)

270.000 Legislation and Regulation

270.973 Hepatitis C Screening Act and Discretion of Physician Practice
It is recommended that PAMED seek to work with the legislature to draft an amendment to Act 87 (which went into effect on September 18, 2016) that clarifies the issues and which will give physicians a better understanding of when they must offer a Hepatitis C screening test and under what circumstances. (Report 4 of the Board of Trustees, adopted in lieu of Res. 16-406, H-2017)

270.974 Oppose Measures That Erode Physician Supervision of Physician Assistants
PAMED is directed to oppose legislation that promotes physician assistant independent practice, and any legislation that erodes the supervisory role of the physician with or in relation to the physician assistant. (Res. 413, H-2017; reaffirmed, Res. 406, H-2018)

270.975 Protection for Pennsylvania DACA Students, Physicians, and Patients
PAMED is directed to support legislative efforts to protect Deferred Action for Childhood Arrivals (DACA)-status medical students, physicians, and patients, and shall issue a statement in support of current U.S. healthcare professionals, including those currently training as medical students or residents and fellows, who are DACA recipients in the Commonwealth of Pennsylvania. (Res. 410, H-2017)

270.976 Freedom from Government Forced Mandates in Physician Practice
The Pennsylvania Medical Society (PAMED) shall actively oppose any legislation seeking to mandate clinical guidelines upon the physician and shall notify its membership in a timely manner of any new legislation from the Pennsylvania General Assembly that seeks to mandate clinical guidelines. (Res. 407, H-2017)

270.977 Fixing Informed Consent
PAMED is directed to work in cooperation with the Hospital and Health System Association of Pennsylvania to introduce legislation that will allow a qualified physician to delegate his or her duty to obtain informed consent to another provider who has knowledge of the patient, the patient's condition, and the procedures to be performed on the patient. This legislation shall include language to ensure that all information exchanged between the patient and the individual obtaining informed consent be admissible in court. (Res. 406, H-2017)

270.978 Air Ambulance Regulations and Reimbursements
The Pennsylvania delegation to the American Medical Association (AMA) is directed to present this issue for national adoption to direct that the AMA, and appropriate stakeholders identified by the AMA, study the role, clinical efficacy, and cost-effectiveness of air ambulance services, including barriers to adequate

competition, reimbursement, quality improvement, and other areas identified by the AMA and its stakeholders, and to provide appropriate recommendations addressing the areas to be studied. (Res. 303, H-2017)

270.979 Protect Confidentiality of Dependents of Insurance Policyholders

The Society is directed to seek legislation that requires health insurers to, upon request, communicate directly and confidentially with individuals insured as dependents who receive any medical services or treatment for which parental or guardian consent is not required including, but not limited to, the EOBs. (Res. 405, H-2016)

270.980 Comprehensive Women’s Reproductive Health Care

The Society has agreed to work to prevent legislation that interferes with the physician-patient relationship and with the practice of medicine. Therefore, the Society shall oppose legislative interference with facilities that provide medically-accepted standard of care reproductive services for women, including contraception, screening for and prevention of sexually transmitted infections, screening for female cancers, and education to prevent unplanned pregnancy. (Res. 404, H-2016)

270.981 Abolish the 30-Day Waiting Period for Tubal Sterilization for Medicaid Beneficiaries

Current Pennsylvania code requires that an individual requesting tubal sterilization give written informed consent at least 30 days, but not more than 180 days, before the sterilization procedure. The Society is directed to support the efforts of the AMA to abolish the mandatory 30-day waiting period for elective tubal sterilization and to urge Pennsylvania’s Congressional Delegation to seek legislative or regulatory elimination of the required 30-day interval between informed consent and a permanent sterilization procedure. (Res. 402, H-2016)

270.982 Retrospective Payment Denial of Medically Appropriate Studies, Procedures, and Testing

The Society shall advocate for legislation to require insurers’ medical policies to reflect current evidence-based medically appropriate studies and treatments, including those for rare and uncommon diseases. The Society is also directed to streamline the process for exceptions for rare or uncommon disease states and to prohibit insurers from using medical coding as the sole justification to deny medical services and diagnostic or therapeutic testing. Further, the Pennsylvania Delegation to the AMA is directed to take this issue forward to the AMA at the next feasible opportunity. (Res. 302, H-2016)

270.983 Standardize Observation Status Among Insurer

The Society is directed to seek through enactment of legislation or regulation the requirement that all insurers or their agents make publicly available the criteria that are used to determine observation status and that a determination of observation or admission be made by the insurer within 24 hours of the time the patient presents for treatment based upon the information available to the attending physician and/or agents. The Society is further directed to advocate that the criteria used to determine observation status be standardized across insurers and to work to compel insurers to provide physicians with a clear and rapid process of appeal and review that includes the recommendations of the attending physician. (Res. 301, H-2016)

270.984 Increase in Availability of Opioid Rescue Medications and Medication-Assisted Treatment

The Society supports the practice that all pharmacies selling opioids also stock for sale opioid reversal agents and medications for the treatment of opioid use disorders and shall collaborate with appropriate stakeholders to identify and rectify existing barriers that impede stocking and selling of opioid reversal agents and medications for the treatment of opioid use disorders. (Res. 209, H-2016)

270.985 Liability Protection in Administration of Naloxone in Schools

Pennsylvania Act 139 of 2014 provides certain immunity to licensed health care professionals who, acting in good faith, prescribe or dispense Naloxone for such prescribing or dispensing or any outcomes resulting from the eventual administration of Naloxone. Act 139 also provides certain immunity to laypersons for the administration of Naloxone to a person whom the layperson believes to be suffering an opioid-related overdose. Act 139 does not provide certain immunity to organizations other than law enforcement agencies, fire companies, and fire departments, nor does it mandate Naloxone education or administration in schools.

A majority of school districts in Pennsylvania presently have not agreed to allow their nurses, teaching staff, or administrators permission to use this medication, due to these groups not specifically being named in Act 139 that provides “Good Samaritan” protection to first responder individuals who opt to administer this medication in suspected overdose situations.

The Society shall seek legislative action that will provide specific immunity for school districts and their employees to include school nurses, teachers, and administrators for the administration of Naloxone on students while on school property with the same Good Samaritan protection provided to other first responders to overdose situations. (Res. 208, H-2016)

270.986 Out-of-State Pharmacies

The Society shall seek appropriate means of state oversight over out-of-state pharmacies. (Report 2, Board of Trustees, H-2013)

270.987 Regulation of Medical Spas

The Society shall study the need for regulation of medical spas. (Res. 401, H-2011)

270.988 Opposition to Taxation of School Tuition

The Society opposes school tuition taxes and any other attendance-based taxes imposed on students by any government entity. (Res. 405, H-2010)

270.989 Assaults on Physicians, Health Care Providers or Their Staff

The Society shall work with the proper government agencies and the state legislature to enact law making it a felony to assault any physician, health care provider or their staff in a healthcare setting. (Res. 213, H-2008)

270.990 Mobile Field Tests

The Society advocates the enactment by legislation or regulation the oversight of mobile health testing units by the Pennsylvania Department of Health. Such oversight requires the licensure of such services, that they be under the direction of a certified specialist physician with a Pennsylvania medical license, and that such services meet standards similar to those required of clinical laboratories in Pennsylvania. (Res. 404, H-2004)

- 270.991 Licensure of Mobile LASIK Surgical Centers**
The Society shall work with the Pennsylvania Academy of Ophthalmology in securing either legislation or regulations, as deemed appropriate, giving the Pennsylvania Department of Health the ability to regulate mobile LASIK surgery centers and creating a penalty for anyone who operates such a facility in violation of such legislation or regulation. (Res. 410, H-2003)
- 270.992 Advanced Cardiac Life Support Training for Nurses**
The Society continues to pursue changes to the Health Care Facility (hospital) regulations requiring that nurses providing care in intensive and/or critical care areas of hospitals be pre-trained in Advanced Cardiac Life Support (ACLS). Report 3, Board of Trustees, H-2000)
- 270.993 Quality Health Care Accountability and Protection Act**
The Society continues its efforts to seek refinement and full implementation of the Quality Healthcare Accountability and Protection Act (Act 68) and continues to lobby for added patient and provider safeguards at the state and federal level. (Report 5, Board of Trustees, and Recommendation 6(b) of the President-Elect, H-2000)
- 270.994 Licensing of Physicians Engaged in Practice of Utilization Review**
The Society seeks either legislation or regulation that would require all physicians practicing utilization review of treatment provided in the Commonwealth of Pennsylvania to be licensed to practice medicine in the Commonwealth of Pennsylvania in order to ensure oversight of this form of the practice of medicine. (Res. 16, H-1993)
- 270.995 Provider-Specific Taxes**
The Society opposes any attempt to levy professional taxes on physicians and other health care providers' services, whether to fund specific health care programs or as a general revenue enhancement. (Res. 40, H-1992)

The Society determined to support legislation protecting medical audit information against disclosure. (Res. 15, H-1973)
- 270.996 PA Health Law Desk Reference**
The Society is to make available, at a reasonable cost, a periodically updated desk reference of state and federal health law affecting medical practice. (Res. 59, H-1989)
- 270.997 Immunity for Obeying State Reporting Requirements**
The Society seeks legislation which prohibits litigation against a physician for having abided by state reporting requirements. Language should be added to legislation to prevent out-of-pocket expense to physician for any defense of action to report. (Res. 15, H-1990; retained in part, H-2000)
- 270.998 Equal Taxation for Hospital Clinics**
Citing its pro-competition policy, the Society recommended that clinics and outpatient facilities operated by not-for-profit institutions in an office setting away from the hospital premises be subject to the same local, county, and state taxes as the private practitioner. The Society is directed to seek legislation requiring hospitals and clinics to compete on an equal basis with the exception of voluntary clinics for indigent care. (Res. 23, H-1983; Revised, H-1993; Revised, H-2003)

- 270.999 Physician Referral and Interpretation**
The Society will preserve regulations requiring physician referral and interpretation. (Res. 18, H-1982; revised H-2002)
-

275.000 Licensure and Discipline

- 275.978 Advocacy for Accused Physicians**
PAMED is directed to develop and coordinate resources for physicians to help engage proper legal representation to deal with prosecutors, the medical board, and the NPDB as well as to assist in addressing negative internet exposure related to their case. PAMED is further directed that an active member of PAMED will not be excluded from the full benefits of membership due to license suspension until or unless due process has resulted in a conviction or a final punishment decree for said acts. (Res. 502, H-2018)

- 275.979 DOJ Opinion for Maintenance of Certification (MOC) Competition**
PAMED is directed to publicize the Department of Justice (DOJ) letter dated September 10, 2018 offering guidance on Maintenance of Certification (MOC) on its website and through its publications. PAMED is also directed to strongly encourage organizations such as hospitals, network employers, and insurance companies to recognize multiple qualified board organizations when credentialing physicians. (Res. 409, H-2018)

- 275.980 Address and Petition CMS and Legislators to Allow for a Process of Appeal to Negative Statements and Reports to the National Practitioner Data Bank**
In its Report 5 of 2017, the Board of Trustees recommended that PAMED oppose the use of the National Practitioner Data Bank (NPDB) to manipulate or dissuade physicians from application and participation on medical staffs and provide its members with education on the NPDB and the NPDB's dispute process. The House approved the Board's recommendation that Report 5 be adopted in lieu of 16-408. (Board of Trustees Report 5, H-2017)

- 275.981 Transfer of Jurisdiction Over Required Clinical Skills Exam to LCME- and COCA-Accredited Medical Schools**
The Society shall support the efforts of the American Medical Association, in conjunction with the Federation of State Medical Boards (FSMB), to eliminate the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and the Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) as a requirement for Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school graduates who have passed a school-administered clinical skills examination. The Society shall advocate for medical schools and medical licensure stakeholders to create standards for clinical skills examinations that would be administered at each LCME-accredited and COCA-accredited medical school in lieu of USMLE Step 2 CS and COMLEX Level 2-PE and that would be a substitute prerequisite for future licensure exams. (Res. 205, H-2016)

- 275.982 Fairness for Physicians Cleared of Wrongdoing by Their State Licensing Board**
The Society is directed to seek a remedy for physicians who must repeatedly disclose the fact that they have been the subject of an investigation by their

licensure board due to a complaint which was filed against them, found to be without merit, and closed without action, and shall propose legislation, if necessary, that eliminates a physician's obligation to report complaints which have been filed against him or her and which have been closed without disciplinary action by his or her licensure board after initial review by the Department of State. (Res. 403, H-2016)

275.983 Parity for International Medical Graduates with US Medical Graduates in Years to Graduate Medical Education Requirement for Licensure

The Society adopted a policy supporting parity in the number of years of Graduate Medical Education (GME) training required for International Medical Graduates (IMGs) and United State Medical Graduates (USMGs) to obtain state medical licensure. The Society shall aggressively pursue, including by legislative means, parity in the number of years of GME training requirement for IMGs and USMGs for licensure, and report back the progress in two years. (Res. 204, H-2015)

275.984 Maintenance of Certification (MOC) Program

The Society directed its delegation to the AMA to introduce, as soon as possible, a resolution that accomplishes the following: (1) The AMA develop and disseminate a public statement, with concomitant direct notification to the American Board of Internal Medicine (ABIM), that their current ABIM MOC program has the appearance of being focused too heavily on enhancing ABIM revenues, and fails to provide a meaningful, evidence-based and accurate assessment of clinical skills; (2) the AMA investigate and/or establish alternative pathways for MOC; (3) forward to the AMA the Statement of Principles as defined by the Board's Task Force on Continuous Professional Education; and (4) the AMA report back to the AMA House of Delegates on the progress of these actions at the Annual Meeting of the AMA in June 2015 (A-15). (Res. 202, H-2014)

The Society shall fully support the concept of viable alternatives to MOC; shall adopt as its policy those principles of recertification as articulated in AMA policy "Maintenance of Certification H-275.924"; shall support the activity of the AMA as articulated in AMA policy "Maintenance of Certification and Osteopathic Continuous Certification D-275.954"; shall oppose MOC certification programs administered by the specialty boards of the ABMS or any similar physician-certifying organization which do not appropriately adhere to the principles codified as AMA policy on Maintenance of Certification; and shall oppose the use of MOC status as mandatory criteria for hospital credentialing, medical licensure plan participation, or state medical licensure. (Sub. Res. 504 & 505, H-2016)

275.985 Maintenance of Certification (MOC) Statement of Principles

The Society approves the following Maintenance of Certification (MOC) Statement of Principles:

The Pennsylvania Medical Society is committed to lifelong learning, cognitive expertise, practice quality improvement, and adherence to the highest standards of medical practice.

The Pennsylvania Medical Society supports a process of continuous learning and improvement based on evidence-based guidelines, national standards, and best practices, in combination with customized continuing education.

The Maintenance of Certification (MOC) process should be designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

The Maintenance of Certification (MOC) process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

Board certificates should have lifetime status, with Maintenance of Certification (MOC) used as a tool for continuous improvement.

The Maintenance of Certification (MOC) program should not be associated with hospital privileges, insurance reimbursements or network participation.

The Maintenance of Certification (MOC) program should not be required for Maintenance of Licensure (MOL).

Specialty boards, which develop Maintenance of Certification (MOC) standards, may approve curriculum, but should be independent from entities designing and delivering that curriculum, and should have no financial interest in the process.

A majority of specialty board members who are involved with the Maintenance of Certification (MOC) program should be actively practicing physicians directly engaged in patient care.

Maintenance of Certification (MOC) activities and measurement should be relevant to real world clinical practice.

The Maintenance of Certification (MOC) process should not be cost prohibitive or present barriers to patient care. (Board of Trustees, October 2014; Res. 201 (H-2014))

275.986 Unification of GME Accreditation Standards

That Society shall seek legislation and/or regulation to: 1) drop the licensure requirements for DOs to do at least one AOA approved year; and 2) make the number of required GME years, whether DO or MD, required to get a full and unrestricted license the same. (Res. 402, H-2014)

275.987 Opposition to Maintenance of Licensure (MOL)

The Society opposes any efforts by the Pennsylvania State Board of Medicine to require the Federation of State Medical Boards, Inc. (FSMB) "maintenance of licensure (MOL)" program as a condition of state medical licensure. Res. 204, H-2013)

275.988 Opposition to Maintenance of Certification (MOC)

The Society acknowledges that the certification requirements within the Maintenance of Certification (MOC) process are costly, time intensive, and result in significant disruptions to the availability of physicians for patient care. Further, the Society opposes mandatory MOC as a condition of medical licensure and encourages physicians to strive constantly to improve their care of patients by the means they find most effective. (Res. 203, H-2013)

The Society was directed to petition the AMA to work with the American Board of Medical Specialties (ABMS) to eliminated practice performance assessment modules as currently written. (Report 3, Board of Trustees; H-2014)

The Society directed that a resolution be drafted to be presented at the AMA November Interim Meeting, calling on the AMA to only support recertification processes that meet the 20 existing AMA MOC principles, and that the resolution includes a second resolved calling on the AMA to oppose recertification processes that do not meet the 20 existing AMA MOC principles. The Society shall explore reaching out to the Liaison Committee for Specialty Boards (LCSB), an organization sponsored by ABMS and AMA/CME, and non-ABMS alternatives to board certification, such as the National Board of Physicians and Surgeons (NBPAS). (Report 8, Board of Trustees: Resolution 13-203, H-2015)

275.989 Pennsylvania State Board of Medicine/Department of State – Physician Notification of Complaints

The Society is directed to review with the Pennsylvania Department of State the procedure regarding the handling of complaints against physicians, and specifically include a review of the process by which a decision or decisions are made to notify or not notify the physician and provide an opportunity for response before commencing an investigation and make available its findings on the member pages of the website of the Pennsylvania Medical Society. (Res. 201, H-2010)

275.990 Locum Tenens Physicians

The Society shall work with the staff of the State Board of Medicine to assist that agency in making the licensure process as efficient as possible; will continue its practice of assisting members to secure licenses for locum tenens physicians they wish to bring into the state; and will also continue to provide assistance to Society members attempting to secure managed care credentialing for locum tenens physicians they wish to bring into the state. (Report 8, Board of Trustees, H-2003)

275.991 Truth-in-Government Request to Bureau of Professional and Occupational Affairs

The Society is directed to pursue a Truth-in-government request to the Pennsylvania Department of State, Bureau of Professional and Occupational Affairs (BPOA), calling upon the BPOA to publicly acknowledge its expanded role in disciplining physicians for non-quality of care issues, and to ask the BPOA to plainly identify, on its website, those physicians being disciplined for purposes arising out of assessment enforcement, as opposed to traditional quality of care issues. (Sub. Res. 210, H-2003)

275.992 Medical Practice Act

The Society affirms its support of the requirements for physicians set forth in the Medical Practice Act. (Res. 212, H-2000)

275.993 Definition of Medical Practice

The Society adopted the following definition of medical practice: Medical practice is the application of the healing arts and sciences which result in the physician's ability to exercise the privileges to provide some or all of the health care services that an individual or group of persons may need. This includes the ability to perform comprehensive evaluations including history-taking, physical examinations, ordering and interpreting diagnostic testing, and establishing diagnoses. It also includes the complete range of therapeutic services including counseling, prescription of medications and the performance of invasive and non-invasive procedures, as well as providing rehabilitation, palliative care and preventive care.

The practice of medicine requires a license. The complexity of this discipline requires extensive education, training, and experience as well as a commitment to lifelong learning. Physicians who have successfully completed the required supervised education and training with graded levels of responsibility and documented competence may receive an unrestricted license to practice medicine and surgery. That unrestricted license authorizes physicians to perform the entire range of medical services. Physicians may delegate, to persons qualified by education and training, the performance of specific aspects of those services.

The responsibility generated by the unique relationship between a physician and a patient demands that physicians be held to the highest moral and ethical standards. (Report 28, Board of Trustees, H-1999)

275.994 Practice of Medicine Remain Under State Board of Medicine

The Society adopted the policy that the regulation of the practice of medicine should continue to remain under the supervision of the State Board of Medicine in the Commonwealth of Pennsylvania. (Board of Trustees, March 2000)

275.995 State Licensure of Office Operating Room Facilities

The physicians of the Commonwealth of Pennsylvania support the recommendation to the State Board of Medicine, or legislation, which recognizes the American Association for the Accreditation of Ambulatory Surgery Facilities, the Association for the Accreditation of Ambulatory Health Care Facilities, and the Joint Commission on Accreditation of Healthcare Organizations as being empowered to provide certification “in lieu” of state licensure or Medicare certification in Class B and C facilities intrinsic to a physician’s office practice. (Res. 203, H-1997)

The Society believes that a new category of temporary license is unnecessary at this time and supports licensure for Pennsylvania physicians through the AMA’s National Credentials Verifying Service. (Report D, Board of Trustees, H-1993)

275.996 Provision of Forensic Medical Services

The Society encourages the Pennsylvania State Board of Medicine to adopt a stated policy to scrutinize the provision of forensic medical services by its licensees in the same manner in which the Board scrutinizes the provision of expert medical care by those licensees. (Res. 20, H-1991)

275.997 License Suspension of Impaired Physicians

The Society asserts that successful treatment of patients with the disease alcoholism, or other dependencies, followed by appropriate medical supervision and monitoring on a continuing basis, will allow most individuals to return to meaningful, productive employment and resume full responsibility of their normal job assignment or profession. The Physicians’ Health Programs of The Foundation of the Pennsylvania Medical Society and the Bureau of Professional and Occupational Affairs have developed a constructive working relationship. We believe that disciplinary license actions, when used in combination with rehabilitative programs, should be at the discretion of the Board of Medicine, rather than for fixed duration. (Res. 56, H-1989; Revised, H-1999)

275.998 Discrepancies between Medical and Osteopathic Practice Acts

The Society opposes the discrepancies between the Medical Practice Act and the Osteopathic Practice Act and is committed to work for a uniform licensing law. (Res. 5, H-1989)

Since the adoption of this policy, the Society has favored increasing the years required for osteopathic physicians to receive unrestricted licenses. Moreover, in 1994, the Council on Education and Science advocated combining the two licensing boards, providing one set of rules for all physicians.

The Society recognizes that the Board of Medicine has a responsibility to protect the citizens of Pennsylvania from inadequately trained physicians and, consequently, that a rationale exists for some variation in regulations between graduates of accredited and unaccredited medical schools. However, the Society agreed some action could be taken to make the licensing requirement more uniform.

The Society recommends that graduates of unaccredited medical schools be permitted to receive an unrestricted license after completing two years of residency

if their residency director consents. This would allow the option of requiring the third year only for residents who need additional training. (Report 4, Board of Trustees, H-1994)

275.999 Competency Sole Criteria for Licensing

The Society reiterated its position that the only condition for licensure in the Commonwealth be training and ability to practice medicine. (Address of the President, and Res. 23, H-1988; reaffirmed, Sub. Res. 421, H-1997). The Society shall also, using “in-house” counsel to minimize expense to the Society, file an amicus brief in the current litigation, Hayes, MD v. Ridge, advocating the Society’s position that the sole criterion for licensing is competency, and a physician’s license should not be denied by his/her inability to make payment of malpractice insurance premiums. (Sub. Res. 421, H-1997) The Society reaffirms its dedication to the elimination of the mandatory liability insurance requirement for licensure in the Commonwealth of Pennsylvania. The Society shall work actively to reintroduce House Bill 2417 of 2002 and make the elimination of the mandatory liability insurance requirement a high priority legislative action item for the Society. (Res. 403, H-2004)

280.000 Long-Term Care

280.995 Mandated Unnecessary Care for Group Home Residents

The Society adopted the policy that patients unable to communicate or advocate for themselves be presented to the office or any other place of service only for indicated, beneficial or potentially beneficial care; further, that legislative, statutory and regulatory codes be changed at local, state and federal levels to mandate only nationally recognized, necessary and indicated medical care through working with appropriate authorities, agencies and legislative modalities. The Society’s AMA Delegation is directed to carry this cost-saving measure to the national level to prevent these practices, if they exist, at a national level. (Res. 418, H-2008)

280.996 Long-Term Care Patient Co-Pays

The Society opposes larger portions of reimbursement being shifted from health plans to long-term care patient co-pays. (Res. 315, H-2005)

280.997 Mandatory Offering of Pneumococcal Vaccinations

The Society shall lobby appropriate government authorities to mandate offering pneumococcal vaccinations to all residents of long-term care facilities within the state. (Res. 210, H-2001; revised, H-2011)

280.998 Mandated Laboratory Testing of Nursing Home Patients

The Society shall study the current Pennsylvania regulations mandating laboratory testing of nursing home patients to determine if they are clinically efficacious and/or cost effective and also study the current methods of reimbursement for such tests. (Res. 507, H-1996; reaffirmed, H-2016)

280.999 Nursing Home Residents Remain Patients of Physicians

The Society reaffirms the primary role of physicians in medical care of patients within nursing home settings. (Res. 26, H-1978)

285.000 Managed Care**285.962 Insurance Abuses**

The Society supports the payment of physicians for their time as documented in the patient chart. The Society is directed to create a central hotline whereby physicians can report insurance abuses with the intent of publicizing these abuses to the media. (Res. 301, H-2013)

285.963 Prior Authorization

The Society shall pursue the introduction of prior authorization legislation in the Pennsylvania General Assembly to address patient care issues associated with the prior authorization process. (Res. 404, H-2012)

285.964 Contract Negotiations with Third-Party Payers

Society staff shall continue to work toward reforms in the negotiation of contracts with third-party payers through legislation. (Report 4, Board of Trustees, H-2007)

285.965 Medicare HMO Reviews

The Society shall investigate and request that Medicare HMOs rescind the policy of forcing physician practices to conduct reviews for the purpose of upgrading the coding for services with the Medicare HMOs and help the physician practices across the state to receive appropriate compensation for this work. (Res. 311, H-2005)

285.966 Reimbursement Prior to Completing Credentialing Process

The Society is directed to work through appropriate means, including the American Medical Association, to assure that physicians who begin work prior to being credentialed within a plan may be able to submit claims for work provided while the application is in process. (Res. 311, H-2002)

285.967 Physician Credentialing

The Society shall seek legislation requiring the credentialing process to be completed by the insurance carriers within 45 days of receipt of a completed clean application, or carriers will face a fine; further, that insurers be required to notify applicants of all discrepancies and omissions in their application and supporting documentation with five (5) business days of receipt of such application and expedite consideration of the corrected application upon receipt. The Society shall investigate the feasibility of a statewide credentialing clearinghouse to facilitate the carriers' ability to meet the 45-day requirement. The Society shall develop a checklist for credentialing that can be sent to residency directors in Pennsylvania. (Res. 302, H-2002)

285.968 Model Contract

The Society is directed to continue to diligently meet with the Insurance Commissioner and third-party payers to establish a "Model Participation Contract" for Pennsylvania physicians. The Society shall continue to pursue in conjunction with the Insurance Commissioner remedies to unfair and coercive participation contracting practices. (Res. 304, H-2002)

285.969 Drug Formularies for Patients in Managed Care

The Society seeks legislative and/or regulatory action in the development of MCO drug formulary standards to ensure that prescription drug benefits are not

unreasonably restrictive; do not jeopardize patient safety; and allow drug coverage to be reasonably priced.

The Society shall continue to monitor the ongoing scientific research being conducted on whether increases in drug costs may be justified by decreased costs attributed to other areas of patient care such as diagnostic testing, surgical intervention, and medical intervention.

The Society shall continue to investigate whether “closed” (restrictive) formularies lead to higher health care costs, rather than a decrease in plan costs and, conversely, do “open” formularies lead to overall decreased plan medical delivery expenses.

The Society shall investigate the development of a centralized, Web-based data base, maintained by the Society, which will provide MCO formulary information in a standardized format. It should allow easy physician search capability to each MCO’s formulary requirements and should accommodate a linkage to hand-held computer devices.

The Society shall continue to explore opportunities with MCOs and others to conduct physician and patient education, using unbiased disease-focused clinical information through its Center for Professional Drug Education.

The Society shall work with and encourage the appropriate state agencies to develop a process for commercial MCO formulary review similar to the process established by the DPW for review of HealthChoices Medicaid MCOs.

The Society seeks funding through grants from pharmaceutical companies, MCOs, foundations, etc., for the purpose of pilot testing hand-held computer devices for their applicability in accessing the centralized database created by the Society. Additionally, the pilot test should include a demonstration as to the value of using hand-held computers for the purpose of medical error prevention. (Report 10, Board of Trustees, H-2000)

285.970 Contingent Residency Completion Certificates

The Society seeks, through dialogue with managed care plans, voluntary acceptance of a contingent residency completion certificate as part of a new physician’s application for provider network participation to expedite processing of such application. The Society also seeks regulatory language providing for the submission of a contingency residency completion certificate as a means of expediting new physician applications for managed care plan provider networks. The Society shall work through the American Medical Association and the National Committee for Quality Assurance to address national standards for physician credentialing to reduce undue delay of physician acceptance into managed care plans. (Report 7, Board of Trustees, H-1999)

285.971 National Committee for Quality Assurance Standards and Physician Credentials

The Society shall study the issue of timely physician credentialing by health insurers, determine what actions are necessary, and seek to improve the timeliness of the process. (Res. 306, H-1999)

- 285.972 **Problems with Managed Care Organizations and the Consequences****
The Society shall (1) endeavor through all appropriate means to encourage standardization of practices across Managed Care Organizations (MCOs) with regard to certification and recertification; (2) encourage better access to information concerning benefit structure, billing and reimbursement information so as to improve efficiency and decrease costs; (3) foster guidelines with regard to best practices, rather than engage in a fruitless dialogue with MCOs about medical necessity; and (4) endeavor to insure that MCOs provide patients with more information about their plans, and the procedures required to access appropriate treatment, rather than leaving it totally up to the provider. (Res. 305, H-1999)
- 285.973 **Timeliness of Credentialing by Managed Care Organizations****
The Society shall endeavor, through all appropriate means, to correct the problem of the timeliness of credentialing by communicating with the Managed Care Organizations (MCOs) the nature of the difficulties with regard to credentialing and re-credentialing, and by providing them with suggested solutions such as time limits for processing applications, with resident applications especially expedited, and encouraging a uniform credentialing process across all plans in the interest of greater efficiency for all. Should this approach not be successful, every effort shall be made to introduce legislation to correct the problem. (Res. 303, H-1999)
- 285.974 **Surgical Pathology in Managed Care****
The Society supports the right of clinical specialists who perform biopsies to have access to a panel of qualified surgical pathology specialists in managed care plans. The Society shall pursue, through negotiation with managed care plans, an agreement that assures the plans will allow clinicians in the plan to have access to a panel of qualified surgical pathologists to whom they can refer biopsy specimens or slides for consultation. (Report 28, Board of Trustees, H-1998)
- 285.975 **Third-Party Payer Responsibility to Patients****
The Society continues efforts to fully implement the provisions of managed care legislation (Act 68 of 1998) and continues to pursue legislation to have physicians and other health care providers held harmless for less desirable outcomes resulting from choice of alternative care options resulting from denial of payment decisions of third-party payers. (Report 10, Board of Trustees, H-1998)
- 285.976 **Managed Care Organization Reimbursement Formulas****
The Society continues to pursue legislation requiring the state to review reimbursement levels to ensure adequacy of providers in managed care networks. (Report 12, Board of Trustees, H-1998)
- 285.977 **Admitting Officer/Hospitalist Programs****
The Society adopted the policy that (1) participation in “admitting officer” or “hospitalist” programs developed and implemented by managed care or other health care organizations should be at the voluntary discretion of the patient and the patient’s physician; (2) managed care plan enrollees and prospective enrollees should receive prior notification regarding the implementation and use of admitting officer or hospitalist programs; and (3) hospitalist systems, when initiated by a hospital or managed care organization, should be developed consistent with Society policy on medical staff bylaws and implemented with approval of the organized medical staff to assure that the principles and structure of the autonomous and self-governing medical staff are retained. (Report of Organized Medical Staff Section, H-1998)

- 285.978 Mandatory Use of Hospitalists**
The Society opposes any mandates from hospitals or payers calling for mandatory use of hospitalists. (Report 31, Board of Trustees, H-1998)
- 285.979 “Not for Cause” Termination of Physician Contracts**
The Society is directed to immediately seek legislation to prohibit “not for cause” termination of physician contracts with insurance companies. (Rec. 4 of the President-Elect, H-1997)
- 285.980 Termination Without Cause Contract Provisions**
The Society opposes physician termination without cause provisions in physician contracts and seeks state legislation banning these contract clauses; further, the Society is directed to take this resolution to the AMA. (Res. 323, H-1997)
- 285.981 Primary and Consultative Care/Physician Credentialing**
The Society adopted the policy that physicians who are qualified to perform both primary and consultative care should not be forced, through the credentialing process, to choose only one or the other. (Res. 307 and 309, H-1997)
- 285.982 Utilization Review in Global Contracts**
The Society shall make physician organizations and individual physicians aware that third-party carriers who have retained utilization review and who have shifted financial risk will no longer be at financial risk for services that they authorize, which may result in increased financial risk and liability to physician organizations and individual physicians; further, the Society shall evaluate whether to establish adjustments to these and future contracts to cover potential costs. (Res. 316, H-1997)
- 285.983 Third-Party Carrier Notification of Subscribers**
The Society shall utilize its resources to have third-party carriers inform members of potential limitations on free access to all of their systems’ hospitals and specialists that may result from the assigning of “covered lives” into a particular healthcare system. Further, the Society shall utilize its resources to have third-party carriers identify all healthcare system affiliations of their hospitals, their primary care physicians, and their specialists in any listings of providers to subscribers and potential subscribers. (Res. 315, H-1997)
- 285.984 Assisting Physicians in Obtaining Copies of Their Annual Contracts**
The Society shall apply whatever appropriate resources are required to ensure that physicians are provided with the appropriate copies of their provider agreements or contracts with third-party payers upon request. (Res. 312, H-1997)
- 285.985 Educating Physicians on Coping with the Realities of Care**
The Society shall place greater emphasis on educating physicians and their office staffs about the realities of managed care and risk contracting so they can (1) develop realistic expectations of what physician organizations can accomplish in the Pennsylvania market, and (2) understand what opportunities exist and what physicians must do to capitalize on them. (Board of Trustees, March 1997; title revised, H-2007)
- 285.986 Managed Care Organization Reimbursement Formulas**
The Society shall seek enactment of regulations or legislation to require that health care insurers use severity of illness adjustment factors in addition to age and sex in payment plans that are designed to evaluate utilization of services and provide

financial incentives or penalties. The Society and the Commonwealth shall encourage the design of payment mechanisms to appropriately compensate physicians to take care of severely ill patients and locate in financially disadvantaged communities. (Res. 304, H-1996; reaffirmed, H-2016)

285.987 Managed Care Organization Termination of Participation

Network adequacy has become a major discussion item at the federal and state level. Increased scrutiny has been applied by regulators as evidence shows many provider directories contain incorrect information regarding participating providers. The Society shall address the continued participation of physicians in managed care organizations who are terminated following a change in practice setting. (Res. 306, H-1996; reaffirmed, H-2016)

285.988 Entities Representing Themselves as Multi-State Networks

The Society shall cooperate with the AMA in the study of entities which represent themselves as national networks of providers and assist in the distribution of this information to the membership in a timely fashion. (Sub. Res. 303, H-1995)

285.989 Policies Excluding Part-Time Physicians

The Society shall work strongly toward encouraging managed care organizations (and the Commonwealth of Pennsylvania) to remove the full-time 20 hour per week direct patient care requirement, especially for academic physicians who practice part-time in research, part-time in teaching, or in administration, so that these physicians, even though they do not meet the 20 hour per week requirements will, if they meet other requirements (i.e., on call, 24-hour continuous-care coverage, etc.) be able to join managed care organizations and be fully credentialed. (Res. 306, H-1995)

285.990 Qualifications/Credentials of Physicians Involved in Managed Care

The Society adopts the policy that selective contracting decisions made by any health delivery or financing system should be based on an evaluation of multiple criteria related to professional competency, quality of care, and the appropriateness by which medical services are provided. In general, no single criterion should provide the sole basis for selecting, retaining, or excluding a physician from a health delivery or financing system. (Res. 304, H-1995)

285.991 “Most Favored Nation”

The Society supports efforts to preclude dominant third-party payers from forcing physicians and other health care providers to accord them “most favored nation” status -- i.e., offer the payer their lowest price. (Report 25, Board of Trustees, H-1995)

285.992 Any Willing Provider Provisions and Laws

The Society:

- (1) acknowledges that health care plans or networks may develop and use criteria to determine the number, geographic distribution, and specialties of physicians needed;
- (2) will advocate strongly that managed care organizations and third-party payers be required to disclose to physicians applying to the plan the selection criteria used to select, retain, or exclude a physician from a managed care plan, including the criteria used to determine the number, geographic distribution, and specialties of physicians needed;
- (3) will advocate strongly that those health care plans or networks that use criteria to determine the number, geographic distribution, and specialties of physicians

- needed be required to report to the public, on a regular basis, the impact that the use of such criteria has on the quality, access, cost, and choice of health care services provided to patients enrolled in such plans or networks;
- (4) will advocate in those cases in which economic issues may be used for consideration of sanction or dismissal, the physician participating in the plan should have the right to receive profile information and education, in a due process manner, before action of any kind is taken;
 - (5) opposes any federal effort to preempt state “any willing provider” laws; and
 - (6) will continue to advocate its “Legislative Specifications for Federal Regulation of Managed Care Plans.” (Report 28, Board of Trustees, H-1994)

The Society believes (1) managed care networks should not be permitted to require physicians to have hospital admitting privileges in those areas of the state where it is impractical for the physician to maintain such privileges or where such a requirement could aggravate a physician shortage; and (2) managed care networks should be encouraged to waive board-certification requirements in those areas of the state where such a requirement could aggravate a physician shortage.

The Society is directed to seek legislatively-mandated safeguards, including the protections called for in the above policies, to protect providers from arbitrary exclusion from managed care networks. The Society reiterates its position that individuals must be free to choose from a full range of health care coverage plans and should not be forced into a plan that limits their choice of provider or misled into selecting such a plan. (Report 28, Board of Trustees, H-1994)

285.993

Approaches to Increase Payer Accountability

The Society supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

- (1) Disclosure Requirements: The Society supports the development of additional draft state and federal legislation to require disclosure in a standard format by health benefit plans to prospective enrollees of information on: (a) coverage provisions, benefits and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician’s fiduciary responsibility to his or her patient; and (d) loss ratio.
- (2) Conduct of Review: The Society supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity of

appropriateness of services or site of services be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within two business days to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex, and time consuming than the completion of standard health insurance claims forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

- (3) **Accountability:** The Society believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above. (Sub. Res. 517, H-1994)

285.994**Qualification Guidelines for Managed Care Medical Directors**

The Society has adopted the following "Guidelines for Qualifications of Medical Directors of Managed Care Organizations":

To the greatest extent possible, physicians who are employed as medical directors of managed care organizations shall:

- (1) Hold an unlimited current license to practice medicine in one of the states served by the managed care organization, and where that Medical Director will be making clinical decisions or be involved in peer review that Medical Director should have a current license in each applicable state;
- (2) meet credentialing requirements equivalent to those met by plan providers;
- (3) be familiar with local medical practices and standards in the plan's service area;
- (4) be knowledgeable concerning the applicable accreditation or "program approval" standards for preferred provider organizations and health maintenance organizations;
- (5) possess good interpersonal and communications skills;
- (6) demonstrate knowledge of risk management standards;
- (7) be experienced in and capable of overseeing the commonly used processes and techniques of peer review, quality assurance, and utilization management;
- (8) demonstrate knowledge of due process procedures for resolving issues between the participating physicians and the health plan administration, including those related to medical decision-making and utilization review;
- (9) be able to establish fair and effective grievance resolution mechanisms for enrollees;
- (10) be able to review, advise, and take action on questionable hospital admissions, medically unnecessary days, and all other medical care cost issues; and
- (11) be willing to interact with physicians on denied authorizations.

The Society strongly encourages managed care organizations and payer groups to utilize these guidelines in their recruitment and retention of medical directors. (Sub. Res. 510, H-1994)

285.995

Managed Care

(1) Those health delivery or financing systems that contract with selected physicians to furnish care should utilize selection criteria based primarily on professional competence and quality of care. Any economic criteria used in such selective contracting should have a demonstrated positive relationship to the quality and appropriateness of care and to professional competency; and (2) health plans that contract with selected providers should have an established mechanism by which any provider willing to abide by terms of the plan contract could appeal a decision to deny the provider's application for participation in the plan. (Report 28, Board of Trustees, H-1994)

285.996

Managed Care

1. INTRODUCTION: The needs of patients are best served by free market competition and free choice by physicians and patients among alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing.
2. DEFINITION: "Managed care" is defined as: systems of techniques generally used by third-party payers or their agents to affect access to and control payment for health care services.
3. TECHNIQUES: Managed care techniques include: (a) Prior, concurrent, and retrospective review of the medical necessity and appropriateness of services and/or site of services; (b) financial incentives or disincentives related to the use of specific providers, services, or service sites; (c) controlled access to and coordination of services by a case manager; (d) payer efforts to identify treatment alternatives and modify benefit restrictions for high-cost patients (high cost case management).
4. FINANCIAL INCENTIVES AND DISINCENTIVES: Any financial arrangements that may tend to limit the services offered to patients, or contractual provisions that may restrict referral or treatment options, should be fully disclosed to prospective enrollees by plans utilizing such arrangements.
Physicians must disclose any financial inducements or contractual agreements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or restrict referral or treatment options. Physicians may satisfy their disclosure obligations by assuring that the managed care plan makes adequate disclosure to patients enrolled in the plan. Physicians must also inform their patients of medically appropriate treatment options regardless of their cost of the extent of their coverage.
Physicians should have the right to enter into whatever contractual arrangements with health care systems they deem desirable and necessary but should be aware of the potential for some types of systems to create conflicts of interest because of financial incentives to withhold medically indicated services. Physicians must not allow such financial incentives to influence their judgment of appropriate therapeutic alternatives to deny their patients access to appropriate services based on such inducements.
Physician payments that provide an incentive to limit the utilization of services should not link financial rewards with individual treatment decisions over periods of time insufficient to identify patterns of care or expose the physician to excessive financial risk for services provided by physicians or institutions to whom he or she refers patients for diagnosis or treatment. When risk-sharing arrangements are relied upon to deter excess utilization, physician incentive payments should be based on performance of groups of physicians rather than individual physicians and should not be based on performance over short periods of time.

Alternative private health benefit plans, with different schedules of deductibles, coinsurance and premiums, should be available to enrollees so that they are aware of the financial trade-offs associated with different plans. Both private and public third-party payment systems should use deductibles and coinsurance as financial incentives for health care recipients to use health care resources in an appropriate manner. However, cost-sharing should not result in an undue financial burden for the health care recipient and should not act to prevent access to needed care.

Physicians, other health professionals, and third-party payers through their reimbursement policies, should continue to encourage use of the least expensive care setting in which medical and surgical services can be provided safely and effectively with no detriment to quality.

5. **CASE MANAGEMENT:** Health plans using the preferred provider concept should not use coverage arrangements which impair the continuity of a patient's care across different treatment settings.

With the increased specialization of modern health care, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by professional preparation to assume this leadership role.

The primary goal of high-cost case management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care.

Any health plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations. (Res. 522, H-1994)

6. **UTILIZATION REVIEW:** The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed.

A physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeal process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has the appropriate expertise and experience in the field.

A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions.

All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of

coverage for the former. The information disclosed should include the proportion of plain income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan.

All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient.

When inordinate amounts of time or effort are involved in providing case management services required by a third-party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "most costly, complex, and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage."

Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollees at the time services requiring prior authorization are recommended by the physicians.

In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the Society strongly opposes the use of this process. (Sub. Res. 513, H-1994)

285.997 Sufficient Opinions

All managed care programs must offer reimbursement for acquisition of sufficient opinions necessary to reach a consensus if options acquired regarding the management of a given issue differ substantially. (Res. 509, H-1994)

285.998 Vertical Divestiture in the Health Care System

It is the policy of the Society to:

- (1) continue to oppose organizational structures that may lead to non-physician control of medical decision-making; and
- (2) hospital-physician business arrangements must be based on mutual respect and shared incentives; hospital programs should be developed that provide medical staff physicians with incentives to render high quality medical care in an effective and efficient manner and leave physicians in control of the clinical aspects of that care. (Report 12, Board of Trustees, H-1994; revised, H-2014)

285.999 Medicaid Managed Care

The Society endorses a primary care management system on a regional basis utilizing the Lancaster Community Health Plan Pilot Project as a model and

encourages the formation of regionalized care networks to ultimately privatize the Medicaid system. (Res. 17, H-1993)

290.000 Medicaid**290.986 Medicaid Physician Reimbursement for Translation and Interpretation Services**

The Pennsylvania Medical Society (PAMED) shall work to obtain state Medicaid funding for medical interpretive services and shall urge the Pennsylvania General Assembly to pass legislation that installs a system of reimbursement for interpretation and translation services accrued during medical encounters. (Res. 305, H-2017)

290.987 Improve Delivery of Peripheral Arterial Disease Care

The Society urges the Pennsylvania Department of Human Services to cover and reimburse for in-office percutaneous peripheral arterial disease (PAD) therapies. (Res. 301, H-2015)

290.988 Reimbursement for Observation Care for Pennsylvania Medicaid Patients

The Society advocates regulatory action that the Pennsylvania Department of Public Welfare provide for reimbursement to physicians for observation care provided to Medicaid patients in the hospital setting. (Res. 302, H-2010)

290.989 Provision of Free or Low-Cost Care

The Society supports the concept of physician participation at facilities or in care models designed to provide free or low-cost care to the uninsured and underinsured and will work to encourage physician leadership and volunteerism in such models within local communities. (Board of Trustees, May 2009)

290.990 Medical Assistance Compensation

The Society shall request from the Department of Public Welfare and Medicaid HMO plans that the fee schedule for Medical Assistance patients be appropriately increased to adequately cover physicians' costs. (Res. 304, H-2005)

290.991 Physician Reimbursement

The Society urges the Pennsylvania Secretary of Welfare to demand increased physician reimbursement from the Medicaid HMO carriers; further, the Society urges the Department of Public Welfare to increase physician reimbursement for fee-for-service Medicaid patients. (Res. 302, H-2004)

290.992 Access to Care for Medical/Surgical Subspecialty

The Society shall seek requirements that Medical Assistance managed care plans retain complete credentialed active specialty panels accessible within 30 minutes to an urban setting or 60 minutes to a rural setting. (Res. 310, H-2002)

290.993 Adequate Reimbursement for Cervical Cancer Screening

The Society calls upon the state to provide adequate reimbursement through its current Medical Assistance programs for cervical cancer screening, consistent with newly established national standards and evolving local and national standards of care. In order to achieve adequate reimbursement, adequate reimbursement must be provided for currently underfunded liquid-based Pap tests; likewise, the state

must begin to provide reimbursement, at an adequate level, for high-risk HPV typing. (Res. 208, H-2002)

290.994 Reimbursement for High-Risk Deliveries

The Society is directed to ask the Pennsylvania Department of Welfare to re-evaluate its reimbursement policy concerning the presence in the delivery room of qualified medical persons trained in neonatal resuscitation at high-risk deliveries. (Res. 303, H-2000)

290.995 Private Sector Administration of Medicaid

The Society determined to develop contingency plans for the private sector administration of Medicaid, which could be implemented without delay, should the present and future Administration's approach to the solution of the Medicaid problem fail. (Resolution 30, H-1981)

290.996 Parity Between Outpatient Departments and Physicians' Offices

The Society urges the Department of Public Welfare to make reimbursement for outpatient care equal between practitioners and hospital outpatient departments. Further, outpatient services, regardless of where rendered, should be reasonably reimbursed. (Res. 4, H-1976; reaffirmed, H-2016)

290.997 Low Physician Fee Schedule Deters Physician Participation

The Society determined to take all available steps to remedy this problem as soon as possible. Although most of Medicaid is now delivered through managed care where fee schedules are negotiable, the starting point is generally the fee-for-service fee schedule. (Res. 22, H-1976; revised, H-2006; reaffirmed, H-2016)

290.998 Early Periodic Screening Diagnosis and Treatment Program

The Society supports the Pennsylvania Chapter of the American Academy of Pediatrics in advocating for:

1. continuity of care in the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT);
2. upgrading of the standard of care covered by the EPSDT program to the current minimum guidelines for routine health supervision of the American Academy of Pediatrics; and
3. re-establishing the EPSDT Technical Advisory Committee as a subcommittee of the Medical Assistance Advisory Committee to provide ongoing input on ways to improve the utilization and effectiveness of the EPSDT program. (Res. 19, H-1987)

290.999 Copayment Plan

The Society urged the Department of Public Welfare to cease punitive actions against physicians who fail to bill and collect the copayment fee. (Res. 19, H-1984)

295.000 Medical Education

295.993 Med School Sexual Harassment Awareness

PAMED is directed to encourage medical schools to work with students to assess the effectiveness of their existing training resources to recognize and respond to sexual harassment. (Res. 213, H-2018)

295.994 Accelerated Primary Care Training Programs
PAMED shall recognize the implementation of combined 6-year medical school-residency accelerated primary care (i.e., family, internal, and pediatric medicine) programs as one possible pathway to tackle the shortage of primary care physicians, and provide pre-clinical education focused on primary care mentorship and patient interaction to produce more prepared primary care physicians. (Res. 209, H-2018)

295.995 Education of Pennsylvania Physicians, Fellows, Residents, and Students to the Legislative Processes of Pennsylvania and How to Participate Therein
The Society is called on to establish a readily available multimedia presentation educating Pennsylvania physicians on the legislative process. When a bill is introduced that may impact Pennsylvania physicians, PAMED communicates this with members via several communications channels, such as the all-member email, mobile app, social media, blogs, etc. Regular communications walk Pennsylvania physicians through the bill's movement in the Pennsylvania General Assembly.

Part of educating physicians on the legislative process is also increasing awareness of PAMED's advocacy efforts. This has included:

- Quick Consult documents on new laws and programs
- Mobile app launched in May 2016
- New print publication ("Physician Advocate") launched in May 2016
- Media call-ins
- Voter Voice calls to action
- New customizable website launched in April 2016
- Annual Advocacy Day

(Report 5, Board of Trustees, H-2016)

295.996 Clearly Articulated Protocol for Sleep Facilities and/or Safe Transportation in All ACGME/AOA-Approved Residencies
The Society advocates that all physician residency programs in Pennsylvania offer the option of safe transportation home, as well as sleep facilities in their institution, for residents who may be too fatigued to safely return home after an overnight shift. The Society shall ask all physician residency programs in Pennsylvania to create and make publicly available via the internet and in internal literature, such as resident physician program handbooks, a clearly articulated protocol for the use of their sleep facilities and transportation services for residents who have overnight shifts. (Res. 207, H-2015)

295.997 Availability of CME at Community Hospitals
The Society directed its AMA Delegation to ask the AMA to petition the Accreditation Council for Continuing Medical Education (ACCME) to modify its guidelines to allow community hospitals to provide accredited CME activities without any financial burden. (Res. 501, H-2012)

295.998 Maintaining Resident Education and Training
The Society encourages all residency training programs in Pennsylvania that must reduce the number of hours that residents work per week, due to new Accreditation Council on Graduate Medical Education (ACGME) standards, to maintain the current total number of hours per week residents spend in didactic educational activities, including training seminars, grand rounds, and conferences. (Res. 209, H-2002)

- 295.999 Health Care Coverage to All Medical Professionals-in-Training**
The Society supports health care coverage to all medical professionals-in-training including medical students, nursing students, allied health care students, and residents. (Report E, Board of Trustees, H-1991)
-

305.000 Medical Education: Financing and Support

- 305.995 State Funding of Medical Education and Training**
The Society is directed to lobby the Pennsylvania state government to provide more funds to support medical education and training in Pennsylvania. (Res. 207, H-2002)

- 305.996 Support for Financial Aid**
The Society actively pursues the continuation of adequate funding, on the federal and state level, of low interest loans and scholarship programs to financially needy students enrolled in Pennsylvania medical schools. (Res. 31, H-1982)

- 305.997 State Legislature Financial Support**
The Society is directed to lobby the state legislature to keep money available for medical education, including low market rate interest loans, service contingent loans, and extended deferrals on loan principal through graduate medical education training; further, that deferment of student loans be extended for three additional years for those medical students who suffer economic hardship, are disabled, or are in school. The Society also vows to continue to support the mission of the Foundation. (Report C, Board of Trustees, H-1986; Res. 42, H-1992; revised, H-2010)

- 305.998 Loan Forgiveness**
The Society continues to support legislation providing a program of loan forgiveness to medical school students who establish necessary practices in underserved areas of the state. The amount of forgiveness is to be directly proportional to the duration of service. (Res. 40, H-1979)

- 305.999 Augment Student Loan Program**
The Society's Board of Trustees is instructed to study the feasibility of augmenting the student loan program through The Educational and Scientific Trust in response to the proportion of rising costs of medical school tuition. (Res. 84, H-1990)
-

310.000 Medical Education: Graduate

- 310.996 Parity for International Medical Graduates**
The Society adopted a policy supporting parity in the number of years of Graduate Medical Education (GME) training required for International Medical Graduates (IMGs) and U.S. Medical Graduates (USMGs) to obtain state medical licensure. (Res. 203, H-2006; reaffirmed, H-2016)

- 310.997 National Residency Match Program Class-Action Lawsuit**
The Society adopted a stance against the recently submitted class-action lawsuit against the National Residency Match Program (NRMP) and several teaching hospitals on grounds that the NRMP violates the nation's antitrust laws in maximizing resident work hours and minimizing resident salaries. The Society shall

work with other organizations, such as the American Medical Association, to educate its membership regarding the basis for the National Residency Match Program lawsuit and disperse information that clearly explains the reasoning behind this position. (Res. 211, H-2003)

310.998 Accreditation of Graduate Medical Education Programs

(1) The Society believes that (a) accreditation and certification programs in graduate medical education should be designed and operated to objectively evaluate the educational quality and content of such programs and to assure a high level of professional training, achievement, and competence; (b) accreditation and certification programs in graduate medical education should not be administered as a means of regulating or restricting the number of physicians entering any specialty or field of medical practice; and (c) qualified physicians who possess the essential prerequisites are entitled to compete for training and subsequently to practice in the specialty or type of practice of their choice upon successful completion of their training. (2) The Society opposes use of the accreditation and certification process as a means of controlling the number of physicians in any specialty or field of medical practice. (Report 3, Board of Trustees, H-1995)

310.999 Resident Physician Working Hours

The Society adopts the AMA principles on residents' working hours. The Society also supports the principle of the specialty specific solution to the length of residents' working hours, consecutive working days, and accompanying supervision, sufficiently flexible to maintain current program uniqueness. The Society supports the principle of intensity of service rendered. The Society supports the principle of minimal graduate education program disruption. The Society opposes the institution of restrictions on graduate medical education by governmental regulation or legislation and specifically opposes the application of restrictions prior to the completion of studies which indicate how to optimize the allocation of resident physician resources to maintain the highest quality of patient care. The Society also supports the principle of adequate and fair compensation for resident services. The Society is determined to monitor this issue through the Board of Trustees. (Res. 49, H-1987)

315.000 Medical Records

315.996 Mandatory Acceptance of Electronic Medical Record Hold Harmless and Indemnification Clauses

The Society shall seek legislative remedies to remove fully from the user physician the burden of responsibility for Electronic Medical Records (EMR) and Health Information Technology (HIT) software malfunction and EMR and HIT application design shortcomings. The Society shall also seek legal determination that signed hold harmless and indemnification clauses are neither legally enforceable nor legally binding on user physicians of EMRs and HITs. (Res. 403, H-2010)

315.997 Secure Access to Medical Records of Veteran's Administration and Military Service-Related Patients

The Society is directed to request the AMA to actively lobby the Veteran's Administration (VA) and Tricare health system to provide secure access to medical records of VA and military service-related patients. (Res. 204, H-2009)

315.998 Electronic Medical Records

The Society continues to study VistA-Office, as well as other Electronic Medical Records (EMR) systems. The Society continues to advocate for EMR standards and promote interoperability, which would allow hospitals, physicians and other providers using diverse EMR systems to exchange health information seamlessly. (Report 3, Board of Trustees, H-2005)

315.999 Limiting Access to Medical Records

The Society is directed to pursue state legislation and regulation which denies insurers random access to patient records; requires that requests for information and the completion of forms be delineated and case specific; allows a summary of pertinent information relative to any inquiry into a patient's medical record to be provided in lieu of a full copy of the records, except in instances of litigation, where the records would be discoverable; and provides proper compensation for the time and skill spent by physicians preparing and completing such forms or summaries. (Sub. Res. 402, H-1994; revised, H-2014)

320.000 Medical Review

320.997 Independent Review of Third-party Payers

The Society is directed to take the necessary actions to have the Insurance Commissioner develop regulations and/or the Pennsylvania legislature to pass legislation which will establish an independent review of third-party payers' adverse decisions (which physicians, hospitals, or patients may access and the results of which will be binding on all parties.) (Res. 508, H-1994)

320.998 Second Opinions

The Society opposes all second opinion programs that have as a basis anything other than medical necessity or patient request; when such medical necessity exists, the insurance carrier should be responsible for the payment for the second opinion. (Res. 49, H-1993)

320.999 Physician Oversight

The Society is directed to work with third-party payers to assure that prior to patient notification of claim rejection based on medical necessity, the affected practitioner be contacted by a physician reviewer. Suggested legislative language to implement the resolved is as follows: "A utilization review organization shall not render an adverse initial determination unless the peer reviewer making the determination on behalf of the organization has notified the health care provider and provided the provider with the opportunity to submit additional information and to speak with the reviewer via telephone or at a location in the Commonwealth of Pennsylvania reasonably accessible to the provider, at a reasonable time." (Res. 46, H-1993)

330.000 Medicare

330.992 Defining Medicare Annual Wellness Visits

The Society's AMA Delegation was asked to consider taking a resolution to the AMA at the next feasible opportunity on the issue of Medicare annual wellness visits being defined as provided by physicians or members of a community-based,

physician-led team that will provide continuity of care to those patients. (Res. 202, H-2015)

330.993 Medicare Available for Purchase

To best serve the needs of our members and our patients, The Society shall remain informed about the discussions which are occurring at the national level and within Pennsylvania to extend insurance options to more citizens. This does not preclude support for the concept of Medicare as a public option, and that might well be one of the options that evolve, but there will certainly be many options that emerge and will be debated. PAMED shall continue to work with the AMA as it closely monitors the national health care debate. Within Pennsylvania, the Society shall continue to be involved in the development of Pennsylvania's Health Insurance Exchange, as research and planning efforts continue by the Corbett Administration to pursue a state-based Exchange. Board Report 3 was distributed to all PAMED members, with emphasis on the results from the Member Opinion Poll of April 2012 that 56% of respondents (a majority) support "making Medicare available for purchase." (Report 3, Board of Trustees, H-2012)

330.994 Time Limits for Recovery Audit Contractor (RAC) Reviews

The Society shall petition the Centers for Medicare and Medicaid Services (CMS) to limit Recovery Audit Contractor (RAC) reviews to less than one year from payment of claims. (Res. 308, H-2012)

330.995 Fair Practice in the Medicare Audit Process

The Society, in conjunction with other interested parties, supports the enactment of federal legislation that requires fairness in the practice of conducting physicians' Medicare post-payment audits. This would include the following: (1) requirement for such audits to be reviewed by a physician board certified within the same specialty prior to any requirement for repayment by the audited physician; (2) requirement for the repayment to be placed in escrow until the appeals process is complete; (3) restrictions on incentives for these contracted government auditors; (4) a mechanism for recovery of legal fees incurred for unsuccessful audits; and (5) full disclosure of contract terms with audit contractors. The AMA Delegation is directed to take this issue to the AMA. (Res. 401, H-2009)

330.996 Documentation Guidelines for E&M Services

The Society reaffirms its position with regard to the introduction of new E&M code guidelines and adopts as policy the contents of AMA Substitute Resolution 801 (A-98): The Society continues to vigorously pursue, in all appropriate manners, the following activities and principles with respect to the development and implementation of documentation guidelines for evaluation and management services: (1) the Society, in cooperation with the AMA, continues to work through the CPT Editorial Panel and with HCFA to develop simplified E&M guidelines that are clinically relevant, realistic and practical and do not require either excessive physician time or documentation in excess of that necessary for good patient care; (2) physicians' medical record documentation should be sufficient for a peer physician to determine whether services have been accurately reported and that payments were made for medically necessary and appropriate services; (3) consistency with simplified E&M Documentation Guidelines should provide a "safe harbor" for physicians whose E&M services are selected for review, but such review should involve peer physicians who are able to consider all pertinent information that would help determine that the level of service reported was correct; (4) support for adequate testing of revised guidelines through pilot tests that are scientifically valid and include a representative sample of all types of practice settings and

geographic regions. The pilot studies should include issues such as cost of compliance, patient and physician satisfaction, effect of a peer review model, whether patient care is improved and whether medical care costs increased or decreased. Organized medicine should be involved in the design, implementation and evaluation of the pilot programs and that physicians participating in the pilot be granted immunity from Medicare sanctions and penalties; and (5) the Society opposes any documentation system that requires quantitative formulas or assigns numeric values to elements in the medical record to qualify as clinically appropriate medical recordkeeping.

The Society directs its delegation to the AMA to continue to use all appropriate means to oppose any change in AMA position under pressure from HCFA that deviates from the nine principles of Substitute Resolution 801 (A-98), especially as it pertains to items #3 and #9. (Res. 306, H-1998)

330.997 Medicare Pre-Payment and Post-Payment Audits

The Society reaffirms its position with regard to the introduction of new E&M Code Guidelines and adopts as policy the contents of AMA Substitute Resolution 801 (A-98): Society policy is that with respect to pre-payment and post-payment audits by the Medicare program, the following principles guide Society advocacy efforts: (1) The confidential medical record should be preserved as an instrument of clinical care, with strong confidentiality protections, and we oppose its use as an accounting document; (2) CMS should discontinue random pre-payment audits of E&M services; (3) in lieu of pre-payment audits, CMS should use focused medical review of outliers based on reviews of patterns of services, using an independent medical peer review process, where physicians practicing in the same specialty review their peers; (4) no financial or legal penalties should be assessed based on one level of disagreement in E&M code assignment; and (5) CMS must stop the practice of requiring physicians to repay alleged Medicare overpayments before an actual appeal is rejected or a final administrative decision or court order is rendered. Legislative relief will be sought if advocacy with CMS is not successful in this regard. (Res. 306, H-1998)

330.998 Reimbursement for Concurrent Care

The Society believes that concurrent care provided by a physician, as requested by the attending physician, should be reimbursed when medically necessary. The Society is directed to (1) interact with HCFA to obtain a clear definition of concurrent care and help that organization in the development of appropriate interspecialty and intraspecialty concurrent care guidelines; (2) urge HCFA to direct its Medicare carriers to follow this nationally uniform reimbursement definition for concurrent care and that the interpretation of concurrent care is not left to the local carrier; (3) pursue actions to assure that reimbursement for providing daily care is rendered to the attending physician; and (4) refer this issue to the AMA. (Sub. Res. 43, H-1992)

330.999 Physicians Remain Patient Advocates

The Society urges physicians to hold foremost the interests of their patients in receiving benefits made available to them under the medical care program enacted into law (Medicare); the Society also determined that state medical societies and the AMA should properly provide such advice and assistance to government agencies and to legislative bodies as may be useful in the shaping of rules and regulations under existing legislation and in the shaping of such proposed legislation as will insure the best interests of the public and the medical profession. (Res. 9, H-1965)

335.000 Medicare: Carrier Review**335.998 Medicare and Insurer Codes**

The Society is directed to make a concerted effort to publicly expose the inappropriate and inaccurate positions taken by insurers on coding and provide a strong ombudsman support for any provider who may be economically sanctioned by insurer's misinterpretation of codes. (Res. 34, H-1993; Revised, H-2003)

335.999 Centers for Medicare and Medicaid Services Oversight of Carriers

The Society should seek to ensure practicing physician representation in policymaking by having the presence of physicians at the Medicare Carrier Medical Directors meetings. The Society should request the Centers for Medicare and Medicaid Services to disseminate to the medical community all of the recommendations arising from the Medicare Carrier Medical Directors Committee meetings prior to their adoption, implementation, and/or publication in the FEDERAL REGISTER. (Res. 39, H-1993; Revised, H-2003; Revised, H-2013)

340.000 Medicare: PRO

345.000 Mental Health**345.992 Psychiatric Bed Shortages within Emergency Departments**

The Society endorses the development of a voluntary shared bed tracking system for behavioral health and detoxification beds across the Commonwealth. The Society is directed to work with the Pennsylvania Psychiatric Society (PaPS) and the Pennsylvania Chapter, American College of Emergency Physicians (PACEP) to secure stakeholder commitment, including the Department of Health (DOH), the Hospital & Healthsystem Association of Pennsylvania (HAP) and others in developing a real-time voluntary reporting system of available psychiatric and substance use detoxification beds by region. (Res. 205, H-2013)

345.993 Improving Mental Health Services in Primary Care

The Society shall facilitate meetings with the Department of Public Welfare and its Medical Assistance behavioral health insurers, major Pennsylvania health insurers/managed care organizations, concerned specialty societies and other stakeholders to discuss the American Academy of Pediatrics/American Academy of Child & Adolescent Psychiatry (AAP/AACAP) recommendations as contained in the white paper of the American Academy of Pediatrics (AAP) and the American Academy of Child and Adolescent Psychiatry (AACAP), in their joint position paper, "Improving Mental Health Services in Primary Care" Pediatrics 2009, 123, 1248-1251 and work toward the adoption of these recommendations to apply to all physicians providing mental health care to children and adolescents. Information regarding the implementation of these administrative changes will be provided to Society members. (Res. 306, H-2009)

345.994 Psychiatric Illness Health Coverage

The Society shall convene meetings with all Pennsylvania health insurers to ensure that psychiatric physician payment is equivalent to all other physician payment for each CPT code, especially E&M codes; that any physician providing evaluation and/or treatment for a mental health diagnosis receive equivalent payment for each

CPT code, especially E&M codes. The Society shall also meet with the Pennsylvania Insurance Commissioner to investigate the legality of paying psychiatric physicians less than other physicians for the same CPT codes. The Society shall seek legislation if discussions with insurers are unsuccessful to accomplish these goals. (Res. 306, H-2008)

345.995 Health Insurance Coverage of Psychiatric Illness

The Society (1) reaffirms its support for the provision of benefits for emotional and mental illness under all governmental and private insurance programs which are equivalent in scope and duration to those benefits provided for other illnesses; (2) reaffirms its support for the continued expansion and improvement of peer review of the quality, necessity, and appropriateness of psychiatric services, and encourages all third-party payers to work with and to utilize the resources of appropriate medical specialty groups in implementing such review; (3) supports development of model legislation for use by states to require all insurance companies that offer either group or individual coverage of hospital, medical, and surgical services to make available for purchase and affirmatively offer coverage of psychiatric services comparable with the coverage provided for other illnesses in their standard group and individual policies; and (4) supports legislation designed to expand psychiatric benefits provided under publicly financed programs of health care to a level comparable with those provided for other illnesses. (Sub. Res. 508, H-1995)

345.996 Physician Staff of State Hospitals

The Society advocates increases in the salary levels of physicians working in the state's general and mental hospitals to make them competitive with those of other states and other programs within the state. (Res. 36, H-1980)

345.997 Physician Responsibility for Psychiatric Treatment

All patients entering the mental health system (both public and private) should be evaluated as soon as practical by a physician trained in the specialty of psychiatry. The physician evaluation is to be used in the development of a diagnosis and an individualized plan of treatment. (Res. 39, H-1980)

345.998 Physician Director of Psychiatric Treatment Team

The Society seeks to amend Act 143 (Mental Health Procedures Act) to require that a physician be the head of the psychiatric treatment team and have responsibility for decisions involving medically necessary treatment based on an individualized treatment plan. (Res. 37, H-1980)

345.999 Director of Psychiatric Services in General Hospitals

The Society supports the principle that a physician trained in the specialty of psychiatry be the director of the psychiatric department/service of any hospital providing such services. (Res. 19, H-1980)

350.000 Minorities

350.995 Standardization of Refugee Health Care

The Society recognizes the unique health needs of refugees; encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees; and supports extending beyond eight months the period during which new refugees are eligible for Medicaid coverage under the Refugee Medical Assistance Program. (Res. 208, H-2009)

350.996**Statement of Principles for Cultural Competency**

To continue caring for an increasingly diverse patient population, physicians and other health care providers must provide services that are compassionate, of high quality, and sensitive to the cultural background of patients. Several organizations, including the American Medical Association (H-295.897), have adopted strategies to advance the concept of cultural competency and guide Members providing services to patients of diverse backgrounds.

In March of 2001, the U.S. Department of Health and Human Services Office of Minority Health issued the document "National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)." These standards, which include recommendations as well as mandates, have become an increasingly important reference point for discussions related to cultural competency and health disparities. Organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reference the CLAS Standards in creating their own guidelines.

The Pennsylvania Medical Society's Task Force on Cultural Competency and Medical Diversity reviewed the CLAS document and supports the intent of the standards. However, the CLAS Standards are primarily directed at health care organizations, not individual providers. The following Statement of Principles for Cultural Competency incorporates the general themes of the CLAS Standards and is meant as a guide for individual physicians as well as physician organizations.

Culturally Competent Care

1. Medical practices and other health care organizations should provide care to all patients, regardless of race, ethnicity, religion, gender, age, or sexual preference, which is effective, understandable, respectful, and sensitive to patients' cultural beliefs and practices.
2. Medical practices and other health care organizations should encourage community members of diverse backgrounds to pursue health care careers. These organizations should consider the demographic characteristics of the service area in recruitment and promotion decisions in order to develop a staff representative of the community.
3. The staff of medical practices and other health care organizations should receive continuing education and training in providing culturally and linguistically appropriate care.

Language Access Services

1. When treating limited English-speaking patients, medical practices and health care organizations should ensure that a means of communication with the patient is established that enables appropriate care to be provided. When practical, the care should be provided using the patient's preferred language either by the provider/staff or through a qualified interpreter. Medical practices and health care organizations should also assure that patient-related written materials and signage include versions printed in languages widely spoken in the area they serve and that are easily understood regardless of literacy levels or other challenges.

Organizational Support for Cultural Competency

1. Medical practices and other health care organizations should establish and maintain contact with community members in order to better understand the

cultural and linguistic characteristics of the community they serve. They should consider developing plans, policies, and procedures based upon that understanding to assure that the care provided is sensitive to the needs of their diverse patients. They should also periodically review and evaluate these plans, policies, and procedures and establish and maintain community contacts to assure that their plans are appropriate and up to date. Medical practices and health care organizations should then inform their patients and the community about their abilities to accommodate the cultural and linguistic needs of the community they serve.

2. Information regarding the patient's health care beliefs and preferences, along with information about languages spoken by the patient, should be recorded in patient records and integrated into the medical practice's or other health care organization's data management system.

(Report 8, Board of Trustees, H-2006; reaffirmed, H-2016)

350.997 Healthy Living in Ethnic Communities

The Society shall work with groups in minority communities in Pennsylvania in collaborative partnerships to promote healthy lifestyles. (Res. 209, H-2007)

350.998 Ethnic and Gender Diversity

The Society shall identify existing programs and community efforts in Pennsylvania currently addressing ethnic and gender diversity in the profession and establish partnerships with organizations and institutions to assure a diverse medical professional community. A status report will be made to the Society's Board of Trustees and will be disseminated to constituent county and specialty societies within six months. (Res. 503, H-2005)

350.999 Minority Medical School Admissions

The Society supports programs that provide assistance to prepare minority pre-medical students to meet the general requirements for admission to medical schools. (Res. 44, H-1977)

360.000 Nurses and Nursing

360.997 Support for All Levels of Nursing

The Society reaffirms its support for all four levels of nursing education as a means to increase the availability of nursing personnel. (Res. 15, H-1982)

360.998 Support Practical Nursing

The Society lends every support to the cause of practical (vocational) nursing, to licensed practical nurses and to the schools and faculties that prepare them in the Commonwealth of Pennsylvania. (Res. 21, H-1969)

360.999 Nursing and Nursing Education

The Society adopted the following position statement:

1. The best possible health care of our fellow human beings is the reason for the existence of, and should be the primary goal of, the professions and technologies concerned with all facets of health. Therefore, the interest of the patient must be the major consideration in all decisions made by either the

- Pennsylvania Commission on Nurse Education or the Pennsylvania Joint Practice Commission concerning the future of nursing in Pennsylvania.
2. The delivery of optimum health care is a coordinated and cooperative team effort. Physicians have the legal responsibility for patient care and must be the leaders of the team. Nursing and all other patient care disciplines should work within their professional ethics and technical skills under the direction of physicians.
 3. Unquestionably the roles of the nurse in the future will be multifaceted and on multi-levels. Nursing education must be geared to produce nurses equipped to the best possible degree to give the finest and most adequate care within each specific sphere. No one system or type of school can encompass the education and training needs to meet these demands IN TOTO. Undergraduate nursing education in all levels should have as its first and basic goal the teaching of primary nursing care of the patient. It is upon such foundation that there must be constructed the advanced training needed to produce the variety and levels of knowledge, skills, and expertise for adequate and satisfactory nursing care in all fields. Because of the varying levels of nursing skills, backgrounds, and specialties plus varying capacities and limitations of individuals, all four levels of nursing education must be maintained and constantly improved. These four levels, each of which is needed, are: practical nursing, associate degree, diploma school, and baccalaureate. The quality of undergraduate nursing education must be maintained by adequate admission requirements for each level of training and by continuing achievement requirements for each in order to attain diploma or degree.
 4. The trend to lump all nursing education in academia should be slowed down. Basic nursing education requires acquisitions of patient care skills as well as theoretical background, and the best place to acquire patient care skills is to work with patients in the place where patients are -- the hospital, the out-patient clinic, and the doctor's office. There is a proper balance between theory and practice, and in the training of students for patient care, practice assumes a larger and larger proportion of that balance. While educational institutions must of necessity handle graduate and baccalaureate education, only those in medical centers or with medical center facilities can adequately give the needed clinical experience. Clinical experience has been well taught outside of academia for years and can still be obtained from those sources if even mild support is offered.
 5. The tendency to require formal education beyond patient needs and individual nurse or student capabilities must be resisted. Graduate education to prepare for advance teaching, major administration, and sophisticated research is a must. Baccalaureate education is needed to prepare for routine teaching, most administration, and as a basis for specialty training. Diploma, associate degree, and practical nurse training are needed to prepare for the basic functions of patient care. All types are necessary for balanced and coordinated delivery of such care. Advancement on the professional career ladder must be available to all nurses. Advancement from practical nurse to associate degree or registered nurse and from associate degree and registered nurse to baccalaureate and higher degree must not only be available but encouraged to the limit of the individual's capability of achievement.
 6. Postgraduate education assumes two primary functions -- training for specialty careers in nursing and the need to keep abreast of progress and developments in the nursing profession. Specialty training is a function of the medical specialty organization, the nursing specialty organizations, and certain educational institutions. Emphasis must be placed on quality instruction and adequacy to meet the needs of the particular nursing specialty. Continuing education is a

must. Postgraduate courses, conferences, symposia, colloquies, workshops, in-service training, etc., to meet predetermined quantitative hour totals to maintain licensure would be a means to ensure that all keep up with advances in the profession, particularly those related to patient care. Postgraduate education for areas involving the practice of medicine -- nurse anesthetists, nurse midwives, nurse practitioners, and physicians' assistants of various types -- is purely a function of the medical profession and its educational facilities.

7. Any committee with too large or too diversified a regular membership becomes ineffectual. To reach satisfactory conclusions concerning the training and qualifications of individuals for delivery to our fellow citizens of the finest medical care, the basic committees should be composed of those who constitute the backbone of the health care delivery team -- physicians and nurses. Other allied or associate professionals should be invited to participate as consultants at appropriate and indicated times. (Report PP, Board of Trustees, H-1991)

370.000 Organ Donation and Transplantation

370.996 Feasibility of Utilizing HIV Positive Donors

The Society supports the concept that organ donation networks should evaluate the feasibility of utilizing HIV-positive donors for selected subsets of organ recipients. (Res. 206, H-2003; Revised, H-2013)

370.997 Presumed Consent for Organ Donation

The Society supports presumed consent for organ donation as a means of increasing the number of organs available for transplantation. (Res. 02-202, H-2003; Revised, H-2013)

370.998 Organ Donation

The Society continues to support organ donation and increasing the pool of potential organ donors. The Society continues to work with the organ procurement organizations as necessary to keep both physicians and the public aware of the need for organ donors. (Report 2, Board of Trustees, H-1998)

375.000 Peer Review

375.994 Protecting Physicians' Rights to Advocate for Quality Patient Care

The Society will explore all aspects of sham (bad faith) peer review and explore ways to prevent the misuse of peer review of both the standard of care and the disruptive physician doctrine/clause. This exploration shall include studying the extent of the issue, consideration of definition of terms, applicable laws, and steps that can be taken to protect physicians' rights to advocate for quality patient care. (Res. 203, H-2004)

375.995 Statewide Peer Review System

The Society seeks the adoption of a statewide blinded, accountable peer review system in which a patient, hospital, or any member of the hospital medical staff could request this level of unbiased review when questions arise about the medical practice of a physician that is not appropriately resolved at the local or regional level. The patient would be able to review the results of the peer review if they agree not to be entitled to non-economic damages. (Recommendation of President-Elect, H-2002)

The Society shall explore the feasibility of establishing a voluntary, double-blinded clinical peer review program for its members' office patients. (Recommendation of President-Elect, H-2003)

375.996 Out-of-State PRO Contracts by KePRO

Approved the recommendation of the KePRO Board of Directors that KePRO investigate and pursue selected PRO contracts in other states where the current PRO contracts are placed in competition. (Board of Trustees, May 1991)

375.997 Reimbursement for Peer Review

The Society supports appropriate reimbursement at reasonable rates for the services of physicians on hospital review committees where the time required is substantial and is primarily for the purpose of certification or recertification of hospital stays needed for patient care or claims review. (Council on Medical Service, H-1973)

375.998 Procedural Safeguards

The Society determined to pursue procedural safeguards in the PRO process. (Address of the President-Elect, H-1991)

375.999 Peer Review

The Society adopted a set of general principles of peer review as guidelines for the operation of programs involving the professional evaluation of the appropriateness, effectiveness and quality of medical care.

General Principles of Peer Review:

1. Definition of Peer Review

Peer review is the evaluation by practicing physicians of the quality, appropriateness, and effectiveness of medical services ordered or performed by other practicing physicians regardless of the setting, i.e., hospital, hospital outpatient department, physician's office, extended care facility, nursing home, etc. Peer review is the all-inclusive term for medical review efforts including, but not necessarily limited to the following activities: utilization review, medical audit, ambulatory care review, and claims review.

2. Objective of Peer Review

The purpose of peer review is to improve the quality of medical care and the appropriateness and effectiveness of its delivery by utilizing objective consensus of peers.

3. Essential Elements of Peer Review

- a. There must be objective peer control of the process for selecting subjects for review, i.e., the criteria for selection must be developed by objective medical opinion and not solely by the agency responsible for cost.
- b. The peer review process should include prospective review procedures to avoid retroactive patient liability or non-payment to provider.
- c. The peer review process must include retrospective review for outcome analysis in relation to criteria to support prospective review and to modify medical care criteria.
- d. The composition of peer review committees must be determined by peer groups. If review is required in other fields, peers will elect peers, i.e., dentistry, podiatry, hospital administration, etc.
- e. Material requiring review must be developed so that the question requiring a decision is clear to peer review committee members.

- f. Promptness of peer review committee decision is essential in questions involving the need for or the continuation of institutional services.
- g. Members of peer review committees must recognize decisions will be re-evaluated by other peer groups.
- h. Peer review committee meetings must be conducted in a professional atmosphere and not as an adversary proceeding.
- i. Recommendations of peer review committees must be followed to avoid a waste of valuable professional time.
- j. Professional liability protection must be available to members of peer review committees, either through statutory proceedings or malpractice insurance.
- k. Actions of peer review committees must be analyzed as a valuable source of information for health planning and development of educational programs.
- l. The methodology of the peer review process and reports (excluding confidential material of individual cases) should be available for review by recognized public representatives as a means of demonstrating public accountability. (Special June Meeting, H-1973)

The Society should work for the creation of a statewide accountable peer review system, based on these guidelines, that provides review of a physician's practice competency that cannot be resolved on a local or regional level. (Revised, H-2003)

385.000 Physician Payment

385.965 Barriers to Health Care

The Society shall seek to work with insurers to provide payments to physicians and physician supervised designees for medications, vaccines and their administration without the burden of prior-authorization or any other administrative barriers; and the Society directed its delegation to the AMA to carry this access to care measure to the November 2014 AMA Interim Meeting. (Res. 302, H-2014)

385.966 Telemedicine

The Society shall work with appropriate stakeholders to evaluate the different applications and uses of electronic technology to adopt standard definitions of what constitutes telemedicine and shall work in collaboration with stakeholders to also identify standards for coverage and payment for the use of telemedicine and work to establish policy in Pennsylvania for the licensure of providers and payment for services. (Res. 303, H-2014)

385.967 Payer Reimbursement for Emergency Services

The Society is directed to develop and advocate for legislation that requires all payers within the Commonwealth to reimburse physicians, as whether an in-network or out-of-network provider, directly for all emergency services. (Res. 304, H-2013)

385.968 Payer Transparency

The Society shall develop and advocate for legislation that requires payers to provide a website that will allow any physician to log in with personal identifying information and learn what their reimbursement rate is for any product and code the physician has agreed to by contract, in a similar fashion as currently offered by Medicare. The Society shall also develop and advocate for legislation that requires

physician reimbursement rates to be transparent across the state. (Res. 303, H-2013)

385.969 Insurer Claims Look Back Period

The Society shall seek legislation limiting the “look back” period for claims repayments to a period not to exceed 180 days from the date of payment. That legislation shall include a provision that disputes be resolved through mediation if possible, and by independent arbitration if necessary. (Res. 401, H-2012)

385.970 Payment for Telemedicine Services

The Society supports efforts to mandate coverage for telemedicine services delivered by physicians licensed in the Commonwealth and delivered to patients who reside in Pennsylvania. (Res. 304, H-2012)

385.971 Antitrust Relief for Physicians

The Society reaffirms its policy of supporting amendments to the National Labor Relations Act and other appropriate federal and state antitrust laws to allow physicians to negotiate collectively with payers who have market power and directed its Pennsylvania Delegation to the AMA to submit a resolution to the November 2011 AMA interim meeting, seeking the same action. The Society supports HR 1409 and is directed to send a letter to Pennsylvania's entire Congressional delegation, asking them to co-sponsor HR 1409 and to Senators Robert Casey and Pat Toomey asking for their support. (Res. 404, H-2011)

385.972 Emergency Short Stay Procedure Reimbursement Category

The Society will work with third-party payers to create a new category of payment for short stay emergent procedures, reimbursing physicians and hospitals at a higher level than an elective ambulatory procedure, but not at the level of an acute inpatient admission. (Res. 301, H-2009)

385.973 Reimbursement for Mental Health Care

The Society adopted a policy stating that physicians of all specialties be reimbursed at fair market value for providing appropriate medical treatment of patients with depression, anxiety and other mental health diagnoses. (Res. 313, H-2005)

385.974 Telephone and Electronic Consultations

The Society shall request the appropriate legislative bodies to require compensation for medical telephone and electronic consultations between physicians and their established patients or patient representatives. (Res. 306, H-2005)

385.975 Fair Valuation of Physicians' Services

The Society shall aggressively work through all possible legislative, regulatory, and/or legal means to establish a mechanism for a fair market valuation for all physician services in third-party payers' contracting with hospitals and hospital systems, possibly based upon the full RBRVS including all modifiers, and at a multiplier that is not less than that for current Medicare fee schedule, so as to protect both the negotiating power of employed physicians and the fair market reimbursement for private practice physicians. The Society's AMA Delegation is directed to carry this issue forward to the AMA House of Delegates for consideration. (Res. 310, H-2005)

- 385.976** **Published Reimbursement Schedules by Private Insurers**
The Society is directed to request that the Insurance Commissioner require private insurers—at least the major payers—to publish the exact reimbursement schedule that they use to pay physicians for their services. If necessary, the Society will request legislative relief from this insurer inequity. The Society was also directed to carry this problem and solution to the AMA. (Res. 304, H-2004)
- 385.977** **Market Dominance by Health Insurance Companies**
The Society shall develop and implement specific regulatory and judicial strategies which will use anti-trust laws to prevent market domination by one or very few insurers. The Society reaffirms its commitment to supporting legislation which would empower physicians to collectively negotiate with market dominant health insurers and would require market dominant insurers to negotiate in good faith. (Res. 410, H-2004)
- 385.978** **Accuracy of Coding**
The Society is directed to ask the Insurance Commissioner to instruct insurers to balance or refund for under-coding, against any discovered over-coding during the course of an audit and not through extrapolation; that the Society ask for legislative relief from insurer inequity of this issue. (Res. 307, H-2003; revised, H-2013)
- 385.979** **Third-party Payer Overpayments**
The Society and the AMA were directed to initiate legislative, regulatory, or legal action, as necessary to (1) determine if unfair business practices exist with regard to third-party payers' possible failure to credit back to premium payers (government/employers/subscribers) "overpayments" that they recover from providers; (2) effect that the same time limits apply, both for physicians to submit charges to third-party payers and for third-party payers to recover erroneous overpayments to physicians; and (3) effect a level playing field for physicians to be able to negotiate economic and patient care issues with monopolistic, market dominant third-party payers. (Res. 314, H-2001)
- 385.980** **"Under Fair Market" Reimbursement**
The Society is directed to make correcting "under fair market" reimbursement of Pennsylvania physicians by market dominant third-party payers equal in its attention and effort to tort reform. (Res. 308 and 504, H-2001)
- 385.981** **Reimbursement Hot Line**
The Society is directed to work with the Pennsylvania Insurance Commissioner and with members of the General Assembly to (1) secure the establishment of clear and enforceable standards to require all insurers to provide a hot line or other mechanism to eliminate long waits and to assist physicians in obtaining prompt responses to pre-certification issues, denial of days, billing questions and prompt reimbursement; and (2) secure vigorous enforcement of those standards. The Society shall also call on medical directors of insurance companies to respond to physicians' requests by verifiable same-day communication, therefore improving delivery of medical care to patients. (Res. 314, H-2000)
- 385.982** **Retrospective Reimbursement Refund Policy**
The Society shall utilize all necessary means to oppose the practice of insurers requesting refunds on payments for services provided at a time frame greater than physicians are contractually allowed to bill. (Res. 321, H-2000)

- 385.983 Contact Capitation**
The Society shall utilize all necessary means to oppose contact capitation of physicians in the Commonwealth of Pennsylvania and shall use available means to eliminate retrospective reimbursement determinations. (Res. 307, H-2000)
- 385.984 Uniformity for Insurance Documentation**
The Society shall continue its efforts, both legislatively and through the regulatory process, to achieve uniformity in requirements for documentation of claims and standardization of utilization and fee review procedures for all forms of insurance, including workers' compensation. (Report 14, Board of Trustees, H-1997)
- 385.985 Reimbursement to Physicians/Other Health Care Providers**
The Society supports legislation assuring that reimbursement to physicians and other health care providers must be at a level that: (1) is consistent with efficiency, economy, and quality of care; (2) is sufficient to enlist enough physicians and other health care providers to ensure that care and services are available to enrollees of health care plans at least to the extent that such services are available to the general population in the geographic area serviced by the health insurance plan; and (3) enables physicians and other health care providers to deliver quality care and services to enrollees. (Res. 408, H-1998)
- 385.986 Fee Schedules**
The Society seeks legislation requiring insurers to provide complete fee schedules to participating providers and provide revised fee schedules at least 90 days prior to implementation of the new fee schedule to allow physicians to determine continuation as participating physicians. (Res. 336, H-1998)
- 385.987 Mandatory Acceptance of All Insurance Company Products**
The Society shall pursue all necessary means, including the enactment of legislation, to have the practice of mandatory acceptance of all products provided by an insurance company declared illegal in Pennsylvania. (Res. 307, H-1998)
- 385.988 Physician Review of Billings and Remittances Made on their Behalf**
The Society adopted the policy that all physicians are entitled to review what medical services are billed and paid for on their behalf and provide assistance to physicians who are denied such information. (Res. 322 H-1997)
- 385.989 Third-party Reimbursement for Services Rendered by Physician**
The Society adopted the following policy: "Third-party reimbursement for services rendered by physicians must at least cover the actual cost of providing those services plus a reasonable reimbursement for professional services. If reimbursement falls below this level, patients will likely have difficulty accessing care. Payers must provide a detailed fiscal and clinical analysis to support any changes they recommend." (Report 25, Board of Trustees, H-1996; reaffirmed, H-2016)
- 385.990 HMO Establishment of All-Inclusive Reimbursement**
The Society will investigate the legality of HMOs and any third-party payer reimbursing a hospital and its hospital-based physicians, including independent billing physicians, through an all-inclusive rate which would be paid to the hospital. In the event that it is determined to be legal, the Society will support legislation to assure patient and physician protection. (Res. 501, H-1995)

- 385.991 Blue Shield Provider Agreements**
The Society is directed to institute appropriate action to ensure that Blue Shield participating doctors are not bound to accept the Blue Shield participating doctor allowance as payment in full for care rendered to enrollees in a plan serviced by a select network unless the physician rendering services is a participating member of the network involved. (Sub. Res. 504, H-1995)
- 385.992 Hospital Observation Services**
The Society is directed to petition the Pennsylvania Department of Public Welfare to recognize and reimburse physicians for hospital observation services provided to Medical Assistance recipients. (Res. 505, H-1994)
- 385.993 Adequate Reimbursement for Medical Services in Accidents**
The Society seeks legislation that would allow physicians to collect appropriate fees for their services until settlement of a legal case and reimburse Medical Assistance for payment previously made. (Res. 11, H-1992)
- 385.994 Workers' Compensation Reform**
The Society opposes a permanent tie-in to the Medicare payment system for the Workers' Compensation bills pending in the Pennsylvania legislature. (Res. 63, H-1992)
- 385.995 Telephone Services**
The Society supports efforts to secure reimbursement for telephone management services. (Res. 50, H-1992)
- 385.996 Reimbursement for Cognitive Services**
The Society supports the concept that third-party payers should provide more equitable reimbursement for physicians' cognitive services in comparison with their procedural services. The Society is committed to promote this concept with third-party payers, business groups, and other professional associations. (Res. 4, H-1984)
- 385.997 Physician Participation in Third-party Plans, Voluntary**
It is the option of the individual physician to participate in Pennsylvania Blue Shield or its successors or to accept assignments for Medicare beneficiaries. (Board of Trustees Report F, H-1980; revised, H-2010)
- 385.998 Payment for Technical and/or Facility Fees**
The Society seeks legislative and/or regulatory changes to require that all insurers in the Commonwealth who provide payment for physicians' services develop a mechanism for determining and instituting payments of technical and/or facility fees for supplies and materials as defined by CPT-4 codes 99070, 99071 and A4550 to physicians who provide these services in their offices. The Society also has communicated with HCFA the need to develop a mechanism for physician payment of technical or facility fees as defined by Medicare Code A4550 for services provided in their offices. (Res. 48, H-1988)
- 385.999 Automobile Insurance Reform Act (Act 6)**
The Society is directed to communicate to the Governor and all Pennsylvania legislators that the Automobile Insurance Reform Act (Act 6) is arbitrary and promotes unfair differential payment of physicians and that this law acts as a deterrent to the recruitment and retention of physicians and contributes to earlier

retirement. The Society is also directed to seek legislation to make such arbitrary, unfair, and differential payment unlawful. (Res. 3, H-1992)

390.000 Physician Payment: Medicare

390.991 Tetanus Vaccine to Medicare Patients

Until compliance of AMA policy H-440.875(6) is actualized to the AMA satisfaction regarding the tetanus vaccine, the Society seeks through its AMA Delegation to ask the AMA to aggressively petition CMS to include tetanus and TDAP at both the “Welcome to Medicare” and Annual Medicare Wellness visits, and other clinically appropriate encounters as additional “triggering event codes” (using the AT or another modifier) that allows for coverage and payment of vaccines to Medicare recipients. (Res. 301, H-2014)

390.992 Elimination of Medicare’s Punitive Payment Adjustment

The Society directed hits AMA Delegation to request that the AMA urge Medicare to eliminate its punitive payment adjustment planned in 2015 for physicians who do not demonstrate meaningful use of electronic medical records (EMRs). (Res. 305, H-2012)

390.993 Medicare Part B Coverage of TDAP

The Society requested its AMA Delegation to forward this resolution to the AMA for action to urge Medicare to include TDAP (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis. (Res. 205, H-2012)

390.994 Observation Care Codes

The Society directed its Pennsylvania Delegation to the AMA to ask the AMA to redouble its efforts to advocate with the Centers for Medicare and Medicaid Services (CMS) for an increase in reimbursement for observation care codes. (Report 3, Board of Trustees, H-2011)

390.995 Urgent Action to Prevent Medicare Cuts

The Society insists that our representatives in Congress make an absolute commitment to passing legislation to halt cuts in payments for physician services and to replace them with positive inflation updates prior to January 1, 2003. The Society informed legislators and the public of the severe consequences to Medicare patients (including fewer physicians being able to take care of all Medicare patients, longer waits for appointments, and higher out-of-pocket expenses) that will occur on January 1 if Congress does not act before then. The Society encouraged every physician in the Commonwealth of Pennsylvania to contact their members of Congress between October 2002 and the election to demand that they take action to halt cuts in Medicare payments for physician services. (Res. 315, H-2002)

390.996 Prompt Payment of Medicare “Managed Care” Insured Claims

The Society seeks through appropriate avenues that standards of prompt payment and penalties for failure to do so be applied to Medicare and Medicaid managed care insurance products similar to those imposed upon traditional Medicare recipients. (Res. 307, H-1999)

390.997 Prospective Payment System and DRGs for Physicians
The Society (1) endorses the concept that any system of reimbursement for physicians' services should be independent of reimbursement systems for other providers of health care; and (2) opposes expansion of prospective pricing systems until their impact on the quality, cost, and access to medical care have been adequately evaluated. (Res. 501, H-1995)

390.998 Active Opposition to DRGs
The Society reaffirms its strong opposition to the inclusion of physicians in any global diagnosis related group (DRG) system. (Res. 501, H-1995)

390.999 Oppose Physician DRGs
The Society (1) continues its vigorous opposition to any proposal that would reimburse physicians according to diagnosis related groups (DRGs); (2) continues its opposition to proposals to include compensation of radiologists, anesthesiologists, and pathologists under in-hospital DRGs; (3) continues to encourage members of the U.S. Congress to oppose the inclusion of physicians in any DRG program; and (4) through its physician members, seeks the support of patients in opposing the inclusion of physicians in the DRG reimbursement plans. (Res. 501, H-95; revised, H-2015)

400.000 Physician Payment: Medicare - RBRVS

400.998 Resource Based Relative Value Scale (RBRVS)
The Society shall work to effect RBRVS as the basis for all fee schedules in Pennsylvania. (Res. 317, H-1998, adopted in lieu of 1999 Board Report 9)

400.999 Inappropriate Use of Hsiao RBRVS by Third-Party Payers
The Society is directed to encourage third-party payers to reflect full RVU values in all fee schedules based on the Hsiao RBRVS, with appropriate modification for geographic and practice cost differences based on the most updated and accurate data, and to report fee schedules by conversion factors for comparison. The Society was further directed to notify member physicians of third-party payer attempts to undermine correct use of the Hsiao-RBRVS. (Res. 50, H-1993)

405.000 Physicians

405.991 Maternity Leave
The Pennsylvania Medical Society (PAMED) shall accept as principle that pregnancy is a unique medical condition, and that maternity leave should not be treated as sick leave. Furthermore, PAMED shall support the elimination of punitive salary policies and negative influences on the future career opportunities of women physicians who become mothers. Finally, the PAMED Women Physicians Section shall study the appropriate length for maternity leave and develop best practice guidelines to be promoted by PAMED to physician employers. (Res. 402, H-2018)

405.992 Creation of Reasonable and Economical Assessment Process
The Society continues to support efforts to create a reasonable and economical assessment process that provides physicians with the information necessary to improve the quality and efficiency of their practices. (Res. 201, H-2014)

- 405.993 Promote MDs and DOs to Singularly Use “Physician” and “Surgeon”**
The Society is directed to ask the AMA to promote MDs and DOs to singularly use “physician” and “surgeon” to distinguish our professional designation and maintain a clear distinction. (Res. 502, H-2012)
- 405.994 HIPAA Violations by Law Firms**
The Society shall investigate the activities of entities including Consumer Injury Alert as they relate to possible HIPAA violations and solicitation of lawsuits and take whatever action is deemed appropriate. The Society is directed to take forward to the AMA the practice of possible HIPAA violations in the solicitation of lawsuits by Consumer Injury Alert with the intent that the AMA will also take whatever action is necessary to stop these activities of entities including Consumer Injury Alert with regard to possible HIPAA violations and solicitations of lawsuits. (Res. 403, H-2011)
- 405.995 Immunity for Employers Providing References**
PAMED advocates for immunity for employers who provide truthful and honest information concerning the character and job performance of their employees. The Society is directed to develop specific human resources programs for physicians to help them to better provide appropriate references for employees and former employees. (Res. 407, H-2007)
- 405.996 Protecting Patient’s Right to Know Who is Treating Them**
PAMED shall pursue through legislation and regulation a requirement that the various Pennsylvania licensing boards and state health systems require and insist that people using the title “Doctor” clearly explain what the doctorate is in, and what their specific scope of practice is when advertising to, meeting with, or treating patients. (Res. 410, H-2006; reaffirmed, H-2016)
- 405.997 Use of Term “Provider”**
PAMED condemns the use of the term “provider” to describe its members and urges any organization which employs the term to describe physicians by their proper, professional title of either “physician” or “doctor”. (Board of Trustees, January 2000)
- 405.998 Physician Information on the Internet**
The Society shall pursue a proactive policy to assure the appropriateness of physician profile data and physician information published on the Internet in formats designed for lay public access. (Res. 425, H-1997)
- 405.999 Primary and Consultative Care**
PAMED is directed to promulgate policies to recognize the services of internists, pediatricians, family physicians, and obstetricians/gynecologists as providing both primary care and consultative care. (Res. 30, H-1993; Revised, H-2013)

425.000 Preventive Medicine

- 425.998 Promotion and Incentivization of Physician Wellness**
PAMED promotes physician and physician-in-training awareness of the importance of personal health, including mental health, healthy BMI maintenance, smoking cessation, exercise facility membership, and routine personal health screening to include cholesterol, triglycerides, blood pressure, and blood glucose. Further, the Society encourages employers, residency programs, and medical schools to

develop positively-oriented physician and physician-in-training workplace incentive programs, including but not limited to financial programs, which reward participants for achievement of personal health improvement goals, including, but not limited to, completion of mental health screening, healthy BMI maintenance, smoking cessation, routine personal health screening, and organized exercise programs. (Res. 206, H-2012)

425.999 Education, Treatment, and Care of Stroke

The Society shall encourage and work to insure (1) that hospitals have the necessary personnel, equipment, and organization to triage and treat patients with stroke rapidly and efficiently; (2) that hospitals have stroke protocols which will allow for the treatment of acute ischemic stroke; (3) that systems be developed in urban and non-urban areas for pre-hospital care and emergency identification and treatment of acute ischemic stroke; and (4) that there be rapid initiation of programs to evaluate and treat acute stroke. (Res. 209, H-2001)

430.000 Prisons

430.996 Hygiene and Health Education in Prisons

PAMED is directed to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in Pennsylvania's state and local prison systems to prevent transmission of oral, foodborne, and sexually-transmitted infections. Also, the Pennsylvania delegation to the American Medical Association (AMA) is directed to put forward a resolution for the 2019 Annual Meeting requesting the AMA collaborate with state medical societies to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in state and local prison systems. (Res. 211, H-2018)

430.997 Feminine Hygiene in Prisons

PAMED shall work with stakeholders to advocate for the removal of barriers to feminine hygiene products in state correctional institutions to ensure incarcerated women be provided appropriate feminine hygiene products at no cost. (Res. 210, H-2018)

430.998 Substance Abuse Medication-Assisted Treatment (MAT) in Prisons

The Pennsylvania Medical Society (PAMED) supports the availability and usage of counseling and all approved medications for treatment of substance use disorder as part of medication-assisted treatment for all inmates in Pennsylvania correctional institutions. (Res. 201, H-2018)

430.999 Prison Health Care

The Society supports the concept that all prisoners transferred from one correction facility to another and from one correction facility to a hospital be accompanied by medical information including but not limited to:

1. A list of major diagnoses;
2. A list of drug and other allergies;
3. A list of current medication and dosages;
4. The results of tests for tuberculosis, HIV, and other communicable diseases;
5. The results of recent abnormal lab, x-ray, EKG, and other test findings; and
6. Three days' supply of necessary medications.

The Society supports the transmission of medical information between correction facilities to be done in a manner consistent with protection of confidentiality. The

Society is directed to communicate this information to the Pennsylvania Department of Corrections, the office of the Governor, and appropriate legislative committees. (Res. 1, H-1992)

435.000 Professional Liability

435.965 Limitation of Liability

The Society shall oppose any attempt to establish a second, separate civil cause of action in addition to a medical liability claim resulting from physicians' treatment of patients. (Res. 403, H-2013)

435.966 Physicians Donating Time at Non-Government Free Clinics

The Society shall develop and work toward the introduction of legislation in which physicians receive free professional liability coverage from the state, in return for donating some of their time at free non-government clinics. Further, the Society supports the development of free non-government clinics where those services can be provided. (Res. 406, H-2011)

435.967 Mcare Fund Constitutionality Vote

The Society will (1) publicize the list of legislators who voted for and against this bill which allows for the commandeering of the Mcare Fund; (2) urgently evaluate the constitutionality of this recent "raiding" of \$100 million from the Mcare Fund which had previously been provided directly by physicians as the Mcare surcharge, thus possibly costing the physicians of Pennsylvania an additional Mcare assessment for this coming year; (3) broadly publicize to all physicians in Pennsylvania that their money has been taken; (4) recommend that all physicians in Pennsylvania strongly consider not paying their next Mcare assessment without a legally binding guarantee that their money cannot be stolen again; and (5) applaud PAMPAC applauded for re-affirming its policy to carefully scrutinize political leaders voting record/scorecards prior to distributing PAC funds to qualified candidates. (Res. 408, H-2009)

435.968 Mcare Fund

The Society continues to advocate for phase-out of the Mcare Fund, but only if adequate sources of funding are available to assure that any phase-out plan is financially viable to Pennsylvania's practicing and future physicians. Until a financially viable Mcare Fund phase-out plan is enacted, the Society seeks redress of past actions by the Commonwealth of Pennsylvania, as well as improvements in the Fund's administration. The Society will use legal resources to seek a method so that no further assessments are transferred into the Mcare Fund without assurances that they will be used for their intended purposes. (Report 31, Board of Trustees, H-2009)

435.969 Clarification of Certificate of Merit Rule

The Society shall work to clarify and modify the current interpretation of the Certificate of Merit (COM) rule to read as follows: "The identity and qualifications of the person providing a COM be revealed to the defendant in any suit filed in Pennsylvania alleging medical malpractice at the time such suit is filed." (Res. 406, H-2008)

- 435.970 Liability Protection for All Uncompensated Care/Providing Immunity for Healthcare Providers of Free or Low-Cost or Emergent Healthcare**
The Society shall seek liability protection for all uncompensated care, regardless of where provided, at a level at least equal to the protections provided by the Good Samaritan law. (Res. 405, H-2008)
- The 2017 House of Delegates mandated that PAMED shall reaffirm policy number 435.967 (Liability Protection for All Uncompensated Care), and that PAMED shall advocate for physicians who volunteer at free clinics to have the same liability protections afforded to physicians who volunteer at Federally Qualified Health Centers (FQHC). (Res. 408, H-2017)
- 435.971 Countersuits/Non-Meritorious Lawsuits**
The Society seeks to strengthen the existing law that permits countersuits against attorneys and persons who file non-meritorious lawsuits against physicians. (Res. 403, H-2007)
- 435.972 Physician Volunteers**
The Society encourages the appropriate agency to a) monitor the number of liability actions brought against physician volunteers; b) educate physicians concerning their responsibility to pay the costs of their defense in a liability action; and c) monitor the physicians' continuing medical education to ensure the retained clinical expertise of physician volunteers. (Report 6, Board of Trustees, H-2007)
- 435.973 Delinkage of Medical Liability Insurance to Physician Licensure**
The Society continues to aggressively support the delinkage of medical liability insurance to physician licensure. (Res. 407, H-2006; reaffirmed, H-2016)
- 435.974 Apology Rule**
The Society supports law and public policy that promotes or supports the implementation of Supreme Court rules or legislation that would make an apology on the part of a health care provider for an adverse outcome of medical intervention inadmissible in any court of law. The Society also supports or promotes the implementation of Supreme Court rules or legislation that would make an admission of liability or error on the part of a health care provider incident to an adverse outcome of medical intervention inadmissible in any court of law. (Res. 403, H-2005)
- 435.975 Standards for Lawyers Practicing in Pennsylvania**
The Society adopted a policy that lawyers practicing in the Commonwealth should be held to the same standards as physicians, requiring all practicing attorneys to purchase professional liability coverage and prohibiting them from the common practice of fee splitting. The Society is directed to take action to have the Pennsylvania Supreme Court enact each of the aforementioned and also to make the process of disciplining lawyers more public. (Res. 411, H-2004; revised, H-2014)
- 435.976 Countersuits to Discourage Frivolous Lawsuit Abuse**
The Society continues to promote the use of countersuits against the plaintiffs and attorneys who file frivolous lawsuits against physicians, and also against the expert witnesses who provide testimony in these cases. The Society shall communicate this position in an effort to deter the continued filing of frivolous lawsuits. (Res. 409, H-2004; revised, H-2014)

- 435.977 Expert Witness Testimony**
The Society advocates for legal penalties for expert medical witnesses who provide misleading testimony or commit perjury. (Res. 406, H-2004)
- 435.978 Expert Witness Testimony**
Expert witness opinion and testimony must be in accordance with acceptable medical standard, and testimony that fails to meet this standard should subject the expert to disciplinary action. False or misleading testimony is a violation of the ethics of the profession. The Society will advocate for effective action by the State Board of Medicine to discipline physicians who provide improper expert witness testimony. The Society will support the efforts of individual specialty societies and specialty boards in identifying and reporting instances of expert witness violations by their members in Pennsylvania. (Board of Trustees, 3/2004 and 9/2004/Report 7, Board of Trustees, H-2004)
- The Society seeks to strengthen the existing expert witness requirements contained in Act 13 of 202. (Res. 404, H-2009)
- 435.979 Sovereign Immunity for Physicians Providing Emergency Care**
The Society advocates for and includes, as part of its medical liability reform initiative, the provision of sovereign immunity for physicians who provide EMTALA mandated care in the Commonwealth of Pennsylvania. (Res. 409, H-2003)
- 435.980 Continued Tort Reform Efforts**
The Society opposes subsidy of the Mcare Fund by physicians and instead seeks its elimination, including its termination, through financial insolvency, with the state to cover future losses through the Pennsylvania Insurance Guaranty Association (PIGA). The Society and all Pennsylvania physicians shall redouble their efforts to achieve appropriate medical liability tort reform, including caps on non-economic damages, alternative dispute mechanisms such as no-fault, early offer and limited tort, and continued efforts at improving the quality of physician and hospital care in Pennsylvania. (Res. 405, H-2003)
- Reaffirmed Society policy supporting the phase-out of Mcare coverage via a plan that minimizes the financial impact on physicians and authorized the Executive Committee to develop and adjust the specifics of the Society's advocacy position on this issue (in lieu of the resolved in Resolution 08-411). (Board of Trustees, February 2009)
- The Society shall advocate for retirement of the Mcare unfunded liability with existing state funds and revenue streams, such as Health Care Provider Retention Account funds generated from the current cigarette tax, while monitoring opportunities for new funding sources (in lieu of the resolved in Resolution 08-410). (Board of Trustees, February 2009)
- The Society shall remain on record as supporting a reduction or elimination of the mandated limits and continue to monitor opportunities to advance this policy (in lieu of the Resolveds in Resolution 08-402). (Board of Trustees, February 2009)
- 435.981 Refund of Mcare Funds Paid for 2003**
The Society requests the Governor to direct the insurance companies to refund the Mcare Funds collected for 2003. (Res. 404, H-2003)

- 435.982 Medical Liability Premiums**
The Society opposes any efforts to reduce the medical liability premiums of high-risk specialties at the expense of increasing the premiums of other specialties. (Res. 402, H-2003)
- 435.983 Coordination of Insurance and Tort Reform Efforts**
The Society and PAMPAC shall coordinate and work together with grassroots organizations in pursuit of medical liability insurance reform and tort reform. (Res. 402, H-2002; revised, H-2012)
- 435.984 Immunity from Professional Liability Tort for Volunteer Services**
The Society is directed to work to formulate and have passed legislation granting immunity from professional liability tort for volunteer services in Pennsylvania, as well as other states, during periods of declared state or national emergency. The Pennsylvania Delegation to the American Medical Association is directed to develop a similar resolution, asking the AMA to work to formulate federal legislation. (Res. 408, H-2002)
- 435.985 Physicians Volunteering Services**
The Society shall seek an extension of existing “Good Samaritan” protection from ruinous litigation for practicing physicians who volunteer their services in an approved community clinic or shelter. (Res. 406, H-2001)
- 435.986 Civil Rights Litigation Against Physicians**
The Society seeks regulations or legislation to indemnify physicians licensed to practice medicine in Pennsylvania with respect to civil rights litigation resulting from actions in the usual scope of medical practice. (Res. 409, H-2000)
- 435.987 Publication of Malpractice Data**
The Society shall continue efforts to ensure that any mandated source of malpractice information be expanded to include all licensed health care practitioners; that it focuses on data useful to consumers, i.e., insurance plans accepted, acceptance of new patients, office hours; and that physicians have the opportunity to review and authenticate their own information. (Report 13, Board of Trustees, H-1998)
- 435.988 Medical Liability Insurance Company Qualifications Standards Reform**
The Society shall seek regulatory reforms and, if necessary, legislative reforms to strengthen licensing and oversight procedures to prevent medical liability insurers from selling policies in Pennsylvania and/or engaging in economic practices that led to the bankruptcies of PIC and PIE. (Res. 409, H-1998)
- 435.989 Meaningful Tort Reform**
The Society shall coordinate and implement significant and meaningful action among physicians throughout the state to bring attention of the public at large and the elected officials of the need for real liability reforms. (Res. 410, H-1997)
- The Society shall actively support and coordinate efforts to educate the people of Pennsylvania and their elected officials concerning the difficulties faced by physicians in the day to day care of their patients which are the direct result of the tort system as it exists in the Commonwealth. This education effort may include a unified modification of professional activity, for a limited time period, that will demonstrate the gravity of the situation, but that will not adversely affect the health of Pennsylvanians. (Res. 424, H-1997)

- 435.990 Privatization of the Malpractice Insurance System**
The following principles shall be a high priority for legislative enactment: (1) Elimination of medical license suspension/revocation for reasons solely related to payment of his/her malpractice premium or surcharge, and (2) modification of current mandatory requirements of malpractice coverage. (Sub. Res. 423, H-1997; revised, H-2007)
- The Society reaffirms its policy to support legislation to eliminate the CAT Fund as soon as reasonably possible while minimizing physician financial costs statewide. The Board of Trustees shall have the discretion to support or oppose specific legislation consistent with this policy. (Report 27, Board of Trustees, H-1999)
- 435.991 Out-of-State Practice of Medicine**
The Society supports the position that all practitioners who practice within the Commonwealth of Pennsylvania, even though they may be physically outside the geographic boundaries of the Commonwealth, must be responsible for their medical decisions, and carry medical malpractice insurance, as required by Pennsylvania law; further, the Society shall work with the Department of State to require that all professionals who are functionally practicing medicine in the Commonwealth are licensed and carry medical malpractice insurance, as required by Pennsylvania law. (Res. 406, H-1997)
- 435.992 Mcare Fund Premium and Surcharge**
The Society did not adopt the recommendation that it actively oppose any effort to assess the Mcare Fund premium and surcharge on any amount other than that actually paid by physicians for their malpractice insurance. [Res. 408, H-1996; retained in part (“CAT” changed to “Mcare”), H-2016]
- 435.993 Abolishment of the CAT Fund**
The Society supports a long-term phase down of the CAT Fund while retaining the Fund to provide Subsection 605 coverage and true catastrophic coverage. (Report 18, Board of Trustees, H-2000)
- 435.994 Malpractice Insurance for Retired Physicians**
The Society affirms the policy that physicians no longer in active practice should not be required to retain malpractice insurance if they prescribe only for themselves. The Society does not believe it acceptable for such a retired physician to write prescriptions for family members without malpractice coverage such as that provided by PMSLIC. In either case, the Society believes physicians should be current on the appropriateness, indications, and characteristics of the medications being prescribed. (Report 3, Board of Trustees, H-1994)
- The Society is directed to seek an amendment to Act 13 to allow an exemption of the requirement to carry medical liability insurance for physicians retired from the clinical practice of medicine and engaged only in a teaching capacity. (Res. 414, H-2004)
- 435.995 Tort Reform a High Priority**
The Society reiterates that promotion of meaningful lawsuit abuse reform is a high priority. (Res. 7, H-1989; Res. 19, H-1991; Res. 13, H-1992; Res. 8, H-1993; revised, H-1999; recommendation 6(c) of the President-Elect, H-2000)
- 435.996 Physician Practice Rights**
The Society states that it is the right of physicians to decide for themselves the circumstances under which they can or cannot continue to practice. It is further the

right of physicians to use all available legal means, without jeopardizing the medical care of their patients, to protest when intolerable and unwarranted burdens are placed upon their patients, the Society, or its members. The Society is determined to continue to study the effects of changing socioeconomic conditions on the ability of physicians to practice medicine. (Res. 14, H-1975)

435.997 More Equitable Rate Structure

The Society determined, through all means at its disposal, to work to affect a more equitable rate structure and to obtain legislative relief from the tort system. (Res. 9, H-1980)

435.998 Tort Reform Top Priority

In 1981, the Society made the professional liability crisis its top priority. (Res. 6, H-1981; reaffirmed, Res. 19, H-1991; reaffirmed, Res. 8, H-1993)

The first priority of the Society through the 2002 House of Delegates meeting shall be tort reform; further, the Society shall devote such resources as are necessary to address this priority. (Res. 402, H-2001)

435.999 Limitation on Awards, Ban Awards for Pain and Suffering

The Society recommends and vigorously promotes legislation which would limit awards and eliminate awards for pain and suffering as is done under the Workmen's Compensation Act. (Res. 33, H-1975)

440.000 Public Health

440.965 Extreme Risk Protection Orders

PAMED is directed to support efforts to establish Extreme Risk Protection Orders (ERPOs) in the Commonwealth. (Res. 407, H-2018)

440.966 Social Determinants of Health

PAMED shall support addressing Social Determinants of Health (SDOH) to provide comprehensive care to patients. (Res. 214, H-2018)

440.967 Comprehensive Health Care

The Pennsylvania Medical Society (PAMED) is directed to support access to preventive and reproductive health services for all patients and to oppose legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population. Additionally, PAMED shall call on the Governor to actively support these and all other measures to insure and protect the rights of women everywhere to have unhindered access to safe and comprehensive health care. (Board Report 2, H-2018)

440.968 CPR Training

PAMED is directed to support state legislation advocating for Basic Life Support (BLS) training in schools for students prior to graduation from high school, and to work with other stakeholder organizations, including the American Heart Association, the American Red Cross, and county medical societies, to advocate for increased BLS training for laypersons. (Res. 402, H-2017)

- 440.969 Stop the Bleed Public Educational Campaign**
PAMED is directed to support the American College of Surgeons' national public educational campaign entitled "Stop the Bleed", and to encourage its component county and specialty associations and all physicians within the Commonwealth of Pennsylvania to promote this education for the health of all patients. (Res. 201, H-2017)
- 440.970 Support for a Moratorium on Fracking**
The Society is directed to urge and support a moratorium on new natural gas extraction using high-volume hydraulic fracturing in Pennsylvania and to urge the Commonwealth of Pennsylvania to fund an independent health registry and commission research studies on the health effects of fracking. (Res. 206, H-2016)
- 440.971 Hydraulic Fracking**
The Society is directed to (1) urge the Environmental Protection Agency (EPA) to immediately release the interim results of its ongoing study on the effects of hydraulic fracking on human health and the environment so that policymakers are not delayed in addressing these issues; (2) seek to have the Pennsylvania DEP monitor well water in areas of fracking annually and report the results within six months, and monitor waste water and soil for radioactivity annually and report the results within six months. Testing should begin as soon as possible, preferably before fracking begins; (3) urge the state legislature to fund independent research studies on the health effects of fracking; and (4) urge the state legislature to clarify the "right to know" rules of physician disclosure of chemicals and other agents used in fracking. (Res. 402, H-2013)
- 440.972 Diabetes Management in Schools**
The Society shall seek by legislation or regulation to support medically authorized self-management of Diabetes Mellitus in schools, when and where needed, and the availability of trained personnel to assist a child with diabetes, whether a school nurse or, in the nurse's absence, school personnel who have received appropriate training by qualified health care personnel. (Res. 408, H-2012)
- 440.973 Automated External Defibrillators in Extended Care Facilities**
The Society shall promote legislative efforts to require extended care facilities to have on site automated external defibrillators. (Res. 403, H-2012)
- 440.974 Battling Obesity**
The Society encourages county medical societies to publicize information for patients on local resources for exercise, nutritional guidance, and relevant mental health services as needed to address obesity and make that information available to physicians at the county level and in links to websites. (Res. 207, H-2012)
- 440.975 Mandatory Fluoridation of Municipal Water Supply**
The Society shall work in conjunction with the Pennsylvania Dental Association to urge the Commonwealth to adopt the fluoridation standards as promulgated by the U.S. Department of Health and Human Services and the Environmental Protection Agency and to apply them through legislative and/or regulatory initiatives. (Res. 205, H-2011)
- 440.976 Review of Public Health Infrastructure Deficiencies in Pennsylvania**
The Society supports sources of energy which decrease environmental risks to the public health from particulate emissions, gases, radiation and chemical pollutants.

The Society directed its Pennsylvania Delegation to the AMA to carry the resolution forward to the AMA Annual Meeting in June 2012. The Society shall study the state public health infrastructure, including environmental risks to public health in Pennsylvania. (Res. 202, H-2011)

440.977 Disclosure of Digitally Altered Advertisements

The Society supports the concept of disclosure of digitally altered advertisements and discourages the altering of photographs in a manner that could promote unrealistic expectations of appropriate body image. (Res. 206, H-2010)

440.978 Public Cord Blood Donations

The Society shall strongly encourage the Pennsylvania legislature to consider a funding method for the transportation of life-saving cord blood samples from the hospital collection sites to public cord blood banks, and to establish public cord blood banks in Pennsylvania. (Res. 205, H-2010)

440.979 Safe Treatment of Head Lice Infestation

The Society shall facilitate the education of Pennsylvania physicians and other health care professionals through coordination with the Pennsylvania Department of Health as to the incidence and severity of adverse events associated with the use of pyrethrin and pyrethroid-based pediculicide shampoos. (Res. 204, H-2006; reaffirmed H-2016)

440.980 Health Impact of High Fructose Syrup

The Society is directed to correspond with the federal Food and Drug Administration, asking that agency to sponsor research to determine the health impact of consuming high fructose syrup. (Report 2, Board of Trustees, H-2006; reaffirmed, H-2016)

440.981 Healthy Choices in Hospital Cafeterias

The Society, working with the Hospital and Healthsystem Association and other appropriate organizations, encourages the provision of health eating options in hospital cafeterias throughout the Commonwealth of Pennsylvania, with healthy food items clearly marked as healthy choices and bearing labels noting nutritional information. (Res. 207, H-2006; reaffirmed, H-2016)

440.982 Promotion of HPV Vaccine

The Society promotes the HPV vaccination of females ages nine through twenty-six years of age through its patient advocacy efforts. (Res. 309, H-2006; reaffirmed, H-2016)

440.983 Diabetes Awareness

The Society shall collaborate with insurers, appropriate state agencies including the Department of Health's Diabetes Stakeholder Group, and employers to increase awareness and adopt prevention and treatment guidelines for diabetes. The Society also seeks legislation to implement the recommendations of the Diabetes Stakeholders Group consistent with Pennsylvania Medical Society policy. (Res. 208, H-2005)

440.984 Healthy Living Initiatives

The Society shall participate in partnerships to further develop and implement Healthy Living initiatives. (Res. 204, H-2005)

- 440.985 Physical Activity Standard for Children**
The Society endorses a standard of minimal daily physical activity for children, especially in school. (Res. 203, H-2005)
- 440.986 Obesity Awareness**
The Society shall continue its involvement in statewide efforts to increase public awareness of the causes and management of obesity, educate healthcare professionals about obesity and provide resources for physicians to use in addressing obesity issues with their patients. (Res. 207, H-2004)
- 440.987 Existing and Future Patient Safety Systems**
The Society shall evaluate the barriers that impede the effectiveness of existing and future patient safety systems. (Res. 207, H-2003)
- 440.988 Elimination of Stigma Associated with Suicidal Behavior**
The Society and the component county medical societies shall continue coordinated efforts to educate physicians both at the state and local levels of the strong biological basis of suicide, as well as the detrimental effect that stigma associated with depression, alcoholism and suicidality has on effective medical intervention. (Res. 203, H-2003); Revised, H-2013)
- 440.989 Support of Suicide Prevention Efforts**
The Society and the component county medical societies will participate in coordinated efforts on the state and local levels and focus both professional and public attention to resources which are available to reduce the prevalence of suicide throughout Pennsylvania. (Res. 202, H-2003)
- The Society and the component county and affiliated specialty societies are committed to helping efforts to prevent suicide in Pennsylvania. The Society's role on this issue is one of support, rather than taking the lead, for local and statewide programs to promote suicide awareness and prevention programs across the state. The Society and the component societies will assist, as appropriate, other organizations working to focus both professional and public attention on reducing the prevalence of suicide throughout Pennsylvania. (Res. 212, H-2004; revised, H-2014)
- 440.990 Patient Concerns and Interests**
The Society shall pursue initiatives, including opening a dialogue with Pennsylvania representatives of AARP, that position the Society, in the public's eye, as being committed to address patient concerns and interests. (Recommendation of President-Elect, H-2003)
- 440.991 Diesel Exhaust Emissions**
The Society urges the State Department of Health to study the subject and issue a report concerning the effects of diesel exhaust emissions on the population and to study means to reduce diesel emissions. (Res. 205, H-2002)
- 440.992 Regulation of Tattooing and Body Piercing**
The Society is directed to support proposed legislation, or submit its own proposed legislation, that would regulate tattooing and body piercing facilities, except for those performing only ear piercing, including their establishment, operation and conduct of business with special reference to hygiene and medical criteria. (Res. 208, H-2001)

440.993

Suicide Prevention

Because many suicides could be prevented, the Society recognizes suicide as a statewide public health problem and suicide prevention as a statewide priority. As no single suicide prevention program or effort will be appropriate for all populations or communities, the Society encourages broad public and private collaboration to develop, implement and evaluate an effective state suicide prevention program, and recognizes the role the medical community must play in local communities to translate state plans into effective and evaluated local action. The Society also recognizes that many persons who have lost loved ones to suicide can be effective in suicide prevention programs and encourages appropriate support for those spokespersons. The Society also encourages the development and promotion of accessible and affordable mental health services for anyone at risk for suicide, free of any stigma. (Res. 215, H-2001; revised, H-2011)

440.994

Establishment of Immunization Program in all Pennsylvania Colleges and Universities

The Society established a policy calling for all colleges and universities in Pennsylvania to establish a program that will assure that their incoming students are immunized according to the recommendations of the Advisory Committee on Immunization Practices. This policy shall recognize appropriate religious and medical exceptions. The Society shall utilize education to try to persuade colleges and universities to implement these immunization programs. The Society shall also seek other associations for assistance in promoting the concept. If these efforts fail to persuade colleges and universities to act, the Medical Society will seek a legislative or regulatory solution. (Report 5, Board of Trustees, H-1999)

440.995

Standards for Blood Donors

The Society accepts the revised standards of the American Association of Blood Banks which represent the current thinking concerning acceptance standards for blood donors. (Report 18, Board of Trustees, H-1996; reaffirmed, H-2016)

440.996

Antibiotic Resistance Surveillance Network

The Society calls on the State Department of Health (or the Physician General) to establish, set up, maintain, fund, and run effectively a statewide antibiotic resistance monitoring program for citizens of the Commonwealth of Pennsylvania, and on a regular and periodic basis, to convey the information about developing resistance trends to all physicians in the Commonwealth. (Res. 216, H-1996; reaffirmed, H-2016)

440.997

Unwanted Pregnancies

The Society supports the continuation and expansion of state and federal birth control programs. It also encourages further studies to elucidate the causes of unwanted pregnancies, such studies to be directed at the interaction of home, school, and religious teachings, in order that more acceptable preventive measures may be found. (Res. 18, H-1981)

440.998

Hypertension

Persons identified by screening programs as having diastolic pressures above the current Joint National Committee's published Evidence-Based Guideline should be referred to a physician or appropriate health care facility. (Res. 13, H-1974; revised, H-2014)

440.999

Access to Maternal and Child Health Care

The Society established, as a public health priority, the issue of access to and delivery of maternal and child health care services and sought involvement of a broad spectrum of lay and professional organizations and agencies with

demonstrated interest in the establishment of a comprehensive approach to the delivery of quality maternal and child health care services in Pennsylvania. (Res. 17, H-1991)

445.000 Public Relations

445.997 Participation of Physicians on Healthcare Organization Boards

The Society will advocate for and promote the membership of actively practicing physicians on the boards of healthcare organizations including, but not limited to, acute care providers, insurance entities, medical device manufacturers, and health technology service organizations; promote educational programs on corporate governance that prepare and enable physicians to participate on health organization boards; and provide existing healthcare boards with resources that increase their awareness of the value of physician participation in governance matters. Additionally, the Pennsylvania Delegation to the American Medical Association (AMA) will craft a similar resolution to take to the 2017 AMA House of Delegates Meeting. (Res. 502, H-2016)

445.998 Public Education Materials in Physicians' Offices

The Society will continue to make available public health educational materials that address the Society's patient advocacy strategic policies and initiatives. These materials will be created to engage patients in healthy lifestyles through a variety of formats and distribution means, according to what attracts and is convenient or appropriate to each patient or physician audience. Formats may range from traditional printed pamphlets, flyers or brochures to materials available on the Society's website that physician practices may print and distribute on an as-needed basis and may include online resources, such as videos, podcasts, web shows, as well as public health messages sent to patients or physicians through social networking sites, such as Twitter, Facebook and others. (Res. 26, H-1990; revised, H-2010)

445.999 Community Committees

The Society recommends that county medical societies establish liaison committees with the people in their communities. (Address of the President, H-1986; reaffirmed, H-2016)

450.000 Quality of Care

450.991 Clinical Pathways

The Society shall advocate that: clinical pathways be developed transparently and collaboratively and that they (a) promote access to evidence-based care for patients; (b) recognize the medical variability among patients and individual patient autonomy; (c) promote access to clinical trials; (d) are continuously updated to reflect the rapid development of new scientific knowledge; and (e) are implemented in ways that promote administrative efficiencies for physicians, other healthcare providers, and payers; that clinical practice guidelines, when used by health plans, must allow variation and take into account individual patient differences and the resources available in the particular health care system or setting to provide recommended care, and should include a statement of their limitations and restrictions; and that formal procedures be adopted to minimize the potential for undue financial or other interests from influencing the development of clinical

guidelines including required disclosure of all potential conflicts of interest by panel members, consultants, staff, and other participants, with the disclosures of panel members' conflicts of interest relating to specific recommendations published with the guidelines or otherwise made public. (Res. 303, H-2016)

450.992 Claims Based Data as a Flawed Quality of Care Measure

The Society adopted the policy and shall pursue AMA support that insurance companies not use claim-based data as the sole determinant of quality of care rendered and furthermore, that insurance companies do not financially penalize physicians for patient non-compliance. (Res. 302, H-2013)

450.993 Preventing Contract Language Limiting a Physician's Ability to Advocate for Quality Patient Care

The Society shall work to pass into legislation the following protection: No contract language or phrase can be permitted or construed to interfere with a physician's ability to act in the best interest of a patient. The Society shall also work to educate the public, legislators, hospital leadership and physicians regarding how current contracts are evolving to limit physicians' ability to advocate for quality patient care. (Res. 405, H-2012)

450.994 Physician Involvement in Healthcare Quality Issues

The Society staff and leadership shall inform themselves about community efforts in development of quality initiatives and implement programs that support the involvement of county and regional societies in these initiatives. (Res. 310, H-2000)

450.995 National Committee on Quality Assurance Survey of Plans

The Society seeks, through appropriate means, to require that local professional organizations be notified of the National Committee on Quality Assurance (NCQA) survey of plans in their survey areas and be provided the opportunity to submit comments. The Society encourages the Pennsylvania Department of Health and national specialty societies to support the same initiative. The Society urges NCQA to require a public notice of surveys similar to those required by JCAHO so that patients, individually or through their patient advocate groups, can have input into the survey process. (Res. 201, H-1998)

450.996 Release of Practice Specific Information

The Society is directed to encourage, in conjunction with the AMA, third-party payers of physician services and others as applicable to divulge information to individual physicians concerning practice-specific performance. This information should be delivered in a timely fashion to allow the potential for practice adaptation prior to initiation of any adverse action toward that medical practice. The Society also is directed to encourage, along with the AMA, third-party payers of physician services and others as applicable to divulge aggregate performance data without physician-specific identifiers to organized medical groups for educational purposes in order to study practice variance, and in conjunction with regional efforts to establish parameters employed in medical care. The Society was further directed to attempt, along with the AMA, to influence third-party payers of physician services and others as applicable to adopt these policies and monitor compliance thereof. (Res. 28, H-1993)

The Society determined to develop a statewide peer review organization which would comply with TEFRA and serve the physicians and public of Pennsylvania. (Res. 15, H-1983)

450.997 Practice Parameters
The Society recognizes and supports the further development of practice parameters through appropriate specialty societies in conjunction with the AMA. The Society is to continue educating its membership about the current and future trends in practice parameters in not only clinical practice, but in residency and medical school training programs. (Res. 2, H-1991)

450.998 Interference with Professional Judgment of Physician
Third-party health insurance carriers should not establish rules and regulations which arbitrarily identify selected procedures as unnecessary without appropriate professional medical review. (Res. 18, H-1977)

450.999 Equal Treatment for Public and Private Sectors
The Society believes that the standards for quality of care, requirements for utilization review, and the regulations for release of statistical medical information should be applied on the same basis for both the public and private sector. (Res. 1, H-1974)

455.000 Radiation and Radiology

455.999 Safety Guidelines for Mammography

- The Society endorses the safety guidelines of the American College of Radiology:
1. Mammography is to be performed in a radiologic facility under the direct control of a radiologist who is Board certified by the American Board of Radiology and has training in mammography.
 2. Interpreting physicians, medical physicists and radiologic technologists who work in mammography must meet the requirements of the Mammography Quality Standards Act (MQSA) final rule as published by the Food and Drug Administration (FDA).
 3. Facilities performing mammography should be accredited by an accreditation body which meets the requirements of the MQSA final rule published by the FDA.
 4. An adequate quality assurance program should be in place which examines the equipment, image quality, and developing criteria, etc.
 5. Mammography equipment must meet the MQSA final rule published by the FDA. Equipment used for diagnostic mammography must have magnification and spot-compression capability. (See American College Guidelines for the Performance of Screening and Diagnostic Mammography.)
 6. Interpreting physicians must have additional training in digital mammography before beginning to use that modality. (Board of Trustees, February 1990; revised, H-2010)
-

460.000 Research

460.997 Clinical Research Trial Site

The Society is directed to provide a link on their website to the National Institutes of Health's clinical research trial site www.clinicaltrials.gov. (Res. 204, H-2014)

460.998 Human Stem Cell Research

The Society endorses human stem cell research in Pennsylvania. (Res. 201, H-2005)

460.999 Use of Animals in Research

The Society strongly endorses the policy of the AMA which unequivocally supports the humane use of animals in biomedical research and teaching. The Society agrees that the use of animals in research and teaching must be carried out in compliance with current federal, state, local, and institutional laws and regulations and that the development of suitable alternatives to the use of animals should be encouraged and supported by government and private organizations. The Society supports efforts by the AMA and other medical societies to actively defend and promote such research and to develop and present educational programs to inform physicians and the public of the benefits of the use of animals in research and training. The Society supports the current AMA intent to organize national meetings to discuss the issue of research and the problems posed by animal rights activists. The Society is to stress to the public its concern regarding the impact of animal rights activists and "animal liberation" groups on the conduct of biomedical research and to condemn all illegal activities which may be used by these groups. The Society opposes many of the other tactics used by animal rights activists and "animal liberation" groups, including picketing, sit-ins, threats, and boycotts, (Res. 49, H-1991)

470.000 Sports and Physical Fitness

470.999 Certified Trainers in School Programs

The Society favors the concept of certified trainers in schools supervised by physicians. (Res. 2, H-1980)

475.000 Surgery

475.998 Definition of Surgery

The Society adopted the following definition of surgery, and shall work with all interested specialties in an effort to have this definition incorporated into Pennsylvania law: Surgery is defined as a treatment (diagnostic, palliative or therapeutic) of conditions or disease processes by using instruments, including lasers, ionizing radiation, scalpels, probes and needles in which human tissue is cut, burned, vaporized, frozen, sutured, probed, manipulated by closed reduction for major dislocations and fractures, or otherwise altered by any mechanical, thermal or chemical means. The definition is not intended to include ministrations that are part of routine bodily hygiene, such as trimming of hair or nails, or infringe on the scope of practice of those already licensed to perform similar limited procedures, such as electrolysis, tattooing, and piercing. (Res. 201, H-2002)

475.999 Surgical Assistants

The Society supports the statement of principles of the Regents of the American College of Surgeons regarding surgical assistants. (Res. 36, H-1982)

480.000 Technology

480.995 Electromyography as the Practice of Medicine

Inasmuch as the procedure known as electromyography involves the invasion of human tissues for the purpose of diagnosing diseases and ailments of the human

body, the Society sees the procedure as the practice of medicine. It is prepared, if necessary, to seek introduction of legislation to amend the Physical Therapy Practice Act of 1975 to clarify the scope of practice of physical therapy by requiring that all invasive procedures and those tests which may constitute the basis of medical diagnosis be done upon request of and under the direct supervision of a physician. (Board of Trustees, March 1983)

The Society reaffirms that needle electromyography is the practice of medicine to be performed solely by licensed physicians and shall develop and advocate for legislation. (Res. 406, H-2010)

480.996 Information Technology Assistance for Members' Practices

The Society will (1) make available to member practices an annually updated list of businesses that could assist with IT needs related to billing and reporting; 2) refer practices to PMSO for guidance on software support; and 3) provide guidelines on doing an RFP to practices that may be interested in purchasing software. (Report 15, Board of Trustees, H-2009)

480.997 Telemedicine/Telehealth

The Society adopted the following policy:

1. Physicians and others practicing telemedicine/telehealth acknowledge that they retain responsibility for patient safety and the quality of services provided to their patients.
2. Only clinical and technical guidelines and practice parameters developed and endorsed for specific telemedicine/telehealth applications by national specialty organizations and other nationally acknowledged authorities (e.g., AMA, US Preventive Services Guidelines, etc.) should be utilized by local facilities as the standard for the performance of telemedicine/telehealth services and procedures.
3. The State Society encourage third-party payers to reimburse all such endorsed telemedicine/telehealth applications, without regard to geographic location.¹ However, the use of telemedicine/telehealth should never be mandated by third-party payers through discriminatory reimbursement policies that discourage patients from obtaining an in-person examination by a physician for such purposes.
4. Pennsylvania health care licensing boards require that all non-resident physicians, NPPs, and technicians participating in telemedicine/telehealth activities in Pennsylvania be duly licensed, certified, and/or registered in Pennsylvania.
5. Hospital medical staffs identify those clinical services that can be prudently provided by telemedicine/telehealth at that hospital and ensure that physicians providing such telemedicine/telehealth services are appropriately credentialed as members of the medical staff.
6. Physicians who routinely screen, diagnose, and treat patients for chronic conditions via telemedicine/telehealth schedule periodic in-person encounters with these patients. In situations where system-directed examinations are occurring, in-person consultations should be arranged between those patients and appropriate specialists.

¹In other words, if the service is clinically acceptable for patients in remote areas, it should also be available anywhere throughout Pennsylvania.

7. Physicians incorporate the regular reporting, recording and supervision of patient care via telemedicine/telehealth into the standard medical record systems used for all other patients.
8. Physicians ensure that their legal and ethical requirements to maintain patient privacy and confidentiality are not compromised during and after telemedicine/telehealth encounters.
9. The State Society monitor all proposed legislation and regulations concerning telemedicine/telehealth and respond in a manner consistent with these recommendations.
10. Medical education via telemedicine continue to be awarded CME credits similar to any other educational modality.
11. The State Society continue its leadership of a state-sponsored Broadband Initiative that will eventually assist physician practices in upgrading their capabilities to practice telemedicine/telehealth. (Report 5, Board of Trustees, H-2007)

480.998 Improving Medical Practice through Information Availability

The Society adopted as policy to actively support community-based efforts to make key laboratory, pharmacy, and physician contact data easily available to physicians in electronic format and encourage health plans, laboratories, pharmacy management companies and health care facilities to design and implement systems that support this goal, consistent with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA), state law, and patient preferences. The Society will monitor the creation and activities of such networks and participate in them where feasible. The Society encourages the county medical societies to do likewise. The Board will continue to explore the feasibility of implementing the related health care technology project identified at the Board's July 2004 retreat. The Society is directed to forward Report 3 of the Board of Trustees to the AMA. (Report 3, Board of Trustees, H-2004)

480.999 Telemedicine

The Society adopts the position that out-of-state health care practitioners must be fully licensed to practice medicine in Pennsylvania in order to be permitted to provide telemedicine services; further, that any physician from another state practicing telemedicine must have malpractice insurance in the state of Pennsylvania. (Report 29, Board of Trustees, H-1996; reaffirmed, H-2016)

Reiterated this policy through correspondence to the State Board of Medicine. (Board of Trustees, March 2001)

490.000 Tobacco

490.992 Electronic Cigarettes

The Society supports electronic cigarette legislation equivalent to Pennsylvania tobacco cigarette laws, including its taxation and sales to minors; further, supports tobacco education in Pennsylvania schools including the potential dangers of electronic cigarettes. (Res. 401, H-2013)

490.993 Statewide Tobacco Legislation Regarding Minors

The Society supports legislative efforts at the state and county levels to prevent minors from possession and/or using tobacco products in public. (Res. 402, H-2007)

490.994 **Reclassification of Tobacco as a Prescription Drug**
The Society believes (1) tobacco has no value as a drug and should not be listed with other prescription drugs which have a medical value; (2) if tobacco were reclassified, physicians would face an ethical dilemma when asked to prescribe a substance for patient use, knowing full well that the substance causes substantial harm and possibly death with extended use; and (3) in light of the current availability of tobacco, any measures to regulate its distribution would meet with strong opposition from the tobacco industry, its affiliates, and the smoking public. (Report 15, Board of Trustees, H-1994)

490.995 **Anti-Tobacco Ordinances**
The Society is directed to work to remove prohibitions on more stringent local anti-tobacco ordinances contained in the Clean Indoor Act. The Society encourages municipalities throughout Pennsylvania to enact local anti-tobacco ordinances and encourages physicians to initiate and support efforts to enact local anti-tobacco ordinances. (Sub. Res. 705, H-1994)

490.996 **Tobacco and Smoking**
The Society calls for health insurance coverage and reimbursement for smoking cessation efforts. (Res. 37, H-1993; Revised, H-2003)

490.997 **Tobacco Related Legislation**
The Society pursues the following legislative initiatives:
1. Mandate reimbursement for medically-monitored smoking cessation efforts;
2. Ban tobacco vending machine sales; and (Res. 63, H-1989; Revised, H-1999)
3. Ban the use of tobacco products in restaurants. (Res. 707, H-1995; Revised, H-1999)

490.998 **Ban on Smoking in Hospitals**
The Society calls for a complete ban on smoking in hospitals. (Res. 24, H-1986; reaffirmed, H-2016)

490.999 **Ban Distribution of Cigarettes and Smokeless Tobacco**
The Society opposes the distribution of free cigarettes and smokeless tobacco in public and seeks to have legislation passed which would bar the distribution of free cigarettes and smokeless tobacco in public in PA. (Res. 25, H-1986; reaffirmed, H-2016)

495.000 **Tobacco: Labeling and Warnings**

495.998 **Smoking Cessation**
The Society urges all hospitals to have mechanisms in place, be it pharmaceutical or other means, to facilitate the treatment of patients who desire help with smoking cessation. Funds received from the Multi-State Tobacco Settlement should be used for this purpose. (Res. 37, H-1991; Revised, H-2001; revised, H-2011)

495.999 **Reimbursement to Physicians and Psychologists who Provide Smoking Cessation**
The Society supports physicians and psychologists providing formal smoking cessation services to their patients. The Society supports reimbursement of these physicians and psychologists with funds received from the Multi-State Tobacco Settlement. (Report W, Board of Trustees, H-1991; Revised H-2001)

500.000 Tobacco: Marketing and Promotion

500.999 E-Cigarette Advertising and Paid Products Placement

The Society directed its AMA Delegation to ask the AMA to work through an appropriate federal process to prohibit e-cigarette companies from paying for product placement in films or hiring celebrity spokespeople; further, that the AMA be asked to work through an appropriate federal process to prohibit e-cigarette advertising on television. (Res. 203, H-2014)

505.000 Tobacco: Prohibitions on Sale and Use

505.996 Elimination of Tobacco Sales

The Society is directed to oppose the sale and public use of tobacco products in the Commonwealth of Pennsylvania. (Res. 201, H-2016)

505.997 Ban Smoking in Public Places and Workplaces

The Society is directed to resume its efforts to ban smoking in public places and workplaces in Pennsylvania, including restaurants and bars, through lobbying efforts at the state legislature and fiscally responsible public awareness campaign. The Society will lobby in support of Senate Bill 1213 or other proposed legislation that calls for a similar prohibition on smoking in public places. The Society is directed to report back on the status of its efforts at each annual meeting until this goal is accomplished. (Res. 214, H-2004)

505.998 Sale of Cigarettes in Pharmacies

The Society objects to the sale of cigarettes and other smoking materials in the pharmacies of Pennsylvania. (Res. 3, H-1988; Revised, H-2001)

505.999 Legislation to Eliminate Smoking in Public Places

The Society supports Act 27 of 2008, The Indoor Clean Air Act, which eliminates smoking in public places or workplaces in Pennsylvania. However, the Society will continue to monitor the implications of the law and lobby for stricter enforcement and appropriate tightening of legislation and regulations to prohibit smoking and protect public health. (Res. 50 and 58, H-1991; revised, H-2011)

520.000 War

520.999 De-alerting/Abolition of Nuclear Weapons

The Society joins military experts and security authorities to call for measures to prevent accidental or inadvertent use of nuclear weapons (Res. 203, H-1998)

530.000 PAMED: Administration and Organization

530.979 Regional Medical Societies

PAMED is directed to assist county society efforts to regionalize by:

- Providing support to counties who voluntarily wish to combine resources to reflect the regional nature of healthcare in Pennsylvania;
- Creating a task force made up of members of the Board of Trustees, delegates, non-delegates, and county medical society staff members who will create a grant process by which county medical societies will apply to receive grant monies to be used for legal fees and other expenses associated with the regionalization process by January 1, 2019. The Task Force will decide the amounts, application process, and outcome reporting; and
- Establishing a grant fund of \$100,000.

Additionally, the PAMED Bylaws shall be amended to allow regional component societies. (Res. 512, H-2018)

530.980 Affirming PAMED Purpose and Mission

PAMED is directed to affirm its Mission Statement and to set it forth in the PAMED Policy Compendium. Also, PAMED shall maintain steadfast commitment to this Mission Statement as the foundation for all PAMED actions and activities such that any justification for an action, decision, policy, or judgment of PAMED, its Trustees, or its component societies can be said to satisfy this mission. (Res. 511, H-2018)

530.981 Reaffirming County Medical Societies in PAMED

PAMED staff and elected leadership are directed to recognize and reaffirm that the county medical societies are integral components of the state medical society and vital to its ongoing success. Further, PAMED staff and leadership shall develop and implement a strategic plan to ensure that all staff and physician leaders are aware of the importance of the county medical societies, are appreciative of the many differences inherent to each county society, and are committed to helping restore a positive, supportive, and ongoing working culture between PAMED and the component county medical societies. Finally, PAMED staff and leadership shall develop and coordinate this strategic plan with the equal input and representation of county medical society elected leaders and executive staff. (Res. 503, H-2018)

530.982 Supporting the Development of Medical Student Leaders

PAMED is committed to providing a fund covering the costs of travel and two nights of lodging for one student at every Pennsylvania medical school to attend American Medical Association Medical Student Section meetings at the Interim and Annual Meetings, effective immediately. (Res. 507, H-2014)

530.983 Reporting of DUIs to Physicians' Health Programs

The Society strongly encourages physicians or their colleagues to contact the Physicians' Health Programs (PHP) with information regarding those who may be suffering consequences of alcohol or drug abuse. The Society will request that the State Board of Medicine make all physicians aware that DUIs are automatically reported to the PHP, encouraging early follow-up. (Res. 201, H-2009)

530.984 Institute for Good Medicine

The Society shall (1) transfer successful projects from the Institute for Good Medicine to appropriate units within PAMED; (2) use resources from the Institute for Good Medicine to help build the PAMED Better Health Network; and (3) in the spirit of Resolution 08-501, preserve the name and trademark of the Institute for Good

Medicine so that it may be used later if merited. (Report 9, Board of Trustees, H-2011)

530.985 Pennsylvania Delegation Membership for AMA Speaker/Vice Speaker

The Society adopted the policy that any Pennsylvania delegate elected to the office of Speaker or Vice Speaker of the AMA House of Delegates be automatically considered a member of the Pennsylvania Delegation to the AMA for as long as she or he serves in that office. (Res. 501, H-2007)

530.986 Society's Group Health Association Plan

The Society shall continue to work closely with its endorsed broker to explore ways in which its association plan can be made more attractive in terms of benefits while remaining competitive. Given that there are currently no alternative solutions or options for association health insurance programs, the Society should continue to offer the most competitively structured and reasonably priced health insurance plans available to its members. The Society should continue to monitor the insurance marketplace for alternative solutions or options for association health insurance programs. (Report 17, Board of Trustees, H-1999; revised, H-2009)

530.987 PMSLIC Sale

The Board of Trustees shall: (a) place the proceeds of the sale of the Society's majority interest in PMSLIC, minus the amount that the Board has committed to fund PMSCO (\$4 million) in a segregated fund; (b) expend no money in the segregated fund during 1998 or 1999, except to the extent required (i) to cover the expenses of the sale transaction and related tax consequences, and (ii) to balance the proposed 1999 budget (including the \$178,000 budgeted for 1999 county grants, but excluding the proposed \$100 dues reduction), unless the expenditure is recommended to the House of Delegates by 75 percent of the Board, and the Board recommendation is thereafter approved by 75 percent of the House of Delegates; (c) limit the 1999 county grants to projects which are consistent with the Society's mission and tax-exempt purposes, and condition those grants upon the Society receiving a favorable IRS private letter, ruling that the grants do not jeopardize the Society's non-profit federal tax exemption and the counties agreeing to comply with any restrictions in the IRS ruling; (d) report back to the House of Delegates at the 1999 annual meeting, with the Board's recommendations as to the disposition of the balance of the segregated fund and the future proceeds of the sale; (e) solicit county input in developing recommendations regarding the future disposition of the segregated fund and the proceeds of the sale; (f) use Board of Trustees Report 38 as the framework for discussions regarding the future disposition of the segregated fund and the proceeds of the sale, especially in the requirement that super-majority (75 percent) be required to invade the principal of the segregated fund; and (g) bring back to the House of Delegates a bylaws change which would require 75 percent Board approval and 75 percent House of Delegates approval to expend principal monies in the segregated fund. (Res. 505, H-1998)

The endowment fund is funded by the net proceeds, after expenses and other associated disbursements, of the sale of Pennsylvania Medical Society Liability Insurance Company and any subsequent contributions to the fund. The inflation adjusted principal of the fund may be invaded only upon recommendation of a super majority vote of 75 percent of the Board of Trustees and subsequent approval by a super majority vote of 75 percent of the credentialed, as the day of the vote, members of the House of Delegates. Net income from the fund, after expenses and an offset to ensure the fund does not drop below the annual inflation

adjusted value of the principal, may be used to support Society programs. Amendment of the super majority vote provisions shall require the same 75 percent super majority votes. Amendments to the Society's bylaws, in the case of the endowment fund, require a vote of 75 percent of the delegates credentialed, as the day of the vote. (Subject 4 of the Official Call, H-1999)

530.988

Commercial Agreements

The Society adopted the following Principles to Guide Corporate Relationships:

Definitions

For purposes of these principles, the following definitions shall apply:

Corporate arrangements shall mean one of several types of transactions which include: unrestricted educational grants, education and health related agreements, member services, and other instances where the Society grants licenses to others to use the Society's information or editorial products, and catalogs. It does not include the Society's real estate transactions or the Society's data base business.

Endorsement shall mean transactions in which an organization, by use of its name and logo, implies approval of a company, product, or service. The Society does receive unrestricted corporate grants to underwrite educational programs. This is not considered to be an endorsement.

(1) When appropriate and desirable, the Society participates in corporate arrangements to support activities that will further its core purpose of promoting the art and science of medicine and the betterment of the public health. In general, rather than responding to others, the Society will choose its priorities for corporate relationships and participate in those activities that fulfill these priorities; (2) all corporate arrangements with any company, organization, association or other entity should be consistent with these principles. Any proposed arrangement must be reviewed and approved by the Board of Trustees to ensure that acceptance of such funds would have no potential influence on Society policies or conflict with the Society's goals; (3) the Society accepts funds or royalties from a corporation only if acceptance does not pose a conflict of interest and in no way impacts the objectivity of the association, its members, activities, programs, or employees; (4) participation in a specific corporate arrangement does not in any way imply the Society's approval of the corporation's policies, nor does it imply that the Society will exert any influence to advance the corporation's interests outside the substance of the arrangement itself. The Society's name and logo may not be used in a manner that would express or imply an endorsement of the corporation or its policies; (5) the Practice Advocacy Executive Council's designee, in consultation with the Office of General Counsel, will review and approve all marketing materials bearing the Society's name or corporate identity in compliance with these principles and guidelines; (6) those corporations providing support to the Society are regularly recognized in Society publications and other appropriate forums, and Society corporate arrangements will be reported regularly as part of the financial reporting to the Board of Trustees and House of Delegates; (7) the Society retains editorial control over any information produced as part of a corporate arrangement. In every case, all materials in print, broadcast, or electronic media prepared by the corporate entity must be submitted to the Society for approval in writing prior to release; (8) whenever possible and feasible, the Society seeks funding for programs from a variety of sources. It is understood, however, that occasions may arise when support of a specific event, publication, or service from a single source is appropriate. The Society will exercise special caution so that in circumstances when single support is granted, the Society avoids conflicts of interest and guards

against any perception of conflict of interest; (9) the Society does not endorse health or medical products or services which are marketed to consumers and which the Society does not design, produce, or control; (10) the Board of Trustees is responsible for the operations of the Society, including relationships with corporations, between meetings of the House of Delegates, consistent with principles and policies adopted by the House of Delegates. Principles governing the Society must be ethically consistent with those which govern individual Society members; (11) the Executive Vice President is responsible for the review and implementation of each specific arrangement according to the above principles; and (12) the chair of the Practice Advocacy Executive Council is responsible for informing the Board of Trustees so that the Board may approve and authorize corporate arrangements that have an economic and/or policy impact for the Society.

Process

1. A small senior management work group, appointed by the Executive Vice President and including the General Counsel, shall initially review all proposed endorsement and report to the Practice Advocacy Executive Council on whether, in their view, the proposed endorsement is consistent with the mission of the Society, the interests of the members and the ethics of the profession
2. Whenever reasonable and/or feasible, Council staff shall seek competitive bids before preparing a recommendation on endorsement. Staff shall prepare a request for proposal as the basis for competitive bids.
3. The Practice Advocacy Executive Council shall review all proposed endorsements, including such materials as requests for proposals and bids. The Council shall consider the benefits and quality of services to the members as well as the financial benefits to the Society.
4. The Practice Advocacy Executive Council shall review existing endorsements regularly, at least once every three years.
5. Each agreement for endorsement shall provide that the Practice Advocacy Executive Council must approve all marketing information for the product.
6. The Board of Trustees shall review and approve, if they agree, all endorsements following recommendations by the Practice Advocacy Executive Council.
7. The Executive Vice President shall sign all endorsement agreements approved by the Board, if consistent with the principles and processes outlined here and with the advice of counsel. (Report 29, Board of Trustees, H-1998)

Addendum

Principles to Guide Corporate Relationships

This Addendum, with its modified process, will apply to situations in which a corporate relationship includes use of name and/or logo, but no funds or royalties are being exchanged by the parties involved. Primary examples are:

- Participation in a coalition
- Participation in a government-sponsored or public health initiative
- Endorsement of a continuing medical education activity

Process

In accordance with Principle 1 of the current Principles, “Rather than responding to others, the Society will choose its priorities for corporate relationships and participate in those activities that fulfill those priorities.”

1. A small senior management work group appointed by the Executive Vice President shall gather and review information pertaining to the request, and report to the Board or Executive Committee when, in their view, the proposed activity is consistent with the priorities of the society, the interests of the members and the ethics of the profession. The following questions will be utilized to determine the appropriateness of the proposed activity:
 - Has our physician survey data identified a recurring member need?
 - Is the activity consistent with the Society’s mission?
 - Does the activity fulfill a corporate priority (patient, practice, or political advocacy)?
 - Is there a clearly defined mission, purpose, and timeframe for the activity?
 - What new value does the activity bring to the Society and its membership?
 - What is the level of credibility/reputation of the requesting organization?
 - What is the level of credibility/reputation of the other participants and/or sponsoring organizations?
 - What financial and staff resources will the activity require?
 - What is the value of the specific benefits extended to members by virtue of the Society’s participation in this activity?
2. The Board, or Executive Committee if timing is an issue, shall review and approve all endorsements.

Note: All individuals involved in the process of approving endorsements are subject to the Society’s policy regarding disclosure of any conflicts of interest. (Report 16, Board of Trustees, H-2005)

530.989 Free Choice to Nominate Individuals

The Society will provide nominations to professional organizations that request them or are mandated by law to request them, provided the Society is given free choice to nominate individuals it deems eligible. If the nominees are physicians, they must be Society members. Organizations that request Society endorsement of a nominee should, if at all possible, submit the name of more than one Society member. (Board of Trustees, October 1994)

530.990 Nonmembers: Price for Society Products/Services

The Society has determined that non-members be required to pay the full value price for any Society product or service except when the materials are used as part of a recruiting campaign. (Board of Trustees, March 1988)

530.991 Legal Action on the Request of an Individual

Reaffirmed the policy that PAMED not support legal action on the request of an individual member or his counsel unless (1) the legal issue raised has broad implications for the general membership of PAMED, and (2) PAMED intervention will have a significant likelihood of affecting the outcome for the benefit of physicians generally, this determination to be made by the Board of Trustees or the Executive Committee acting in the Board’s stead with the advice of legal counsel.

However, the PAMED Legal Department may consult with members' lawyers and local trustees and medical societies may involve themselves in legal issues to gain factual understanding. (Board of Trustees, March 1991; H-2011)

530.992 Demographic Reports on Annual Basis to County Societies

The Board shall provide physician demographic reports on an annual basis to all county societies*. These reports should contain statistical information on young physicians, women physicians, and IMGs by all physicians statewide and by county, by members statewide and by county, and by delegations within the most recent House of Delegates. Further, counties and districts comprising smaller counties should be recognized at future House meetings for their efforts to improve statistical balance within their delegations. (*Small counties, unlike their larger counterparts, will experience difficulty in achieving statistically balanced representation within their small delegations. For this reason, statistical reports for small counties will be generated by district to encourage a balanced representation among all delegations within a district, rather than within an individual county delegation.) (Report of Ad Hoc Committee on House Representation, H-1997)

530.993 Elected Officials and Conflict of Interest

Candidates for the office of president shall disclose substantial involvement in policy development or as a board member of (a) a health insurer, (b) a governmental agency, or (c) a health care association with significant involvement in legislative matters. This requirement shall not extend to other offices at this time. (Report 18, Board of Trustees, H-1997; Report of Speaker, House of Delegates, H-1998)

530.994 Numerical Balance Between AMA Delegates and Alternates

(1) the Pennsylvania Delegation's Executive Committee retain the flexibility to recommend alternate delegates for elevation to permanent delegate based on a combination of length of service on the delegation; the preferences of the House of Delegates as expressed in preceding elections; elected and appointed positions within the delegation; demographics; particular expertise; and elected or appointed leadership positions within the Society; and (2) these same criteria also apply to temporary appointments. (Report 17, Board of Trustees, H-1997; revised, H-2007)

530.995 Voluntary Term Limits for Pennsylvania AMA Delegates

The Society shall establish voluntary term limits for AMA delegates based on the following criteria: Six two-year terms as a delegate (alternate delegate term of service not included). The following categories of delegates shall be excepted from voluntary term limits: (1) a delegate who currently holds AMA office, (2) a delegate who is considered a likely and strong candidate for AMA office, and (3) a delegate who is invaluable in a specific, identifiable way to the delegation. (Report 34, Board of Trustees, H-1997)

530.996 Mainstreaming Underrepresented Physician Groups

The House of Delegates shall identify ways to encourage county medical societies and other delegations within the House to mainstream underrepresented young physicians, international medical graduates, and women physicians into their component societies and delegations. (Report of Ad Hoc Committee on House Representation, H-1996; reaffirmed, H-2016)

530.997 Physicians' Health Programs (PHP)

The Society reaffirms its commitment to serve its colleagues in need through the Physicians' Health Programs (PHP) of The Foundation of the Pennsylvania Medical Society and continue to support the PHP. (Res. 609, H-1994)

The Society supports the Physicians' Health Programs' (PHP) committee's decision to take all necessary steps to preserve the confidentiality of the program; further, the Society continues its ongoing support for the work of the PHP in its efforts to assist Pennsylvania physicians with health problems which potentially could cause impairment. (Res. 205, H-1995)

530.998 Ten-Year Sunset

Resolution 89-9 directed that all policies adopted prior to 1981 be reviewed and presented to the House. During 1990, the subject Society policies were reviewed by appropriate councils and the Board, producing a series of recommendations for the House. The intent is that the House will review all policies enacted on their tenth anniversary. Those not renewed by the House, automatically expire. The House acted on these recommendations in 1990. (Res. 9, H-1989; Report L, Board of Trustees, H-1990)

530.999 Full Slate of Alternate Delegates

The Society requires that one fully funded alternate delegate be sent to the AMA for each fully funded delegate. (Res. 41, H-1990; Board of Trustees Report HH, H-1990; reaffirmed, Report A, Special Committee on AMA Delegation Matters, H-1991)

The Society approved the recommendation that attendance requirements at AMA meetings for alternate delegates be changed to permit alternates to attend either the annual meeting or the interim meeting in any year during their first two terms; during this time, however, the alternate is to attend at least two annual meetings and two interim meetings. The decision to attend one meeting or the other, as well as the decision to attend both meetings, will be left to each eligible alternate. This attendance requirement would also apply to all current alternate delegates with less than four years of service. At the end of four years of service, an alternate must indicate a commitment to attend both AMA meetings or an inability to meet this commitment by not running for re-election. (Report 14, Board of Trustees, H-1994; revised, H-2014)

535.000 PAMED: Board of Trustees

535.995 PAMED Financial Transparency

The 2018 House of Delegates declared that in any future transactions, potential or actual conflicts of interest involving spouses, children, other family members, or friends of members of the Board of Trustees, the Executive Committee, or Executive Leadership are mandated to be revealed consistent with full disclosure. Additionally, all Board of Trustees members, members of the Executive Leadership team, and PAMED Staff are directed to declare any financial or ethical conflicts they may have and they must recuse themselves from votes or actions if a conflict with the issue exists. (Res. 510, H-2018)

535.996 PAMED Board of Trustees Transparency

The Executive Committee of the Board of Trustees is directed to review PAMED's Conflict of Interest and Code of Conduct policies to ensure transparency and the best interests of members, the county and state specialty societies/associations,

and PAMED. Additionally, these policies shall be reviewed in accordance with the PAMED Ten-Year Sunset Policy. (Res. 506, H-2018)

535.997 Transparency within the Functioning of the Pennsylvania Medical Society
The Pennsylvania Medical Society (PAMED) shall disseminate to the counties and subsequently their members information to include but not limited to: Agenda Action Forms, Executive Summary of Issues, and Discussion Items for upcoming Board meetings. (Res. 506, H-2017)

535.998 Chair of AMA Delegation Ex Officio Non-Voting Member
The chair of the Pennsylvania Delegation to the AMA shall serve as an ex officio, without vote, member of the Board of Trustees. (Subject 5 of the Official Call, H-1999)

535.999 Executive Committee to Act for the Board
Authorized the Executive Committee to act for the Board between meetings; further, that the full Board be notified as quickly as possible of Executive Committee actions or of actions of quick response teams. (Board of Trustees, September 1991)

540.000 PAMED: Councils and Committees

540.998 Sunsetting Review of Committees, Commissions, and Work Groups
All committees (with the exception of standing committees), commissions, and work groups shall be subject to a sunsetting review on a yearly basis. This shall be done by the Chair of the Board of Trustees at each September Board meeting and shall require concurrence by the entire Board at that meeting. (Address of President-Elect, H-1998)

540.999 Nominations—Councils, Commissions, Committees, and Subsidiary Boards
The Society and its subsidiaries were directed to always solicit nominations from the county medical societies whenever they must fill vacancies on any entity, including boards, councils, commissions, and committees; to follow a standard procedure whenever they solicit nominees for any entity, including boards, councils, committees, and commissions; and that this standard procedure include, as a minimum, soliciting nominees from both the district trustees and the presidents of the county medical societies. (Res. 614, H-1994)

545.000 PAMED: House of Delegates

545.984 Reaffirming PAMED Policymaking by the House of Delegates
The House of Delegates (HOD) shall be reaffirmed in its role as the primary policymaking body of the Pennsylvania Medical Society (PAMED). (Res. 505, H-2018)

545.985 Transparency of Resolution Research
PAMED staff shall provide access to all research on all resolutions for the current year to all PAMED members for that same year at the same time as such is provided to the Board of Trustees. (Res. 504, H-2018)

545.986 HOD Engagement Task Force

PAMED is directed to form a task force comprised of both delegates and non-delegates to address the recommendations of the 2018 HOD Engagement Task Force to explore the incremental virtualization of the House of Delegates process. The goal of the task force is to increase member input, involvement, and satisfaction while maintaining the transparency of PAMED's governance process. This task force will be charged with recommending and proposing necessary Bylaws changes for consideration by the 2019 PAMED HOD. (Res. 501, H-2018)

545.987 Medical Ethics CME

PAMED shall initiate a forum for Continuing Medical Education (CME) at the House of Delegates (HOD) for review of cutting-edge science and technology as it relates to the ethics of medical practice. PAMED shall also initiate further online CME activities regarding these important scientific discoveries and debates of medical ethical challenges for forum discussion. (Res. 203, H-2018)

545.988 Financing for Student and Resident Delegates

The Pennsylvania Medical Society (PAMED) shall explore multiple funding avenues, collaborative relationships, and engagement opportunities as methods by which to engage students, residents, fellows, and physicians in the annual House of Delegates meeting. (Res. 502, H-2017)

545.989 Promotion of Resolutions Submitted to House of Delegates

The Society shall use the member section of its website and other means to promote member submission of resolutions to the House of Delegates. (Res. 501, H-2011)

545.990 Continued Identification of Authors of Resolutions

The Society adopted the policy that the name or names of author(s) and the county medical society or other entity be carried with the resolution and be a means of identification when presented to the Pennsylvania Medical Society, thus permitting clarification, defense and redefinitions, if needed, from the original author(s). The Society directed its AMA Delegation to examine the possibility of proposing a similar resolution to the AMA that would identify the name(s) of author(s) and county medical society or other entity. (Res. 502, H-2010)

545.991 Policy Regarding Authors of Resolutions Referred for Study

Adopted the following policy regarding informing authors of resolutions that are referred for study of the actions taken by the Society regarding their resolution, as recommended by the Executive Committee: 1) following the Annual Business meeting, a memo will be distributed to the Society staff member assigned to the resolution referred for study. The memo will remind the staff that authors should be contacted and provided the opportunity to submit any additional information they believe might be helpful in supporting the intent of the resolution; and further that authors may be invited and encouraged to participate in any study involving their resolutions and 2) when appropriate and feasible staff may invite and encourage authors to participate in the implementation process of resolutions passed by the House. (Board of Trustees, September 2010)

545.992 Color Coded Name Badge System for PAMPAC Members

The Society adopted a color-coded name badge identification system for the House of Delegates, effective with the 2010 meeting, that clearly distinguishes between delegates and alternate delegates who are current members of PAMPAC and those who are not. As part of the color-coded name badge system, an easy and quick

way to join PAMPAC will be made available to all delegates and alternate delegates at the time of registration and throughout the annual meeting. PAMPAC members will have the option to decline the recognition. (Res. 508, H-2009)

545.993 Keeping Resolution Authors Informed

The Society established a policy whereby authors of resolutions referred for study by the House of Delegates will be invited and encouraged to participate in the study and implementation of said resolution. (Res. 506, H-2009; adopted amended language in lieu of Res. 507, H-2018)

545.994 Corporate Sponsorship

Approved the recommendation of the Executive Committee that the opportunity for sponsorship of House of Delegates events be extended to appropriate corporate entities including, but not limited to, the State Society's endorsed vendors, provided such sponsorship remains consistent with current AMA policy on "Gifts to Physicians from Industry". (Board of Trustees, January 2003)

545.995 Time of House of Delegates Meeting

The annual House of Delegates meetings shall continue to be held in October. (Report 14, Board of Trustees, H-1996; reaffirmed, H-2016)

545.996 Appendixes to Resolutions

Documents may be appended to resolutions, where necessary, to facilitate the discussion by the reference committees. (Res. 609, H-1996; reaffirmed, H-2016)

545.997 Conflict of Interest

The Society adopted the following policy: Members of the Pennsylvania Medical Society House of Delegates who have a substantial financial interest in a commercial enterprise, which interest will be materially affected by a matter before the House of Delegates, must publicly disclose the interest before: (1) testifying at a reference committee on the matter; or (2) speaking on the floor of the House of Delegates on the matter. (Sub. Res. 608, H-1995)

545.998 Resolution Fiscal Notes

The Society is directed that with each statement of fiscal impact of a resolution, there be some explanation as to how that figure was derived. (Res. 58, H-1993)

The Society adopted the following policy: Resolutions shall be accompanied by a fiscal note generated by the Society staff in consultation with the author, and the Society shall ask the AMA to amend its policy on fiscal notes to incorporate this concept. Any resolution introduced to the Society's House of Delegates shall require Society staff to consult with the author of the resolution in order to be aware of current Society policy on the subject matter of such resolution and whether such policy may render the proposed resolution unnecessary by being substantially duplicative of present policy. When the author of a Society resolution requests that it be forwarded to the AMA House of Delegates, the author shall ask Society staff to consult with AMA staff in order to inform the author whether the proposed resolution is substantially duplicative of current AMA policy. Further, the staff of the Society and AMA shall examine the feasibility of placing PAMED and AMA policies on appropriate media. (Res. 607, H-1995)

545.999 Inclusion of Map in Official Reports Book

The Society will include a map of the Commonwealth in future "Official Reports Books" indicating the location and boundaries of each county and the number of

physicians in each county as well as the number of delegate positions allotted each county. (Res. 43, H-1990)

555.000 PAMED: Membership and Dues

555.990 Practicing Physician Declining Membership Analysis

The Society is directed to petition the American Medical Association (AMA) to release to its membership in its annual report all aggregate survey data for the given year pertaining to reasons physicians are either leaving or not joining the AMA. (Res. 503, H-2017)

555.991 Membership Terminations

The Society is directed to cease terminating members prior to the end of the membership year for which they have paid and offer full benefits for the entire membership cycle even if advance notice is given not to renew membership for the following year. (Res. 505, H-2012)

555.992 County Presidents' Forum

The Society shall establish a County Presidents' Forum to provide discussion of county membership programs and services which may be adopted by other counties. (Res. 505, H-2003)

555.993 Membership Recruitment

The Society shall redefine its role in the process of recruiting members and provide the necessary support to its constituent county and specialty organizations. The Society is to take more aggressive action in providing each county medical society, specialty society and organized medical staff with current, accurate lists of non-members and a strong encouragement to work together in involving all members in making their societies stronger. These lists of non-members shall be widely circulated so that each physician who is identified as a recruitment candidate will be approached by several current members. (Res. 502, H-1998)

555.994 Individual Member Recruitment Efforts

The Society shall establish a mechanism to track individual recruitment efforts, and the recruitment efforts of individual members shall be regularly published in information reports to the entire Society membership. (Res. 613, H-1996)

555.995 Medical Student Dues

Dues for medical students in Pennsylvania shall be \$0; further, medical students shall have full access to Society services. (Ad Hoc Committee on House Representation, H-1996; revised, H-2006; reaffirmed, H-2016)

555.996 AMA Membership

The Society continues to urge physicians to join the AMA on a voluntary basis. (Res. 101, 11-95; revised, H-2015)

555.997 Graduated Dues Discount

The Society is directed to instruct all counties to comply with the young physician graduated dues program implemented in 1994 by the Pennsylvania Medical Society House of Delegates beginning at the time of the inception of the 1996 dues billing cycle; further, that should county societies not fulfill the Bylaws requirement, the Board of Trustees consider implementation of Chapter II, Section 3 of the

Pennsylvania Medical Society Bylaws. (Sub. Res. 610, H-1995)

555.998 Osteopathic Physician Members

The Society affirms its policy that osteopathic physician members must belong both to the State Society and county medical societies. (Report 2, Board of Trustees, H-1995)

555.999 Elimination of Society Membership Requirement for PMSLIC Insurance

The Society eliminated the membership requirement in order to be insured by PMSLIC and approved the payment of dividends by PMSLIC to PennMed. (Report 28, Board of Trustees, H-1995)

565.000 PAMED: Political Action

565.998 Evaluation of Judicial Candidates

The Society is directed to actively involve itself and its members in judicial elections starting immediately, and without major reliance on other entities. (Res. 405, H-2000)

565.999 Membership in PAMPAC

The Society adopted as a priority membership in PAMPAC for all PAMED members. The Society strongly encourages all PAMED members in a leadership position, including those who are delegates and alternate delegates to the PAMED House or to the AMA House, council chairs and members, PAMED Board members and officers, and all county society officers to become PAMPAC members. (Res. 3, H-1993)

INDEX

- Abortion
 - Abortion, 1
 - Testifying Before State Legislature, 1
- Accident Prevention
 - Driving and Cell Phones, 1
 - Farm Machine Injury Prevention for Low-Income Farmers, 1
 - Motorcycle Helmet Law, 1
 - Protective Head Gear for Equestrian Events, 1
- Accident Prevention – Motor Vehicles
 - Automobile Accidents with Tractor Trailers, 2
 - Improve Pennsylvania’s Safety Belt Law, 2
 - Improving Pennsylvania’s Child Occupant Protection Law, 2
 - Mandatory Drivers’ License Reexamination for Senior Citizens, 2
 - Mandatory Seat Belt Laws, 2
 - Mandatory Use of Seat Belts, 2
 - Regulatory Reporting Requirement under Motor Vehicle Law, 2
- Acquired Immunodeficiency Syndrome (AIDS)
 - Accidental Exposure, 3
 - Act 148 of 1990, 4
 - Action by the Medical Society, 4
 - Certification of Significant Exposure, 6
 - Contact Reporting Immunity for Physicians, 6
 - Government Funding, 4
 - HIV Education, 3
 - HIV Positives Reported to Public Health Officials, 5
 - HIV Reporting, 5
 - HIV/AIDS Patients Who Purposely Threaten Others, 5
 - Individual Physician Behavior toward HIV Infected Patients, 4
 - Mandatory HIV Testing, 4
 - Mandatory Reporting of HIV Infection, 5
 - Patient Counseling, 3
 - Physician with AIDS to Consult with Colleagues, 5
 - Reporting to Department of Health, 5
 - Student/Resident Exposure to Blood-Borne Pathogens, 5
 - Unrestricted Testing, 3
 - Voluntary Testing, 3
 - Written Consent Requirements, 3
- Aging
 - Adult Day Care Centers, 6
 - Physician Membership in AARP, 6
- Alcohol and Alcoholism
 - Blood Alcohol Concentration, 6
 - Community Hospitals Meet Needs, 7
 - Identification and Rehabilitation of Drunk Drivers, 7
 - Underage Drinking and Strict Enforcement of DUI, 6
- Allied Health Professions
 - Advertising by Non-Physician Health Care Providers, 8
 - Department of Transportation Physical Examinations by Chiropractors, 8
 - Direct Reimbursement of Nurse Anesthetists, 10
 - Licensure Status for Physician Assistants, 9
 - Limited Licensed Practitioners, 9
 - Medical Anestheticians, 7
 - Oppose Primary Eye Care by Optometrists, 9
 - PA Society of American Association of Medical Assistants, 9
 - Physician Delegation Regulations, 8
 - Physician Non-Physician Relationships, 9
 - Restrictions of Medical Use of Lasers, 8
 - Scope of Practice of Dentistry, 8
 - Scope of Practice Reform, 9
 - Scope of Psychological Practice in the Hospital Setting, 9
 - Store-Based Health Clinics in Pennsylvania, 7
 - Supporting the Need for Physician Oversight, 7
- Cancer
 - Colorectal Cancer Surveillance, 10
 - Screening for Early Lung Cancer, 10
- Children and Youth
 - Cost and Availability of Immunization, 10
 - Health Passport, 11
 - More Stringent Vaccinations, 10
 - Periodic Preventive Health Exams for Children and Adolescents, 10
 - Proper Passenger Restraints on Airlines for Children, 10
 - Use of FDA Approved Adult Medications in Pediatric Care, 10
- Civil and Human Rights
 - Limited English Proficiency Policy Guidance Document, 11
- Coding and Nomenclature
 - Billing Modifiers, 11
 - CPT Code Modifiers, 11
 - Multiple Procedure Modifier Reimbursement, 11
 - Revision of Evaluation and Management Codes, 11
 - Uniform Disease and Procedural Coding, 11
- Crime
 - Confidentiality of Rape Counselors’ Files, 12
 - Sexual Harassment, 12
- Death
 - Advance Directives, 12
 - Death Certificate Guidelines, 13
 - Euthanasia, 13
 - Financial Incentives for Autopsies, 12
 - Hospice Programs, 13
 - Medical Examiner System, 13
 - Pronouncement of Death in Nursing Homes, 13
 - Providing a Home for the POLST Program, 12
 - Right to Die Legislation, 12
- Drug Abuse
 - Access to Treatment for Addiction, 14
 - Decriminalization of Illicit Drugs, 15
 - Education on Overdose Prevention/Naloxone Prescribing, 14
 - Prescription Drug Monitoring Legislation, 15
 - Provision of Clean Needles/Syringes to Drug Addicts, 15
 - Use of Medical Marijuana, 14

- Drugs
 - Appropriate Unused Medication Disposal, 16
 - Establishment of a Registry for Clozapine Users with Benign Ethnic Neutropenia, 16
 - One Fee One Number, 15
 - Safe Disposal of Prescription and Over-the-Counter Drugs, 16
 - Use of Anorexiant for Treatment of Obesity, 17
 - Use of Drug Enforcement Agency (DEA) Numbers, 16
- Drugs - Cost
 - Costs for Prescriptions, 17
 - Pharmacy Benefit Plans, 17
 - Physician Education on Pharmacy Benefits, 17
- Drugs – Labeling and Packaging
 - Consistent Prescription Medication Outdating, 18
 - Expiration Date of Prescriptions, 18
 - Prescription Drug Expiration Dates, 17
- Drugs – Prescribing and Dispensing
 - Geriatric Prescribing, 18
 - Pennsylvania Prescription Drug Monitoring Data Base, 18
 - Pharmaceutical Companies' Access to Physician Prescribing, 19
 - Pharmaceuticals Administered by Physician Practices, 18
 - Prepaid Prescription Plans and Unsound Medical Practices, 19
 - Prescription Drugs for Indigent Patients, 19
 - Prescription Pad Theft, 18
 - Safe and Appropriate Medication Dosages for Geriatric Patients, 18
 - Use of FDA Approved Drug Product/Medical Device, 19
- Drugs - Substitution
 - Changes in Medications Ordered by Physicians, 20
 - Changes in Medications Prescribed by Physicians, 20
 - Coverage for All Dosage Strengths in Formulary . Approved Products, 20
 - Enforcement of the Drug Substitution Law, 21
 - Information on Generic Drugs, 21
 - Informed Substitution of Anticonvulsant Drugs, 19
 - Non-Generic Drugs, 20
 - Pharmacy Benefits and Prescription Changes, 20
 - Pharmacy Scope of Practice, 20
 - Substitution of Foreign-Made Generic Medications by U.S. Pharmacies, 19
- Emergency Medical Services
 - Bioterrorism, 21
 - Care Delivered by On-Call Physicians, 22
 - Continued Improvement of Emergency Response, 21
 - Emergency Department Crowding, 21
 - Prudent Layperson Definition of an Emergency, 22
 - Utilizing Emergency Department to Connect Victims of Violence to Community Resources, 21
- Environmental Health
 - Acid Rain, 23
 - Acid Rain Policy Adopted, 22
 - Air Pollution, 24
- Future Policies on Environmental Issues, 24
- Pesticides and Herbicides, 23
- Radon Policy, 22
- Ethics
 - Confidentiality of Genetic Testing, 24
 - Joint Venture Contracts, 25
 - Non-compete Clauses in Physician Contracts, 24
 - Physician Advertising, 24
 - Restrictive Covenants in Medicine, 25
 - Restrictive Covenants in Physician Contracts, 24
 - Treatment of Chronic Pain, 24
- Firearms – Safety and Regulation
 - Firearms Safety Programs for Children, 25
 - Gun Violence, 25
 - Health Consequences of Firearms, 26
 - Promotion of Firearms Safety, 25
- Health Care Costs
 - Cost of Disposable Equipment, 26
 - Costs of Highmark Automatic Audits, 26
 - Health Insurance Company Comparatives, 26
 - Pennsylvania Health Care Cost Containment Council, 26
 - Release of Raw Data by HC-4, 27
 - Reporting of Advertising Expenditures, 26
 - Tax Exemption of Health Care Expenses, 27
- Health Care Delivery
 - Acceptable Standards of Treatment for Specific Disease Entities, 28
 - Access to Health Care, 28
 - Access to Quality Medical Care, 30
 - Blues on Call Program, 29
 - Choice of Physicians vs. Non-physicians in Managed Care, 32
 - Competition, 31
 - Corporate Practice of Medicine Doctrine, 28
 - Endorsement of Programs Which Improve Access to Health Care for the Uninsured and Underinsured, 27
 - Health Care Case Management, 31
 - Health Care Delivery Models, 30
 - Health Care Services to the Underserved, 28
 - Highmark Quality Reporting Initiative, Fall 2007, 28
 - Preserving Patient Access and Physician Choice of Practice, 27
 - Preserving Physician/Patient Relationship, 31
 - Prioritization of Health Care Resources, 31
 - Prompt Communication of Medical Information from Urgent Care Clinics, 27
 - Public Education, Importance of Continuity of Care by Personal Physician, 30
 - Reporting Forms, 27
 - Sharing of Patient Health Information, 28
 - Society Voluntary Indigent Health Plan, 30
 - Support for Multiple Approaches to Delivery and Financing, 30
 - Third-party Interference with Patient Management, 30
 - Timely, Humane Care for the Medically Indigent, 30
 - Universal Patient Transfer Form, 27
- Health Insurance
 - Appropriate Reimbursement for Professional Services, 38
 - Blue Cross/Blue Shield Tax Status, 39
 - Children's Health Care Act, 39

- Diversion of Insurance Premiums, 39
- Due Process in Contracts between Physician and Hospital, 39
- Independent Practice Access to Facilities and Insurance Program Participation, 38
- Insurance Company Reminders of Appropriateness of Care, 38
- Out-of-Network Rate Calculation Methodologies, 38
- Participation by Physicians in Health Insurance Programs, 39
- Payment Delays for Physicians' Services, 39
- Physician Qualification for Insurer Programs, 40
- Proper Payment under Assignment of Benefits, 38
- Regulatory Oversight of the Blues, 39
- Reimbursement for Services Related to Obesity Diagnosis, 38
- Reimbursement for Services Related to Tobacco Abuse Diagnosis, 38
- Remove Special Status of Blue Shield and Blue Cross, 40
- Requiring Insurer Contracts with Hospitals, 38
- Universal Physician/Insurance Carrier Credentialing, 39
- Health Insurance – Benefits and Coverage
 - Abnormal Pap Smears for Uninsured Women, 42
 - Access to Affordable Health Insurance, 41
 - Availability of Insurance Coverage Information to Patients, 43
 - Child Health Insurance, 45
 - Contraceptive Coverage, 42
 - Coverage for Outpatient Pre-operative Consultations, 45
 - Denial of Care, 44
 - Denials by Insurers, 43
 - Department of Public Welfare--Explanation of Medical Benefits, 45
 - Diagnostic Imaging Tests by Insurers, 43
 - Differences in Restrictive Formularies, 41
 - Disclosure of Health Care Benefits by Insurers, 42
 - Emergency Room Precertification, 44
 - Employer Medical Coverage, 42
 - Establishment of Payments for the Management of Chronic Medical Conditions, 40
 - Evidence-based Guidelines for Reimbursement for Medical Necessity Decisions, 41
 - Health Care Coverage for Uninsured and Underinsured, 42
 - Health Plan Payment Policies, 40
 - Insurance Coverage of Psychiatric Consultations in Medical-Surgical Hospitals, 40
 - Legality of Fining Physicians, 41
 - Maintenance Medications, 41
 - Mandating Contraceptive Coverage by Pennsylvania Health Insurers, 40
 - Medical Savings Accounts, 43
 - Modification of Waiver of ERISA, 44
 - Non-Sedating Antihistamines, 41
 - Obesity as a Treatable Disorder, 42
 - Physician Phone Appeals for Denied Procedures, 41
 - Precertification Process, 44
 - Psychiatric Insurance Benefit Carve-Outs, 45
 - Reimbursement for HPV Vaccination, 41
 - Timing of Screening Examinations, 42
 - Use of Oral Contraceptives in Non-Contraceptive Medical Conditions, 42
- Health Insurance – Claims Forms and Claims Processing
 - Electronic Billing, 46
 - Electronic Explanation of Benefits, 46
 - Patient Confidentiality by Third-party Payers, 46
 - Release of Medical Record Information to Third-party Payers, 45
 - Use of Interoperable Systems in Deployment of Health Information Technology, 45
- Health Maintenance Organizations
 - Involuntary Assignment to HMO Panels, 46
 - Unfair Business Practice Regarding Inpatient Care, 46
- Health System Reform
 - Access to Quality Health Care, 34
 - Anti-Trust Exemptions for Insurance Companies, 35
 - Any Willing Facility, 37
 - Any Willing Provider, 38
 - Conversions of Non-Profit Health Care Entities, 35
 - Development of General Health Care Plan Policy, 37
 - ERISA Limitations on Utilization Review Accountability, 36
 - ERISA Limitations on Utilization Review Accountability and Physician Liability, 36
 - For-Profit Conversions of Health Care Organizations, 35
 - Health Care Affordability Act of 2010, 33
 - Health Insurance Carriers Canceling Coverage for Thousands of Pennsylvania Patients, 32
 - Health System Reform, 37
 - Managed Competition, 37
 - National Health Insurance Pilot Program, 35
 - Patient Access to Specialty Care in Managed Care Systems, 37
 - Pennsylvania Medical Society's Guiding Principles of Health System Reform, 34
 - Safeguards for Physicians in Health Care Plans, 36
- Health Workforce
 - Enlisting Physicians to Practice in Underserved Areas, 47
 - Improving the Medical Practice Climate in Pennsylvania, 47
 - Physician Population in Pennsylvania, 47
 - Society Support for Family Practice, 47
 - Training of Family Physicians a Concern of Medicine, 47
- Home Health Services
 - Medicare Physician Reimbursement for Home Health Visits, 47
- Hospitals
 - Alleviation of Hospital Overcrowding, 48
 - Hospital Protocols for Patient Transfers, 48
 - Optimizing Hospital and Emergency Department Patient Flow, 48
 - Pennsylvania Act 13 of 2002 (Mcare Act) Enforcement, 48
- Hospitals – Medical Staff
 - Control of Medical Staff Funds, 55
 - Doctors on Governing Boards, 55

- Due Process Rights, 55
- Hospital Imposed Exclusivity Restrictions for Medical Staff Members, 48
- Medical Executive Committee Investigation, 54
- Medical Staff Development Plans, 49
- Model Medical Staff Code of Conduct, 49
- PA Department of Health Position on Verbal Order Regulations, 49
- Preserving Medical Staff Members' Rights, 48
- Review of Hospital Bylaws by Executive Committee, 55
- Hospitals – Medical Staff – Credentialing and Privileges
 - Criteria for Hospital Medical Staff Credentialing, 56
 - Economic Credentialing, 56
 - Effect of Changes in Hospital Character Upon Medical Staff Credentialing, 56
 - Exclusive Contracts, 57
 - Linkage of Academic Privileges and Hospital Privileges, 55
 - Private Physician Health Care Network Relationships, 55
 - Protocol for Hospital Medical Staff Credentials Files, 56
 - Selective Contracting, 56
 - Unfair Discrimination in Medical Staff Application/Selection Process, 55
- Hospitals – Medical Staff – Organization
 - Explicit Medical Staff Bylaws, 59
 - Medical Staff Bylaws, 59
 - Medical Staff Self-Governance, 58
 - Medical Staff Self-Governance and Independence, 57
 - Medical Staffs Participate in Hospital Governance, 58
 - Non-Interference in Hospital Medical Staff Elections, 58
 - Physician Review of Medical Staff Activities, 57
 - Right to Meet in Executive Session, 58
 - Satellite Staff Become Members of Parent Staff, 58
 - The Role of the Hospital Medical Director, 58
 - Updating PAMED Medical Staff Bylaws Handbook (DVD), 57
- Hospitals – Reimbursement
 - Medicare's Ambulance Service Regulations, 59
- International Medical Graduates
 - Clinical Clerkships, 60
 - Discrimination Against International Medical Graduates, 60
 - State Regulations on Moonlighting Privileges for IMGs, 59
- Laboratories
 - Alpha Fetoprotein Testing, 60
 - Pennsylvania State Laboratory Regulations, 60
 - Physicians' Office Laboratories, 60
 - Resident Education in Laboratory Utilization, 60
 - Specimen Handling Fee, 60
- Legislation and Regulation
 - Advanced Cardiac Life Support Training for Nurses, 61
 - Assaults on Physicians, Health Care Providers or Their Staff, 61
 - Equal Taxation for Hospital Clinics, 62
 - Generics, Compulsory, 62
 - Immunity for Obeying State Reporting Requirements, 62
 - Licensing of Physicians Engaged in Practice of Utilization Review, 62
 - Licensure of Mobile LASIK Surgical Centers, 61
 - Mobile Field Tests, 61
 - Occupational Tax Assessment in Commonwealth of Pennsylvania, 62
 - Opposition to Taxation of School Tuition, 61
 - Out-of-State Pharmacies, 61
 - PA Health Law Desk Reference, 62
 - Pennsylvania Secretary of Health, 62
 - Physician Referral and Interpretation, 62
 - Provider-Specific Taxes, 62
 - Quality Health Care Accountability and Protection Act, 62
 - Regulation of Medical Spas, 61
 - Support for Breastfeeding, 61
 - Tanning Parlors, 61
- Licensure and Discipline
 - Competency only Criteria for Licensure, 67
 - Competency Sole Criteria for Licensing, 67
 - Definition of Medical Practice, 65
 - Discrepancies between Medical and Osteopathic Practice Acts, 66
 - Guidelines for Act 66, 66
 - Improve Operations of the State Board of Medicine, 66
 - License Suspension of Impaired Physicians, 66
 - Locum Tenens Physicians, 64
 - Maintenance of Certification (MOC) Program, 63
 - Maintenance of Certification (MOC) Statement of Principles, 63
 - Medical Practice Act, 64
 - Opposition to Maintenance of Certification (MOC), 64
 - Opposition to Maintenance of Licensure (MOL), 64
 - Pennsylvania State Board of Medicine/Department of State – Physician Notification of Complaints, 64
 - Practice of Medicine Remain Under State Board of Medicine, 65
 - Provision of Forensic Medical Services, 65
 - State Licensure of Office Operating Room Facilities, 65
 - Truth-in-Government Request to Bureau of Professional and Occupational Affairs, 64
 - Unification of GME Accreditation Standards, 63
- Long Term Care
 - Long Term Care Patient Co-Pays, 67
 - Mandated Laboratory Testing of Nursing Home Patients, 67
 - Mandated Unnecessary Care for Group Home Residents, 67
 - Mandatory Offering of Pneumococcal Vaccinations, 67
- Managed Care
 - Admitting Officer/Hospitalist Programs, 71
 - Any Willing Provider Provisions and Laws, 73
 - Approaches to Increase Payer Accountability, 73
 - Assisting Physicians in Obtaining Copies of their Annual Contracts, 72
 - Contingent Residency Completion Certificates, 69

- Contract Negotiations with Third-party Payers, 68
- Drug Formularies for Patients in Managed Care, 69
- Educating Physicians on Coping with the Realities of Care, 72
- Entities Representing Themselves as Multi-State Networks, 72
- Insurance Abuses, 68
- Managed Care, 75
- Managed Care Organization Reimbursement Formulas, 70, 72
- Managed Care Organization Termination of Participation, 72
- Mandatory Use of Hospitalists, 71
- Medicaid Managed Care, 77
- Medicare HMO Reviews, 68
- Model Contract, 68
- Most Favored Nation, 72
- National Committee for Quality Assurance Standards and Physician Credentials, 69
- Not for Cause Termination of Physician Contracts, 71
- Physician Credentialing, 68
- Policies Excluding Part-Time Physicians, 72
- Primary and Consultative Care/Physician Credentialing, 71
- Prior Authorization, 68
- Problems with Managed Care Organizations and the Consequences, 70
- Qualification Guidelines for Managed Care Medical Directors, 74
- Qualifications/Credentials of Physicians Involved in Managed Care, 72
- Reimbursement Prior to Completing Credentialing Process, 68
- Self-Deselection, 71
- Statewide Managed Care Legislation, 70
- Sufficient Opinions, 77
- Surgical Pathology in Managed Care, 70
- Termination without Cause Contract Provisions, 71
- Third-party Carrier Notification of Subscribers, 71
- Third-Party Payer Responsibility to Patients, 70
- Timeliness of Credentialing by Managed Care Organizations, 70
- Utilization Review in Global Contracts, 71
- Vertical Divestiture in the Health Care System, 77
- Medicaid
 - Access to Care for Medical/Surgical Subspecialty, 78
 - Adequate Reimbursement for Cervical Cancer Screening, 78
 - Adequately Fund, 79
 - Copayment Plan, 79
 - Early Periodic Screening Diagnosis and Treatment Program, 79
 - Low Physician Fee Schedule Deters Physician Participation, 79
 - Medical Assistance Compensation, 78
 - Parity Between Outpatient Departments and Physicians' Offices, 79
 - Physician Reimbursement, 78
 - Private Sector Administration of Medicaid, 78
 - Provision of Free or Low-Cost Care, 78
 - Reimbursement for High-Risk Deliveries, 78
 - Reimbursement for Observation Care for Pennsylvania Medicaid Patients, 78
 - Unreasonable Medicaid Hospital Denials, 78
- Medical Education
 - Availability of CME at Community Hospitals, 79
 - Health Care Coverage to All Medical Professionals-in-Training, 80
 - Maintaining Resident Education and Training, 79
 - Placement of Medical Students, Residents, and Fellows, 80
- Medical Education – Financing and Support
 - Augment Student Loan Program, 80
 - Loan Forgiveness, 80
 - State Funding of Medical Education and Training, 80
 - State Legislature Financial Support, 80
 - Support for Financial Aid, 80
- Medical Education – Graduate
 - Accreditation of Graduate Medical Education Programs, 81
 - National Residency Match Program Class-Action Lawsuit, 81
 - Parity for International Medical Graduates, 80
 - Resident Physician Working Hours, 81
- Medical Records
 - Electronic Medical Records, 82
 - Limiting Access to Medical Records, 82
 - Mandatory Acceptance of Electronic Medical Record Hold Harmless and Indemnification Clauses, 81
 - Secure Access to Medical Records of Veteran's Administration and Military Service-Related Patients, 81
 - Time Frame for Release of Medical Records, 82
- Medical Review
 - Independent Review of Third-party Payers, 82
 - Physician Oversight, 82
 - Second Opinions, 82
- Medicare
 - Clinic Patients Need Personal Doctor, 86
 - Delay of Implementation of E&M Codes, 85
 - Diagnostic Testing on Medicare Patients, 83
 - Direct Payment to Physicians in all Cases of Assignment, 86
 - Documentation Guidelines for E&M Services, 83
 - Fair Practice in the Medicare Audit Process, 83
 - Marketing of Durable Medical Equipment, 86
 - Medicare Home Health Benefits, 86
 - Medicare PQRI Appeals and Feedback Reporting, 83
 - Medicare Prepayment and Postpayment Audits, 84
 - Physicians Remain Patient Advocates, 85
 - Reimbursement for Concurrent Care, 85
 - Unassigned Medicare Patients in Hospital Clinics, 85
- Medicare – Carrier Review
 - Centers for Medicare and Medicaid Services Oversight of Carriers, 86
 - Medicare and Insurer Codes, 86
- Medicare – PRO
 - Non-Coverage to Medicare Members Discharged from Hospital, 86
- Medicare:, 83
- Mental Health

- Director of Psychiatric Services in General Hospitals, 88
- Health Insurance Coverage of Psychiatric Illness, 87
- Improving Mental Health Services in Primary Care, 87
- Physician Director of Psychiatric Treatment Team, 88
- Physician Responsibility for Psychiatric Treatment, 88
- Physician Staff of State Hospitals, 88
- Psychiatric Bed Shortages within Emergency Departments, 87
- Psychiatric Illness Health Coverage, 87
- Minorities
 - Ethnic and Gender Diversity, 90
 - Healthy Living in Ethnic Communities, 90
 - Minority Medical School Admissions, 90
 - Standardization of Refugee Health Care, 88
 - Statement of Principles for Cultural Competency, 88
- Nurses and Nursing
 - Nursing and Nursing Education, 90
 - Reopen Diploma Schools of Nursing, 90
 - Support for All Levels of Nursing, 90
 - Support Practical Nursing, 90
- Organ Donation and Transplantation
 - Education of Physicians on Donor Programs and Law, 92
 - Feasibility of Utilizing HIV Positive Donors, 92
 - Organ Donation, 92
 - Presumed Consent for Organ Donation, 92
- Peer Review
 - Out-of-State PRO Contracts by KePRO, 92
 - Peer Review, 93
 - Procedural Safeguards, 93
 - Protecting Physicians' Rights to Advocate for Quality Patient Care, 92
 - Reimbursement for Peer Review, 93
 - Statewide Peer Review System, 92
- Physician Payment
 - Accuracy of Coding, 96
 - Adequate Reimbursement for Medical Services in Accidents, 99
 - Americans with Disabilities Act, 98
 - Anti-Trust Exemption for Physicians, 97
 - Antitrust Relief for Physicians, 95
 - Automobile Insurance Reform Act (Act 6), 99
 - Barriers to Health Care, 94
 - Blue Shield Provider Agreements, 98
 - Blue Shield/Blue Cross Cooperation, 99
 - Collective Negotiating with Third-party Payers, 98
 - Contact Capitation, 97
 - Emergency Short Stay Procedure Reimbursement Category, 95
 - Fair Valuation of Physicians' Services, 96
 - Fee Schedules, 97
 - Fragmentation of Professional Fees, 99
 - HMO Establishment of All-Inclusive Reimbursement, 98
 - Hospital Observation Services, 98
 - Insurer Claims Look Back Period, 94
 - Managed Care Organization Reimbursement Formulas, 97
 - Mandating Availability of Fee-for-Service Health Insurance, 97
 - Mandatory Acceptance of All Insurance Company Products, 98
 - Market Dominance by Health Insurance Companies, 96
 - Payer Reimbursement for Emergency Services, 94
 - Payer Transparency, 94
 - Payment for Technical and/or Facility Fees, 99
 - Payment for Telemedicine Services, 94
 - Physician Participation in Third-party Plans, Voluntary, 99
 - Physician Review of Billings and Remittances Made on their Behalf, 98
 - Published Reimbursement Schedules by Private Insurers, 96
 - Reimbursement for Cognitive Services, 99
 - Reimbursement for Extended Time for Patient Care, 95
 - Reimbursement for Immunizations, 95
 - Reimbursement for Mental Health Care, 95
 - Reimbursement Hot Line, 96
 - Reimbursement to Physicians/Other Health Care Providers, 97
 - Retrospective Reimbursement Refund Policy, 97
 - Telemedicine, 94
 - Telephone and Electronic Consultations, 95
 - Telephone Services, 99
 - Third-party Payer Overpayments, 96
 - Third-party Reimbursement for Services Rendered by Physician, 98
 - Under Fair Market Reimbursement, 96
 - Uniformity for Insurance Documentation, 97
 - Workers' Compensation Reform, 99
- Physician Payment - Medicare
 - Active Opposition to DRGs, 100
 - Elimination of Medicare's Punitive Payment Adjustment, 100
 - Medicare Part B Coverage of Tdap, 100
 - Observation Care Codes, 100
 - Oppose Physician DRGs, 101
 - Prompt Payment of Medicare Managed Care Insured Claims, 100
 - Prospective Payment System and DRGs for Physicians, 100
 - Tetanus Vaccine to Medicare Patients, 100
 - Urgent Action to Prevent Medicare Cuts, 100
- Physician Payment - RBRVS
 - Inappropriate Use of Hsaio RBRVS by Third-party Payers, 101
 - Resource Based Relative Value Scale (RBRVS), 101
- Physicians
 - Creation of Reasonable and Economical Assessment Process, 101
 - HIPAA Violations by Law Firms, 101
 - Immunity for Employers Providing References, 102
 - Physician Information on the Internet, 102
 - Primary and Consultative Care, 102
 - Promote MDs and DOs to Singularly use Physician and Surgeon, 101
 - Protecting Patient's Right to Know Who is Treating The, 102
 - Use of Term, Provider, 102

PMS - Administration and Organization

- CME Program, 127
 - Commercial Agreements, 124
 - Demographic Reports on Annual Basis to County Societies, 128
 - Elected Officials and Conflict of Interest, 128
 - Forums, 128
 - Free Choice to Nominate Individuals, 127
 - Full Slate of Alternate Delegates, 129
 - Institute for Good Medicine, 123
 - Legal Action on the Request of an Individual, 128
 - Mainstreaming Underrepresented Physician Groups, 129
 - Nonmembers
 - Price for Society Products/Services, 127
 - Numerical Balance between AMA Delegates and Alternates, 128
 - Pennsylvania Delegation Membership for AMA Speaker/Vice Speaker, 123
 - Physician Referral Directory, 127
 - Physicians' Health Programs (PHP), 129
 - PMSLIC Sale, 124
 - Reporting of DUIs to Physicians' Health Programs, 123
 - Society's Group Health Association Plan, 124
 - Supporting the Development of Medical Student Leaders, 123
 - Ten Year Sunset, 129
 - Voluntary Term Limits for Pennsylvania AMA Delegates, 128
- PAMED - Board of Trustees**
- Chair of AMA Delegates Ex Officio Non-Voting Member, 129
 - Executive Committee to Act for the Board, 129
- PAMED - Councils and Committees**
- Nominations--Councils, Commissions, Committees and Subsidiary Boards, 130
 - Sunsetting Review of Committees, Commissions, and Work Groups, 130
- PAMED - House of Delegates**
- Appendixes to Resolutions, 131
 - Color Coded Name Badge System for PAMPAC Members, 130
 - Conflict of Interest, 131
 - Continued Identification of Authors of Resolutions, 130
 - Inclusion of Map in Official Reports Book, 131
 - Keeping Resolution Authors Informed, 131
 - Policy Regarding Authors of Resolutions Referred for Study, 130
 - Promotion of Resolutions Submitted to House of Delegates, 130
 - Resolution Fiscal Notes, 131
 - Time of House of Delegates Meeting, 131
- PAMED – Membership and Dues**
- County Presidents' Forum, 132
 - Demonstrating the Value of Membership, 132
 - Elimination of Mandatory AMA Membership Requirement, 132
 - Elimination of Society Membership Requirement for PMSLIC Insurance, 133
 - Graduated Dues Discount, 132
 - Individual Member Recruitment Efforts, 132
 - Medical Student Dues, 132
 - Membership Recruitment, 132
 - Membership Terminations, 132

- Osteopathic Physician Members, 133
- PAMED – Political Action**
- Evaluation of Judicial Candidates, 133
 - Membership in PAMPAC, 133
- Preventive Medicine**
- Education, Treatment and Care of Stroke, 102
 - Promotion and Incentivisation of Physician Wellness, 102
- Prisons**
- Prison Health Care, 103
- Professional Liability**
- Abolishment of the CAT Fund, 108
 - Apology Rule, 104
 - CAT Fund Premium and Surcharge, 108
 - Civil Rights Litigation Against Physicians, 106
 - Clarification of Certificate of Merit Rule, 104
 - Collateral Benefits Reform, 109
 - Continued Tort Reform Efforts, 105
 - Coordination of Insurance and Tort Reform Efforts, 106
 - Countersuits to Discourage Frivolous Lawsuit Abuse, 105
 - Countersuits/Non-Meritorious Lawsuits, 104
 - Delinkage of Medical Liability Insurance to Physician Licensure, 104
 - ERISA Malpractice Protection, 106
 - Expert Witness Testimony, 105
 - Immunity from Professional Liability Tort for Volunteer Services, 106
 - Lawsuit Abuse Reform Act, 107
 - Liability Protection for All Uncompensated Care, 104
 - Limitation of Liability, 103
 - Limitation on Awards, Ban Awards for Pain and Suffering, 109
 - Malpractice Insurance for Retired Physicians, 108
 - Mcare Fund, 104
 - Mcare Fund Constitutionality Vote, 103
 - Meaningful Tort Reform, 107
 - Medical Liability Insurance Company Qualifications Standards Reform, 106
 - Medical Liability Premiums, 106
 - More Equitable Rate Structure, 109
 - Out of State Practice of Medicine, 107
 - Physician Practice Rights, 108
 - Physician Volunteers, 104
 - Physicians Donating Time at Non-government Free Clinics, 103
 - Physicians Volunteering Services, 106
 - Privatization of the Malpractice Insurance System, 107
 - Publication of Malpractice Data, 106
 - Refund of Mcare Funds Paid for 2003, 106
 - Sovereign Immunity for Physicians Providing Emergency Care, 105
 - Standards for Lawyers Practicing in Pennsylvania, 104
 - Tort Reform a High Priority, 108
 - Tort Reform Top Priority, 109
 - Tort Reform/CAT Fund Reform 10-Point Action Plan, 108
- Public Health**
- Access to Maternal and Child Health Care, 113
 - Air Pollution Caused by Diesel Trucks, 110
 - Antibiotic Resistance Surveillance Network, 112

- Automated External Defibrillators in Extended Care Facilities, 109
- Battling Obesity, 109
- Diabetes Awareness, 111
- Diabetes Management in Schools, 109
- Diesel Exhaust Emissions, 111
- Disclosure of Digitally Altered Advertisements, 110
- Elimination of Stigma Associated with Suicidal Behavior, 111
- Establishment of Immunization Program in all Pennsylvania Colleges and Universities, 112
- Existing and Future Patient Safety Systems, 111
- Health Impact of High Fructose Syrup, 110
- Healthy Choices in Hospital Cafeterias, 110
- Healthy Living Initiatives, 111
- Hydraulic Fracking, 109
- Hypertension, 113
- Legal Protection, Mass Immunization, 113
- Mandatory Fluoridation of Municipal Water Supply, 110
- Obesity Awareness, 111
- Patient Concerns and Interests, 111
- Physical Activity Standard for Children, 111
- Promotion of HPV Vaccine, 110
- Public Cord Blood Donations, 110
- Rabies Prophylaxis, 113
- Regulation of Tattooing and Body Piercing, 112
- Replacement of Powdered Latex Gloves, 112
- Review of Public Health Infrastructure Deficiencies in Pennsylvania, 110
- Safe Treatment of Head Lice Infestation, 110
- Standards for Blood Donors, 112
- Suicide Prevention, 112
- Support of Suicide Prevention Efforts, 111
- Unwanted Pregnancies, 112
- Public Relations
 - Community Committees, 113
 - Public Education Materials in Physicians' Offices, 113
- Quality of Care
 - Claims Based Data as a Flawed Quality of Care Measure, 113
 - Equal Treatment for Public and Private Sectors, 114
 - Interference with Professional Judgment of Physician, 114
 - National Committee on Quality Assurance Survey of Plans, 114
 - Physician Involvement in Healthcare Quality Issues, 114
 - Practice Parameters, 114
 - Preventing Contract Language Limiting a Physician's Ability to Advocate for Quality Patient Care, 114
 - Release of Practice Specific Information, 114
- Radiation and Radiology
 - Safety Guidelines for Mammography Endorsed, 115
- Research
 - Human Stem Cell Research, 115
 - Use of Animals in Research, 115
- Sports and Physical Fitness
 - Certified Trainers in School Programs, 116
 - Scholastic Coaches, 116
- Surgery
 - Definition of Surgery, 116
 - Surgical Assistants, 116
- Technology
 - Electromyography as the Practice of Medicine, 116
 - Improving Medical Practice through Information Availability, 118
 - Information Technology Assistance for Members' Practices, 117
 - Telemedicine, 118
 - Telemedicine/Telehealth, 117
- Tobacco
 - Anti-Tobacco Ordinances, 120
 - Ban Distribution of Cigarettes and Smokeless Tobacco, 120
 - Ban on Smoking in Hospitals, 120
 - Cigar Smoking/Chewing Tobacco, 118
 - Electronic Cigarettes, 118
 - Reclassification of Tobacco as a Prescription Drug, 120
 - Report of Advisory Committee on Tobacco Policy and Public Health, 119
 - Smoking Cessation, 118
 - Statewide Tobacco Legislation Regarding Minors, 118
 - Tobacco and Smoking, 120
 - Tobacco Related Legislation, 120
- Tobacco – Labeling and Warnings
 - Physicians as Role Models, 121
 - Reimbursement to Physicians and Psychologists who Provide Smoking Cessation, 121
 - Smoking, 121
 - Smoking Cessation, 120
- Tobacco – Marketing and Promotion
 - Banning Tobacco Advertising from Physicians' Offices, 121
 - E-Cigarette Advertising and Paid Products Placement, 121
 - Objections to Glamorizing Use of Tobacco Products, 121
 - Total Ban on Tobacco Advertising, 121
- Tobacco – Prohibitions on Sale and Use
 - Ban Smoking in Public Places and Workplaces, 122
 - Legislation to Eliminate Smoking in Public Places, 122
 - Sale of Cigarettes in Pharmacies, 122
- War
 - De-alerting/Abolition of Nuclear Weapons, 122
 - Persian Gulf War Veterans, 122
 - Vietnam Women's Memorial, 123